East London Health & Care Partnership

## Best practice guidance on planning for discharge

Placing the voice of the child and the family at the heart of discharge planning is essential. Whilst being in hospital is a stressful experience for most children and families, some families will be very anxious about caring for their child at home with ongoing or complex health needs. Professionals need to take the time to understand the family's particular circumstances, needs and wishes in order to ensure that the discharge will be safe and successful.

Strong multidisciplinary working, co-ordination and communication between all professionals involved in the care of the child both in hospital and in the community, including children's social care will help facilitate understanding of the family's particular circumstances to ensure their needs are met. Coordination and good communication between agencies will also support robust safeguarding of the child.

To assist with early planning a set of prompts have been set out below to help guide the process and planning.

| Prompts | Comments |
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| **Identification and documentation of the child's medical, social and educational needs in notes/files**<br>• The more complex the child's needs the more important these are identified early and are reviewed throughout the process as they may change.<br>• Check if the child is registered with a GP if not support the family to register.<br>• Check if the child has a child protection or child in need plan or is looked after.<br>• This should form the basis of a multi-agency plan as discharge planning progresses. | |
| **An individual is identified who is responsible for coordinating discharge**<br>• this involves setting up meetings, inviting key partners, keeping a record of what was discussed and sharing this with the MDT group<br>• Identifying an lead professional in the community, who will take the lead for ensuring work is coordinate and care is holistic and effective | |
| **Ensure the parents and child's views and wishes are heard throughout the process.** This may require advocacy or language /BSL support/require communication via other methods. | |
| **Schedule an early/initial discharge-planning meeting (DPM)**<br>• This will bring together the necessary agencies to agree actions and timescales.<br>• Decide if you will invite parent/carer or young person to DPMs- if so ascertain if they require interpreters and translated materials.<br>• If the family is currently supported by a voluntary sector organisation it may be helpful to involve them in the planning with the families consent | |

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| • Setting up an email contact list will help ensure the right people are fully involved form the beginning. It is also important to ensure one "email thread" is consistently used to stop separate conversations and different plans being developed and also to ensure all relevant people remain in the loop.<br>• Agree at the first DPM how regularly the DPMs will take place. | |
| **If there is an estimated date for discharge (EDD)** ensure all members of The MDT have been informed and understand their responsibilities and agreed actions to facilitate this. | |
| **All the relevant agencies are contacted and correct referrals made to notify them of the discharge.** See below. | |
| **If the child will require a follow up from their GP once discharged make sure the GP is notified and parents carers are aware of this**<br>• For children admitted or seen for asthma GP follow up should be within 48 hours of discharge.<br>• If the child has very severe asthma or multiple attendances ensure a referral is made to the specialist asthma nurse in the borough | |
| **If it is known that the child/ family has a social worker**<br>• Check that the social worker is fully informed and involved in any decision making and communication as this will ensure better discharge planning and safeguarding<br>• Do you have the contact details for the relevent social work team? If not contact the local authority responsible MASH (multi-agency safeguarding hub) or Early Help services. | |
| **If there are any safeguarding concerns** and social care is not known to be involved refer to the responsible borough MASH team<br>• Where there are evident needs of the whole family refer to Early Help. | |
| **If the admission is for social emotional or mental health reasons** a referral to CAMHS may be required | |
| **If the children's community nursing team will be involved** in the child's ongoing care ensure an early referral has been made and they are involved in all discharge planning meetings. | |
| **Check if an assessment has been made of the family's current housing situation and its suitability for the child to go home to.** If the families current home/accommodation is not suitable.<br>• Ensure the social worker has made the necessary referrals | |
| **If the home is suitable but the child will need equipment or home adaptations** ensure the provider for the child's borough is involved early to prevent unnecessary delays. | |
| **If the child/family will need any 'step down' care** e.g. to a children's hospice for a step down care package before going home<br>• Contact and involve the children's hospices early so they are involved in planning<br>• Ensure parents/carers are aware of the support the hospice can offer before discharge and eligibility for ongoing respite. | |

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| **If the family is likely to be eligible for a continuing care package**<br>• Notify CCG commissioners, continuing care nurse and CSC to start assessment and approval process.<br>• Consider how long it will take carers to be trained to deliver the care package, and who will train and sign of their competencies<br>• Consider when the package will need to be reviewed post discharge | |
| **If parent/carers will require training to care for their child at home**<br>• Identify who is responsible for delivering training and signing off competencies.<br>• Ensure parents/carers understand what is required of them and how they will be provided with training and support.<br>• If the child has a foster carer who requires training ensure the social worker is aware of what is required and who will provide it | |
| **It is important to understand early if the child 'crosses' different geographical areas** as this will impact as this will impact on the local teams to be involved (community nursing, social care) and who pays for any care package (CCG and social care). For example, a child can be in hospital in one borough, reside in another and have their GP in a third place. This is especially important for children in care plus some families move or circumstances change whilst their child is in hospital. | |
| **Ensure the MDT is aware of any additional heath needs of the child, or members of their family.** These may emerge during the planning process and could include special educational needs or mental health issues that could impact on discharge. | |
| **If the child will require therapy once home** – have the appropriate community therapy team been informed /involved? | |
| **Ensure the school health services and health visiting services in the child home borough are notified** of the child and family needs and any adaptions/support needed at home or school. | |
| **Check if the family needs interpreters or translated materials**<br>If a virtual follow up is required ensure the family can access this medium. | |
| **Ensure parent/carers understand arrangements for prescribing of medication** or other supplies once the child is home. | |
| **If the child has a learning disability issue a hospital passport for the family** to assist them and the child when accessing future hospital treatment. | |
| **If the family may require more support once home** agree a backup or parallel support plan with them as this may prevent an unplanned admission. | |

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