Introduction
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Executive Summary

NHS Wales provides inpatient care to thousands of people every year. In addition there are hundreds of thousands of attendances at Accident & Emergency Departments. The profile of health policy in recent years has been to focus on reducing the delays that patients are experiencing in getting access to hospital. However, a continual theme within reviews such as the report by Derek Wanless, ‘The Review of Health and Social Care in Wales 2003’, emphasised how significant amounts of resources have been used caring for patients in hospital beds who ideally could and should have been discharged to a more appropriate setting for their needs.

Even though it has been estimated that 80% of all discharges are simple in nature, it is acknowledged that providing a safe and effective discharge for every person who attends our hospitals can become complicated. Practitioners have to ensure that the specific needs of every single patient are catered for, to make sure that they can leave hospital safely and on time.

Taking a proactive approach to discharge planning with every individual will have a positive impact on the causes of delayed transfers of care.

To do this effectively requires careful patient assessment, planning and the cooperation of many professionals not just from health and social care, but also from other allied agencies including commercial, charitable and voluntary organisations.

The challenges of making discharge safe, appropriate, timely and effective have been around for a long time. Changes in society’s expectations means that a much more sophisticated response is now required.
Effective discharge can be dependent on many factors such as the need to make adjustments to the persons’ home, determining long term funding arrangements or the identification of a suitable care setting.

The Change Agent Team (CAT) is based within the National Leadership and Innovation Agency in Healthcare (NLIAH). The overall aim of CAT is to work with health and social care professionals to improve the journey and experience of individuals throughout the care system.

In 2007, CAT published “Six Steps from DToC to EToC – A Summary Report of the National Self Assessment of Discharge Planning in Wales”. This report identified that there is a weakness in the knowledge, skill and confidence of front line staff in managing the discharge of patients from hospital.

Health and social care professionals highlighted that the increasing complexity of discharge processes, actually helping patients to leave hospital, seemed to require greater and greater involvement and leadership of key specialist staff such as Discharge Liaison Nurses. Reasons for this were broadly accepted as:

- The faster pace of the Ward or A&E environment
- More performance pressures upon staff
- Increasingly complex needs of patients
- The increasing challenge of translating health and social care policy into practice

Practitioners are becoming more reliant upon specialists in discharge to make discharge happen, in cases where any Practitioner could and should be able to manage the process.
'Passing the Baton’ is the result of NLIAH working directly with health and social care professionals and can be described as many things – a toolkit, a resource file, or even a general reference guide. It is designed to provide Practitioners with the basic knowledge and information they need to play a greater role in managing the patient discharge.

Whereas the learning within the Guide is intended to be useful for all Practitioners, the practical content primarily refers to adults. As such, the technical references quoted within the Guide are predominantly adult oriented. For Practitioners caring for specific groups, such as Children or Mental Health, reference should always be made to existing statutory guidance.

This Guide is not designed to be read in one sitting. It has been produced by Practitioners across Wales to provide information, advice and support on all aspects of discharge. It should be used to complement and develop local tools and operational policies already in existence.

The intention is to continue the development of the Guide beyond the initial publication, to ensure that it remains compliant with current policy. Part of this development will include the production of more detailed information on improving the effectiveness of discharge planning for specific groups.

It is always challenging to write something that will be of practical use to everyone. Some people, who read this, may not learn anything new and for them the challenge becomes putting the skills into practice, consistently. For others such as newly qualified Practitioners, the amount of information may seem overwhelming at first. However, the Guide is designed to support the development of knowledge and skill over time.
Passing the Baton Metaphor

‘Passing the Baton’ may seem a strange title for a document about discharge planning. The Health and Social Care Practitioners, who have written this Guide, believe that effective discharge from secondary care can be likened to the smooth flow in which relay runners pass the baton over to the next runner.

“In a relay race you can’t just throw the baton up in the air and hope the next person catches it. You must keep a firm hold of the baton until you’re absolutely sure the next person has got it.”

In this case the baton symbolises the responsibility to deliver the right care using knowledge and understanding of the patient’s needs. Each athlete is responsible for carrying the baton and playing their part in the race to the best of their ability. At the right time and in the right place, the baton must be passed to the right person.

In athletics there are usually only four runners in each team, all moving at the same speed over the same distance neatly, one after another. To produce the best performance in athletics and pass the baton effectively, each athlete requires a good plan, dedication to training and the development of trust in each other. The goal is to produce synergy in the team, so that they can achieve more together, than could have been possible separately.
In health and social care there can be several teams, each moving at different speeds, over variable distances, all running at the same time. Producing a good performance will require a more sophisticated approach, better planning, more training, extra dedication and considerable amounts of mutual trust and understanding.

“Good discharge planning is the only way to ensure that the baton is passed safely and effectively across health and social care.”

The Welsh Assembly Government (WAG) has set out significant challenges for Health and Social Care Services in order to achieve world class standards. For example “Designed for Life” published in 2005 and “Fullfilled Lives; Supportive Communities” published in 2007. Many of the targets for each agency cannot be delivered without improving the practices and processes that enable patients to move smoothly through the hospital and wider care system.

There is an opportunity to impact upon the whole system, improving the patient journey and the patient experience by re-enforcing what needs to be done to make discharge safe and effective.
Acknowledgements

Editors
The Change Agent Team (CAT) within the National Leadership and Innovation Agency for Healthcare (NLIAH), has been responsible for facilitating the development of this Guide and providing the editorial function, bringing together the contributions into a single product:

Lynda Chandler
Lynda.chandler@nliah.wales.nhs.uk

Matt Wyatt
Matt.wyatt@nliah.wales.nhs.uk

Iain Roberts
Iain.roberts@nliah.wales.nhs.uk

Administrative support for the Community of Practice was provided by Lisa Conway.

Methodology
Producing this Guide has been a unique achievement in harnessing the knowledge and expertise of Health and Social Care Practitioners across Wales. The aim has been to produce a practical document which reflects the real-life experiences and aspirations of those on the frontline of effective discharge planning practice.

Grateful thanks are offered to the participating organisations for allowing people the time to attend workshops and for permission to share their tacit knowledge. The work has been completed ‘on top of the day job’ and everyone involved must be congratulated and thanked for their commitment and perseverance.
All of the individuals listed below are members of the national Discharge Planning Community of Practice (CoP). To reflect the different types of contribution that have been made, participants have been listed in three groups:

- A core group of CoP members attended most workshops and wrote elements of the Guide. These are listed as ‘authors’.
- Another group of CoP members were unable to attend workshops but did provide invaluable support by commenting on drafts and sharing information, policies and relevant documents. These are listed as ‘contributors’.
- The Expert Panel provided much valued external scrutiny and advice to ensure that the Guide supports the appropriate legal, regulatory and policy frameworks.

The Community of Practice is open to all health and social care Practitioners and managers who share the passion to make a difference. If you would like to join or require further information please contact the Change Agent Team.

Authors

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
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<tbody>
<tr>
<td>Wayne Turner</td>
<td>Blaenau Gwent Social Services</td>
</tr>
<tr>
<td>Sarah Thomas</td>
<td>Bridgend Local Health Board</td>
</tr>
<tr>
<td>Audrey Roach</td>
<td>Bro Morgannwg NHS Trust</td>
</tr>
<tr>
<td>Geraldine Bizby</td>
<td>Bro Morgannwg NHS Trust</td>
</tr>
<tr>
<td>Mandy Edwards</td>
<td>Bro Morgannwg NHS Trust</td>
</tr>
<tr>
<td>Judith Viney</td>
<td>Cardiff Social Services</td>
</tr>
<tr>
<td>Linda Jenkins</td>
<td>Cardiff &amp; Vale NHS Trust</td>
</tr>
<tr>
<td>Louise Williams</td>
<td>Cardiff &amp; Vale NHS Trust</td>
</tr>
<tr>
<td>Carole Walters</td>
<td>Carmarthen NHS Trust</td>
</tr>
<tr>
<td>Lynne Morgan</td>
<td>Carmarthen NHS Trust</td>
</tr>
<tr>
<td>Jon Rees</td>
<td>Carmarthen Social Services</td>
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<tr>
<td>Name</td>
<td>Organization</td>
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<tr>
<td>Gaby Staite</td>
<td>Ceredigion Health &amp; Social Care</td>
</tr>
<tr>
<td>Janet Davies</td>
<td>Conwy &amp; Denbighshire NHS Trust</td>
</tr>
<tr>
<td>Sue Fitton</td>
<td>North East Wales UA Partnership</td>
</tr>
<tr>
<td>Angela Michael</td>
<td>Gwent Healthcare NHS Trust</td>
</tr>
<tr>
<td>David Hopkins</td>
<td>Gwent Healthcare NHS Trust</td>
</tr>
<tr>
<td>Nicola Beerenbrock</td>
<td>Gwent healthcare NHS Trust</td>
</tr>
<tr>
<td>Cheryl Way</td>
<td>Informing Health Care</td>
</tr>
<tr>
<td>Wendy Rees</td>
<td>Monmouthshire Local Health Board</td>
</tr>
<tr>
<td>Sue Price</td>
<td>Monmouthshire Social Services</td>
</tr>
<tr>
<td>Janet Hawkridge</td>
<td>Neath Port Talbot Social Services</td>
</tr>
<tr>
<td>Carol James</td>
<td>Newport Social Services</td>
</tr>
<tr>
<td>Angela Fry</td>
<td>NLIAH</td>
</tr>
<tr>
<td>Gillian Jackson</td>
<td>NLIAH</td>
</tr>
<tr>
<td>Shari Lewis</td>
<td>NLIAH</td>
</tr>
<tr>
<td>Wendy Chaloner</td>
<td>North East Wales NHS Trust</td>
</tr>
<tr>
<td>Christina Griffith</td>
<td>North West Wales NHS Trust</td>
</tr>
<tr>
<td>Sharon Thomas</td>
<td>North West Wales NHS Trust</td>
</tr>
<tr>
<td>Christine Phillips</td>
<td>Pembrokeshire &amp; Derwen NHS Trust</td>
</tr>
<tr>
<td>Iris Lee</td>
<td>Pembrokeshire Social Services</td>
</tr>
<tr>
<td>Hilary Mullan</td>
<td>Powys Local Health Board</td>
</tr>
<tr>
<td>Jane James</td>
<td>Swansea University</td>
</tr>
<tr>
<td>Ceri Hamilton</td>
<td>Velindre NHS Trust</td>
</tr>
</tbody>
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**Contributors**

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Joanne Beecham</td>
<td>Caerphilly Local Health Board</td>
</tr>
<tr>
<td>Pose Akande</td>
<td>Cardiff Social Services</td>
</tr>
<tr>
<td>Mary Dykes</td>
<td>Cardiff Social Services</td>
</tr>
</tbody>
</table>
Angela Williams  |  Cardiff & Vale NHS Trust  
Debbie Murphy  |  Conwy & Denbighshire NHS Trust  
Margaret Rennocks  |  NLIAH  
Deb Harris  |  North Glamorgan NHS Trust  
Meryl Swales  |  Pontypridd & Rhondda NHS Trust  
Gill Haram  |  Swansea NHS Trust  
Chris Hennessy  |  Torfaen Social Services  
Vicky McCourt  |  Social Services Improvement Agency  
Lynne Turner  |  Workforce Development Unit Expert Panel  

**Expert Panel**

Neil Desmond  |  Welsh Local Government Association  
Gaynor Williams  |  Welsh Assembly Government – Waiting Times & Emergency Care  
Stephen Griffiths  |  NLIAH – Workforce Development Unit  
Jean White  |  Welsh Assembly Government – Office of the Chief Nursing Officer  
Malcolm Fisk  |  National Partnership Forum for Older People  
Molly Hughes  |  Carers’ Representative  
Paula Martyn  |  Welsh Assembly Government – Continuing NHS Health Care  
Rob Pickford  |  Care & Social Services Inspectorate for Wales  
Tessa Shellens  |  Morgan Cole Solicitors  
Trish Buchan  |  Powys Association of Voluntary Organisations  
Vivienne Walters  |  University of Swansea
How to Use the Guide

This Guide could be read in one long sitting, however the format is designed to enable Practitioners to dip in and out and pick up pertinent advice as and when it is needed.

The Guide should be relevant to a broad spectrum of staff across health and social care, so the use of language has been considered carefully.

The word Practitioner has been used as a common term to denote a member of qualified staff in any profession. Similarly there are many words used to describe the people who use public services and the terms person, individual, user, citizen and patient have been used across the document in the most appropriate context.

Throughout the Guide visual symbols have been used to easily identify significant learning points:

This icon identifies an insight or quote that provides an opportunity for Practitioners to reflect on their experience and practice.

This icon identifies a direct quote or paraphrased description of the experience of a service user.

This icon identifies a Case Study a real experience of how things have worked in practice or an example of how things should work.
Structure of the Guide

The Knowledge Barometer
Read this section first! It describes four steps to help individuals and teams begin to apply the Guide in to practice.

1. Principles of Effective Discharge Planning
Six common principles upon which effective discharge planning and successful transfers of care are dependent

2. Communicating with Patients & Families
How to develop effective dialogue with the patient, their family and carers and become a more effective communicator

3. Assessing the Whole Person
How to build a detailed, full and clear understanding of every service user through individualised assessments

4. Individualised Care Options
Proactively responding to individual needs by considering creative care packages tailored to each set of circumstances

5. Legal Issues Relating to Discharge
Making the effort to get it right first time by raising awareness of the current legal rights and obligations in the provision of care

6. Passing the Baton in Practice
Putting it all together on the day and creating a framework for identifying, training and developing the necessary expertise
The previous diagram highlights the Guide’s structure and colour coding. There is also an Appendix which includes a Bibliography and more detailed Subject Index.

‘Passing the Baton’ is structured over six chapters, each focussing on a specific aspect of discharge. Before the formal chapters begin, there is an important section of the Guide, called ‘The Knowledge Barometer’.

The Knowledge Barometer

The Knowledge Barometer should be read first as it contains a four step exercise to help begin the process of improving discharge planning practices. The ‘High Level Pathway’ and ‘Simplicity Matrix’ are tools that reinforce the core principles that are integral to all elements of the Guide.

Formal Chapters

Chapter 1 sets out the ‘Principles of Effective Discharge Planning’, refreshing the common aims and enabling Practitioners to begin to reflect on the purpose of discharge planning. It identifies that discharge is not an isolated event at the end of a patient’s stay in hospital. It is a process that starts on, or even before, admission and works best when planned collaboratively with colleagues, the patient and their family.

Chapter 2 offers tools, tips and advice for ‘Communicating with Patients and Families’. This Chapter will be of value to all staff, particularly as we know that the majority of complaints from service users are triggered by poor communication. One of the most important messages in this section is to remember that good communication requires a personal approach but is a collective responsibility. Care is provided by a team that must
communicate effectively with each other, with the patient, their family and carers, and also with colleagues in other agencies and locations.

**Chapter 3** focuses on ‘Assessing the Whole Person’ and the planning processes required to make discharge safe and effective. Very often health and social care Practitioners are focussed on dealing with the immediate clinical or social needs of the individual. This Chapter advocates taking a broader person centred approach and tools such as the ‘Daily RAP’ and the ‘4Ps’ will help Practitioners to embed the principles of effective discharge planning into everyday practice.

**Chapter 4** explores the need for discharge assessment and planning to take a much more creative approach, to produce ‘Individualised Care Options’. There is a need to develop care packages that are tailored to support individuals in ways that enable them to maintain their health and well-being for the longer term. There is real potential for this approach to develop and inform future commissioning arrangements.

**Chapter 5** works step by step through the complexities of the ‘Legal Issues Relating to Discharge’. This Chapter is not designed to turn people into amateur lawyers. It has been written with a number of very readable case studies to help guide staff through some of the more challenging aspects of discharge. Discharge can seem complicated with issues such as the Mental Capacity Act, Continuing NHS Health Care, the Protection of Vulnerable Adults and the Chapter will help de-mystify these and similar issues.

**Chapter 6** is devoted to the final practical steps to be taken in order to facilitate safe and effective discharge planning and actually ‘Passing the Baton in Practice’. This is a very simple summary to focus the minds of Practitioners on the operational considerations that lead up to the actual discharge or transfer of care. This Chapter also includes a section that provides guidance
for Practitioners responsible for education and training. It makes recommendations for developing local education programmes within a strategic Training Framework.

Currently there is no other single resource available in NHS Wales focused on discharge in the detail described in ‘Passing the Baton’. It is a living resource, so as practice changes and improves, or health and social care policy changes, so the Guide will be updated. In the meantime, within the Guide and the accompanying resources on the CD, there are many examples of good practice, information and tools available for use and development.

“There are real consequences to dropping the baton starting with the patient and emanating out to untold people who have to pick it back up. Compensating for poor planning wastes time and energy, requires more money that we don’t have and ultimately takes other Practitioners away from other patients. Nobody wins!”