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# Discharge Planning from Physical Healthcare Hospitals when there are Safeguarding Concerns about a Child

## Related guidance

* Local Protocol for Assessment
* Perplexing Presentations and Fabricated or Induced Illness
* Report a concern about a child process [Concern about a child | NELC](https://www.nelincs.gov.uk/health-wellbeing-and-social-care/childrens-social-care/report-a-concern-about-a-child/)

## 1. Introduction

When a child is in hospital and safeguarding concerns arise/are known, it is essential that effective planning between key professionals working with the child is undertaken before the child is discharged from hospital. This guidance is relevant from birth to a young person's 18th Birthday.

Effective discharge planning promotes a child–centred and co-ordinated approach to safeguarding children. Where possible, plans for the child's discharge should commence at the time the child is admitted to hospital and should build on other existing planning processes; such as Core Groups, Child Protection Conferences or Child in Need plans.

Discharge planning should include consideration of the child's health and safety. For children admitted with health concerns alone, the main issue to consider prior to the child's discharge is whether they are medically fit to be discharged back into the care of their parents/carers. For children who are admitted where there are health and safeguarding/child protection concerns or where safeguarding/child protection concerns arise during admission, the main issues to take into consideration prior to the child's discharge are whether they are medically fit and that it is safe for them to be discharged back into the care of their parents/carers.

The purpose of this procedure is to ensure that all Practitioners are clear about the steps to take to ensure a safe discharge from hospital where their health or well-being may be compromised or where further significant harm could occur.

When the criteria for convening a Discharge Planning Meeting (DPM) is met (as outlined in Section 2, Criteria for Convening a Discharge Planning Meeting) it is essential to ensure that the child is not discharged into the parent/carer's care until he/she is medically fit and it is assessed as being safe for him/her to be discharged.

Consideration should be given to the wider environment the child will be returning to; including siblings, and other members of the household and wider support mechanisms.

## 2. Criteria for Convening a Discharge Planning Meeting

A Discharge Planning Meeting must be convened before the child is discharged to return to their parent/carers care when:

* A child is admitted to hospital and there are identified safeguarding concerns;
* A child is admitted to hospital who is known to Children's Social Care and there are identified current safeguarding concerns in relation to the child;
* A child is admitted to hospital following an incident/safeguarding concern and is subject to a Child Protection Plan;
* A baby is born and is subject to a Pre-Birth Assessment or Child Protection Plan or Pre-legal proceedings;
* A child has complex healthcare need(s) and is being discharged into the care of a Foster Carer/other Family member who will be required to understand/manage the child's complex need(s).

For a child who is subject to Section 47 Enquiries and is assessed as being at risk of Significant Harm, a safe discharge from hospital should have been considered as part of the safety planning. A Strategy Meeting should be re-convened before the child is discharged from hospital if there are additional concerns or a new incident has occurred since the last meeting. If a Strategy Discussion is held – the Consultant/Ward Manager/Member of the NLaG Safeguarding Team must be invited to participate in the discussion to ensure the most accurate and up to date information is shared.

If the safeguarding concerns about a child relate to Fabricated or Induced Illness, a Strategy Meeting must be convened or re-convened before the child is discharged from hospital if Section 47 Enquiries have not already been undertaken in relation to this concern and a strategy meeting subsequently held.

If the safeguarding concerns about a child at risk of being subjected to illegal procedures, consideration should be given for whether a Strategy Meeting be convened or re-convened before the child is discharged from hospital. For example:

* Female Genital Mutilation Procedure;
* Forced Marriage Procedure;
* There are grounds for concern that a person may be a victim of human trafficking or modern slavery;
* Child Criminal Exploitation procedure and Child Sexual Exploitation Procedure.

Consideration for convening a Discharge Planning Meeting should be given when:

* A child is admitted to hospital who is subject to a Child in Need Plan;
* The child is subject to a court order or in voluntary placement as a 'Looked After Child' (LAC);
* A child or young person has been admitted because of mental health concerns including self-harm or suicidal ideation;
* Concerns have arisen during the child's stay in hospital; such as poor nutrition, faltering growth, poor frequency of visiting by parents/carers, parental mental health or substance misuse or concerns that the child may be living in a domestic abuse household and is therefore a victim themselves. Any other indicator of abuse or neglect should be considered;
* If the child is not subject to a child in need plan, where a child and family early help assessment should be completed to ascertain whether single agency or Team Around the Family (TAF) management is appropriate. If the ward staff complete the child and family early help assessment, the initial TAF meeting could double as the discharge planning meeting.

For more information, see:

* Neglect Procedure;
* Faltering Growth; [Overview | Faltering growth | Quality standards | NICE](https://www.nice.org.uk/guidance/qs197)
* Parents who Misuse Substances Procedure;
* Working with parents with mental health problems (see Parental Mental Health Procedure)
* Domestic Abuse Guidance

If safeguarding concerns arise about a child during their stay in hospital, or if, at any time, there are concerns that the child has suffered or is likely to suffer Significant Harm and the child's case is already open to Children's Services, the situation should be discussed with the relevant Children's Services Team. If the case is not open a referral should be made to relevant Children's Services Integrated Front Door - as per your Agency's referral protocol. Consideration should be given as to whether the threshold for Significant Harm has been met and a Strategy Discussion/Meeting held.

## 3. Reasons for NOT having a Discharge Planning Meeting

There may be a reason for not holding a discharge planning meeting when a child meets the criteria for doing so. For example, there has been a very recent (within 72 hours of discharge) Multi-Agency meeting (e.g. Child Protection Conference) where a robust plan was agreed, and the reason for admission is not linked to the concerns identified in the plan and there have been no concerns raised on the ward. This course of action requires agreement between Senior Managers in Children's Services; the Safeguarding Children Team) and the child's Consultant. Assurance must be provided that evidence of proposed discharge planning is fully referenced in the documents linked to the Multi-Agency meeting and that no significant changes have occurred which could impact upon the original discharge arrangements. If a DPM is not convened, the reason for not holding a meeting and Senior Managers who have been consulted must be recorded on the child's file.

There is no need to convene a discharge planning meeting if the reason for the current admission is unrelated to safeguarding concerns and involves routine medical treatment or intervention, e.g. a child subject to a Child Protection Plan is having their tonsils removed.

A Discharge Planning meeting would not be required if a child/young person, who was already subject to Social Care involvement, attended A&E/at an Emergency Care Centre/Unscheduled Care Centre; however, it is expected that there would be a discussion between the A&E/at an Emergency Care Centre/Unscheduled Care Centre staff and the child's Social Care Team to notify them of the reason for the child's attendance and any additional concerns arising. If there is no current Social Care involvement, consideration should be given to the reason for the attendance and whether any safeguarding concerns have arisen/could arise as a result of discharge and the relevant action taken, as per Agencies' referral protocols. In either instance, if it is felt that the child/young person was not safe to return home, discussions should be held between the Senior Clinician, NLaG Safeguarding Team and Social Care to discuss alternative accommodation.

## 4. Convening a Discharge Planning Meeting

The Discharge Planning Meeting should be held no less than 24 hours prior to the proposed discharge and ideally48 hoursahead of the proposed discharge. This may not always be possible; the reasons for not convening a Discharge Planning Meeting (DPM) within this timescale should be recorded on all clinical records.

It is not good practice to discharge a child with safeguarding concerns over a weekend, unless this has been agreed as part of a Discharge Planning Meeting. If a child is discharged over a weekend without a Discharge Planning Meeting being held, the decision must be agreed by Senior Managers from NLaG and Children's Services and the decision recorded on file.

Professionals should not give the impression to parents/carers that the DPM is merely a formality ahead of the child's discharge taking place, as consideration needs to be given to the fact that whilst the child is medically fit for discharge it may not yet be safe to discharge into the care of the parent/carer.

## 5. Membership of the Discharge Planning Meeting

The meeting will be coordinated by the Nursing staff/Ward Manager looking after the child/young person in consultation with the allocated Social Worker's/ Practice Supervisor who will chair the meeting. The meeting will be held in the hospital and parents/carers must be invited unless fabricated and induced illness is suspected, for more information seePerplexing Presentations and Fabricated or Induced Illness Procedure. The child should also be invited to participate, according to their wishes, if of sufficient age and understanding.

See Perplexing Presentations and Fabricated or Induced Illness procedure

Consideration should be given to inviting all Practitioners who are involved in the support of the child, for example:

* Health Professional for Children's Health (0-19 years' service) depending on the age of the child;
* GP - should be invited (especially if concerns re. FII have arisen) and/or contacted for relevant information by medical staff, as required;
* Paediatrician;
* Professionals allied to Medicine (e.g. CYPMHS, Dietician, Children's Therapy);
* Midwife looking after the child/mother/Community Midwife;
* Nursing staff from the Paediatric Ward;
* School or Education representative if relevant;
* Send Case Worker if relevant;
* Health Visitor;
* Children's Community Therapist;
* Specific staff groups where expertise is required e.g. Mental Health, Edan Lincs), Drug and Alcohol support Services, Early Help, Probation, Housing, Police.

Please note that this list is not exhaustive. e meetings should include Health Practitioners from both Hospital and Community Services and other Practitioners relevant to the child or family, and the Parent(s) or adult(s) with Parental Responsibility.

If the relevant Practitioners cannot attend, consideration should be given for the meeting to be adjourned and re-convened as soon as possible (the next day at the latest), with the Senior Managers from Social Care and Clinical Services notified. The child must not be discharged home until the DPM has taken place. For a meeting to be quorate representatives from Children's Services, NLaG and children's health if a child is under 6 years old. If this is in relation to a newborn baby a midwife and/or named midwife be present.

## 6. Conduct of the Discharge Planning Meeting

The meeting will be chaired by the Children's Services Practice Supervisor, responsible for the child. Where possible a minute taker will be provided by Children's Social Care; however, where this is not possible, the minute taker will be agreed at the meeting.

The Discharge Planning Meeting should agree post-discharge action as appropriate:

* Legal advice is sought in a timely way, if appropriate;
* Placement from hospital is agreed and transport arrangements for this, if necessary;
* Contact and supervision arrangements with parents is agreed if the child is not returning home;
* Assurance gained re. the suitability of wider family involvement (i.e. identified support networks are safe and appropriate);
* Timeframe for stay in hospital is agreed;
* Post-discharge Professional visiting arrangements are agreed and documented for family/carer(s) (with Professionals' contact details also provided);
* Post-discharge follow up medical and professional appointments for child/parents are agreed and provided;
* Contingency arrangements are agreed;
* Review process is agreed.

If it is considered unsafe to discharge a child, Children's Social Care will facilitate alternative accommodation in a time frame which is specified and agreed as part of the plan.

## 7. Recording the Discharge Planning Meeting

The Chair will ensure that written notes recording actions agreed at the DPM are circulated to all relevant people at the end of the meeting. The Chair will agree the minutes which will be typed and distributed to all relevant people within five working days.

The minutes will include a separate sheet which outlines the details (where, when and who with) of arranged Medical and Professional appointments for the child and family.

If changes have been agreed to the Child Protection Plan or Child in Need plan, those plans should be updated to reflect the changes. For children who are subject to a child protection plan or Looked After the Social Worker needs to discuss any significant issues with the IRO or Conference Chair. Where a Child and Family Early Help Assessment is in place this will need to be updated and the safety plan reviewed.

If at any stage of this process differing opinions arise in relation to the need for a DPM, or in relation to the discharge plan itself (i.e. assurance not gained re. robustness of the proposed plan), Professionals should initiate the Professional Resolution and Escalation Procedure.