CONFERENCE ABSTRACT

**West Lothian Health and Social Care Partnership Integrated Daily Discharge Flow Huddle**

22nd International Conference on Integrated Care, Odense, Denmark, 23-25 May 2022

Fiona Wilson¹

1: West Lothian Health And Social Care Partnership, Scotland, United Kingdom

**Introduction:** An integrated discharge hub was established at St John’s Hospital in Livingston in 2018 in an effort to improve delayed discharges and reduce the time it took to secure ongoing social care support in the community. Staff from hospital, community health, social work and social care teams all worked in partnership with multi-disciplinary ward teams, representatives from the local carers centre, patients and their families to plan the safe, effective and timely discharge of patients for ongoing community assessment. The approach was in line with the principles of ‘Home First’ – a programme with local and national support.

**Objectives:** The onset of wave one of the Covid-19 pandemic in March 2020 and the increasing numbers of transmissions led to significant impact on acute bed capacity, compounded by high residual numbers of complex, delayed discharges of 60-70 people. During the first wave, managers based themselves in the integrated hub, developed a patient tracker and led daily flow huddles, overseeing all aspects of discharge planning. The project was established to improve patient flow through the health and social care system, reduce delayed discharges and improve the patient journey.

**Results:** The daily, multi-agency discharge flow meeting is chaired by a senior manager who determines actions and timescales for the team, and most of all, supports the team in unlocking any barriers to discharge. In January 2021 there was a renewed approach with the flow huddle going online in response to the second wave of Covid-19, increases in delayed discharges, staffing challenges and safety concerns around large in-person meetings.

West Lothian has:

- Sustained improved performance for days lost to delays in discharge over the last year
- Improved processes for interim placements when awaiting care home of choice
- Developed stronger joint discharge planning with third sector
- Reduced average length of stay
- Reduced occupied acute bed days particularly in medicine
- Supported the acute site to operate within footprint and reduce levels of boarding
- Developed pathways - intermediate care step down rehabilitation, discharge to assess, increased reablement.
**Conclusion:** Through strong, effective leadership, the establishment of an integrated daily flow huddle and patient tracker, improvements have been achieved in managing delayed discharges and assessing for community support. The pandemic allowed a different approach to discharge planning to be tested with positive outcome for patients, staff and system capacity.

**Implications:** The West Lothian health and Social Care Partnership has drawn interest in the approach from other areas of Scotland. A revised management structure in being put in place to ensure sustainability and enable further development of the partnership’s Home First approach to managing whole system flow.