Discharge Hub
Victoria Hospital
Fife

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Team Leader
Why change?

- Multiple discharge routes from hospital.
- Scattergun approach to service referral.
- Desire to improve discharge planning.
- Proactive approach to complex cases.
- Delays to discharges.
- Lists, lists, lists
- ICASS assessment model – works!
The Vision

- To improve the patient pathway by placing the patient and their carers at the centre of their care and discharge from hospital.
- To access appropriate and timely treatment and services.
- Facilitate early and effective discharge planning.
- Ensure a PDD (predicted date of discharge) is determined.
- Reduce the patients’ length of stay in the acute setting.
The Vision

• Reduce inappropriate transfers.

• Provide consistent care.

• Increase the level of quality patient information.

• Maintain and have ownership of Edison, offering a more consistent approach to the management of delayed discharge.

• Co-ordinate transfers to downstream beds.
Criteria for Discharge Hub referral

- Clinically fit for discharge.
- PDD within 48 hours of their clinical fit date.
- Require support on discharge.
Who is involved?

- Team leader.
- Patient Flow Co-ordinators.
- Fife Council Home Care Managers+ Administrator support
- Edison Administrator.
- Hub Administrator.
How it works...........

- Patient medically fit for discharge
- PDD within 48 hours
- Support required on discharge

Electronic eferral to Integrated Discharge Hub (PAGES 1 and 2 of SSA)

Patient flow co-ordinator visits ward to carry out assessment (within 4 hours)

Patient flow co-ordinator recommends discharge pathway and plan

Discharge options discussed and agreed with patient family and carer

Discharge plan implemented – referrals made to appropriate agencies

Patient discharged from VHK
What if...........

• The person cannot go home
  – Depends why?

  DSB
  EDISON
  SW referral
  STAR Beds

• Patient Flow co-ordinator will make the onwards referrals and will review the patient every 48 hours.
Progress

- Implemented August to December 2013.
- Based in Improvement Resource Room
- Hub implementation plan now completed.
- Social Work involvement.
- IT access.

More work to be done

- Sustainability
- Complete community bed management model.
Performance

- Weekly report.
- Number of patients through hub.
- Referrals received before midday.
- 4 hour compliance.
- Discharge destination.
- Discharges within 48 hours.
- Percentage discharges within same week.
- Change of pathway.
- Reasons for delays.
## Activity

<table>
<thead>
<tr>
<th>Total No. through hub</th>
<th>Total Referrals before midday</th>
<th>Total Assessed same day (referrals before midday)</th>
<th>Restart POC</th>
<th>Increased POC</th>
<th>New POC</th>
</tr>
</thead>
<tbody>
<tr>
<td>85</td>
<td>51</td>
<td>48</td>
<td>24</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>ICASS</td>
<td>Placed on EDISON</td>
<td>DSB</td>
<td>STAR</td>
<td>48 hour PDD</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>3</td>
<td>20</td>
<td>3</td>
<td>42</td>
<td></td>
</tr>
</tbody>
</table>
Hub Performance

HUB Performance

- Referrals
- % Ref Before 12PM
- % Discharged <7 days
- % Discharged <48hrs PDD

Data for dates from 11-Oct to 07-Feb.
Congratulations!

NHS Fife Discharge Hub!

It all revolves around me!

Patient