Leicestershire Partnership NHS Trust

Discharge/Transfer of Care of Children and Young People Policy
Families, Young People and Children's Services Directorate

The purpose of this policy is to ensure there is evidence based practice and sound underpinning decision making relating to the discharge or transfer of care from Families, Young People and Children's (FYPC) services within LPT

Key Words:	Discharge/transfer children	
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Adopted by:	QAC	
Date Adopted	21/6/16	
Name of Author:	Anne Mensforth	
Name of responsible Committee:	Patient Safety Group	
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Expiry date:	1 July 2021	
Target audience:	All clinical staff	
Type of Policy	Clinical ✓	Non Clinical
Which Relevant CQC Fundamental Standards?	Regulation 9 and 12	

Contents

Version Control and Summary of Changes

Version number	Date	Comments (description change and amendments)
1	06.07.2012	Original CCHS and LCR policies combined and out into new format., verbal comments gathered at Clinical Governance (24/09/2012)re DNA section
1.1	26/09/2012	2nd draft based on comments received from those listed in circulation list and safeguarding
1.2	24/10/2012	Final draft checked and presented to clinical governance. Amended to reflect final few comments
2	8.2.2016	Policy reviewed and updated following consultation, to update definitions and reflect comments. Key changes: - Cancellation 'on the day' no longer constitutes a DNA - Clinically appropriate timescale for post discharge communication agreed

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Equality Statement
Leicestershire Partnership NHS Trust (LPT) aims to design and implement policy documents that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others.

It takes into account the provisions of the Equality Act 2010 and promotes equal opportunities for all.

This document has been assessed to ensure that no one receives less favourable treatment on the protected characteristics of their age, disability, sex (gender), gender reassignment, sexual orientation, marriage and civil partnership, race, religion or belief, pregnancy and maternity.

In carrying out its functions, LPT must have due regard to the different needs of different protected equality groups in their area. This applies to all the activities for which LPT is responsible, including policy development and review.

Due Regard

LPT must have **due regard** to the aims of eliminating discrimination and promoting equality when policies are being developed. Information about due regard can be found on the Equality page on e-source and/or by contacting the LPT Equalities Team.

The Due regard assessment – see Appendix 4 of this document

Definitions that apply to this Policy

FYPC	Families, Young People and Children's Services
Discharge	Discharge is the end of an episode of care or the lack of engagement of the person with legal responsibility for the child with the service offered. In some cases some services will not have commenced. At the point of discharge the responsibility of the professional and service providing that care ends.
Was Not Brought	Children and young people who do not attend appointments and are dependent on others bringing them should be classed as 'Was Not Brought'. For statistical purposes this still classes as a DNA but ensures the safeguarding aspects are considered
Transfer of Care	Transfer of care is where care is transferred within an organisation or to another organisation.
Episode of Care	An episode of care is an inpatient episode, a day case episode, a day patient episode, a haemodialysis patient episode, an outpatient episode or an Allied Health Profession episode. Each episode is initiated by a referral (including re-referral) or admission and is ended by a discharge.
Did Not Attend (DNA)	"Where the patient fails to attend an appointment where no prior notice was given by the patient to the service" (NHS Data Model and Dictionary). As FYPC delivers a significant proportion of child/young person contacts in the family home, the following is also included in our definition of DNA:-Where a member of staff arrives at a family's home or other care setting for a pre-arranged appointment and there is no one home or the child is not available
Due Regard	Having due regard for advancing equality involves: • Removing or minimising disadvantages suffered by people due to their protected characteristics. • Taking steps to meet the needs of people from protected groups where these are different from the needs of other people. • Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.
Cancellation	Where an appointment is cancelled by the family or young person.

1.0. Purpose of the Policy

The purpose of this policy is to ensure there is evidence based practice and sound underpinning decision-making relating to the discharge or transfer of care from Families, Young People and Children's (FYPC) services within LPT, with safeguarding paramount to the process.

The need to provide high quality care at the right time, in the right place, delivered by the right people is of paramount importance in reducing pressure on hospital and community services. Equally important is the need to ensure that service users have a good experience whilst in our care and that discharge is safe, timely, co-ordinated, and well communicated.

Discharge planning is an essential element in the operational management of services, in conjunction with the child and family. Timely and appropriate discharge or transfer benefits children and families, and also benefits services in achieving throughput of cases and protecting capacity for new referrals.

Research documentation and guidance generally refers only to discharge in the context of hospital services where adults, children and young people are discharged from inpatient facilities. Leicestershire Partnership Trust has a discharge policy for inpatients and a DNA policy, however the inpatient discharge policy does not describe the requirements for discharge of non-inpatient children and young people, and this policy is therefore required alongside those referred to above.

FYPC services collectively promote a whole system, integrated approach to the care of children and young people who may have escalating or decreasing needs over time; transferring care between universal and specialist services. The policy is intended to guide staff and multi-professional teams to ensure that all transfers and discharges are appropriately managed to minimise the risk to service users and to improve outcomes and quality of care. It aims to ensure that children and young people are discharged appropriately and care is returned to the General Practitioner.

2.0. Summary and Key Points

This policy applies to FYPC staff and those staff working in a contracted capacity who are involved in clinical decision making for discharge or transfer of care, and the supporting administration staff.

Children and young people will only remain in the care of individual FYPC services for as long as they gain added value and benefit from that specific service's involvement. Specific timescales where no contact or intervention has occurred, and subsequent case review demonstrates no clinical needs, can be set locally by individual services to guide clinical decision making and caseload management. The integrated teams around the child should work in the most efficient and effective way to deliver care at the point of least intervention.

It is anticipated that the majority of children and young people will transfer between specialist and universal services, or be discharged back to the care of their GP.

Assessment relating to discharge should commence at the earliest opportunity and discharge planning should be considered at all times during the patient and carer journey.

Discharge will be facilitated by a 'whole systems' approach to the assessment and delivery of services. The MDT will work together in an atmosphere of collaboration and co-operation to provide information, medication, equipment or specialist input. Children, young people and their carers will be encouraged to engage and participate in the process of discharge as equal partners.

Failure of a child or young person to attend clinic appointments following referral may trigger concern, given that they are reliant on their parent or carer to take them to the appointment. Failure to attend can be an indicator of a family's vulnerability, potentially placing the child's welfare in jeopardy. It can equally be an indicator that services are difficult for families to access or considered inappropriate, and need reviewing.' DfES, DH (2004:10)

3.0 Introduction

FYPC delivers a range of both universal and specialist services across a multidisciplinary spectrum. Requirements for discharge or transfer will be different for early intervention and prevention services. Mental health services in FYPC follow the Care Programme Approach. This policy addresses all these aspects

Specialist services deliver care to children with a range of needs. Children are referred via several access routes and may have a range of services delivering interventions e.g. CAMHS and Mental Health Services, Therapies, Medical, Children's Community Nurses, Dietetics etc. The inpatient facility for CAMHS and Eating Disorders is accessed via community mental health teams or on call protocols. The policy recognises that all children have differing needs at different times. There will be times when input will be more frequent and other times when the children can be discharged, and care transferred back to the General Practitioner or other FYPC services. In addition, the Health visitor (for pre-school children) or the School Nurse should be informed of the discharge from intervention services. This is especially important if the reason for discharge is non-attendance and/or where there are safeguarding concerns. Discharge will take place at the completion of an episode of care from the specialist service.

This concept of current needs and end points of phases of care is central to delivery of care to children with long term conditions. Access and discharge from the service at differing points is related to the needs of the child and family.

Diana Services work with children with complex and life- limiting/threatening needs who sometimes need admission to the acute unit. This may occur out of hours. Emergency admissions for mental health will be facilitated using the on-call procedures.

Universal Services including School Nursing and Health Visiting Teams provide a

public health function to all children. Within that scope there are packages of specific care which might be delivered to children in response to identified need. This policy should also be applied to universal services in the following situations:-

- Transfer of care from Health Visitor to School Nurse at school entry. (see Appendix 13 of the Standard Operating Guidance for Health Visiting teams delivering the Healthy Child Programme)
- Discharge or transfer of care from School Nursing Service at school leaving age. See Standard Operating Guidance for School Nursing

4.0 Criteria for Ending Episodes of Care

Discharge should be considered in collaboration with a child or young person and their family at the end of an episode of care if any of the following criteria are met:

- No clinical or functional gain is expected from continued intervention from specialist services.
- Achievement of potential following intervention.
- The child, young person or their family has become confident in self-management of the condition for which the referral was made.
- There is no added value of the particular service continuing to be involved with the child's care and/or the child/young person's needs could be met within other LPT, local authority or voluntary services
- Disability is having minimal impact on family function and the impact would not be reduced by further input from specialist services.
- Deterioration is not expected in the person's functional abilities that could be prevented or the impact minimised by further input from specialist services.
- Needs are being met by opportunities provided by other services or in everyday activities and environments.
- Identified healthcare needs have been resolved by FYPC.
- Withdrawal of consent to treatment. Communication with appropriate services must be carried out Consider Fraser Competencies http://www.nspcc.org.uk/Inform/research/questions/gillick_wda61289.html
- Where the safety of the child may be compromised (refer to Appendix 5) or where capacity to consent needs further assessment http://www.legislation.gov.uk/ukpga/2005/9/contents
- The prescribed course of treatment is not followed. Communication with appropriate services must be carried out and safeguarding issues (adult and child) must be considered.
- Children receiving medication can be discharged back to primary care providing there are clear guidelines for the receiving practice in terms of continuation of medication, weaning of medications where appropriate and a mechanism for re-escalation of care if necessary.

- The child and family have moved away out of area. Best practice guidelines must be followed to transfer care to the relevant services in the new area.
- The child's condition has changed, necessitating acute services intervention.
- Did Not Attend (DNA) or Was Not Brought (WNB) (see Section 7.0).
- Transfer to adult services for ongoing input
- The use of a service-specific step down mechanism, for example – open appointments 'red card system – Diana Service' can be used where there is doubt about the safety of immediate discharge for a maximum of 12 months.

In certain situations a child will remain under the care of FYPC services while intermittently an inpatient in an acute Trust hospital, where it is known that long term health requirements will necessitate involvement of both Acute and Community services. In this case verbal handover will be needed between Trusts, and children may have open access to both.

Did Not Attend (DNA) or Was Not Brought (WNB)

DNA and access to services are inextricably linked. Children who do not attend appointments and are dependent on others bringing them should be classed as 'Was Not Brought'. The NICE guidelines on when to suspect child maltreatment state the clinician should 'consider neglect if parents or carers repeatedly fail to attend essential follow-up appointments that are necessary for their child's health and well-being.'

National Institute for Health and Clinical Excellence (2009) When to suspect child maltreatment: www.nice.org.uk/CG89

In addition missed appointments are a prominent feature in the SCR/child death literature (albeit this represents small numbers). When children are not brought for appointments they would be recorded as DNA and therefore the safeguarding considerations and communications links must be paramount in terms of following actions. Informing the health visitor/school nurse and the GP should be standard practice so any necessary follow up actions can be taken. As FYPC delivers a significant proportion of child/young person contacts in the family home, the following is also included in our definition of DNA:-
'Where a member of staff arrives at a family's home or other care setting for a pre-arranged appointment and there is no one home or the child is not available.' In this situation best practice is for the service involved to leave a calling card with contact information and explaining that the practitioner had attempted to see the child at home as arranged.

Usual practice is that discharge should be considered if safeguarding concerns have been acted on after one DNA or repeated cancellations as described in 8.2

If parent and child, young person or young adult DNA in terms of these definitions the following actions should occur prior to discharge:

1. As part of the session in which the DNA occurred, clinician reviews notes to identify.
    a) Any access issues e.g. language, disability, siblings.
    b) Any clinical reasons why the child should not be discharged. (Consider safeguarding issues e.g. child protection).
    c) Whether the child is subject to a Child Protection Plan via the electronic record, health visitor or school nurse or the Named Nurse. Consider associated actions for none attendance.
    d) If the clinician has any Safeguarding concerns about the child/family this information should be shared with other professionals who have continued involvement before discharge and/or a direct referral to Children's Social Care.
2. Communication is made to inform the referrer of the DNA and copied to Health Visitor/School Nurse (if appropriate) and GP using shared electronic records where possible.
3. The discharging service should make reasonable attempts to make contact with family. This will include checking that the family remains at the same address etc.
4. The service ensures that relevant professionals receive a copy of the discharge letter relating to DNA where no EPR links are present.
5. Consider alternative approaches or venues.
6. If more than one appointment is offered the reason must be recorded in the notes**.**

If all these actions have been followed, children can be discharged using the clinical judgement of risk to the child, young person or young adult by the clinician **after one DNA**.

Cancellations

Professional discretion should be exercised regarding discharge in the event of cancellation.

Repeated cancellations

Where there are more than 3 within an episode of care discharge should be considered within safeguarding principles. Exceptions include hospital admission, and clinicians should always exercise their clinical judgements and discretion where repeated non attendances occur. Repeated missed appointments in an education setting should prompt rearranging the child's appointment to a health setting for intervention.

Access to Services

Where access is identified as an issue, the referrer/primary health care worker (e.g. Health Visitor) or care navigator should be contacted to find out how best to facilitate access and the engagement process.

For example the following could help:

- Use of appropriate first language through interpreting/language services
- Copy information about appointment details to HV/SN, family outreach worker or other appropriate person.
- Consider alternative locations for service delivery
- Request chaperoning
- Telephone or mailed tested reminders
- Use of volunteer drivers, taxi service

If parents fail to attend or contact the service for first or follow up appointment safeguarding issues should always be considered in these cases. The referrer (and the School Nurse or Health Visitor where appropriate) should always be informed of the non-attendance and subsequent discharge

5.0 Discharge process

Discharge decision-making is supported by the Discharge Flowchart (6). Discharge should be made with negotiation and discussion with parents/carers and the child, and the School Nurse/Health Visitor kept informed where appropriate and possible when ending the episode of care.

A child, young person or young adult should be discharged with advice on on-going activities and information about how to obtain further advice or input from the service, including the referral routes back to the service if required.

Essential actions on discharge include:

- Letter/Discharge Summary to be sent to referrer and General Practitioner, parent (where appropriate) and any other relevant professionals. The General Practitioner as the end custodian of care should be informed through the shared electronic record where possible or copies of letters. The letter should include information the parent needs on discharge, routes for re-referral to the service, whom to contact in the event of equipment failure/breakdown, signposting to other services and links to the website etc. and should be filed in the patient paper or electronic record. The discharge letter must be issued to the GP within 24 hours when being discharged from an inpatient unit. Forward planning for this point is common practice in some services and can be continued. For discharge of non-inpatients, the discharge letter must be issued within 4 weeks, unless clinical judgement indicates that urgent communication is needed (e.g. actions required by another service, or concerns)

- Record discharge in patient record.
- Refer to discharge Checklist Proforma (Appendix 5) to ensure all actions complete
- Complete SEND annual review if appropriate, stating discharge and informing the relevant education agencies of the service to which the young person has been transferred if applicable
- Ensure safeguarding issues are recorded in the patient record and dealt with according to LPT's Safeguarding Children Policy and Practice Guidance and Leicester, Leicestershire and Rutland Local Safeguarding Children's Board procedures.
- Where emerging or actual safeguarding concerns exist, alert the receiving professional by telephone

Other actions could include:

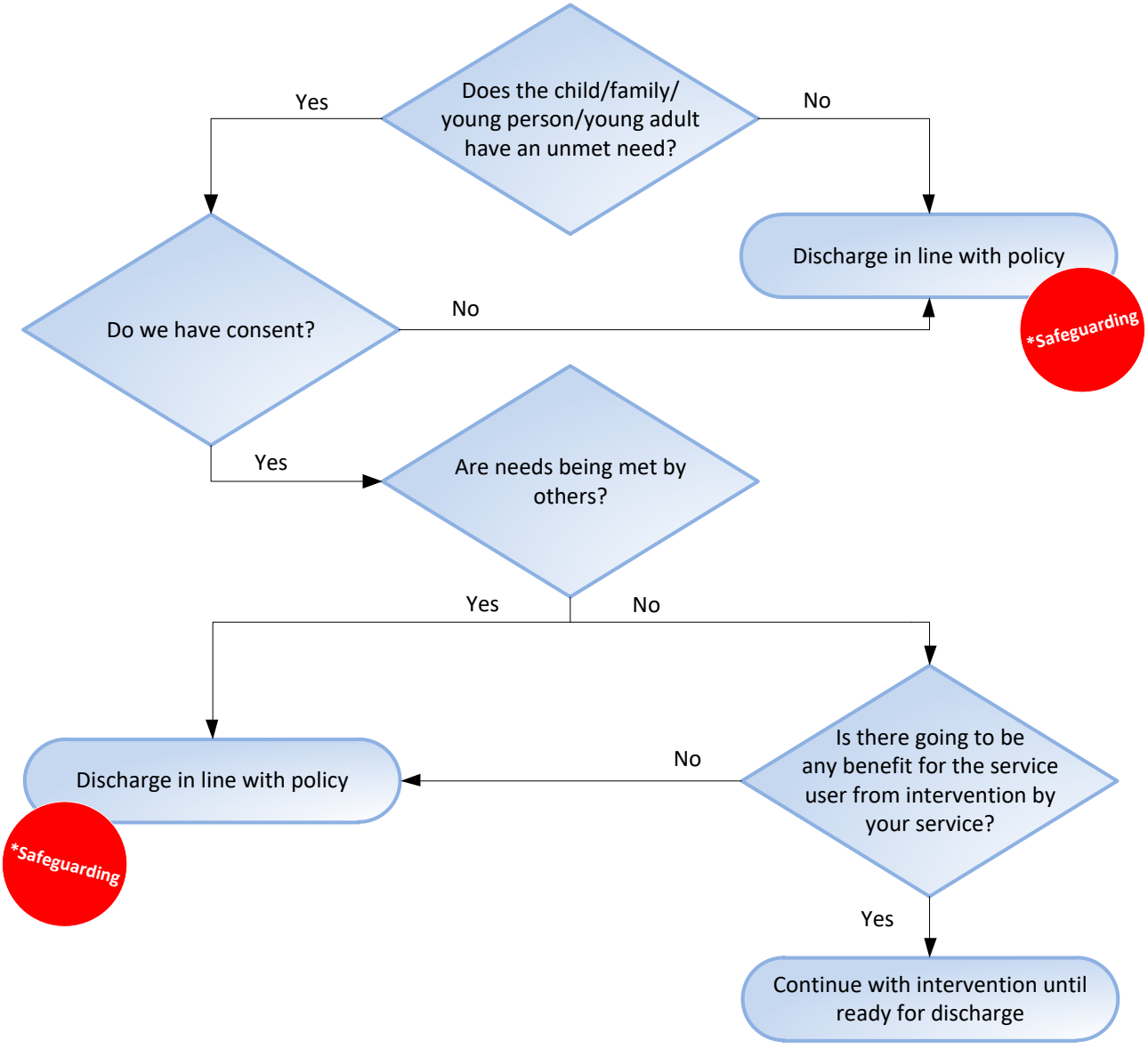
- Request Health Visitor or School Nurses follow-up.
- Telephone contact with other professionals or agencies, via care navigator or neighbourhood forum where applicable

Children and Young People with equipment prescribed by FYPC and Duty of Care:

The child or young person who has equipment prescribed by health professionals from FYPC can be discharged if the duty of care has been fulfilled. Providing the health professional has taken all reasonable steps to ensure that the needs of the child, young person and family have been addressed, considered and properly documented with any concerns shared appropriately with relevant others then the duty of care will have been met (Community Equipment Code of Practice - A quality framework for procurement and provision of services (England 2011) Brain Donnelly (Community Equipment Solutions Ltd)

Individual consideration is required relating to individuals who are moving away from the area

6.0. Flowchart / process chart



*Safeguarding Consider safeguarding issues. If any concerns follow safeguarding procedures found at www.lscb-llr.org.uk

7.0 Duties within the Organisation

7.1 The Trust Board has a legal responsibility for Trust policies and for ensuring that they are carried out effectively.

7.2 Trust Board Sub-committees have the responsibility for ratifying policies and protocols.

7.3 Service Directors and Heads of Service are responsible for
- ensuring that the requirements of this policy are disseminated, implemented, and audited within their area of responsibility
- ensuring appropriate and effective local procedures are developed in their designated areas within their scope of responsibility.
- ensuring there are appropriate resources provided within their service area to train, implement and adhere to the policy.

7.4 Managers and Team leaders are responsible for:

- Developing local protocols in line with this policy
- Implementing local protocols in their designated area

7.5 Responsibility of Staff

All staff who have responsibility for discharging or transferring children's care within FYPC services are responsible for:

- Using this policy in their clinical practice when discharging/transferring the care of children/young people/families from FYPC services
- Ensuring high standards of discharge/transfer planning are maintained and examples of non-adherence are reported through the incident reporting system.
- All administration and clerical staff involved in booking appointments should be made aware of and adhere to this policy.

7.6 Independent Mental Capacity Advocate (IMCA)

- The IMCA Service has been established under the Mental Capacity Act 2005 to provide:
- Independent safeguards for people who lack capacity to make certain important decisions and, at the time such decisions need to be made, have no-one else (other than paid staff) to support or represent them or be consulted" (Mental Capacity Act 2005 Code of Practice).
- Staff should refer to their local arrangements for access to Advocacy and IMCA in Mental Health Areas and Learning Disabilities Specifically

7.7 Named Nurse/Care Co-ordinator/Lead Professional (Care Programme Approach)

- Please follow the Care Programme Approach (CPA) Policy which can be found on the Trust intranet.
- For service users who have an existing CPA Care Co-ordinator, the co-

ordinator will be responsible for close liaison between themselves and the allocated named nurse on the ward.

- The CPA Care Co-ordinator of the service user in the community will retain his/her role if the service user becomes an inpatient user.
- When there is not a CPA care co-ordinator identified, a member of the ward staff must take on the role temporarily and commence the discharge process.

7.8 Service User's Advocate

- The services of an advocate are of particular importance if a service user is feeling threatened, vulnerable or in some way disadvantaged. They will provide an independent view to facilitate the service user's needs being met and opinions heard. Independent Mental Capacity Advocates can be used for those who lack capacity to agree to their care and treatment and have no family / friends to support them

8.0 Training needs

There is no training requirement identified within this policy

This policy should be included in all new starters' service induction/preceptorships.

All staff should be made aware of this policy through their manager's dissemination of policies.

9.0. Monitoring Compliance and Effectiveness

Every 6 months there will be an internal CPA audit led by enabling services. CPA 7 day follow-up and Delayed Transfer of Care (DToC) will be monitored on a monthly basis and reported via the monthly Integrated Quality and Performance Report to the Trust Board.

On-going internal monitoring through clinical supervision and caseload reviews ensures that discharges are clinically appropriate. Incident forms relating to discharge practice will be reviewed through clinical governance structures

Ref	Minimum Requirements	Evidence for Self-assessment	Process for Monitoring	Responsible Individual / Group	Frequency of monitoring
	Discharge requirements for all patients	Policy included in induction for relevant staff (Page 14 8.0)	Sample checks within teams or services	Service managers or team leaders	Annual, aligned with records audit
	Information to be provided to the receiving healthcare professional (as well as GP)	Discharge letter provided to the referrer and any other relevant individuals(Page 10 5.0)	Sample checks within teams or services	Service managers or team leaders	Annual, aligned with records audit
	Information to be given to the patient when they are discharged	Evidence of verbal information from the record, or copy of letter in notes (Page 10 5.0)	Sample checks within teams or services	Service managers or team leaders	Annual, aligned with records audit
	Out of hours discharge process	CPA policy (page 13 7.7)	Sample checks within teams using CPA	Team leaders	monthly

10.0. Standards/Performance Indicators

Target/Standards	Key Performance Indicator
This policy also supports the CQC Fundamental Standards	Regulation 12 - Safe care and treatment Regulation 9 – Person centred care

9.0. References and Bibliography

The policy was drafted with reference to the following:

- This policy is in line with recommendations from the Royal Colleges for Paediatrics and Child Health, College of Occupational Therapy, Royal College of Speech & Language Therapists, Chartered Society of Physiotherapy and Health Professions Council Standards of Conduct, Performance and Ethics, Nursing and Midwifery Council, Royal College of Psychiatrists

- LSCB Procedures and Practice Guidance for safeguarding children can be found at www.lrsb.org.uk/

- FYPC Standard Operating Guidance for Health Visiting Teams delivering the Healthy Child Programme (2015)
- Standard Operating Guidance for School Nursing (2016)

- LPT Record Keeping and the management of the quality of records Policy
- Transition planning for Young People from Children's to Adult Health Services. Protocol for good practice.
- Inpatient Discharge Policy
- LPT management of non-attendance/ did not attend (DNA) policy (2016)
- Information Sharing Policy
- LPT CPA Policy
- LPT Safeguarding Children Policy
- Think Family
- Discharge from Hospital: pathway process and practice (DH 2003)
- Mental Capacity Act 2005
- Consent to examination or treatment policy
- LPT Infection Control Policies
- Risk Management Strategy
- Medicines Management Policy
- NHSLA Version 1: Publication Date- January 2012.
- CPA Association Handbook
- *'A Positive Outlook: a good practice guide to improve discharge from in-service user health care*' (CSIP/NIMHE, 2007)
- *'Preventing Suicide: a toolkit for Mental Health Services'* (NIMHE, 2003)
- Nursing and Midwifery Council (2015) The Code: Standards of conduct, performance and ethics for nurses and midwives.
- Chartered Society of Physiotherapy (2012) Quality Assurance Standards
- College of Occupational Therapy (2015) Code of Ethics and Professional Conduct for Occupational Therapists
- British Dietetic Association (2008) Code of Professional Conduct
- Health and Care Professions Council (2016) Standards of performance, conduct and ethics
- Powell, C., Appleton, JV (2012) Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' –

a review of the evidence for Practice Journal Research in Nursing 17:2, 181-192

- Munro, E. (2012) Review: Children and young people's missed health care appointments: reconceptualising 'Did Not Attend' to 'Was Not Brought' – a review of the evidence for Practice Journal Research in Nursing 17:2, 193-194.
- Arai, L., et al (2015) Arch Dis Child. The unseen child and safeguarding: 'Did not attend' guidelines in the NHS Accessed at **http://adc.bmj.com/content/100/6/517.full?sid=88b6eca0-b26e-407f-b1ba-b831d0b06d48**

Training Requirements **Appendix 1**

Training Needs Analysis

Training Required	YES	NO x
Training topic:		
Type of training: (see study leave policy)	☐ Mandatory (must be on mandatory training register) ☐ Role specific ☐ Personal development	
Division(s) to which the training is applicable:	☐ Adult Mental Health & Learning Disability Services ☐ Community Health Services ☐ Enabling Services ☐ Families Young People Children ☐ Hosted Services	
Staff groups who require the training:	*Please specify…*	
Regularity of Update requirement:		
Who is responsible for delivery of this training?		
Have resources been identified?		
Has a training plan been agreed?		
Where will completion of this training be recorded?	☐ ULearn ☐ Other (please specify)	
How is this training going to be monitored?		

Appendix 2

The NHS Constitution

The NHS will provide a universal service for all based on clinical need, not ability to pay. The NHS will provide a comprehensive range of services

Shape its services around the needs and preferences of individual patients, their families and their carers	☐✓
Respond to different needs of different sectors of the population	☐✓
Work continuously to improve quality services and to minimise errors	☐✓
Support and value its staff	☐
Work together with others to ensure a seamless service for patients	☐✓
Help keep people healthy and work to reduce health inequalities	☐
Respect the confidentiality of individual patients and provide open access to information about services, treatment and performance	☐

Stakeholders and Consultation **Appendix 3**

Key individuals involved in developing the document

Name	Designation
Anne Mensforth	Clinical Dietetic Manager, Nutrition & Dietetic Service
Helen Burchnall	FYPC Divisional Clinical Director
Deanne Rennie	Allied Health Professionals lead

Circulated to the following individuals for comment

Name	Designation
Nicy Turney	Professional Lead, Health Visiting
Krutika Patel	Consultant Community Paediatrician
Graham Calvert	FYPC Clinical Lead for IT
Vicki Spencer	FYPC Clinical Governance and Quality Lead
Sandip Ghosh	Consultant Community Paediatrician
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Katie Willetts	Senior Nurse- Specialist Nursing
Theresa Heffernan	Child Health Operational Manager
Stephanie Squires	Administrative Support Manager
Vyv Wilkins	Equality and Human Rights Coordinator
Suzanne Ziegler	Clinical Lead, Children's Physiotherapy
Karen Hayden	Clinical Lead Speech and Language Therapy
Theresa Norris	Community Nurse
Margaret Clarke	Senior Nurse, School Nursing
Carolyn Corbett	Professional Lead, Safeguarding Children
Rebecca Pope	Advanced Practitioner, Children's Occupational Therapy
Dorothy Sebuliba	Head of Primary Mental Health Services, CAHMS
Catherine Coffee	Consultant
Alison Eivors	Clinical Psychologist
Jeanette Bowlay-Williams	Consultant Clinical Psychologist
Maeve McColgan	Systemic and Family Psychotherapist
Zoe Thistlewood	Senior clinical nurse specialist, Child and Family Psychiatric Service
Julie Dudek	Team leader, Paediatric Audiology
Julia Bolton	Family Service manager
Tracy Jackman	Transformational lead
Katrina Coley	Children's Speech and Language Therapist
John Eardley	Family Services Manager (East)
Julie Border	Family Services Manager (City)
Chris Davies	Family Services Manager
Jane Sansom	Family Services Manager
Theresa Farndon	Family Services Manager

Due Regard Screening Template **Appendix 4**

Section 1	
Name of activity/proposal	Discharge/Transfer of Care of children an Young People from the Families, young people and children's services division of FYPC
Date Screening commenced	3.2.16
Directorate / Service carrying out the assessment	FYPC
Name and role of person undertaking this Due Regard (Equality Analysis)	Anne Mensforth
Give an overview of the aims, objectives and purpose of the proposal:	
AIMS: The purpose of this policy is to ensure there is evidence based practice and sound underpinning decision making relating to the discharge or transfer of care from FYPC LPT with safeguarding paramount to the process.	
OBJECTIVES: The policy is intended to guide staff so that all discharges are appropriately managed to minimise the risk to service users and to improve outcomes and quality of care. It aims to ensure that children and young people are discharged appropriately and the care is returned to the General Practitioner	

Section 2	
Protected Characteristic	**If the proposal/s have a positive or negative impact please give brief details**
Age	A key component of the policy is the communication between child/young person, parent/carer and professional. The policy actively promotes equality of opportunity as it seeks to improve decision making and communication to improve outcomes and ensure all children and young people have their needs met.
Disability	LPT will respond appropriately to all requests for information in alternative formats and ensure that all attempts are made to ensure it is understood. Alternative methods of communication such as signs and symbols or Makaton may be required in order to ensure understanding where there is a disability.
Gender reassignment	N/A
Marriage & Civil Partnership	N/A
Pregnancy & Maternity	Where young people under 18 years are pregnant they will receive care from UHL community midwifery with communication and involvement from LPT Health Visiting services. No pregnant young person will be discharged.
Race	Language may not be English and all reasonable attempts to provide written information in alternative languages will be made. Use of translators, interpreters and Language Line will be

	routinely used.
Religion and Belief	Policy applies to all children and young people regardless of religion or belief.
Sex	No negative impacts identified.
Sexual Orientation	No negative impacts identified.
Other equality groups?	No negative impacts identified.

Section 3

Does this activity propose major changes in terms of scale or significance for LPT? For example, is there a clear indication that, although the proposal is minor it is likely to have a major affect for people from an equality group/s? Please tick appropriate box below.

Yes		No ✓	
High risk: Complete a full EIA starting click here to proceed to Part B		Low risk: Go to Section 4.	

Section 4

If this proposal is low risk please give evidence or justification for how you reached this decision:

This is relevant to all children and young people under the care of FYPC services but the policy seeks to ensure that no group is disadvantaged through adherence to criteria for ending episodes of care

Signed by reviewer/assessor	Anne Mensforth	**Date**	3.2.16
Sign off that this proposal is low risk and does not require a full Equality Analysis			
Head of Service Signed		**Date**	

Discharge checklist **Appendix 5**

		Initial or tick for electronic records	Enter date for paper records
1.	Child meets discharge criteria (refer to flowchart and section 5)		
2.	Ensure all documentation is completed		
3.	Ensure all safeguarding needs are checked, recorded and acted on where necessary		
4.	Discharge discussed with key worker/named professional/Health Visitor/School Nurse (where appropriate)		
5.	Discharge and outstanding health needs discussed with parent/carer (unless discharge related to DNA or child not brought)		
6.	Re-referral routes explained to parents/carers		
7.	Check all equipment supplied through FYPC and ensure parent has information for service/repair		
8.	Check that unnecessary equipment has been returned		
9.	If child has a statement of special education needs, annual review to be completed with a note about discharging from annual review		
10.	Ensure that all CPA processes are fully completed		
11.	Inform GP and any other relevant professionals of discharge. Discharge summary, if relevant, circulated to referrer, GP and any other relevant professionals, and copied to parents (To GP within 24 hours from IP unit)		
12.	Notes secured and archived, discharge completed from electronic system where appropriate		