The End Of Life Discharge Facilitators role began in October 2011, designed to facilitate and support timely discharge at End Of Life, for patients who express their wish to be cared for at home through provision of an interface between the acute trust, hospices and District Nursing in Leeds.

The main objectives of the role were to improve collaborative working across organisations and the co-ordination of care provision in the transfer of care to increase the number of deaths in usual place of residence and reduce the number of hospital deaths in line with the vision outlined within the Palliative Care Strategy 2008. Locally it was felt that there were a number of reasons some patients were not always achieving their preferred place of care including:

- District Nurse availability to attend a care planning meeting in a timely manner to facilitate the discharge for patients wishing to have end of life care at home.

- The role supports the District Nursing teams across the city, not only facilitating seamless transfer of care also contributing to the education and training of ward and community staff around discharge planning.

There are already demonstrable outcomes in terms of facilitating patient choice at end of life. To date the facilitators have supported 350 discharges to preferred place of care.
The initiative has significantly increased the capacity of the District Nursing teams, as the facilitator completes a quality, robust set of notes, ordering of equipment, ensuring anticipatory medications, DNACPR documentation accompany the patient home where appropriate. This has meant the receiving District Nursing team use their time more effectively with the patient at point of discharge.

The post has further streamlined existing systems and processes re discharge as the facilitators have been able to highlight areas for improvement, enabling them to greatly reduce the numbers of poor/failed discharges.