HEALTH AND SOCIAL CARE SCOTLAND

Embedded and emerging good practice in health and social care

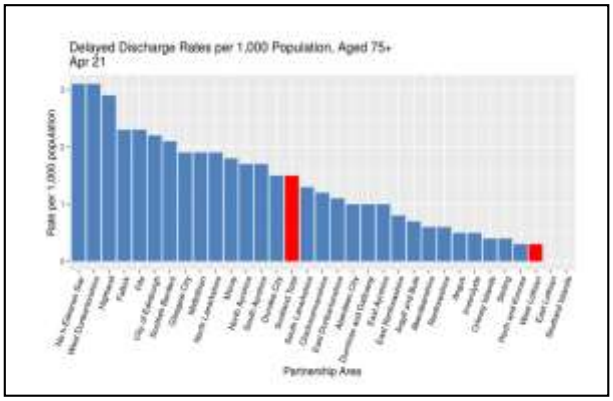
Aligned to the *Framework for Community Health and Social Care Integrated Services*

Health and Social Care Partnership: West Lothian				
Author and contact details:				
Name of good practice: Integrated Daily Flow Huddle				
Select (x) all areas that apply to your good practice (select more than one if applicable)				
CLIENT GROUP	Children and young people		Older adults	x
	Younger adults	x		
SETTING	City		Remote & rural (incl islands)	
	Corporate		Urban	x
SERVICE AREA	Addictions		Management team	
	Admission avoidance		Mental health	
	Community care services incl care at home/care homes		Physical disabilities	
	Day services		Physical health	
	Housing incl Homelessness		Primary care	
	Intermediate Care incl Hospital at Home	x	Rehabilitation	x
	Justice services		Social care services	x
	Learning disabilities		Supported discharge	x
	Other – please specify			
ELEMENTS of FRAMEWORK	Anticipatory care planning		Live independently at home or in a homely setting	x
	Assets based approach		Manage own care	
	Connect with communities		Reablement	
	First point of contact		Seamless working with acute	x
	Enhanced care in care homes / supported accom		Short term targeted interv to meet more complex needs	
	Fully integrated community teams		Teams aligned with general practice	
	Other – please specify			
ENABLERS	Agile working	x	Information sharing	x
	Aligned plans	x	Infrastructure	x
	Clarity of vision	x	Management information	x
	Clinical and care governance	x	Shared accountability	x
	Collaborative leadership	x	Strong team ethos	x
	Culture and values	x	Technology	
	Fit for purpose premises		Well-developed lead professional roles	x
	Improvement capacity	x	Well-developed relationships	x
	Other – please specify			

West Lothian HSCP

Integrated Daily Flow Huddle

SITUATION	The onset of wave one of COVID-19 in March 2020 and the increasing numbers of transmissions led to significant impacts to the acute bed capacity, resulting in rising numbers of delays. This position was compounded by high residual numbers of complex, delayed discharges of 60-70 people, including all off-site delays. The local hospital in West Lothian, St John's, has a well-established integrated discharge planning hub with staff from all health and social care partner organisations and the third sector. It was acknowledged, however, that the existing matrix management approach whilst beneficial could be often challenged by the coordination of patients with multi-complexities. During the first COVID-19 wave managers based themselves in the integrated hub and led the flow huddles, overseeing all aspects of discharge planning significant reduction in delays down to zero on the acute sites for a few days. As winter approached and the inevitable second wave, the delayed discharge numbers started to increase exponentially; the organisation experienced staffing challenges and safety concerns around large numbers meeting in person. In January 2021 there was a renewed approach where the flow huddle went online, enhanced by a daily commitment by senior management to attend each huddle in order to unlock any barriers that the team encountered to discharging patients in a timely manner. The focus was on preventing a delay, reducing length of stay and optimising a person's safely on a community pathway at the earliest point, through a joint decision-making, whole system presence. West Lothian has sustained an upper quartile local authority performance for days lost to delays in discharge over the last year, and has been nationally recognised.
ACTIONS TAKEN	Leadership on the ground was, and remains, pivotal to sustaining optimal delayed-discharge performance. A senior manager chairs the daily multi-agency discharge flow meeting and determines agreed actions and timescales for the team, and most of all, supports the team in unlocking any barriers to discharge. Enhanced community services to extend hours over 7 days. The flow meeting has a structured agenda and is supported by the use of a patient 'tracker', containing brief patient information and open actions, together with colour-coding to show when discharge dates are secure. Patient discharge planning commences at the earliest point in their acute episode and any community need identified are assessed and plans put in place in preparation for safely timely discharge. All patients known to the integrated discharge team are discussed daily to ensure all actions are taken to prevent any further delay. The meeting is stepped-up to twice-a-day in times of extreme pressure or clinical need, and actions are monitored throughout the day. The tracker actively manages over 75 people a day, with between 80-85% not becoming a delay.

OUTCOME / IMPACT	 • Sustained reduction of delays onsite (at one point no delays on acute site) • Engaged supported group of staff • Collectively working towards a common goal • Real time decision making with close attention to the detail ie tracking guardianship process and each decision taken towards safe discharge • Increased confidence from the acute site and NHS Lothian who are willing to invest further in the partnership. • Improved processes for interim placements when awaiting for care home of choice and a person no longer requires bed based care • Strengthen and joint discharge planning with third sector in 'real time' • Our focus is about 'changing the dial' to prevention, assessment and early intervention in order to promote independence and prevent further deterioration WLHSCP has sustained a delayed discharge position of between 7-10 acute site delays, compared with circa 30: this translates to a reduction of over 66%. Moreover, our delay numbers reflect our total delays recorded across all acute and community sites; this does not following national guidance where delays in step down beds don't count. The level of leadership required to affect changes in practice, a collaborative culture and team ownership should not be underestimated. These improvements have demanded strong, effective leadership, leading to enhanced ways of working and tangible improvements leading to a collaborative culture where delays and associated potential harm have lessened and services have, therefore, improved. In summary, despite a challenging situation, evidence suggests adversity has been successfully challenged and discharge services have been improved.
Measures/ indicators of success	• Reduction in average length of stay (ALOS) • Reduction in occupied acute bed days particularly in medicine (OBDs) • Supported the acute site to operate within footprint and reduced the high levels of boarding • Nationally recognised in the top performing HSCPs around delayed discharge rates • Sustained the performance when other HSCPs have struggled between COVID-19 waves • Whole system approach and embraced by the acute site (SJH) • Development of pathways, intermediate care step down rehabilitation, discharge to assess (d2A), increased reablement We are recognising that we need to constantly build capacity around the community in response to the changes we make.

Even better if …
(enablers to further the principles of integration and result in even better outcomes if …)

- More resource on acute site in wards to identify people's needs, at the earliest opportunity.
- Timely decision making and setting of planned discharge date at a faster pace.
- Identified too many people going to hospital and being admitted, so partnership are seeking to take a 4-hour approach to the community setting through a community single point of contact.

NATIONAL HEALTH AND WELLBEING OUTCOMES	
1. People are able to look after and improve their own health and wellbeing and live in good health for longer.	x
2. People, including those with disabilities or long term conditions, or who are frail, are able to live, as far as reasonably practicable, independently and at home or in a homely setting in their community.	x
3. People who use health and social care services have positive experiences of those services, and have their dignity respected.	x
4. Health and social care services are centred on helping to maintain or improve the quality of life of people who use those services.	x
5. Health and social care services contribute to reducing health inequalities.	
6. People who provide unpaid care are supported to look after their own health and wellbeing, including to reduce any negative impact of their caring role on their own health and well-being.	x
7. People who use health and social care services are safe from harm.	
8. People who work in health and social care services feel engaged with the work they do and are supported to continuously improve the information, support, care and treatment they provide.	x
9. Resources are used effectively and efficiently in the provision of health and social care services.	x
Health and Social Care Scotland's 5 Essential Elements (click link to listen to statement of intent)	
1. Transforming the approach to improving health, wellbeing and independence	x
2. Building stronger community care systems and primary care services	x
3. Establishing a new focus on mental health	x
4. Securing a sustainable acute hospital service and specialist care service	x
5. Strengthening future partnerships to ensure a modern sustainable workforce	x

Links to any published reviews/evaluations	

Before submitting this example of good practice please ensure approval and sign-off by your head of service / chief officer.

Approved for online publication *(signature and position)*	Alison White, Chief Officer
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