Discharge to Assess Project Queen Elizabeth Hospital Joint Collaboration between Adult Social Care and Health

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- The Discharge to Assess (D2A) Project supports people who are clinically optimized and do not require an acute hospital bed, but may still require care services. They are provided with short term, funded support to be discharged to their own home (where appropriate) or another community setting. Assessment for longer-term care and support needs is then undertaken in the most appropriate setting and at the right time for the person.

- Supporting people to go home should be the default pathway. This includes patients who may require 24 hour care at home for a very short period (3 days is the aim) to settle in or assess the need for ongoing 24 hour care in another setting such as a residential care home.

- Social care and CHC assessments are completed in the patient's home to plan ongoing care (if required). Social care staff act as trusted assessors and complete the CHC checklists at the same time as they complete the needs assessment.

- The Local Authority have an agreement with the Bexley CHC Team that a DST will be completed within 48 hours of receipt of the CHC Checklist. The assessment is conducted in the home environment with a nurse from the CHC team and the social care worker who completed the CHC checklist.

- Since starting the D2A project in November 2017 540 people have been discharged with checklists being completed at home for each one. Approx. 15 – 20 DST's have been completed with a small number of those qualifying for Fast Track CHC funding.

- This is a significant number of checklists no longer being undertaken in the acute setting which in turn has reduced the number of people waiting on wards to have CHC assessments completed.