Chapter 6
PASSING THE BATON in Practice
PASSING THE BATON in Practice

» Chapter Overview
» The Anchor Leg
» Information for Trainers
» A Test of Endurance
Chapter Overview

This Chapter provides a final summary of the practical application of the Guide, the actual process of discharging or transferring the patient.

“Having developed rapport with the patient while undertaking their individualised assessment, you have been able to agree a unique package of care that will enable an early discharge from hospital. The rest is easy!”

Also included is information for educators which describes a Training Framework that will be developed further during the ongoing implementation of ‘Passing the Baton’ across Wales.

A whole person approach has been advocated throughout this Guide as the best way to ensure that individual needs are understood. This approach is equally relevant to the way Practitioners are trained and developed.

Training programmes must include specific content that encourages talent and reflects on personal values to ensure that the knowledge and skills gained can be fully applied into practice.

Making a real and sustainable improvement will require as many people as possible to embrace the change. Creating a social movement is an evidenced methodology as discussed in the last section entitled ‘A Test of Endurance’.
The Anchor Leg

In an ideal situation, the whole journey through care and the discharge process will be working exactly to plan. In which case, this last stage should be easy:

Practitioners will have:
- Developed an individualised care plan based on the specific needs the individual
- Adhered to locally agreed discharge policies and procedures
- Met any and all legal and professional responsibilities

As a result, there will be:
- An accurate understanding of the individual’s discharge needs and wants
- A plan of care to meet those needs and wants agreed by everyone involved
- An agreed date of discharge

Many departments already use checklists at this point while others have developed a Discharge Integrated Care Pathway. Examples of these tools are available in the resource pack accompanying this Guide.

The local guidance will need to have included the following eight day of discharge issues:
1. Timescale

Maintaining attention to detail is essential in the period leading up to discharge. It is difficult to set a specific timescale for this last stage as lengths of stay and levels of complexity for each individual vary so significantly.

For longer lengths of stay, it is reasonable to expect final arrangements to be confirmed 48 hours before the actual discharge. Often, simple logistical arrangements such as hospital transport require this level of notice.

One thing is certain; prior to formally confirming all the discharge arrangements, Practitioners must speak to the individual, their family and carers first, to check that the EDD is reasonable and that there are no obvious reasons to avoid a particular date of discharge.

The remaining steps assume that an actual date of discharge has been agreed and confirmed.
2. Protocol or Practitioner-led Discharge

Traditionally, decisions to discharge from hospital have been made almost exclusively on the Ward Round. As a result, discharges can occur late in the day and rarely at weekends or Bank Holidays.

Improved multidisciplinary ways of working mean that other professional Practitioners can safely make the final decision to discharge, subject to protocols agreed specifically for individual patients.

Whilst some NHS Trusts have developed pre-printed proforma, others work by writing clear instructions in collaborative patient notes. Regardless of the format used, agreed instructions for protocol-led discharge will include the following as a minimum:

- Consensus that protocol led discharge is appropriate for the particular patient
- The proposed date and time of discharge
- The lead clinician signs off the protocol for the individual patient concerned
- The agreed clinical parameters that will constitute medical fitness for discharge for example, vital signs within normal limits is clearly documented
- The designation and grade of the Practitioner with delegated responsibility for making the decision to discharge
- Confirmation that all planned discharge arrangements are in place
- The person responsible for discharging the patient ensures all communication requirements are met
- The discharging Practitioner’s contact information is available in case of query
3. Transport:

Ensure that you have asked the patient about their transport needs for discharge at least two days prior to their EDD. In most cases relatives, carers or friends will be more than happy to help if they are given adequate notice.

- Follow your local protocol for ordering transport and give as much notice as possible
- If the patient does qualify for transport, consider the use of voluntary transport in the first instance, as many Trusts have contracts with agencies such as St John’s Ambulance. Any potential costs to patients must be explained in advance

"Only offer ambulance transport home or to onward place of care where there is a clinical need for it. This is a limited resource which we all have a duty to use to maximum effect."

- Ensure that you communicate any particular requirements, such as transportation of Zimmer frames or bulky luggage
- Any specific clinical instructions for the individuals care in transport together with requirements for their physical movement such as a chair or trolley
4. Medication To Take Home (TTH)

There are continued reports of short but frequent delays in discharge caused by poor coordination of TTH medication. This is often because prescriptions are not written until after the ward round on the day of discharge.

"Such delays are frustrating for patients and carers and in the vast majority of cases totally avoidable."

- If working to an EDD, the TTHs should be written no later than the day before. In some Trusts ward-based pharmacists are able to transcribe TTH prescriptions on behalf of the clinicians.

- If there are changes made to current medication on the final medical review for example warfarin dosage, the TTH should be written immediately to allow time for dispensing and collection.

- As already addressed as part of the assessment and discharge planning process, confirm that your patient understands their medication regime and is able to comply with it.

- Provide written information to support verbal discussion about the medication regime which includes a clear description of potential side effects.

- If supervision or support with medication compliance is needed, double-check that appropriate arrangements are in place.

- Ensure that any intravenous cannulae that are no longer required are safely removed.

- Ensure that arrangements are in place for submission of repeat prescription requests and the collection or delivery of medicines.
5. Home Environment:

Everyday activities can be taken for granted, so sending someone home without thinking about with their immediate needs can cause a loss of confidence. There are a few straightforward points to consider so that the journey home is made smooth:

- Confirm that all required equipment has been delivered, installed and the relevant personnel trained to use it
- Ensure all home adaptations have been fully completed and signed off as safe
- The individual has been made aware of any adaptations and received appropriate training, preferably through an accompanied home visit with a suitable Practitioner prior to discharge
- Check that the accommodation will be adequately heated ready for the patient’s arrival home
- Check there is adequate provision of food and means of preparation
- Check that the patient or whoever accompanying or meeting them on discharge has a key to access the property
6. Ongoing Care Setting:

Similarly if the person is not returning to their usual or previous home environment, consideration must be given to any new requirements:

- Full details of the new setting and its location and transport links are available
- The patient, their family or carers have visited the new setting prior to discharge
- Access and physical transport arrangements have been confirmed with the receiving department
- The contact name and details of the person charged with receiving the handover are confirmed
- Any specific domestic or personal care requirements are catered for

7. Information Sharing on Discharge:

All MDT decisions, including those regarding the assessment of eligibility for Continuing NHS Health Care or NHS Funded Nursing Care must be recorded in the patient’s notes and documented in the discharge information. A copy should also be provided for the patient and carer.

A comprehensive assessment must be documented and shared, subject to consent and local protocols, with those who will be providing care on discharge.

The Care Coordinator should be responsible for the formal handover upon discharge. At this point the Care Coordinator role may be passed on, for example, from named nurse to community-based social worker.
Where an ongoing care plan is required, it will need to be agreed with the individual, their carer or advocate and provided in writing including clinical follow up arrangements such as an out-patient appointment.

GPs report failures in continuity of treatment, which can lead to errors or avoidable readmission, due to poor or untimely communication of essential information on discharge.

Although some health communities have developed a local means of prompt electronic transfer of discharge information, others still have to rely on traditional summaries.

The Practitioner overseeing the discharge process needs to ensure that the GP Practice receives legible information within 24 hours of discharge to include:

- Diagnosis
- Inpatient investigations and treatment
- Changes to existing medication
- Follow up
- Discharge arrangements

If it is usual practice to send this information with the patient, Practitioners must ensure that they have the means to deliver it to their GP surgery within the same timeframe.
8. Use of Discharge Lounges

Many Trusts have designated Discharge Lounges, usually staffed by nurses, to which patients can safely be transferred in the morning of the day of discharge.

If all the measures advocated in this Guide have been implemented there should be little need for such facilities. However, at present the effective use of the Discharge Lounge can significantly assist in maintaining patient flow throughout the hospital.

Most patients are happy to be transferred to the Discharge Lounge, if the rationale for doing so is explained to them. However, many nurses still instinctively feel that the best place for the patient to wait for discharge is on the ward.

Patient information provided on admission should state that as a matter of routine patients who are medically fit will be transferred to the Discharge Lounge before 10am on the morning of their discharge.

In Hospitals where Discharge Lounges are routinely use, it is good practice to inform allied departments that the patient will be leaving the hospital via the discharge lounge. This can provide an opportunity to coordinate activities such as delivering TTHs through the Discharge Lounge.

Discharge Lounges should provide a pleasant and comfortable experience for patients looking forward to going home. Many examples in Wales provide:

- Comfortable seating
- Tea and coffee making facilities
- Snacks or warm meals
- Reading materials and TV
- An accessible pick up point for relatives, voluntary or ambulance transport
- An opportunity for final reassurance or discussion with competent and compassionate staff
Information for Trainers

This guide is aimed at frontline Practitioners, who already have a great deal of knowledge and skill. To ensure that there is recognition of the range of expertise required in discharge planning it needs to sit within a larger structure and this is described as a Training Framework.

The Training Framework is a more strategic view of what is necessary to deliver effective discharge planning and will be developed further as part of the ongoing implementation of ‘Passing the Baton’.

Potentially this will involve the creation of formally accredited programmes of education in patient flow and managing the journey through care.

"The objective is to provide expert Practitioners and educators with a framework to develop more specific local training plans and resources."

The use of Expert Practitioners is essential to the delivery of ongoing training and education in discharge planning. Although nursing is the largest staff group, these ‘Champions’ for discharge planning will be needed in a range of professions.

To underpin this and support development in practice, undergraduate programmes will need to strengthen the curriculum with more explicit application of the knowledge and skills necessary to manage the care process.

These two approaches represent two arms of a single integrated plan to improve discharge planning through training.
For both arms of training, organisations will also need to consider what opportunities are available to deliver this training in a joined up, inter professional and inter agency programme of shared learning and development.

"Integration is increasingly the way services are delivered in the real world, just look at the expansion of intermediate care and it’s inevitably going to increase in the future."

It is clear that there are many training and development programmes going on separately in many partner organisations. Local training leads have developed bespoke programmes, presentations and teaching resources within the formal staff development plans of each organisation.

Subsequently for those organisations who want to deliver shared learning, it is more of a logistical issue than one of needing additional funding. The aim is to create a complimentary programme of trainers and champions collaborating within a systematised approach to continuous improvement.

**Elements of Training**

If Practitioners actively use the knowledge Barometer they will naturally identify gaps in their knowledge and skill. The challenge for educators and training departments becomes how to respond to that need for development.

Every health and social care community will need to tailor their programme to encompass the particular organisational relationships and services active within their catchment.
To deal with the issues of locality while ensuring that good practice is implemented consistently, each programme must be based around a common core of knowledge, skills, tools and techniques. ‘Passing the Baton’ represents this basic level of common principles and their practical application.

Management of the expectations of the patient, their family and carers is part of the knowledge base along with practical ability to deliver care and activate the organisation’s processes. Consequently a large part of the competency should be based around professional and interpersonal communication skills.

Throughout the Guide, the interaction with the patient and carers is emphasised as critical to managing expectations. As a result an essential of effective practice is ensuring that the sophistication of the dialogue is congruent with the complexity of the patient journey and the level of understanding of the Practitioners, the patient, carers and wider family.

“We must be aware of evolving patient and carer expertise and as a Practitioner correspond to the increasing need for involvement, as well as knowledge and information.”

Intellectual need is only one part of what has to be covered in the training programme. The content must also reinforce recognition of emotional needs and cover aspects of both cultural and social diversity.

The practical content of a training programme therefore needs to cover a broad spectrum of issues:

- Understanding your own and other’s roles in delivering care and managing the care process
- Knowledge of the practical skills in the care process across several organisational partners
• Skills in applying the knowledge consistently on a routine day to day basis
• Communicating effectively with people who have a diverse range of needs and expectations
• Impact of effective care processes to create systematised information, learning and improvement
• Recognition that equity and diversity goes beyond ethnicity to social, cultural and legal obligations

These traditional areas of learning and their practical application need to be combined in a way that extends beyond technical ability.

The Chapters dealing with principles, communication and assessment each advocate taking a whole person, holistic view connecting to the patient and their family with compassion. This whole person approach requires Practitioners to develop a range of empathic skills to recognise a person’s needs in mind, body, heart and spirit.

“It really saddens me that we seem to have lost something so essential... training in these aspects of personal values and their legitimacy in modern practice has to become much more explicit.”

If organisations want Practitioners to deal with ‘whole people’, then they need to be developed as ‘whole people’ themselves. The training programme must encompass personal development and reflective practice processes that help each Practitioner to understand their own mind, body, heart and spirit.
The Expert Model

The following diagram is a useful model to consider how to apply whole person thinking to a training and development programme. The Expert Model has four internal characteristics and four external requirements that combine to create ‘Expertise’.

The left side represents ‘Competence’ and the practical training elements of Knowledge and Skill the mind and the body. Competence alone is not enough, despite its recent focus, as it means “only just”. Without continuous evidence of practice it’s just a small step from incompetence.
The right side refers to the ‘Application’ of that knowledge and skill. The innate talent that a person has and the values they hold in acting upon that talent. It is the heart and spirit of a person and the manifestation of the empathy that connects them to other people.

When considering the vision of being able to deal with the whole person across a diverse community, the training and professional development frameworks must be explicit in the education and development of all four characteristics; Knowledge, Skill, Talent and Values and reflect how they change over time.

"At the start of a career you have talent and some skill and the ‘Motivation’ to deploy those capacities. As your career progresses with appropriate support, you gain greater knowledge and greater confidence in your ability to act on that knowledge. This is essentially ‘Experience’. If you can maintain the connection between your experiences and your personal values you gain greater insight into your own sense of purpose. The Practitioner becomes powerful and compassionate, someone who others will see to physically represent high moral understanding and be able to influence people on many levels, dealing with the whole person."
A Framework for Development

Across the range of undergraduate education programmes, there are several academic modules and practical placements that are aimed at acquiring knowledge and skill in the care process. Some have specific discharge planning objectives.

However, it is not routine to offer practical placements with experts in managing the patient journey. The placements with specialist nurses tend to be around recognised disease pathways. Some wards do have designated link nurses for discharge planning and other similar care processes, but their input is generally not formally recognised within the competency framework.

There is an issue to overcome in connecting up inter-professionally to educate and train people involved in more complicated processes with a common language and knowledge base. In particular for advanced roles where care processes like discharge planning or care coordination are the primary purposes of the job.

There is a clear need to further explore the development of accredited training or perhaps a post graduate qualification in subjects that encompass managing the patient journey, care pathways or operational healthcare dynamics.

At the other end of the scale, education must also extend to patients, their family and carers. There is potential to develop new support programmes and qualifications that are aimed at priority groups such as new carers, alongside general awareness and signposting.

"Every LHB must have a Carer’s Strategy and services that link with Health Social Care & Wellbeing Plans, with access to support services and education.”
The framework needs to identify individuals and the correlating level, content and type of training in relation to their role or exposure to processes in practice.

The Training Framework has been developed to describe the people, requirements and structure of training across 8 levels of expertise split into 4 categories:

- General Awareness
- Standard Practitioner
- Enhanced Practitioner
- Expert Practitioner

Although this Guide is aimed at front line health and social care staff identified as ‘Standard Practitioner’ on the Framework, a complimentary programme of education and training needs to be developed to spread consistent knowledge across the entire care process.

With regard to Level 1 on the Framework, part of the ongoing development and implementation of ‘Passing the Baton’ will be the production of a training video. It will be aimed at raising basic awareness of the care process and how services users, their family and carers, together with support staff across public services can contribute to the journey through care.
## General Awareness
### Level 1

| Role | All citizens  
Staff from voluntary, independent and public services associated to but with little or no experience of the hospital process |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to &amp; Complexity of Discharge Process</td>
<td>No routine or day to day involvement with the patient journey</td>
</tr>
<tr>
<td>Application of Training</td>
<td>The All Wales National Effective Discharge Planning Awareness Video</td>
</tr>
</tbody>
</table>
| Content | Knowledge – A common language for what discharge planning involves and why it’s important to get home as quickly and safely as possible  
Skill – Provision of basic advice and signposting on what to expect  
Values – Empathy for the staff and patients involved in delivering and receiving a complex service |
**General Awareness Level 2**

| Role | All health and social care staff for general employee awareness
|      | The patient, their family and carers involving a long term condition |
|      | General non clinical or indirect involvement in the discharge process and no requirement to deal with situations beyond normal indirect remit |
| Exposure to & Complexity of Discharge Process | Corporate Induction and organisational mandatory refresher training |
| Application of Training | Knowledge – Your role and relationship to the patients journey
|      | Skill – To ask questions pertinent to facilitating effective discharge
|      | Values - Ability to recognise the potential disempowering effect of hospital settings |
| **Standard Practitioner**  
| **Level 3** |
| **Role** | Junior clinical staff, support staff and carers involved in the day to day delivery of care |
| **Exposure to & Complexity of Discharge Process** | Mostly dealing with simple discharges and provision of information for patients and carers and basic awareness to communicate on discharge |
| **Application of Training** | Departmental Mandatory training on a rolling basis |
| **Content** | Knowledge – Ongoing variation in the understanding and information needs of patients and carers  
| | Skill - Recognition of triggers that escalate discharge complexity  
| | Values – Ability to engage with patients and carers to reduce anxiety |
### Standard Practitioner
#### Level 4

<table>
<thead>
<tr>
<th>Role</th>
<th>Staff directly involved in the management of the patient pathway</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Exposure to &amp; Complexity of Discharge Process</th>
<th>Mostly dealing with uncomplicated discharge and the provision of patient information and regular need for a formal clinical handover</th>
</tr>
</thead>
</table>

| Application of Training | Departmental Mandatory training on a rolling basis  
Self directed and departmental learning through audit and review |
|-------------------------|----------------------------------------------------------------------------------------------------------------------------------|

| Content | Knowledge – Operational understanding of hospital processes related to effective discharge  
Skill – Active recognition and management of patients and carer expectations of the discharge process  
Values – Ability to explore and identify patient’s emotional needs and offer explicit advice or service |
|----------|----------------------------------------------------------------------------------------------------------------------------------|

| Enhanced Practitioner  
Level 5 |  
| --- |  
| **Role** | Experienced clinical staff and operational leaders with responsibility for other staff and allocation of day to day resources  
| **Exposure to & Complexity of Discharge Process** | Regular management and overview of patients who routinely require post discharge management and support from one or more agencies  
| **Application of Training** | Internal organisational training and development workshops linked to findings of local audit and review  
| **Content** | Knowledge – Care coordination and management of multidisciplinary team meetings and case conferences  
Skill – Advanced clinical assessment, planning and reporting  
Values – Ability to advocate on behalf of patient and initiate action to meet individual needs  

## Enhanced Practitioner

### Level 6

<table>
<thead>
<tr>
<th><strong>Role</strong></th>
<th>Specialised Practitioners, link nurses, care coordinators and other patient liaison staff</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exposure to &amp; Complexity of Discharge Process</strong></td>
<td>Overview of multiple patients on specific or complex clinical care pathways routinely involving multidisciplinary follow up post discharge</td>
</tr>
<tr>
<td><strong>Application of Training</strong></td>
<td>Externally facilitated workshops linked to health community improvement plans</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>Knowledge – interagency working and the development of local professional partnerships</td>
</tr>
<tr>
<td></td>
<td>Skill – chairing of multidisciplinary team meetings and case conferences</td>
</tr>
<tr>
<td></td>
<td>Values – Ability to individually tailor discharge planning processes</td>
</tr>
</tbody>
</table>
# Expert Practitioner

**Level 7**

<table>
<thead>
<tr>
<th>Role</th>
<th>Senior clinical and managerial staff with broad organisational responsibilities for assessment and escalation of risk</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Exposure to &amp; Complexity of Discharge Process</strong></td>
<td>Dealing with operational resources and management authority to enable effective discharge for patients who require new or additional interagency services</td>
</tr>
<tr>
<td><strong>Application of Training</strong></td>
<td>Professionally accredited training module linked to formal CPD</td>
</tr>
<tr>
<td><strong>Content</strong></td>
<td>Knowledge – Development of systematic and organisational improvement in patient flows</td>
</tr>
<tr>
<td></td>
<td>Skill – Maintaining a physical overview of the environment and dependencies of care</td>
</tr>
<tr>
<td></td>
<td>Values – Ability to relate policy and strategy to the hands on delivery of compassionate care</td>
</tr>
</tbody>
</table>
## Expert Practitioner

### Level 8

<table>
<thead>
<tr>
<th>Role</th>
<th>Expert Practitioners and managers with a primary role or responsibility for discharge planning and dealing with complex care coordination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exposure to &amp; Complexity of Discharge Process</td>
<td>Operational case management of multiple patients with complex needs that require an individualised package of care in place prior to discharge</td>
</tr>
<tr>
<td>Application of Training</td>
<td>Formal post graduate qualification in a patient flow or clinical pathway methodology</td>
</tr>
</tbody>
</table>
| Content | Knowledge – Whole system approach to delivering effective transfers of care  
Skill – to motivate, advocate and educate individuals and influence organisational processes  
Values – Ability to lead in the service of others |
When considering a programme for Practitioners at a particular level, the whole framework can be related directly to the broad communication requirements identified within the knowledge and skills framework used in healthcare:

<table>
<thead>
<tr>
<th>Category 1</th>
<th>Communicate with a limited range of people on day-to-day matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 2</td>
<td>Regularly communicate with a range of people on a range of matters</td>
</tr>
<tr>
<td>Category 3</td>
<td>Develop and maintain communication with people about difficult matters and in difficult situations</td>
</tr>
<tr>
<td>Category 4</td>
<td>Develop and maintain communication with people on complex matters in complex situations</td>
</tr>
</tbody>
</table>

This can then translate into practical teaching opportunities:

- Champion led education sessions with opportunities for multidisciplinary and agency reflective practice
- General presentations on discharge processes, DToCs, simple versus complex pathways
- Workshops to develop checklists with triggers to identify common complicating factors with awareness and drop in sessions run by specialist Practitioners
- Ongoing novice programme for newly qualified staff on all aspects of discharge planning and the care process
- Rolling programme of update session on the role of specialist patient flow teams
- In house formal training programme delivered by champions and specialist Practitioners on relevant changes to policy and practice
- Supervised involvement in MDT to gain experience in coordinating meetings and care planning
- Full technical training plan on discharge planning using ‘Passing the Baton’ as a workbook
A Test of Endurance

Let’s be honest, implementing the contents of this Guide isn’t going to be easy. What change ever is?

“To take the athletics analogy one step further, embedding these principles into everyday working practices in hospitals, social work departments and community services across Wales, will require the combination of the expertise of the relay team with the psychological traits of the marathon runner.”

Characteristics cited as essential to ‘going the distance’ include:

- Discipline
- Dedication
- Determination
- Persistence

The working environment for all Health and Social Care Practitioners is challenging because of the pressures of workload and the perceived increasing complexity of the individuals who require their services. This Guide is about the response and approach of Health and Social Care Practitioners to those pressures.

Having a rational agreement that this is how we should do things, will not be sufficient to ensure that consistent standards are maintained during times of pressure. As the old adage goes:

“Change happens in the heart not the head.”
In all its content, this Guide has appealed to the inherent ethos and values of health and Social Care Practitioners and the known desire to do the best job possible.

In order to achieve and sustain improvements in discharge planning practice, all readers of this Guide will need to become change agents themselves, forming a social movement that actually makes it uncomfortable to do anything else.

Bate et al (2005) describe six groups of factors that influence the mobilisation of collective action or social movement:

<table>
<thead>
<tr>
<th>Rational:</th>
<th>“I understand why this is worth doing”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emotional:</td>
<td>“It feels right”</td>
</tr>
<tr>
<td>Social:</td>
<td>“My organisation supports it”</td>
</tr>
<tr>
<td>Behavioural:</td>
<td>“My professional practice and that of my colleagues is underpinned by it”</td>
</tr>
<tr>
<td>Organisational:</td>
<td>“Our policies and operational processes enable me to do it”</td>
</tr>
<tr>
<td>Leadership:</td>
<td>“Employees and managers at all levels of the organisation agree it is a priority and give me space to do it”</td>
</tr>
</tbody>
</table>

In this context, it is clear that everyone has a responsibility to drive the improvement in practice and that all contributions, from whatever level in the organisation, are equally valid. This principle has underpinned the development of the Guide so far, harnessing:

- the support of executives and managers
- the skills and expertise of Practitioners from a variety of professions and agencies
- the advice of experts
“At present, prevailing strategies rely largely on outmoded theories of control and standardisation of work. More modern, and much more effective, theories of production seek to harness the imagination and participation of the workforce in reinventing the system.” Berwick, 2003

‘Passing the Baton’ has never been envisaged as being the silver bullet that will solve all the problems encountered when discharging patients from an acute hospital setting. It became clear during its development that the key to success is not a ‘big bang’ but to do relatively small things correctly and consistently.

“Movements are more likely to fine-tune reality than to give rise to the brave new world.” Palmer, 1997

The messages in the Guide are not new and they are not rocket science. Rather, the Guide should be seen as catalyst around which enthusiasts can gather their efforts in order to mainstream change and improve practice.

“Roll out and implementation will seek to maintain momentum by supporting a federated NHS improvement movement.” Bate et al, 2005

This will involve the setting up of local and national networks via the Community of Practice, which will support practical training, problem solving, feedback mechanisms and further development.

The Guide is designed to be a living and evolving document. The authors actively encourage you to use the feedback mechanisms provided and engage in its development and most of all, to join them in the journey to really make a difference to patients’ experiences.
“You can’t wait for inspiration...

... you have to go after it with a club.”

Jack London