A Practical Guide to Delivering

Effective Discharge Planning and Practice

Improving transfer of care

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15% Group booking discount**

Monday 10 July 2017 De Vere West One Conference Centre, London

Chair and Speakers include:

Liz Deutsch
Consultant Nurse (acute medicine) Currently undertaking an NIHR funded PhD Research Fellowship in Discharge Practice and Risk Assessment

Liz Sargeant
ECIP Clinical Lead Integration Health and Social Care
NHS Improvement

Supporting Organisations

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"Many acute beds in all hospitals are occupied by patients who no longer need them and indeed whose recovery may be jeopardised by them staying in hospital too long. Delayed discharges are not just an inconvenience; they lead to poorer experiences for patients and prevent hospitals providing responsive care for other patients requiring acute care and, frequently, for patients needing admission for planned procedures." Care Quality Commission, 2nd March 2017

"Some patients in England face delays of months - and in one case over a year - to leave hospital.. Hospital records suggest nearly three-quarters of NHS trusts had seen patients stranded for more than 100 days in the past three years. Those caught up in the problem said the experience had left them feeling down, isolated and frightened...The numbers of days lost to delays has nearly doubled since 2010 to 200,000 a month." BBC News 8th February 2017

This conference focuses on improving discharge planning and practice. Through national updates and practical case studies the conference will provide you with the latest evidence and practice tools to improve discharge practice in your service.

By attending this conference you will:

- **Understand how to change the way discharge planning works learning from organisations who have achieved 0% of overstaying older people**
- **Improve joint working on discharge between primary care, hospitals, GPs, community services and adult social services**
- **Develop your skills in effective implementation of Discharge to Assess**
- **Ensure the effective use of Discharge Protocols and tools in practice**
- **Monitor progress against the NICE Guideline on Transition between inpatient hospital settings and community or care home settings for adults with social care needs**
- **Improve safety at discharge and transfer of care**
- **Change the way we work in discharge of the frail elderly and developing the role of the Discharge Coordinator**
- **Improve patient transition pathways including a re-enablement programme to promote independence and hospital discharge optimisation**
- **Network with other leading practitioners working on discharge practice**

Follow this conference on Twitter #DischargeNHS

10.00 Chair's Welcome & Introduction

Liz Deutsch *Consultant Nurse (acute medicine) Currently undertaking an NIHR funded PhD Research Fellowship in Discharge Practice and Risk Assessment*

10.10 Hospital to Home: Changing the way discharge planning works to achieve 0% of overstaying older people

Dr David Evans
Chief Executive
Northumbria Healthcare NHS Trust

- hospital to home: changing the way discharge planning works
- bringing together GPs, hospitals, community teams and social care workers to jointly develop and redesign care and services to strengthen re-ablement and rehabilitation for patients
- how we have achieved 0% of overstaying older people
- learning from the Northumbria Model

10.40 EXTENDED SESSION: Helping people home: Working together to reduce delayed transfers of care

Sarah Mitchell
Director
Towards Excellence in Adult Social Care (TEASC) LGA

- improving joint working on discharge between primary care, hospitals, GPs, community services and adult social services
- models of care for discharge to assess, and assess to admit
- improving patient flows within the hospital, smoothing transitions between modes of care
- giving people the training and tools to remain independent after discharge
- the impact on delayed discharge

11.20 Question and answers, followed by tea & coffee at 11.30

12.00 EXTENDED SESSION: Effective Discharge Planning from acute care

Liz Deutsch
Consultant Nurse (acute medicine) NIHR funded PhD Research Fellowship Discharge Practice and Risk Assessment: in highly acute care settings

Health and social care organisations should agree clear discharge planning protocols, NICE, November 2015

- brief introduction to research
- what is meant by risk?
- how is assessment for discharge undertaken in acute care?
- challenges of discharge assessment on admission (staff)
- what are the patient and carer perspectives of discharge assessment in acute care?
- summary: what improvements could be made?
- moving forward: developing and agreeing clear discharge protocols

12.45 Question and answers, followed by lunch at 12.55

13.50 Monitoring progress against the NICE Guideline on Transition between inpatient hospital settings and community or care home settings for adults with social care needs

Dr Olivier Gaillemin
Member, Guideline Development Group, Transition between inpatient hospital settings and community or care home settings for adults with social care needs NICE & *Consultant Physician in Acute Medicine*
Salford Royal NHS Foundation Trust

- improving discharge planning and practice
- implementing the NICE recommendations
- delivering a person-centred care approach to discharge

14.20 EXTENDED SESSION: Practical steps and tools for good discharge practice

Liz Sargeant
ECIP Clinical Lead Integration Health and Social Care
NHS Improvement

- the red to green approach
- developing good discharge practice: case studies and tools that can help
- interactive group work and discussion

14.50 A collaborative approach to improving safety at discharge and transfer of care

Dr Patrick Waterson
Reader in Human Factors and Complex Systems
and Eva-Maria Carman
Research Associate
Human Factors in Complex Systems Research Group
Loughborough Design School Loughborough University

- analysis of the risks to patient safety during transfers between hospital and patients' usual place of residence
- identification of system aspects that promote safety and efficiency of the discharge process
- identification of potential areas for improvement of safety with regards to the discharge process

15.30 Question and answers, followed by tea & coffee at 15.40

15.50 Changing the way we work in discharge of the frail elderly and developing the role of the Discharge Coordinator

Sue Jones
Director of Nursing
North Bristol NHS Trust

"NICE recommends that a single health or social care practitioner should be made responsible for coordinating a person's discharge" November 2015

- how do we meet the NICE recommendation that a single health or social care practitioner should be responsible for coordinating a persons discharge?
- increasing the use of 'discharge to assess'
- our experience

16.20 Improving patient transition pathways including a re-enablement programme to promote independence and hospital discharge optimisation

Lisa Martin
Team Manager Short Term Pathway
with Claire Casarotto
Integrated Discharge Team Lead
Kent County Council

- integrated discharge team development
- developing and effective re-enablement programme to promote independence
- improving patient transition pathways
- hospital discharge optimisation
- our experience

16.50 Question and answers, followed by close at 17.00

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Date Monday 10 July 2017

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