

THURSDAY 16 SEPTEMBER 2010 MANCHESTER CONFERENCE CENTRE

A Practical Guide to delivering

Effective Discharge Practice and Transfer of Care

FOR ALL MEMBERS OF THE MULTIDISCIPLINARY TEAM

Following the announcement in the recently revised operating framework for 2010/11 to develop re-ablement and post discharge support and ensure that hospitals are responsible for patients for 30 days after discharge

Topics include:

- Planning the discharge and transfer of patients: national update
- Delayed discharge and increased length of stay: a CEO perspective
- Delivering Effective Discharge Practice: the impact on quality and productivity
- Monitoring and evaluating the causes, length and types of delays in the patient pathway to support discharge planning
- Planning for discharge or transfer of care at pre-assessment
- The patient perspective on discharge
- Sharing responsibility for discharge: nurse led discharge
- Improving medicines management practice at discharge or transfer of care
- Aligning services to ensure continuity of care: improving the interface between hospital, community, and social care
- Managing complex discharges in practice
- Transfer of care for those at end of life: a Hospice perspective

Case Studies include:

- Implementing the High Impact Action: Ready to go – no delays
- The Enhanced Recovery Programme
- Introducing a patient healthcare book for use when discharging patients from hospital
- Discharging children and young people with high support needs from hospital

Chair and keynote speakers:

Ruth Eley

*Programme Head Older People
and Dementia Programme
Department of Health*

Dr Mark Newbold

*Chief Executive
Heart of England NHS Foundation Trust*

David Long

*Senior Respiratory Nurse Specialist
Taunton and Somerset NHS Trust*

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“Making hospitals responsible for a patient's ongoing care after discharge will create more joined-up working between hospitals and community services and may be supported by the developments in re-ablement and post-discharge support. This will improve quality and performance and shift the focus to the outcome for the patient.”

REVISION TO THE OPERATING FRAMEWORK FOR THE NHS IN ENGLAND 2010/11 DEPARTMENT OF HEALTH JUNE 2010

Following the announcement in the recently revised operating framework for 2010/11 to develop re-ablement and post discharge support and ensure that hospitals are responsible for patients for 30 days after discharge, chair **Ruth Eley** *Programme Head Older People and Dementia Programme* Department of Health will open this seventh national conference with an introduction to meeting the new standard to improve patient outcomes and reduce readmissions. Ruth will also discuss the 10 key steps for discharge or care transfer as outlined in the Department of Health publication: ‘Ready to go? Planning the discharge and the transfer of patients from hospital to intermediate care’.

“Discharge or care transfer is an essential part of care management in any setting. It ensures that health and social care systems are proactive in supporting individuals and their families and carers to either return home or transfer to another setting. It also ensures that systems are using resources efficiently.”

READY TO GO? PLANNING THE DISCHARGE AND THE TRANSFER OF PATIENTS FROM HOSPITAL AND INTERMEDIATE CARE DEPARTMENT OF HEALTH MARCH 2010

Focussing on effective discharge practice and transfer of care the conference continues with a variety of topics including; a CEO perspective, delivering quality and productivity gains, and monitoring and evaluating the causes, length and types of delays in the patient pathway to support discharge planning. The conference also features case studies, including High Impact Action: Ready to go - no delays, introducing a patient healthcare book for use when discharging patients from hospital, the Enhanced Recovery Programme (*a multidisciplinary initiative aiming to prepare patients for surgery and reduce its physical impact, helping patients to recover more quickly*) and Discharging children and young people with high support needs from hospital.

Delegates will have the opportunity to hear practical advice from leading practitioners on improving and redesigning the discharge process to deliver high quality care, improve the patient experience and make efficiency savings.

10.00 Chair's welcome and introduction

Planning the discharge and transfer of patients: national update

Ruth Eley

Programme Head, Older People and Dementia Programme
Department of Health

- providing re-ablement and post-discharge support: working collaboratively
- Ready to go? an overview of the recently published guidance and the 10 key steps for discharge or care transfer

10.35 Delayed discharge and increased length of stay: a CEO perspective

Dr Mark Newbold

Chief Executive
Heart of England NHS Foundation Trust

- a productivity issue, or an ethical one?
- acute hospital or health system problem?
- caring for our elderly – the single most important issue facing the Acute Trust?

11.00 Delivering effective discharge practice: the impact on quality and productivity

Case study: implementing the High Impact Action: Ready to go – no delays

David Long

Senior Respiratory Nurse Specialist
Taunton and Somerset NHS Trust

- an overview of the Taunton Hospital Respiratory Early Assisted Discharge Scheme (THREADS) 'Experience'
- ensuring Early Assisted Discharge is safe and effective
- the impact on quality and costs including length of stay

11.25 Questions and answers, followed by coffee and exhibition at 11.35

FOCUS: UNDERSTANDING AND IMPROVING DISCHARGE PRACTICE/PLANNING AND TRANSFER OF CARE

11.50 Monitoring and evaluating the causes, length and types of delays in the patient pathway to support discharge planning

Speaker to be announced

- 'walking the patient pathway' to identify bottlenecks and areas for improvement
- reducing variation and delay in the patterns of patient discharge
- predicting length of stay

12.20 Planning for discharge or transfer of care at pre-assessment

Case study: the Enhanced Recovery Programme

The Enhanced Recovery Programme is a multidisciplinary initiative aiming to prepare patients for surgery and reduce its physical impact, helping patients to recover more quickly.

Jennie Burch Enhanced Recovery Facilitator

with a dietician and physiotherapist

The North West London Hospitals NHS Trust

- supporting surgical patients to recover more quickly and preparing for timely discharge
- improving patient experience: discharge planning at pre-assessment
- informing patients of how they are to be involved in their care and what they can do to reduce postoperative complications and their length of stay
- preparing patients for early mobilisation and feeding postoperatively: working with the multidisciplinary team

12.50 Questions and answers, followed by lunch and exhibition at 13.00

FOCUS: COLLABORATIVE WORKING TO REDUCE DELAYS AND ENSURE CONTINUITY OF CARE

14.00 The patient perspective on discharge

Paul Mainwaring

Chair Patients Council and
Member Greater Manchester Essence of Care Panel
The Patients Council in Manchester now has over 18,000 members

- what are the issues that matter to patients within the discharge process
- lessons from a large scale patient led research survey into discharge practice in Manchester
- how patients can be involved in the discharge pathway
- how could the process be improved from a patient perspective

14.25 Sharing responsibility for discharge: nurse led discharge

Julie Pilley Senior Nurse/Discharge Coordinator

and Ann Prime Emergency Care Development Project Manager
Luton and Dunstable Hospital Foundation Trust

- rotating ward staff through the role of discharge coordinator
- ensuring ward nurses are competent to lead discharge planning
- implementing the Productive Ward module on admission and discharge planning
- the impact on delayed discharges and length of stay

14.50 Improving medicines management practice at discharge or transfer of care

Case study: introducing a patient healthcare book for use when discharging patients from hospital

Dr Labib Tadros

Senior Clinical Pharmacist
County Durham and Darlington NHS Foundation Trust

- raising awareness: involving patients in the care process and empowering them to have control over their own medication
- the patient healthcare book and the impact on the quality and safety of patient care
- ensuring GPs are provided with clear, comprehensive and complete discharge documentation within 24 hours of discharge
- implementing systems to ensure medicines are not omitted or delayed during transfer of care

15.15 Questions and answers, followed by tea and exhibition at 15.25

15.45 Aligning services to ensure continuity of care: improving the interface between hospital, community, and social care

Eileen Burns

Consultant and Clinical Director, Care of the Elderly
The Leeds Teaching NHS Trust

- delivering the right care in the right place: our experiences in Leeds
- notifying social care: ensuring the assessment and discharge notifications are met
- the common pitfalls and how to overcome them: communicating with patients and their carers and the multidisciplinary/multi agency team

16.10 Managing complex discharges in practice

Case study: discharging children and young people with high support needs from hospital

Amanda Allard

Principal Officer
Council for Disabled Children

- working together to negotiate and plan the discharge of children and young people with high support needs
- outlining six basic principles on which to base the discharge process
- overcoming obstacles to complex discharges: addressing the concerns of primary care staff

16.35 Transfer of care for those at end of life: a Hospice perspective

Paul Read

Admissions and Discharge Co-ordinator
St Catherine's Hospice

with Christine Addelsee

Discharge Co-Ordinator
The Martlets Hospice

- ensuring mechanisms are in place for assessing the needs and preferences of those approaching end of life
- improving the patient experience, promoting choice and supporting relatives and carers
- training and educating the multidisciplinary or multi agency team

17.00 Questions and answers, followed by close

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Conference Registration

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Date

Thursday 16 September 2010.

Conference fee

- £365 + VAT (£428.88) for NHS, social care, private healthcare organisations and universities.
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