Children's Hospital Discharge Home Policy

For Children and Young People Leaving Hospital

Approved By:	Policy & Guideline Committee
Date of Original Approval:	17 September 2021
Trust Reference:	B35/2021
Version:	1
Supersedes:	V7 (Discharge and Transfer Care (Going Home Policy) for Adults Children and Young People UHL Policy – June 2019
Trust Lead:	Anna Duke Head of Nursing
Board Director Lead:	Carolyn Fox, Chief Nurse
Date of Latest Approval	17 September 2021
Next Review Date:	**September 2023**

Contents

Review dates and details of changes made during the review

April 2021. V7 (Discharge and Transfer Care (Going Home Policy) for Adults Children and Young People UHL Policy – June 2019 has been reviewed and a stand-alone. Childrens and Young person's policy has been developed for the Children's Hospital

Key words
Discharge ,Transfer of Care, Estimated Date of Discharge, Criteria led discharge

1. Introduction and Overview

1.1 This policy describes best practice guidelines for all University Hospitals of Leicester (UHL) staff who are discharging a Child or Young Person from UHL Children's Hospital.

1.2 This policy has been developed to ensure:

a) All families experience well organised, safe and timely discharge from hospital.
b) Patients, carers and staff are supported to set realistic expectations of hospital stays.
c) Patients, carers and families are prepared, physically and psychologically for discharge.
d) There is effective and timely involvement of and communication with patients, carers and family in discharge planning.
e) There is effective and efficient use of the hospitals inpatient bed capacity by reducing unnecessary delays in discharge.
f) That discharge planning commences prior to, or immediately on admission to hospital and continues throughout the patient's acute hospital admission.
g) That unplanned re-admissions do not occur as a result of poor discharge planning.

1.3 Planning for discharge should start as early as possible in the patient's journey. Where a patient is known to require ongoing healthcare after discharge, this planning should start before admission. Where pre-operative assessment is in place, discharge planning should start at pre-assessment. For all other patients, discharge planning should start on admission.

1.4 The decision to discharge a child or young person is a clinical one, but planning should involve children and young people and their families. They should be involved at every stage of the planning process, and referrals to other services should be made early to ensure discharge can be planned. Early planning will reduce stress for the child and family and reduce fragmentation of care. Effective discharge planning involves a multi-disciplinary approach where the child has ongoing health care needs.

1.5 Children or young people who require continuing support from other health or social care agencies should not be discharged in the evenings, at weekends or during bank holidays without prior consultation with involved agencies, if a need or potential need for intervention is perceived prior to the next working day. Children and young people may be discharged at these times at the discretion of the consultant, provided agreement has been reached that the family are able to provide adequate support. This must be documented in the nursing and medical records.

2 POLICY SCOPE

2.1 This policy applies to all staff who work with children employed within the University Hospitals of Leicester NHS Trust, those staff working in a contracted capacity, and staff contracted with partner agencies or NHS Trusts and working within UHL.

2.2 This policy applies to all Children and Young People being discharged from inpatient care in UHL.

2.3 This policy applies to the discharge of Children and Young People from the Trust to their own home or a place of safety. This policy does not cover inter-ward or inter-hospital transfer of Children and Young People (refer to section 9.3)

2.4 This policy does not apply to patients attending as out-patients to out-patients areas.

2.5 Patients who have remained in hospital for 3 months or longer will be subject to Section 85 of the Children Act 2004. The Trust has a responsibility to notify social services in these circumstances, and when the patient is discharged to another health provider.

2.6 Internal transfer of patients should follow the procedure laid out in the Trust Policy (ref: C101/2016 and C100/2016)

2.7 External transfer of patients should follow the procedure laid out in the Trust Policy (ref: C249/2016 and C175/2016)

3 DEFINITIONS AND ABBREVIATIONS

3.1 Discharge
This is the process where the patient transfers from hospital care to home. This may be associated with the end of treatment or may involve home care (either self-care or provided by community staff.)

3.2 Estimated Discharge Date (EDD)
The date a patient is estimated to be medically optimised for Discharge Home

3.3 Criteria Led
Discharge may be Criteria led following completion of the relevant competency package for identified patient groups.

3.4 The Allocated Nurse
This is the in-patient nurse with allocated responsibility for a patient, either during a specific shift or with ongoing responsibilities for coordination of care over a number of shifts.

3.5 The Medical Team
The team of medical staff, led by a consultant but consisting of middle grade and junior doctors.

3.6 Complex Patients
Examples of complex patients who may require discharge planning meetings include those:

- With life threatening/life limiting conditions e.g. technology dependant, tracheostomy, and oncology patients
- Requiring specialist equipment for home use such as enteral/TPN feeding, home oxygen, and suction
- With special needs e.g. Neuro-disability
- With long term rehabilitation needs e.g. neurological conditions/post head injury
- Patients who are receiving care from multiple teams specialities including safeguarding and multi-agency involvement.

3.7 Multi Disciplinary Team (MDT)

A team of staff from a range of disciplines who work collaboratively for the best interests of the patient.

3.8 Out of Hours

A discharge that occurs after 17:00 weekdays or at the weekend and Bank Holidays.

3.9 Patient

The term 'Patient' relates to Children and Young People.

3.10 Family / Carer

'Family /Carer' relates to those persons identified legally as next of kin, they may be a Parent, have Parental Responsibility or be the identified person whom that acts on their behalf in and their best interests.

4 Roles and Responsibilities

4.1 **The Medical Director and Chief Nurse** have overall responsibility for the quality of medical and nursing intervention to support the policy.

4.2 **The Chief Operating Officer** has overall responsibility for ensuring that there are effective arrangements for discharge and transfer of care planning within the trust.

4.3 It is the responsibility of the **Consultant** to ensure that:

a) All patients in his/her care have an EDD within 24 hours of admission to hospital and that this is discussed with the patient and family/ carer and is reviewed daily in line with the Red2Green bed days approach and recorded on nerve centre.

b) The EDD is the date that the MDT predict that the patient will meet specific clinical criteria to enable them to be discharged and highlights when support will be required to facilitate discharge at the earliest opportunity.

c) Board/ward rounds occur every day, to identify patients who are ready for discharge. Patients potentially ready for discharge should be reviewed as early in the day as is consistent with clinical priorities (i.e. at the beginning of the board/ward rounds wherever possible, sickest patients first then potential discharges, then new patient and then the ward round of remaining patients).

d) The frequency of individual patient discharge reviews reflects the clinical condition of the patient and the nature of the discharge plans.

e) To Take Out (TTO) prescriptions for discharge are written at least 24 hours before discharge or as soon as practicable when discharge is confirmed with less than 24 hours' notice.

f) Plans are put in place to identify patients who may be ready for discharge at weekends and bank holidays when board/ward rounds may not be routine. Consideration should be given to delegated Nurse/ Criteria led discharge. For further details please refer to the Trust's policy (ref:C20/2019)

g) The Consultant and MDT have responsibility for agreeing the patient is ready for discharge and that this is recorded in the medical notes as 'medically optimised for

discharge/ medically suitable/ medically stable for discharge' This is a statutory requirement under the Care Act 2014.

h) Keeping the patient and parent /carers fully informed of their progress and treatment in order to progress assessment needs.

i) Complete an electronic discharge summary for each patient prior to the EDD using the Trust's electronic system (currently ICE).

4.4 **The Heads of Nursing, Deputy Heads of Nursing and Matrons** are responsible for ensuring compliance with this policy, supporting audit, reviewing results and implementing change where appropriate. Delays in discharge should be monitored and escalated for support and if necessary improvements made to the process, if delays for failing to meet the EDD are due to non-clinical reasons.

4.5 **The Ward Sister/Charge nurse** has responsibility for ensuring that systems are in place to facilitate a safe, timely discharge for all patients Discharge needs to be coordinated through a multidisciplinary approach by the Ward Sister/Charge nurse or their deputy, to enable discharge by the EDD. The sister/ charge nurse should ensure that standards of discharge planning are maintained and that staff report any examples of non-adherence to the policy through the hospital adverse events datix reporting system.

a) Ensuring that the nerve centre board round profile is completed and kept up to date.

b) Ensuring that all patients have an EDD recorded in their notes, detailed on nerve centre and that this date has been communicated to the patient, relatives/carer, as appropriate.

c) All information relating to the discharge is recorded on the board round profile on nerve centre.

d) Ensuring that systems are in place so that patient discharge is co-ordinated and progresses according to plan.

e) Jointly work with the Medical Team to ensure review of patients at daily Board Rounds and later in the day follow up of actions in line with Red2Green principles.

f) Ensuring that information required to plan and manage patient discharges is gathered, and recorded accurately, especially in respect of conversations with the patient, their family and/or carers: including the date and times of those conversations.

g) Continuously monitoring the discharge progress of all patients, ensure positive action is taken to expedite discharges for those who are fit to leave an acute bed and have exceeded their EDD.

h) Any delays to patient progress (diagnostics, tertiary opinion, referrals) to be reviewed and escalated through Matron or General Manager.

i) Ensuring discharge notifications are submitted in a timely way through the ICE system.

4.6 **The Registered Nurse / Allocated Nurse** is responsible for ensuring:

a) Discharge planning commences within 24 hours of admission and that progress is

appropriate to achieve the EDD.

b) Discharge notifications are submitted on ICE in a timely way.

c) The patient and relatives / carers are fully involved in the discharge planning process, their needs and wishes are taken into account and they have at least 24 hours notice of the discharge date, whenever possible.

d) In the absence of the Senior Nurse /Nurse in Charge jointly work with the Medical Team to ensure review of patients at daily Board Rounds and later in the day follow up of actions.

e) All information relating to the patients discharge is recorded on the patients discharge care plan and on nerve centre.

f) The patient's medication is ordered 24 hours before the discharge for known next day discharges.

g) Transport should only be provided for discharge when there are no family or friends to transport the patient / family and has been authorised by the Bleep Holder / Matron.

h) The patient has the necessary medication, dressings (as commissioned) and relevant information about post discharge care.

i) All arrangements and referrals in relation to discharge planning are clearly documented, signed and dated within the discharge planning documentation.

j) Any potential delays in discharge are referred immediately to the Bed Co-ordinator as soon as they become known outlining the reasons for the delay or potential delay.

k) All necessary information for discharge/transfer of care and management is gathered, recorded and communicated appropriately.

4.7 **All members of the MDT** have the responsibility to ensure patients their families and carers are consulted and regularly updated about discharge planning from admission (or preadmission when patients are attending pre-assessment clinics prior to admission); throughout inpatient stay and up until 30 days post discharge.

4.8 **The Ward Clerk** is responsible for working in support of the MDT and for arranging outpatient's appointments and ensuring the recording of timely and accurate discharge time within the patient record and the electronic patient information systems.

4.9 **The Allied Health Professionals** (OT, Physio, and other allied groups) provide holistic functional patient assessment and consider equipment or adaptations. They will liaise with patients and parents/ carers and the MDT within UHL and externally to enable the needs of the patient to be met.

4.10 **Pharmacy staff** are responsible for timely preparation of discharge medication and ensuring medicines are returned to the appropriate ward.

Where the patient has been using their own medication on the ward, this may form part of the dispensed prescription, at the pharmacist's discretion. If the parent / carer states that they have adequate supplies of the patient's regular medication at home, it may not be necessary to issue further supplies. If the patient has brought in medication that they no longer require it should be returned to pharmacy for disposal, with permission of the patient/parents/carers.
It is a legal requirement that medicines taken out of the hospital must

- Be in containers fitted with child-resistant closures.
- Labels on medicines must always reflect the current dosage instructions.
- Where the patient's own medication is returned to them on discharge, labels must be amended by the hospital pharmacy to reflect any changes in dosage.

4.11 **The Bed Co-ordinator Team** manage the daily flow of patients into and out of the Trust and promote/initiate the use of appropriate services and schemes to enable safe and early transition to home. They will maintain and communicate accurate information on bed status and liaise with clinical staff to support an overview and understanding of pressures within the service to inform operational and clinical decision making processes.

5 Policy Implementation

5.1 Discharge Planning on Admission

5.1.1 The admitting nurse should initiate and document the discharge planning process on admission. Where admission is planned and a patient is known to have ongoing healthcare needs, discharge planning should start before admission, this includes liaising with partner agencies to ensure the safety and welfare of the child is considered

5.1.2 The patient and parent / carer should be involved at every stage of the discharge planning process, and referrals to other services should be made early to ensure discharge can be planned.

5.1.3 Effective communication with the patient, parent/carer and other agencies involved with the patient is essential to achieving a smooth transition from hospital to home.

5.1.4 <u>EDD</u>
An EDD should be given, wherever possible, and recorded on Nerve Centre by the admitting nurse. This should be explained to the patient and parent/carer, and reviewed on a daily basis. Where there is an allocated social worker they should also be notified of the proposed discharge date

5.1.5 <u>Transport</u>
Transport home should be discussed as part of the admission process. It is the responsibility of the parent/carer to arrange their own transport, unless there is a medical need for other arrangements.

5.1.6 Social Issues

Consideration of any social issues likely to impact on discharge should be discussed with the parent/carer and safeguarding on admission, in order to plan for expected date of discharge.

5.1.7 Language

Any translation or language needs should have been identified prior to any planned admission. Action should be taken on admission to address any identified needs as far as is reasonably possible.

5.1.8 Suspicion of Deliberate Harm

If a patient is admitted and deliberate harm is suspected, information should be obtained about previous admissions to this or other hospitals. No patient with deliberate harm concerns should be discharged from hospital without a Safe Discharge Meeting. Responsibility for ensuring this rests with the hospital consultant under whose care the patient has been admitted. The Children's Safeguarding team can be contacted for advice and support

5.2 Discharge of Patients without Continuing Healthcare Needs

5.2.1 All discharges must include:

- Discharge summary to the GP, completed electronically in ICE, as part of the discharge process

- Referral to health visitor / school nurse / community midwife team as appropriate
    - Parent / carer must be informed about the referral
    - Health Visitor/ School Nurse to receive ICE notification of discharge
    - Community midwife referrals via telephone

- Take home medication and / or consumables supplied (if prescribed):
    - Medication supplied (minimum 3 day supply)
    - Consumables / Equipment supplied (minimum 3 days)
    - Prescription checked:
        - Name checked against discharge prescription
        - Correct medication supplied against prescription
        - Parent /carer understands label directions
        - Parent /carer is aware of when each medication was last given and when it is due.

- Copy of ICE discharge notification letter and appropriate information given, in writing, where available, for patient, and parents /carers about:
    - Any likely after effects and follow on treatment
    - Information about medication, including safe storage and side effects
    - What to do if the patient's condition deteriorates
    - Point of contact in case of difficulty
    - Arrangements for follow-up

- Written information should be explained to the parent/carer and any questions answered.
    - Documentation of the information given to the parent/carer (e.g. patient information leaflet) should be documented
    - Any translation or language needs should be reflected in the information provided on discharge.

- Follow-up appointment details (if required):
    - Parent / carer informed that appointment will be sent by post

- Community referral (if required):
    - Online referral to Diana Team / appropriate community children's nursing team specifying the service required (eg wound check)
    - Referral should specify the diagnosis, intervention required, timescale or date for intervention to be delivered, and any other relevant medical or social issues to be considered.

- Discharge from Patient Centre and Bed Board updated

- Criteria Led Discharge
    - Criteria Led discharge can be undertaken by nursing staff, once the relevant competency package has been completed. There are both medical and surgicalCriteria Led discharge competencies.
    - This process aids effective, timely and safe discharge of certain identified patient groups as outlined in the different protocols as agreed with medical staff.
    - Refer to trust policy C20/2019

5.3 Discharge of Patients with Complex Ongoing Healthcare Needs

5.3.1 Where there is a more complex hospital episode and / or the patient has ongoing health care needs (eg long term illness, disability or life limiting conditions), discharge planning must start early.

5.3.2 For all patients with complex ongoing health needs, in addition to the requirements in Section 5.2 (above), appropriate consideration must also be given to:

- Ensure that a complete and accurate ICE discharge summary is available for the parent/carer to receive on discharge
- Social Services contact and follow-up arrangements
- Primary Care contact and follow-up arrangements
- Community Children's Nursing / Allied Health Professional contact and follow-up arrangements. (The ward needs to be aware of the roles of these groups, their referral processes and the information they require, prior to discharge, to support patients who are discharged with additional needs)
- Community Paediatrician contact details and follow-up
- Ongoing hospital contact and follow-up arrangements
- Equipment needs

- Parent / carer's proficiency in managing their child's condition and associated needs.
- Parents / Carer's training needs
- Educational needs
- Specific transport needs
- Home environment / adaptation needs
- Notification to the school nurse or health visitor

5.3.3 Multi-agency meetings will be arranged, and should involve professionals from both the hospital and community setting (where appropriate). The patient's parent / carer should be invited to attend the meeting and minutes should be taken. Community services should be updated on a regular basis.
Services that should be considered include:

- Housing
- Social workers
- Therapists
- Dietician
- CCG Management
- Consultants
- Community nurses
- Secondary (DGH) Health Care
- GP
- Education

5.3.4 Ward staff should ensure that parents/ carers are adequately trained in the care of their child before discharge. This applies to the administration of medicine in addition to the management of any equipment.

5.3.5 Where there is a need for care packages to be put in place for the patient's discharge, ward nursing teams should work in partnership with community services to support training of carers.

5.4 Delayed Discharges due to Social Issues

5.4.1 If a patient is medically optimised for discharge, but their discharge is significantly delayed awaiting provision of social care services, the following steps should be taken:
The named consultant should record in the case notes and nerve centre that the patient is medically fit for discharge.

5.4.2 Inform the patient's social worker that the patient is fit for discharge and record in the medical noes that the delayed discharge has been escalated to the social worker team.

5.4.3 Inform the Bed Co-ordinator, Matron and General Manager in the first instance. Ensure the Children's Safeguarding team are notified

5.5 Discharge of Children and Young People in Special Circumstances

5.5.1 In addition to the requirements in Sections 5 (above), further requirements apply to children and young people in specific circumstances.

5.5.2 Child Protection Concerns

Where there are concerns about possible child protection issues, the Safeguarding Nursing Team must be informed of all discharge plans and a multi-agency safe discharge meeting must be agreed and recorded before the patient leaves hospital.

Any legal orders arising from the admission should be recorded (with copies filed if available).

The patient must be registered with a GP before discharge

No patient can be discharged without permission of the responsible consultant paediatrician. This can only be given once a clear, agreed action plan is in place and confirmation that the patient is being discharged to a place of safety.

So far as possible, all investigations should be completed before discharge, even if the patient is deemed medically optimised, with clearly documented plans in place for any remaining investigations or follow-up.

If a p[atient has been treated at another hospital, medical information should be sought from previous NHS Trusts before discharge where a patient is admitted with an ongoing medical problem, or is recognised as ‘at risk of harm’.

Follow-up plans for all agencies must be clearly documented in the health record, taking appropriate care to protect confidentiality.

The Safeguarding Nursing Team should be contacted for further advice. If there are urgent concerns out of hours, contact the Child Protection Doctor on call for the Trust.

5.5.3 Palliative Care Needs

Patients with palliative care needs must have an identified professional to co-ordinate an appropriate support network within the home setting. They require a written plan of treatment and intervention, details of which have been agreed with the family and shared with community teams prior to discharge.

5.5.4 Discharge of Patients with Mental Health Issues

Where a patient has an identified mental health need, arrangements must be made for follow-up by Child and Adolescent Mental Health Services (CAMHS). Where this is not thought to be necessary, the reasons for this decision need to be agreed with the patient’s consultant and documented in the medical notes.

5.6 Discharges Against Medical Advice

5.6.1 If a parent/carer chooses to discharge their child against medical advice, staff must discuss this with the parent/carer, establishing their reasons and explaining the potential risks to their child's health. All discussions must be clearly documented in the patient's medical notes.

5.6.2 If the parent/carer still requests discharge, the appropriate doctor must be contacted immediately in order to review the patient, and explain any associated risks, and potential outcomes, to the parent/carer of a discharge against medical advice.

5.6.3 If the parent/carer is not deterred, the impact on the patient's welfare must be assessed by nursing and medical staff, and safeguarding procedures must be followed if leaving the hospital would place the patient at significant risk of harm. Safeguarding procedures must also be followed if the patient is subject to a child protection plan or is a child in care.

5.6.4 If the patient is removed against medical advice and there are significant safeguarding concerns, the Trust security department must be contacted to assist, and an immediate referral to Children's Social Care must be made. Staff must not place themselves at risk in trying to prevent the parent/carer leaving with the patient.

5.6.5 If there are no safeguarding concerns, and the patient will not be at significant risk of harm following discharge, the parent/carer's decision to take their child against medical advice must be fully documented in the patient's medical notes. The parent/carer must be advised to contact their GP practice for ongoing care. If possible, normal discharge procedures must be followed with regard to giving advice, arranging medication etc. Wherever clinically indicated, appropriate out-patient follow-up arrangements must still be offered / made when a patient or parent/carer discharges against medical advice.

5.6.6 A patient assessed as having capacity to understand the consequences of taking their own discharge against medical advice may wish to take their own discharge. In this case, staff must try to dissuade the patient from doing so. If this is unsuccessful, the patient's parent/carer must be notified and the patient's decision to take their own discharge against medical advice must be fully documented in the medical notes. They must be advised that other relevant professionals (eg GP, Social Worker, School Nurse) will be informed of their decision.

5.6.7 Without exception, the patient's GP and Health Visitor / School Nurse and any other key professionals involved in the patient's care must be informed at the earliest opportunity, preferably within 24 hours, that the patient has left / been removed from the ward.

5.6.8 If a parent/carer expresses that they wish to discharge their child due to a complaint or concern about care, every effort must be made to address and resolve the complaint / concern with reference to the Trust Complaints Policy, to enable care to continue.

5.7 Patients who Refuse Discharge

5.7.1 On occasion's parent /carer's of a patient optimised for discharge, may refuse to leave hospital. In these circumstances the person refusing should be evaluated by the doctor to establish medical/psych/social basis for that patient's refusal. If no resolution from the MDT involve the Trust Legal team.

5.8 Key Services in Discharge Planning

5.8.1 **Health Visitor & School Nurse Service**

The Children's Liaison Service provide essential communication between hospital and the patient's health visitor or school nurse when a patient attends the Accident & Emergency department and/or is admitted and discharged from hospital. This enables the relevant health professional to be involved in multidisciplinary planning, with statutory and voluntary agencies, alongside other health professionals, as well as enabling them to provide appropriate support and advice to the patient and parent/carer when the patient is an inpatient and on discharge.

The Children's' Liaison Service also communicates with Safeguarding Children Specialist Nurse and Looked After Children's Nurses locally as well as the rest of the country when necessary.

- All pre-school children will have a Health Visitor contact
- All school age children attending school will have a School Nurse contact C9 - Discharge Planning Policy
- For School age children **not** attending school, a referral should still be made to the School Nurse Liaison

5.8.2 **Safeguarding Children (Child Protection)**

For safeguarding children concerns and suspected non-accidental injury the Safeguarding Policy, and associated procedures, outline action to be taken.

5.8.3 **Diana Children's Community Nursing Team**

The team provide acute and chronic nursing care to children and young people within their own home as an alternative to hospital inpatient stay.

They are able to provide resources and equipment for children and families.

The team have direct involvement with the child and family, assisting parents to care for their child. The team are a readily accessible source of support, information and advice for families. The team communicates closely with the multidisciplinary team, including GP's, Health Visitors, School Nurses, Social Workers, Medical team, Nurses, Nurse Specialists, Pharmacy and Pathology staff, in order to share information and ensure a smooth transition between hospital and community.

The team provide a safe and effective service, which promotes the well being of the family, empowers carers and supports the philosophy of family centred care.

This is a nurse led service managing the patient's episode from admission to discharge from the service.
.
The team provide a 7 days a week service.

Contact details: 0116 2955080

Referrals can be made online:
https://www.leicspart.nhs.uk/services/referrals/?v=12930

5.8.4 **The Home Enteral Nutrition Service (HENS)**

A team of Specialist Dieticians, a Dietetic Assistant Practitioner, Dietetic Support Workers and Administration Assistants, who work with patients who have feeding tubes in the community.

The HENS team provide support with feeding plans, feeding tubes and equipment and any problems with feeding.

Contactable weekdays 08:30-16:30 0116 2227161

5.8.5 **Physiotherapy / Occupational Therapy services**

Children's Community Physiotherapy Service is provided for children and young people with disorders or delays in their movement skills who will benefit from physiotherapy. Physiotherapy helps to develop (or re-gain) movement abilities and prevent or minimise long-term problems and can be summarised as the 'medicine for movement'.
They see children with:
Developmental disorders or delays in their movement and gross motor skills

- Neurological deficit
- Acquired neurology
- Neuromuscular deficit
- Complex special needs that includes neurodevelopmental delay with complex physical disability equivalent to GMFSC III to V in CP
-

Diana Children's Community Paediatric Physiotherapist Services see children who require respiratory Physiotherapy in the community.

The Children's Community Occupational Therapy team works with children from birth to age 16 (up to 19 years in statutory education) who have difficulty participating in everyday activities because of physical disability or a medical condition to live more productive and enjoyable lives.
They see children with:

- Complex physical needs (birth trauma, genetic disorder, acquired and congenital disorder autistic spectrum disorders)
- Neuromuscular conditions
- Acquired conditions
- DCD / Dyspraxia / ADHD

- Developmental delay
- Environmental circumstances

5.8.6 Child and Adolescent Mental Health Services (CAMHS)

CAMHS helps children and young people who have been referred by another healthcare professional. Referrals are made if it is thought a young person has significant mental health difficulties with a moderate to severe impact on functioning, which requires specialist mental health support:

- Depression (Moderate to Severe)
- Anxiety, Phobia, Panic (moderate to severe) Disorders
- Obsessive Compulsive Disorder
- Post-Traumatic Stress Disorder
- Eating Disorders (Eating Disorder Team)
- Psychosis
- Self-Harm associated with any of the above presentations
- Diagnostic assessment and management of ADHD and associated comorbidities in children and young people aged 11years and above
- Diagnostic assessment and management of Autism and associated comorbidities
- School refusal or severe behavioural difficulties or significant attachment difficulties ONLY where there are significant co-morbid mental health difficulties as listed above

6 EDUCATION AND TRAINING REQUIREMENTS

6.1 UHL is committed to raising awareness of effective discharge planning by the provision of discharge training for all staff within the Trust and partner agencies.

6.2 Ward Sisters, Matrons, Heads and Deputy Heads of Nursing, CMG Heads of Operations, Consultants and Clinical Directors will ensure that all staff have access to training and education through HELM and the CMG to maintain up to date knowledge of local and national policies relating to discharge planning.

7 PROCESS FOR MONITORING COMPLIANCE

7.1 To understand if a discharge or transfer of care is safe, timely and effective the following key performance metrics/indicators will be monitored:

a) Evidence of a discharge care plan; including EDD, patient/ carer awareness.

b) Completion of discharge / transfer of care letter/TTO.

c) Readmission rates within the first 7 days of discharge.

d) Datix incidents relating to discharge

e) Complaint trends and themes where discharge is the key theme.

f) Patient satisfaction in relation to the specific national patient experience questions in relation to discharge.

8 EQUALITY IMPACT ASSESSMENT

8.1 The Trust recognises the diversity of the local community it serves. Our aim therefore is to provide a safe environment free from discrimination and treat all individuals fairly with dignity and appropriately according to their needs.

8.2 As part of its development, this policy and its impact on equality have been reviewed and no detriment was identified.

9. SUPPORTING REFERENCES, EVIDENCE BASE AND RELATED POLICIES

9.1 This document has been developed in conjunction with hospital staff, local LLR Health and social care partners.

9.2 The documents listed below have been used in the formulation of this policy:

a) National Framework for Children and Young Peoples Continuing Care (DH 2010)
b) Children and Families Act (2014)
c) The Children Act (2004)
d) Working Together to Safeguard Children: A Guide to inter-agency working to safeguard and promote the welfare of children. (2018)
e) Health and Social Care Act (2012)
f) The Care Act (2014)
g) NHS Improvement 'A brief guide to developing Criteria led discharge' (2017)
h) A report of investigations into unsafe discharge form hospital. Parliamentary & Health Ombudsman. May 2016. www.ombudsman.org.uk
i) NHS Commitment to carers (NHS England 2014) http: //www.england.nhs.uk/ourwork/pe/commitment-to-carers/

9.3 Related policies

a) Children's Hospital Escalation (ref: C7/2019)
b) Criteria Led Discharge (ref: C20/2019)
c) Transfer of a Child Requiring Specialist Escort to Another Hospital (ref: C249/2016)
d) Transfer of a Child to Another Hospital Requiring a Escort (ref: C175/2016)
e) Transfer of a Child or Young Person Requiring Specialist Escort within the Hospital (ref: C101/2016)
f) Transfer of a Child who Requires an Escort to Another Ward (ref: C100/2016)

10 PROCESS FOR VERSION CONTROL, DOCUMENT ARCHIVING AND REVIEW

10.1 This document will be reviewed and updated every three years, or sooner in response to any identified patient care issues or risks.

10.2 The updated version of the Policy will then be uploaded and available through INsite Documents and the Trust's externally-accessible Freedom of Information publication scheme. It will be archived through the Trusts PAGL system

.