

# Workshop: Social Worker participation in Hospital Discharge Management Team

**Norman Devlin and  
Carmel Reilly**  
Darlington

Integration and  
Better Care Fund



# Multi-disciplinary Discharge

Darlington

County Durham and Darlington   
NHS Foundation Trust



# Objectives and approach of the Darlington MDT discharge approach

To facilitate safe, speedy discharge of medically/ multi –disciplinary fit patients

Reduce all DToC and deliver zero ASC-attributed DToC

BCF funds two full time Social Workers to be based in the hospital working in partnership with the discharge management team, ward sisters and ward co-ordinators, and multi-disciplinary colleagues.

# The Darlington MDT discharge approach

Daily Discharge Management Team meetings at Darlington Memorial Hospital are attended by Darlington Borough Council (DBC) Social Workers.

Established team members over the past two years, leading to a very good **understanding** of hospital systems, positive relationships with nurses, ward staff, therapy staff – enabling them to contribute to the efficiency and effectiveness of those meetings.

A shared understanding of objectives and everyone's roles in achieving them.

# The Darlington MDT discharge approach

Provides a natural platform for sharing **learning**.

The approach is also spread through links with Community staff in the community hospitals.

Hospital staff are part of RIACT (Responsive Integrated Assessment Care Team), so share the ethos/philosophy.

Learning from RIACT team is shared across the community team, and community teams refer into hospital social workers, to take advantage of their detailed hospital intelligence.

# The Darlington MDT discharge approach

The embedded social workers also provide a link to **expertise** to support complex cases, around areas like mental capacity, sharing knowledge and information.

Being present in the hospital facilitates a collective analysis of risk, working in partnership on the complexities of some patients through participation in case conferences, ward meetings, safeguarding discussions etc. to mitigate risk and enable safe discharges.

Care Connect is linked into the discharge planning providing support for patients with low level need, but who need a little support to transition back to the community. SW bring knowledge of these kinds of resources.

# The value of a shared understanding

The robustness of the MDT at the “front line” made it possible for managers to get together collectively to review DToC cases as a system, and build a new level of shared understanding at that level about what is a reportable DToC.

This led to greatly reduced reported DToC, and complete confidence in the numbers subsequently reported, and enhanced dialogue in the SitRep validation process.

# The value of a platform for learning

In DBC this year, social care is focusing on developing strength-based work, building staff capability and ability.

This led to a letter for patients on admission, setting expectations about discharge and reablement, contributing to busting the “six weeks free care” myth.

This has been shared with colleagues in health and beyond Darlington.

The initial feedback is very positive in supporting discussions with patients and families around planning for discharge.

# The value of additional expertise

Social Workers are proactively supportive of hospital colleagues around areas like mental capacity, sharing knowledge and information.

Their access to hospital services and resources means they are able better to liaise with Social Workers on discharge management

Being present in the hospital facilitates a collective analysis of risk, working in partnership on the complexities of some patients through participation in case conferences, ward meetings, safeguarding discussions etc. to mitigate risk and enable safe discharges.

# Key benefits

Significant advantages arising from the proximity of social workers. They are visible, present, responsive, and have acquired a clear profile in the hospital leading to trusted relationships.

Shared understanding and shared agenda across health and social care, supporting safe and timely discharge from hospital

The MDT meetings allow early notification of people moving towards being medically fit for discharge. Discharge coordinators and ward sisters provide a “heads up” that someone is approaching being medically fit, so allowing the LA to respond flexibly to demand, prioritising and de-prioritising continually.

Relationships and trust – a shared agenda – no-one to stay longer in hospital than they need to.

This intelligence helps us identify blips. For example in Q4 17/18 there were some blips in DToC reports (triggered by the introduction of e-notices) which were identified before the data itself was published, allowing a very quick system-wide response to bring things back on track and with significantly improved understanding of the process.

# Key outcomes

Low and reducing DToC.

Excellent relationships and levels of trust sufficient to enable system leaders to work together on improving understanding and reporting DToC.

Recent RPIW on patients with packages of care across CDDFT brought out very clearly from hospital staff that having the SW a part of the team was a significant contribution to good performance – they “made all the difference”.

This intelligence and close working facilitates quick identification of changes and quick action to pull things back on track.

# Impact on the numbers

