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POLICY DOCUMENT

Transfer and Discharge from Care Policy

UT Compliance

BUNDLE PACKAGE | DOMICILIARY CARE

DOCUMENT REFERENCE	EFFECTIVE DATE
—	15 January 2026
VERSION	REVIEW DATE
DC/TDC/001	—
STATUS	APPROVED BY
Publish	—

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1. Scope

1.1 Purpose

This policy establishes the framework for managing transfers and discharges from care services provided by . It ensures that all transitions, whether planned or unplanned, are conducted safely, lawfully, and with respect for the service user's rights, dignity, and wellbeing. The policy supports continuity of care and protects vulnerable adults during periods of change.

1.2 Application

This policy applies to all service users receiving domiciliary care from , regardless of funding source, care package complexity, or length of service. It covers planned discharges, emergency transfers, service user choice to end care, provider-initiated discharge, transfers to other care providers, admission to residential or nursing care, and discharge following death.

1.3 Types of Discharge Covered

Planned discharge where care needs are met or no longer required

Transfer to alternative care provider at service user or family request

Transfer to residential or nursing care following assessment

Hospital admission requiring temporary suspension or permanent discharge

Provider-initiated discharge due to relationship breakdown, risk, or inability to meet needs

Emergency discharge due to safeguarding concerns or immediate risk

Discharge following death of service user

1.4 Exclusions

This policy does not cover temporary service interruptions due to staff sickness or annual leave (covered by Business Continuity Plan), routine care plan reviews that do not result in discharge, or short-term hospital admissions where care restarts immediately upon return home.

1.5 Interfaces with Other Policies

This policy integrates with and should be read alongside our Safeguarding Policy, Mental Capacity Act Policy, Complaints Policy, Risk Management Policy, Information Governance Policy, and Care Planning and Review Policy.

2. Legal and Regulatory Framework

Transfer and discharge processes must comply with statutory duties and regulatory requirements. The following framework governs our practice:

Legislation/Regulation	Discharge and Transfer Requirements
Care Act 2014	Requires local authorities to ensure continuity of care and prevent needs escalating during transitions. Providers must cooperate with authorities to ensure safe, planned transitions.
Health and Social Care Act 2008 (Regulated Activities) Regulations 2014	Mandates that care must continue to be provided safely until properly concluded. Prevents unsafe discharge that would leave vulnerable adults at risk.
CQC Regulation 12 (Safe Care and Treatment)	Requires providers to assess and mitigate risks during discharge, ensure proper handovers, and maintain safety throughout transitions.
CQC Regulation 17 (Good Governance)	Requires systems to monitor discharge quality, maintain accurate records, and ensure appropriate decision-making during care transitions.
Mental Capacity Act 2005	Requires assessment of capacity for discharge decisions, best interests processes where capacity lacks, and involvement of appropriate representatives.
Human Rights Act 1998	Protects Article 2 (right to life), Article 3 (freedom from inhuman or degrading treatment), and Article 8 (right to private and family life) during transitions.
Equality Act 2010	Prevents discrimination during discharge decisions and requires reasonable adjustments to support protected characteristics.
Data Protection Act 2018 and UK GDPR	Governs information sharing during transitions, requires consent for disclosure, and mandates secure transfer of personal records.
Consumer Rights Act 2015	Establishes contract termination rights, notice period requirements, and fair treatment of service users ending care arrangements.
Care and Support Statutory Guidance (2014)	Provides detailed guidance on discharge planning, transition assessments, portability of care plans, and multi-agency coordination.
NHS and Local Authority Partnership Guidance	Establishes frameworks for hospital discharge, intermediate care transitions, and integrated care pathways requiring provider cooperation.

3. Definitions of Key Terms

The following terms are used throughout this policy:

Term	Definition
Discharge	The permanent ending of care services provided by , whether planned, unplanned, at service user request, or provider-initiated.
Transfer	The movement of a service user from to another care provider, residential setting, or different level of care support.
Planned Discharge	A discharge arranged in advance with appropriate notice, risk assessment, and transition planning involving all relevant parties.

Unplanned Discharge	A discharge occurring with minimal notice due to emergency circumstances, immediate risk, or sudden change in situation requiring rapid response.
Service User-Initiated Discharge	Discharge requested by the service user or their legal representative exercising choice and control over their care arrangements.
Provider-Initiated Discharge	Discharge initiated by where continuation of care is not feasible due to inability to meet needs, relationship breakdown, or risk factors.
Discharge Risk Assessment	A systematic evaluation of risks associated with ending or transferring care, identifying safeguards needed to ensure safe transition.
Transition Plan	A documented plan outlining steps, responsibilities, timescales, and safeguards for managing a care transfer or discharge safely and effectively.
Handover	The process of transferring responsibility for a service user's care to another provider, including communication of essential information and documentation.
Continuity of Care	Maintaining safe, effective care throughout transitions without gaps that could compromise service user safety or wellbeing.
Notice Period	The minimum time between notification of discharge and actual ending of care, as specified in service agreements or required by circumstances.
Multi-Disciplinary Meeting	A coordinated meeting involving health, social care, and other relevant professionals to plan complex transitions requiring multi-agency input.
Discharge Summary	A comprehensive document detailing the service user's care history, current needs, risks, and recommendations to inform ongoing or alternative care provision.

4. Policy Statement

4.1 Commitment

is committed to ensuring that all transfers and discharges from care are managed safely, respectfully, and in accordance with legal and ethical obligations. We recognise that transitions represent vulnerable periods where service users may be at increased risk. Therefore, we will ensure that every discharge is properly planned, risks are assessed and mitigated, appropriate notice is given, and continuity of care is maintained throughout the transition period.

4.2 Core Principles

Person-Centred Approach: Service users remain at the centre of all discharge decisions with their views, preferences, and wellbeing prioritised throughout the process.

Safety First: No discharge will proceed if it would place the service user at unacceptable risk. Risk assessments inform all transition decisions.

Choice and Control: Service users have the right to choose to end care or transfer to alternative providers, subject to capacity and safeguarding considerations.

Dignity and Respect: All transitions are managed with sensitivity, maintaining dignity, privacy, and respect for the service user

and their family.

Transparency: Reasons for discharge, processes followed, and alternatives available are communicated clearly and documented thoroughly.

Partnership Working: We work collaboratively with local authorities, NHS services, families, and receiving providers to ensure seamless transitions.

Last Resort: Provider-initiated discharge is used only when all alternatives have been exhausted and continuation of care is genuinely not feasible.

4.3 Rights During Discharge

Service users have the right to:

Be informed clearly about reasons for discharge and processes being followed

Receive adequate notice unless emergency circumstances prevent this

Have their capacity to understand and consent to discharge decisions assessed

Participate in discharge planning and transition arrangements

Request advocacy support during discharge processes

Raise concerns or complaints about discharge decisions

Have safeguarding concerns addressed if discharge creates risk

Receive comprehensive handover information for continuity of care

4.4 Provider Responsibilities

will:

Conduct thorough risk assessments before any discharge

Provide reasonable notice periods according to circumstances

Work constructively with local authorities when they disagree with discharge decisions

Make safeguarding referrals if discharge would create risk

Continue care during notice periods and dispute resolution

Document all decisions, communications, and actions comprehensively

Learn from discharge processes to improve practice

5. Roles and Responsibilities

Clear allocation of responsibilities ensures discharge processes are managed effectively and safely:

Role	Responsibilities
Registered Manager ()	Approves all provider-initiated discharges. Ensures policy compliance. Reviews complex or disputed cases. Liaises with commissioners and local authorities. Authorises deviation from standard notice periods. Oversees safeguarding interface. Signs off discharge summaries for high-risk transitions.
Care Coordinator/Care Manager	Leads discharge planning for allocated service users. Conducts discharge risk assessments. Coordinates transition meetings. Prepares discharge summaries. Communicates with families and representatives. Arranges handovers to receiving providers. Documents all discharge processes. Monitors safety during transition periods.
Safeguarding Lead ()	Assesses safeguarding implications of discharge. Advises on protective measures during transitions. Makes safeguarding referrals where discharge creates risk. Liaises with local authority safeguarding teams. Ensures vulnerable adults are protected throughout discharge processes.
Health and Safety Officer ()	Reviews environmental and physical risks during discharge. Advises on safe transition arrangements. Ensures equipment is appropriately transferred or retrieved. Addresses health and safety concerns raised by discharge circumstances.
Data Protection Officer ()	Ensures compliant information sharing during transitions. Reviews consent for disclosure of personal information. Oversees secure transfer of care records. Addresses data protection queries during discharge. Ensures retention and disposal comply with requirements.
Care Workers	Report concerns about planned discharges to care coordinators. Continue to provide high-quality care during transition periods. Contribute to discharge assessments based on direct care knowledge. Support service users emotionally during transitions. Complete handover notes for receiving providers.
Finance/Contracts Manager	Reviews contractual obligations regarding notice periods and termination. Processes final invoices and account closures. Coordinates with commissioners regarding funding cessation. Addresses financial aspects of discharge including debt recovery if applicable.
Quality Assurance Lead	Monitors discharge processes for policy compliance. Conducts audits of discharge documentation. Analyses discharge data for trends and learning. Ensures complaints about discharge are properly investigated. Identifies improvements to discharge procedures.

6. Procedures

6.1 Service User-Initiated Discharge

When a service user or their representative requests discharge:

Step 1: Receive and Document Request

Record the discharge request immediately including date, time, who made the request, and stated reasons. Acknowledge receipt verbally and in writing within 24 hours.

Step 2: Explore Reasons and Alternatives

Arrange a meeting to understand reasons for discharge. Where concerns about service quality exist, explore resolution options. Discuss alternative care arrangements if needs have changed. Ensure decision is informed and voluntary.

Step 3: Assess Mental Capacity

Assess the service user's capacity to make the discharge decision using Mental Capacity Act principles. Document the capacity assessment. If capacity is lacking, identify appropriate decision-makers and follow best interests processes.

Step 4: Conduct Risk Assessment

Complete a discharge risk assessment identifying risks from ending care, impact on health and wellbeing, safeguarding concerns, and mitigation measures. Consider whether discharge creates immediate danger requiring safeguarding referral.

Step 5: Notify Relevant Parties

Inform the commissioning local authority, GP, and other professionals involved in care. Share risk assessment findings. Allow reasonable time for alternative arrangements to be made.

Step 6: Agree Notice Period and Transition Plan

Agree an appropriate notice period (minimum as per contract, typically 7-28 days depending on complexity). Develop a transition plan including end date, alternative care arrangements, handover requirements, and monitoring during notice period.

Step 7: Prepare Discharge Summary

Complete comprehensive discharge summary including care history, current needs, risks, medication details, equipment requirements, and recommendations for ongoing care.

Step 8: Handover to Alternative Provider

If transferring to another provider, arrange handover meeting or telephone discussion. Share discharge summary with appropriate consent. Clarify final visit timing to ensure no gaps in care.

Step 9: Final Review and Closure

Conduct final care visit with completion of closure documentation. Retrieve equipment if applicable. Close care records. Send confirmation letter. Complete quality feedback survey.

6.2 Provider-Initiated Discharge

Provider-initiated discharge is only used when continuation of care is genuinely not feasible. Circumstances may include:

Service user needs exceed our capability to provide safe care

Persistent violence, aggression, or abusive behaviour despite interventions

Irretrievable relationship breakdown preventing effective care

Service user consistently refuses essential care creating critical risk

Non-payment of fees by self-funders despite reasonable efforts to resolve

Procedure for Provider-Initiated Discharge:

Step 1: Escalation and Evidence Gathering

Document all issues leading to discharge consideration including dates, incidents, actions taken, and outcomes. Escalate to Registered Manager with comprehensive evidence. Ensure all reasonable alternatives have been exhausted.

Step 2: Registered Manager Review

Registered Manager reviews all evidence and considers whether discharge is justified and proportionate, legal and regulatory compliance, safeguarding implications, and reputational risks. Decision to proceed must be approved in writing.

Step 3: Risk Assessment and Safeguarding

Complete comprehensive risk assessment of discharge impact. If discharge creates safeguarding risk, make immediate referral to local authority. Continue care while safeguarding processes are followed.

Step 4: Formal Notification

Provide formal written notice to service user, family, and legal representatives stating clear reasons, notice period being given, discharge date, actions taken to resolve issues, and right to complain. Send copies to commissioning authority, GP, and relevant professionals.

Step 5: Extended Notice Period

Provide extended notice period (minimum 28 days, longer if complexity warrants) to allow alternative arrangements. Continue full care provision during notice period unless immediate risk requires emergency measures.

Step 6: Multi-Agency Meeting

Convene multi-agency meeting including local authority, health professionals, family, and advocates. Discuss discharge rationale, alternative care options, transition planning, and dispute resolution if applicable.

Step 7: Dispute Resolution

If local authority or family dispute discharge, engage in good faith discussion. Consider independent review or mediation. Continue care during dispute resolution unless emergency circumstances prevent this.

Step 8: Commissioner Liaison

Work closely with commissioners to secure alternative provision. Provide comprehensive information to support assessment and commissioning. Do not withdraw care until alternative arrangements are confirmed unless safeguarding requires emergency action.

Step 9: Managed Transition

Complete full handover to receiving provider. Provide detailed discharge summary. Support phased transition if appropriate. Ensure continuity of care without gaps.

6.3 Emergency Discharge

Emergency discharge may be required when:

Immediate violence or serious threat to staff safety

Acute safeguarding crisis requiring immediate protective action

Criminal behaviour preventing safe care delivery

Emergency discharge procedure requires immediate cessation of care visits, immediate notification to local authority adult safeguarding team, police involvement if criminal activity or immediate danger, documentation of emergency circumstances, formal written confirmation within 24 hours, and Registered Manager ratification within 48 hours.

6.4 Discharge Due to Hospital Admission

When service users are admitted to hospital:

Suspend care visits and document admission details. Maintain contact with hospital and family regarding expected discharge. Participate in hospital discharge planning meetings. Assess whether care can resume on return home or whether needs have changed requiring reassessment. Liaise with local authority if increased care needs funding. Ensure smooth transition back home with care visits recommencing as required.

If hospital stay is extended or permanent residential care is needed, follow planned discharge procedures in conjunction with hospital discharge team.

6.5 Transfer to Residential or Nursing Care

When service users move to residential or nursing care:

Support assessment processes for residential placement. Provide information to inform care home placement decisions. Agree final domiciliary care date coordinated with care home admission. Complete comprehensive handover to care home including detailed care summary, current support plan, risk assessments, and medication records. Support service user and family during emotional transition. Offer gradual transition with reducing visits if appropriate. Close care records on admission date.

6.6 Discharge Following Death

When a service user dies:

Record date, time, and circumstances of death. Inform Registered Manager immediately. Notify commissioners and relevant professionals. Provide emotional support to family. Retrieve equipment respectfully with family consent. Complete closure documentation including final care notes. Send condolence letter to family. Offer staff debriefing and support. Complete any required safeguarding or serious incident reporting. Close records in accordance with retention policies.

7. Risk Assessment and Safety Planning

7.1 Discharge Risk Assessment Requirements

Every discharge requires a documented risk assessment completed by the care coordinator in consultation with relevant professionals. The assessment must identify:

Risks to physical health from ending care (malnutrition, dehydration, pressure sores, medication errors)

Risks to mental health and emotional wellbeing (isolation, anxiety, depression)

Safeguarding risks (neglect, abuse, self-neglect, financial exploitation)

Environmental risks (falls, fire, home safety hazards)

Impact on informal carers (carer breakdown, health deterioration)

Consequences of gaps in care provision

Adequacy of alternative care arrangements

7.2 Risk Mitigation Strategies

For each identified risk, mitigation measures must be specified including:

Actions to reduce likelihood or impact of risk

Who is responsible for implementing mitigation

Timescales for implementation

Monitoring arrangements during transition period

Contingency plans if mitigation fails

Safeguarding referral triggers

7.3 Safeguarding Interface

Discharge processes must not compromise safeguarding duties. Safeguarding referrals are required when:

Discharge would leave a vulnerable adult at significant risk of harm

Service user lacks capacity and discharge is not in their best interests

Coercion or undue pressure is influencing discharge decisions

Alternative arrangements are inadequate to meet critical needs

Family are preventing necessary care through discharge request

When safeguarding referrals are made, care must continue until safeguarding processes are completed and the local authority confirms alternative arrangements are in place.

7.4 High-Risk Discharge Criteria

Discharges are classified as high-risk and require Registered Manager approval when:

Service user has critical care needs (end-of-life care, complex clinical needs, high medication requirements)

Safeguarding concerns are present or have been raised historically

Service user lacks capacity to consent to discharge

Local authority or health professionals oppose discharge

Provider-initiated discharge with disputed reasons

No alternative care arrangements are in place

Service user lives alone with no informal support

8. Communication and Documentation

8.1 Communication with Service Users and Families

All discharge communications must be:

Clear: Using plain language avoiding jargon, explaining processes and timescales, confirming understanding through discussion

Timely: Providing adequate notice, allowing time for questions and planning, keeping parties informed of progress

Accessible: Providing information in appropriate formats, arranging interpreters if needed, involving advocates where appropriate

Documented: Recording all significant conversations, confirming agreements in writing, maintaining audit trail

8.2 Multi-Agency Communication

Discharge processes require coordination with multiple agencies. Communication protocols include:

Local Authority: Formal notification of discharge within 48 hours, risk assessment sharing, participation in multi-agency meetings, cooperation with alternative commissioning

NHS Services: Informing GPs of discharge decisions, liaison with district nurses and therapists, coordination with hospital discharge teams, medication information sharing

Receiving Providers: Comprehensive handover discussions, discharge summary provision, agreed transition dates, clarification of responsibilities

Regulatory Bodies: CQC notification of significant discharges if required, transparency about provider-initiated discharges, cooperation with investigations

8.3 Information Sharing and Consent

Information sharing during discharge must comply with data protection legislation:

Obtain explicit consent to share discharge summaries and care information with receiving providers

Share information with local authorities under legal duty to cooperate with Care Act assessments

Share without consent only where lawful basis exists (safeguarding, vital interests, legal obligations)

Document consent obtained or legal basis for sharing without consent

Share minimum necessary information proportionate to purpose

Ensure secure transmission of personal data

8.4 Discharge Summary Contents

Every discharge requires a comprehensive summary document including:

Service User Details: Name, date of birth, address, NHS number, next of kin

Care History: Dates of service, reason for referral, care provided, significant events

Current Needs: Physical care needs, mobility support, personal care requirements, nutrition and hydration needs, medication administration

Medical Information: Diagnoses, medication list with dosages and timings, allergies, medical devices, clinical monitoring requirements

Risk Assessment: Key risks identified, control measures in place, safeguarding considerations, behavioural or environmental risks

Mental Capacity: Assessment of capacity for specific decisions, best interests considerations, lasting powers of attorney or deputies

Social Context: Living arrangements, informal carers, family dynamics, community connections

Equipment: Aids and equipment in use, suppliers, maintenance requirements

Professional Network: GP details, district nurses, social workers, therapists, other involved services

Recommendations: Suggested ongoing care arrangements, monitoring requirements, follow-up actions

8.5 Record Keeping Standards

Discharge records must meet professional and legal standards:

Contemporaneous recording of all discharge-related events and decisions

Clear, factual, objective documentation avoiding opinion without evidence

Signed and dated entries with legible author identification

Secure storage compliant with data protection requirements

Retention in accordance with records management policy (minimum 7 years)

Accessible for audit, inspection, or legal proceedings

9. Mental Capacity and Best Interests

9.1 Capacity Assessment for Discharge Decisions

Mental capacity must be assessed for the specific decision to discharge. Staff must apply Mental Capacity Act principles:

Principle 1: Assume capacity unless established otherwise through assessment

Principle 2: Provide all practicable support to help the person make their own decision

Principle 3: Unwise decisions do not automatically indicate lack of capacity

Principle 4: Decisions made on behalf of those lacking capacity must be in their best interests

Principle 5: Least restrictive option must be considered

9.2 Capacity Assessment Process

Assessment follows the two-stage functional test:

Stage 1: Diagnostic Threshold – Does the person have an impairment of, or disturbance in the functioning of, the mind or brain (temporary or permanent)?

Stage 2: Functional Test – Can the person: Understand information relevant to the discharge decision? Retain that information long enough to make the decision? Use or weigh that information as part of decision-making? Communicate their decision (by any means)?

Document findings clearly including evidence considered, conclusion reached, and date of assessment. Remember capacity is time and decision-specific, requiring reassessment if circumstances change.

9.3 Best Interests Decision-Making

When a service user lacks capacity to consent to discharge, decisions must be made in their best interests. The best interests process involves:

Consulting with relevant people (family, friends, carers, professionals) about the person's wishes, feelings, beliefs, and values

Considering all relevant circumstances including medical, psychological, emotional, and social factors

Identifying whether capacity might be regained (delaying decision if appropriate)

Examining whether the person's previous wishes and feelings can be ascertained

Exploring less restrictive alternatives to discharge

Weighing benefits and burdens of different options

Making a decision that prioritises the person's wellbeing, rights, and dignity

9.4 Role of Attorneys and Deputies

Where Lasting Powers of Attorney (Health and Welfare) or Court-appointed Deputies exist:

Verify authority through registration documents

Confirm scope of authority covers care and support decisions

Involve attorneys/deputies in discharge planning and decision-making

Attorneys/deputies must act in best interests and follow MCA principles

Challenge attorney/deputy decisions if not in service user's best interests

9.5 Advocacy Support

Service users may benefit from independent advocacy during discharge processes:

Care Act advocacy for those with substantial difficulty participating in processes

Independent Mental Capacity Advocates (IMCA) for unbefriended individuals lacking capacity for serious decisions

Generic advocacy services to support understanding and expressing views

Inform service users and families of right to advocacy

Facilitate advocate involvement and information sharing

10. Complaints and Appeals

10.1 Right to Complain

Service users, families, and representatives have the right to complain about discharge decisions or processes. Complaints are welcomed as opportunities to improve practice and resolve concerns.

10.2 Complaints Process

Complaints about discharge should be made in writing to the Registered Manager. We will:

Acknowledge receipt within 3 working days

Investigate thoroughly and impartially

Respond within 28 days (or explain delays)

Provide clear findings and any remedial actions

Continue care during complaint investigation unless safety prevents this

10.3 Suspension of Discharge

Where serious concerns are raised about discharge decisions, the Registered Manager may suspend the discharge pending:

Independent review of discharge rationale

Multi-agency meeting to resolve disputes

Safeguarding investigation completion

Legal advice on disputed capacity or best interests

Court of Protection application if necessary

10.4 External Review Options

If complainants remain dissatisfied, they may pursue:

Local Government and Social Care Ombudsman (for commissioned services)

Care Quality Commission concerns reporting

Local authority safeguarding referral

Legal action through civil courts

Professional body complaints (for regulated professional decisions)

11. Training and Development

11.1 Training Requirements

All staff involved in discharge processes receive appropriate training:

Induction training covering discharge policy overview, reporting procedures, and safeguarding interface

Role-specific training for care coordinators covering discharge risk assessment, transition planning, and documentation standards

Mental Capacity Act training for all staff involved in capacity assessment or best interests decisions

Safeguarding training emphasising recognition of discharge-related risks

Communication skills training for difficult conversations about discharge

Information governance training covering confidentiality and information sharing during transitions

11.2 Competency Assessment

Staff competency in discharge procedures is assessed through:

Observation of practice during supervision

Review of discharge documentation quality

Case study discussions in team meetings

Knowledge assessments following training

Audit findings identifying training needs

11.3 Continuous Professional Development

Ongoing learning opportunities include:

Reflective practice sessions discussing discharge cases

External training on legal and regulatory developments

Multi-agency learning events with local authority partners

Case law updates affecting discharge practice

Best practice sharing with sector networks

12. Monitoring and Review

12.1 Monitoring Arrangements

monitors discharge processes through:

Discharge Data Analysis: Monthly reports tracking discharge numbers by type, reasons, notice periods, and outcomes

Documentation Audits: Quarterly audit of 10% of discharge records assessing risk assessment quality, capacity assessment documentation, transition planning adequacy, and communication records

Safeguarding Interface Review: Analysis of safeguarding referrals related to discharge identifying patterns or concerns

Stakeholder Feedback: Surveys of service users, families, and receiving providers about discharge experience

Complaints Analysis: Review of discharge-related complaints for themes and improvement opportunities

Commissioner Feedback: Regular dialogue with commissioning authorities about discharge performance

12.2 Quality Indicators

Key performance indicators for discharge quality:

100% of planned discharges have documented risk assessments

95% of discharges provide minimum contractual notice period

100% of discharges involving capacity concerns have documented MCA assessments

100% of high-risk discharges approved by Registered Manager

90% of receiving providers rate handover quality as good or excellent

Zero discharge-related safeguarding incidents resulting from inadequate planning

100% of provider-initiated discharges have multi-agency involvement

12.3 Policy Review

This policy is reviewed:

Annually as standard practice

Following significant incidents involving discharge

When legislative or regulatory requirements change

Following CQC inspection feedback

When audit findings identify systematic issues

At commissioner request

Reviews incorporate feedback from staff, service users, families, commissioners, and partner agencies. Updated versions are communicated to all stakeholders and archived appropriately.

12.4 Continuous Improvement

Learning from discharge processes informs service improvement through:

Case reviews identifying good practice and areas for development

Action plans addressing audit findings and complaints themes

Staff suggestions for procedural improvements

Benchmarking with sector best practice

Integration of new guidance and case law developments

13. Reporting Concerns

13.1 Staff Duty to Report

All staff have a duty to report concerns about discharge processes including:

Discharges proceeding without adequate risk assessment

Service users lacking capacity making discharge decisions without proper assessment

Coercion or undue pressure influencing discharge

Inadequate notice periods creating risk

Failure to involve relevant agencies in complex discharges

Poor quality handovers compromising continuity of care

Discriminatory discharge decisions

13.2 Reporting Channels

Concerns should be raised through:

Direct discussion with care coordinator or line manager

Escalation to Registered Manager for serious concerns

Safeguarding referral if vulnerable adult at risk

Whistleblowing procedures for systemic issues or management failings

CQC whistleblowing line for regulatory breaches

13.3 Protection for Whistleblowers

Staff who raise genuine concerns in good faith are protected from detriment under whistleblowing legislation. will:

Take all concerns seriously and investigate appropriately

Protect whistleblowers from victimisation or retaliation

Maintain confidentiality where possible

Provide feedback on investigation outcomes

Take disciplinary action against those who retaliate against whistleblowers

13.4 Investigation of Concerns

Reported concerns are investigated promptly and thoroughly:

Immediate action to protect service users if risk identified

Gathering of evidence including records, interviews, and observations

Objective assessment of whether concerns are substantiated

Remedial actions to address identified failings

Feedback to concerned staff member

Learning and improvement actions to prevent recurrence

14. Related Policies and Procedures

This policy should be read in conjunction with:

Safeguarding Adults Policy

Mental Capacity Act and Deprivation of Liberty Policy

Care Planning and Review Policy

Risk Assessment and Management Policy

Complaints Policy

Information Governance and Data Protection Policy

Whistleblowing Policy

Equality, Diversity and Inclusion Policy

Record Keeping Policy

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Policy Approval & Review

APPROVED BY	SIGNATURE
Not Specified	*No signature on file*
REVIEW DATE	NEXT REVIEW DATE
1 January 1970	19 February 2027

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