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Local Authority Chief Executives
Local Authority Directors of Social Work/Chief Social Workers
Local Authority Directors of Housing
Local Authority Directors of Finance
NHS Chief Executives
Relevant Voluntary Sector Organisations

13 January 2004

Dear Colleague

FRAMEWORK FOR THE PRODUCTION OF JOINT HOSPITAL DISCHARGE PROTOCOLS

Background

1. This circular provides a model framework for the production of hospital discharge protocols.

2. The Scottish Executive's *Delayed Discharge Action Plan*[1] (March 2002) included a commitment to develop, implement and audit joint discharge policies and protocols. The basis for this was first provided in Scottish Executive Circular SWSG 10/98 – *Community Care Needs of Frail Older People – Integrating Professional Assessments and Care Arrangements*[2]*, paragraph 29*:

   "All [NHS] Boards, NHS Trusts, social work and housing authorities should agree local protocols that enable discharge from hospital when the person's in-patient treatment is concluded."

3. Circular SWSG 10/98 anticipated joint local discharge protocols being put in place across the country for frail older people.

4. A recent survey of Local Authority and NHS Board Partnerships showed that only some areas have joint local discharge protocols or formalised agreements in place. The Scottish Executive considers that there are clear advantages to working to a formal, jointly agreed protocol covering discharges from both acute and longer–term settings. These provide a more effective way to plan and deliver services which involve a number of different organisations and also ensure a more consistent service for those people who move on to an additional stage of care after hospital. The need to tackle delayed discharge reinforces the importance

[1] http://www.show.scot.nhs.uk/sehd/publications/dc20020305delaydisch.pdf
[2] http://www.scotland.gov.uk/library/swsg/index-f/c216.htm

of ensuring that effective protocols are now put in place in every NHS Board and Local Authority area to cover the discharge of all people.

Purpose

5. This guidance is for the attention of Local Authorities and NHS Boards. It is a description of best practice which should be adopted by each body involved in the process and is issued as statutory guidance to Local Authorities for the purposes of section 5(1) of the Social Work (Scotland) Act 1968.

Rationale

6. To help ensure broad consistency across Scotland in terms of approach, coverage, content and administrative arrangements, the Scottish Executive is offering guidance on the framework for joint protocols. The guidance includes a checklist (see Annex) which is intended to be directly relevant and useful to Local Authority and NHS Partnerships in producing local joint protocols. Each Partnership should work to produce an effective protocol. Partnerships should train staff in the implementation of the protocol, set themselves a deadline for implementing it and should carry out joint reviews, at least annually, to check the protocol is producing the intended results.

7. The framework for the production of discharge protocols which follows has been drafted in the specific context of the *Delayed Discharge Action Plan*. A framework for the production of hospital discharge protocols has a broader application and needs to take account of the fact that the vast majority of patients leaving hospital care will go home without the need for post-hospital care services. The checklist that follows aims to provide a good practice model that will apply to any local joint discharge protocol and also take account of the factors that result in delayed discharge.

Joint working

8. The arrangements for discharge planning are part of wider joint working underpinned by the Joint Future Agenda. There is now a context of Single Shared Assessment[3], joint partnerships, joint management, joint resourcing and joint services that aims to produce better results for individuals. Discharge arrangements need to reflect that and to contribute to it. Joint working is essential for the effective management of discharge from hospital. In some cases, decisions on the best care for an individual following discharge from hospital are based on a professional assessment of his/her health, social care and housing needs. It is important therefore, that the input from these professionals is co-ordinated effectively and promptly. Developing and working to agreed joint local protocols helps to ensure these outcomes. It is very important that there are no gaps in service or unnecessary duplication of effort. People being discharged from hospital are entitled to expect a smooth transition from one stage of their care to the next. The introduction of the Single Shared Assessment should now be

[3] Single Shared Assessment (SSA) was introduced following the Joint Future Group's Report, "Community Care: A Joint Future". The guidance on SSA issued in November 2001 sets out expectations for SSA and the steps partner agencies can take to implement shared arrangements for assessment in community care across social work, health and housing. SSA should eliminate duplication in assessment, ensure that information is shared across agencies with the consent of the person being assessed, and speed up the delivery of appropriate services. A lead professional will co-ordinate input to the assessment, ensure that agreed services are put in place and be a point of contact for the service user. The SSA process is an administrative arrangement between local authorities and relevant NHS bodies to improve the results for people who use services and make better use of agencies' resources and professionals' skills. It should be implemented for all community care groups from 1 April.

having an impact on the process followed by Partnerships when managing discharge. The whole emphasis should be on a more streamlined approach in assessment.

Management of discharge from hospital

9. There is already specific guidance for Local Authorities, NHS Boards and housing partners to work to in managing discharges from hospital. Circular SWSG 10/98 (referenced earlier) provides detailed guidance on integrating discharge planning for frail older people. The same guidance circular also requires that clear targets and timescales for the provision of community and health care services should be set out in local protocols. This guidance circular supplements and updates SWSG 10/98. With regard to community care assessment, social work departments should agree timescales with their health and housing partners and suggest 'good practice' targets for the assessment of older people with both straightforward and more complex needs. These are important elements of any protocol.

10. The individual's interests must remain central to discharge planning. The assessment and discharge planning process should at all stages be person-centred and should always involve regular consultation with the individual and his or her family/carer/advocate. Decisions to be made about any aspect of the individual's care should take into account the needs and wishes of the individual (and his or her carer) at all times. It is crucial that consultation through the assessment and discharge planning process is co-ordinated and that the individual and his or her carer have the quickest possible access to services. Joint local discharge protocols should take into account the Scottish Executive's *Choice of Accommodation – Discharge from Hospital* Guidance (CCD 8/2003).

11. Joint local discharge protocols help to ensure a consistent and systematic understanding of the roles and responsibilities of local staff involved in the assessment and discharge planning process. Where such protocols are in place, it is more likely that services will be co-ordinated to best meet the individual needs of the person receiving care and be in line with his/her wishes. Protocols are also more likely to provide a solid basis for NHS and Local Authority staff to work together to deliver effective integration between social work, continuing NHS care and care management arrangements.

12. After consultation and discussion with Local Authority and NHS professionals about what is required, the checklist framework has been drawn up for Local Authority and NHS Board Partnerships to follow. A checklist of key elements that their own local protocol *should* incorporate is included at the Annex to this document. These elements are not an exhaustive list of everything that might be included and the framework has been designed to enable Partnerships to incorporate additional, local or service-specific information, alongside those elements described in the checklist. The Scottish Executive recognises the fact that the independent and voluntary sectors play an important role in providing care for many people after discharge from hospital. Joint local discharge protocols should where appropriate, recognise the contribution made by independent and voluntary care services.

Action

13. Protocols are *working documents.* As services and practices develop at a local level, protocols will inevitably need to be reviewed to improve or add to ways of working and to accommodate new service developments in each area (for example the Single Shared Assessment). Regular review dates are an important part of the protocol process.

14. Once the protocols have been agreed, the Scottish Executive proposes to audit them before making them available as part of the Scottish Executive Health Department website[4] .

15. All enquiries relating to this letter and Annex should be addressed to John Waugh (e-mail JohnD.Waugh@scotland.gsi.gov.uk, telephone 0131 244 3748).

Yours sincerely

MS JINNY HUTCHISON

[4] http://www.scotland.gov.uk/Topics/?pageID=248

Hospital Discharge Protocols: Checklist of minimum requirements

Minimum requirements	Does protocol meet requirement? Y/N	If not, provide: (a) date for review; and (b) name of responsible officer
General 1. Endorsed by Partnership Joint Board or the Chief Executives of the relevant Local Authorities and NHS bodies for each planning area. <u>Principles and Values</u> 2. Outlines principles and values and sets out a basic commitment to meeting the needs and wishes of those being discharged from inpatient care in hospital, and those of their carers. <u>Joint Working</u> (The protocol clearly reflects the Joint Future agenda and identifies specific arrangements for joint working throughout the discharge planning process. Where appropriate this should involve the independent and voluntary sectors.) 3. Describes how joint working will be effected between: - The person, family/carers - The Primary Care team - The Secondary Care team - The Social Care team - Associated Healthcare Professionals - Registered providers of health services - Pharmaceutical professionals - Registered providers of Care services - Housing authorities and providers		

[5] Scotland's eCare website at http://www.show.scot.nhs.uk/ecare/draftprotocols/ details current issues and arrangements relating to the sharing of information by health and social care practitioners.

[6] For people that require admission to a care home following their treatment in hospital the Scottish Executive guidance circular, *Choice of Accommodation – Discharge from Hospital* (CCD 8/2003), indicates that the whole discharge process should normally take **no longer than 6 weeks** from the moment the patient is clinically ready for discharge.

- Ambulance services - Voluntary services - Independent advocacy services 4. Defines the roles, involvement and responsibilities of all the parties involved in the assessment and discharge from hospital. This description should detail responsibility for planning and co-ordination, as well as for the patient's welfare. <u>Delayed Discharge</u> 5. Places the Protocol in the context of local joint work to tackle the issue of delayed discharge. <u>Information Sharing</u> 6. Identifies arrangements for sharing information between the respective teams and professionals across organisational boundaries.[5] <u>Discharge Plan</u> 7. Indicates which named member(s) of staff should have responsibility for discharge planning. Involves the patient and their carer, where applicable, in discharge planning. In the case of planned admissions it will often be possible for discharge planning to be initiated prior to admission. <u>Process of discharge</u> 8. Identifies the medical staff responsible for making the clinical decision that a patient is ready for discharge. Outlines the role of social work staff, associated health professionals, carers and other professionals in the discharge process. <u>Time Framework</u>[6] 9. Sets out a clear time framework for the delivery of each service and should also set out maximum time expectations by which each service should be delivered or each professional		

intervention made. 10. Sets out procedures to ensure assessments are completed promptly. <u>Information for Patients</u> 11. Sets out arrangements for involving the patient (and his or her family/carers/advocates) in decisions made at each stage of the assessment and discharge from hospital process. These arrangements should make clear whose responsibility it is to provide information. 12. Makes provision where appropriate for the availability of information in an accessible format on patients' rights, post-hospital care services and choice of accommodation. <u>Carers</u> 13. Sets out arrangements for informing and involving carers at all stages of the discharge process, establishing the level of care they are able and willing to provide and offering support where necessary.		
Specific <u>Standard Procedure</u> 14. Provides an outline of a 'standard' discharge procedure for professionals to refer to. This should include details of how discharge from hospital is actively promoted and arranged from the pre-admission stage on, including who is responsible for making it happen. <u>Those Entering Hospital for Elective Surgery</u> 15. This should include details of how discharge from hospital is actively promoted and arranged from the pre-admission stage on, including who is responsible for making it happen		

Vulnerable or 'At Risk' Individuals 16. Sets out specific arrangements for professionals to deal with vulnerable or 'at risk' individuals. These should include early identification and intervention arrangements (e.g. pre-admission screening and early referral by admitting nurse to care manager), contract arrangements with independent care providers and detail on how these individuals will progress to the next stage of care after hospital, including who has responsibility for making it happen. Specific timescales for actions should be identified. Individuals with Complex Needs 17. Sets out specific arrangements for professionals to deal with individuals with complex needs. These should include early identification and intervention arrangements (e.g. pre-admission screening and early referral by admitting nurse to care manager) and detail on how these individuals will progress to the next stage of care after hospital, including who has responsibility for making it happen. Specific timescales for actions should be identified. Dealing with Disputes 18. Sets out specific, local arrangements to deal with legal disputes, disagreements over financial assessment and any other disputes and clearly defines responsibilities. 19. Existing Scottish Executive Guidance and the NHS complaints procedure should be used in the resolution of any appeals and complaints where appropriate. Discharge to residential care 20. Sets out arrangements in line with the Scottish Executive *Choice of Accommodation – Directions on Choice* Guidance 1993 and *Choice of*		

Accommodation – Discharge From Hospital (CCD 8/2003) guidance. 21. Outlines both short and long term planning and support mechanisms for post-hospital care. Assigns responsibility for discharge team to identify the patient's G.P. and inform him/her of the discharge arrangements. Free Care on Leaving Hospital 22. The protocol will identify the services available free of charge for the first 28 days following discharge.		
Monitoring and Review mechanisms Discharge planning and process 23. Provides a mechanism to monitor and evaluate the effectiveness of the discharge from hospital for each individual, and to report on this regularly to Partners. Evaluation should include the patient/carer perspective on the effectiveness of the system. Review of procedures 24. Outlines a commitment by the respective partners to conduct ongoing reviews of the discharge from hospital procedures and planning and indicates who is responsible for this, at what intervals review is to be carried out, and how it is to be reported to Partners (consistent with any requirements of the Scottish Executive). A date should also be specified for review of the discharge protocol. 25. Describes the process of monitoring discharge arrangements and how this information is made available to professionals and patients/carers.		