

A Practical Guide to Delivering Effective Discharge Planning and Practice

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*Meeting the NICE Guidance on Transition between
inpatient hospital settings and community or care home settings
for adults with social care needs*

Wednesday 19 October 2016 Hallam Conference Centre



Speakers include

Dr Olivier Gaillemain *Member, Guideline Development Group, NICE &
Consultant Physician Salford Royal NHS Foundation Trust*

Liz Deutsch *Consultant Nurse Acute Medicine*

Supporting Organisations



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"Our investigations have found that some of the most vulnerable patients, including frail and older people, are enduring harrowing ordeals when they leave hospital....'Poor planning, coordination and communication between hospital staff and between health and social care services are failing patients, compromising their safety and dignity....We are aware that structural and systemic barriers to effective discharge planning are long standing and cannot be fixed overnight....Health and social care leaders must work harder to uncover why ten years of guidance to prevent unsafe discharge is not being followed, causing misery and distress for patients, families and carers."

Parliamentary and Health Service Ombudsman, 11th May 2016

"This report shows unacceptable failings in care and some patients have been terribly let down, so it is vital that we ensure lessons are learned. We expect the NHS to ensure patient safety and social care needs are taken into account when making clinical decisions about discharging patients from hospital." Department of Health May 2016

"Rather than frail elderly people staying in hospital longer than they need to, it is better to get patients home as quickly as possible and to assess them in their own homes rather than in a hospital – but this must be done with the right help and support in place." NHS Improvement May 2016

Following the May 2016 Ombudsman Report of investigations into unsafe discharge from hospital, and the 1st December 2015 NICE national guideline on the Transition between inpatient hospital settings and community or care home settings for adults with social care needs, this conference focuses on improving discharge planning and practice and meeting the new recommendations in practice.

The new guideline calls for continuity of care for people being transferred from hospital...Hospitals should ensure that any pressure to make beds available does not result in unplanned and uncoordinated discharges...In addition, hospital and community teams should work together to tackle factors that could prevent a safe and timely transfer of care from hospital.

"Delays in the discharge of patients place a huge burden on the NHS. Figures from NHS England show that more than a million hospital days were lost due to delayed discharges over the past year. In September, 5,247 patients were delayed from being discharged, which is the highest figure so far in 2015. Ensuring people also receive the most appropriate services when they are discharged from hospital also has a crucial effect on a person's wellbeing. It can speed up their recovery and ensure they are not readmitted because they are not receiving the right support at home." NICE, December 2015

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10.00 Chairs Introduction

Liz Deutsch

Consultant Nurse (Acute Medicine)

Currently undertaking an NIHR funded PhD Research Fellowship in Discharge Practice and Risk Assessment

10.05 Learning from the 2016 Ombudsman report of investigations into unsafe discharge from hospital

Representative

Parliamentary and Health Service Ombudsman

- learning from the Ombudsman report and overcoming the issues identified
- issue one: patients being discharged before they are clinically ready to leave hospital
- issue two: patients not being assessed or consulted properly before they leave
- issue three: relatives and carers not being told that their loved one has been discharged
- issue four: Patients being discharged with no home-care plan in place or being kept in hospital due to poor co-ordination across services
- moving forward

10.35 Meeting the New NICE Guidelines on transition between inpatient hospital settings and community or care home settings for adults with social care needs

Dr Olivier Gaillemain

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 practice

11.05 EXTENDED SESSION: Helping people home Working together to reduced delayed transfer 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

11.40 Question and answers, followed by coffee

12.15 Extended Facilitated Session: Effective Discharge Planning and Discharge Protocols

“Health and social care organisations should agree clear discharge planning protocols” NICE 2015

Liz Deutsch

Consultant Nurse (Acute Medicine)

Currently undertaking an NIHR funded PhD Research Fellowship in Discharge Practice and Risk Assessment

This interactive session will focus on

- assessment on admission
- what's the risk?
- developing and agreeing clear discharge protocols
- synopsis of current research
- follow up after discharge
- what's the patient's story?
- Nurse facilitated discharge update
- summary of what we are learning

13.00 Question and answers, followed by lunch

13.45 Changing the way we work in discharge of the frail elderly and developing the role of the discharge liaison coordinator

Tamsin Cater

Lead Discharge Liaison Nurse

Oxford University Hospitals NHS Foundation Trust

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

14.15 Changing the way discharge planning works: Operational Planning to achieve NICE 27

Speaker to be announced

- changing the way we work to achieve NICE 27
- developing local protocols and procedures
- developing the role of the Supported Integrated Discharge (SID) team at Birmingham Heartlands

14.45 Discharge to assess in practice

Speaker to be announced

- implementing 'Discharge to Assess' in practice: our experience
- barriers to routine discharge management and solutions
- developing effective ward round practice and process: the impact on discharge
- developing community health and social care to support early discharge

15.30 Question and answers, followed by tea

16.00 Improving the discharge pathway for complex discharges Case Study: Rapid Discharge at End of Life

Carolyn Haydon

End of Life Education Facilitator, Transform Team

Blackpool Teaching Hospitals NHS Foundation Trust

- managing complex discharges in practice: the importance of having a plan and protocol
- improving the interface between primary and secondary care
- case study: rapid discharge for patients at the end of life

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

Lisa Martin

Team Manager, Short Term Pathway
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

17.00 Question and answers, followed by close

Effective Discharge Planning and Practice

Wednesday 19 October 2016 Hallam Conference Centre London

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Venue

Hallam Conference Centre, 44 Hallam Street, London W1W 6JJ. A map of the venue will be sent with confirmation of your booking.

Date

Wednesday 19 October 2016

Conference Fee

- ☐ £365 + VAT (£438.00) for NHS, Social care, private healthcare organisations and universities.
☐ £300 + VAT (£360.00) for voluntary sector / charities.
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