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A Practical Guide to Delivering

Effective Discharge Planning and Practice

Improving transfer of care

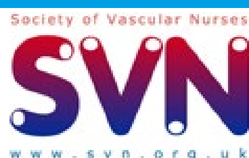
Monday 22 January 2018 De Vere West One Conference Centre, London

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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"While our time is busy and important, our patients' time is sacred – let's make giving back time by enabling our patients to return to the place they call home our challenge. It's one where every member of our clinical teams and every member of staff can have an impact and make a difference." **Jane Cummings, Chief Nursing Officer, NHS England, December 2017**

The biggest challenge that hospital trusts face is maintaining a consistent flow of patients through the acute medical and surgical pathways…. Over the past three years, delays in transfers of care have all increased substantially. The majority of days delayed are still attributed to the NHS (55% in March 2017).However, the sharpest increases have been in certain adult social care attributed delays... Overall, keeping patients in hospital longer than required can have a number of detrimental effects. Long stays can affect patient morale, mobility, and increase the risk of hospital-acquired infections." **Care Quality Commission 10th October 2017**

"Last year there were 2.25 million delayed discharges, up 24.5% from 1.81 million in the previous year. This government is clear that no-one should stay in a hospital bed longer than necessary: it removes people's dignity; reduces their quality of life; leads to poorer health and care outcomes for people; and is more expensive for the taxpayer." **Jeremy Hunt, Secretary of State for Health July 2017**

"A delayed transfer of care occurs when a patient is medically fit for discharge from acute or non-acute care and is still occupying a bed…There were 178,400 total delayed days in June 2017" **Delayed Transfers of Care Data, England June 2017**

"The transfer of care – from hospital to home, or between any other part of the system – represents major pinch points where services and processes often struggle to be truly integrated around the needs of individuals." **SCIE**

"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 to reduce delayed transfer of care. 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
- Learn from national developments in the deliver of the Better Care Metrics
- 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
- Change the way you think about patient experience to improve discharge: delivering the Last1000days, SAFER care bundle, Red2Green and #EndPJparalysis
- Ensure the effective use of Discharge Protocols and tools in practice
- Improve safety at discharge and transfer of care
- Understand how to improve practice in complex discharges
- Change the way we work in discharge of the frail elderly increase the use of discharge to assess
- Network with other leading practitioners working on discharge practice

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 Reducing delayed transfer of care: lessons from Better Care

Rosie Seymour
Deputy Programme Director
Better Care Support Team

- current developments
- metrics for reducing delayed discharges from hospital
- Integration and Better Care Fund Planning Requirements 2017-19
- current developments and case studies of good practice

10.40 EXTENDED SESSION: Hospital to Home
Changing the way discharge planning works to achieve 0% of over Staying 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

11.25 Question and answers, followed by tea & coffee at 11.35

12.00 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

12.45 Changing the way we think about patient experience to improve discharge
Bringing the Last1000days and Red2Green to life through #EndPJparalysis

Anne-Marie Riley
Deputy Chief Nurse (Operations)
Nottingham University Hospitals NHS Foundation Trust

- enabling patients to get into their own clothes to build system capacity by improving patient flow, enabling more timely discharges, reducing length of stay, and more timely admissions for other patients
- last 1000 days and Red2Green explained
- the impact on patient experience

13.15 Question and answers, followed by lunch at 13.25

14.15 EXTENDED SESSION: Effective Discharge Planning from acute care: Improving safety at discharge

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

- 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

15.00 Question and answers, followed by tea & coffee at 15.10

15.30 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
- the SAFER care bundle
- developing good discharge practice: case studies and tools that can help
- interactive group work and discussion

16.15 Changing the way we work in discharge of the frail elderly: discharge 2 assess

Emma Bowyer
Trust Lead for UHS@home
University Hospitals Southampton NHS Foundation Trust

- working in partnership in health and social care to get patients home whilst they are well, reducing the delay to care assessment and facilitating assessment in the patients home
- increasing the use of 'discharge to assess'
- improving patient transition pathways
- our experience in Southampton

16.45 Question and answers, followed by close at 16.55

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Effective Discharge Planning and Practice

Monday 22nd January 2018

De Vere West One Conference Centre, London

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Venue
De Vere West One Conference Centre, 9-10 Portland Place, London, W1B 1PR. A map of the venue will be sent with confirmation of your booking.

Date Monday 22 January 2018

Conference Fee
☐ £365 + VAT (£438.00) for NHS, Social care, private healthcare organisations and universities.
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