



Thursday 8th February | etc venues, Manchester

Agenda for today:





Welcome to The Patient Flow  
Conference!



8th February 2024  
9am – 5:30pm  
etc Venues, Manchester



# Chairs Opening Address



**Conor Burke**

CEO - UHUK (Urgent Health UK)



## Slido

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



SCAN ME



Speaking Now...



**Chris Morrow-Frost**  
National Clinical Advisor to Secondary  
Care - NHS England

# Learning from the highest performing trusts on admitted flow

Charlotte Aston

Director of Hospital Transformation, NHS England

Chris Morrow-Frost

National Clinical Advisor to Hospitals, NHS England

January 2024

# Good practice admitted flow visits

- 11 sites visited by the national UEC team and ECIST (with regional and ICS partners)
- Sites initially chosen using data (In hospital flow metrics for UEC) and regional discussions
- SAPIT (Summary Acute Provider Table) used for each visit
- Each visit focussed upon post ED flow, Discharge to Assess and pre complex discharge (but the whole UEC pathway was considered)
- Combining the measures – 12 hour, CTR, occupancy, Length of stay (7, 14, 21 days): (v = visited)
  - Barnsley (v)
  - Bradford (v)
  - Dartford and Gravesham (v)
  - East Lancashire (v)
  - East Suffolk and North Essex
  - Homerton (v)
  - Kettering (v)
  - Newcastle (v)
  - Northumbria (v)
  - North Tees (v)
  - Royal Surrey (v)
  - University College London (v)

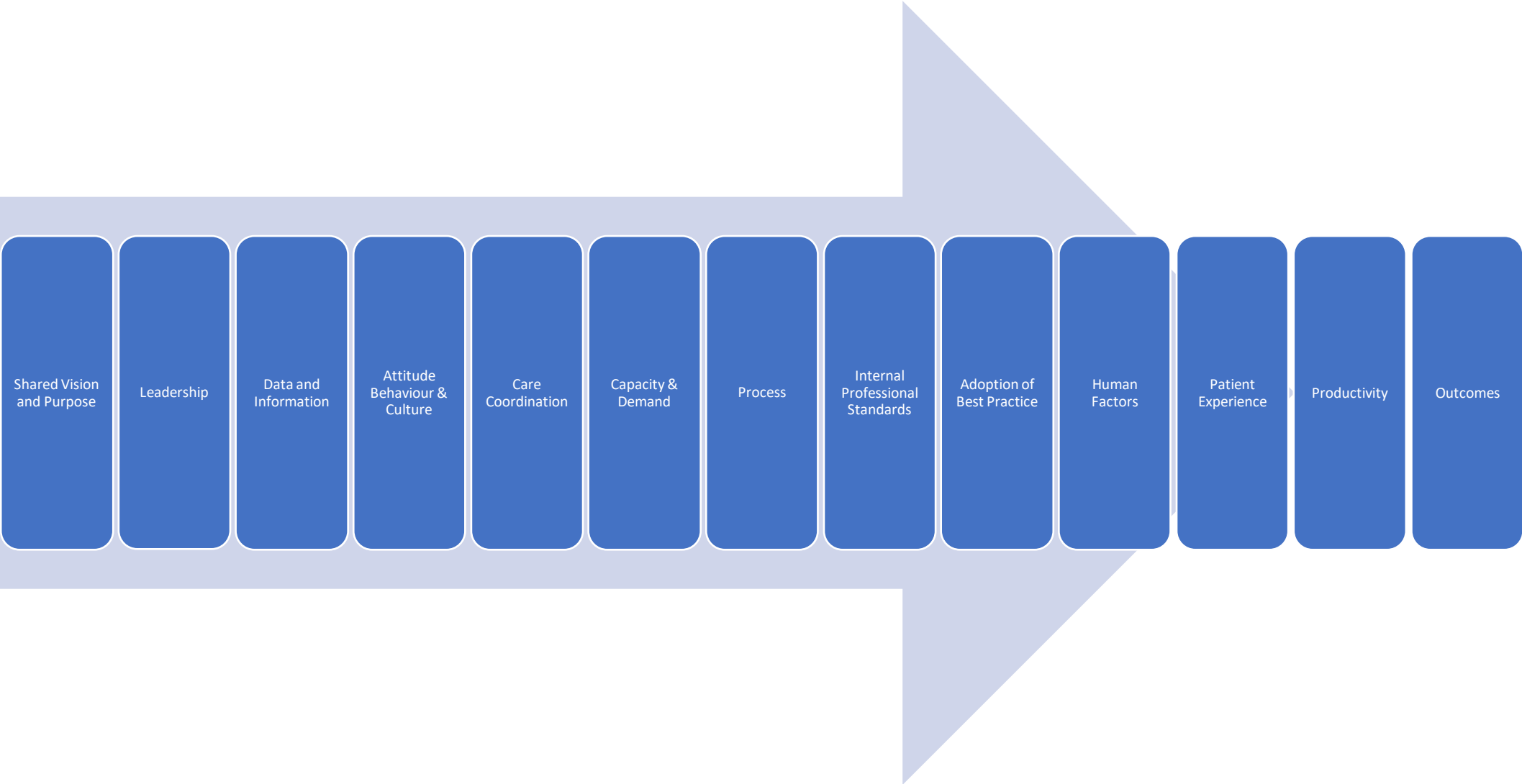


# Terms of Reference

- To gather intelligence on what factors lead to high performance in patient flow, discharge and UEC
- To understand the local application of known good practice in D2A pathways 0-1- 2- 3 (specifically pathway 0)
- To gather tools, techniques and experience that might be shared across the NHS in improving admitted flow



# Areas of focus – what we looked for....



# System priority to stop conveyance / admissions

- Joined up services (care coordination hubs, call to convey etc) in the integrated care system (ICS) that enable ambulance personnel to access services that go to the patient physically / virtually and prevent conveyance
- Primary Care, Urgent Care and Community partners on acute site daily, 7 days.
- Open and easy access criteria in community
- Acutes & community teams provide remote support and advice
- Effective and timely urgent community response



# Admission avoidance – right clinician, right time, first time

- High levels of streaming on arrival at the emergency department e.g. to same day emergency care, urgent treatment centre, assessment unit, frailty, specialties and community services, upwards of 60% activity
- Cultures of open access criteria and trust
- Easy to refer and transfer patients
- High culture of trust – especially around nursing competency



# Admission avoidance – Discharge starts on arrival

- Discharge planning documentation on arrival
- Discharge conversations and planning in ED
- Therapists and Community partners working in ED



# Effective operational site management

- Exactly same as ambulance handover good practice visits
- Significant digital solutions with live information
- Mostly virtual
- Significant divisional management and clinical representation
- Often director / executive presence and leadership
- Shared purpose with collaborative solution finding
- Strong clinical and operational working
- Structured and proactively action focused
- Medical colleagues engaged early to help reduce unnecessary patient waiting



# Inpatient ward processes

- Inpatient wards are aware of the risk of a crowding along the whole pathway (Ambulance, ED, AMU etc) ‘it’s our problem’
- Standardised use of ward and board round approaches e.g. the SAFER patient flow bundle, (board and ward rounds) and a home first culture
- Empowered nursing, allied health professionals and administrative staff – they have co designed ‘how we do things here’ and hold each other to account
- Teams work the same every day 7 days a week
- All outlie but strong outlier management



# Inpatient ward processes

- Team empowerment. Genuine collapsible hierarchy on a ward level
- Discharge processes split between sites who protect nursing to deliver it, discharge coordinators who take on complex discharge to free up nursing time, discharge coordinators who manage all discharge
- Therapy cover 7 days
- Consultant cover 7 days so all patients who should be seen are
- Significant exec level QI methodology used over 1-2 years to create MDT designed and sustained 'how we work here'
- No one has cracked Criteria Led Discharge



# Executive Leadership

- Exactly same findings as the ambulance handover good practice visits
- Staff describe visible executives who feed demonstrate a values driven culture
- They are seen daily / weekly in clinical areas & in site management meetings
- They are described as professionals who are caring, accessible, listen to patient facing & operational teams and give permission to do the right thing
- Staff across the organisation echo and repeat widely ‘zero tolerance’ messages to unnecessary patient waiting which originates from executive leadership teams





# People

- Strong culture of ‘it’s not just the emergency department’s problem’
- Good ABCs (attitudes behaviors and culture)
- Strong belief and adherence to internal professional standards. Mature approach to IPS : don’t worry about following written instructions, people are empowered to hold each other to account and / or trust when teams can’t deliver immediately
- Little escalation usage – people are empowered to talk to each other and solve each others’ problems
- Most heavily emphasise staff welfare, empowerment, engagement

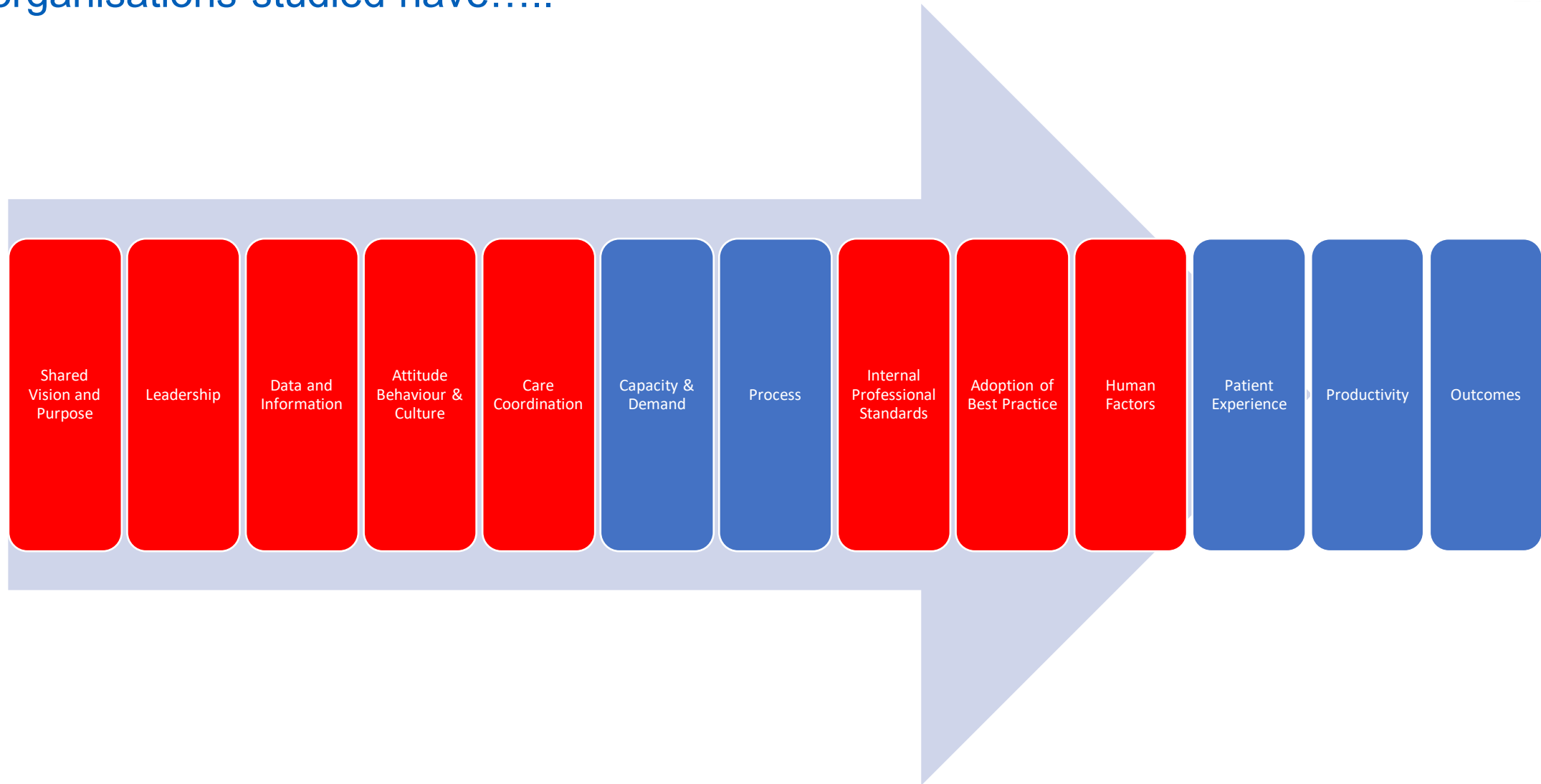


# Hospital service structures

- SDECs with high takes and open access criteria
- Co-located UTCs or equivalent
- Streaming
- Specialties take their patients to their own areas rather than ED
- Strong Acute Medicine model with protected length of stay standards
- Strong strategy and use of virtual wards



Our findings in summary.... what consistent factors did the organisations studied have.....



# Conclusions

- Multiple ways to influence admitted flow
- Most sustainable models require prehospital, in hospital and leadership / cultural interventions
- Most prevalent solutions
  - Strong Executive leadership and daily oversight
  - Strong joined up clinical & operational cultures
  - Multiple joined up pre-hospital services
  - Clinically co-designed approach to ward processes which are culturally held to account
  - Empowered, open, on site UTC (or equivalent), SDEC, Assessment Units, Frailty services
  - Integration with community services



# Thanks for Listening



Chris Morrow-Frost  
MSc, BA (hons), Dip N  
National Clinical Advisor to Hospitals  
NHS England  
Mobile: 07912161394  
LinkedIn: Chris Morrow-Frost  
Email: [chris.morrow-frost@nhs.net](mailto:chris.morrow-frost@nhs.net)



## Speaking Now...



**Victoria Cardona**  
Head of Patient Flow  
Service - North of  
England Care System  
Support



**Louis Coles**  
Digital Solutions Service  
Manager - North of  
England Care System  
Support

A graphic element for the OPTICA logo, consisting of seven short, thick, colored lines radiating from the left side of the word 'OPTICA'. The colors from top to bottom are yellow, orange, green, pink, blue, and purple.

# OPTICA

Patient discharge optimisation

An NHS England Product



**Patient Flow Conference**  
8 February 2024

**Louis Coles**  
Digital Solutions Service Manager  
NHS North of England Care Support

**Victoria Cardona**  
Head of Patient Flow Services  
North Tees & Hartlepool NHS FT

- 🗨️ Patients were experiencing an **inconsistent, convoluted and inefficient discharge process** which often led to:
  - 🗨️ Unnecessary waiting time in acute beds
  - 🗨️ Long waits to access community services
  - 🗨️ Consuming valuable hospital capacity that could be used for elective recovery
  - 🗨️ Avoidable deterioration of patient health
- 🗨️ Rapid discharges with delayed assessment, whilst necessary during the pandemic, shifted the problem downstream with more delays occurring in community settings. Post pandemic this shifted back.
  - 🗨️ Teams are unable to see where patients are at a given time in the process and what the next action should be and who should be owning it, leading to further inefficiency, confusion and avoidable costs

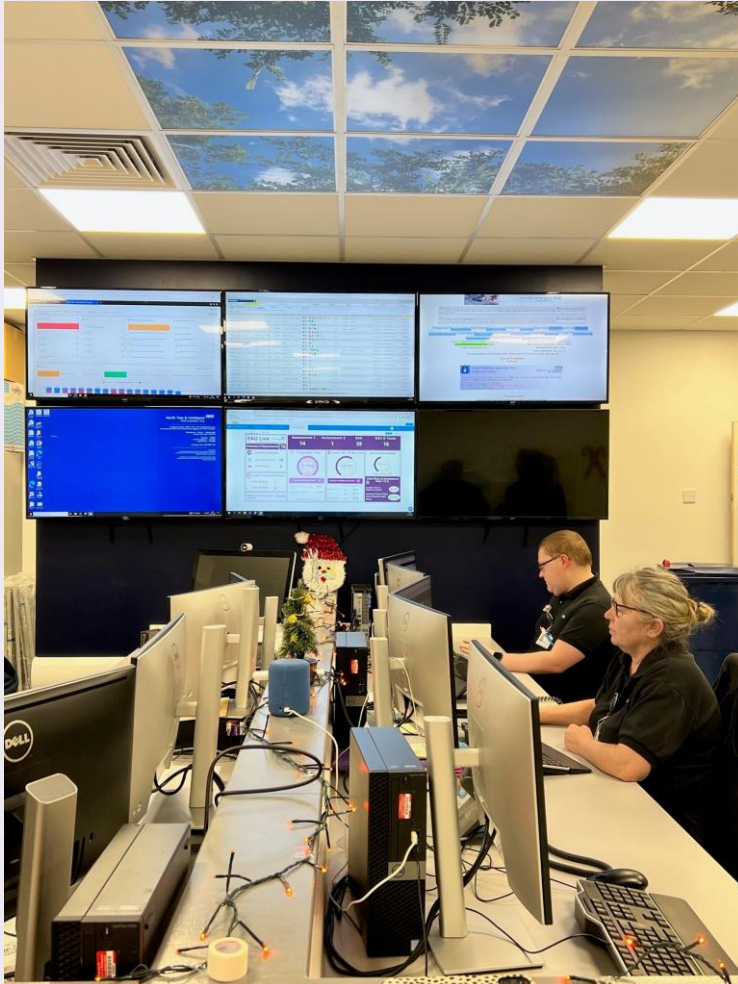


- 🗨️ **Limited integration between health and social care** which hindered our collectively ability to effectively co-manage patients and this led to potential confusion around responsibility:
  - **Data was disparate** and not readily available or in one place to support decision-makers
  - **Communication was manual** and ad-hoc (lots of paperwork, emails, phone calls etc.)
- 🗨️ **Delayed discharges** from both acute and community settings **consumed valuable NHS capacity and impacted on flow at front of house**
- 🗨️ NHS & Social Care teams **didn't have enough visibility** into upcoming discharges, so it was hard for us to assess the volume of patients coming through and prepare accordingly
- 🗨️ Several other barriers adversely impacted on flow out of hospital, including transportation & medication not being arranged in time

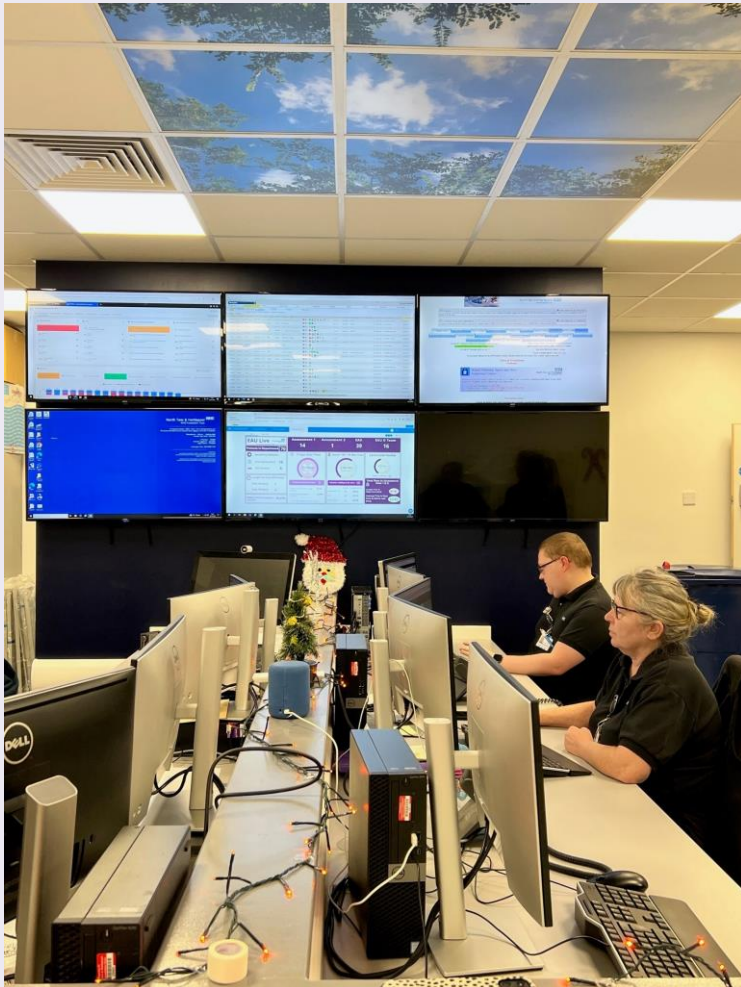
- Nationally, **366,856 patients** with a LoS of 21+days were unnecessarily delayed/ no longer met the criteria to reside. The total delay for these patients was **5.57 million days**.
  - 273,581 patients (**74.66%**) were delayed waiting for a P1 – P3 pathway
  - 92,860 patients (**25.34%**) were delayed for some other reason - principally internal hospital processes
- The missed opportunity cost of these delayed days was **£2.2 billion\*** based on an assumed **£395 per hospital Excess Bed Day** (Kings Fund research). *\*NB. these are not cash-releasing savings but direct costs of delayed discharges alone (excluding additional costs from activities such as cancelled operations, staff time spent arranging care packages, patients deconditioning resulting in additional out of hospital care costs etc).*
- If all Trusts realised this one benefit reduction, over **2 million delay days per year** could be saved, to treat patients entering hospital via an elective or urgent care pathway. This is an equivalent saving of more than **£785m**.
- The **10 Trusts** with the highest number of delay days in England account for **35%** of these potential savings. In total **728,000 days could be saved, equivalent to £286m missed opportunity cost**

*None of the above considers the added impact of delayed discharge on patients. It is widely accepted that for every 10 days of bed-rest in hospital, the equivalent of 10 years of muscle ageing occurs in people over 80-years old, and building this muscle strength back up takes twice as long as it does to deteriorate which adds to the cost of out of hospital care.*

- The Discharge team and the Patient Flow team weren't co-located and were based at opposite ends of the hospital
- Both teams would attend OPEL meetings with completely different information around discharge
- **Challenge was not knowing where to target our effort as we didn't know where the bottlenecks were using multiple spread sheets and lists.**



- Co-located both teams into the ICC funded by the post-COVID Elective Recovery Fund to support flow
- One centralised team focused on the end-to-end flow process from front of house to back of house
- Discharge lounge also brought into the structure
- Worth noting prior to this, we'd already brought NHS and LA teams together virtually to form the Integrated Single Point of Access, ISPA (now ToC Hub)
- Established ward huddles and flagged C2R status, albeit on spreadsheets
- ISPA started to have a very close relationship with new ICC
- Created a new Head of Patient Flow role
  - Full pathway oversight
  - Enabled key decisions to be made eg adapting processes
  - Trust coordination with Local Authorities



- Looked at what information was already accessible to help us make decisions
  - Ambulance handover screens
  - EPR – who was in beds
  - Developed various dashboards for Front of house metrics
- BUT....we had nothing to tell us when patients were expected to be discharged without delving into each patient's EPR record and using spreadsheets (often out of date)
  - The EDD was typically inaccurate as based on medical interventions only, not the additional discharge related tasks
- AND we were still blind to the extent of the delays and the causes of the delays
- AND we were quick to blame the LAs even though delays were often internal processes
- However, our Trust was always a good discharge performer nationally
  - Low LLoS, 4hr ED
- **Worked in this way for circa 6 months, doing our best but none of us really knew how or if digital tech could help us.**

- Build on the discharge transformation work already undertaken in the Trust
- Further optimise patient flow, maximise bed availability and minimise avoidable delayed discharges
- Optimise collaboration between Health and Social Care
- Improve efficiency of multi-disciplinary discharge teams
- NHSE also wanted a Foundry 'use-case' and a scalable solution to benefit other Trusts/Local Authorities
- High level of skepticism!

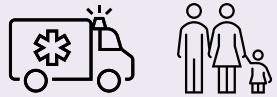


# The Solution - OPTICA Dynamic Discharge

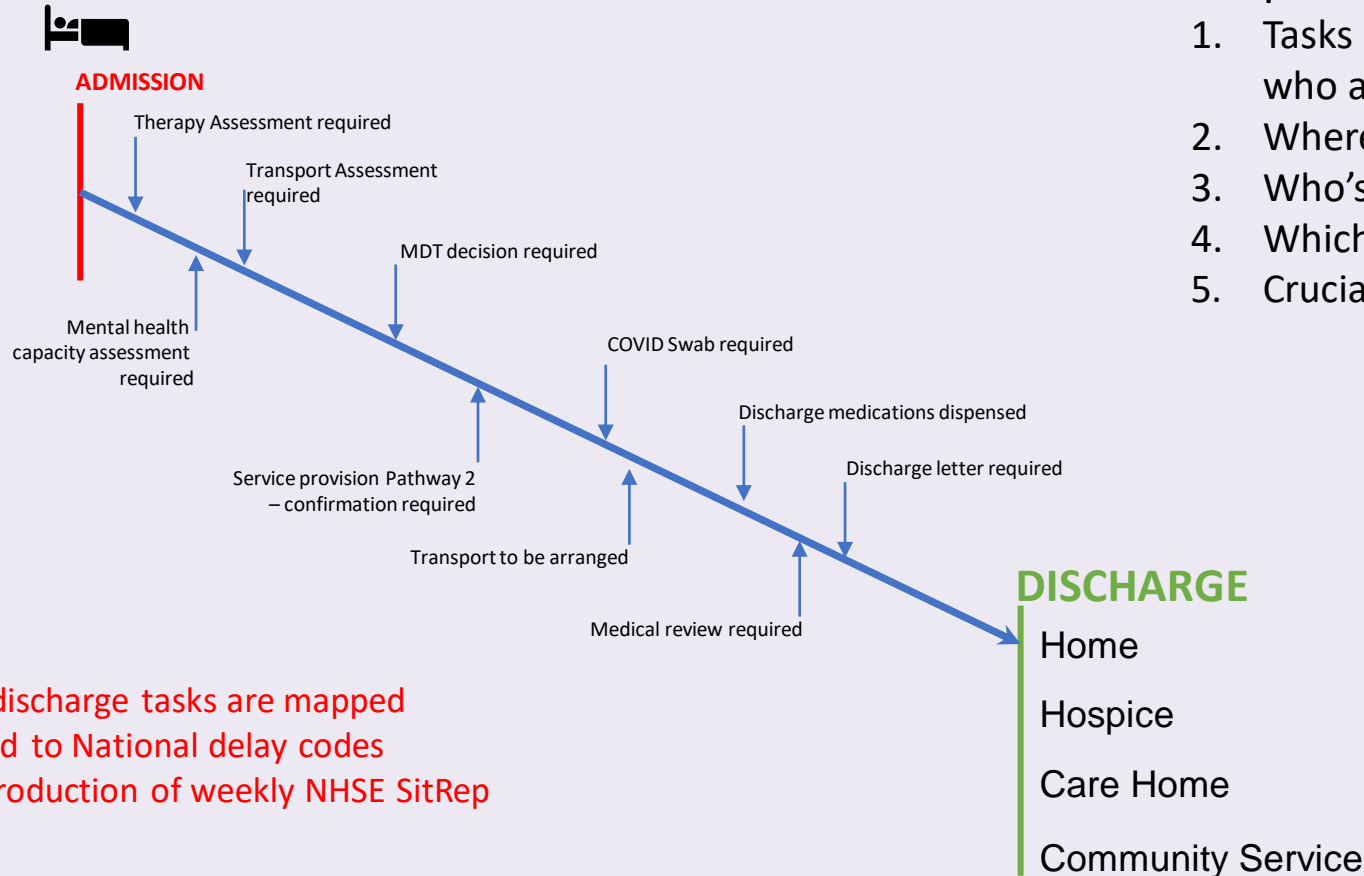
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- OPTICA is an application built by NECS and NTHFT on the Foundry platform that **tracks all admitted patients and the tasks** relating to their discharge **in real-time** through their hospital journey.
- Fully **integrated with hospital electronic patient records, other health data systems** to ensure relevant information related to discharge is available to clinical teams and leaders in one place. The **automated dataflows** can be **easily augmented** with updates from operational teams.
- Drives an **efficient, shared way of working for health and social care teams** providing actionable intelligence to help care teams properly plan for timely discharges, helping ensure avoidable delays leaving hospital are kept to a minimum and hospital beds aren't unnecessarily occupied.
- Enables the MDTs to **easily understand** exactly where discharges from hospital are being avoidably delayed, for how long, why, who's responsible and attaches a proxy indication of missed opportunity cost to the organisation.
- Provides **operational grip** (workflows) and **organisational grip** (comprehensive reporting & analytics)
- Helps organisations to minimise **missed opportunities** and get patients home when discharge ready.



**Data Rich  
Upstream but  
Relatively  
Data Poor re  
Discharges**



**Locally defined** discharge tasks are mapped in the background to National delay codes for automated production of weekly NHSE SitRep

Helps discharge teams to quickly identify:

1. Tasks preventing patients from leaving hospital who are Discharge Ready;
2. Where the blockages are;
3. Who's got ownership of the blockages;
4. Which patients are being impacted.
5. Crucially, where to focus their resources



# "Why has my patient not been discharged?"

Immediately obvious to the MDT what's holding up the patient's discharge and who's responsible

Task Owners add their latest update to share with the MDT

If a Discharge Task relates to finding a care home placement, users can link directly to the NHS Capacity Tracker

**Patient Overview**  
 Hughes, John ☆  
 [OPTICA] Admission

Checklist Tasks Patient Details Status Updates Admission History Edit History

Show OPTICA tasks only  Show only selected admission tasks

[Edit Checklist Task](#) [View History](#) [Add Discharge Checklist Task](#)

[Open CPMS](#) [Open Capacity Tracker](#)

Task Stage	Status	Assignee Group	Assignee Details	Task Duration	Created At	Last Edited	Requires Immediate Action	Notes	Timestamp Overdue	Source	Admission Date	Admission Status	Discharge Date
Best interest decision required	Overdue	IDT	JM	96 days, 19 hours	6 Sept 2023, 14:42	30 Nov 2023, 11:44	No value	MDT to Decide tomorrow	8 Sept 2023, 14:42	OPTICA	11 Dec 2023	Admitted	null
Service provision availability	Overdue	Local Authority	No value	461 days, 22 hours	6 Sept 2022, 11:39	No value	No value	Serv provision in progress	6 Sept 2022, 15:39	No value	11 Dec 2023	Admitted	null
Best interest decision required	Complete	IDT	MS	0 days, 0 hours	23 Jan 2023, 16:28	23 Jan 2023, 16:33	No value	Assessment complete	23 Jan 2023, 20:28	OPTICA	11 Dec 2023	Admitted	null
Medical review required	Complete	CCG	FG	0 days, 0 hours	18 Nov 2022, 11:13	18 Nov 2022, 11:16	No	For review	18 Nov 2022, 15:13	No value	11 Dec 2023	Admitted	null
Therapy assessment	Complete	Other	Hannah Martin		6 Sept 2022, 11:38	No value	No value	Confirm status	1 Sept 2022, 15:37	No value	11 Dec 2023	Admitted	null
Covid swab required	Complete	Other	Hannah Martin		6 Sept 2022, 11:38	No value	No value	Confirm status	6 Sept 2022, 15:38	No value	11 Dec 2023	Admitted	null

# "My Tasks...For Every Patient...In One Place?"

See and update 'My Tasks' for every patient that I've got to do something for, in one place

Really quick and easy for Users to update all Discharge Tasks on the fly

DPTL 
  Admitted Patients 
  Discharged Patients 
  Bed Status 
  DPTL Reports 
  Checklist Tasks

Filters	Patient Name	Date of Birth	Meets Criteria To Reside	Task Description	Notes	Last Edited	Created At	Status	Task Priority	Require Immediate Action	Assignee Details	Assignee Group	Discharge Pathway	Sub Pathway	Admission Status
<input type="checkbox"/>	Barnes, Richard	Wed, Feb 16, 1983	No	Medical review required	Waiting on placement confirmation	No value	23 Oct 2023, 16:56	Overdue	High	No value	EB	IDT	Pathway 2	Hospice	Admitted
<input type="checkbox"/>	Brady, Ralph	Thu, Oct 10, 1974	No	Transport - to be arranged	Sent to A for assessment bed	No value	13 Nov 2023, 21:48	Overdue	High	No value	EB	ISPA	Pathway 2		Admitted
<input type="checkbox"/>	Ellis, Michaela	Sat, Aug 22, 1970	No	Transport - to be arranged	Paperwork sent	No value	7 Nov 2023, 02:30	Overdue	High	No value	EB	IDT	Unstated		Admitted
<input type="checkbox"/>	Ellis, Michaela	Sat, Aug 22, 1970	No	Prescription required	Waiting on placement confirmation	No value	3 Nov 2023, 03:44	Overdue	High	No value	EB	CHC	Unstated		Admitted
<input type="checkbox"/>	Foster, Alan	Fri, Mar 23, 1984	No	Discharge medications dispensed	Sent to A for assessment bed	No value	4 Nov 2023, 21:51	Overdue	High	No value	EB	ISPA	Pathway 3		Admitted
<input type="checkbox"/>	Foster, Alan	Fri, Mar 23, 1984	No	Therapy assessment required	Bloods scheduled for tomorrow	No value	7 Nov 2023, 09:39	Overdue	High	No value	EB	CCG	Pathway 3		Admitted
<input type="checkbox"/>	Gomez, Salena	Mon, Aug 2, 1993	No	Rapid response assessment required	Bloods scheduled for tomorrow	No value	11 Dec 2023, 04:06	Overdue	Low	No value	EB	CHC	Pathway 0		Admitted
<input type="checkbox"/>	Gomez, Salena	Mon, Aug 2, 1993	No	MDT decision required	Sent to A for assessment bed	No value	14 Dec 2023, 20:09	In Progress	No Alert	No value	EB	IDT	Pathway 0		Admitted
<input type="checkbox"/>	Howard, Laura	Fri, Oct 3, 1980	Yes	Ward TCH 1	Paperwork sent	No value	28 Oct 2023, 09:36	Overdue	High	No value	EB	IDT	Pathway 3		Admitted
<input type="checkbox"/>	Hughes, John	Tue, Apr 26, 1955	No value	MDT decision required	Sent to A for assessment bed	No value	13 Dec 2023, 13:17	In Progress	No Alert	No value	EB	IDT	Pathway 0	Homeless	Admitted
<input type="checkbox"/>	Johnson, Jose	Sun, Oct 13, 1974	No	Discharge letter required	Waiting on placement confirmation	No value	6 Oct 2023, 01:12	Overdue	High	No value	EB	CCG	Pathway 2		Admitted
<input type="checkbox"/>	Johnson, Jose	Sun, Oct 13, 1974	No	Covid swab required	Bloods scheduled for tomorrow	No value	5 Oct 2023, 08:15	Overdue	High	No value	EB	CHC	Pathway 2		Admitted
<input type="checkbox"/>	Jones, Dale	Mon, Dec 23, 1963	No	Rapid response assessment required	Sent to A for assessment bed	No value	18 Oct 2023, 01:09	Overdue	High	No value	EB	ISPA	Pathway 3	Designated Setting	Admitted
<input type="checkbox"/>	Lyons, Alexa	Fri, Mar 13, 1959	No	Discharge medications dispensed	Awaiting paperwork from A	No value	8 Nov 2023, 16:50	Overdue	High	No value	EB	Local Authority	Pathway 1	District Nursing	Admitted
<input type="checkbox"/>	Lyons, Alexa	Fri, Mar 13, 1959	No	Therapy assessment required	Awaiting paperwork from A	No value	5 Nov 2023, 07:03	Overdue	High	No value	EB	Local Authority	Pathway 1	District Nursing	Admitted
<input type="checkbox"/>	Marshall, Barbara	Sun, Jul 12, 1953	No	Discharge medications dispensed	Paperwork sent	No value	7 Nov 2023, 13:32	Overdue	High	No value	EB	CHC	Pathway 2		Admitted
<input type="checkbox"/>	Owens, Rick	Thu, Jan 15, 1970	No	MDT decision required	Sent to A for assessment bed	No value	7 Nov 2023, 18:30	Overdue	High	No value	EB	ISPA	Pathway 2		Admitted
<input type="checkbox"/>	Owens, Rick	Thu, Jan 15, 1970	No	Therapy assessment required	Awaiting paperwork from A	No value	6 Nov 2023, 12:42	Overdue	High	No value	EB	ISPA	Pathway 2		Admitted



# Bed Capacity Management



DPTL [Admitted Patients](#) [Discharged Patients](#) [Bed Status](#) [DPTL Reports](#) [Checklist Tasks](#)

## Metrics

Core Beds	Additional Beds	Out Of Commission Beds	Total Useable Beds	Current Beds Occupied	Available Beds	Occupancy Rate
513	38	1	550	508	42	92.4%

Patients With Expected Discharge Date (EDD) Today	Patients With Planned Discharge Date (PDD) Today	Patients With Confirmed Planned Discharge Date (PDD)	Patients With Unconfirmed Planned Discharge Date (PDD)	Total Number Of Patients Already Discharged Today
48	19	13	12	5

## Bed Status by Ward

Ward	Ward Specialty	Core Beds	Additional Beds	Out Of Commission Beds	Total Useable Beds	Current Beds Occupied	Available Beds	Occupancy Rate	Patients That Don't Meet C2R	Confirmed To Be Discharged today	Unconfirmed Discharges Today	Estimated Discharges Tomorrow	Estimated Discharges Beyond 48 hours	Last User Edit
Acute Cardiac Unit (NT)	Cardiology	30	0	0	30	30	0	100%	3	0	4	21	16	Jul 7, 2023, 10:36 AM
Discharge Lounge (NT)	Discharge Lounge	0	0	0	0	1	-1	0%	0	0	4	0	0	May 12, 2023, 3:00 PM
EAU (NT)	General Medicine	60	0	0	60	57	3	95%	1	1	10	46	51	Jul 7, 2023, 10:38 AM
Surgical Decision Unit	Surgery	22	0	0	22	19	3	86%	0	2	1	21	5	Nov 21, 2023, 3:32 PM
Ward 04 (HP)	null	15	0	0	15	6	9	40%	3	0	2	3	3	Nov 29, 2023, 10:07 AM
Ward 20 (ITU) (NT)	null	16	0	0	16	11	5	69%	0	0	1	2	2	No value
Ward 24 (NT)	null	28	0	0	28	27	1	96%	3	0	1	16	15	No value
Ward 25 (NT)	null	28	0	0	28	28	0	100%	3	0	0	20	9	No value
Ward 26 (NT)	null	31	0	0	31	31	0	100%	9	0	3	16	25	No value
Ward 27 (NT)	null	30	0	0	30	30	0	100%	0	0	0	27	9	Nov 28, 2023, 7:44 PM
Ward 28 (NT)	null	31	0	1	30	30	0	100%	5	0	9	22	8	Nov 21, 2023, 3:28 PM



# Discharge Command Centre – Organisation Oversight and Assurance



## OPTICA - Admitted Patients Report

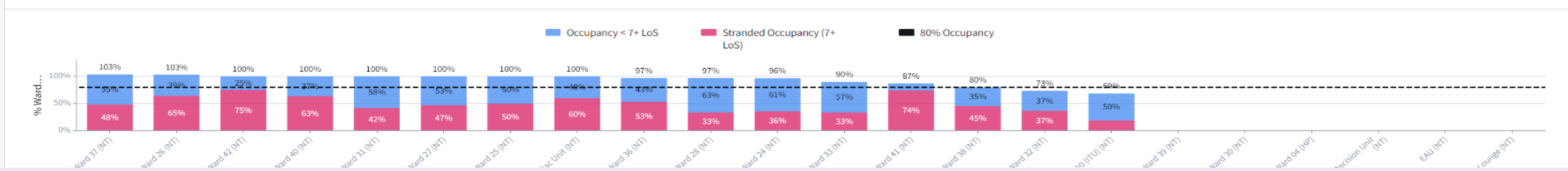
Open

All Command Centre Admitted Patients Discharge Delays Length Of Stay Discharge Ready Admission Profile Local Authorities

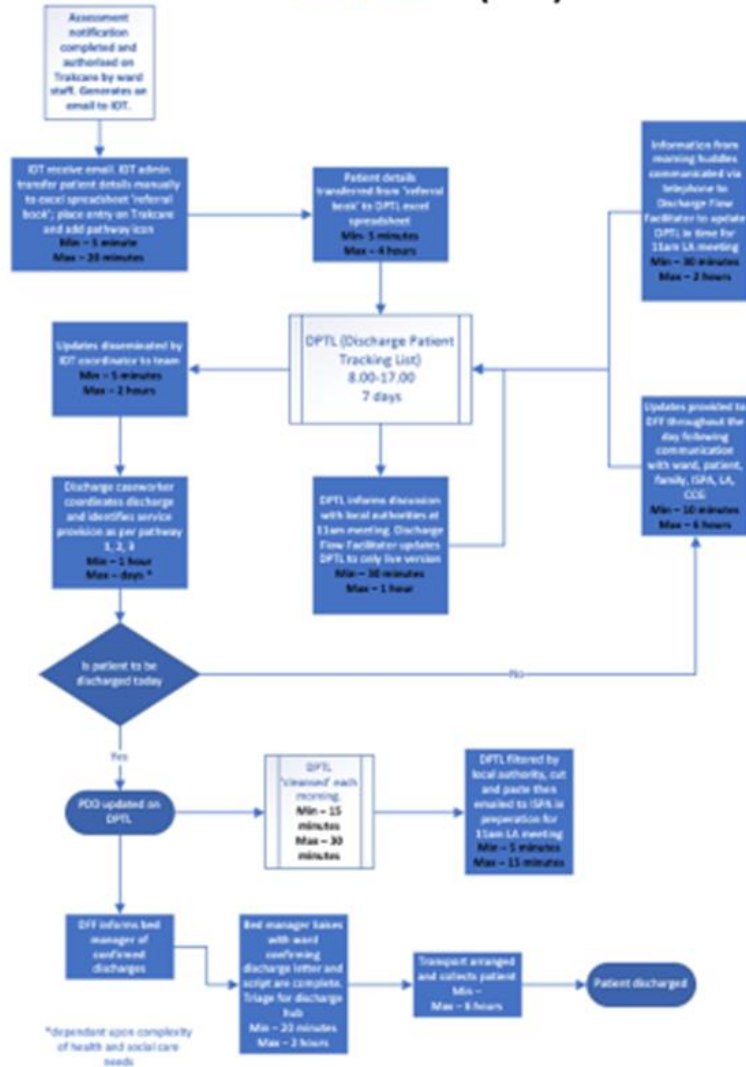
Refresh Data

Admitted Patients	DPTL	Criteria To Reside	Current And Forecasted Discharges
<p><b>510</b> Admitted Patients -68 \ Since Yesterday</p> <ul style="list-style-type: none"> <li>39 Pathway 0 (8%)</li> <li>33 Pathway 1 (6.5%)</li> <li>49 Pathway 2 (9.6%)</li> <li>17 Pathway 3 (3.3%)</li> <li>372 Pathway Unstated (72.9%)</li> </ul>	<p><b>154</b> Number Of Patients -54 \ Since Yesterday</p> <ul style="list-style-type: none"> <li>39 Pathway 0 (25.3%)</li> <li>33 Pathway 1 (21.4%)</li> <li>43 Pathway 2 (27.9%)</li> <li>14 Pathway 3 (9.1%)</li> <li>25 Pathway Unstated (16.2%)</li> </ul>	<p><b>101</b> Admitted Patients Who Do Not Meet Criteria To Reside -49 \ Since Yesterday</p> <ul style="list-style-type: none"> <li>73 Do Not Meet Criteria To Reside And Have No Planned Discharge Date (PDD)</li> <li>43 Do Not Meet Criteria To Reside, Have No Planned Discharge Date And Currently Delayed &gt; 1 Day</li> <li>84 Do Not Meet Criteria To Reside And Stranded (7+ LoS)</li> <li>50 Do Not Meet Criteria To Reside And Medium Stranded (14+ LoS)</li> <li>29 Do Not Meet Criteria To Reside And Super Stranded (21+ LoS)</li> </ul>	<ul style="list-style-type: none"> <li>0 Delayed Discharge From Yesterday</li> <li>6 Already Discharged Today</li> <li>27 PDD Today</li> <li>15 Confirmed PDD Today</li> <li>3 PDD Tomorrow (0.6%)</li> <li>3 PDD Beyond Tomorrow (0.6%)</li> </ul>

**92.7%** Current Occupancy Rate    550 Total Useable Beds    510 Current Beds Occupied    40 Available Beds    77 Patients With EDD Today    108 Patients With EDD In 24h    206 Patients With EDD In 48h    107 Patients With EDD Beyond 48h



**DPTL process (OLD)**



**OPTICA Discharge Process (NEW)**





Better patient flow resulting in better bed utilisation to support emergency/elective pressures



More efficient use of MDT staff time



Improved NHS and Social Care collaboration



Increased system resilience by accommodating more medical divers



Reduction in average length of stay and in avoidable delay days



Improved Patient Experience – Less exposure to infections, go home with minimum delay

**50% fewer** patients occupy a hospital bed for 21 days or more compared with the England average

**£75K** efficiency savings due to improved discharge processes

**36% reduction** in the average number of delay days for patients with a length of stay of 21+ days

**25% reduction** in long length of stay patients within 2 months of implementing OPTICA

**43% fewer** beds occupied by patients with a Length of stay of 14+ days compared to the national averages

- Information from OPTICA enabled us to rethink how we structured our discharge team based on the workload
- Introduced it incrementally to gain confidence, initially with the key members of the discharge team
- Extended OPTICA to the wider Flow Team
- Then granted access to the Local Authority partners
  - SVOT for NHS and Social Care incl C2R status of every patient
  - Everyone aware of who needed to do what and by when
  - MDTs were much more efficient because we could focus on Overdue tasks and discussing the care requirements rather than establishing information about patients
  - Pause processes for patients who meet the C2R
- 'Patient Process Facilitators' on key med/surg wards updated OPTICA from a ward perspective
- OPTICA enabled us to minimize administrative burden previously required to maintain spreadsheets and chase local authorities and wards for information
- Reinvested process efficiency savings into transport scheduling, trusted assessors etc
- Provided Trust Board assurance

- Immediate identification of patients for the **Discharge Lounge**
- Ensure all wards have completed criteria to reside on every patients at the 0900 huddle
- List of **Pathway 0** patients who don't meet criteria to reside
- Ensure a plans are in place/progress for **all** patients who don't meet criteria to reside
- Clear understanding of barriers internally as well as externally
- Movement of **staffing resources** internally e.g discharge resource/medical staffing to focus on discharge letter
- Step up **early escalation meetings** with partner leads, additional to the daily one that clinical staff have.
- Movement of staffing resource focus -discharge or other e.g medical for discharge letters
- **Additional support** requested from partners



- Rapidly identify patients who could **board** on the elective site
- Identification in "**extremist**" of potential patients who could move to Day Case unit overnight.
- **Accurate information to the ICB** surge team or other trusts
- Review of all **out of area patients**
- **Repatriation** possibilities explored
- **Assurance** that everything possible has been explored



# Question and Answers

Better insights. Better decisions. Better health.



# Headline Sponsor...





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## Speaking Now...



**Dr Jon Tose**  
GP, Senior Clinical  
Editor and Clinical Lead  
for - Pathways Alliance



**Dr Alastair Roeves**  
National Clinical Lead  
for Primary Care &  
Community Care for  
Wales National Clinical  
Lead for Health & Care  
Pathways - NHS Wales



# Pathways into practice

An all of Wales approach

THURSDAY, 08 FEBRUARY 2024



The next 25 minutes...

1. So, what is it?
2. Community HealthPathways in Wales: a case study
3. Completing the journey – Hospital HealthPathways
4. Q&A

# Our presenters

---



## Dr Alastair Roeves

GP, National Clinical Lead for Primary Care & Community Care for Wales  
& National Clinical Lead for Health & Care Pathways

*No Conflicts of Interest*



## Dr Jon Tose

GP, Senior Clinical Editor & Clinical Lead for Pathways Alliance UK

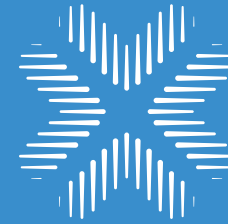




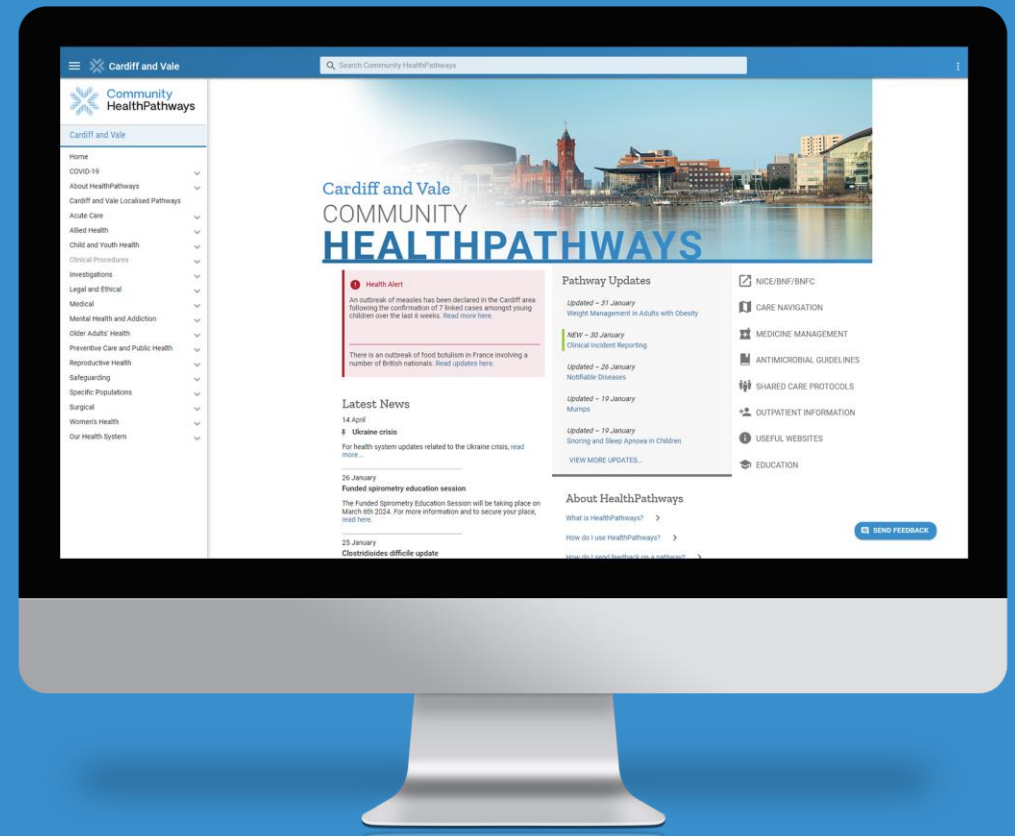
# So, what is it?

➤ An online manual used by clinicians to assess and help manage patients in the community and in an acute settings. It supports informed referral decisions across the local system

➤ Each pathway is developed by the local HealthPathways team as a collaboration between primary and specialist clinicians to reflect agreed local service provision and ways of working



# Community HealthPathways



# What is it for?

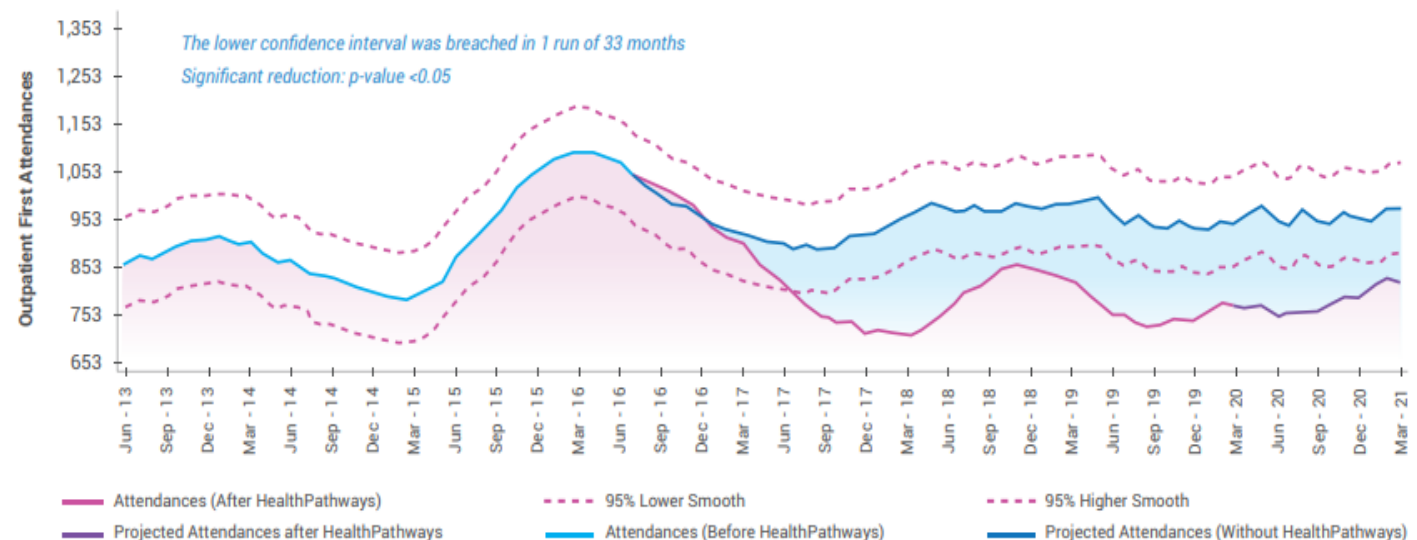
## HealthPathways promotes:

- Support to general practice at the point of care
- Clinical engagement, collaboration and agreement
- Translation of national policy and guidance into local practice
- Service development, using feedback loops to improve pathways
- Standardisation

## HealthPathways reduces:

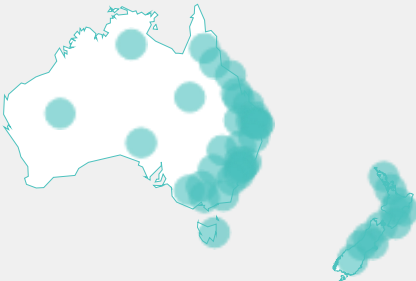
- Unwarranted variation in care
- Wasted patient and clinical time
- Uncertainty between clinicians about how a patient should be managed

Outpatient first attendances, South Tyneside, UK

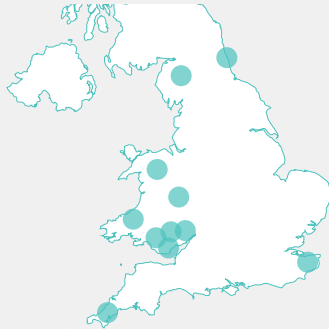


# The HealthPathways Community at a glance 2023

Australia and New Zealand regions



United Kingdom regions



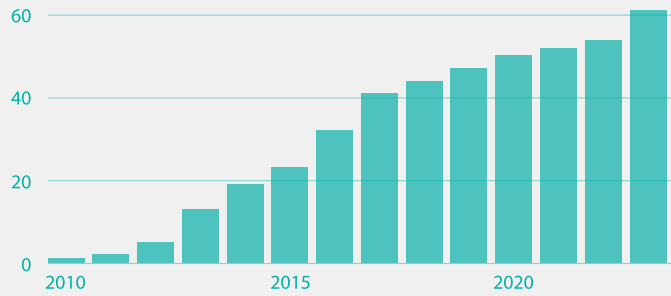
Total number of implementations



Total patient numbers in regions

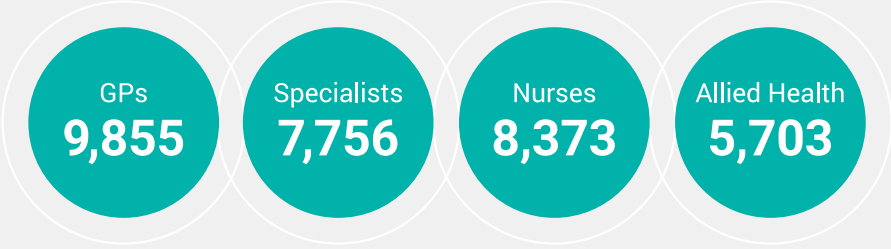


Cumulative number of regions over time

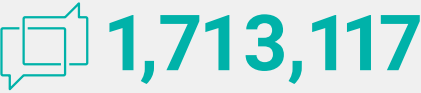


Clinical pathways localised	Pages currently being localised	Page reviews completed	Page reviews in progress	Services in HealthPathways Directory
<b>19,416</b>	<b>4,151</b>	<b>18,881</b>	<b>4,125</b>	<b>45,808</b>

Total people contributing feedback or to pathway development



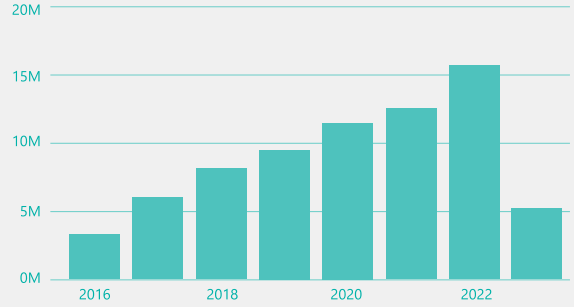
Total feedback posts



Page views in last 12 months



Total website page views



# All of Wales: a case study

## Cardiff and Vale University Health Board

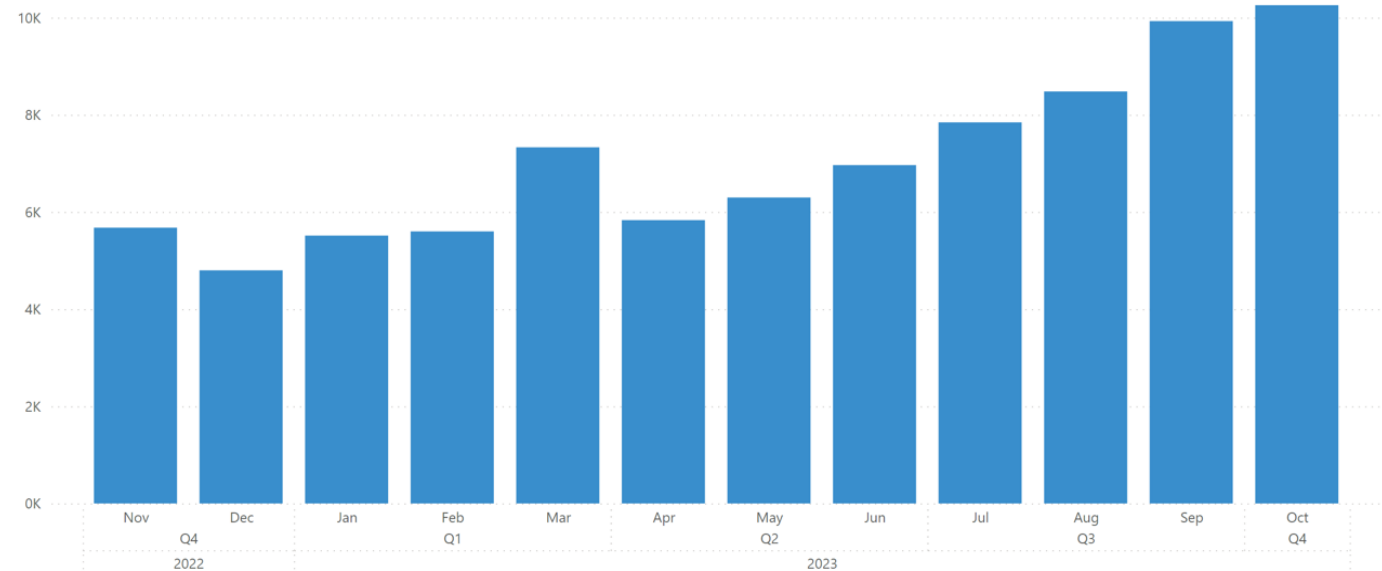
- Vanguard site in 2019
- Population of 534,756
- 56 GMS practices
- 541 GPs and 122 GP registrars
- By 2022
  - 500 localised pathways
  - 1,500 monthly users
  - 20,000 page views per month



### User engagement trend

Cardiff and Vale

Total user sessions

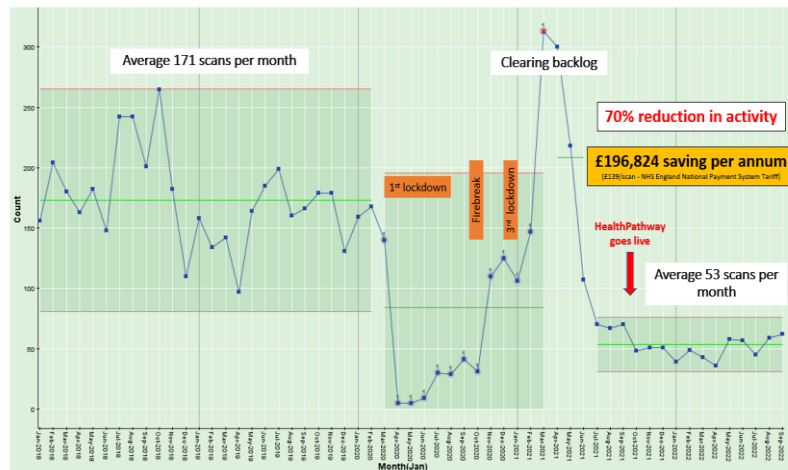


# Impact on radiology referrals of the knee, shoulder and L-spine

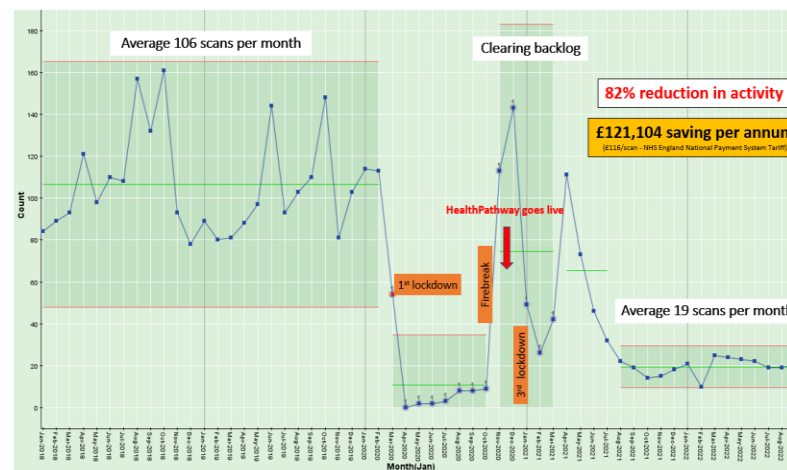
## Pre-HealthPathways: Open Access Policy for GPs

- MRI /yr: >2000 L-Spine >1200 Knee (27% of all scanning capacity)
- U/S /yr: >1300 Shoulders
- Only 6% of scans made a difference
- Most patients who had a scan were referred anyway

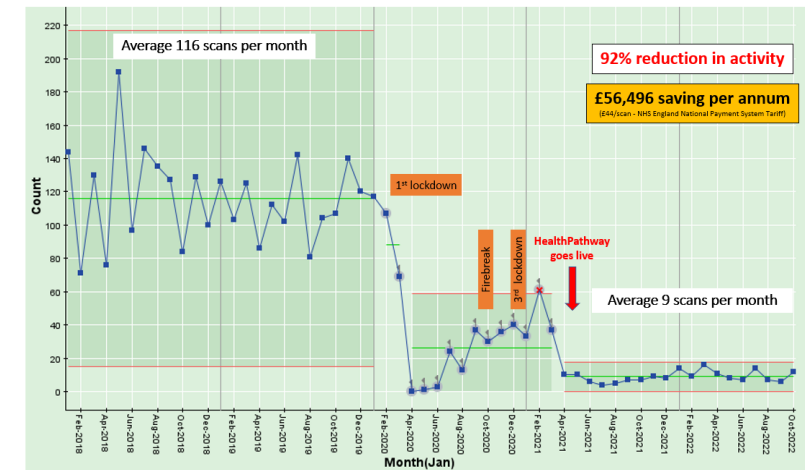
MRI Lumbar Spine – Scans undertaken (Jan 2018 – Sept 2022)



MRI Knee – Scans undertaken (Jan 2018 – Sept 2022)

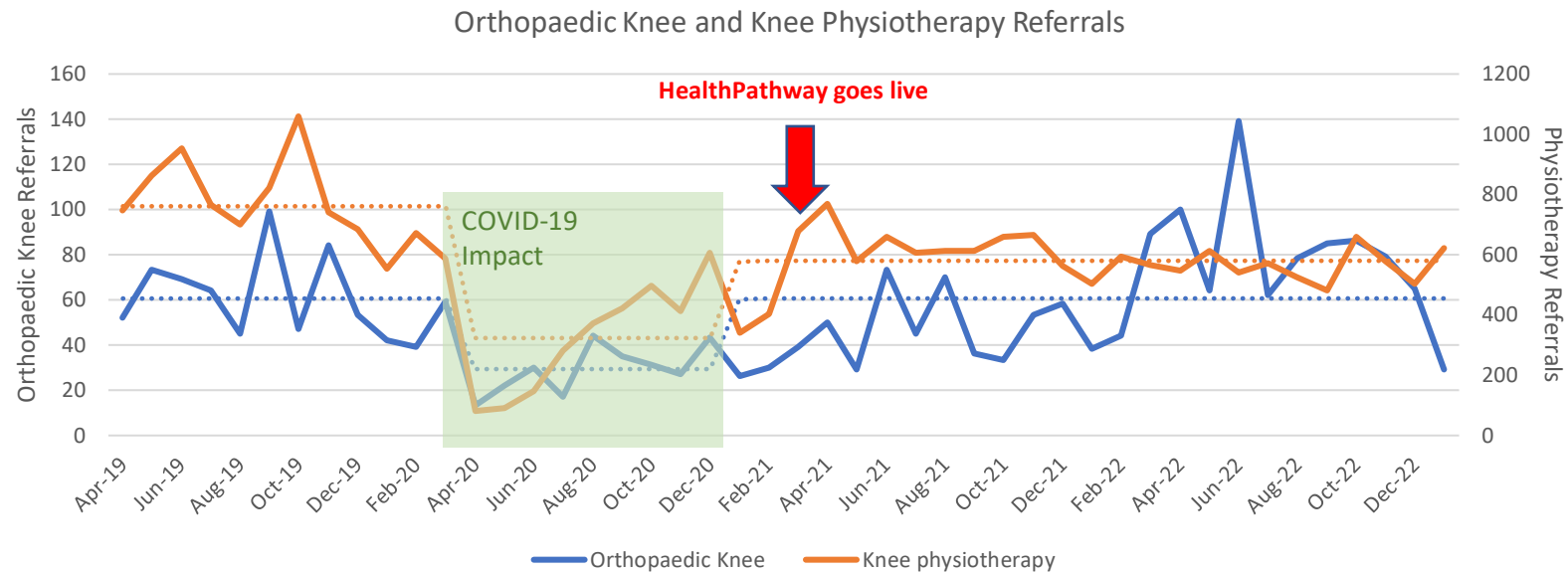


U/S Shoulders – Scans Undertaken (Jan 2018 – Oct 2022)



## Post-HealthPathways: No Open Access

- Localised Best practice guidance pathways by condition
- MSK radiology providing *ConsultantConnect* support by phone



- Freed diagnostic capacity supported COVID recovery
- Theoretical saving of £374,424 per year on diagnostic imaging
- Physio referrals now increasing with little change in T&O

# Interface GP triage & advice of diabetes referrals

## Pre-Interface GP:

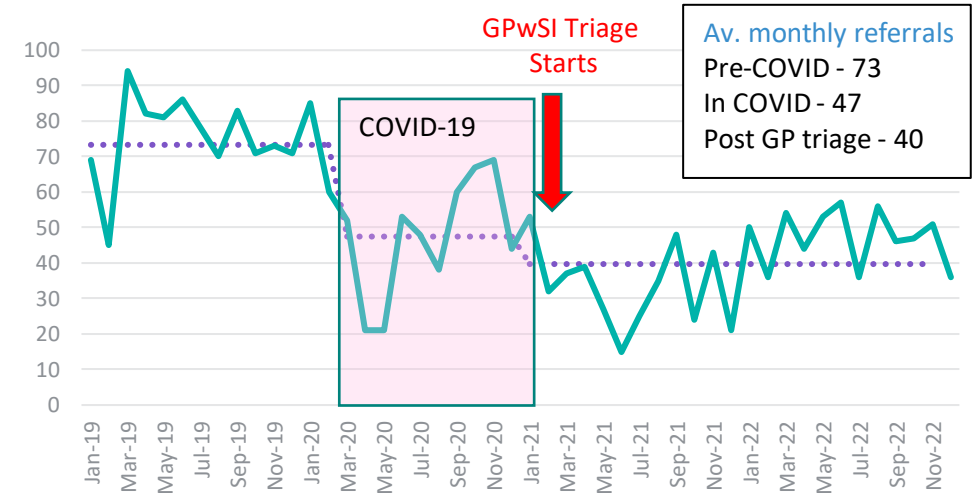
- 78% of referrals seen by consultants in secondary care clinics
  - “Return with advice” rates of 18%
  - 4% seen by Diabetic Specialist Nurses

## Post-Interface GP:

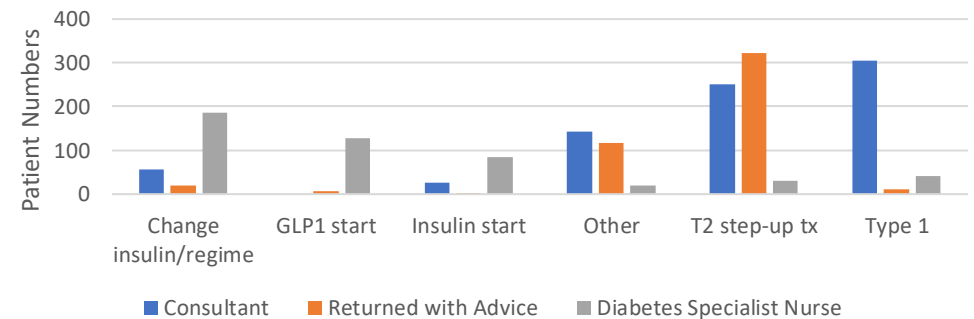
- HealthPathways* in Place
- 47% now seen by consultants
  - “Returned with advice” rates now 23%
  - 23% now seen by Diabetic Specialist Nurses - **>5 fold increase**
  - 5% of patient now see a dietician

- 270 consultant appointments freed up
- Specialists see cases only they can see
- Annual cost benefit - £45,090**

Accepted secondary care referrals



Conditions Breakdown



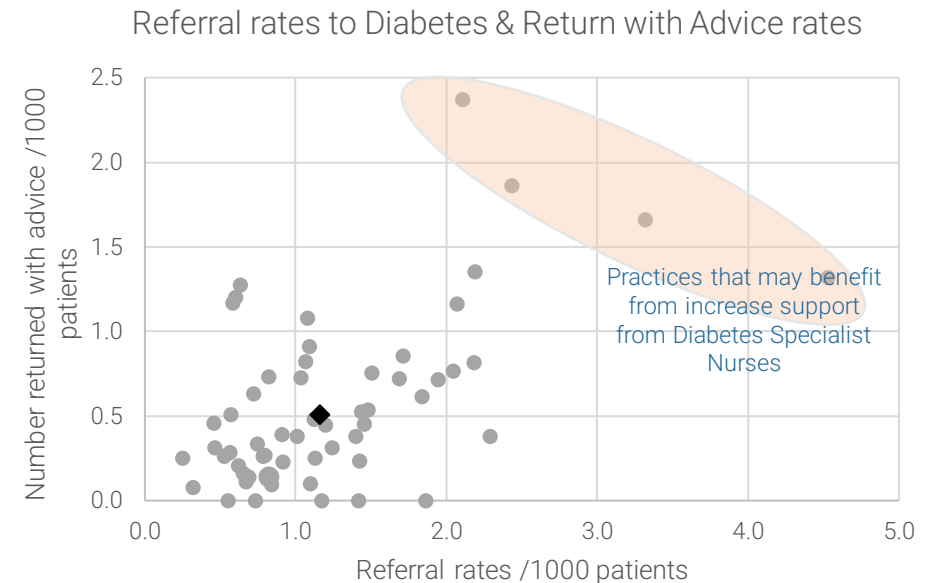
# Embedding Interface GP and HealthPathways

## Identifying Missing Clinical Pathways

- New pathways identified and created uniquely for CAV:
  - Lateral Hip Pain
  - Continuous monitoring devices in diabetes care
  - Vasectomies

## Supporting outliers

- By comparing referral rates of practices across CAV outlying practices can be identified:
  - Targeted Support & Education
  - Improved referral quality
  - Reduced administrative burden on practices
- Potential to reduce health inequalities as additional services can be targeted at areas with higher referral rates





# HealthPathways are the Foundation on which to Build the System

---

## HealthPathways makes it possible to ...

- Have a single version of the truth across the whole Health Board
- Build relationships between primary and secondary care

## HealthPathways enables

- Always Up-to-date local guidance
- Referral Data collection at condition (referral pathway) level
- Remote Advice and Guidance (e.g. *ConsultantConnect*)
- Interface GPs to be embedded in secondary care
  - Triage
  - Referral Feedback
  - Advisory to Service
  - Education
- Referral Letter Quality Improvement Scheme (LES)
- Welsh Legislation (GMS and DES)
- Service Transformation

---

This is how we do things  
around here, today...

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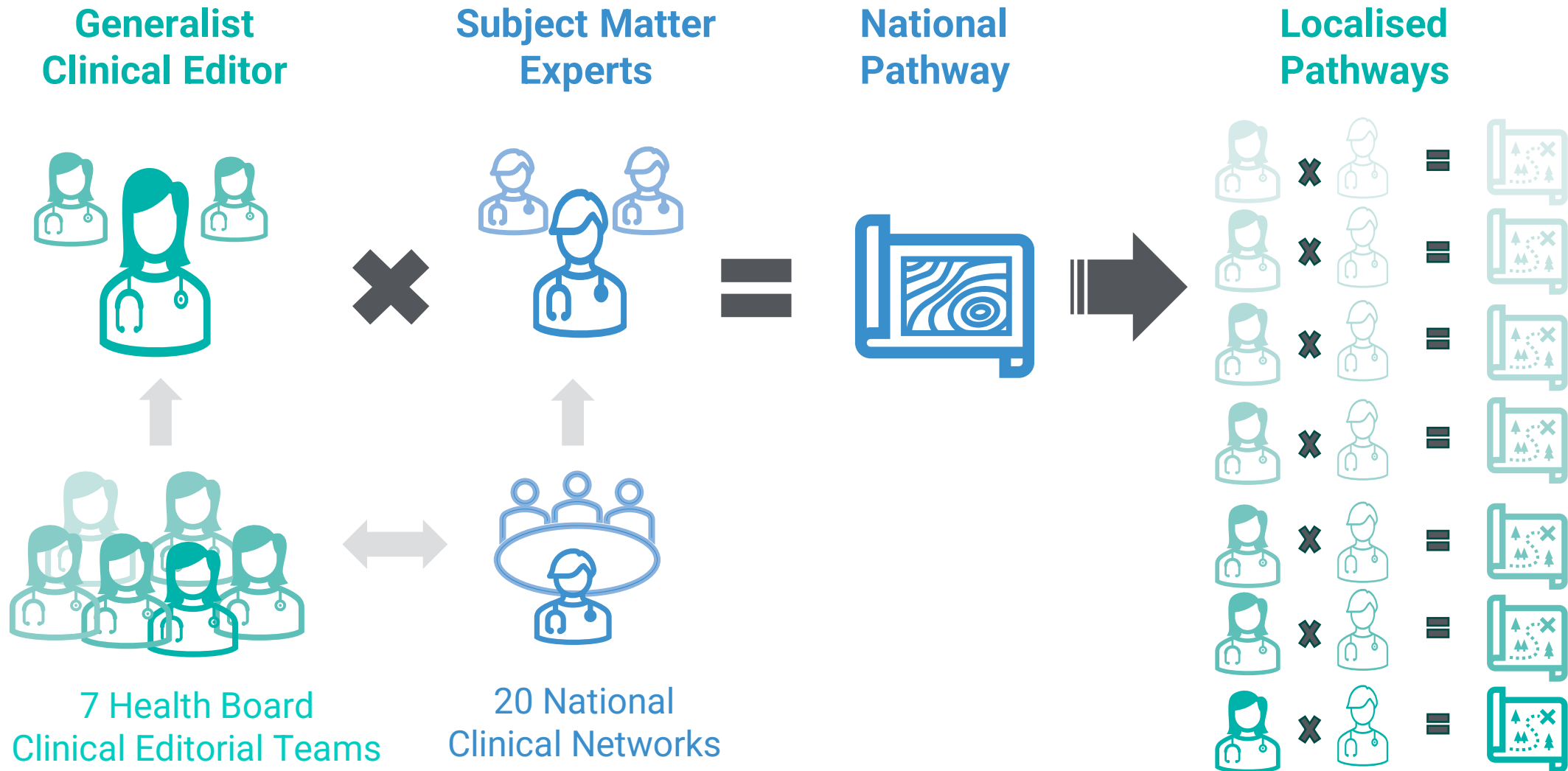
# All of Wales: a case study

- “A single version of the truth for Wales”
- 2023: Decision made by Welsh Government and NHS Wales to procure **Community HealthPathways** as a national programme to support all 7 Health Boards with management of patient flow
- 5 year contract
- Supported and enabled by a change in Unified GMS Contract 1st October 2023

First devolved nation to contractually require all GPs to manage every patient “*after consideration of relevant nationally agreed clinical guidance or pathways*”



# National pathway sharing



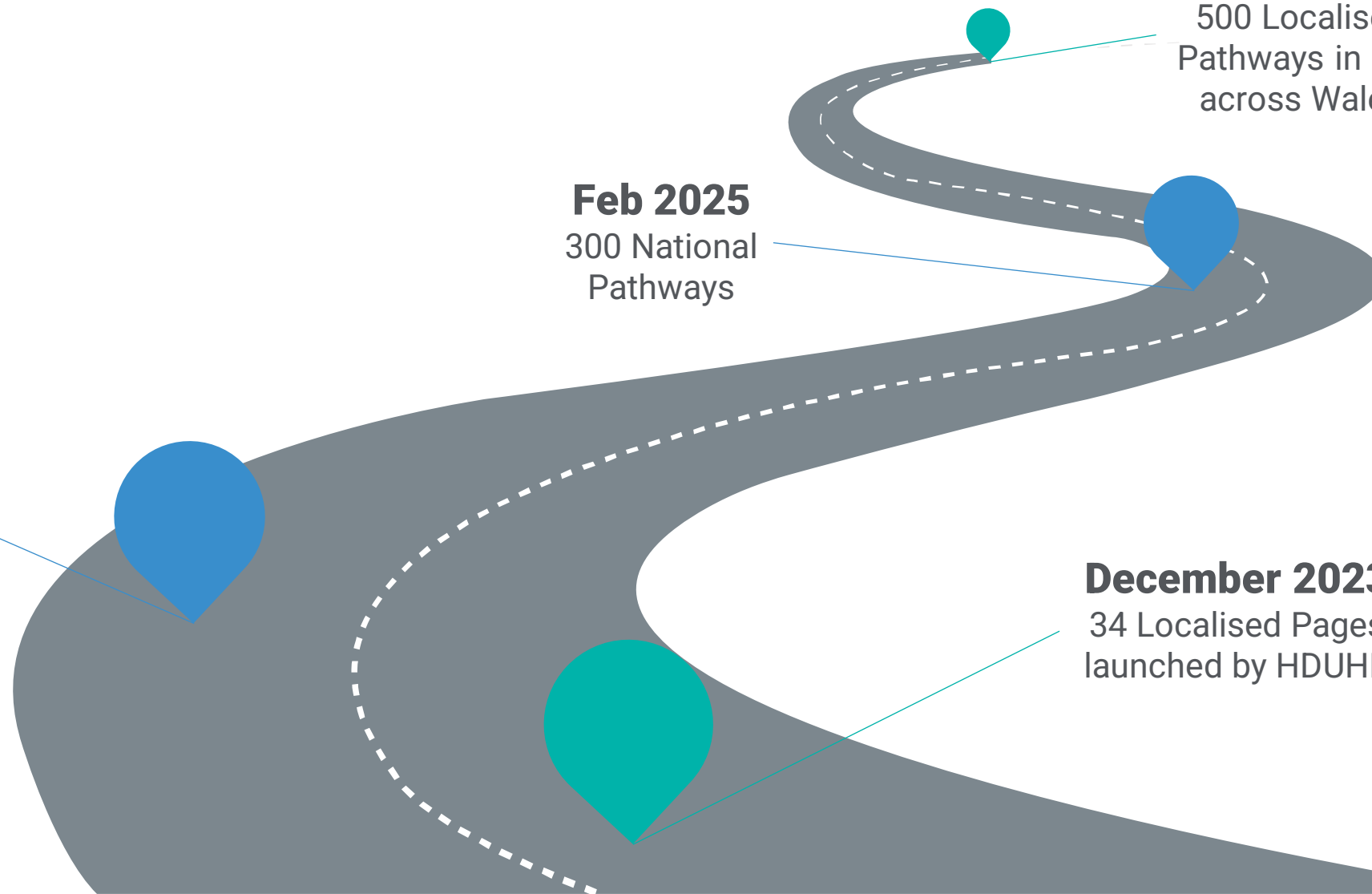
# Pathway sharing milestones

**Feb 2024**  
100 National  
Pathways

**Feb 2025**  
300 National  
Pathways

**December 2023**  
34 Localised Pages  
launched by HDUHB

**Feb 2026**  
500 Localised  
Pathways in use  
across Wales



# Pathway Progress

ALL-WALES PATHWAYS DEVELOPMENT, 5 FEBRUARY 2024



# Pathway usage

## Cardiff & Vale UHB

1 Oct 2023 - 31 Dec 2023

Rank	Generic page name	Pageviews
1	Faecal Immunochemical Test (FIT)	828
2	Abnormal Liver Function Tests	706
3	Headaches in Adults	580
4	Hypertension	507
5	Vitamin D Supplementation	440
6	Menopause Hormone Therapy (MHT)	376
7	Haematuria	356
7	Urinary Incontinence in Women	356
9	Dyspepsia and Reflux	344
10	Back Pain	341
11	Neck Lumps in Adults	340
12	Hyperlipidaemia	330
12	UTI in Adults	330
14	Polycystic Ovarian Syndrome (PCOS)	312
15	Rhinosinusitis	308
16	Spirometry	295
17	Acne	289
18	Non-acute Asthma in Adults	287
19	Diabetes Medications	278
19	Menopause	278

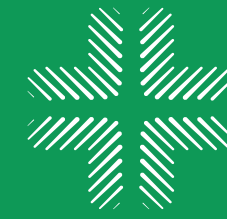
## All Health Boards

1 Oct 2023 - 31 Dec 2023

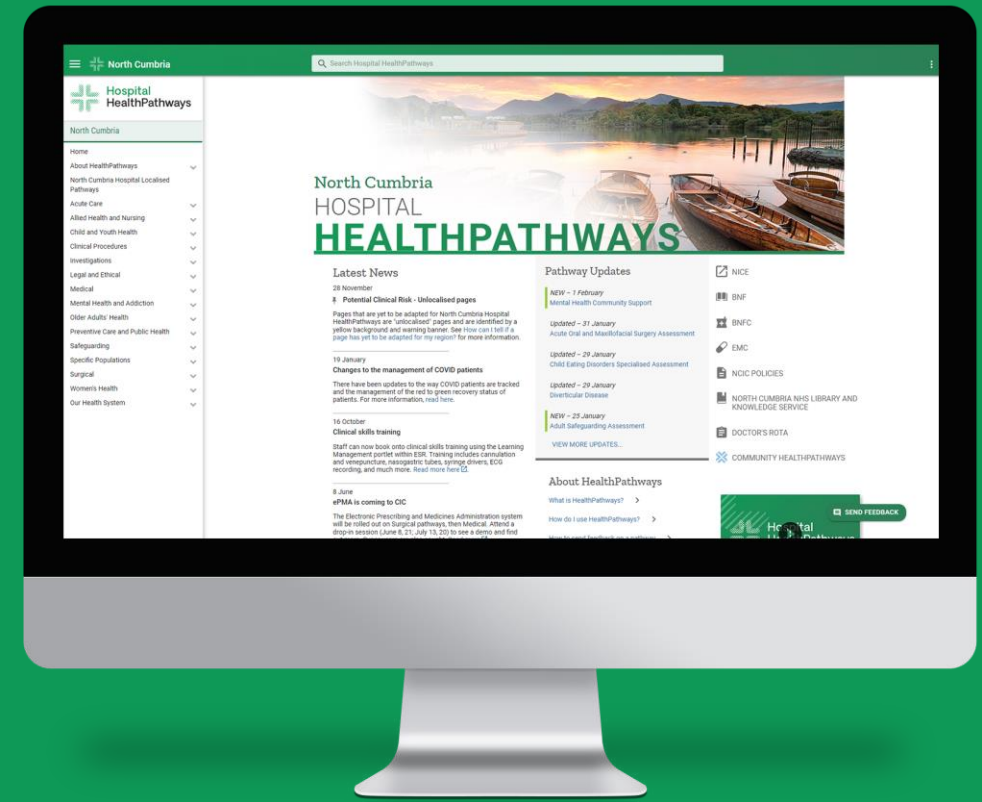
Site	Pageviews	Sessions	Users*	New users**
Aneurin Bevan	37	16	8	1
Betsi Cadwaladr	2	1	1	0
Cardiff and Vale	86,436	29,074	5,147	2,028
Cwm Taf Morgannwg	104	54	20	4
Hywel Dda	3,912	643	303	239
Swansea Bay	41	20	10	2
<b>Total</b>	<b>90,532</b>	<b>29,808</b>	<b>5,489</b>	<b>2,274</b>

# Completing the journey

- As a result of demand from secondary care clinicians Community HealthPathways sister platform, **Hospital HealthPathways** was developed
- Utilising the same methodology and approach as Community HealthPathways, Hospital HealthPathways provides secondary care clinicians with access to a suite of localised content that reflect the agreed pathways of care within an acute Trust
- written primarily for junior doctors, senior doctors working outside their specialty, and doctors working in non-specialty areas, such as emergency or general medicine
- It facilitates informed decisions at the point of care, promotes standardised ways of working, and supports patient flow, including early discharge to the community.



## Hospital HealthPathways



# How does it benefit systems?

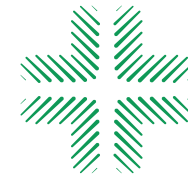


OF CLINICIANS USE  
HHP AT LEAST  
ONCE A WEEK



OF CLINICIANS USE  
HHP EVERY OR  
MOST WORKING DAYS

- Reducing variation in practice for better patient outcomes
- Reducing unnecessary diagnostic orders
- Enabling better and safer use of locums and junior doctors
- Helping patient flow within and between departments
- Improving discharge planning and transition of patients back into the community with appropriate supports



## Hospital HealthPathways

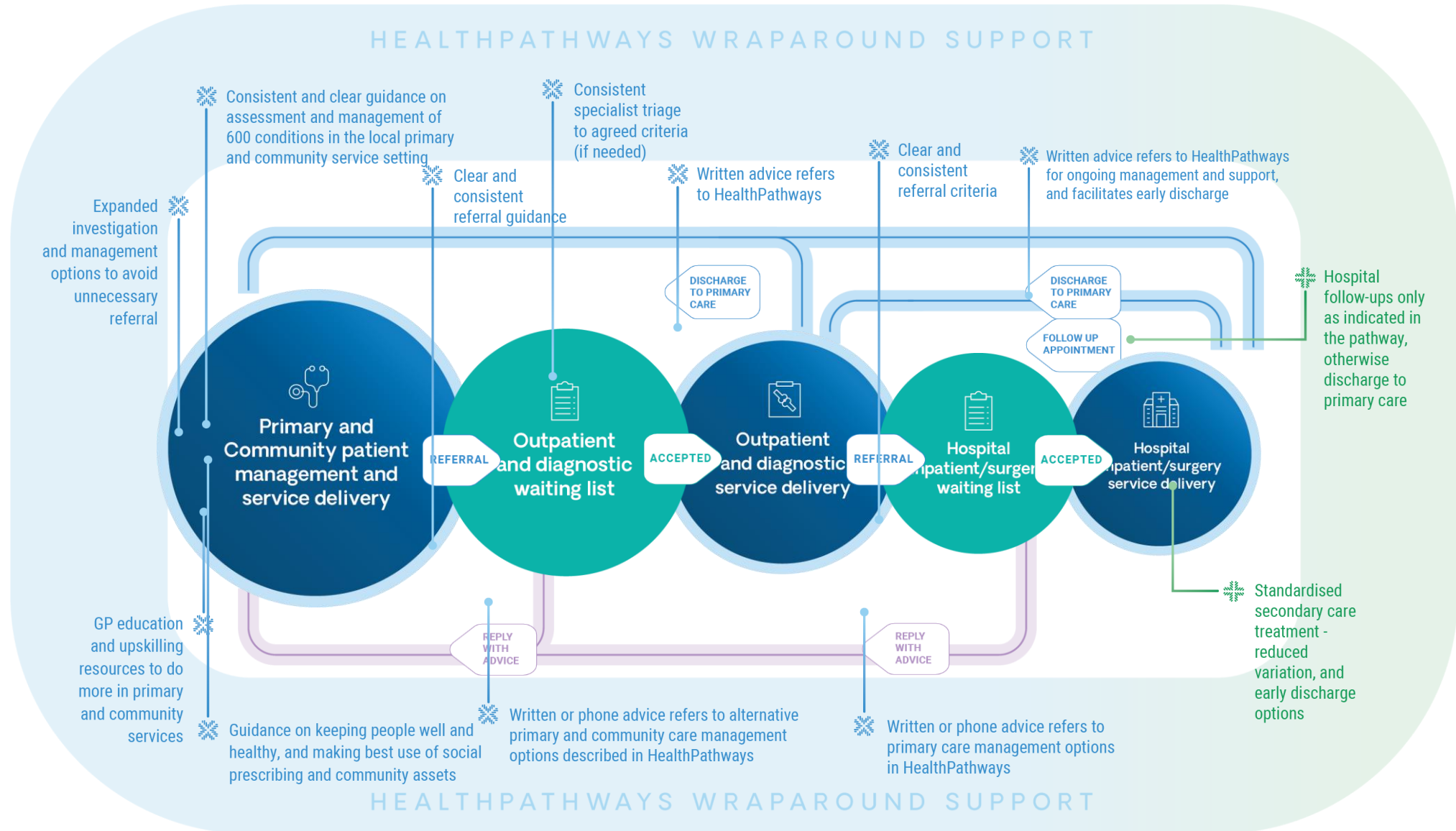


*It's an incredibly useful resource that's been invaluable in day-to-day practice, especially as a junior doctor, and especially out of regular working hours when seeking the advice of senior colleagues is potentially less easily accessible.*





# Impact across the system





What has connected?

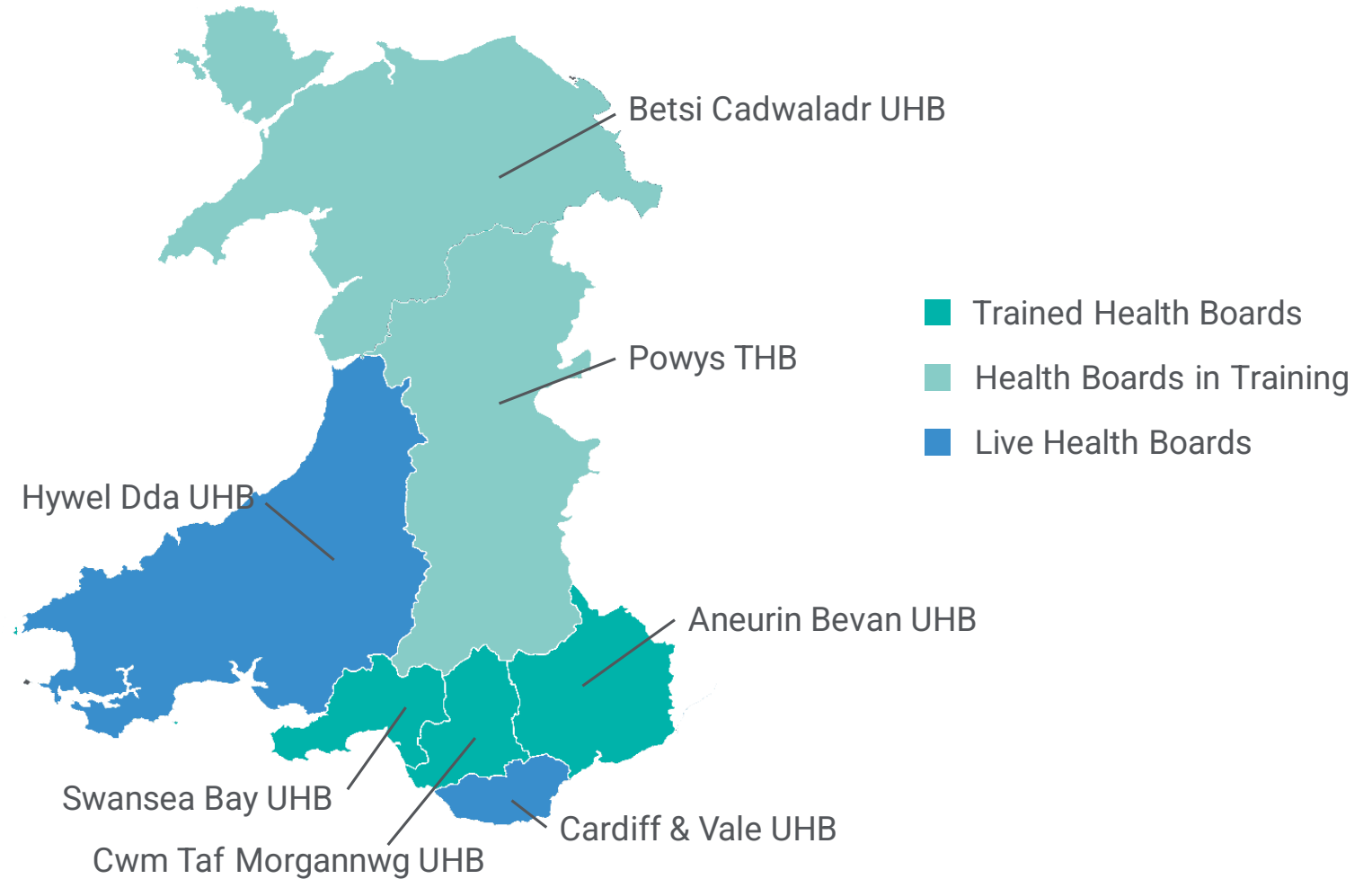


Anything else?



What needs further discussion?

## HealthPathways - an All-Wales programme



# Get in touch

## **NHS Wales**

Alastair Roeves | [alastair.roeves@wales.nhs.uk](mailto:alastair.roeves@wales.nhs.uk) | National Clinical Lead for Health & Care Pathways

## **Pathways Alliance**

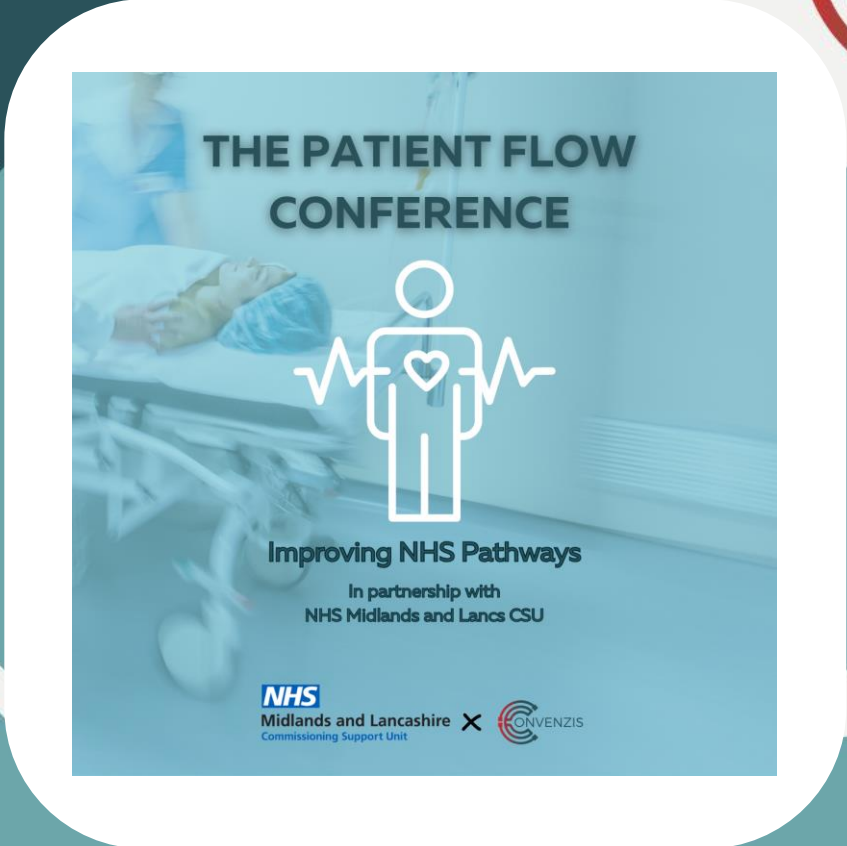
Jon Tose | [j.tose@nhs.net](mailto:j.tose@nhs.net) | Clinical Lead, Pathways Alliance

Mark Girvan | [mark.girvan@healthpathwayscommunity.org](mailto:mark.girvan@healthpathwayscommunity.org) | Director of Operations, Pathways Alliance

Tim Watts | [tim.watts@healthpathwayscommunity.org](mailto:tim.watts@healthpathwayscommunity.org) | National Programme Manager, Pathways Alliance

[www.healthpathwayscommunity.org](http://www.healthpathwayscommunity.org)





# Refreshments & Networking



## Chairs Morning Reflection



**Conor Burke**

CEO - UHUK (Urgent Health UK)



Up Next...





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Speaking Now...



**Krista Burslam-Dawe**  
Chief Operating Officer  
opto





Up Next...



**boxxe**  
Tech Solutions



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## Speaking Now...



**Liz Lees-Deutsch**  
Professor for Nursing  
Practice  
University Hospital  
Coventry and  
Warwickshire NHS  
Trust and Coventry  
University



**Roz Young**  
Assistant Director of  
Nursing  
NHSE Midlands

# Developing Criteria Led Discharge in Hospital Settings: Opportunities and Characteristics



**Liz Lees-Deutsch**

Professor for Nursing Practice

Coventry University (CHC) and University Hospitals  
Coventry and Warwickshire NHS Trust (CfCE)

**Rosslyn Young**

Associate Director of Nursing and Quality

Professional and System Development, NHS  
England Midlands

By the end of our talk today we will have:

1. Framed our CLD work in relation to the national landscape
2. Defined what CLD is and how it can help patient flow
3. Provided a quick trot through of our theoretical foundation
4. SPEED: Quantified the opportunities for developing CLD in the Midlands
5. SPEED: Quantified the typical characteristics of patients suitable for CLD
6. Shared key messages regarding engagement and implementation of CLD

# The National Landscape

- SAFER bundle
- Hospital Discharge Policy
- Discharge to assess pathways
- Royal college of Physicians: modern ward rounds work
- Midlands MADE
- 100 day challenge 2022
- **Improve ambulance response and A&E waiting times (23/24)**

## The five core components of the SAFER care bundle are:

- S** **senior** review. All patients will have a senior review before midday by a clinician able to make management and discharge decisions.
- A** **all** patients will have an expected discharge date (EDD) and clinical criteria for discharge (CCD), set by assuming ideal recovery and assuming no unnecessary waiting.
- F** **flow** of patients to commence at the earliest opportunity from assessment units to inpatient wards. Wards routinely receiving patients from assessment units will ensure the first patient arrives on the ward by 10am.
- E** **early** discharge. Thirty-three per cent of patients will be discharged from base inpatient wards before midday.
- R** **review**. A systematic multidisciplinary team review of patients with extended lengths of stay, with a clear 'home first' mind set.



# What is Criteria Led Discharge?

*‘Criteria led discharge is a process where the **clinical** parameters for a patient’s discharge are clearly defined. The Consultant leading the care and the multi-professional team must agree the clinical criteria; these may be standardised for particular procedures or conditions, however must always be adapted to provide person centred discharge.*

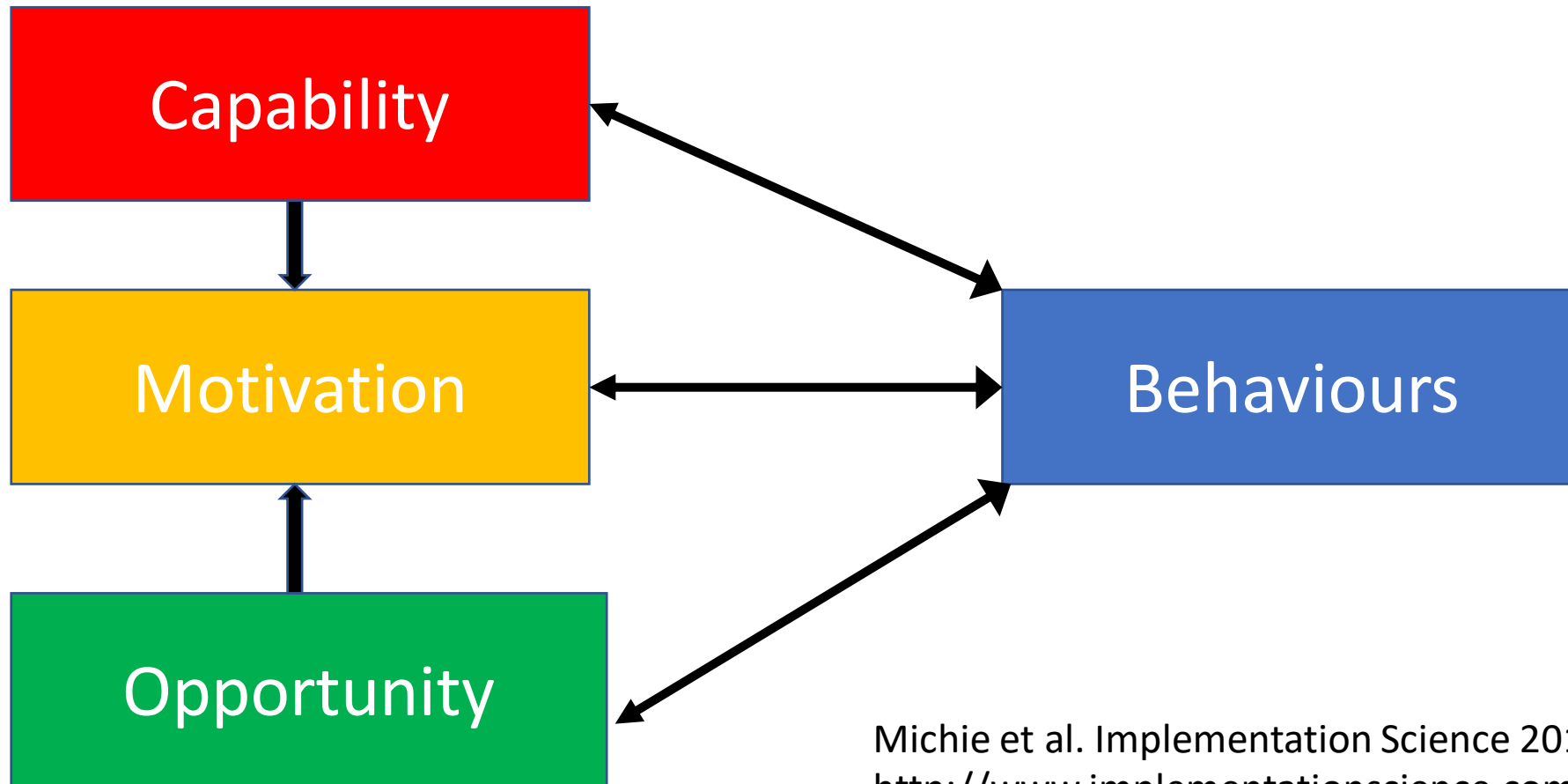
*Clinical Criteria can be determined in accordance with; a care pathway, a clinical protocol or guidance (condition specific) or a bespoke discharge plan.*

*The patient should be actively involved in the process of criteria led discharge. The patient's discharge can then be facilitated by a competent member of staff once those the criteria have been met’.*

A Systematic Review of Criteria Led Patient Discharge. 2018; J Nurs. Care Qual.

Lees-Deutsch L, Robinson J.

# Optimization of Criteria Led Discharge: The COM-B System

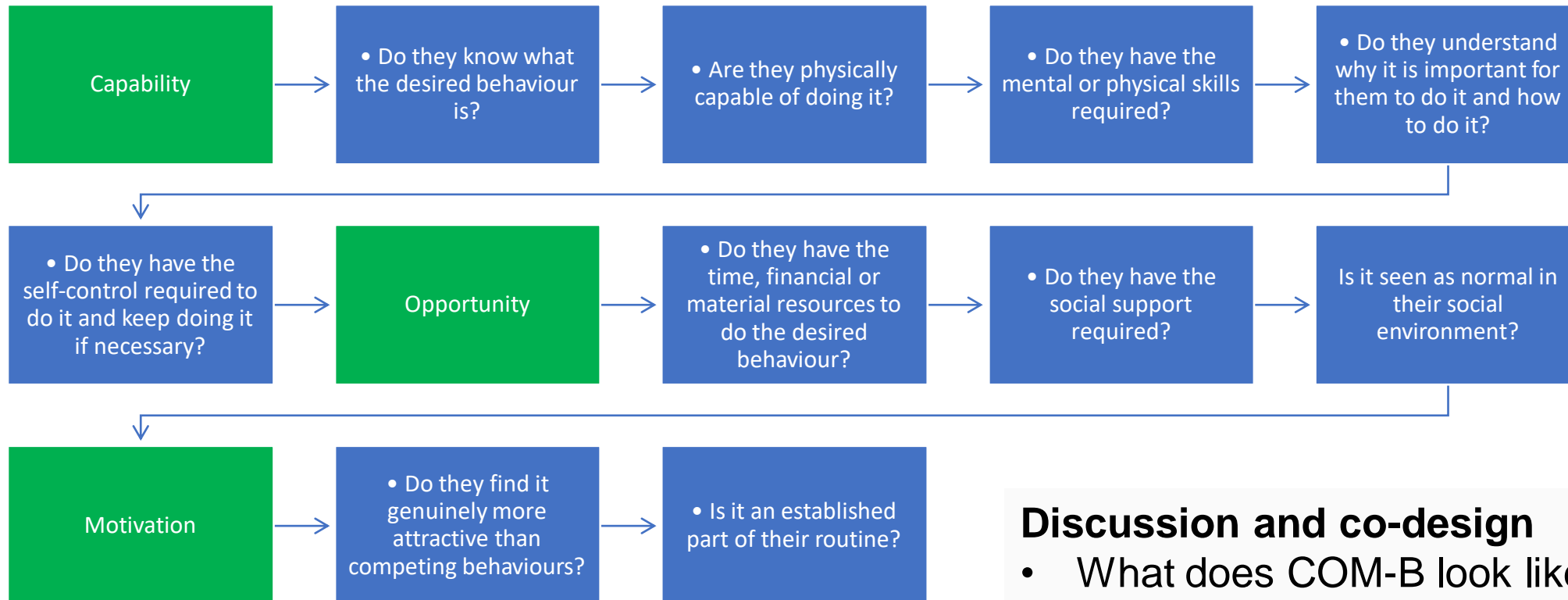


Michie et al. Implementation Science 2011, 6:42  
<http://www.implementationscience.com/content/6/1/42>  
2 (23 April 2011)



# Capability, Opportunity and Motivations [COM-B]

The [COM-B model](#) recognises that for any behaviour to be enacted people must have the capability, and the opportunity, and they must be more motivated to do that behaviour than anything else.



## Discussion and co-design

- What does COM-B look like for your organisation?

# Capabilities for Criteria Led Discharge

Global Systematic  
Review of Evidence  
(2018)

Developed National  
Competencies  
(Updated 2021)

National CLD Policy  
(2021)

Ward Managers  
Toolkit

Standard Operating  
Procedure  
(2021/2022)

Streaming Patients  
and Discharge  
Categorization

Patient Selection  
Process (Eligibility)

# Opportunities and Motivations before Surveys

Create secondment opportunities to lead

Highly selective – clinical areas with good leadership

Work closely with your senior clinicians....

Areas with ACPs, ANPs and N.M.Prescribers work well

Map current discharge process [ward level]

Align patients into D<sub>2</sub>A pathways [scale of potential]

Short term - exclude complexity [pathways 2 and 3]

Identifying condition groups – always in question!



What site are you reporting from (e.g. Lancaster Royal Infirmary)	What specialty ward is the patient located on (e.g. geriatric, cardiac, acute medicine, orthopaedic)	Other -specialty ward	What age range does the patient fall into	What was the patient's route of admission	Primary reason for admission (e.g. fall, chest infection, heart attack, stroke, overdose etc)	What primary specialty is the patient under?	What was the patient's length of stay (in days)?	Is the patient suitable for CLD (if you select YES go to L, if NO complete J)	If the patient is not suitable for CLD, why?	Other, why?	Who is the CLD Lead?	What discharge pathway is the patient on?	Does the patient meet criteria for discharge today?
UH	General Surgery		25-64	Emergency	Abdominal pain resulting in iliotomy	General Surgery	8-14	No	Daily consultant review occurring			0 (Usual place of residence)	No
UH	General Surgery		70-74	Elective	elective iliotomy	General Surgery	22+	Yes			ACP	0 (Usual place of residence)	No
UH	General Surgery		25-64	Elective	elective iliotomy	General Surgery	4-7	No	Complex patient			0 (Usual place of residence)	No
UH	General Surgery		25-64	Elective	elective nephrothotomy	General Surgery	4-7	Yes			ACP	0 (Usual place of residence)	No
UH	General Surgery		75-79	Elective	elective appendectomy	General Surgery	1-3	Yes			Ward Nurse	0 (Usual place of residence)	Yes
UH	General Surgery		25-64	Elective	elective thyroidectomy	General Surgery	1-3	Yes			Ward Nurse	0 (Usual place of residence)	Yes
UH	General Surgery		70-74	Elective	elective radical prostatectomy	General Surgery	1-3	Yes			Ward Nurse	0 (Usual place of residence)	No
UH	General Surgery		70-74	Elective	elective radical prostatectomy	General Surgery	1-3	Yes			Ward Nurse	0 (Usual place of residence)	No
UH	General Surgery		25-64	Elective	elective hemi thyroidectomy	General Surgery	1-3	Yes			Ward Nurse	0 (Usual place of residence)	No
UH	General Surgery		75-79	Elective	elective laparotomy	General Surgery	1-3	Yes			ACP	0 (Usual place of residence)	No
UH	General Surgery		85-89	Elective	elective laparotomy	General Surgery	1-3	Yes			Ward Nurse	0 (Usual place of residence)	Yes
UH	General Surgery		25-64	Elective	elective mastectomy	General Surgery	1-3	Yes			Ward Nurse	0 (Usual place of residence)	Yes
UH	General Surgery		25-64	Elective	elective hysterectomy	General Surgery	1-3	Yes			Ward Nurse	0 (Usual place of residence)	Yes
UH	General Surgery		85-89	Elective	elective biopsy of chest lesion	General Surgery	1-3	Yes			Ward Nurse	0 (Usual place of residence)	Yes
UH	General Medicine		80-84	Emergency	community acquired pneumonia	General Medicine	1-3	Yes			AHP - OT/PT	0 (Usual place of residence)	Yes
UH	General Medicine		25-64	Emergency	fall secondary to erratic BMs	General Medicine	8-14	No	Complex patient			0 (Usual place of residence)	
UH	General Medicine		75-79	Emergency	flare up of gout	Older Persons Care	22+	No	Complex patient			0 (Usual place of residence)	
UH	General Medicine		25-64	Emergency	possible new diagnosis of sarcoidosis	General Medicine	8-14	No	Awaiting inpatient diagnosis			0 (Usual place of residence)	
UH	General Medicine		75-79	Emergency	Axi and LRTI	General Medicine	1-3	Yes			AHP - OT/PT	0 (Usual place of residence)	
UH	General Medicine		25-64	Emergency	new type 1 diabetes	General Medicine	4-7	Yes			Ward Nurse	0 (Usual place of residence)	



Age	Admission	Specialty	LOS	V/N	Not for CLD	CLD Lead	Discharge pathway
0-24	Emergency	Acute Medicine	1-3	Yes	Awaiting medical decision making	Nurse	0 (Usual place of residence)
25-64	Elective	Acute Surgery REMOVE	4-7	No	Awaiting therapy decision making	ACP	1 (Usual place of residence with interim support)
65-69		Cardiology	8-14		Complex patient requiring in patient	AHP	2 (Rehab/re-enablement)
70-74		Gastroenterology	15-21		Awaiting daily consultant review	Doctor (Junior)	3 (Complex support)
75-79		General Surgery	22+		Discharge arrangements incomplete	Other HCP	
80-84		Infectious Diseases			DOLS REMOVE		
85-89		Older Persons Care			Last hours of life		
90 and over		Ophthalmology			On going treatment needs REMOVE		
		Oncology			Other - Enter in next column		
		Respiratory Medicine			Risk of acute life threatening deterioration		
		Trauma and Orthopaedics			Acute functional/ neurological impairment in excess of home/community care		
		Urology					

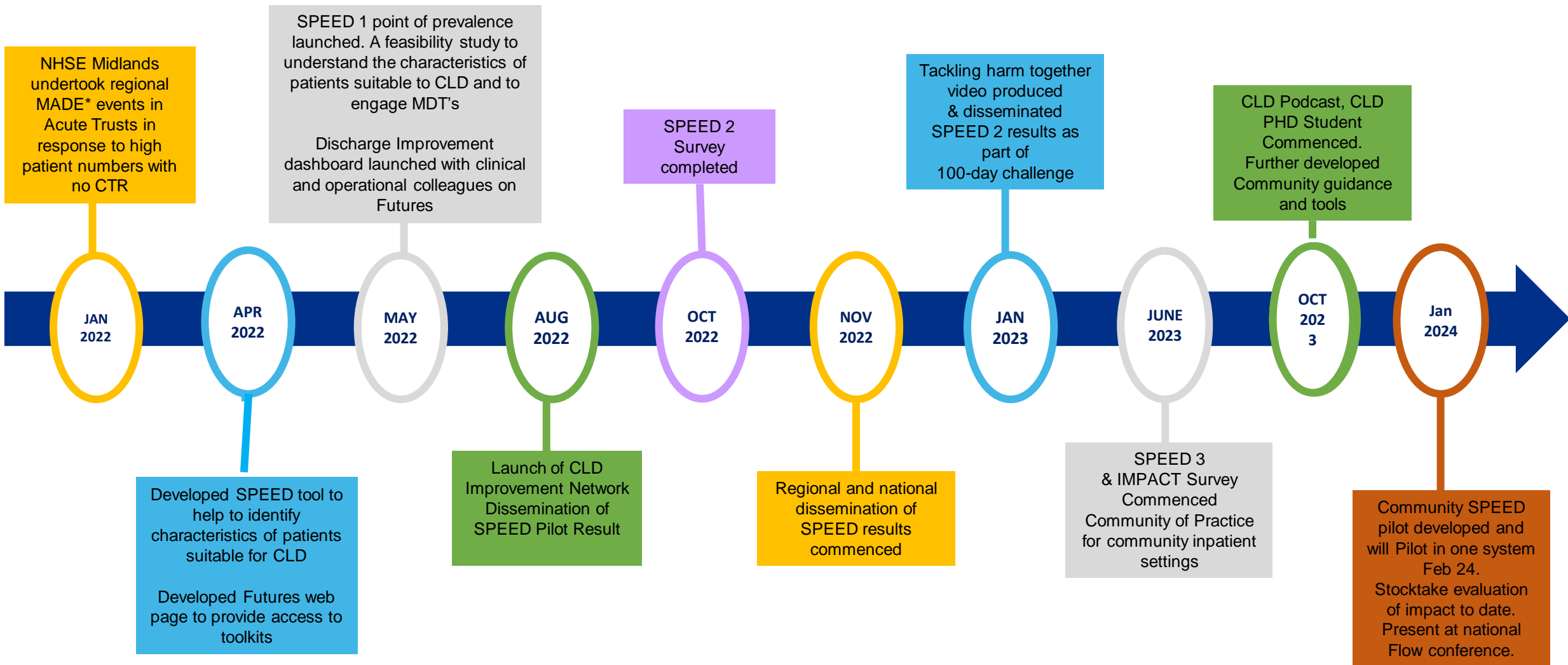
# Development of a Point Prevalence Tool Midlands

## How did we do it?

# Words of Wisdom / Caution



# Summary of Midlands Criteria Led Discharge Work



**Abbreviation key**  
 No CTR = No Criteria to reside  
 MADE = Multi Agency Discharge Event  
 MDT= Multi Disciplinary Team  
 SPEED= Selecting patients for effective and efficient discharge

# Network Membership

Network membership is well established and stretches across the whole Midlands and other parts of England as far south as Cornwall

Network events are now accessible with a QR code – you do not need to be a member to join

Established a collaborative with NHSE East of England and the NHSE Midlands and a Tacking Harm Together workstream to share learning and expertise.

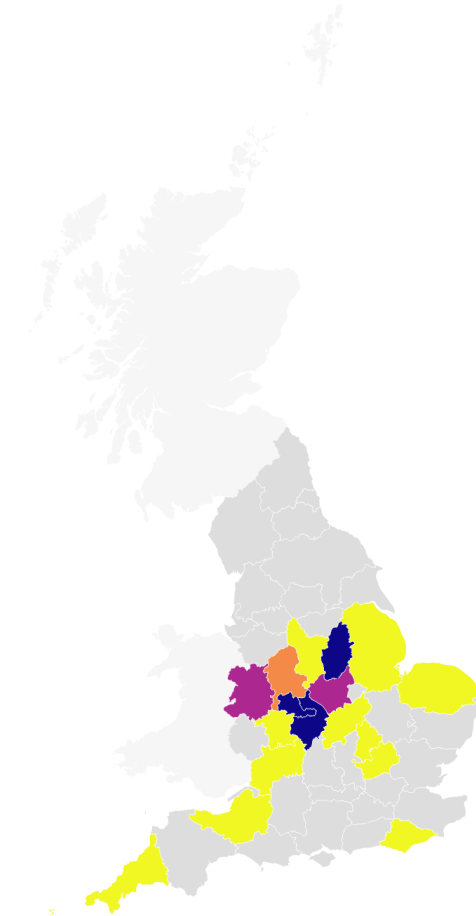
A NHS Futures platform established for members to access tools and support and toolkits have been linked to NHSE and ECIST work

Members present practice improvements at the network meetings and seek peer support

Built improvement methods education into our network because our network members said it would add value

## Network Membership

■ < 5 ■ 5-10 ■ 10-15 ■ ≥ 15



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# CRITERIA LED DISCHARGE (CLD) SPEED

## Point of Prevalence Surveys

### SPEED is voluntary

- Participation has grown (snowball effect)
- 16 systems (all systems in the Midlands participated)
- 82 wards
- 17 Specialties
- >2000 touch points with patients
- Approx > 246 staff participated
- Average 47% opportunity

Locations taking part in CLD pilots (May 2022 - June 2023)

■ Acute Trusts ■ Community & MH Trusts



Created with Datawrapper

### IMPACT Survey

- 83% said SPEED helped them to understand characteristics of patients suitable for CLD
- 75% said it helped support the development of CLD in their organization
- 100% effective implementation is multifaceted. however, identified clinical leadership is identified as the most important

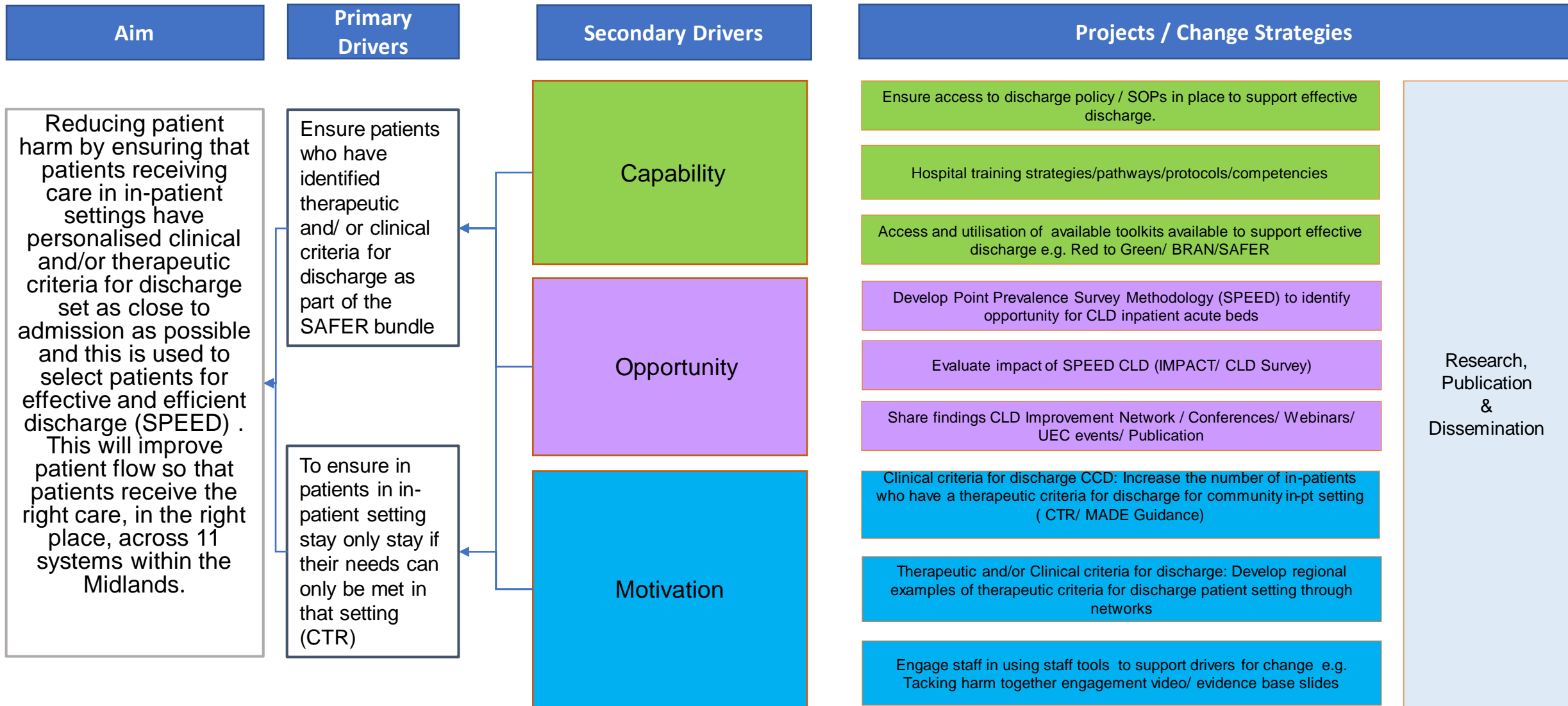




# Is there opportunity for CLD?

Suitable for CLD?	SPEED Round 3: June 2023		SPEED Round 2: October 2022		SPEED Round 1: May 2022		Total (all rounds)	
	Number	%	Number	%	Number	%	Number	%
Yes	442	41.4%	437	52.3%	143	52.8%	1022	47.0%
No	590	55.3%	396	47.4%	111	41.0%	1097	50.5%
No Response / Other	35	3.3%	3	0.3%	17	6.3%	55	2.5%
<b>Total</b>	<b>1067</b>	<b>100.0%</b>	<b>836</b>	<b>100.0%</b>	<b>271</b>	<b>100.0%</b>	<b>2174</b>	<b>100.0%</b>

# Criteria Led Discharge January 2022 – December 2023



# Key Implementation and Engagement Messages

## National

- To embed CLD, policy needs to stipulate that all patients in in-patient or virtual ward settings must have documented clinical and therapeutic criteria for discharge (CCD) or transfer to the next setting.
- Digital systems will support effective contemporaneous CCD and TCD to facilitated CLD

## Regional

- Disseminate impact of SPEED at conferences, podcasts and publication

## System

- Provide clinical sponsorship forward based Improvements
- Disseminate SPEED
- Consider setting up improvement collaboratives for CLD as part of Urgent Care transformation

## Providers

- Provide clinical sponsorship for ward based Improvements
- Disseminate SPEED results
- A SPEED off the shelf toolkit will be available on NHS Futures (Link) from March 2024 for use in acute settings .



Selecting Patients for Efficient and Effective Discharge: A Retrospective Case Note Analysis [GF0493]

Developing the SPEED tool for the Selection of Patients for Efficient and Effective Discharge: A Feasibility Study [GF0482] (*in submission*)

**PhD Students:**

Emma Brangwin – Contact [brangwine@uni.coventry.ac.uk](mailto:brangwine@uni.coventry.ac.uk)

Bushra Zaidi Batool – Contact [Zaidib@uni.coventry.ac.uk](mailto:Zaidib@uni.coventry.ac.uk)



Up Next...



ALCIDION



## Slido

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SCAN ME



# Lunch & Networking



## Chairs Afternoon Address



**Conor Burke**

CEO - UHUK (Urgent Health UK)





Up Next...





## Slido

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



**SCAN ME**



Speaking Now...



**Bill Kloes**

Chief Operating Officer  
Navenio



# Patient Flow Conference

8<sup>th</sup> February 2024

*Real-Time Indoor Location  
and Intelligent Tasking  
(RTLS 2.0)*



# Patient Flow Realities

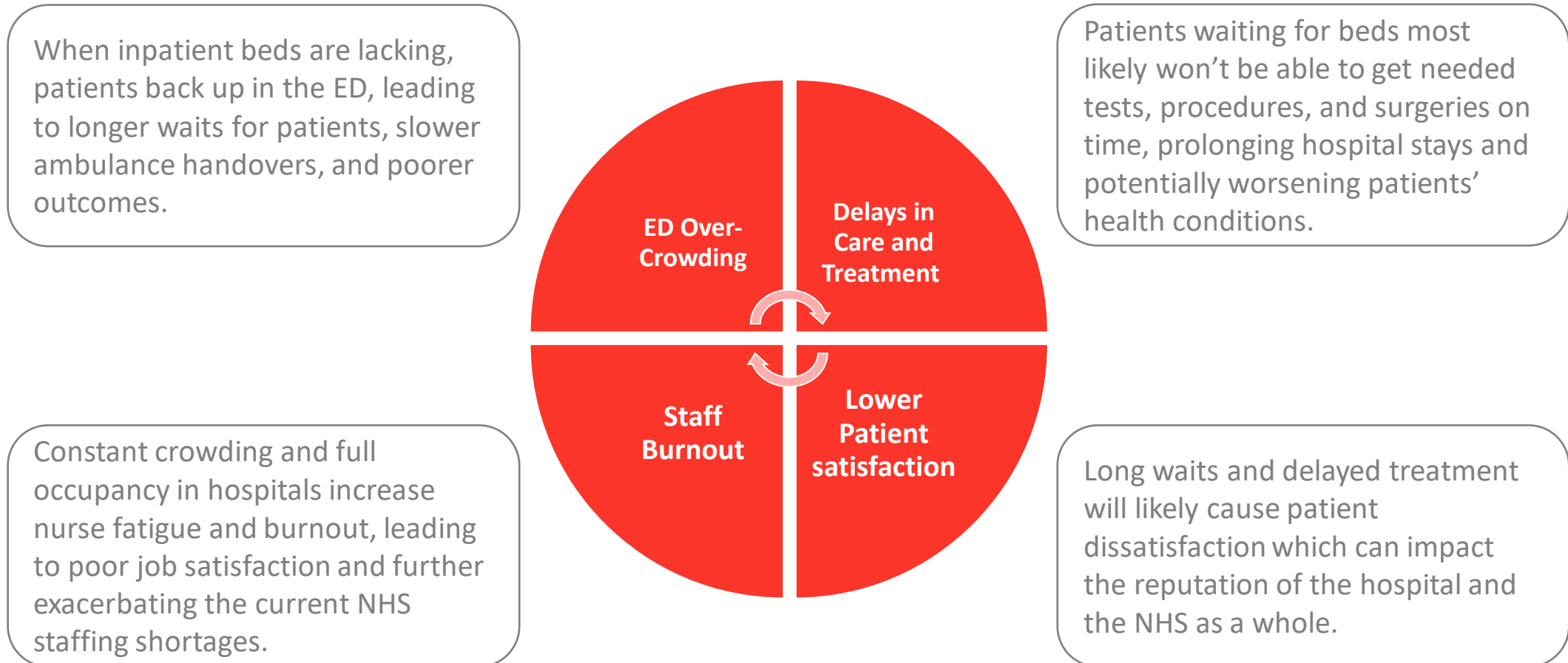


Area / Themes	Challenges / Barriers
Internal	<ul style="list-style-type: none"> <li>High work in process</li> <li>Inefficient Capacity Coordination</li> <li>Inefficient Capacity Utilisation</li> <li>Insufficient Capacity</li> <li>Large Capacity vs Utilisation Gaps</li> <li>Long Lead Times</li> </ul>
Transfer	<ul style="list-style-type: none"> <li>Inefficient Patient-Transfer Process</li> <li>Inefficient Support-Transfer Process</li> </ul>
Entry	<ul style="list-style-type: none"> <li>Changing Demand</li> <li>Unpredictable Inflow Variation</li> </ul>
Discharge	<ul style="list-style-type: none"> <li>Inefficient Outflow Process</li> </ul>
Management System	<ul style="list-style-type: none"> <li>Low Interorganisational Coordination</li> </ul>

Root Causes	
<ul style="list-style-type: none"> <li>Increasing Demand</li> <li>Insufficient Communication</li> <li>Insufficient Discharge Routine</li> <li>Insufficient Facilities</li> <li>Suboptimal Facility Layouts</li> <li>Insufficient Operational Planning</li> <li>Insufficient Transfer Coordination</li> <li>Unpredictable Patient Problems</li> </ul>	<ul style="list-style-type: none"> <li>Lack of Ancillary Services</li> <li>Lack of Beds</li> <li>Lack of IT Functions</li> <li>Lack of Separate Tracks</li> <li>Lack of Staff</li> <li>Lack of Standards and Routines</li> <li>Medical Quality Priorities</li> <li>Random Internal Disturbances</li> </ul>

# Consequences of poor patient flow in hospitals

Poor patient flow in hospitals has wide-reaching consequences, not just for hospitals and patients, but also for the whole healthcare system



# Nurses Carry a Heavy Burden



**66%**

2/3 nurses say they 'seldom or never have the ancillary staff they need' <sup>1</sup>

**25%**

Nurses spent up to 1/4 of their time looking for medical devices <sup>2</sup>

**66%**

2/3 of nurses describe themselves as experiencing burnout <sup>3</sup>

**20+%**

Percent of time spent on support activities that could be delegated <sup>4</sup>



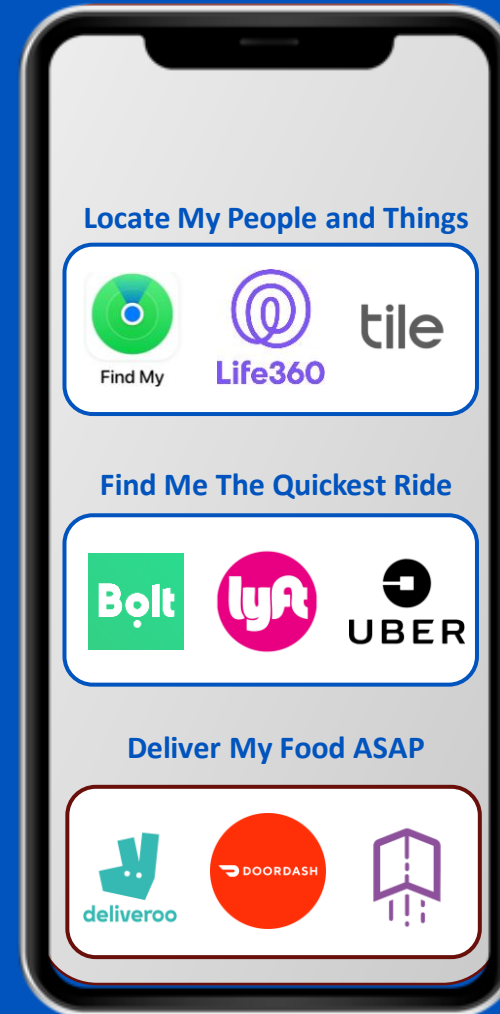
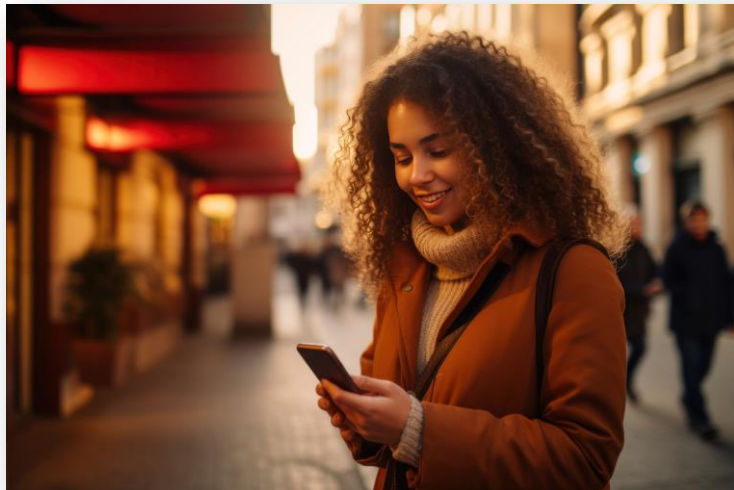
RTLS can significantly truncate patient wait times and improve room utilisation. Thus, it paves the way for **improved patient flow by enabling real-time monitoring of patient movement and equipment location.**



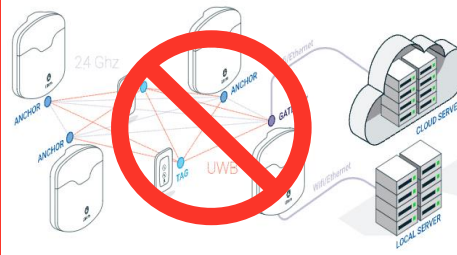
What if we could apply.....

# Location Awareness and Intelligent Tasking

.....like we experience everyday in our personal lives



# Infrastructure-Free

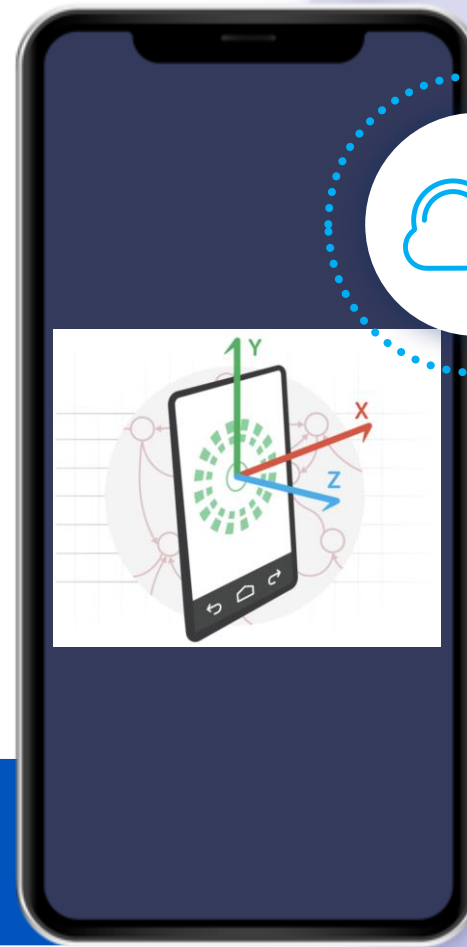


## Real-Time Location Services (RTLS) & Intelligent Tasking

### Highly Sophisticated Sensor Devices

- ✓ Proximity
- ✓ Atmospheric
- ✓ Position
- ✓ Temperature
- ✓ Ambient Light
- ✓ GPS
- ✓ Motion
- ✓ Humidity
- ✓ Magnetometer
- ✓ Accelerometer
- ✓ Gyroscope
- ✓ Hall Sensor
- ✓ Barometer
- ✓ Environmental

ROOM LEVEL ACCURACY FOR LOCATING PEOPLE AND THINGS REQUIRING ONLY A MOBILE DEVICE AND WIFI



Near immediate, ubiquitous location awareness for patients, staff and medical equipment

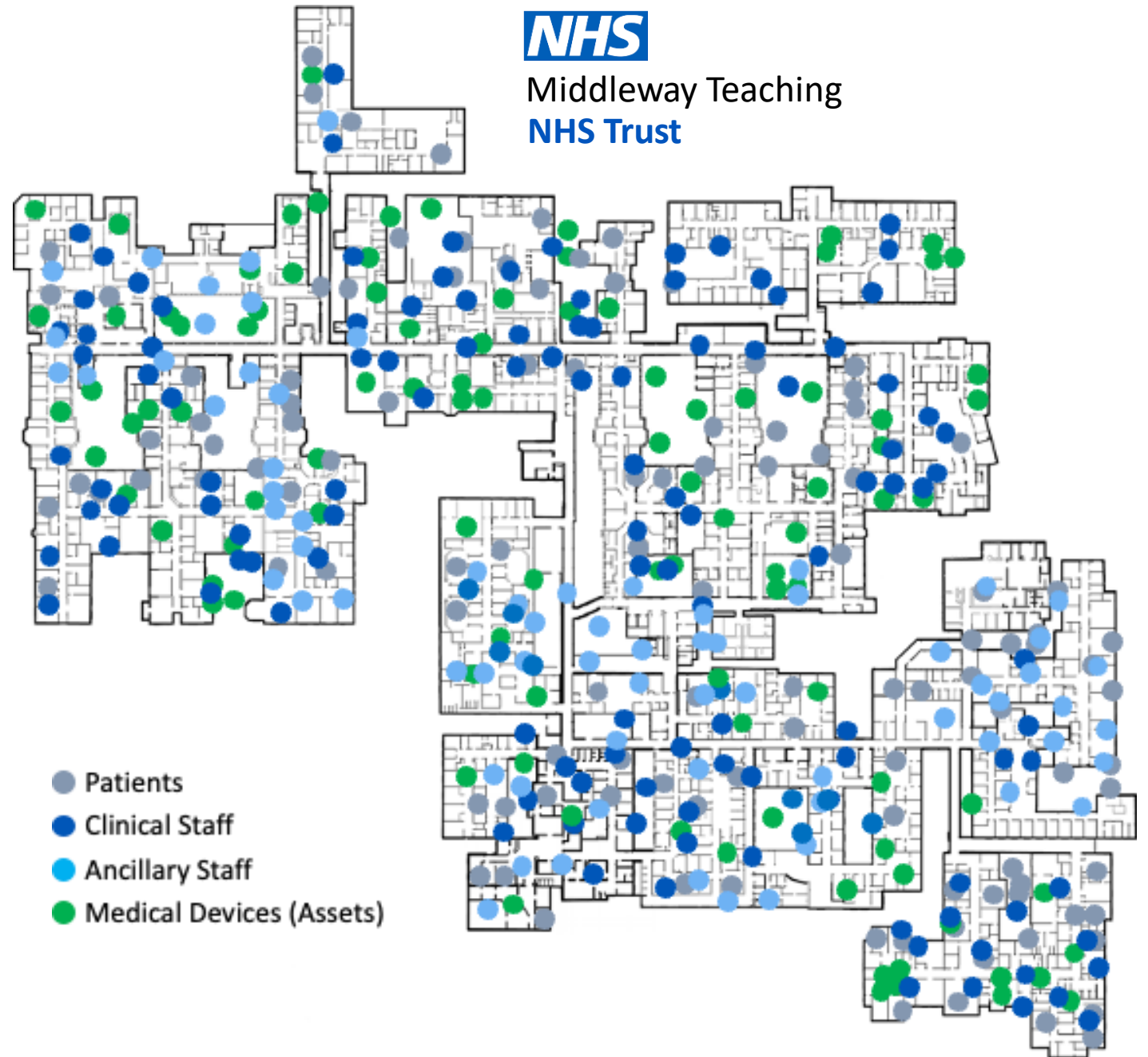


Completely  
Virtual  
Infrastructure



**NHS**

Middleway Teaching  
NHS Trust



- Patients
- Clinical Staff
- Ancillary Staff
- Medical Devices (Assets)

# Indoor Location Intelligence & Smart Tasking

## Real-Time Location Services

Room level accuracy, automated map creation and updates, mobile device & Wi-Fi, leverage existing infrastructure

## Intelligent Matching Services

“Uber” like algorithms to match right resource and/or asset to the right task for optimal workflow efficiency and effectiveness

## Advanced Data Analytics

Real-Time data capture and modeling for comprehensive Time, Motion, Behavior Research – Nursing Workflow, Asset Utilizations

Patient Flow



Nurse Call Automation



Asset Tracking



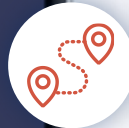
Staff Duress



Task Workflow Optimization



Facility Layout Optimization



Command Centre Solution



Embedded and Enabling



## CASE STUDY:

# Using Technology, Data Insights, and System Interoperability to improve Patient Flow

### TECHNOLOGY

- Replaced raising tasks through the helpdesk and radioing porters and cleaners with an online RTLS system.
- Ward staff and bed management had visibility of tasks including estimated time of arrival.
- This led to an increase in task volumes, and improvements in response time, task handling time, and bed turnaround time



Portering



Infection



A&E



Cleaning



Bed Management



Imaging

Average Task Handling Time Reduction

-62%

Average Response Time Reduction

-61%

Average Increase in Cleaning Task Volumes

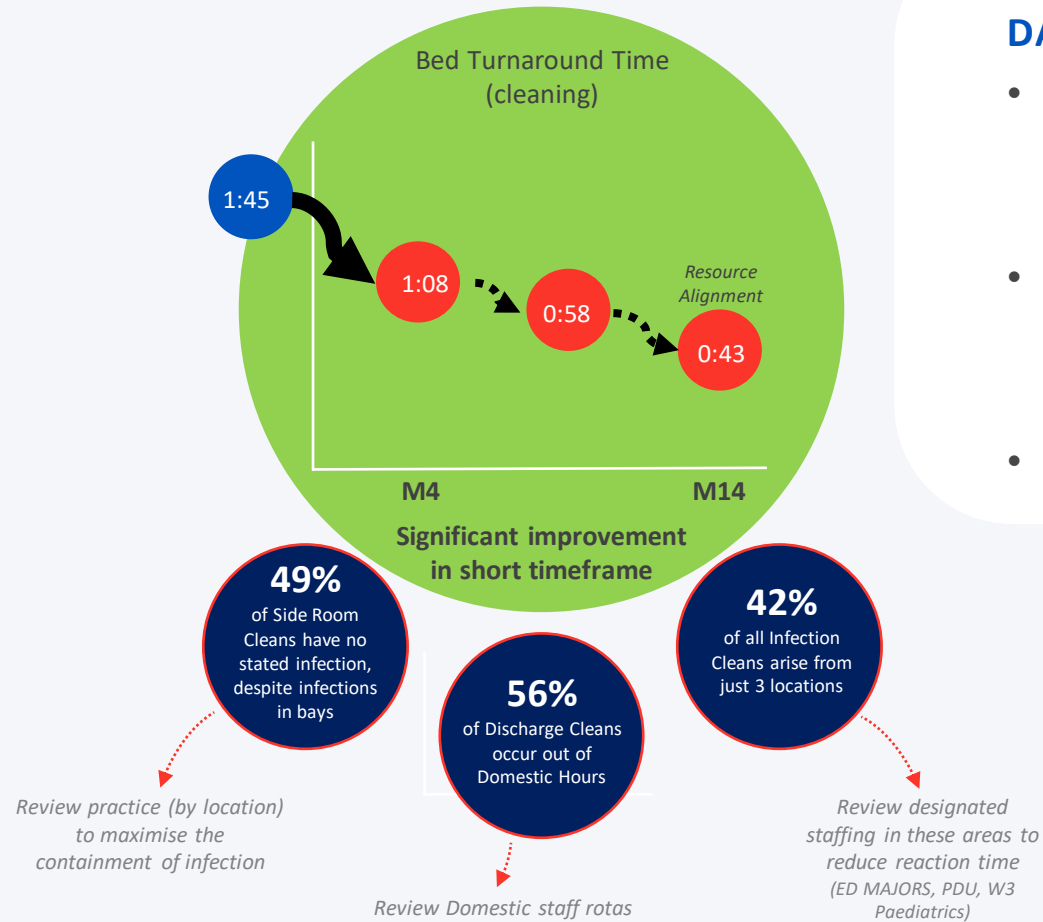
35%

Bed Turnaround Time Reduction

-59%

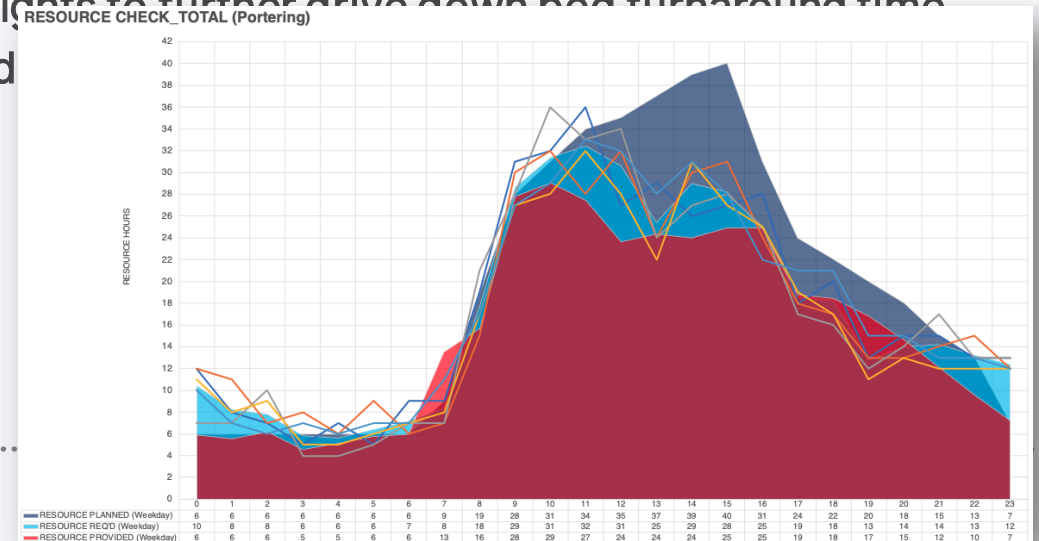
## CASE STUDY:

# Using Technology, Data Insights, and System Interoperability to improve Patient Flow



## DATA INSIGHTS

- Used infection clean data and patient move infection data to track movement of infectious patients within the hospital.
- Conducted rota demand and projection reviews comparing task volumes with provided and planned staff rotas.
- Using data from the system provided actionable insights to further drive down bed turnaround time and



## CASE STUDY:

# Using Technology, Data Insights, and System Interoperability to improve Patient Flow

## SYSTEM INTEROPERABILITY

- Connected to Trust PAS Admission and Discharge data.
- This allowed the patient flow coordinators to follow the journeys of patients throughout their stay including readmissions.
- **Visibility of upcoming empty beds and available (clean) beds aided and reducing bed turnaround times and highlighted areas creating blockages to patient flow**

Patient	Navenio time in ED (hours)	No of scans	Infection present or suspected?	No of moves to a different inpatient ward	Inpatient Ward (s)	Navenio Time in Hospital (days)	Re-entered within 21 days?
Patient A	31.2	2	N	1	AMU/CDU	2.4	N
Patient B	23.8	3	N	1	Ward 7	54.9	N
Patient C	1	1	N	0	n/a	0.6	Y
Patient C Re Admission	0.5	0	N	1	Ward 7	3.7	N
Patient D	0.9	0	Y	2	Ward 18	7.8	N
Patient E	0.09	1	Y	2	SAU / Ward 18	5.9	N
Patient F	Unknown	5	N	3	AMU / SAU / Ward 7	16.6	N
Patient G	47.4	2	Y	1	Ward 6	7.7	Y
Patient G Re Admission	23	5	Y	1	Ward 6	2.6	N
Patient H	Unknown	2	N	2	SAU / Ward 18	2.6	Y
Patient H Re Admission	0.07	0	N	0	n/a	Unknown	Y
Patient H Re Admission 2	18.3	2	N	1	Ward 18	10	N
Patient I	20.8	4	Y	1	Ward 8	32.3	N
Patient J	7.2	3	N	0	n/a	0.3	Y
Patient J Re Admission	15.5	2	N	1	Short Stay Ward	3.3	N
Average	14.6	2.1	33%	1.1		10.8	33%

## Future Plans:

1. Automatically trigger discharge cleans when a patient is moved
2. Data connections with more systems across the hospital



Speaking Now...



**Samantha Singh**

Clinical Lead – Nursing and Urgent Care  
NHS MLCSU

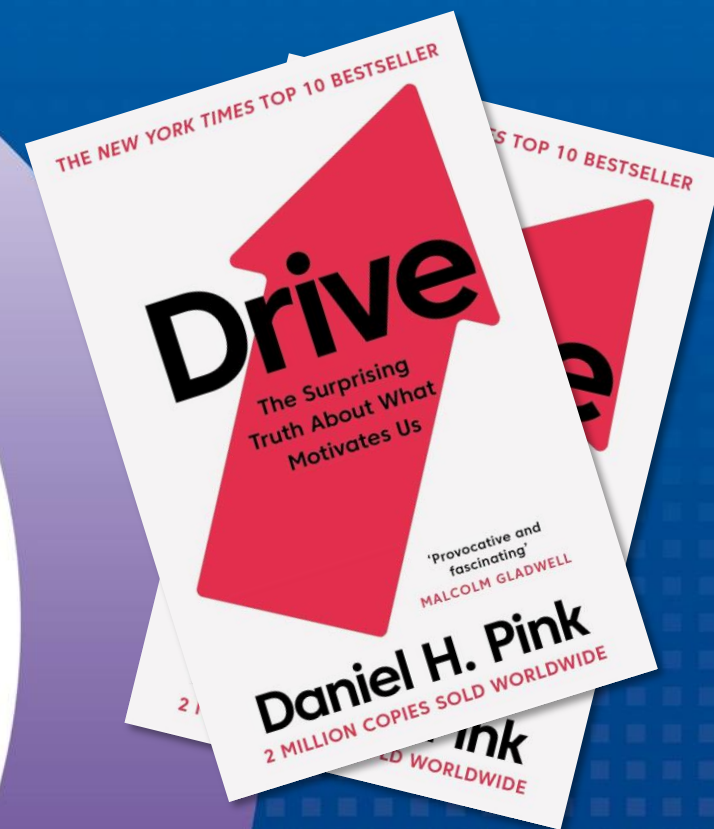


# Flowing Together, Unblocking Flow

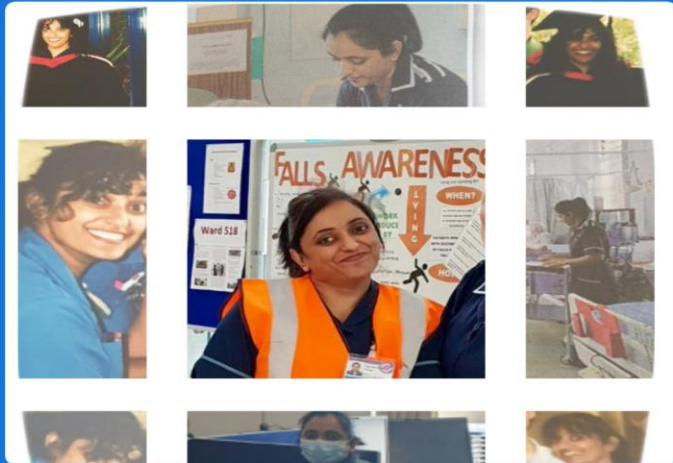
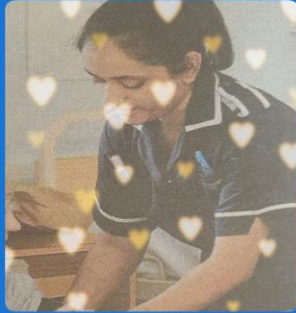
Navigating challenges in NHS efficiency for  
healthier minds

**Samantha Singh**  
Clinical Lead, Nursing and Urgent Care

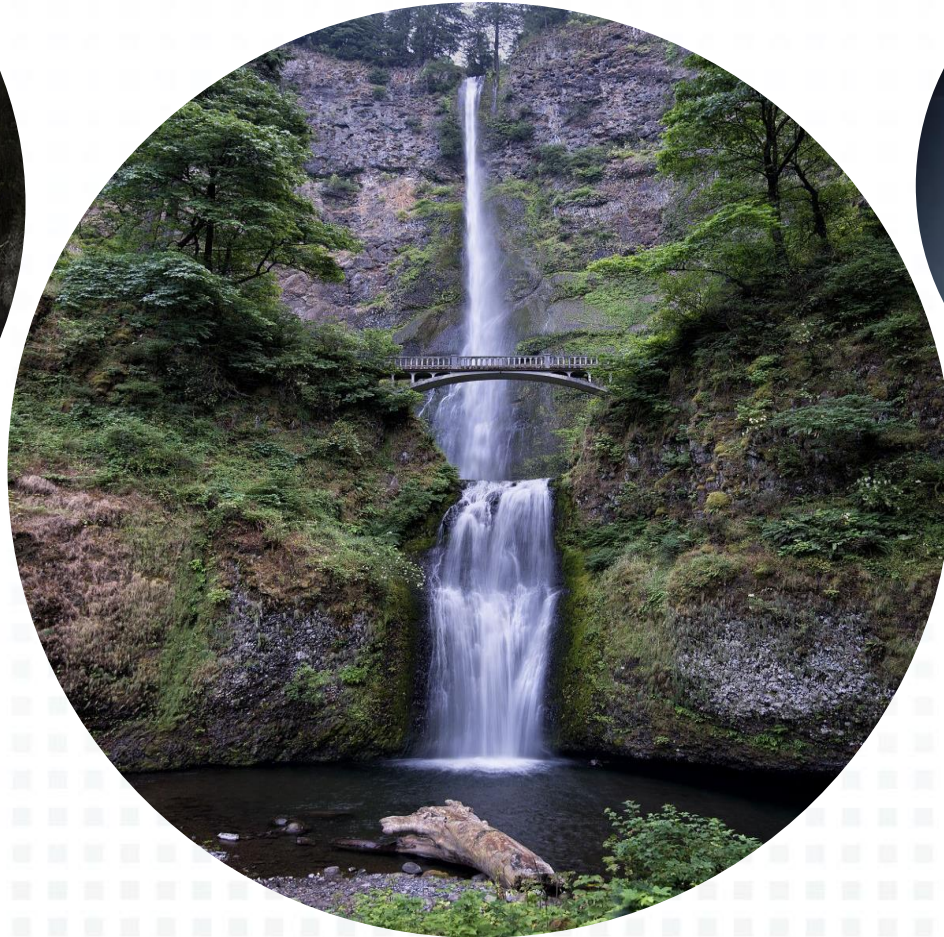
February 2024



# About me



# What does flow mean to you?



# What does flow mean in the NHS?



# Eliminating obstacles and enhance flow

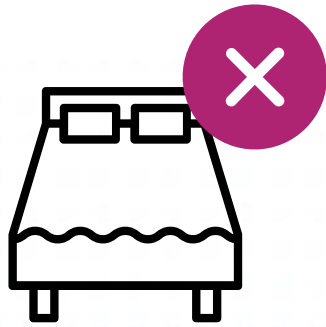


Transfer Team

Managing outliers



# Eliminating obstacles and enhance flow



1.

Knowing a ward bed was not a now bed because...



2.

Knowing a bed is AMU is potentially ready, but the patient is still in the bed because...



3.

Patient in ED can go to the available ward bed, but waiting, because...

# Our team



## Trained Nurse Band 6/7

- Nurse Prescriber
- Cannulation trained
- IV competent
- Wide range of medical experience



## Health care assistance

- Phlebotomy trained
- Trained on the use of bladder scanner/ECG
- Physio and OT experience assistance





# The Pack and Wrap Team = Transfer Team

The Transfer Team is responsible for facilitating the movement of patients between different departments, units, or healthcare facilities. Their primary objective is to ensure a smooth and coordinated transition for patients who require transfer to create capacity earlier.

Key responsibilities of a transfer team may include:

- **Patient Assessment:** Conducting a thorough assessment of the patient's medical condition to determine the appropriate level of care and the correct destination (ward). Communication and coordination with medical staff, nurses, and other healthcare professionals to communicate relevant information about the patient's condition, medical history, and any special requirements during the transfer.
- **Logistics Planning:** Arranging the logistics of the transfer, including coordinating transportation, ensuring the availability of necessary medical equipment, and organising the receiving team at the destination.
- **Documentation:** Ensuring accurate and complete documentation of the patient's medical records, transfer orders, and any other relevant paperwork to maintain continuity of care.





# The Pack and Wrap Team = Transfer Team (cont'd)

- **Patient and Family Support:** Providing information and support to the patient and their family members throughout the transfer process, addressing any concerns or questions they may have.
- **Collaboration:** Collaborating with various healthcare professionals, including physicians, nurses, and paramedics, to guarantee a seamless transfer and continuity of care.

Overall, the transfer team plays a crucial role in optimising patient care by ensuring that patients receive the right level of treatment and support at each stage of their healthcare journey within the hospital or between different healthcare facilities.

# A day in the life of the Transfer Team

At 4pm visit ward for the list of patients that are to be discharged:

- Check TTO's ( nurse prescriber prep  
TTO's – draft )
- Hand patient over to discharge lounge

Day before

IN ED

Give patient their morning meds; pack and wrap patient

Inform relatives of patient movements

Do latest entry of test i.e. bladder scan /  
bloods /iv meds

Transfer and settle patient on to the ward

Complete all initial ward assessments

IN AMU

The ward

Priorities the discharges  
Per ward and AMU demand

Introduce self to patient –

Pack and wrap patient

Scan notes

Inform pt and family of where they will be  
going to.

Give the last-minute meds that were  
prescribed.

Transfer and settle patient to AMU /Ward

Ensuring patient have  
their morning meds

Support with the  
discharge



Ring district nurse; help  
with stairs assessment

Support TTO education

Inform NOK of discharge

Book Transport &

Transfer to Discharge  
lounge

Once the patient has left the bed area

The bed space is cleaned and the  
admission packs

And admission details placed on the bed  
space

Ready for the next patient

# Outliers



Robust capacity planning



Flexible staffing and cross training



Streamline communication protocols



Ensure enhanced monitoring of the outliers



Patient-centric care plans

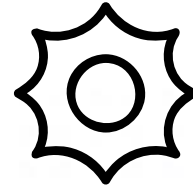


# A day in the life of the **Outlier Team**



## Morning

- Review of the patients that were outlined overnight
- Allocate patients to a named consultant
- Attend morning site meeting – ensuring the wards are aware of who is responsible for the patient's care



## Midday

- Review all medical outliers' notes
- Ensure patients' plans are followed by the ward
- Liaise with consultants around patients who needed to be transferred to a medical ward due to their conditions deteriorating
- Liaise with the transfer team to transfer the patient



## Evening

- Identify wards that will have capacity to support outliers over night
- Identify patients that could be outlie from AMU /ED
- Provide the site team with the names
- Update the outliers list - Discharged patients and or transferred patients



**The way to get  
started is to quit  
talking and begin  
doing.**

*Walt Disney*

# Finance





# Navigating challenges in NHS efficiency for healthier minds



## Reduction in anxiety and stress in staff

- Earlier transfers
- Not trying to come up with a plan last minute to avoid a breach
- No time wasted on ringing porter/walking to wards and looking for beds or not having phone calls answered
- One person to get the information you need

## Reduction in anxiety and stress in patients and relatives

- Less waiting time from when told of a transfer or move
- All their personal belongs are brought up with the patient
- Patients feel more settled into their new environment
- Relaxed as their NOK informed of their whereabouts



# Unexpected and bonus outcomes

- Reduction in complaints
- Reduction in lost medication (savings made)
- Reduction in missed doses of drugs
- Reduction in paying out for loss of patients' property
- Increase in patients getting to the right speciality.





MLCSU  
**Clinical**  
Nursing and Urgent Care



**Midlands and Lancashire**  
Commissioning Support Unit

# Thank you

**Samantha Singh**  
**Clinical Lead, Nursing and Urgent Care**

samantha.singh@nhs.uk

**February 2024**



Speaking Now...



**Colin Frey**

Chief Executive / Cross-sector flow specialist / Advisor on major programmes Heathrow Airport



# Canapés, Drinks and Networking



**Thank you for attending The Patient Flow Conference!**



**THE PATIENT FLOW  
CONFERENCE**



**Improving NHS Pathways**

**Register for the next Patient Flow  
Conference in July 2024...**

