Tuesday 7th November | 15Hatfields, London

# Welcome to The Patient Flow Conference South!

7th November 2023
8am – 4pm
15Hatfields, London

# Slido

**Please scan the QR Code on the screen. This will take you through to Slido, where you can interact with us.**

# Chairs Opening Address

The
Patient Flow
Conference
South 2023

**Kelly Bishop**
Assistant Director of Nursing and Urgent Care - Midlands and Lancashire Commissioning Support Unit (MLCSU)

## Speaking Now...

**Justine Howe**
Head of Urgent Care - NHS MLCSU

# Improving Quality and Outcomes in Northern Ireland

Our Flow, Occupancy and Crowding Improvement Initiative

**Justine Howe**
**Head of Urgent Care**

**November 2023**

# The health and care system in Northern Ireland

Oversees health and social services for 1.8 million citizens in Northern Ireland, managing a £5.5 billion budget and spending £15 million daily, while ensuring quality and accessible care

Western Trust
Northern Trust
Belfast Trust
Southern Trust
South Eastern Trust

Coleraine
Ballymoney
Limavady
L/Derry
Ballymena
Larne
Strabane
Magherafelt
Antrim
Cookstown
Omagh
Bangor
Belfast
Lisburn
Dungannon
Portadown
Armagh
Banbridge
Downpatrick
Enniskillen
Newcastle
Newry

# Our team and approach

We…

- offer **specialist clinical and analytical guidance** on multiple scales.
- are experts in **system transformation, urgent care redesign, and discharge optimisation**.
- have a strong **track record in urgent care pathways**.
- collaborate with diverse providers, including NHS England.
- are a part of one of England's four CSUs, **backed by thousands of experts in various fields**.
- **transform data** into actionable, clinically-led solutions.
- stand **shoulder-to-shoulder with your teams** for optimal patient care and efficiency.

Compassionately support process growth and staff progression.

Act as a critical friend, using data to offer insights and recognise areas for improvement

## Our principles

Our values, fuelled by passion and commitment, lay the foundation for everything we do:

1. **Enhancing patient experience**
2. **Data-driven decisions**
3. **Of the NHS, for the NHS**
4. **Trust and collaboration.**

# Priority activities

**Establish a whole system control/ co-ordination function**

Because we lose more clinical time in RED time and stop-starts.

**Do today's work today**

Because being timely is not the same as doing more.

**Target the delays that extend handover time and extend LoS**

Because "we injure more people through poor and delayed process than poor medicine and nursing".

**Ensure quality and patient engagement at every step**

Because our "3rd duty" is to build patient confidence and trust in the services we provide and the advice we give.

**Target the issues that lead to the most harm for the majority of patients**

Because moving away from a pre-programmed approach for all patients to a personalised approach reduces hospital acquired harm.

**Pool good practice and then 'just do it'**

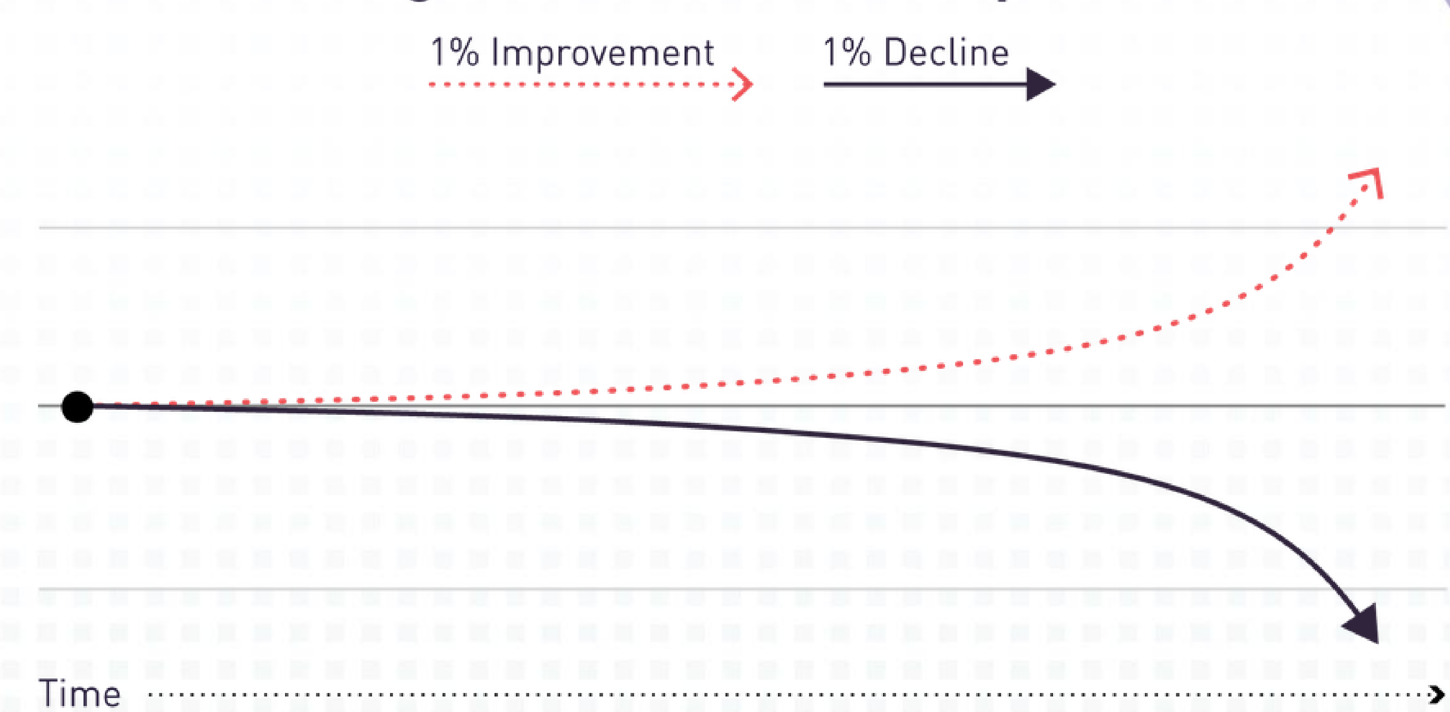
Because if it's good enough this week, it's good enough all the time.

# Aggregation of marginal gains

Central to the programme is understanding the numerous marginal gains required and managing as many of these as possible.

Underperformance results from a series of marginal issues.

**Recovery is the opposite: no big bang but lots of small ones**



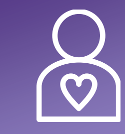
# The features of excellent care…

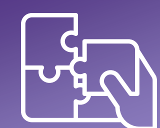
**No compromises – prioritise collective safety alongside individual patient care.**

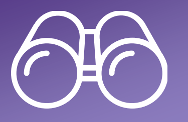
Max 15 minute handover in ED

'Fit to Sit' principle and intentional rounds.

Designated decision-making space within ED


Patients as active co-producers of their care


Collaborative work across all staff levels; embrace 'Every Minute Counts'


Senior oversight for each patient; use ED trackers to prevent delays

Optimal utilisation of the Discharge Lounge

Incorporate advanced methods, including nurse-led discharge

# Preparation phase

Several pre-meets to ensure:

- Focus on GOLDEN patients: identify likely discharges for the next day, ensure medications, support discharge plans, and prepare families.
- Inform the wider Trust of the "test of change" approach.
- Secure agreement with Exec/SMT to prioritise patient safety over performance.
- Engage with external stakeholders, ensuring mutual benefit agreements.
- Ensure senior director presence in the Control room and throughout the hospital for the entire 3-day period
- Reach agreement on the value of constructive challenges.
- Highlight that patient flow represents the primary clinical risk and opportunity.
- Prioritise overall patient care over just Emergency Department (ED) processes.
- Adhere to all standards (e.g., bare below elbows, trolley sides, infection prevention control, uniform compliance) to showcase pride in clinical service and the NHS.

# Control Room

The Control Room is a decision-making function, not just an information exchange, and will:

- Convene at 8am with secondary meetings at 10:30, 12:30, and 4pm at the Control Room's discretion.
- Serve as the single point for interdepartmental escalation when necessary, without delay.
- Establish discharge expectations: determine whether there's a surplus or deficit, consider any diagnostic delays in Mental Health and Ambulance services, and coordinate related actions.
- Receive previously identified information from the Emergency Department (ED) and Wards, including ICU and CCU.
- Establish and manage system-wide priorities dynamically, ensuring department-specific actions remain local.
- Monitor and benchmark the fulfilment of all identified priorities.
- Dynamically manage risk: evenly distribute workload and risk across the hospital.
- Plan ahead: set priorities for the upcoming day, week, etc.

Agree on clear numeric success criteria, e.g. 1 by 10, sick and quick, target all with > 7 day LoS. Performance is clinically led: it's a consequence of a quality approach, not the goal in itself. Expectations are communicated and followed up. Any commitments made and actions agreed upon are "held to account". **The Control function is tactical, not operational – that's the job of bed management.**

# Preparation phase

- Ambulance delays: >60 minutes, >30 minutes, and total.
- Number of patients in the department: admitted and non-admitted.
- Patients waiting to be seen, waiting for diagnostics, waiting for specialties.
- Patients waiting for a bed, waiting for transfer home, or to "other".
- Wait time to be seen and number of DTAs in the department by speciality.
- Longest wait, longest MH wait, mean time in the department for both admitted and non-admitted.
- Resus & majors occupancy.
- Pressure score e.g. OPEL.

## ED initiatives:

- Interventional triage
- Intentional rounding
- Consultant sign-off of all speciality referrals
- Fit to sit
- Use of alternative pathways
- Reduce clerking in ED

In order to determine a plan for the next hour, 2 hours, 4 hours, support needed to deliver a safe ED

# Improving flow and discharge

**Essential to consider a whole-system approach and, where possible, in advance:**

- Consumption levels of post-discharge services and rates of long-term care.
- Rates of discharge to the usual address and to pathways 0-3.
- Risk thresholds for discharge.
- Whole system visibility of demand, capacity, and flow.
- Processes across all acute and community services, e.g., Choice policy, SAFER/R2G.
- Capacity, capability, and access of out-of-hospital service.

- Improve flow and immediate pressures through discharge pathways, including Community and hospital MADEs, 'pull' rather than 'push' model, priority pathways e.g., frailty, PARIS, and addressing priority processes.
- Active and enhanced use of the Transfer of Care Hubs and Discharge Lounges to facilitate a minimum of 1 by 10, 2 by 12 midday discharges - targeting GOLDEN patients and focusing on home for lunch.
- Focus on specialties owning their flow, not ED, and eradicating process delays e.g., Diagnostics, Pharmacy, AHP assessment.
- Patient board changes to "clinical steps required to enhance outcomes" rather than a list of patient attributes.

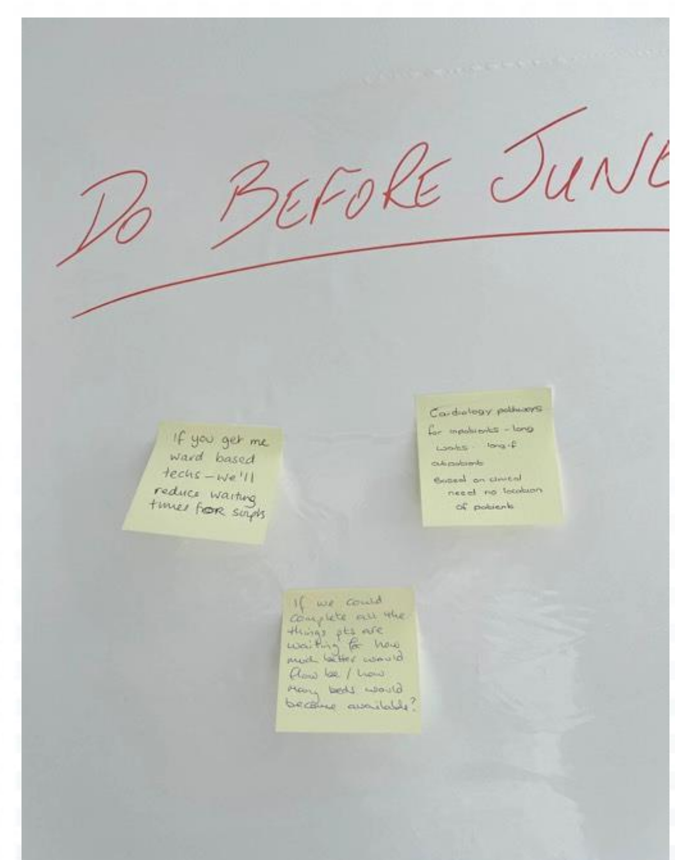
# Key outcomes

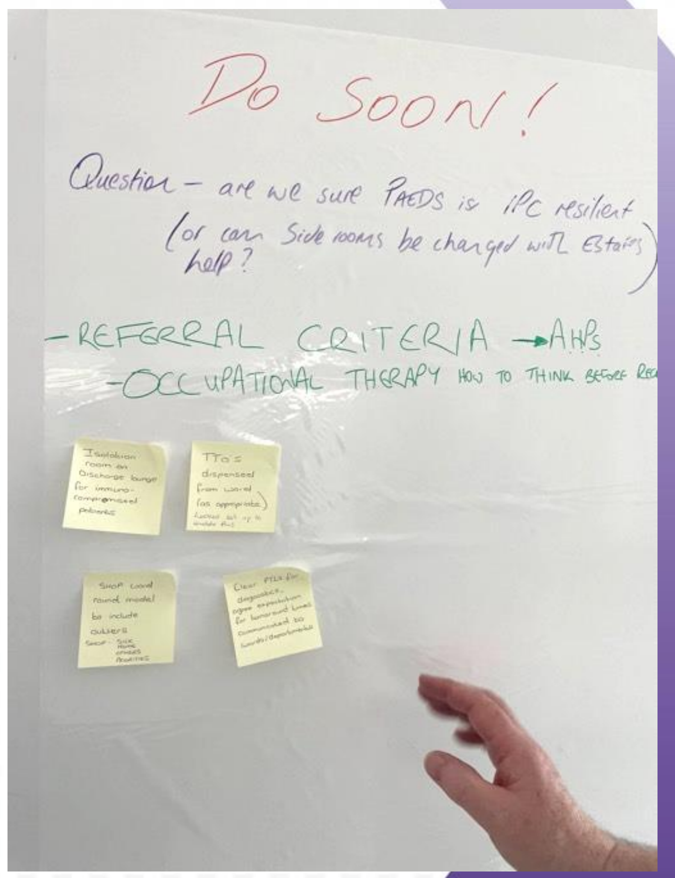
- ✓ **Zero ambulance delays and improved handover times, with the added benefits of crews completing their shifts on time.**
- ✓ Our efforts led to earlier discharges and better utilisation of discharge lounge capacity, accelerating hospital flow. As a result, beds were made available at least three hours earlier at each site.
- ✓ **We introduced hospital operation centres that made use of data and information, providing a single, clear version of the truth to guide critical decision-making.**
- ✓ We adjusted capacity in response to incoming demand, underlining the pivotal role of technology and efficient processes in benefiting patients.
- ✓ **We actively collaborated with trust staff at the grassroots level, fostering and bolstering the cultural transition needed to safely and enduringly integrate changes.**
- ✓ Our team championed transparency and oversight of information flow outside the hospital. This hastened acute hospital discharges and curtailed unnecessary hospital stays.
- ✓ **Every action and solution was steered by a commitment to safety and the well-being of patients, marking a move towards excellence, not just fulfilling an objective.**

# Identifying and prioritising **improvement initiatives**

**During the visit ideas from staff were captured and prioritised to inform an improvement plan:**

- ✓ **Do Now**
- ✓ **Do Soon**
- ✓ **Do by the end of June!**



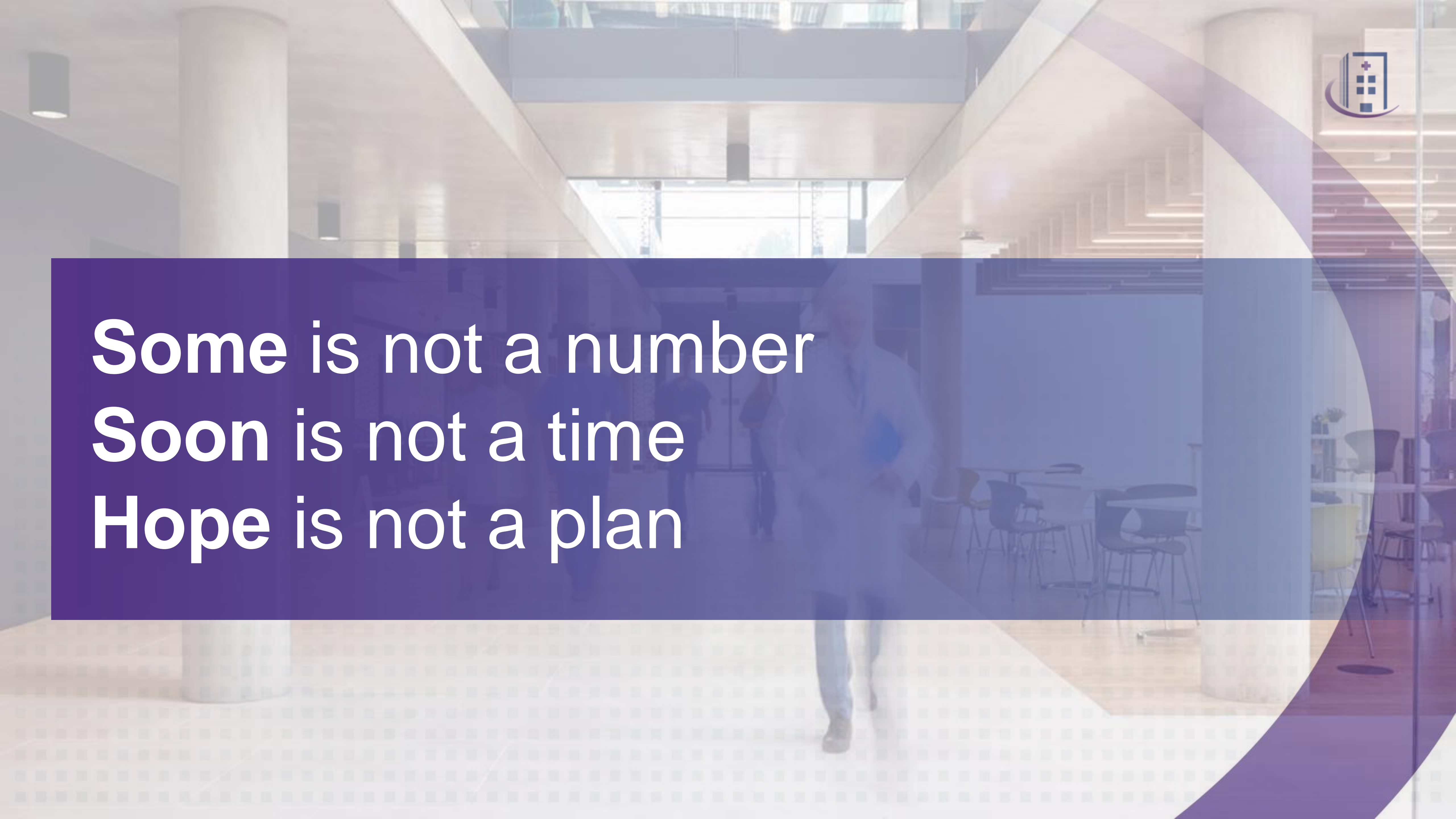



# Will the changes be sustainable?

We are ambitious realists - our team has significant clinical and operational NHS experience, and we understand that not all changes will endure, but many will.

Our focus is not solely on improving performance; rather, we prioritise enhancing patient outcomes. Improved performance is a by-product of this approach.

We work with your teams in their own environment to build relationships, coach and constructively challenge using subject matter expertise and data to drive decisions and monitor progress.


**Some** is not a number
**Soon** is not a time
**Hope** is not a plan

## Speaking Now…

**Dr Sulaxni Nainani**
Deputy Chief Medical Officer - NHS Leicester, Leicestershire & Rutland ICB

# Supporting patient flow and improving experience

Dr Sulaxni Nainani, Deputy Chief Medical Officer LLR ICB

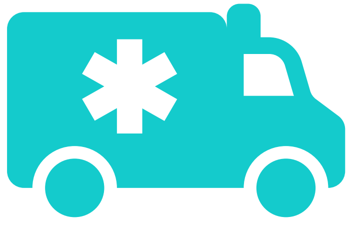
Kerryjit Kaur, Head of Integration and Transformation LLR ICB

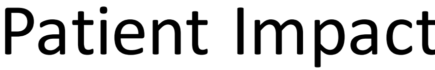
A proud partner in the:

# Our need for change

# Supporting..

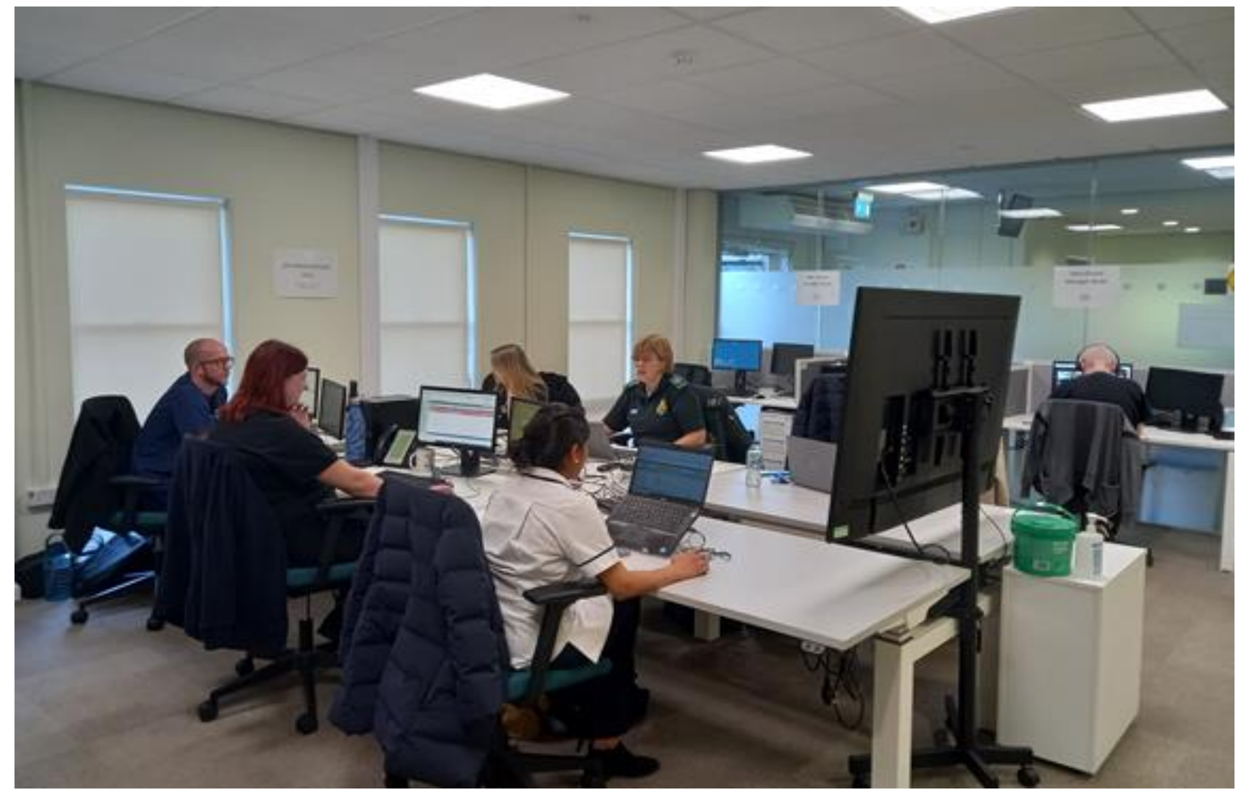
System Impact

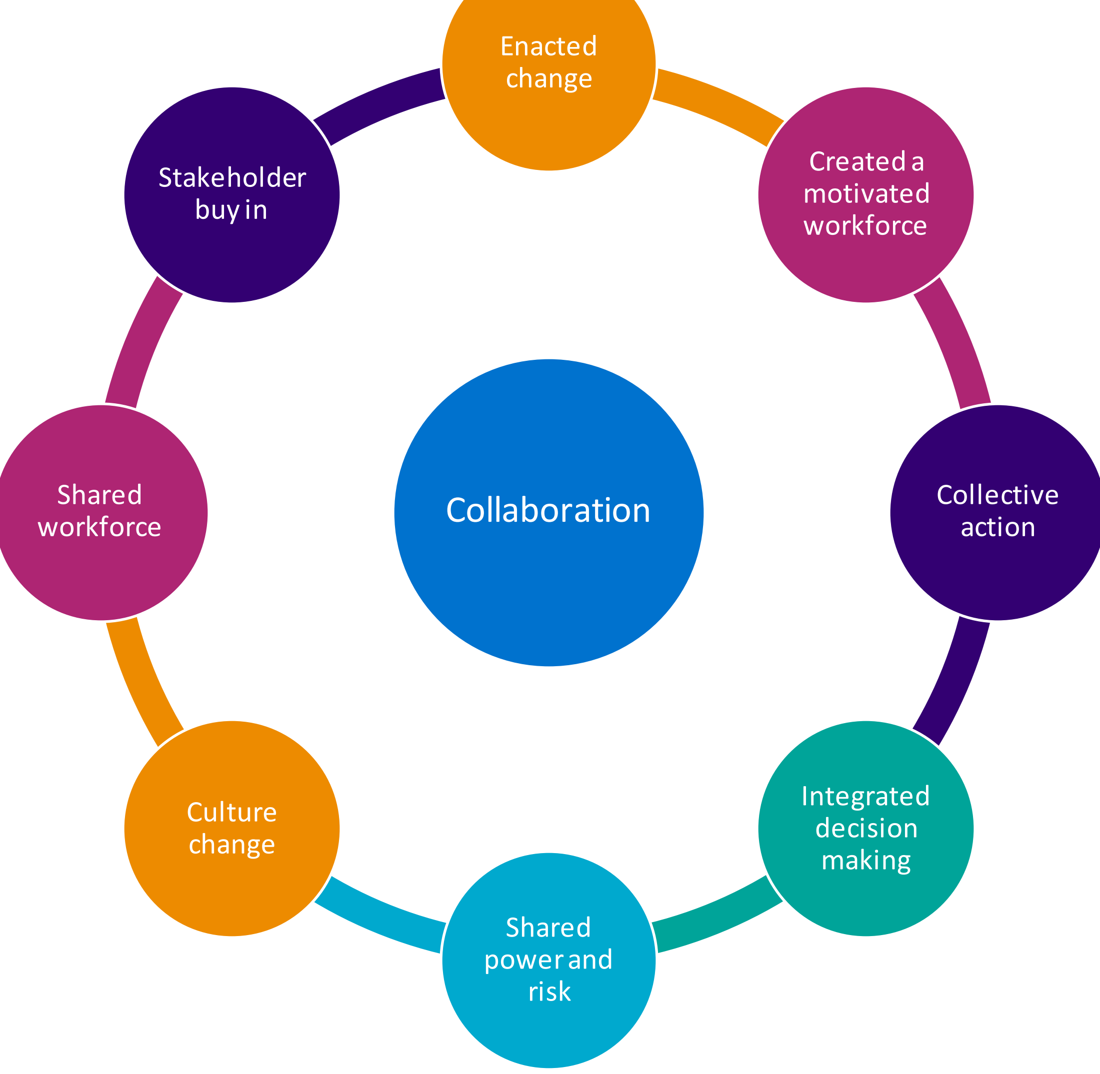




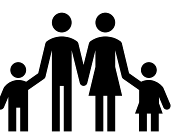
Collaboration

# Collaboration

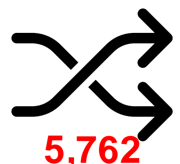




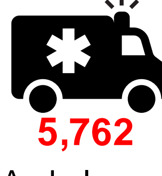
# Impact and Scale April 22 – March 23



**5,880**
Cases supported through the UCCH



**5,762**
**98%** Redirected to alternative pathways



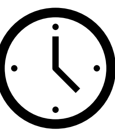
**5,762**
Ambulances dispatched avoided
Saving of
**£847,014**

**4,898**
**85%** remained at home

**40** members of staff
**8** organisations

**2,448**
ED attendances avoided.
Cost saving of
**£335,376**

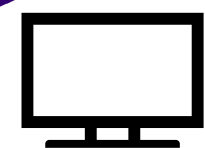
**5,762**
Appropriate Interventions deployed – 2hours, 4 hours



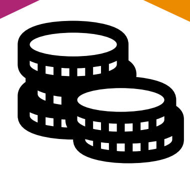
**20,821**
Hours of clinical EMAS time saved

Visited by **10** ICS's
**8** providers, NHSE Teams

Local recognition "Excellence in partnership award"



Media coverage – SKY and BBC News



Financial Efficiencies
**£792,390**

# How Patients feel

It was reassuring to have support in this difficult situation, as we have at times, felt as though we are on our own with all of this

Everyone has done as much as they can to help me gain my independence back

They worked together as a team to support me and improved my life

I didn't want to go to hospital, I was scared this might happen. I was listened to, and everything was sorted so I could stay at home

Angels in disguise

They are so kind, I am treated with absolute respect and dignity

# How Clinicians feel

What a great service and coordinated response, it now frees us up to get to our next emergency call "EMAS paramedic" – May 2023

'Consistency in advice' 'Escalation has allowed early detection and hospital avoidance' 'For the first time we have a real time, joint decision-making process as an integrated team that helps us understand the community services offer, share risk and resources and embed the shared ethos of right care, right time, right place'

"I feel supported" – Therapist on scene – April 2023

I know that I can get an immediate response – "District Nurse" – March 2023

Supporting clinicians on the ground – "Home visiting clinician

# How Stakeholders feel

Phenomenal efforts, managing to support EMAS, our acute trust and mostly our patients. This is truly integrated working in action
**"Dr Nilesh J. Sanganee" (ICB Medical director)**

We see this as the start of something very special that will evolve, grow and contribute towards the health and social care system at a time of unprecedented demand
**Jagjit Bains (head of service, Leicester City Council)**

The hub has consistently demonstrated exceptional teamwork, working together seamlessly to provide excellent care to their patients. They have been diligent in ensuring that patients receive consistent and uninterrupted care, even in challenging situations. This team truly embodies the values of collaboration, passion, and innovation.
**Leicestershire Partnership Trust (LPT)**

It was evident the team shared respect for each other's skills and experience and I was impressed by the quality of the clinical discussion taking place. Keep up the great work.
**Pauline Tagg (ICB non-executive director)**

We're proud to play our part in the LLR system through close partnership working, delighted to see the working relationship between the services in the hub blossom, and the many alternative care pathways being used successfully for the benefit of the patients
**Derbyshire Healthcare (DHU)**

## Speaking Now…

**Andrew Stradling**
Chief Medical Officer | Medical Director - NHS LPP | Medway & Swale Health & Care Partnership.

FLOW

# Behaviours

Public

Patient

Clinician

Manager

Behaviours

NHS

# NHS England ad campaign hopes to change behaviours and relieve service

Exclusive: The Help Us Help You campaign by M&C Saatchi, worth up to £28.6m, encourages people to cut down on in-person GP visits

You wouldn't call the coastguard if you fell in a puddle...

Ambulances are only for emergencies.
Think before you dial!
#999wise

Not an emergency?
Get advice by:
- Telephoning NHS number 111
- Contacting your GP or pharmacist
- Going to an Urgent Care Centre
- Visiting www.nhs.uk

You wouldn't call the coastguard if you fell in a puddle...

Emergency Ambulance

This is an emergency

0845 4647

pharmacy,

walk-in centre

ACTING QUICKLY CAN SAVE 14,000 LIVES FROM SEPSIS

EMERGENCY AMBULANCE

West Midlands Ambulance Service

NHS

Accident & Emergency

Where should you be?
www.nhs.uk or call NHS 111
A&E at the hospital is only for emergencies

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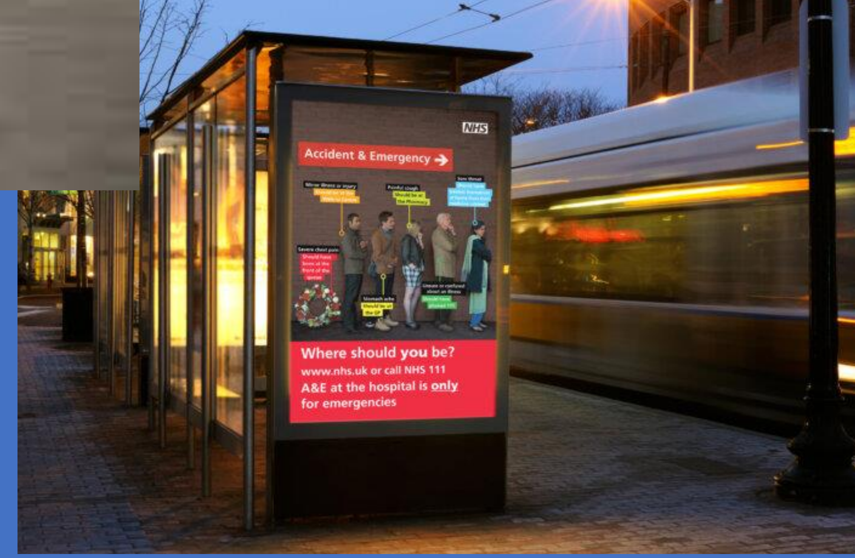
This is an emergency

We send the EU £350 million a week
let's fund our NHS instead
Vote Leave
Let's take back control

ACTING QUICKLY CAN SAVE 14,000 LIVES FROM SEPSIS
EMERGENCY AMBULANCE

You wouldn't call the coastguard if you fell in a puddle...

NHS
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ACTING QUICKLY CAN SAVE 14,000 LIVES FROM SEPSIS

EMERGENCY AMBULANCE

NHS

Accident & Emergency

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FLAPS
www.gillesvidal.com

EGTA
AYLESBURY/
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SFC-2500'

# We have arbitrary rules that no-one can justify

We have arbitrary rules that no-one can justify

**Hospital at night is inadequately staffed**

We have arbitrary rules that no-one can justify

Hospital at night is inadequately staffed

**We don’t have safe staffing ratios**

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**Our criteria are not patient-centred**

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**I don’t feel supported to discharge the patient**

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I don’t feel supported to discharge the patient

I don’t feel supported to discharge the patient

**MH patients deserve to receive the appropriate care in an appropriate setting**

We have arbitrary rules that no-one can justify

Hospital at night is inadequately staffed

We don’t have safe staffing ratios

Our criteria are not patient-centred

Hospital at night is inadequately staffed

I don’t feel supported to discharge the patient

I don’t feel supported to discharge the patient

MH patients deserve to receive the appropriate care in an appropriate setting

**I don’t feel supported to make a discharge decision**

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Hospital at night is inadequately staffed

We don’t have safe staffing ratios

Our criteria are not patient-centred

Hospital at night is inadequately staffed

I don’t feel supported to discharge the patient

I don’t feel supported to discharge the patient

MH patients deserve to receive the appropriate care in an appropriate setting

I don’t feel supported to make a discharge decision

**What if medication is changed immediately prior to discharge?**

We have arbitrary rules that no-one can justify

Hospital at night is inadequately staffed

We don’t have safe staffing ratios

Our criteria are not patient-centred

Hospital at night is inadequately staffed

I don’t feel supported to discharge the patient

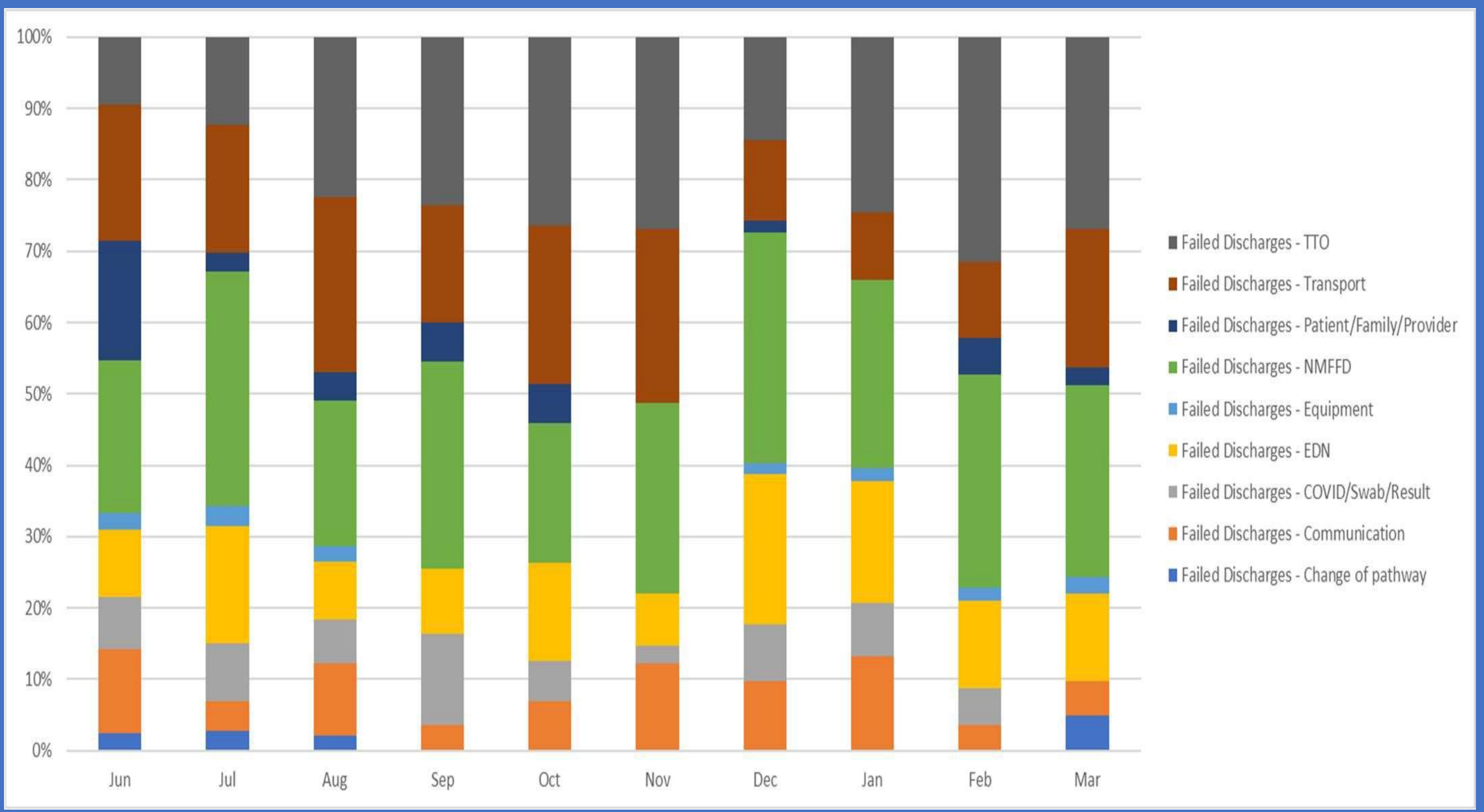
I don’t feel supported to discharge the patient

MH patients deserve to receive the appropriate care in an appropriate setting

I don’t feel supported to make a discharge decision

What if medication is changed immediately prior to discharge?

Ambulance Entrance
EMERGENCY
AMBULANCE
EMERGENCY
AMBULANCE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Failed Discharges - Transport
Failed Discharges - Patient/Family/Provider
Failed Discharges - NMFFD
Failed Discharges - Equipment
Failed Discharges - EDN
Failed Discharges - COVID/Swab/Result
Failed Discharges - Communication
Failed Discharges - Change of pathway

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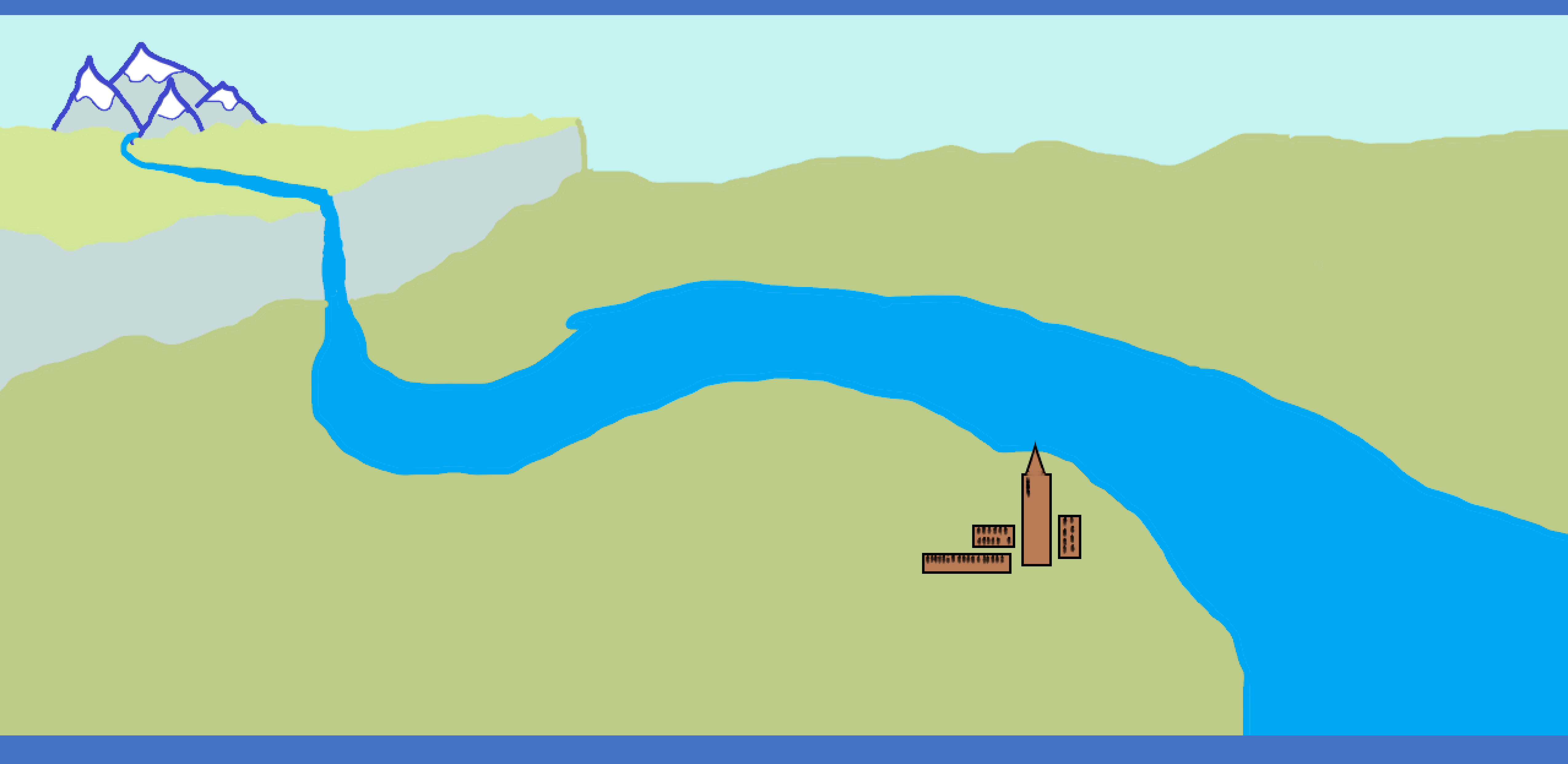
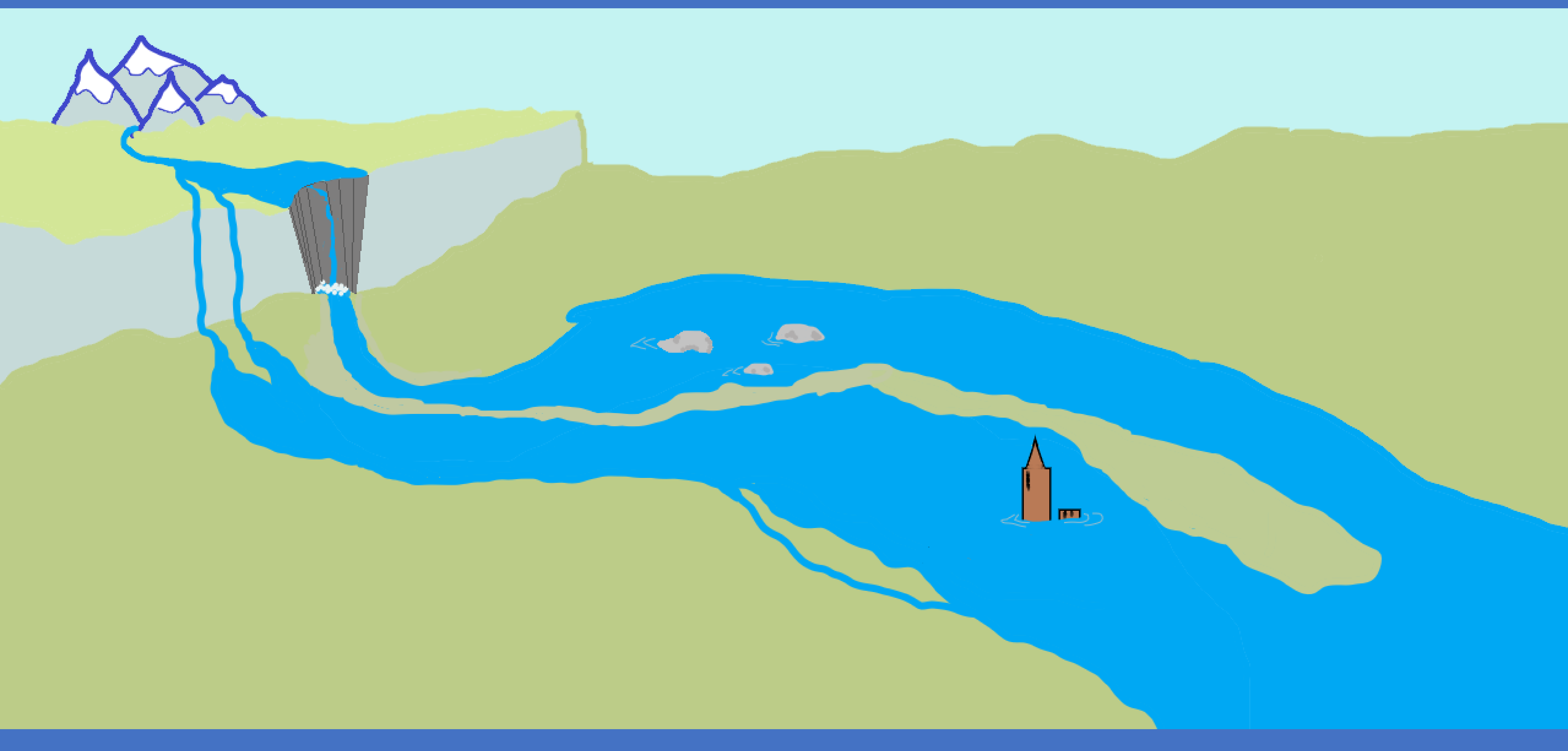
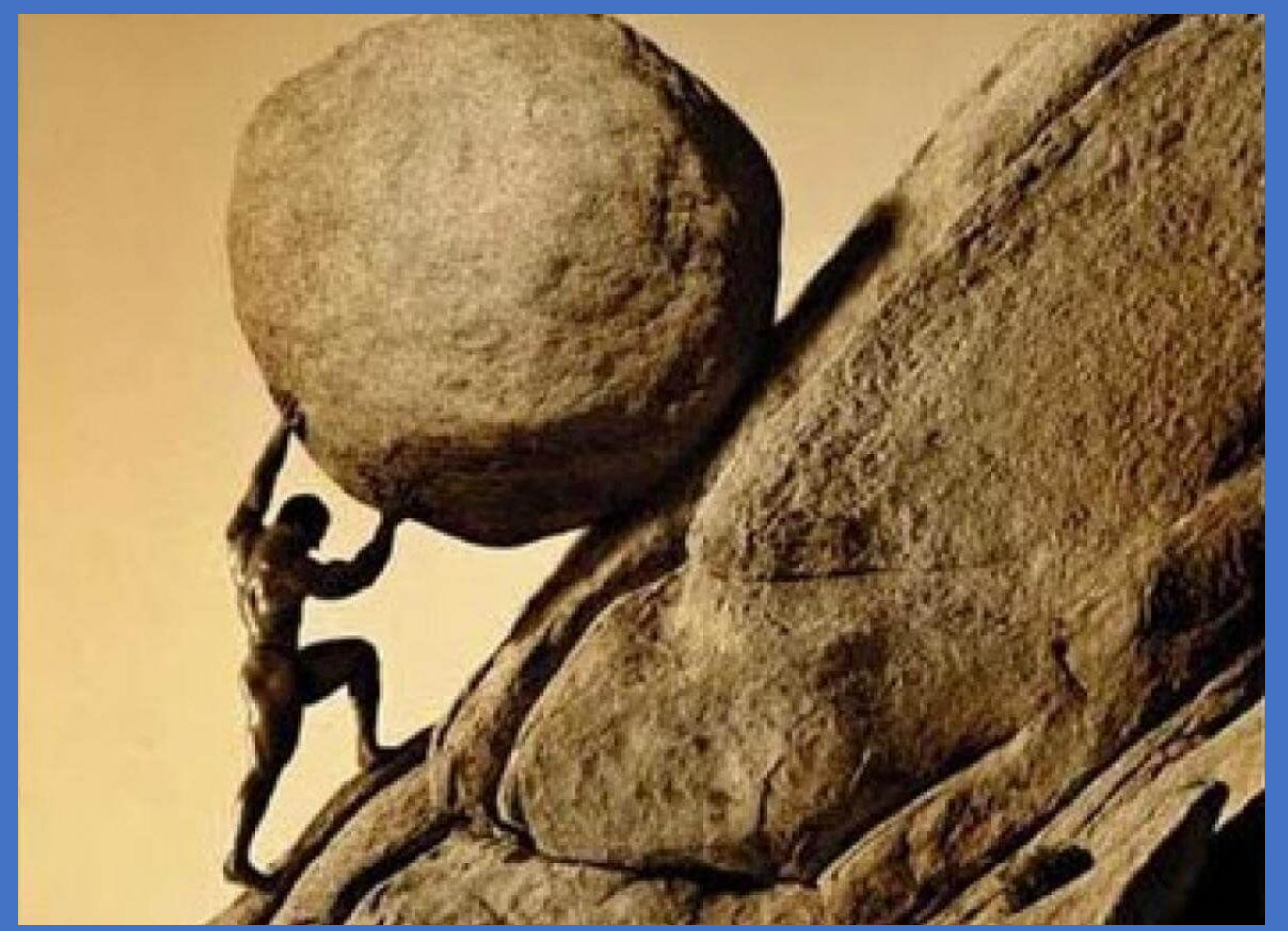
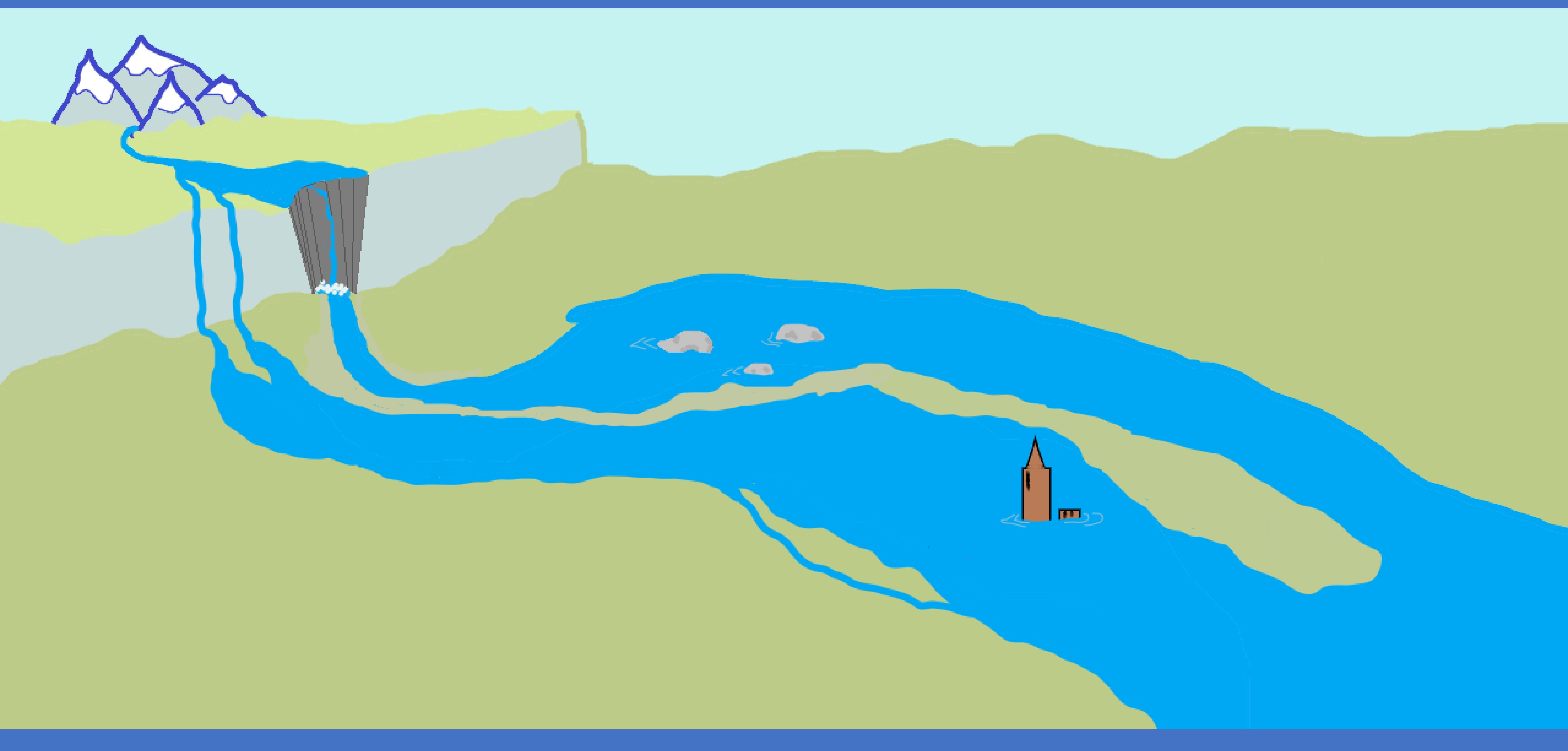
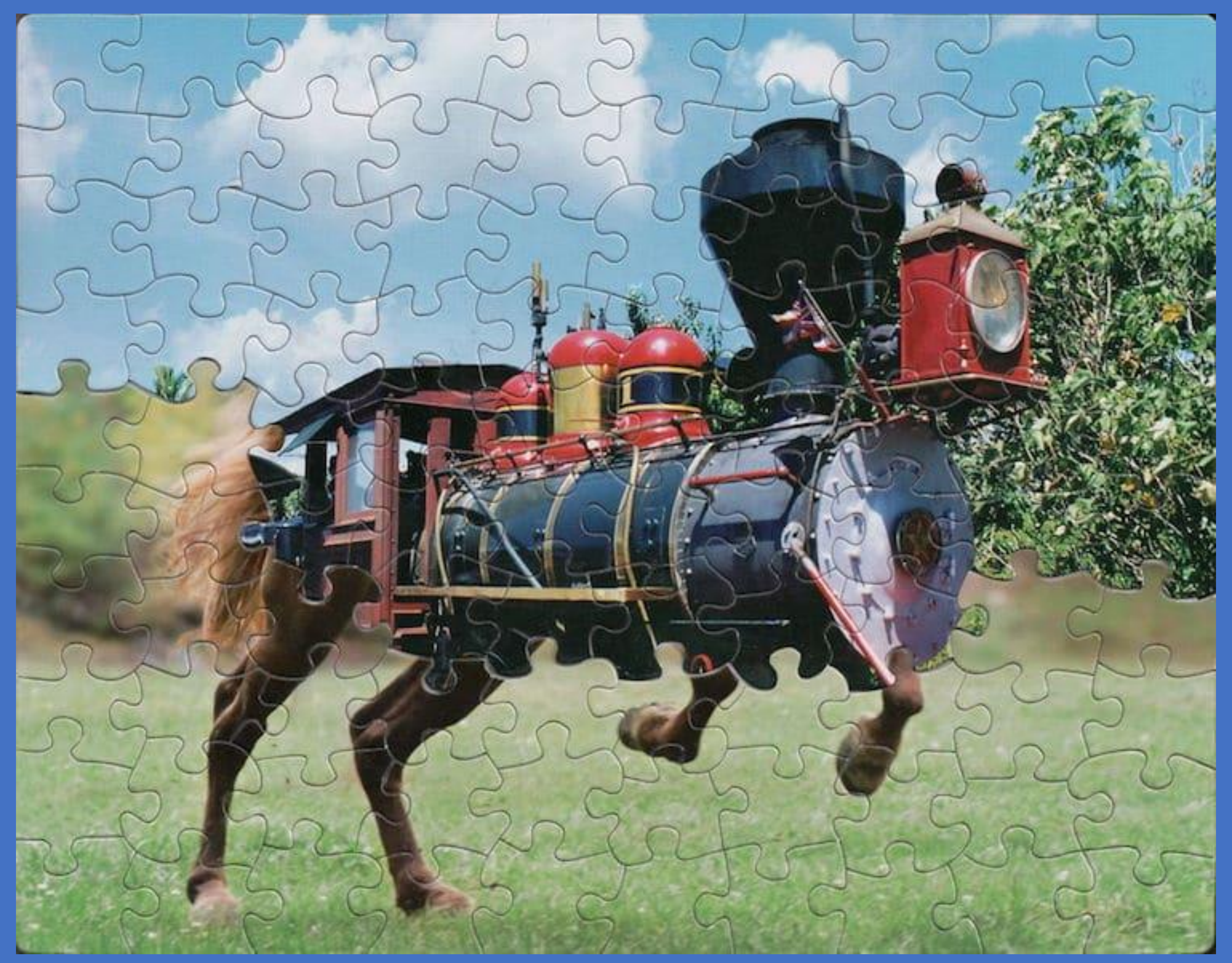
NWA445
NWA1269
NWA731











Flownership

Data

Behaviour

Virtual Wards

CDCs

Pathway redesign

# Thank you for listening

# Up Next…

## Speaking Now…

**Jardine Barrington Cook**
Head of Interoperability and Data - The Access Group

# Slido

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# Q&A Panel

# Morning Break

# Chairs Morning Reflection

**Kelly Bishop**
Assistant Director of Nursing and Urgent Care - Midlands and Lancashire Commissioning Support Unit (MLCSU)

# Up Next…

## Speaking Now…

**Lisa Riley**
Deputy CEO & Vice President of Strategy and Sales
VitalHub UK

# Slido

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# Up Next…

## Speaking Now…

**Clinton Schick**
Chief Executive / Non-Executive Director
Healthcare - Strata Health UK Ltd.

# Slido

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## Speaking Now…

**Cherry Jordan**
Head of Patient Flow and Discharge
Ashford and St Peters NHS Trust

# Internal process to support timely and safe discharge

Cherry Jordan
Head of Patient Flow and Discharge

# Background

Coming out of the pandemic we had large numbers of beds open across both our hospital sites at St Peter's and Ashford as well as significant NHS operated bed capacity in the community

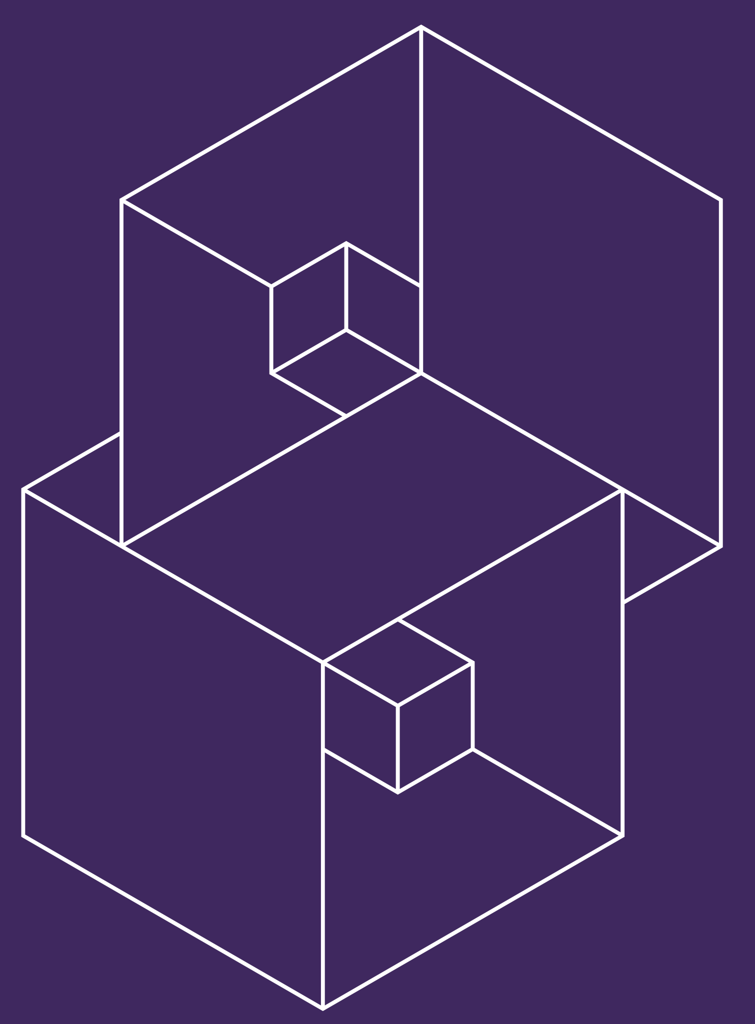
January 2022 Ashford and St Peters had 117 Escalation beds open

January 2022 Average of 150-180/Day of no Criteria to reside patients across both sites

2021 Average of 15-25 Daily discharges of Complex Patients (Pathway 1-3 )

# The following services were invested in to increase capacity by NWS Alliance

- **60 Dedicated Care Home Beds in a 5 year strategic partnership with CHD Living**
- Step Down Housing Units delivered by our Borough Councils
- 20% Increase in core community services through CSH Surrey
- Tripling of referral capacity in Urgent Community Response Service
- Consolidation of Community Hospital Beds reducing beds and wards but delivering a critical mass of rehab expertise



As a Trust here's what we have done so far to support and improve our practice and performance

- Home First Team
- MFFD Ward and Therapy Led Unit
- Home Banner

on your way
Home
We really care about what happens next ...
Carers Care Home Equipment
All Sorted? - Great!
- Not quite?
Then we may ask you to stay with us for a while
in another ward, or with one of our partners
APS SERVICES
T: 01932 564444
M: 07966 549909

Flow Coordinator WhatsApp group

HOTLINE for contacting the Complex Discharge Team contact hotline 3591

Discharge stickers - Prioritising specimens for Discharge patients.

## Discharge Stickers

Specimens for patients potentially going home should be labelled with DISCHARGE STICKERS so it can be prioritised.

## Daily Non Right to Reside call

- Change approach – ensure all ward attendance
- Identifying complex patients early

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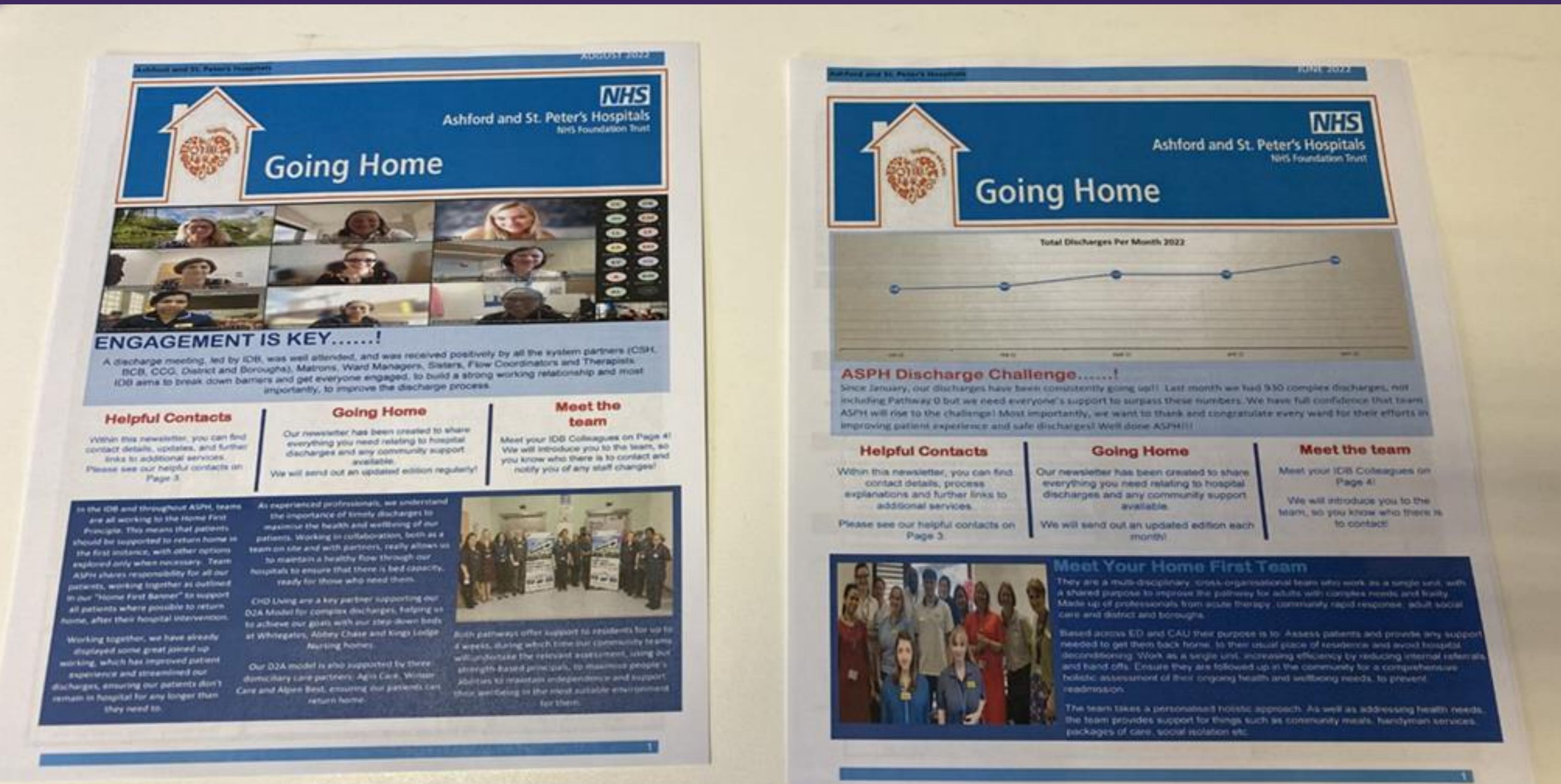
## IDB Newsletter

To inform wards of community support and upcoming projects, platform for other divisions or system partners, focused on top tips and share positive feedback

# Newsletter



Millbrook read-only access

- To confirm equipment and delivery

D2A training

- To empower ward and not sole responsibility of therapist

Border discharge work – standardising referral forms, reviewing pathway, preventing delays

IDB Equipment stock e.g. zimmer frame , Mowbray seat etc kept in IDB

Food Bank Champions and Supplies in the IDB

Building strong relationship with Care Homes

Visiting Care homes and meeting care managers to strengthen relationships with system/community partners.

# IDB and System Partners Engagement Event

# Discharges
# Lets Get It Right
# Study Day

Speakers from system partners (Community rehab, transport services, private funders, ASC, CHC, District and Borough Locality, District Nurses, etc)

# Care Home and CSH Escalation Process

Patient Discharged to Care Homes who have concerns on:

- Discharge letter
- Medications
- RESPECT form
- Wound dressings and equipment

In hours (8 am - 4 pm)

- Contact the Ward
- Contact the Complex Discharge Team on 01932 723591
- If the issue remains unsolved, contact the Patient Flow and Discharge Lead om 01932 723591 or 01932 726228

Out of Hours (Including weekends and Bank Holidays)

- Contact the Ward
- Contact the Complex Discharge Team via pager 5980 or pager 8807
- If the issue remains unsolved, contact the Clinical Site Nurse Practitioner (CSNP) via switchboard 01932 872000 bleep 5001 or 5380

# District Nurse Poster

NHS
Ashford and
St. Peter's Hospitals
NHS Foundation Trust

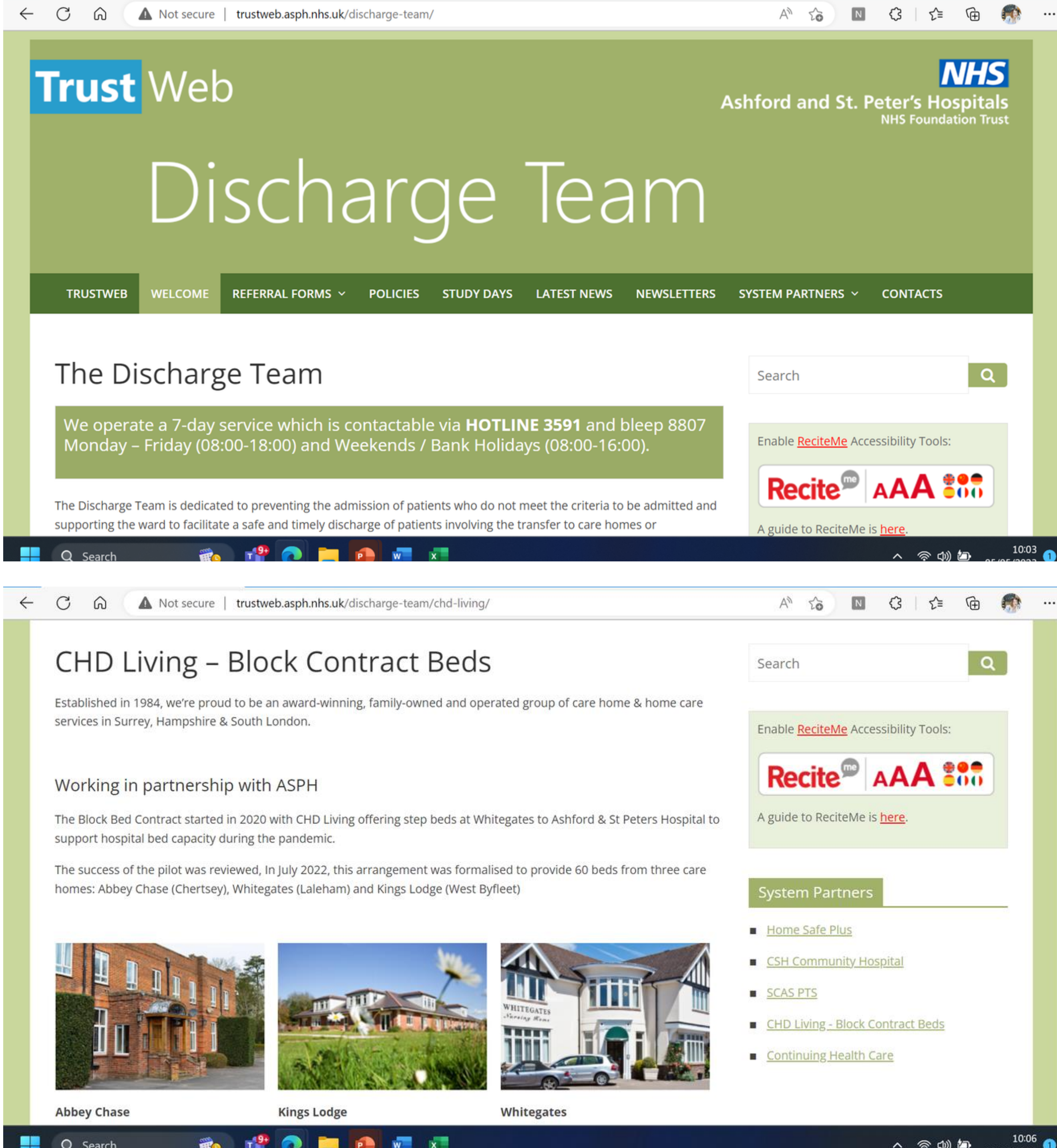
**Patient Going Home?**

**Have You Completed your patient's District Nurse Referral?**

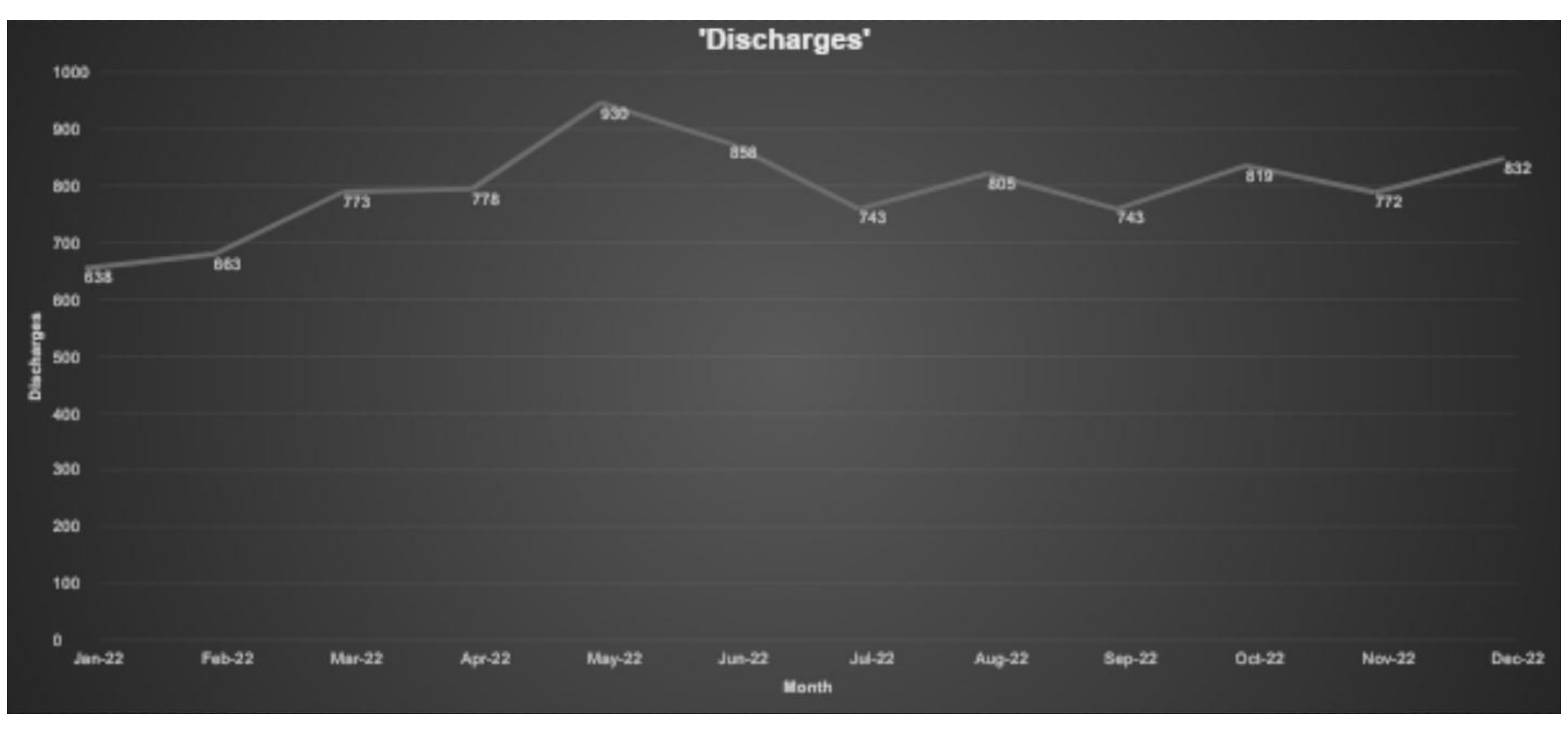
***48hrs before discharge...***

- Teaching and Engagement in Clinical Trust Induction
- Teaching and Engagement with Third Year Students and TNA’s
- Shadowing Integrated Discharge Bureau

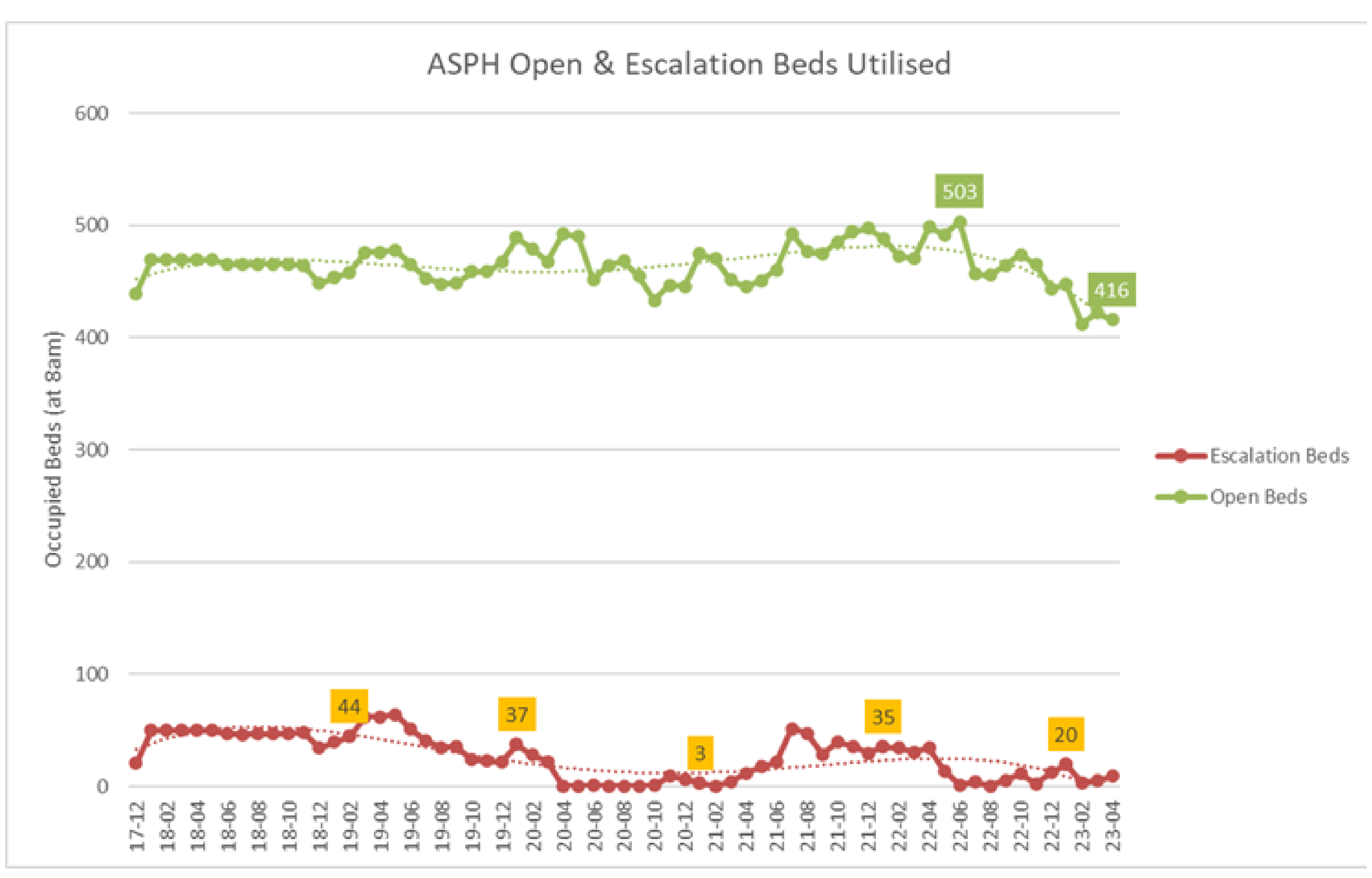
# NEW Discharge Team Website



# Complex Cases and Pathway Discharges 2022



# 117 Medical Beds Closed




- SD Beds (39) - May 22
- Walton (19) - Jun 22
- Wordsworth (21) - Dec 22
- Chaucer (13) - Dec 22
- Heron (15) - Jan23
- Community (10) – Jun 22

# Investment approach & ROI

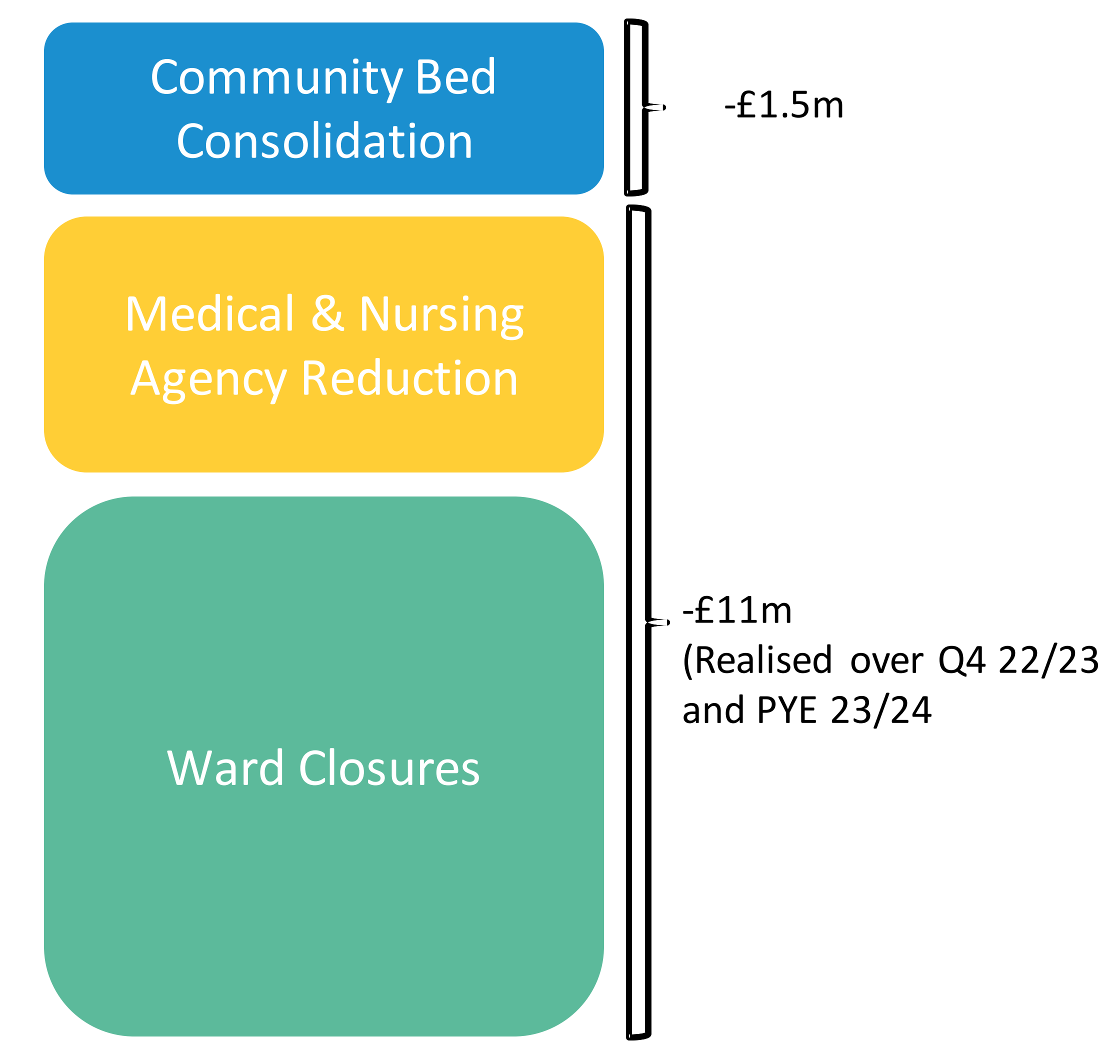
£7.3m spent with all investment deployed from a different use of existing budgets

£300k (BCF) — Step Down Housing

£3m (Ageing Well & Demand/Capacity Fund) — Urgent Community Response; Community Services Expansion

£4m (D2A) — Care Sector Strategic Partnership

Net return on investment of £4.2m realised across 2022/23 and 2023/24

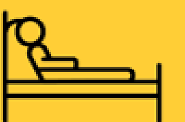


# Another Achievement for the Trust!

| Date | Total no. MFFD | Total no. @ 7 days and over | No. @ 7 days | No. >7 days | Total Bed Days @ 7 days and over | Achievement/s |
|---|---|---|---|---|---|---|
| 13th Aug | 48 (39 P1 - P3) | 3 | 0 | 3 | 39 | • Only 3 patients with a stay of greater than 7 days. 39 bed days lowest record since January 2023 |

# Other results & impacts

**Reduce patients in hospital over 7 days by 31%; 14 days by 13% and 21 days by 24%**

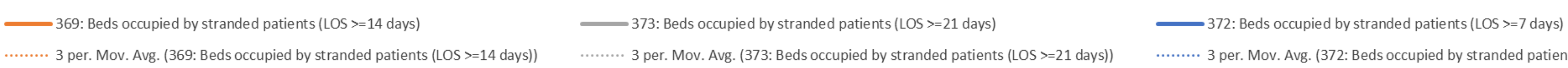


**Consolidated safer staffing,** reducing medical agency spending by over **40%** and nursing agency spend by over **25%**

CQC Good Achieved across Community Services

Lowest sickness rates and highest staff retention rates

Beds Occupied by Stranded Patients



# Current performance benchmarks - August

Regional & national top performer for LOS and stranded patients

| | | Rank | Number of 21+ day patients | % beds occupied by 21+ day patients | ...4 week average | Number of 14+ day patients | % beds occupied by 14+ day patients | ...4 week average | Number of 7+ day patients | % beds occupied by 7+ day patients | ...4 week average | Number of 14-20 day patients | Number of 7-13 day patients | Total bed occupancy |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| National | 14/08/2023 | 1 | 16,840 | 19.2% | 18.9% | 25,776 | 29.4% | 29.1% | 43,799 | 49.9% | 49.6% | 8,936 | 18,022 | 91.7% |
| Region | | | | | | | | | | | | | | |
| South East | 14/08/2023 | 1 | 2,305 | 19.5% | 19.4% | 3,564 | 30.2% | 30.1% | 6,063 | 51.3% | 51.0% | 1,259 | 2,499 | 94.3% |
| STP | | | | | | | | | | | | | | |
| Sussex Health And Care Partnership STP | 14/08/2023 | 6 | 520 | 22.4% | 22.6% | 785 | 33.8% | 33.6% | 1,290 | 55.6% | 55.3% | 265 | 506 | 95.5% |
| Kent And Medway STP | 14/08/2023 | 5 | 528 | 20.6% | 20.8% | 803 | 31.4% | 31.8% | 1,359 | 53.2% | 53.4% | 275 | 556 | 91.1% |
| Frimley Health & Care Ics (STP) | 14/08/2023 | 4 | 260 | 21.5% | 20.7% | 395 | 32.6% | 31.6% | 662 | 54.7% | 52.9% | 135 | 267 | 96.4% |
| Hampshire And The Isle Of Wight STP | 14/08/2023 | 3 | 463 | 16.9% | 17.8% | 742 | 27.1% | 28.8% | 1,296 | 47.4% | 49.3% | 279 | 555 | 96.1% |
| Surrey Heartlands Health & Care Partnership (STP) | 14/08/2023 | 2 | 276 | 18.4% | 17.7% | 439 | 29.3% | 27.7% | 738 | 49.3% | 47.4% | 163 | 299 | 95.4% |
| Buckinghamshire, Oxfordshire And Berkshire West STP | 14/08/2023 | 1 | 259 | 17.4% | 16.7% | 401 | 26.9% | 26.4% | 718 | 48.2% | 46.4% | 142 | 316 | 92.6% |
| Trust | | | | | | | | | | | | | | |
| University Hospitals Sussex NHS Foundation Trust | 14/08/2023 | 17 | 400 | 24.9% | 25.2% | 590 | 36.6% | 36.6% | 934 | 58.0% | 58.5% | 189 | 345 | 95.3% |
| East Kent Hospitals University NHS Foundation Trust | 14/08/2023 | 16 | 245 | 24.5% | 24.3% | 357 | 35.7% | 34.9% | 535 | 53.6% | 53.8% | 112 | 178 | 92.4% |
| Isle of Wight NHS Trust | 14/08/2023 | 15 | 52 | 22.7% | 23.1% | 76 | 33.4% | 35.3% | 126 | 55.3% | 57.8% | 24 | 50 | 93.7% |
| Surrey and Sussex Healthcare NHS Trust | 14/08/2023 | 14 | 155 | 23.5% | 22.5% | 228 | 34.4% | 33.8% | 357 | 53.8% | 54.7% | 72 | 129 | 98.0% |
| Dartford and Gravesham NHS Trust | 14/08/2023 | 13 | 106 | 21.0% | 21.0% | 158 | 31.3% | 32.7% | 283 | 55.9% | 57.1% | 52 | 125 | 92.1% |
| Frimley Health NHS Foundation Trust | 14/08/2023 | 12 | 260 | 21.5% | 20.7% | 395 | 32.6% | 31.6% | 662 | 54.7% | 52.9% | 135 | 267 | 96.4% |
| Buckinghamshire Healthcare NHS Trust | 14/08/2023 | 11 | 80 | 19.7% | 20.0% | 120 | 29.6% | 29.6% | 203 | 50.1% | 49.0% | 40 | 83 | 92.1% |
| University Hospital Southampton NHS Foundation Trust | 14/08/2023 | 10 | 194 | 19.6% | 19.8% | 300 | 30.2% | 31.0% | 526 | 53.0% | 53.4% | 106 | 226 | 95.4% |
| Royal Surrey County Hospital NHS Foundation Trust | 14/08/2023 | 9 | 80 | 17.6% | 18.1% | 131 | 28.6% | 28.4% | 230 | 50.1% | 49.3% | 51 | 99 | 94.1% |
| Medway NHS Foundation Trust | 14/08/2023 | 8 | 86 | 19.1% | 18.0% | 138 | 30.7% | 29.7% | 253 | 56.1% | 53.8% | 52 | 114 | 90.3% |
| Maidstone and Tunbridge Wells NHS Trust | 14/08/2023 | 7 | 90 | 15.0% | 17.1% | 149 | 24.9% | 27.8% | 288 | 48.1% | 49.6% | 59 | 139 | 88.9% |
| East Sussex Healthcare NHS Trust | 14/08/2023 | 6 | 120 | 16.8% | 16.8% | 195 | 27.5% | 26.9% | 356 | 50.1% | 48.1% | 75 | 161 | 95.8% |
| Hampshire Hospitals NHS Foundation Trust | 14/08/2023 | 5 | 99 | 13.0% | 16.3% | 158 | 20.8% | 25.3% | 297 | 39.1% | 44.8% | 59 | 140 | 96.3% |
| Royal Berkshire NHS Foundation Trust | 14/08/2023 | 4 | 96 | 17.2% | 16.1% | 146 | 26.1% | 25.2% | 264 | 47.3% | 45.1% | 50 | 119 | 91.7% |
| Portsmouth Hospitals University National Health Servic.. | 14/08/2023 | 3 | 165 | 15.6% | 15.6% | 291 | 27.5% | 27.6% | 486 | 46.0% | 46.4% | 126 | 195 | 97.6% |
| Oxford University Hospitals NHS Foundation Trust | 14/08/2023 | 2 | 146 | 15.8% | 15.4% | 238 | 25.8% | 25.6% | 439 | 47.7% | 46.1% | 92 | 201 | 94.1% |
| Ashford and St Peter's Hospitals NHS Foundation Trust | 14/08/2023 | 1 | 40 | 10.6% | 8.4% | 80 | 21.4% | 15.8% | 151 | 40.3% | 31.9% | 40 | 71 | 92.5% |

# Current performance benchmarks - September

Regional & national top performer for LOS and stranded patients

| | Date | Rank | Number of 21+ day patients | % beds occupied by 21+ day patients | ...4 week average | Number of 14+ day patients | % beds occupied by 14+ day patients | ...4 week average | Number of 7+ day patients | % beds occupied by 7+ day patients | ...4 week average | Number of 14-20 day patients | Number of 7-13 day patients | Total bed occupancy |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **National** | 04/09/2023 | 1 | 17,780 | 19.7% | 19.5% | 27,247 | 30.2% | 29.9% | 44,960 | 49.9% | 50.4% | 9,467 | 17,713 | 93.4% |
| **Region** | | | | | | | | | | | | | | |
| South East | 04/09/2023 | 1 | 2,618 | 20.9% | 20.3% | 4,018 | 32.0% | 31.3% | 6,515 | 51.9% | 52.4% | 1,400 | 2,498 | 95.0% |
| **STP** | | | | | | | | | | | | | | |
| Sussex Health And Care Partnership STP | 04/09/2023 | 6 | 600 | 25.4% | 24.0% | 890 | 37.6% | 35.9% | 1,352 | 57.1% | 57.3% | 289 | 462 | 96.4% |
| Frimley Health & Care Ics (STP) | 04/09/2023 | 5 | 285 | 23.3% | 22.3% | 412 | 33.7% | 33.6% | 661 | 54.1% | 54.8% | 127 | 249 | 97.0% |
| Kent And Medway STP | 04/09/2023 | 4 | 516 | 21.2% | 21.1% | 783 | 32.2% | 32.3% | 1,283 | 52.8% | 53.9% | 267 | 500 | 90.4% |
| Surrey Heartlands Health & Care Partnership (STP) | 04/09/2023 | 3 | 307 | 20.1% | 19.3% | 466 | 30.5% | 29.8% | 755 | 49.4% | 50.6% | 159 | 289 | 96.3% |
| Hampshire And The Isle Of Wight STP | 04/09/2023 | 2 | 573 | 18.4% | 17.9% | 944 | 30.4% | 29.2% | 1,604 | 51.6% | 50.7% | 371 | 659 | 96.9% |
| Buckinghamshire, Oxfordshire And Berkshire West STP | 04/09/2023 | 1 | 337 | 17.7% | 17.8% | 523 | 27.5% | 27.5% | 860 | 45.3% | 47.2% | 186 | 338 | 94.4% |
| **Trust** | | | | | | | | | | | | | | |
| University Hospitals Sussex NHS Foundation Trust | 04/09/2023 | 17 | 466 | 28.1% | 26.5% | 677 | 40.8% | 39.0% | 992 | 59.8% | 60.7% | 211 | 315 | 96.9% |
| East Kent Hospitals University NHS Foundation Trust | 04/09/2023 | 16 | 245 | 24.6% | 24.7% | 359 | 36.0% | 35.7% | 534 | 53.6% | 54.3% | 114 | 175 | 91.6% |
| Surrey and Sussex Healthcare NHS Trust | 04/09/2023 | 15 | 171 | 25.2% | 24.2% | 253 | 37.3% | 35.6% | 387 | 57.0% | 56.3% | 82 | 134 | 98.7% |
| Frimley Health NHS Foundation Trust | 04/09/2023 | 14 | 285 | 23.3% | 22.3% | 412 | 33.7% | 33.6% | 661 | 54.1% | 54.8% | 127 | 249 | 97.0% |
| Isle of Wight NHS Trust | 04/09/2023 | 13 | 53 | 22.6% | 21.7% | 80 | 34.0% | 33.5% | 134 | 56.7% | 56.0% | 27 | 54 | 92.3% |
| Buckinghamshire Healthcare NHS Trust | 04/09/2023 | 12 | 87 | 21.5% | 21.1% | 121 | 30.1% | 30.3% | 189 | 46.8% | 48.0% | 34 | 68 | 93.1% |
| Dartford and Gravesham NHS Trust | 04/09/2023 | 11 | 96 | 19.1% | 20.4% | 147 | 29.1% | 30.8% | 258 | 51.1% | 53.8% | 51 | 111 | 91.8% |
| Medway NHS Foundation Trust | 04/09/2023 | 10 | 68 | 20.7% | 20.3% | 104 | 31.8% | 32.3% | 178 | 54.4% | 56.0% | 36 | 74 | 87.1% |
| Royal Surrey County Hospital NHS Foundation Trust | 04/09/2023 | 9 | 103 | 22.3% | 19.5% | 158 | 33.9% | 30.5% | 251 | 54.1% | 52.0% | 54 | 94 | 94.3% |
| University Hospital Southampton NHS Foundation Trust | 04/09/2023 | 8 | 206 | 20.0% | 19.3% | 339 | 33.0% | 30.7% | 575 | 55.9% | 54.2% | 133 | 235 | 96.0% |
| East Sussex Healthcare NHS Trust | 04/09/2023 | 7 | 134 | 19.0% | 18.0% | 213 | 30.1% | 28.8% | 360 | 50.9% | 49.5% | 78 | 147 | 95.2% |
| Royal Berkshire NHS Foundation Trust | 04/09/2023 | 6 | 98 | 17.6% | 17.7% | 159 | 28.5% | 27.3% | 263 | 47.0% | 47.3% | 61 | 104 | 92.8% |
| Hampshire Hospitals NHS Foundation Trust | 04/09/2023 | 5 | 144 | 18.2% | 16.9% | 225 | 28.5% | 27.2% | 396 | 50.1% | 49.1% | 82 | 171 | 98.4% |
| Portsmouth Hospitals University National Health Servic... | 04/09/2023 | 4 | 171 | 16.2% | 16.6% | 299 | 28.4% | 28.2% | 499 | 47.3% | 47.3% | 129 | 200 | 97.7% |
| Maidstone and Tunbridge Wells NHS Trust | 04/09/2023 | 3 | 107 | 17.8% | 16.5% | 173 | 28.7% | 27.7% | 314 | 52.0% | 51.9% | 66 | 140 | 89.2% |
| Oxford University Hospitals NHS Foundation Trust | 04/09/2023 | 2 | 152 | 16.2% | 16.4% | 243 | 25.9% | 26.3% | 409 | 43.6% | 46.8% | 91 | 166 | 95.9% |
| Ashford and St Peter's Hospitals NHS Foundation Trust | 04/09/2023 | 1 | 32 | 8.3% | 10.4% | 55 | 14.3% | 18.8% | 116 | 30.2% | 38.7% | 23 | 61 | 94.7% |

## Up Next…

## Speaking Now…

**Jenni Woods**
Health and Business Intelligence Lead - NHS Tayside

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# Q&A Panel

# Lunch & Networking

# Chairs Afternoon Address

**Kelly Bishop**
Assistant Director of Nursing and Urgent Care - Midlands and Lancashire Commissioning Support Unit (MLCSU)

# Up Next…

faculty

## Speaking Now…

**Hugh Neylan**
Head of Health - Faculty AI

# Slido

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## Speaking Now…

**Miss Pei-Fen Lin**
Consultant Ophthalmic Surgeon, Clinical Director of Digital Innovations - Moorfields Eye Hospital NHS Foundation Trust

# The Rapid Access Clinic Playbook: How we cut eye casualty attendance by 50%

Miss Pei-Fen Lin, MBBS, MA, FRCOphth
Consultant Ophthalmologist, CD Digital Innovation

The Patient Flow Conference

# Moorfields @ Croydon

Service the largest London borough: population 391,000

Eye clinic : 47,000 Out-patient appts per year

5,894 seen in eye casualty in 2017-2018

Projection of increased demand yearly

# Eye Casualty

De facto **'Go-to'** eye clinic for anything and everything for anyone

Commissioned originally as acute-referral clinic (ARC) model but defaults into walk-in service

Inefficient

Costly

Unsustainable

# 78% Inappropriate for eye casualty

Audit : 350 consecutive attendances in Eye casualty in 2018

96% walked-in

46% self -referred

50% brought a paper referral with them

31% does not need eye hospital care at all

Mean symptom onset: 26 days

# How did we end up in this funk?

Treating the worried well most of the time

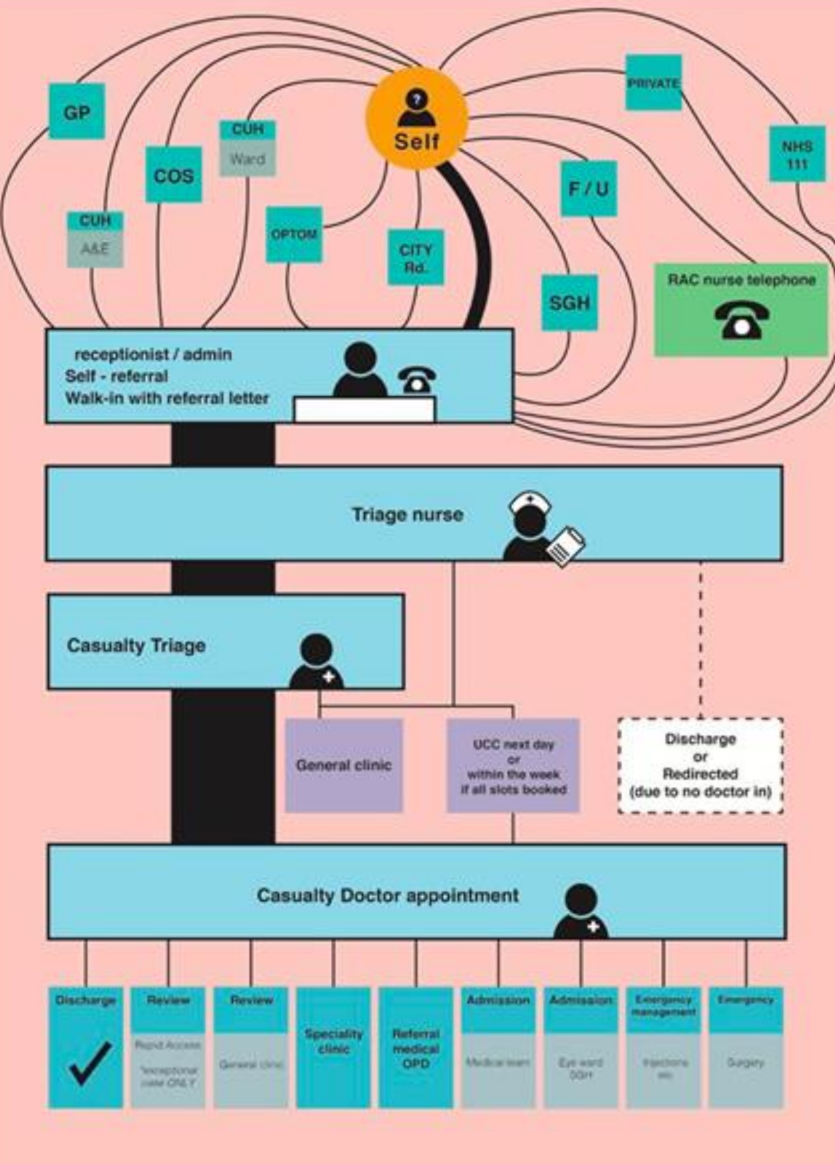
Walk-in with referral = self referral

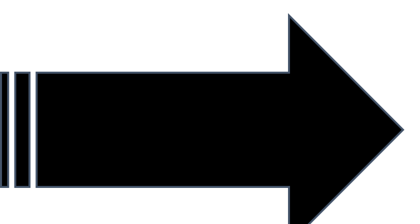
32 different historical formats of referral methods

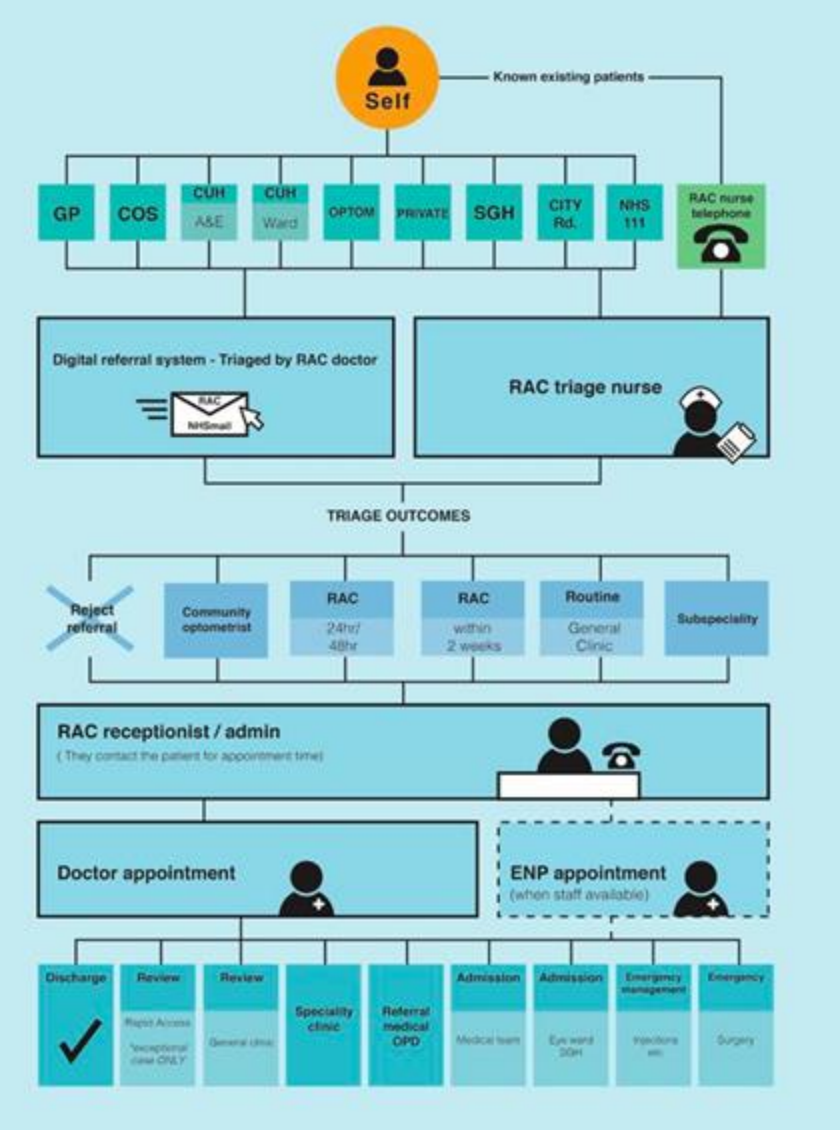
Eye health knowledge lacking in both patient and primary care

No rejection / Feedback

Too convenient


BEFORE
CURRENT URGENT EYE CARE
GP
COS
CUH Ward
CUH A&E
OPTOM
Self
CITY Rd.
PRIVATE
F / U
NHS 111
SGH
RAC nurse telephone
receptionist / admin
Self - referral
Walk-in with referral letter
Triage nurse
Casualty Triage
General clinic
UCC next day or within the week if all slots booked
Discharge or Redirected (due to no doctor in)
Casualty Doctor appointment
Discharge
Review
Review
Speciality clinic
Referral medical OPD
Admission
Admission
Emergency management
Emergency




AFTER
RAPID ACCESS EYE EMERGENCY CLINIC
Self
Known existing patients
GP
COS
CUH A&E
CUH Ward
OPTOM
PRIVATE
SGH
CITY Rd.
NHS 111
RAC nurse telephone
Digital referral system - Triaged by RAC doctor
RAC
NHSmail
RAC triage nurse
TRIAGE OUTCOMES
Reject referral
Community optometrist
RAC 24hr/48hr
RAC within 2 weeks
Routine General Clinic
Subspeciality
RAC receptionist / admin
Doctor appointment
ENP appointment
(when staff available)
Discharge
Review
Review
Speciality clinic
Referral medical OPD
Admission
Admission
Emergency management
Emergency

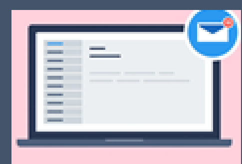
# Stakeholder engagement

## Co-design with frontline and service users

# Rapid Access Clinic

## Forward Virtual triage model

Standardised form



Centralized referral/triage

Golden team of 3 :
- -Senior ophthalmologist
- -Ophthalmic triage nurse
- -Dedicated admin receptionist

Communication campaign

PDSA, feedback, education events

# MVP

Finding our ‘ Digital’ platform
Simple is key

MUST HAVES :

- Centralising triage
- Openly accessible to referrers
- Information Governance compliant

Could have

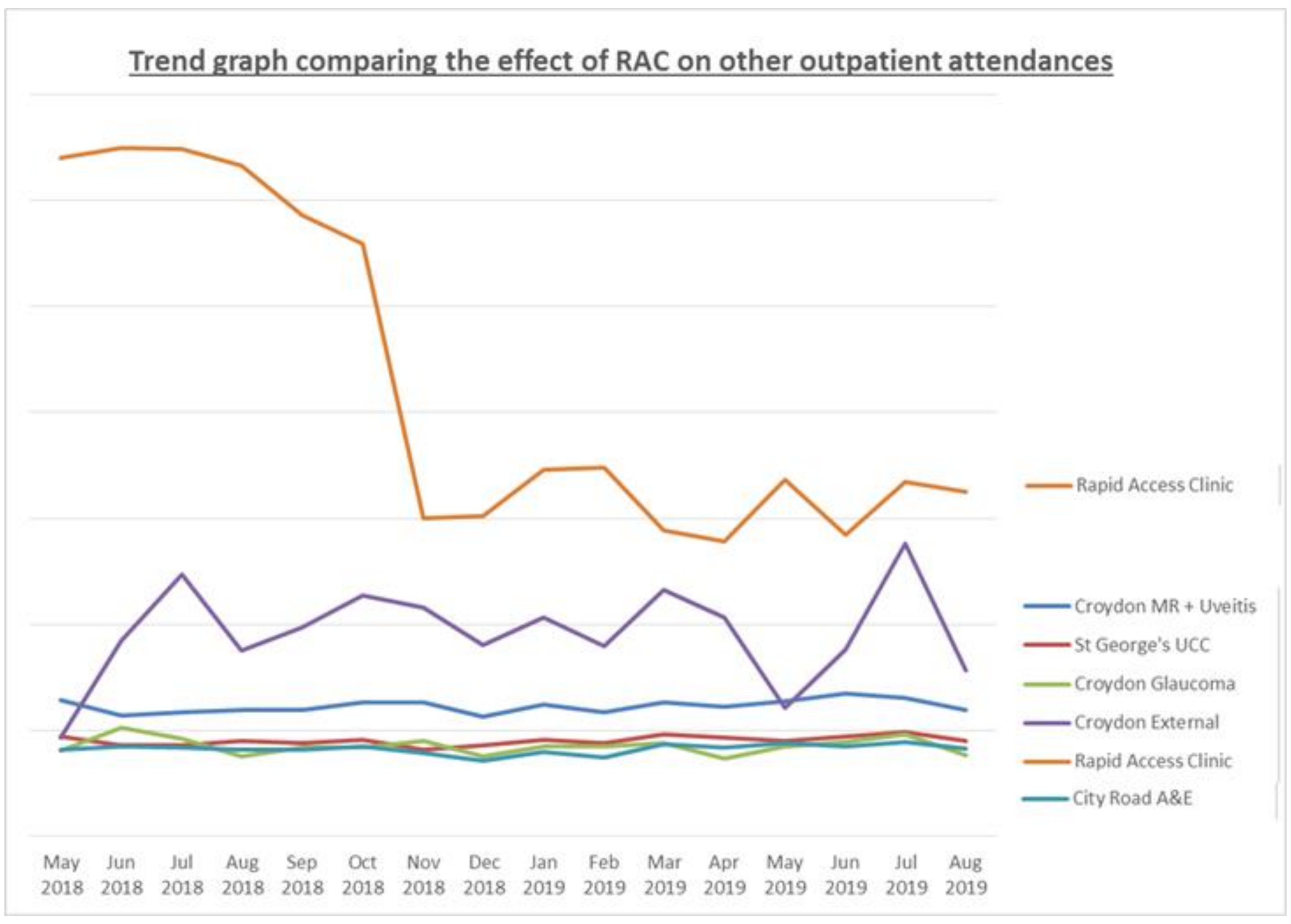
- Audit function

Won’t have

- Expensive onboard or maintenance cost

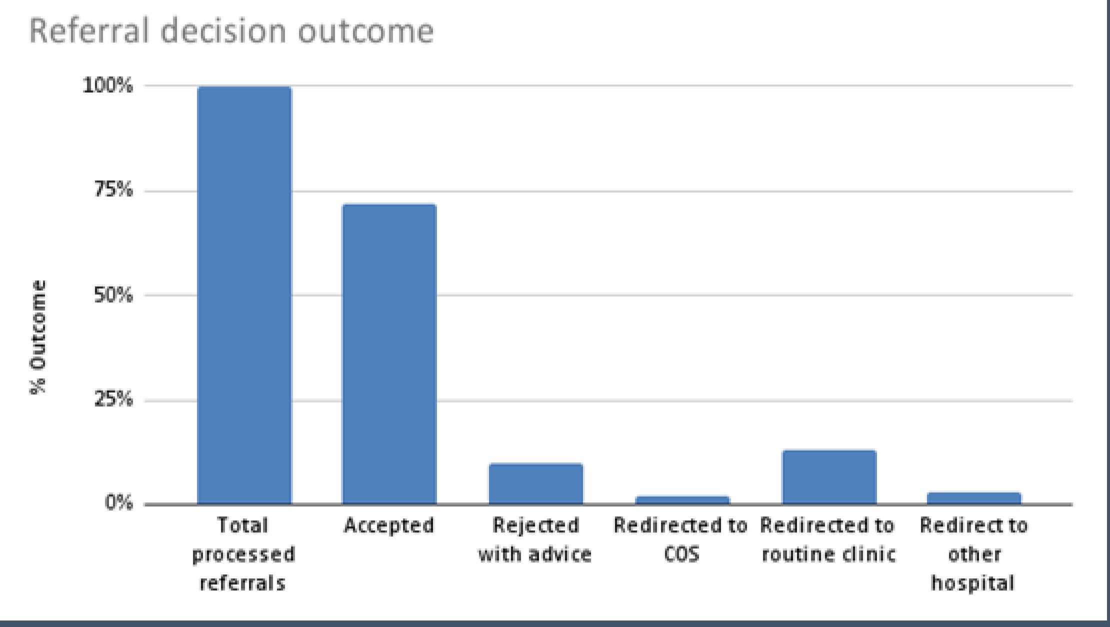
# 1st year

50%
Sustained decrease in attendance



# Controlling Access

Triage and book according to clinical urgency




70% Referrals accepted

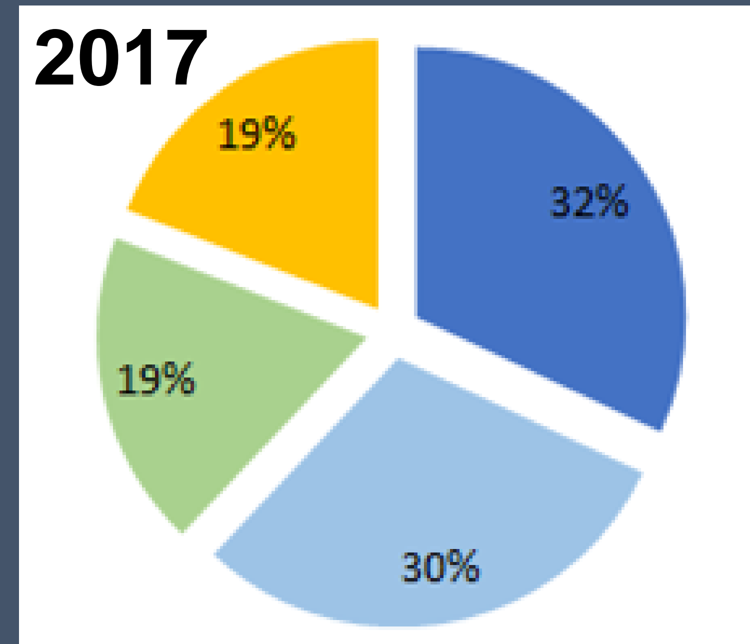
30% accepted for 24 hour review

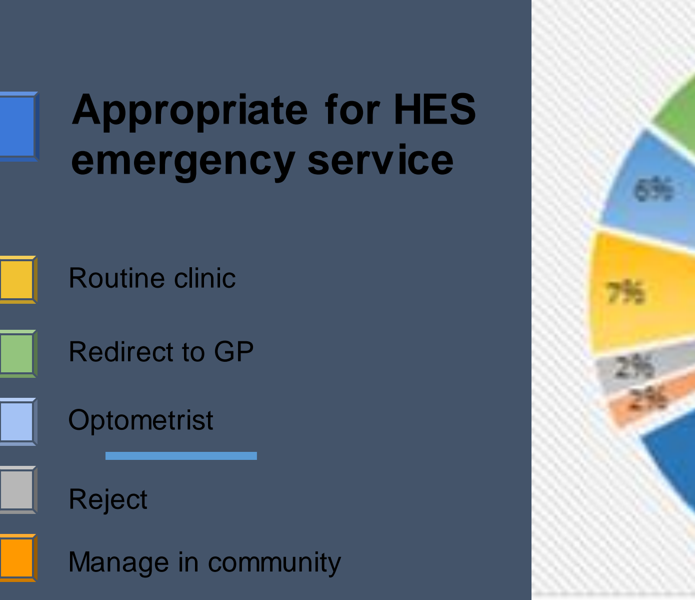
25-30% rejected

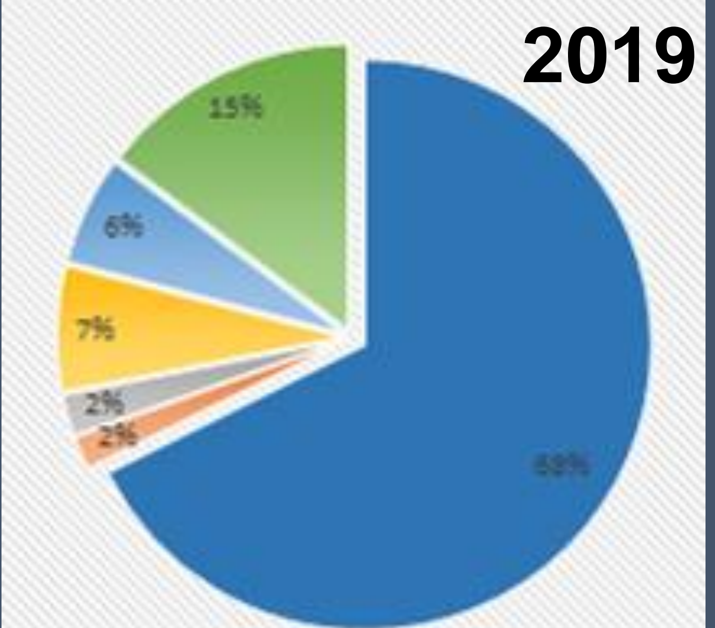
- Advice and Guidance
- Redirected

# Referral Quality improved within 1 year

Improved from 32% to 68% appropriate



# Friends and Family Test (dynamic data up to August 2023)

## RAC

% +ve Rate (Q5,4)

94.3% (1,251/1,326)

% -ve Rate

1.3% (17/1,326)

## Walk-in eye casualty

% +ve Rate (Q5,4)

91.3% (5,223/5,723)

% -ve Rate

4.1% (234/5,723)

# The user reviews

- Patient survey : 8.5 / 10
- Referrer survey : 7.7 / 10
- Staff survey : 9.3 /10
- Trainee survey : 95/100

Why?

- Less waiting time and duplication of appointments
- Communication bridged between referrer and ophthalmologist
- Being the "real Eye A&E"
- Finishing on time!

# The challenges

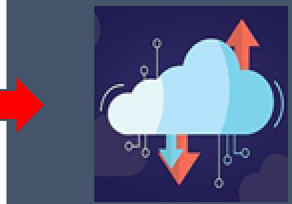
Past and Present

Changing behaviours of ALL users

Staffing

"Performance" management

Commissioning and payment



Technology

# The next 5 years

## Sustainability & Innovation

Sustained and enhanced the network with our referrers

Automating audit / feedback function

Teleconsultation

Chatbot assisted consultation

AI assisted triage

# Thank you

Email : P.lin@nhs.net

Twitter: @peipemeow

Special thanks to:

Entire RAC team

Maria Eleftheriadou

Aye Thi Han

Kirsten Malcomson (RAC service improvement project manager)

Rose Sebwato ( RAC nurse)

Kasuri Ganapathy (RAC admin)

## Speaking Now…

**Dr Anne Kinderlerer**
CD discharge, integrated care and therapies
AMD for PSIRF Clinical Digital Health Lead RCP
- Imperial college healthcare NHS Trust

# Discharge , data, and digital transformation - Can we reduce risk to patients ?

**Anne Kinderlerer Consultant Rheumatologist**

**Clinical Director Integrated Care and Discharge**

**Associate Medical Director PSRF**

**Imperial Healthcare NHS Trust**

**RCP Digital Health Clinical Lead**

# Patient 1

ED
4/12/22
26h35m

81 year old Tamil speaking woman
Pre-existing dementia
Frail (Rankin 3) large L MCA stroke R sided weakness
D1 CT

Ward 1
05/12/22
5 days

NG D2-D8

IP echo 12/12 ( 7 days post admission)
Holter result 14/12 ( 10 days post admission) Therapies –drowsy – 13/12

D10
MO

Ward 2
10/12/22
82 days

D34 NBA discussion of discharge destination ( but no EDN)
D35 EDN sent
D38chase SW allocation
D46 formal planning family meeting
D48 NBA QDS POC / request for photos of home
D58 access visit
D61 family unable to clear room
D69 new NBA – NH EOL / family wishes
D73 NBA accepted – nursing needs no complexity
D82 with brokerage
D87 NH1 allocated

D10 documentation of baseline function
D17 goal setting meeting
D33 agreed short term goals met – 1st request for home setup ( family request NH)
D34-41 Week Trial of therapies with interpreter
D41 maintenance therapy only
D58 palliative referral weight loss / lack of engagement

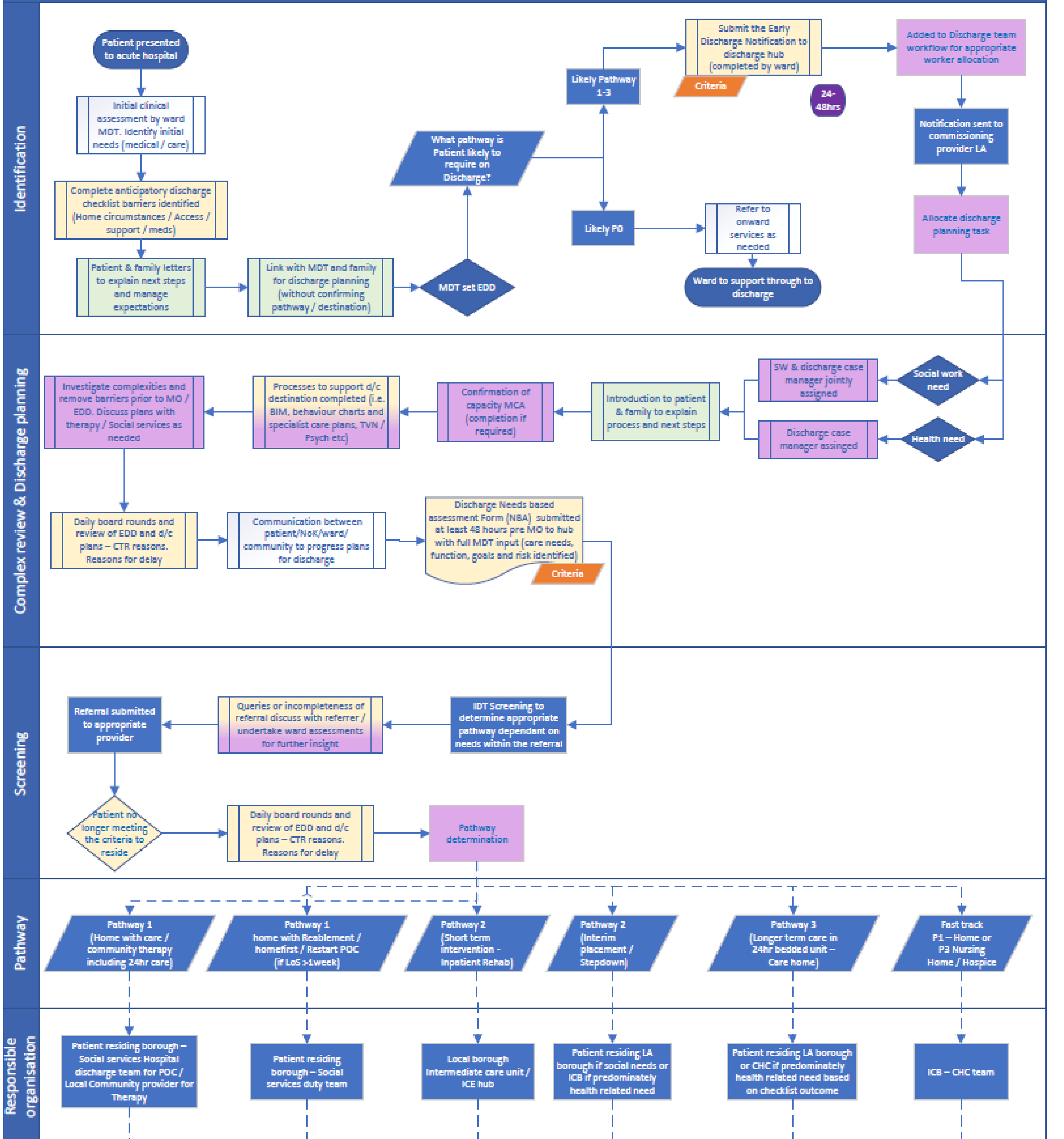
Ward 3
02/03/24
29 days

D96 family refuse NH1 ( no documentation of choice policy)
D97 attemot to discharge NH2 invoke choice policy – no documentation given to family
D98 NH2 declines patient ( ? Family)
D102 tilt chairs rationed ( so pt not sat out as maintenance agreement D41)

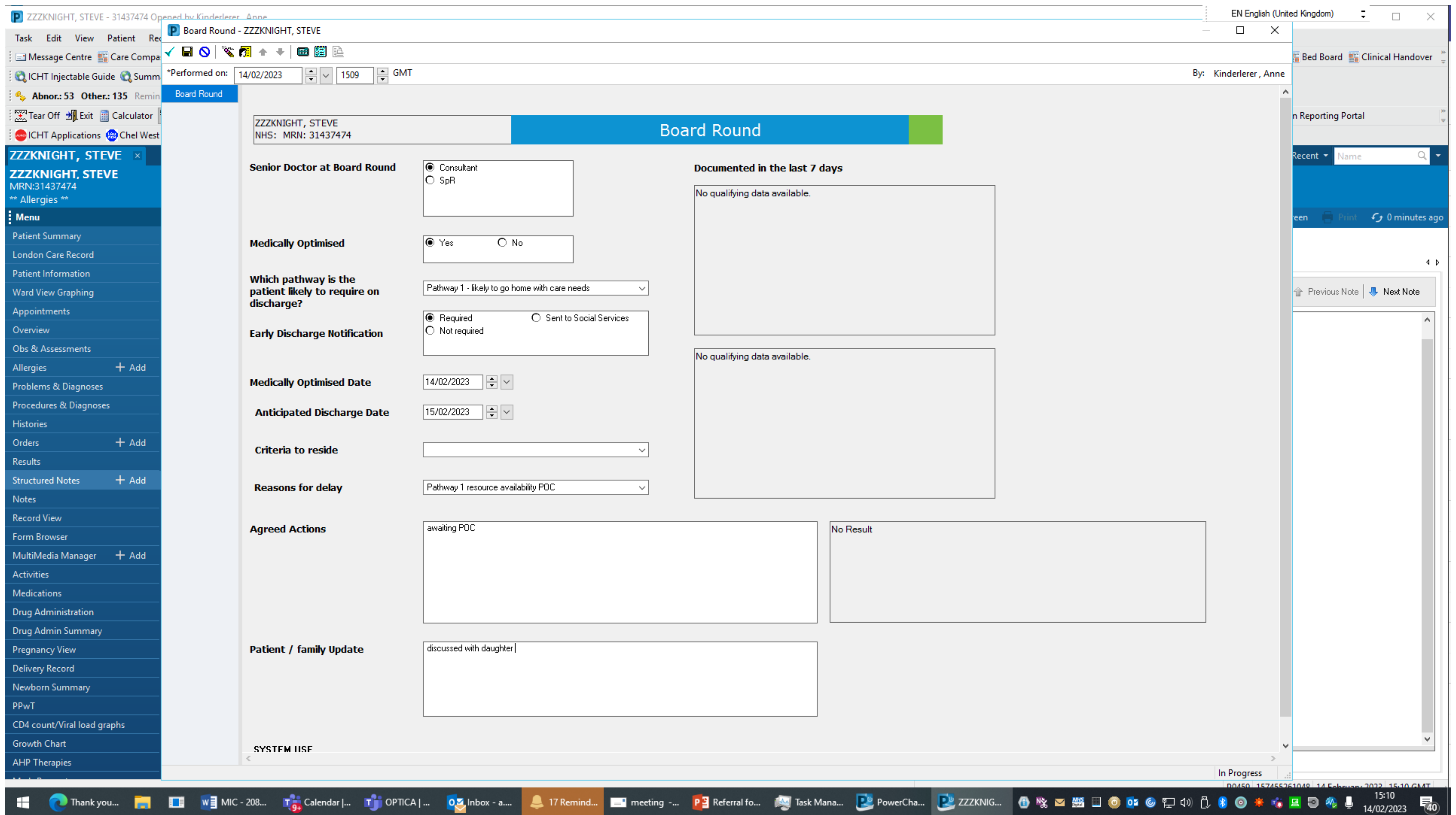
NH
30/03/23
D117

D117 choice letter sent to family on Day of Discharge to NH3

Family express intention to complain



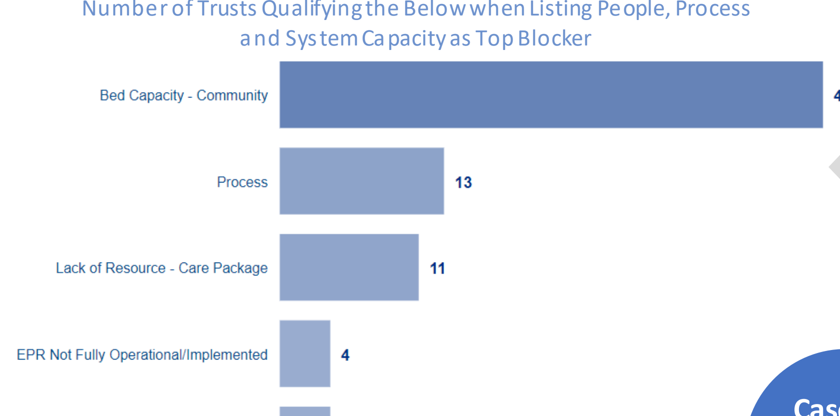
Identification
Patient presented to acute hospital
Initial clinical assessment by ward MDT. Identify initial needs (medical / care)
Complete anticipatory discharge checklist barriers identified (Home circumstances / Access / support / meds)
Patient & family letters to explain next steps and manage expectations
Link with MDT and family for discharge planning (without confirming pathway / destination)
MDT set EDD
What pathway is Patient likely to require on Discharge?
Likely Pathway 1-3
Likely P0
Submit the Early Discharge Notification to discharge hub (completed by ward)
Criteria
24-48hrs
Refer to onward services as needed
Ward to support through to discharge
Added to Discharge team workflow for appropriate worker allocation
Notification sent to commissioning provider LA
Allocate discharge planning task
Complex review & Discharge planning
Social work need
Health need
SW & discharge case manager jointly assigned
Discharge case manager assinged
Introduction to patient & family to explain process and next steps
Confirmation of capacity MCA (completion if required)
Processes to support d/c destination completed (i.e. BIM, behaviour charts and specialist care plans, TVN / Psych etc)
Investigate complexities and remove barriers prior to MO / EDD. Discuss plans with therapy / Social services as needed
Daily board rounds and review of EDD and d/c plans – CTR reasons. Reasons for delay
Communication between patient/NoK/ward/ community to progress plans for discharge
Discharge Needs based assessment Form (NBA) submitted at least 48 hours pre MO to hub with full MDT input (care needs, function, goals and risk identified)
Criteria
Screening
IDT Screening to determine appropriate pathway dependant on needs within the referral
Queries or incompleteness of referral discuss with referrer / undertake ward assessments for further insight
Referral submitted to appropriate provider
Patient no longer meeting the criteria to reside
Daily board rounds and review of EDD and d/c plans – CTR reasons. Reasons for delay
Pathway determination
Pathway
Pathway 1 (Home with care / community therapy including 24hr care)
Pathway 1 home with Reablement / homefirst / Restart POC (if LoS >1week)
Pathway 2 (Short term intervention - Inpatient Rehab)
Pathway 2 (Interim placement / Stepdown)
Pathway 3 (Longer term care in 24hr bedded unit – Care home)
Fast track P1 – Home or P3 Nursing Home / Hospice
Responsible organisation
Patient residing borough – Social services Hospital discharge team for POC / Local Community provider for Therapy
Patient residing borough – Social services duty team
Local borough Intermediate care unit / ICE hub
Patient residing LA borough if social needs or ICB if predominately health related need
Patient residing LA borough or CHC if predominately health related need based on checklist outcome
ICB – CHC team



ZZZKNIGHT, STEVE - 31437474 Opened by Kinderlerer, Anne
Board Round - ZZZKNIGHT, STEVE
*Performed on: 14/02/2023 1509 GMT
By: Kinderlerer, Anne
Board Round
ZZZKNIGHT, STEVE
NHS: MRN: 31437474
Board Round
Senior Doctor at Board Round
Consultant
SpR
Documented in the last 7 days
No qualifying data available.
Medically Optimised
Yes
No
Which pathway is the patient likely to require on discharge?
Pathway 1 - likely to go home with care needs
Early Discharge Notification
Required
Sent to Social Services
Not required
No qualifying data available.
Medically Optimised Date
14/02/2023
Anticipated Discharge Date
15/02/2023
Criteria to reside
Reasons for delay
Pathway 1 resource availability POC
Agreed Actions
awaiting POC
No Result
Patient / family Update
discussed with daughter
SYSTEM USE
In Progress
ZZZKNIGHT, STEVE
MRN:31437474
** Allergies **
Menu
Patient Summary
London Care Record
Patient Information
Ward View Graphing
Appointments
Overview
Obs & Assessments
Allergies
Problems & Diagnoses
Procedures & Diagnoses
Histories
Orders
Results
Structured Notes
Notes
Record View
Form Browser
MultiMedia Manager
Activities
Medications
Drug Administration
Drug Admin Summary
Pregnancy View
Delivery Record
Newborn Summary
PPwT
CD4 count/Viral load graphs
Growth Chart
AHP Therapies

- There is a fine balance between having enough people to effectively exploit digital discharge solutions, and using resources to compensate for low digital discharge maturity

## Survey and Interview Findings




**5.1** Across self-reported maturity levels, **resources** are often a constraint which hinder Trusts from capitalising on their full digital discharge capabilities. 15 Trusts cited a lack of resource as their top blocker to discharge, spanning all self-reported maturity levels.

**5.2** Some Trusts are able to supplement their digital discharge capability with **additional people** employed in discharge-specific roles. Interviewed Trusts reported that whilst this allows for more timely discharge during the week, often a **lag in discharge times is still experienced at the weekend** as these supplementary staff tend to work a 5 day week.

**Case Study 5: Level 3 Trust experiencing weekend discharge challenges**

One Trust cited seven-day working as their top blocker, as they have around 30% fewer staff across all functions in attendance at the weekend. Pathways for discharge at the weekend are diminished, for example Mental Health services have less access to discharge data at the weekend. Discharge numbers on a Monday are the lowest of the week, which is likely because discharge processes are often not being requested and initiated until the Monday.

### Conclusion

There is an optimal resource profile needed to maximise the benefits from technology. Too few resources mean technology is not sufficiently exploited; too many will suppress the efficiency that technology could present

- Where technology is aligned to Trusts' and ICS' needs, stronger digital capability is likely to be achieved

**Case Study 3: Level 4 Trust with EPR tailored to address ICS challenges**

One Level 4 Trust has adapted their dashboards, workflows and digital processes to support the planning of discharge. For example, they identified that **clinical teams were reluctant to set a definitive Expected Date of Discharge**, so replaced this with a **range of options** including 'definite today, possibly today, tomorrow within the next 72 hours and more than 72 hours'.
They commented, "It seems to be working much better than when we kept pushing clinical teams to state a date… Actually having a softer target, they seem to be more comfortable in setting."

**Quote 6: Level 4 Trust using a range of devices to view system availability**

"We have got… Community, ambulance navigation hub, volunteers, everybody. They use [bed management system] or if they haven't got it on their own desktop at the time, the whole place is set up a bit like a flight deck, so there's walls of analytics and we just huddle and we use [bed management system] live in the room."

**3.3** In-depth interviews with the most digitally mature Trusts also highlighted how accessibility of digital discharge data across a range of devices can be a strong tool to allow discharge decisions to be taken any time, anywhere.

**Case Study 4: Level 4 Trust using a range of devices to schedule community visits**

One Level 4 Trust uses a scheduling system for community visits which generates the most effective routes for those visits. Importantly, all community staff can access this on their mobile, and the Trust can view any additional capacity or where staff are, so drop in additional visits.

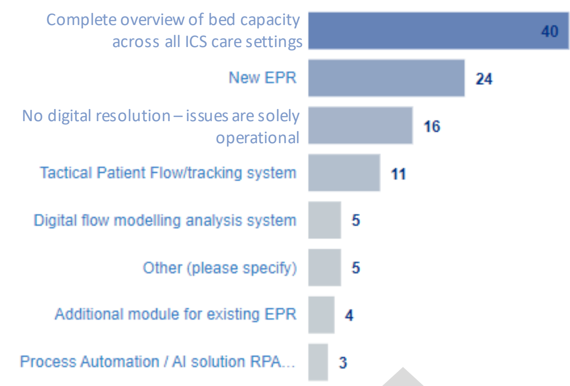
**Conclusion**

There is no stand-out digital system supplier providing the full suite of functionality which all Trusts need. However tailoring EPR and bed management systems to ICS' specific needs, or developing in-house digital systems, can help to facilitate digital discharge processes which work well for Trusts.

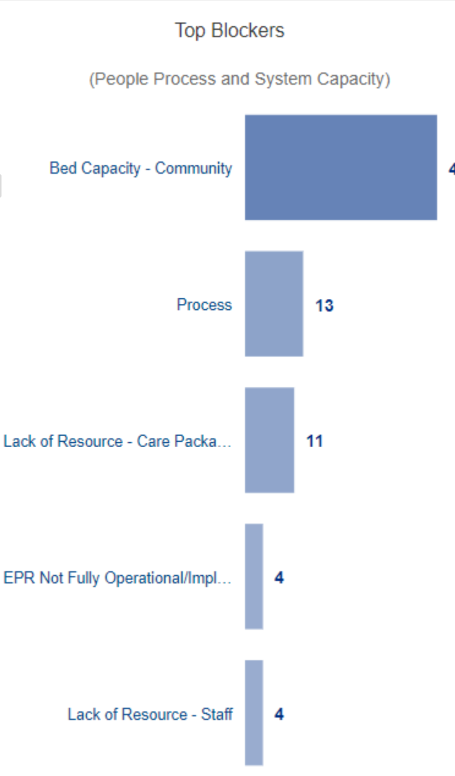
## Most Trusts are currently unable to see bed availability across the ICS, hindering discharge processes

### Survey and Interview Findings

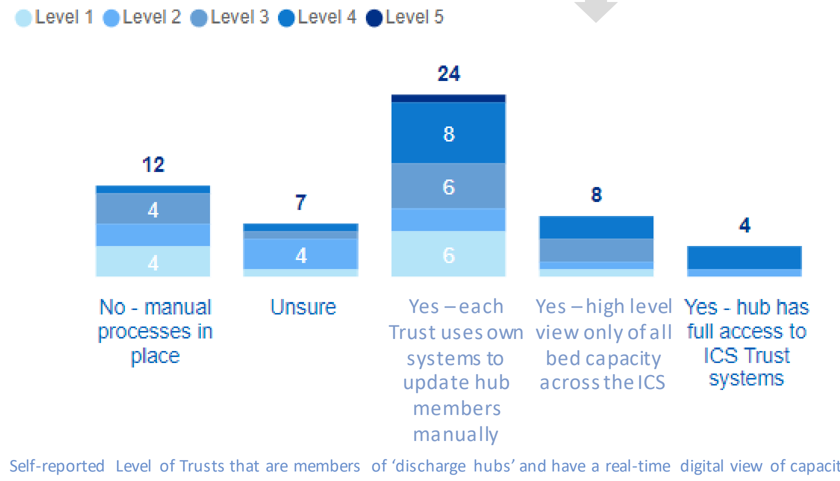
**1.1** The top blocker to discharge reported by Trusts through the survey was 'people, process and system capacity', with 82 of 110 respondents choosing this category. The majority of Trusts within this qualified that **community bed capacity** was their top blocker, which remains the most reported blocker across the entire cohort.




**1.2** Trusts were asked to identify which digital system enabler would help most in unblocking their discharge delays. The most cited enabler was **'complete overview of bed capacity across all ICS care settings'.**



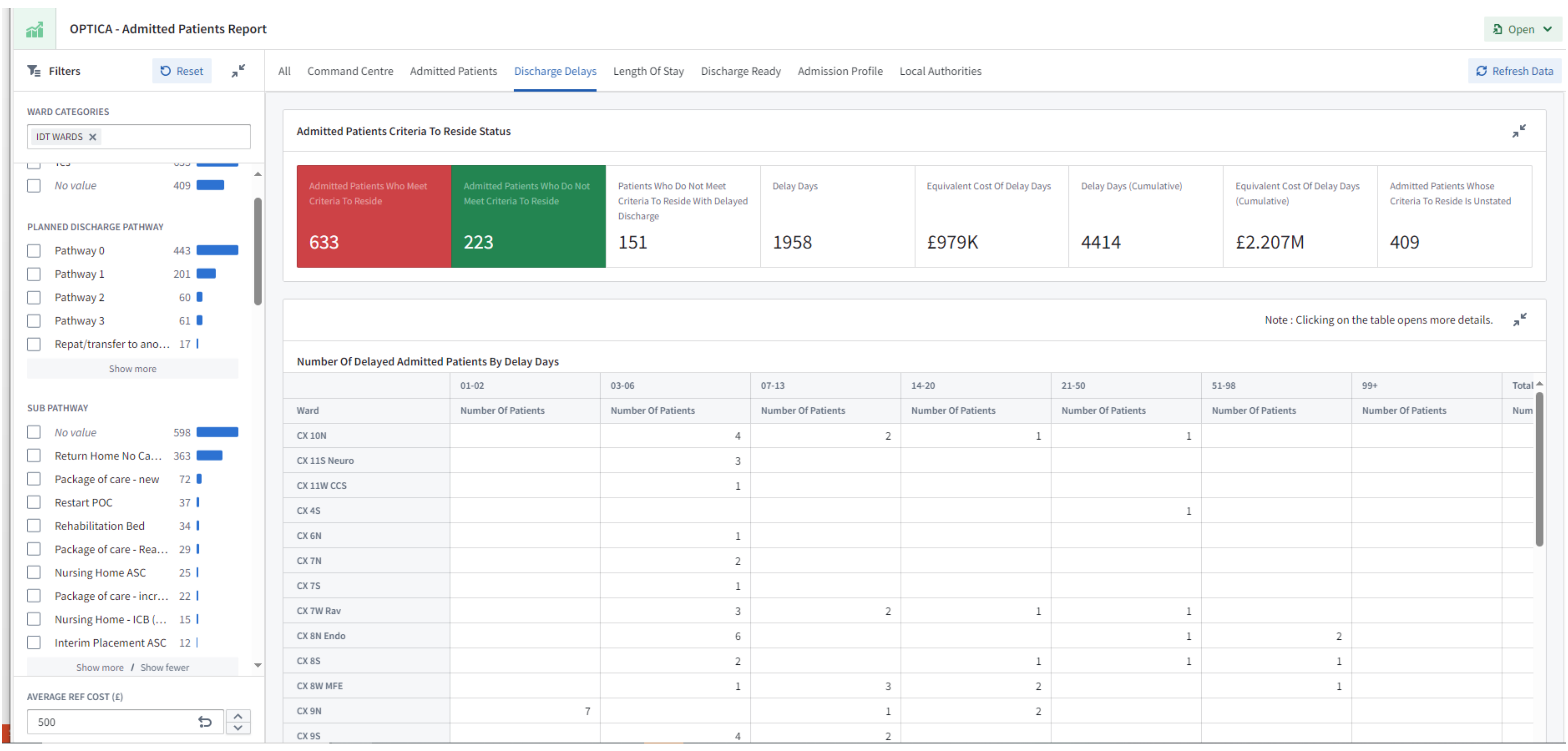

**1.3** Trusts which have a **real-time digital view of availability** in their local ICS system are reporting to be the most digitally capable. Only 4 of 110 Trusts have a full digital overview of community beds within their ICS, and 8 have a high level view only – of these, 75% self-report as Level 4 or 5.



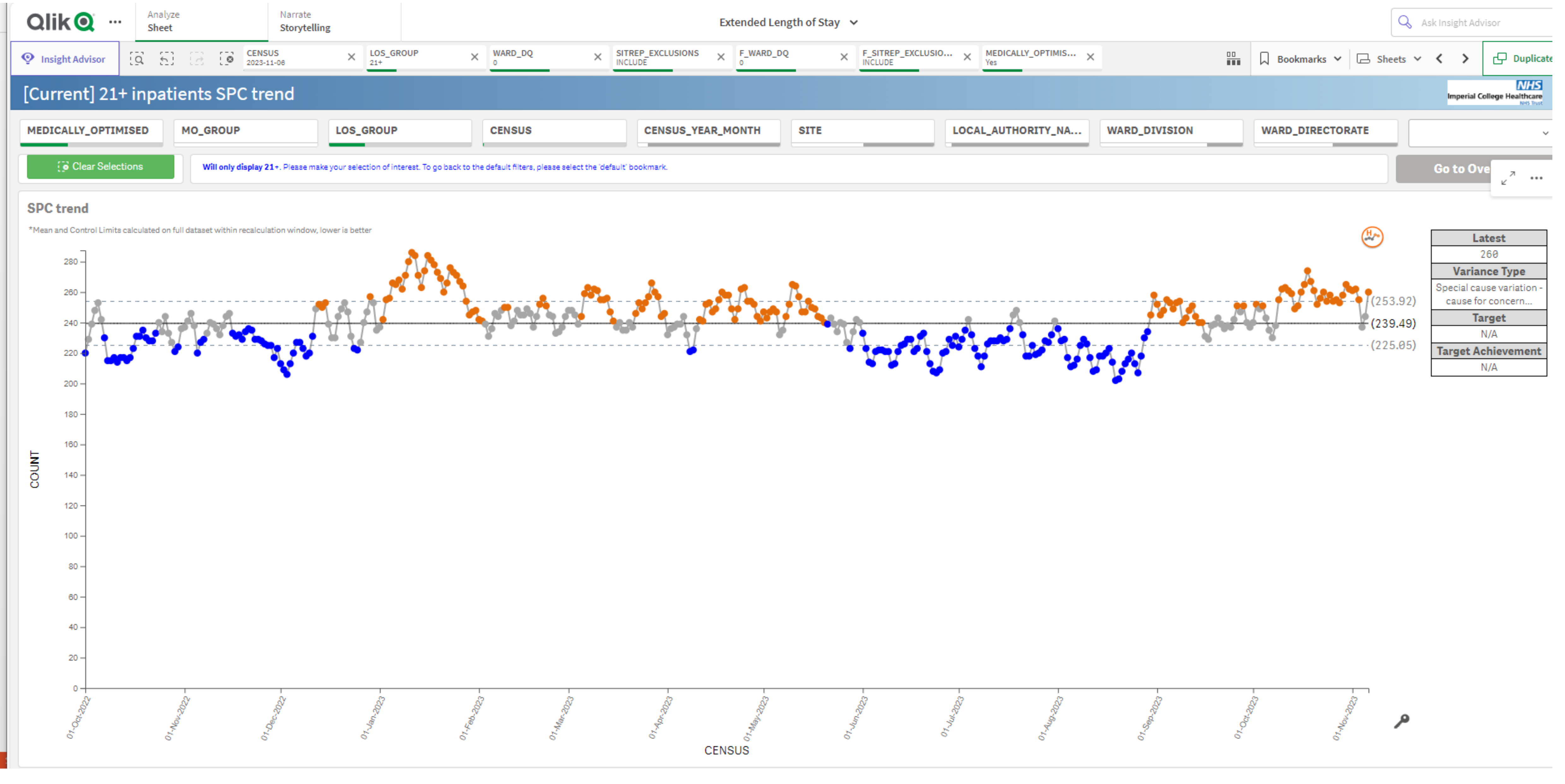

Self-reported Level of Trusts that are members of 'discharge hubs' and have a real-time digital view of capacity in their local ICS system

**Quote 1: Level 4 Trust doing manual data sharing**

"We have a twice-daily Sit-Rep that is filled in by all of our partners that is then shared. So we go log on, fill in our section. The information's amalgamated and shared back out again... but we don't have a means of sharing that on an ongoing basis through the day electronically."




| | 01-02 | 03-06 | 07-13 | 14-20 | 21-50 | 51-98 | 99+ | Total |
|---|---|---|---|---|---|---|---|---|
| Ward | Number Of Patients | Number Of Patients | Number Of Patients | Number Of Patients | Number Of Patients | Number Of Patients | Number Of Patients | Num |
| CX 10N | | 4 | 2 | 1 | 1 | | | |
| CX 11S Neuro | | 3 | | | | | | |
| CX 11W CCS | | 1 | | | | | | |
| CX 4S | | | | | 1 | | | |
| CX 6N | | 1 | | | | | | |
| CX 7N | | 2 | | | | | | |
| CX 7S | | 1 | | | | | | |
| CX 7W Rav | | 3 | 2 | 1 | 1 | | | |
| CX 8N Endo | | 6 | | | 1 | 2 | | |
| CX 8S | | 2 | | 1 | 1 | 1 | | |
| CX 8W MFE | | 1 | 3 | 2 | | 1 | | |
| CX 9N | 7 | | 1 | 2 | | | | |
| CX 9S | | 4 | 2 | | | | | |



Analyze
Sheet
Narrate
Storytelling
Extended Length of Stay
Ask Insight Advisor
Insight Advisor
CENSUS
2023-11-06
LOS_GROUP
21+
WARD_DQ
0
SITREP_EXCLUSIONS
INCLUDE
F_WARD_DQ
0
F_SITREP_EXCLUSIO...
INCLUDE
MEDICALLY_OPTIMIS...
Yes
Bookmarks
Sheets
Duplicate
[Current] 21+ inpatients SPC trend
NHS
Imperial College Healthcare
MEDICALLY_OPTIMISED
MO_GROUP
LOS_GROUP
CENSUS
CENSUS_YEAR_MONTH
SITE
LOCAL_AUTHORITY_NA...
WARD_DIVISION
WARD_DIRECTORATE
Clear Selections
Will only display 21+. Please make your selection of interest. To go back to the default filters, please select the 'default' bookmark.
Go to Ove
SPC trend
*Mean and Control Limits calculated on full dataset within recalculation window, lower is better
COUNT
CENSUS
(253.92)
(239.49)
(225.05)
Latest
260
Variance Type
Special cause variation - cause for concern...
Target
N/A
Target Achievement
N/A

# Speaking Now…

**Tracy Stocker**
Director of Operations for Flow and Integration - Medway NHS Foundation Trust

**Nick Sinclair**
Chief Operating Officer
Medway NHS Foundation Trust

# Using Technology to Improve Flow

Nick Sinclair

Chief Operating Officer

Situational Awareness

# What Is Situational Awareness?

- Defined:
  - Situational awareness is the understanding of an environment, its elements, and how it changes with respect to time or other factors.
  - Situational awareness is important for effective decision making in many environments
  - Always monitoring your surroundings.

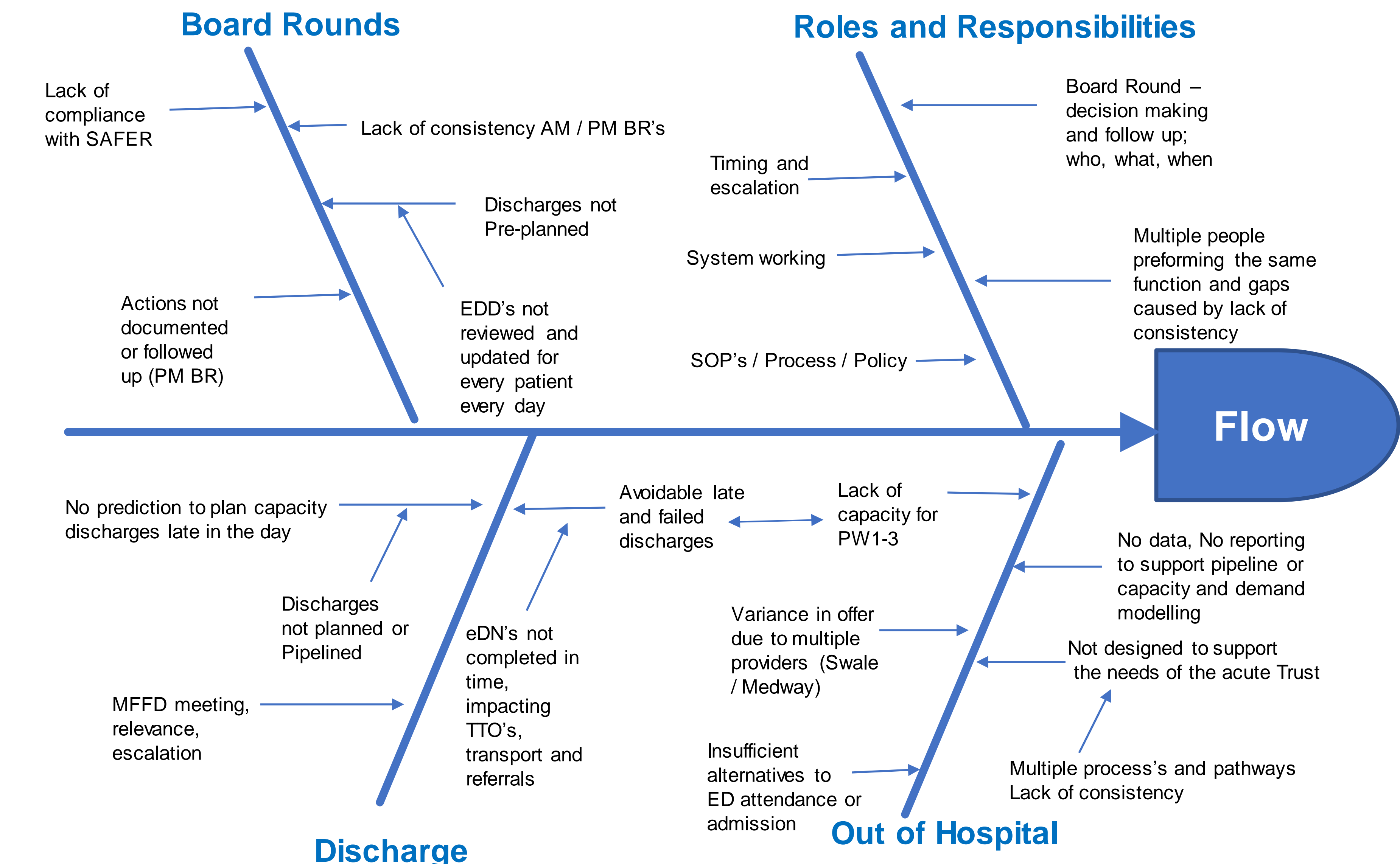
# Situational Awareness Medway NHS Foundation Trust

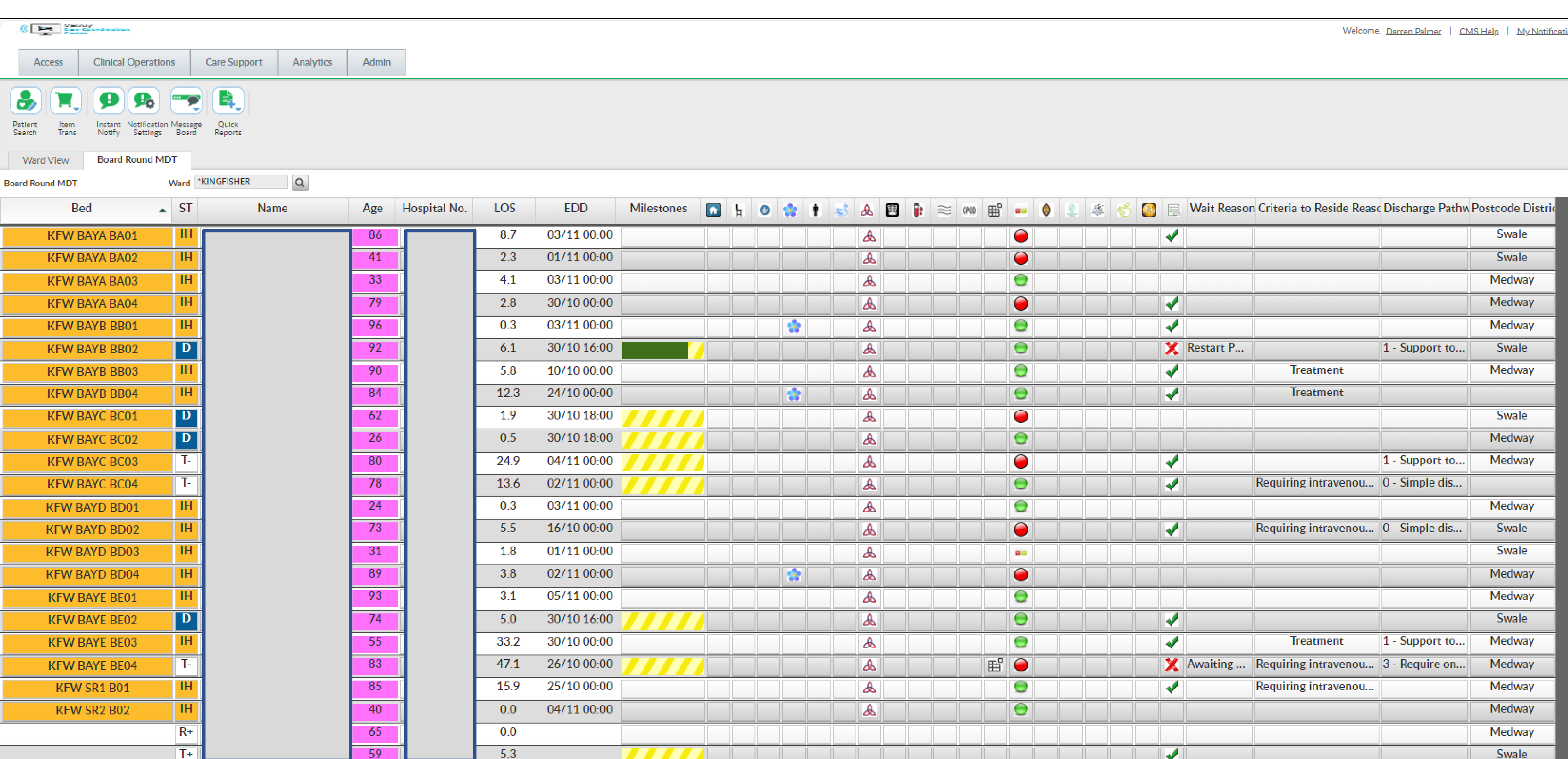
# Situational Awareness Medway NHS Foundation Trust

- Previous Position
  - Meetings three times daily
  - 150+ WhatsApp messages daily
  - Manual calculation
  - Multiple staff running to find information
  - Paper and clipboards
- Current Position
  - Integrated Care Coordination Centre
  - Powered by TeleTracking
  - Co-location of:
    - Tactical Commander
    - Clinical Site Manager
    - EPRR Advisor
    - Facilities Supervisor
    - Bed Placement Specialists

TeleTracking
SynapseIQ | Infection Control
SynapseIQ | System Wide Occupancy
SynapseIQ | Patient Flow
Patient Flow - Tunbridge Wells
SynapseIQ | Bed Demand & Cleaning Capacity
Volume Analysis
NHS

# Fishbone






| Bed | ST | Name | Age | Hospital No. | LOS | EDD | Milestones | Wait Reason | Criteria to Reside Reasc | Discharge Pathw | Postcode Distric |
|---|---|---|---|---|---|---|---|---|---|---|---|
| KFW BAYA BA01 | IH | | 86 | | 8.7 | 03/11 00:00 | | | | | Swale |
| KFW BAYA BA02 | IH | | 41 | | 2.3 | 01/11 00:00 | | | | | Swale |
| KFW BAYA BA03 | IH | | 33 | | 4.1 | 03/11 00:00 | | | | | Medway |
| KFW BAYA BA04 | IH | | 79 | | 2.8 | 30/10 00:00 | | | | | Medway |
| KFW BAYB BB01 | IH | | 96 | | 0.3 | 03/11 00:00 | | | | | Medway |
| KFW BAYB BB02 | D | | 92 | | 6.1 | 30/10 16:00 | | Restart P... | | 1 - Support to... | Swale |
| KFW BAYB BB03 | IH | | 90 | | 5.8 | 10/10 00:00 | | | Treatment | | Medway |
| KFW BAYB BB04 | IH | | 84 | | 12.3 | 24/10 00:00 | | | Treatment | | |
| KFW BAYC BC01 | D | | 62 | | 1.9 | 30/10 18:00 | | | | | Swale |
| KFW BAYC BC02 | D | | 26 | | 0.5 | 30/10 18:00 | | | | | Medway |
| KFW BAYC BC03 | T- | | 80 | | 24.9 | 04/11 00:00 | | | | 1 - Support to... | Medway |
| KFW BAYC BC04 | T- | | 78 | | 13.6 | 02/11 00:00 | | | Requiring intravenou... | 0 - Simple dis... | |
| KFW BAYD BD01 | IH | | 24 | | 0.3 | 03/11 00:00 | | | | | Medway |
| KFW BAYD BD02 | IH | | 73 | | 5.5 | 16/10 00:00 | | | Requiring intravenou... | 0 - Simple dis... | Swale |
| KFW BAYD BD03 | IH | | 31 | | 1.8 | 01/11 00:00 | | | | | Swale |
| KFW BAYD BD04 | IH | | 89 | | 3.8 | 02/11 00:00 | | | | | Medway |
| KFW BAYE BE01 | IH | | 93 | | 3.1 | 05/11 00:00 | | | | | Medway |
| KFW BAYE BE02 | D | | 74 | | 5.0 | 30/10 16:00 | | | | | Swale |
| KFW BAYE BE03 | IH | | 55 | | 33.2 | 30/10 00:00 | | | Treatment | 1 - Support to... | Medway |
| KFW BAYE BE04 | T- | | 83 | | 47.1 | 26/10 00:00 | | Awaiting ... | Requiring intravenou... | 3 - Require on... | Medway |
| KFW SR1 B01 | IH | | 85 | | 15.9 | 25/10 00:00 | | | Requiring intravenou... | | Medway |
| KFW SR2 B02 | IH | | 40 | | 0.0 | 04/11 00:00 | | | | | Medway |
| | R+ | | 65 | | 0.0 | | | | | | Medway |
| | T+ | | 59 | | 5.3 | | | | | | Swale |

# EPR Ward Dashboard

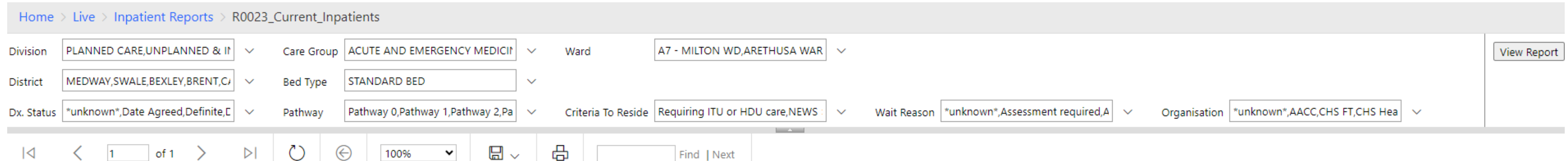
A5 - Byron Ward (Active)

Refresh C

Active Patients: 27

| Location | Patient Name | Age / Gender | Consultant | Working Diagnosis | Resus Status | Vital Signs | NEWS2 | VTE Status New | Nutrition & Hydration (New) | Clinical Indicators | 4AT Known | MUST Score | Waterlow Score | EDD | Discharge Status. | LOS | Falls Risk | SAMBA | Covid Screening Date | Covid Swab Result |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Bay 1 Bed 1 | | 89y /F | | Worsening of Vascular dementia<br>Hyperactive Delirium secondary t<br>Increase care needs<br>Rib fracture secondary to fall | DNACPR | VS | 0 | On Admission | Normal Fluids Lev | DoLS | 8 | 0 | 17 | | TTO PHARMACY DISPENSED EDN WRITTEN | 24d 12h | Y | Covid - De | | |
| Bay 1 Bed 2 | | 91y /F | | Decompensated HF<br>Hypervolemic Hyponatraemia + m<br>left leg haematoma<br>haematuria (spontaneous) improve<br>LRTI treated with Co-amoxiclav<br>Hypomagnesaemia - on replaceme<br>Pressure sore - ungradable | DNACPR | VS | 2 | On Admission | Normal Flui | | 4 | 1 | 22 | 01-Nov-2023 | | 24d 10h | Y | Covid - No | | |
| Bay 1 Bed 3 | | 91y /F | | Right sided pneumonia CURB 65><br>Comminuted fracture seen involvi<br>Severe OA hip<br>Delirium due to above on bg Alzhe<br>AKI 1 due to sepsis and dehydratic<br>Presure injury over Lt heel<br>CFS 7<br>ABG T1RF<br>Mass R inferior gluteal region - for<br>Vitamin D deficiency<br>IDA | DNACPR | VS | 4 | On Admission | Normal Flui | | 5 | 2 | 25 | 02-Nov-2023 | | 8d 18h | Y | Covid - No | | |
| Bay 1 Bed 4 | | 78y /F | | Fall - secondary to increasing frail<br>L distal clavical fracture (high risk<br>Iron Deficiency Anaemia<br>B12 Deficiency<br>Vit D deficiency<br>Hypoactive delirium secondary to | DNACPR | VS | 1 | On Admission | Normal Flui | DoLS 1:1 | 8 | 1 | 18 | | | 10d 17h | Y | Covid - No | | |
| Bay 2 Bed 5 | | 91y /M | | Delirium secondary to recent infec<br>Moderate to severe frailty<br>Incomplete resolution of chest infe | DNACPR | VS | 2 | On Admission | | | 2 | 0 | 18 | | | 2d 12h | Y | | | |
| Bay 2 Bed 6 | | 81y /M | | Syncope secondary to Orthostatic<br>CAP - CURB 3<br>T2MI<br>Delirium- resolved<br>Long term normocytic anaemia<br>- R/o urine retention | DNACPR | VS | 1 | On Admission | | | 1 | 1 | 11 | 03-Nov-2023 | | 2d 12h | Y | | | |
| Bay 2 Bed 7 | | 93y /M | | Community Acquired Pneumonia<br>CFS 6/7<br>Ascending Aorta dilatation - vascu<br>Folate + iron deficiency anaemia -<br>Diarrhoea - secondary to medicati<br>Hypokaelamia secondary to above | DNACPR | VS | 2 | On Admission | Normal Fluids Nor | | 5 | 0 | 17 | | | 8d 12h | Y | Covid - No | | |
| Bay 2 Bed 8 | | 87y /M | | Post stroke seizures<br>Severe Frailty<br>Thrombocytopenia (resolved) - on<br>Hypoactive deliruim - improving | DNACPR | VS | 1 | On Admission | Normal Fluids Nor | DoLS | 6 | 0 | 17 | 25-Sep-2023 | TTO PHARMACY DISPENSED EDN WRITTEN | 43d 10h | Y | | | |
| Bay 3 Bed 09 | | 91y /M | | Multifactoral fall Secondary to frail<br>Haematoma + overlying soft tissue<br>Hypocalcemia secondary to CKD<br>Normocytic anemia<br>Constipation- resolved; now loose<br>Poor mobility and increased care<br>High risk of pressure sores- previ<br>Hypoactive delirum - ongoing | DNACPR | VS | 1 | On Admission | Normal Fluids Nor | | 6 | 2 | 17 | 30-Oct-2023 | | 29d 20h | Y | Covid - No | | |
| Bay 3 Bed 10 | | 79y /M | | HAP (resolved)<br>COVID pnemonitis (resolved)<br>Iron deficency anaemia - ferrinject<br>Vitamin D deficiency<br>Folic acid deficiency<br>Ongoing Maculopapular rash - sus<br>Constipation | DNACPR | VS | 2 | On Admission | Normal Fluids Nor | | 0 | 0 | 22 | 13-Oct-2023 | TTO RESENT EDN WRITTEN | 68d 02h | Y | Covid - No | 06-Sep-2023 10:54 | Negative |
| Bay 3 Bed 11 | | 70y /M | | Multifactorial fall secondary to PD,<br>LRTI (completed abx) ~ High risk<br>Pelvis mass on CT CAP - Probabl<br>Constipation - resolved<br>Rule out covid/aspiration<br>Hypokalaemia - resolved | DNACPR | VS | 4 | On Admission | Normal Fluids | P | 6 | 2 | 30 | | TTO PHARMACY DISPENSED EDN WRITTEN | 15d 12h | Y | Covid - No | 02-Nov-2023 15:10 | Negative |

# In-Patient Tracker List - ward view




## Current Inpatients - Patient List

**Last Refresh:** 03-Nov-2023 11:32:48 Patients: **819** LoS 21d+: **147** NCTR: **156**

| Ward | Bed | PAS No | NHS No | Patient Name | District | Age | Type | Admitted | LOS | Dx. Status | Actions | EDN | Pwy | Criteria To Reside | NCTR Dt | NCTR | Wait.Rsn. | Org | Dx.Fail. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A7 - MILTON WD | 1 | | | (F) | MEDWAY | 91 | | 02/11 00:00 | 1 | | | | 0 | | | | | | |
| A7 - MILTON WD | 2 | | | (F) | SWALE | 94 | | 20/10 02:00 | 13 | | | | 3 | None | 02/11 | 1 | Palliative review needed | MCH | |
| A7 - MILTON WD | 3 | | | (F) | MEDWAY | 89 | | 04/10 19:22 | 29 | | | | 3 | None | | | Assessment required | Medway Council | |
| A7 - MILTON WD | 4 | | | (F) | MEDWAY | 96 | | 30/10 01:00 | 3 | | | | 0 | | | | | | |
| A7 - MILTON WD | 5 | | | (F) | MEDWAY | 77 | | 22/10 11:55 | 11 | | | | 3 | None | | | Assessment required | Medway Council | |
| A7 - MILTON WD | 6 | | | (F) | MEDWAY | 80 | | 21/10 16:25 | 12 | | | | 1 | Treatment | | | Awaiting POC | AACC | |
| A7 - MILTON WD | 7 | | | (F) | MEDWAY | 80 | | 07/10 02:30 | 26 | | | | 3 | None | 20/10 | 14 | Assessment required | MFT ward | |
| A7 - MILTON WD | 8 | | | (F) | MEDWAY | 89 | | 21/10 17:36 | 12 | | | | 1 | None | 30/10 | 4 | Furniture move - family | MFT therapy | |
| A7 - MILTON WD | 9 | | | (M | MEDWAY | 80 | | 24/10 19:25 | 9 | | | | 0 | | | | | | |
| A7 - MILTON WD | 10 | | | (M | MEDWAY | 91 | | 07/10 22:52 | 26 | | | R | 3 | None | 19/10 | 15 | Awaiting residential dementia bed | CHS Health | |
| A7 - MILTON WD | 11 | | | (M | MEDWAY | 88 | | 14/09 10:45 | 49 | | | | 3 | None | | | Pathway to be determined | Medway Council | |
| A7 - MILTON WD | 12 | | | (M | MEDWAY | 77 | | 21/07 11:15 | 104 | | | | 3 | None | 20/10 | 14 | Awaiting nursing dementia bed | Medway Council | |
| A7 - MILTON WD | 13 | | | (M | MEDWAY | 70 | | 01/11 00:00 | 2 | | | | 0 | | | | | | |
| A7 - MILTON WD | 14 | | | (M | MEDWAY | 85 | | 01/11 17:30 | 2 | | | | 3 | None | 02/11 | 1 | Pathway to be determined | Medway Council | |
| A7 - MILTON WD | 15 | | | (M | MEDWAY | 83 | | 28/10 13:55 | 5 | | | R | 1 | None | 02/11 | 1 | Restart POC | Medway Council | |
| A7 - MILTON WD | 16 | | | (M | MEDWAY | 67 | | 01/11 18:48 | 2 | | | | 0 | | | | | | |
| A7 - MILTON WD | 17 | | | (M | SWALE | 83 | | 01/11 12:14 | 2 | | | | 0 | | | | | | |
| A7 - MILTON WD | 18 | | | (F) | MEDWAY | 81 | | 27/10 18:14 | 6 | | | | 0 | | | | | | |
| A7 - MILTON WD | 19 | | | (F) | MEDWAY | 89 | | 04/10 16:14 | 29 | | | | 3 | None | 23/10 | 11 | Awaiting EOL bed | CHS FT | |
| A7 - MILTON WD | 20 | | | (F) | MEDWAY | 75 | | 21/10 17:15 | 12 | | | | 0 | | | | | | |

# In-Patient Tracker List Filtered to NCTR view

## Current Inpatients - Patient List

Last Refresh: 03-Nov-2023 09:06:16 Patients: 145 LoS 21d+: 56 NCTR: 145

| Ward | Bed | PAS No | NHS No | Patient Name | District | Age | Type | Admitted | LOS | Dx. Status | Actions | EDN | Pwy | Criteria To Reside | NCTR Dt | NCTR | Wait.Rsn. | Org | Dx.Fail. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A7 - MILTON WD | 2 | | | | SWALE | 94 | | 20/10 02:00 | 13 | | | | 3 | None | 02/11 | 1 | Palliative review needed | MCH | |
| A7 - MILTON WD | 3 | | | | MEDWAY | 89 | | 04/10 19:22 | 29 | | | | 3 | None | | | Assessment required | Medway Council | |
| A7 - MILTON WD | 5 | | | | MEDWAY | 77 | | 22/10 11:55 | 11 | | | | 3 | None | | | Assessment required | Medway Council | |
| A7 - MILTON WD | 7 | | | | MEDWAY | 80 | | 07/10 02:30 | 26 | | | | 3 | None | 20/10 | 14 | Assessment required | MFT ward | |
| A7 - MILTON WD | 8 | | | | MEDWAY | 89 | | 21/10 17:36 | 12 | | | | 1 | None | 30/10 | 4 | Furniture move - family | MFT therapy | |
| A7 - MILTON WD | 15 | | | | MEDWAY | 83 | | 28/10 13:55 | 5 | | | | 1 | None | 02/11 | 1 | Restart POC | Medway Council | |
| A7 - MILTON WD | 19 | | | | MEDWAY | 89 | | 04/10 16:14 | 29 | | | | 3 | None | 23/10 | 11 | Awaiting EOL bed | CHS FT | |
| A7 - MILTON WD | 23 | | | | MEDWAY | 93 | | 27/09 18:30 | 36 | Potential | | | 3 | None | 20/10 | 14 | Awaiting nursing bed | Medway Council | EDN |
| A7 - MILTON WD | 28 | | | | MEDWAY | 91 | | 29/10 00:37 | 4 | | | | 3 | None | 02/11 | 1 | Pathway to be determined | Medway Council | |
| ARETHUSA WARD | | | | | MEDWAY | 45 | | 30/10 17:05 | 4 | Definite | | | 0 | None | 02/11 | 1 | Transport | MFT ward | |
| BRONTE WD | 8 | | | | MEDWAY | 83 | | 20/10 00:00 | 13 | Potential - Today | | | 0 | None | 02/11 | 1 | EDN | MFT ward | |
| BYRON WARD | 1 | | | | MEDWAY | 89 | | 09/10 23:55 | 24 | | | | 3 | None | 25/10 | 9 | Awaiting EOL bed | CHS FT | |
| BYRON WARD | 4 | | | | MEDWAY | 78 | | 23/10 18:30 | 10 | | | | 3 | None | 26/10 | 8 | Assessment required | Medway Council | |
| BYRON WARD | 8 | | | | MEDWAY | 87 | | 21/09 01:50 | 42 | | | | 3 | None | 20/10 | 14 | Awaiting residential bed | Medway Council | |
| BYRON WARD | 10 | | | | MEDWAY | 79 | | 27/08 10:12 | 67 | | | | 3 | None | 20/10 | 14 | Awaiting residential bed | Medway Council | |
| BYRON WARD | 11 | | | | MEDWAY | 70 | | 19/10 00:00 | 14 | Definite | | | 3 | None | 25/10 | 9 | Awaiting nursing bed | MCH | |
| BYRON WARD | 12 | | | | MEDWAY | 72 | | 14/09 17:54 | 49 | | | | 3 | None | 22/10 | 12 | Awaiting EOL bed | CHS FT | |
| BYRON WARD | 13 | | | | TONBRIDGE AND | 90 | | 06/10 23:37 | 27 | | | | 1 | None | 30/10 | 4 | Equipment | MFT therapy | |
| BYRON WARD | 14 | | | | SWALE | 92 | | 10/08 18:55 | 84 | | | | 2 | None | 09/10 | 25 | Awaiitng neuro rehab bed | MFT therapy | |
| BYRON WARD | 18 | | | | MEDWAY | 90 | | 19/10 00:00 | 14 | | | | 1 | None | 25/10 | 9 | Therapy assesment | MFT therapy | |
| BYRON WARD | 23 | | | | MEDWAY | 91 | | 18/10 00:00 | 15 | | | | 0 | None | 02/11 | 1 | Referral/ handover required | IDT | |
| BYRON WARD | 24 | | | | MEDWAY | 83 | | 11/10 14:30 | 23 | Definite - Today | | | 1 | None | 30/10 | 4 | Transport | MFT ward | |
| DISCHARGE LOUNGE | 01 | | | | MEDWAY | 91 | | 12/10 10:41 | 22 | Potential | | | 2 | None | 31/10 | 3 | Awaiting general rehab bed | MCH | TTO |
| DISCHARGE LOUNGE | 02 | | | | MEDWAY | 84 | | 20/10 06:11 | 13 | Definite - Today | | | 1 | None | 02/11 | 1 | Transport | MFT ward | |
| DISCHARGE LOUNGE | 03 | | | | GRAVESHAM | 94 | | 14/10 00:00 | 20 | Definite - Today | | | 3 | None | 19/10 | 15 | Awaiting nursing bed | CHS Health | |
| DISCHARGE LOUNGE | 04 | | | | SWALE | 94 | | 19/10 10:50 | 15 | | | | 1 | None | 31/10 | 3 | Awaiting POC | CHS Health | |
| DISCHARGE LOUNGE | 05 | | | | GRAVESHAM | 71 | | 15/10 13:40 | 18 | Definite | | | 1 | None | 17/10 | 17 | EDN | MFT ward | |
| EMERALD SHORT STAY WARD | 3 | | | | SWALE | 75 | | 27/10 15:06 | 6 | | | | 1 | None | 02/11 | 1 | Therapy assesment | MFT therapy | |
| EMERALD SHORT STAY WARD | 5 | | | | MEDWAY | 80 | | 21/10 06:35 | 12 | | | | 2 | None | 29/10 | 5 | Awaiting general rehab bed | MCH | |
| EMERALD SHORT STAY WARD | 6 | | | | MEDWAY | 94 | | 23/10 10:28 | 10 | | | | 1 | None | 26/10 | 8 | Equipment | Kyndi | |
| EMERALD SHORT STAY WARD | 13 | | | | SWALE | 87 | | 16/10 11:26 | 17 | | | | 0 | None | | | Therapy assesment | MFT therapy | |
| EMERALD SHORT STAY WARD | 15 | | | | MEDWAY | 82 | | 29/10 23:00 | 4 | | | | 1 | None | 02/11 | 1 | EDN | MFT ward | |
| EMERALD SHORT STAY WARD | 2A | | | | MEDWAY | 83 | | 18/10 00:00 | 15 | | | | 3 | None | 25/10 | 9 | Assessment required | Medway Council | |
| EMERALD SHORT STAY WARD | 4A | | | | MEDWAY | 94 | | 27/10 17:23 | 6 | | | | 1 | None | 02/11 | 1 | TTO | MFT ward | |
| EMERALD SHORT STAY WARD | 6A | | | | MEDWAY | 85 | | 30/10 09:17 | 3 | | | | 1 | None | 31/10 | 3 | Awaiting POC | Medway Council | |

# In-Patient Tracker List ward view

## Current Inpatients - Patient List

Last Refresh: 03-Nov-2023 09:08:16 | Patients: 145 | LoS 21d+: 56 | NCTR: 145

| Ward | Bed | PAS No | NHS No | Patient Name | District | Age | Type | Admitted | LOS | Dx. Status | Actions | EDN | Pwy | Criteria To Reside | NCTR Dt | NCTR | Wait.Rsn. | Org | Dx.Fail. |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| A7 - MILTON WD | 2 | | | | SWALE | 94 | | 20/10 02:00 | 13 | | | | 3 | None | 02/11 | 1 | Palliative review needed | MCH | |
| A7 - MILTON WD | 3 | | | | MEDWAY | 89 | | 04/10 19:22 | 29 | | | | 3 | None | | | Assessment required | Medway Council | |
| A7 - MILTON WD | 5 | | | | MEDWAY | 77 | | 22/10 11:55 | 11 | | | | 3 | None | | | Assessment required | Medway Council | |
| A7 - MILTON WD | 7 | | | | MEDWAY | 80 | | 07/10 02:30 | 26 | | | | 3 | None | 20/10 | 14 | Assessment required | MFT ward | |
| A7 - MILTON WD | 8 | | | | MEDWAY | 89 | | 21/10 17:36 | 12 | | | | 1 | None | | | | | |
| A7 - MILTON WD | 15 | | | | MEDWAY | 83 | | 28/10 13:55 | 5 | | | | 1 | None | | | | il | |
| A7 - MILTON WD | 19 | | | | MEDWAY | 89 | | 04/10 16:14 | 29 | | | | 3 | None | | | | | |
| A7 - MILTON WD | 23 | | | | MEDWAY | 93 | | 27/09 18:30 | 36 | Potential | | | 3 | None | | | | il | EDN |
| A7 - MILTON WD | 28 | | | | MEDWAY | 91 | | 29/10 00:37 | 4 | | | | 3 | None | | | | il | |
| ARETHUSA WARD | | | | | MEDWAY | 45 | | 30/10 17:05 | 4 | Definite | | | 0 | None | | | | | |
| BRONTE WD | 8 | | | | MEDWAY | 83 | | 20/10 00:00 | 13 | Potential - Today | | | 0 | None | 02/11 | 1 | EDN | MFT ward | |
| BYRON WARD | 1 | | | | MEDWAY | 89 | | 09/10 23:55 | 24 | | | | 3 | None | 25/10 | 9 | Awaiting EOL bed | CHS FT | |
| BYRON WARD | 4 | | | | MEDWAY | 78 | | 23/10 18:30 | 10 | | | | 3 | None | 26/10 | 8 | Assessment required | Medway Council | |
| BYRON WARD | 8 | | | | MEDWAY | 87 | | 21/09 01:50 | 42 | | | | 3 | None | 20/10 | 14 | Awaiting residential bed | Medway Council | |
| BYRON WARD | 10 | | | | MEDWAY | 79 | | 27/08 10:12 | 67 | | | | 3 | None | 20/10 | 14 | Awaiting residential bed | Medway Council | |
| BYRON WARD | 11 | | | | MEDWAY | 70 | | 19/10 00:00 | 14 | Definite | | | 3 | None | 25/10 | 9 | Awaiting nursing bed | MCH | |
| BYRON WARD | 12 | | | | MEDWAY | 72 | | 14/09 17:54 | 49 | | | | 3 | None | 22/10 | 12 | Awaiting EOL bed | CHS FT | |
| BYRON WARD | 13 | | | | TONBRIDGE AND | 90 | | 06/10 23:37 | 27 | | | | 1 | None | 30/10 | 4 | Equipment | MFT therapy | |
| BYRON WARD | 14 | | | | SWALE | 92 | | 10/08 18:55 | 84 | | | | 2 | None | 09/10 | 25 | Awaiitng neuro rehab bed | MFT therapy | |
| BYRON WARD | 18 | | | | MEDWAY | 90 | | 19/10 00:00 | 14 | | | | 1 | None | 25/10 | 9 | Therapy assesment | MFT therapy | |
| BYRON WARD | 23 | | | | MEDWAY | 91 | | 18/10 00:00 | 15 | | | | 0 | None | | | | | |
| BYRON WARD | 24 | | | | MEDWAY | 83 | | 11/10 14:30 | 23 | Definite - Today | | | 1 | None | | | | | |
| DISCHARGE LOUNGE | 01 | | | | MEDWAY | 91 | | 12/10 10:41 | 22 | Potential | | | 2 | None | | | | | TTO |
| DISCHARGE LOUNGE | 02 | | | | MEDWAY | 84 | | 20/10 06:11 | 13 | Definite - Today | | | 1 | None | | | | | |
| DISCHARGE LOUNGE | 03 | | | | GRAVESHAM | 94 | | 14/10 00:00 | 20 | Definite - Today | | | 3 | None | | | | | |
| DISCHARGE LOUNGE | 04 | | | | SWALE | 94 | | 19/10 10:50 | 15 | | | | 1 | None | | | | | |
| DISCHARGE LOUNGE | 05 | | | | GRAVESHAM | 71 | | 15/10 13:40 | 18 | Definite | | | 1 | None | | | | | |
| EMERALD SHORT STAY WARD | 3 | | | | SWALE | 75 | | 27/10 15:06 | 6 | | | | 1 | None | | | | | |
| EMERALD SHORT STAY WARD | 5 | | | | MEDWAY | 80 | | 21/10 06:35 | 12 | | | | 2 | None | | | | | |
| EMERALD SHORT STAY WARD | 6 | | | | MEDWAY | 94 | | 23/10 10:28 | 10 | | | | 1 | None | 26/10 | 8 | Equipment | Kyndi | |
| EMERALD SHORT STAY WARD | 13 | | | | SWALE | 87 | | 16/10 11:26 | 17 | | | | 0 | None | | | Therapy assesment | MFT therapy | |
| EMERALD SHORT STAY WARD | 15 | | | | MEDWAY | 82 | | 29/10 23:00 | 4 | | | | 1 | None | 02/11 | 1 | EDN | MFT ward | |
| EMERALD SHORT STAY WARD | 2A | | | | MEDWAY | 83 | | 18/10 00:00 | 15 | | | | 3 | None | 25/10 | 9 | Assessment required | Medway Council | |
| EMERALD SHORT STAY WARD | 4A | | | | MEDWAY | 94 | | 27/10 17:23 | 6 | | | | 1 | None | 02/11 | 1 | TTO | MFT ward | |
| EMERALD SHORT STAY WARD | 6A | | | | MEDWAY | 85 | | 30/10 09:17 | 3 | | | | 1 | None | 31/10 | 3 | Awaiting POC | Medway Council | |

Standard Bed

Side Room

eDN status
- Not started
- eDN started but medications not complete
- Complete and pharmacy to supply TTO – authorised
- Complete and pharmacy to supply TTO – rejected
- Complete

20/10/23 – TOC Completed sent to LA
23/10/23 – AX Coper Beaches NH
24/10/23 – Copper Beaches declined
25/10/23 – AX Charing House
25/10/23 – CT Scan revealed NAD, can be DC to Charring House
27/10/23 – Family concerns re capacity and safety requesting Amhurst Court
01/11/23 - Medw ay Council have advised there is a family disagreement regarding placement and discharge plans

# Real time reporting from EPR

fig.1 - Snip demonstrating the discharge, EDD, eDN and MFFD data from the operational pressures report. This data is pulled directly from the PTL and is updated every 10 minutes. This enables us to review our discharge position and predictions to manage disharges across the Trust. EDD and eDN compliance has improved and this visibility enable site and the divisions to review and plan.

Fig.2 - Snip from the delayed discharge report. This report pulls from the PTL and again is in real time. The report shows all discharges per discharge pathway with the top delay reasons. When in the live report we can click on the pathway and this will open the PTL for those patients enabling us to review and manage the delay. We can also click on the delay reason and again this opens the PTL for these patients

| Actual Discharges | Expected Discharges |
|---|---|
| 6 | 45 |

| Exp. Disch. Breakdown | | By Care Group: SpecMd | TOPs | Emerg. | Surg | Other | By EDN Status: Comp. | Disp. | NotRdy |
|---|---|---|---|---|---|---|---|---|---|
| DEF | 12 | 0 | 5 | 1 | 5 | 1 | 0 | 6 | 6 |
| POT | 33 | 2 | 6 | 6 | 17 | 2 | 0 | 4 | 29 |
| EDD Today | 104 | 21 | 25 | 9 | 20 | 29 | 0 | 14 | 90 |
| EDD Tomor. | 54 | 5 | 9 | 8 | 15 | 17 | 0 | 4 | 50 |

MFFD Patients

93

| 7 | 35 | 16 | 22 | 13 |
|---|---|---|---|---|
| p0 | p1 | p2 | p3 | unk. |

| MFFD LoS | | By Care Group: SpecMd | TOPs | Emerg. | Surg | Other | By EDN Status: Comp. | Disp. | NotRdy |
|---|---|---|---|---|---|---|---|---|---|
| >1d | 64 | 10 | 34 | 5 | 13 | 0 | 0 | 37 | 27 |
| >7d | 13 | 3 | 8 | 0 | 2 | 0 | 0 | 11 | 2 |

Fig.1

## Current Inpatients | Live Reporting

Last Refresh: 03-Nov-2023 11:57:17

Patient Listing Link

BUSINESS INTELLIGENCE

### No Criteria To Reside - Delay Reason Analysis 143 total || 120 with no discharge

**Pathway 0** — 20 total || 17 with no discharge

Days LoS since NC2R

| Def. Today | Pot. Today | Def. Tomor. | Pot. Tomor. | Date Agreed | Gone |
|---|---|---|---|---|---|
| 0 | 3 | 0 | 0 | 0 | 0 |

Top Delay Reasons

| | |
|---|---|
| Therapy assesment | 10 |
| Awaiting tertiary transfer | 1 |
| EDN | 1 |
| Family meeting/MDT | 1 |
| Referral/ handover required | 1 |
| Return to care home | 1 |
| Transport | 1 |

| NC2R LoS | Delay Reason | Pathway Org. |
|---|---|---|
| | Therapy assesment | MFT therapy |
| | Transport | MFT ward |
| 0 | | |
| 0 | EDN | MFT ward |
| 1 | Referral/ handover required | IDT |
| 1 | Therapy assesment | MFT therapy |
| 1 | Therapy assesment | MFT therapy |
| 1 | Therapy assesment | MFT therapy |
| 1 | Therapy assesment | MFT therapy |
| 2 | Return to care home | MFT ward |
| 2 | Therapy assesment | MFT therapy |
| 4 | Family meeting/MDT | MFT ward |
| 4 | Therapy assesment | MFT therapy |
| 4 | Therapy assesment | MFT therapy |
| 4 | Therapy assesment | MFT therapy |
| 7 | Therapy assesment | MFT therapy |
| 15 | Awaiting tertiary transfer | MFT ward |

**Pathway 1** — 47 total || 34 with no discharge

Days LoS since NC2R

| Def. Today | Pot. Today | Def. Tomor. | Pot. Tomor. | Date Agreed | Gone |
|---|---|---|---|---|---|
| 9 | 2 | 1 | 0 | 1 | 0 |

Top Delay Reasons

| | |
|---|---|
| Awaiting POC | 7 |
| Therapy assesment | 6 |
| Equipment | 5 |

| NC2R LoS | Delay Reason | Pathway Org. |
|---|---|---|
| | Safeguarding incl. MCA | Kent County Council |
| 0 | EDN | MFT ward |
| 0 | Private POC/ Private Placement | MFT ward |
| 1 | Awaiting POC | Kent County Council |
| 1 | EDN | MFT ward |
| 1 | Equipment | MFT therapy |
| 1 | Pathway to be determined | MFT ward |
| 1 | Restart POC | Medway Council |
| 1 | Restart POC | Medway Council |
| 1 | Therapy assesment | MFT therapy |
| 1 | Therapy assesment | MFT therapy |
| 1 | Therapy assesment | MFT therapy |
| 1 | Therapy assesment | MFT therapy |
| 1 | TOC required | MFT therapy |
| 1 | TOC required | MFT ward |
| 1 | TTO | MFT ward |
| 2 | Awaiting POC | Kent County Council |
| 2 | Awaiting POC | OOA |
| 3 | Awaiting POC | CHS Health |
| 3 | Awaiting POC | Medway Council |
| 3 | Equipment | MFT therapy |
| 3 | Therapy assesment | MFT therapy |
| 4 | Equipment | MFT therapy |
| 4 | Furniture move - family | MFT therapy |
| 7 | Awaiting POC | Kent County Council |
| 8 | Awaiting POC | CHS Health |
| 8 | Equipment | Kyndi |
| 9 | Referral/ handover required | IDT |
| 10 | Equipment | IMAGO |
| 10 | TOC required | MFT ward |
| 15 | Private POC/ Private Placement | CHS Self |
| 15 | TOC required | MFT ward |
| 16 | Therapy assesment | MFT therapy |
| 17 | Housing incl. utilities - Medway | Patient/ Family |

**Pathway 2** — 17 total || 15 with no discharge

Days LoS since NC2R

| Def. Today | Pot. Today | Def. Tomor. | Pot. Tomor. | Date Agreed | Gone |
|---|---|---|---|---|---|
| 0 | 0 | 0 | 0 | 2 | 0 |

Top Delay Reasons

| | |
|---|---|
| Awaiitng neuro rehab bed | 7 |
| Awaiting general rehab bed | 4 |
| TOC required | 2 |

| NC2R LoS | Delay Reason | Pathway Org. |
|---|---|---|
| 1 | Awaiitng neuro rehab bed | MFT therapy |
| 1 | Awaiitng neuro rehab bed | MFT therapy |
| 1 | TOC required | IDT |
| 1 | TOC required | IDT |
| 2 | Awaiting general rehab bed | HCRG |
| 3 | Awaiting general rehab bed | MCH |
| 3 | Awaiting general rehab bed | MCH |
| 7 | Awaiitng neuro rehab bed | MFT therapy |
| 7 | NWB bed | CHS Health |
| 10 | Awaiting general rehab bed | MCH |
| 10 | Awaiting stroke rehab bed | MCH |
| 15 | Awaiitng neuro rehab bed | MFT therapy |
| 15 | Awaiitng neuro rehab bed | MFT therapy |
| 17 | Awaiitng neuro rehab bed | MFT therapy |
| 25 | Awaiitng neuro rehab bed | MFT therapy |

**Pathway 3** — 59 total || 54 with no discharge

Days LoS since NC2R

| Def. Today | Pot. Today | Def. Tomor. | Pot. Tomor. | Date Agreed | Gone |
|---|---|---|---|---|---|
| 4 | 0 | 0 | 0 | 1 | 0 |

Top Delay Reasons

| | |
|---|---|
| Awaiting residential bed | 9 |
| Pathway to be determined | 9 |
| Assessment required | 8 |
| Awaiting nursing bed | 6 |

| NC2R LoS | Delay Reason | Pathway Org. |
|---|---|---|
| | Assessment required | Medway Council |
| | Assessment required | Medway Council |
| 0 | Referral/ handover required | IDT |
| 1 | Awaiting nursing bed | CHS Health |
| 1 | Awaiting residential bed | CHS Health |
| 1 | Awaiting residential bed | Medway Council |
| 1 | Family meeting/MDT | MFT ward |
| 1 | Housing incl. utilities - Medway | IDT |
| 1 | Palliative review needed | MCH |
| 1 | Pathway to be determined | Medway Council |
| 1 | Pathway to be determined | Medway Council |
| 1 | Pathway to be determined | Medway Council |
| 1 | Pathway to be determined | Medway Council |
| 1 | Pathway to be determined | Medway Council |
| 2 | Awaiting nursing dementia bed | CHS Health |
| 2 | Housing incl. utilities - Medway | Medway Council |
| 2 | Pathway to be determined | Medway Council |
| 2 | Pathway to be determined | Medway Council |
| 4 | Pathway to be determined | Medway Council |
| 7 | Assessment required | Medway Council |
| 7 | Pathway to be determined | Medway Council |
| 7 | Safeguarding incl. MCA | Kent County Council |
| 8 | Assessment required | Medway Council |
| 9 | Assessment required | Medway Council |
| 9 | Assessment required | Medway Council |
| 9 | Awaiting EOL bed | CHS FT |
| 9 | Safeguarding incl. MCA | Medway Council |
| 10 | Housing incl. utilities - Medway | IDT |
| 11 | Awaiting EOL bed | CHS FT |
| 12 | Awaiting EOL bed | CHS FT |
| 14 | Assessment required | CHS Health |
| 14 | Assessment required | MFT ward |
| 14 | Awaiting nursing bed | CHS Health |
| 14 | Awaiting nursing bed | Medway Council |
| 14 | Awaiting nursing bed | Medway Council |

Fig.2

# Care at home Technology

## Remote Patient Monitoring (RPM) tailored to the patient's needs

**Capture the broadest picture of patient health with access to continuous and intermittent RPM devices in addition to patient-reported data.**

### The Current Health **wearable device.**

Our CE/CA-certified wireless biosensor continuously and passively captures vital signs with the same accuracy of an ICU monitor, providing hospital-grade monitoring at home for (PROMS) patients.

- Pulse rate
- Respiration rate
- Mobility and step count
- Oxygen saturation
- Body temperature

### Best-in-class **peripheral devices.**

Devices come preconfigured as part of our kit for easy patient setup. Data is transmitted wirelessly and integrated into our clinical dashboard for a single view of patient health.

OMRON
Blood Pressure

Axillary Temperature

Oxygen saturation

MIR
Spirometry

iHealth
Weight

+More integrations in development

### Patient reported **outcomes (PRO).**

Daily activity data and self-reported symptoms provide a holistic picture of patient health and help teams to monitor care, plan engagement and medication adherence.

# Care at home Technology

## Making care at home accessible for diverse patient populations

**<u>Connectivity for all</u>**

We provide everything the patient needs to get online, including cellular connectivity without the need for Wi-Fi connection, and a tablet to help increase accessibility for your patients.

**88%**

of patients 'strongly agree' or 'agree' it was easy to set up the kit

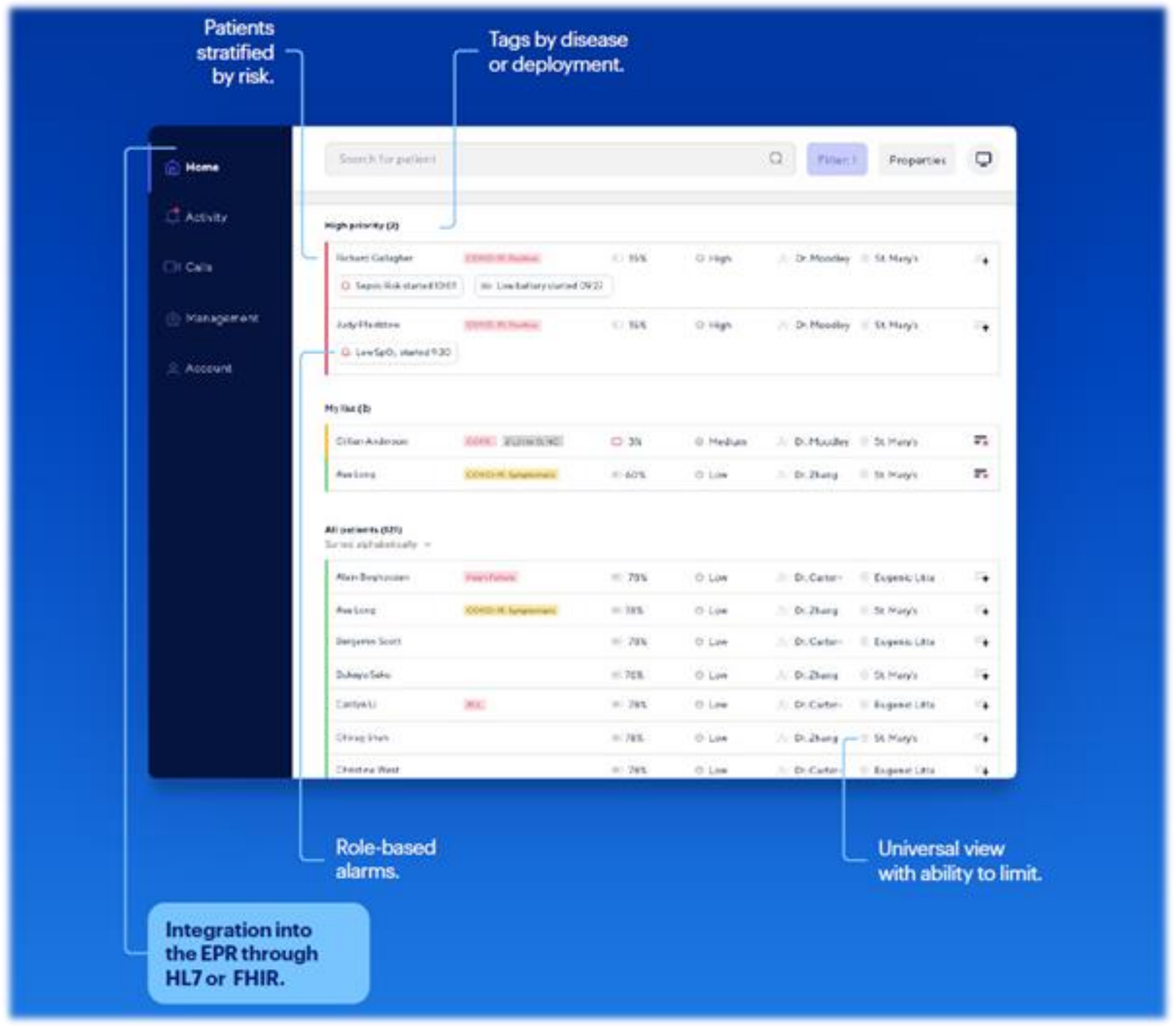
**<u>Passive & ambient</u>**

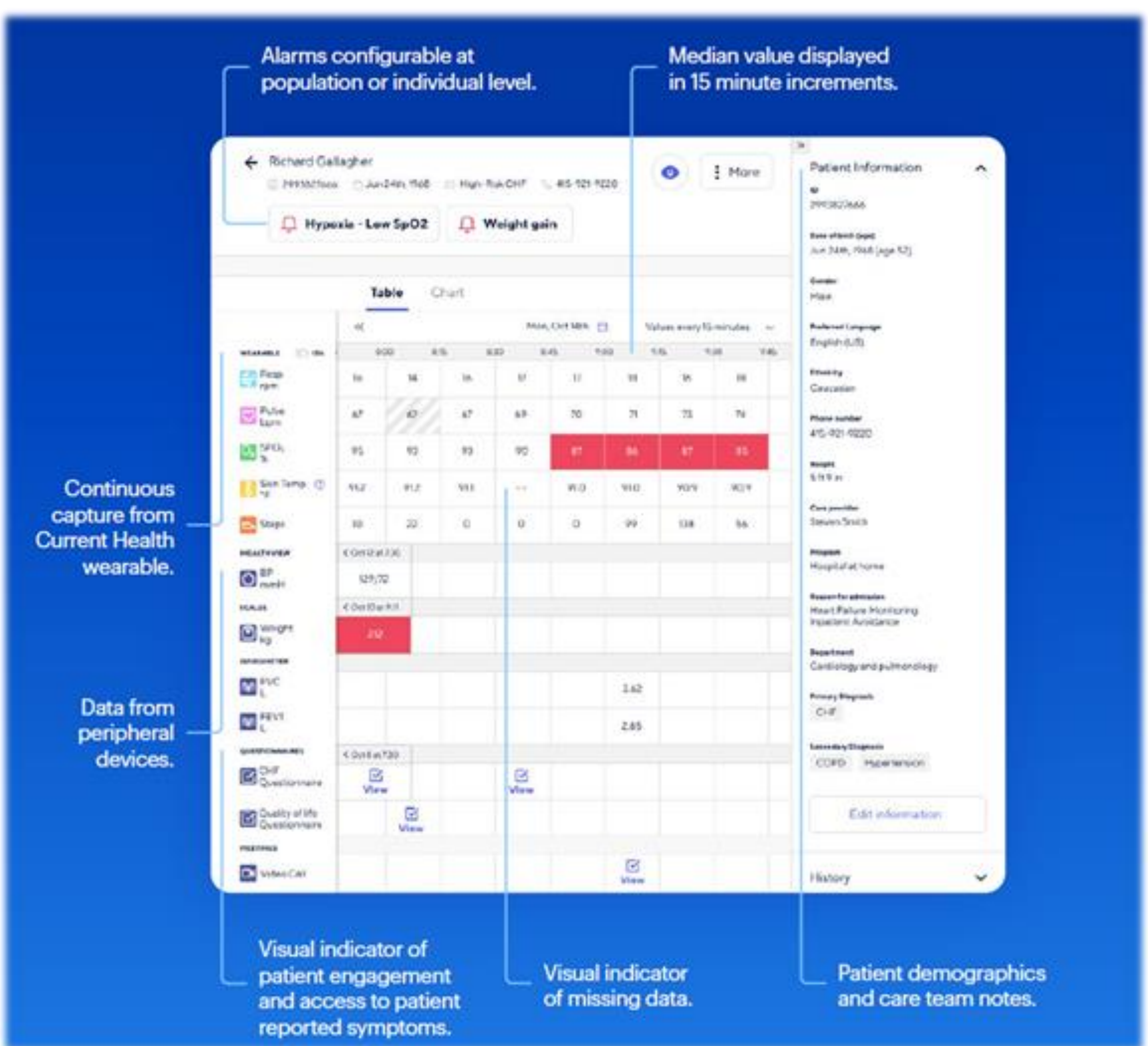
No action is needed from the patient … erything is transmitted automatically to the Current Health p… ess connection.

**<u>Simplified instructions</u>**

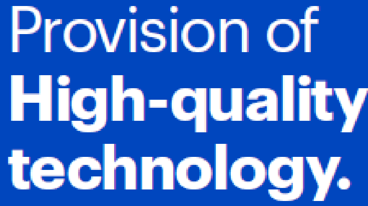
Easy, clear, and visual instructions for patients with low literacy levels – all patient-facing content written at age 10-13 reading level, translated in to multiple languages.

# One dashboard for all clinicians



# One platform, providing technology to enable good quality care at home




Our advanced technology comprises a diverse ecosystem of CE/CA marked devices for continuous vital sign monitoring, and intermittent vital sign capture. This enables remote patient care across diverse clinical pathways.

RPM Devices

Telehealth

Clinical Dashboard

EPR Integration

## Wrap around **Programme support.**

The delivery of high-class technology alone is not enough for a successful care at home programme, so we've developed extensive wrap-around services to aid your programme's operations.

Professional Services

Clinical Research

Logistics Services

Virtual Monitoring Hub

Our step down Virtual Ward includes:
- Post Operative ESD
- Post Operative direct from Recovery (Breast Surgery Patients)
- Heart Failure
- Respiratory
- Paediatric pilot
- Neonatal pilot
- Acufuser IV's

Our step up Virtual Ward includes:
- Heart Failure
- Respiratory
- AtED
- Admission Avoidance
- Attendance Avoidance

# Case Study

## Virtual Ward

**Utilisation of remote patient monitoring to improve capacity and reduce acute bed requirements.**

### The issue

Identifying opportunities to support post-op patients out of the acute hospital at the start of and during Covid.

Our post-op breast patients who needed a surgical drain that requires acute monitoring prior to discharge, were being admitted onto a ward with an average seven day length of stay in an acute bed for monitoring.

Daily visits to support these patients by the team was not practical due to capacity.

Patient reviews carried out by phone led to patients receiving a face-to-face visit most frequently because patients, descriptions of concerns needed clinically verifying.

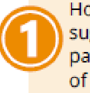
This put additional pressure on the service to accommodate a patient often resulting in a couple of days stay in an acute bed before they could be transferred to the SMART team.

**In April 2023, twelve patients were directly admitted onto the virtual ward (VW) following breast surgical procedures.**

The combined length of stay (LOS) on the VW was **73 days average 6.08 days**. The majority of these patients had drains in place and require some remote monitoring via RPM technology. There were 27 face-to-face visits by SMART practitioners across these patients who were supported via Remote Patient Monitoring (RPM) technology. These patients were brought back in for the drain to be removed and then discharged from the SMART virtual ward.

This pathway provided a **73-day elective bed saving in April** which provides an efficiency in length of stay and flow and a cost avoidance. This pathway enables these physical elective beds to be used for other elective patients, freeing up bed days to enable additional elective activity which will contribute towards meeting/exceeding operational planed activity.

### What we did to make a difference



1. Hospital at Home pathways for inpatients suggest daily face-to-face visits to ensure patient safety. However, the introduction of Remote Patient Monitoring (RPM) enabled SMART to accept patients directly from recovery when safe to go home, directly onto the virtual ward.

2. Patients were educated on post-op pain control and taught how to change redivac bottle.

3. All patients are called twice daily via video and remotely monitored via RPM.

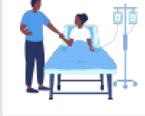
4. Patients have a chat link to communicate with the SMART virtual hub nurses.

5. Patients feel empowered by being involved in their care.

6. We have a ratio of 1 HCP to 20 patients on our virtual pathway.

7. RPM requires less face-to-face interaction and more virtual care.

### Our key outcomes



Average LOS of a breast patient is **seven days on a ward**, this **saves** an average **seven acute bed days per patient**

**Face-to-face interaction 2x weekly** for wound review and bottle change if required.

Patients are able to **recover in their home environment** which is generally agreed as a driver for quality health outcomes

**Pain well controlled** due to self-medication.

**Bed day efficiency** which supports improvement in our elective capacity.

Thank You

# Q&A Panel

## Thank you for attending the Patient Flow Conference!

# Upcoming Conferences this Week...

Tomorrow

Thursday

**Register for the next NHS Patient Flow Conference in February 2024…**