What is the Discharge to Assess Model?

- The Discharge to Assess model is the new way of working for the Hospital Social Work Team. The discharge to Assess model will be implemented by the end of October 2020.

- The Hospital Social Work team will be split into two areas:
  - Hospital
  - Community

- The Hospital Team will be split into two teams; “Home First Discharge to Assess Team” and “Hospital Complex Team”. Both of these teams will initially capture the person’s needs who is Medically Optimised for Discharge (MOFD) and triage for next steps.

- The Villa Care/Wharfedale team will manage MOFD persons at Villa Care and Wharfedale

- The Community Bed Discharge Team will assess an MOFD person through the Community Care Bed or Discharge to Assess pathways.

- The Hospital Social Work team will continue to be supported by Business Support and an interim Hospital Service Delivery Manager.

What do we need our ward teams to do ?

- Talk to patients and relatives as soon as possible following admission about discharge. This should include explaining the term “ medically fit” and the plan to discharge home or transfer to a bed in the community for further assessment, recuperation or rehabilitation as part of the patients plan of care
- Use the agreed letters to support the conversation
- As soon as it is agreed that a patient is medically fit complete the EDID referral form on PPM+. This should be a description of the patient (new document)
- Send the EDID referral to the single point of contact (SPUR)
- The single point of contact team will review all referrals and try wherever possible to get the patient home with support.
- If home is not possible a community bed will be allocated appropriate to the patients needs