“When am I going home”

https://vimeo.com/547867938/4d5acba6d4

“Going into hospital can elicit a maelstrom of emotion. . .
“The majority are simply very anxious of the unfamiliar and the unknown. They just want to know when they can go home.”

Bev MacLean, Discharge Facilitator, University Hospital Hairmyres

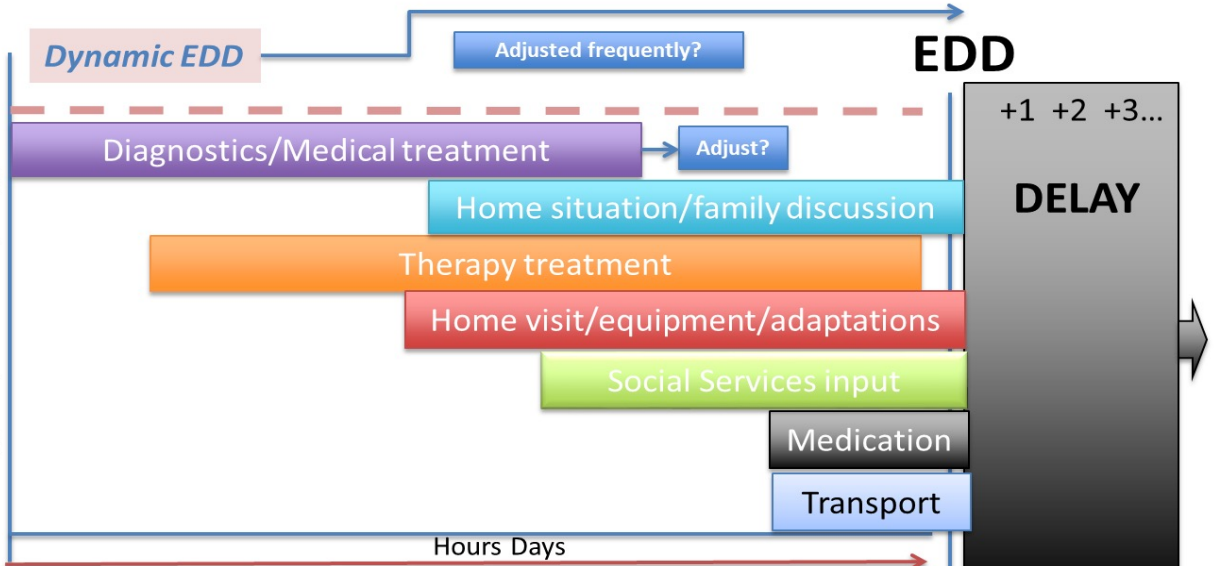
What is Discharge Without Delay

- https://vimeo.com/694425658/17d55f139b

Home should be the default position for all people leaving hospital	• This will mean partnerships must adopt a Home First approach, asking "why not home, why not now" at every stage of a person's hospital journey. A range of intermediate care services will need to be developed and an assertive attitude taken to risk.
All parties work towards an agreed Planned Date of Discharge	• This will require everyone working as one team with a shared goal, working towards the PDD rather than from the ready for discharge date. Early referral will be needed for any on-going support needs.
People should not be assessed for their long-term support needs in an acute environment when at their most vulnerable.	• Partnerships should adopt "Discharge to Assess" as an ethos and commission dedicated "Transition Teams" to provide immediate support on discharge. As a rule, no-one should transfer directly from an acute setting to a long-term residential care setting without all options to go home being exercised.
Decisions are made and discharge occur across seven days.	• This will need decision makers and decision making processes in place across seven days and for providers to be available for new starts or re-starts of community based care. Transition Teams should be available to support weekend discharges. Pharmacy and transport must also be available, along with technology and other equipment to support safe discharge. Early discharge planning should support timely ordering and availability.
There is good communication between professionals and with the patient, family and carer.	• Community supports must have a single point of contact and access, and be readily accessible. Patients, family and carers should be involved in discharge planning with good, accessible information on what will be available to support discharge arrangements.
There is robust data and a series of indicators by which to measure performance and identify concerns.	• There must be a single, agreed, version of the truth, with accurate numbers and coding, to fully understand the key indicators of successful performance. SMART (Specific Measurable Achievable Realistic Timely) objectives should be set to measure the impact of these key aims.

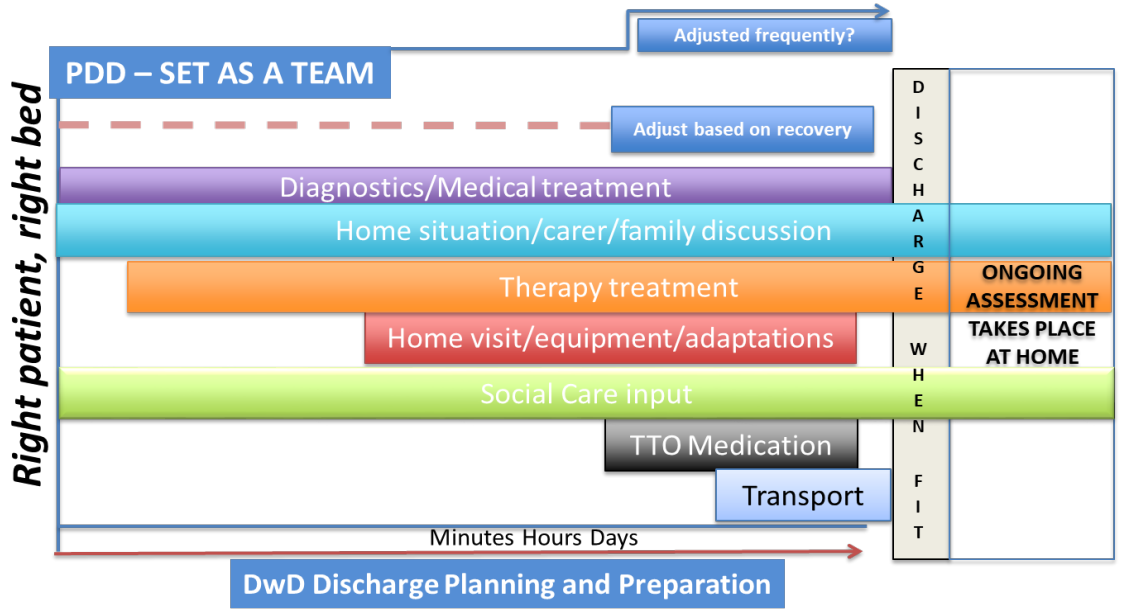
Estimated Date of Discharge Features

- Focused on acute requirements (**the date on which we estimate we will complete acute care and discharge**)
- Set by the ward team only, no external awareness of plan
- Poor visibility of alternatives to continuing inpatient care
- Often used as a ‘handover’ date and for bed management purposes
- Patients wait in hospital for assessment and care as a delay, poorer outcomes and experience



Planned Date of Discharge Features

- Set as part of wider MDT discussions **(the date we have jointly agreed this patient is likely to be sufficiently well enough to be discharged)**
- Allows extended team to contribute, give advice, give assurance re perceived risk and ultimately manage expectations
- **Visibility of the plan allows for preparation in advance**
- An ‘inreach/integrated model
- Patients are able to return home for ongoing assessment



PDD and the Journey

Support for Unpaid Carers

- Part of Planned Discharge Process
- Engagement with Patients, Families and Carers on Admission
- Discharge to assess
- Funding for carers support organisations to ensure support is offered

And finally

- Any questions?