



Welcome to the NHS Patient Flow Conference



9th July 2026
etc.venues, Prospero House, 241 Borough
High St, London, SE1 1GA





PatientPath

FEATURED ORGANISATIONS

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£100 voucher!



Imatis





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below to register your interest for our
accredited training courses.

Register your Interest





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Join the Healthcare Engagement Society (HES)

- **What it is** – A secure, year-round platform bringing NHS professionals together across six specialist communities.
- **Why it matters** – Stay connected beyond today's event, share challenges, and learn from peers facing the same priorities.
- **Your benefits** – Exclusive access to interviews, insights, best practice, and real-time discussion threads with colleagues nationwide.
- **How to join** – Simply scan the QR code, choose your community, and start connecting today.



SCAN ME

Stay Connected Beyond Today

Join the **HES Primary & Long Term Care WhatsApp Community** to stay connected with the people, ideas and conversations shaping this space. Receive relevant updates, access focused peer discussion groups, share practical insight and be first to hear about future events, resources and opportunities.



Scan the QR code to join the Community



Chair Morning Address



Chris Morrow-Frost

National Clinical Advisor to Secondary Care
NHS England



Keynote Presentation



Michael Bland
Deputy Director UEC
GIRFT



Dr Leilah Dare
UEC Lead further faster
programme and Consultant in
Emergency Medicine
GIRFT



Clinical Operational Standards

Creating one agreed way of working
across urgent and emergency care



GIRFT UEC Team:



Dr Leilah Dare

EM Consultant and GIRFT UEC Clinical Lead



Michael Bland

Deputy Director GIRFT UEC



Clear standards



Clear ownership



Safer patient care

Clinical Operational Standards

Creating one agreed way of working across urgent and emergency care

? What are they?

1



Reduce unwarranted variation

Standardise expectations of how we work.

2



Patient-centred care

Every decision should improve safety and experience.

3



Time-critical processes

Create a reasonable set of time frames around critical processes.

4



Clear clinical responsibility

Everyone knows who owns the patient at every stage.

5



Whole acute pathway

Across the whole of the acute site UEC pathway – not just the ED.

6



Minimise incivility

A respectful culture supports safety, teamwork and better outcomes.

7



Harm is caused by long waits

Delays are not just inconvenient – they cause harm.

8



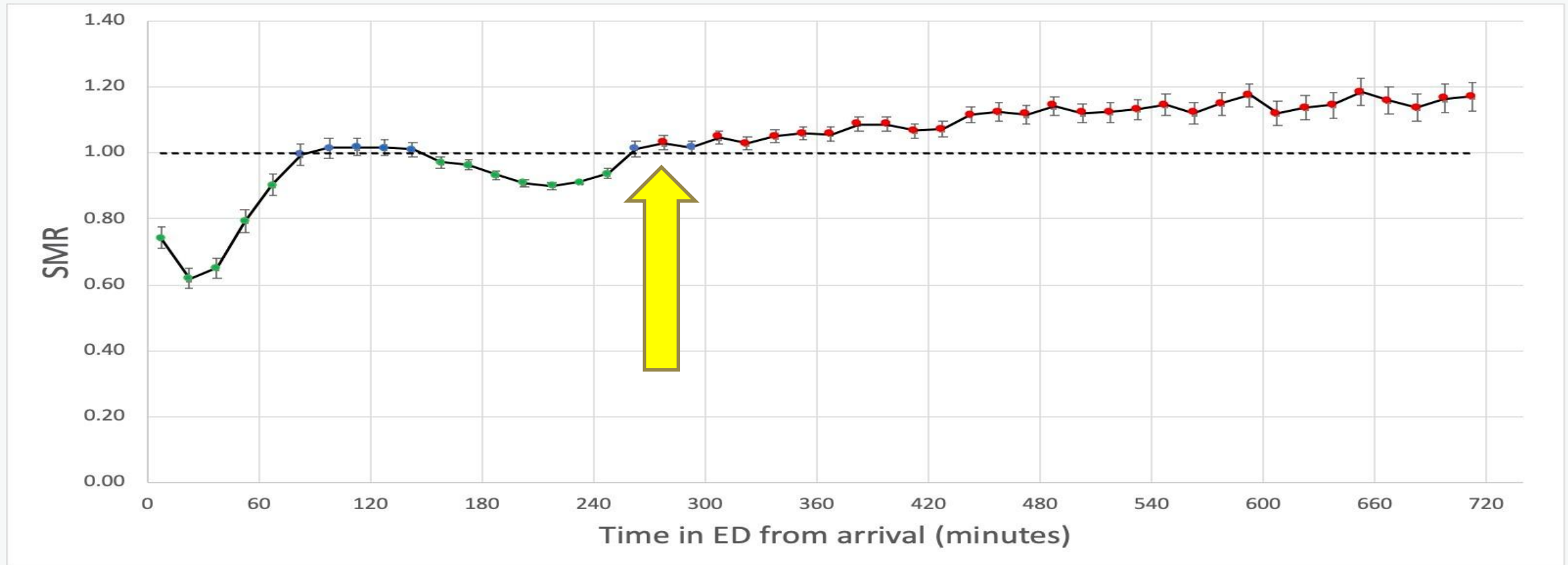
24/7 Application

Does it pass the 3 am test?



Clear standards. **Clear ownership.** Safer patient care.

Delay-related harm: The association between time in ED before admission and all-cause 30-day mortality.



1

Urgent cross sectional (CT/MRI) **imaging** should be **reported within 4 hours** of request.



2

Core **laboratory services** should be **available 24/7**, and turnaround times should be monitored regularly and reported monthly (timeframes can be found in the [Principles for Acute patient care](#)).



3

All patients arriving on or being transferred to an assessment unit (e.g. AMU, SDEC, SAU, etc) should have **NEWS2** calculated. The NEWS2 should be used in conjunction with the presenting condition to prioritise care.



4

All patients should have a full assessment undertaken by a **competent clinical decision maker**, ideally within one hour and certainly, within a maximum of four hours of the decision to admit or of arrival on the assessment unit (whichever is earlier).



5

All patients should be reviewed by an **expert clinical decision maker** within six hours of the decision to admit or of arrival on the assessment unit (whichever is earlier) from 08:00-20:00h or within 14 hours outside of these times.



6

When a patient on an assessment unit is accepted to a speciality, the **receiving speciality immediately assumes responsibility** for that patient's care.



7

Patients transferring out of **critical care units** (CCU, ICU, HDU, ECU) should be **prioritised for inpatient bed allocation**, above other requests for available beds.



8

Where specialties provide an admissions unit, an **expert/senior decision maker** should receive referrals and provide advice to the community and hospitals every day to prevent unnecessary hospital attendance/admission and to facilitate hospital discharge.



9

Twice-daily consultant ward rounds is the optimal model and should be delivered in higher acuity areas, e.g. ICU, AMU, SSW, SAU, CCU, and other medical wards if possible.



10

Patients aged over 65 presenting to hospital as an emergency should be assessed on arrival using the **Clinical Frailty Scale** (CFS) and 4AT tool for delirium.



1

Hospitals to **pre-determine conditions** which are anticipated to be specific speciality depending on presentation – see patient dispositions ([Appendix 1](#)) as a starting point.



2

Utilise **hotlines, urgent clinics and SDEC** to prevent emergency visits and admissions, as well as supporting earlier discharge.



3

Run a **Consultant of the week model** for inpatient care:

Morning ward rounds – use SHOP (Sick, Home, Other Patients) model, 7 days a week.

Afternoon board rounds including facilitating next day morning discharge – with a targeted face to face review if needed, 7 days a week.

Weekend review list – to ensure sick, new, and potential discharge patients are reviewed.



4

A **dedicated additional consultant** may also be required to achieve early review of ward referrals/in-reach.



5

Cross-sectional **imaging** should not delay clinical assessment or speciality opinion.



6

Once the patient is accepted/allocated to (see point 1) the specialist team, they are responsible for the patient, including any **onward referral**. The patient remains under their care until accepted by another speciality.



7

Utilise **virtual wards (Hospital at home)** - both step-up and step-down, to avoid hospital admission, and to facilitate early discharge from hospital.



8

DCCs (e.g. operating lists or outpatient clinic) should not interfere with the **availability of clinical staff** for emergency assessments.



9

Agree in-reach standards for AMU and ED particularly for key specialities e.g. cardiology, geriatrics, respiratory, gastroenterology, and mental health.



10

Patients referred to **alternative sites and to tertiary services** should not wait in ED.



11

Discharge summaries to be completed and sent on discharge. Medication should be prescribed for an appropriate time frame following discharge from hospital. ICBs should agree and communicate a standardised guideline.



Appendix 1: Example of Agreed Patient Dispositions

Overarching principle: Patients should have equitable access to professionals with the skills required for their individual care, independent of the location of their bed or the nominal admitting specialty.

Specialty designation or patient specialty ownership

It is beneficial to have patient dispositions because this avoids patients being subject to multiple patient discussions or moves. This recognises that there are commonly used specialist pathways for STEMI, acute stroke and major trauma. **This appendix is an example of patient dispositions for common conditions that can be modified to suit local needs with agreement between specialties.**

The presenting complaint will determine which specialty the patient is referred to and which specialty will admit the patient if required. This is irrespective of whether the patient will go to theatre or not.

CRITICAL CARE (CC)

- CC middle grade or consultant will attend within 30 mins.
- All CC referrals must be accompanied by a primary specialty referral. The primary specialty should continue to provide care after the patient has been discharged from critical care.
- Decisions to admit will be made by CC consultant (in collaboration with specialty teams).

The [NICE Guideline for Acutely ill adults in hospital](#) outlines how to manage the deteriorating patient.

OBSTETRICS AND GYNAECOLOGY

- PV bleeding in pregnancy
- Menorrhagia leading to anaemia/haemodynamic compromise
- Acute pelvic pain in women
- Lower abdomen/iliac fossa pain in early pregnancy (<16 weeks)
- Vaginal lumps/abscess
- Suspected gynaecological malignancy
- Haemodynamic compromise/collapse in pregnancy
- Patients <16 weeks pregnancy to emergency gynae and >16 weeks to labour ward triage
- Urgent pregnancy testing for women of reproductive age

GERIATRIC MEDICINE

Age >65 and with CFS ≥5 and/or care home residents presenting with:

- Reduction or decline in mobility or immobility without major injury.
- Instability presenting with falls without major injury.
- Incontinence of urine or faeces.
- Delirium or acute impairment of intellect or memory.
- Anorexia and progressive weight loss.

MEDICINE

- Chest pain
- Cardiac Arrhythmia/Palpitations
- Dyspnoea (Asthma/COPD/Pneumonia)
- Haemoptysis
- Haematemesis
- Seizures
- Headache
- Dysphagia
- Spontaneous pneumothorax
- Lower and upper limb DVT
- DKA/HHS/Hypoglycaemia/Hyperglycaemia
- Non-specific deterioration in an elderly patient
- Overdose requiring admission
- Pyelonephritis (NOT obstructive uropathy/bladder outflow obstruction for UROLOGY)
- Jaundice - painless
- Cellulitis
- Falls
- Delirium

PALLIATIVE MEDICINE

Patients requiring palliative care should be admitted under the specialty responsible for the condition or previously caring for that patient* and referred to palliative care as an inpatient.

*Team must be made aware of the patient ASAP.

The impact of patient waits: Mrs Smith's story

Delays at every stage lead to harm. Together, we can change this.

✗ Without Clinical Operational Standards

Too long. Too many handovers. Too much harm.

Arrival in ED

Elderly patient with mechanical fall and possible neck of femur fracture.



⌚ Wait in ED
2+ hours

X-ray

X-ray completed – no fracture seen.



⌚ Wait for X-ray
2+ hours

CT scan

CT requested to look for occult fracture – no fracture seen.



⌚ Wait for CT
8+ hours

Still in pain, can't mobilise

Unable to mobilise safely and cannot go home.



⌚ Wait on decision
4+ hours

Decision / argument

Unclear which specialty should admit – Geriatric Medicine or Orthopaedics?



⌚ Further delay
Many more hours



Mrs Smith comes to harm

- ✗ Prolonged pain and distress
- ✗ Risk of deconditioning and complications
- ✗ Delayed rehabilitation
- ✗ Longer length of stay
- ✗ Higher cost to the system



Total time lost: 18+ hours

Unnecessary waits. Unclear ownership. Preventable harm.

✓ With Clinical Operational Standards

Right place. Right time. Right outcome.

Arrival in ED

Rapid assessment and initial plan within ED.



⌚ Within
60 minutes

X-ray

X-ray within 1 hour.



⌚ Within
60 minutes

CT scan (if required)

Appropriate imaging pathway followed without delay.



⌚ Within
4 hours

Early senior review and plan

Clinical decision on mobility, pain control and next steps.



⌚ Within
60 minutes

Clear ownership

Agreed pathway: Geriatric Medicine if no fracture and frailty needs, or Orthopaedics if surgical concerns persist.



⌚ No unnecessary delay



Mrs Smith receives the right care, first time

- ✓ Less pain and distress
- ✓ Lower risk of harm
- ✓ Early mobilization
- ✓ Shorter length of stay
- ✓ Lower cost to the NHS



Best practice, every time: Standards drive the right care, in the right place, first time.



Clear standards. Clear ownership. Safer patient care.

How we implement Clinical Operational Standards

One team. One standard. Better care for every patient.



1. Start from the top

Visible leadership sets the tone and drives the change.



Chief Executive

Sets the priority, provides resources and removes barriers.



Chief Nurse

Leads the culture, ensures safe, high quality care.



Chief Medical Officer

Drives clinical engagement and leads by example.

Leaders lead by example – they champion the standards and make them everyone's business.

2 Bring everyone together



Clinical and operational teams in the room, working together.

One shared goal: the best pathway for our patients.

3 Agree the best pathway



Design the ideal pathway using the resources we have.

Right patient, right specialty, right time, first time.

4 Gap analysis



Compare current practice against the GIRFT Clinical Operational Standards.

Understand the gaps, variation and root causes.

5 Close the gaps



Agree actions, owners and timescales to meet the standards.

Focus on quick wins and long-term change.

6 Implement and embed



Put actions into practice, measure, learn and adapt.

Sustain improvement through daily behaviours.

7 Monitor, learn and improve



Use data and feedback to drive continuous improvement.

Celebrate success and share learning.



Strong foundations – culture is everything

- Treat each other with respect
- Challenge for the patient's best interest
- Speak up when standards aren't met
- Support, listen and learn together



Overcome barriers, enable success

Common barriers

- Capacity and demand
- Workforce and skills
- Communication & handovers
- Systems and processes
- Data and visibility

Key enablers

- ✓ Senior leadership support
- ✓ Clear roles and accountability
- ✓ Effective communication
- ✓ Standardised processes
- ✓ Data-driven decisions



Work with what you have

- Use local resources wisely
- Adapt standards to local context
- Focus on what matters most for your patients



The outcome



Patients seen by the right specialty



At the right time



First time



Better experience, better outcomes



Clear standards. Clear ownership. Safer patient care.



Right patient



Right specialty



Right time



First time

How can we escalate when they aren't followed?

Clinical Operational Standards (COS): Escalation protocol for non-adherence

Patient delay recognised due to non-adherence to COS/Internal Professional Standards (IPS) such as:

- Delayed senior/expert decision maker review.
- Specialty response longer than two hours (or other locally agreed standard).
- Referral to specialty refused without good clinical reason.
- Initial specialty declined and sent patient back to ED instead of referring on to the appropriate specialty.
- Agreed patient dispositions ignored.
- Unnecessary tests requested that delay patient transfer.
- Ward/Assessment Unit not receiving patient within 30 minutes of agreed acceptance.
- Bed management issue delaying ongoing care.
- Difficulty transferring patient to another hospital.
- Communication, interpersonal or behavioural issues.



Immediate actions:

- Start the clock and record the time in the EPR/patient record.
- Ensure patient care is not compromised at any time.
- Document the issue using the QR code below and the linked form.



Senior medical, nursing and operational escalation (locally agreed):

- Notify senior doctors, nurses and operational leads using the agreed trust protocol for the relevant time of day.
- Ensure executive oversight of the whole process.
- Support governance review of the failed COS implementation.

Scan this QR code to
complete and submit
COS report form:





Thank You



@NHSGIRFT



Getting It Right First Time (GIRFT)



gettingitrightfirsttime.co.uk

Slido

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



Skill Clinic



Rachel Williams

Associate Chief Operating Officer
South Warwickshire University
Foundation Trust



Megan Hazell

GIRFT UEC Head of Improvement
NHS England





Headline Sponsor



Headline Sponsor



Will Broadbent

Commercial Director

Wandsworth Healthcare (representing DNV Imatis)





A Systems-Based Approach
to Improving Patient Flow



A Collaboration



Ambition

Unlock the UK's capacity to care by becoming the partner of choice for digital patient journey.

We will deliver this ambition by:



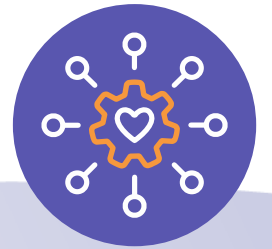
Focusing on the needs
of patients and staff



Enabling
digital transformation



Unlocking
efficiency



Making data
meaningful

A Wide Data Set DNV Imatis



8 Countries



46 Hospitals



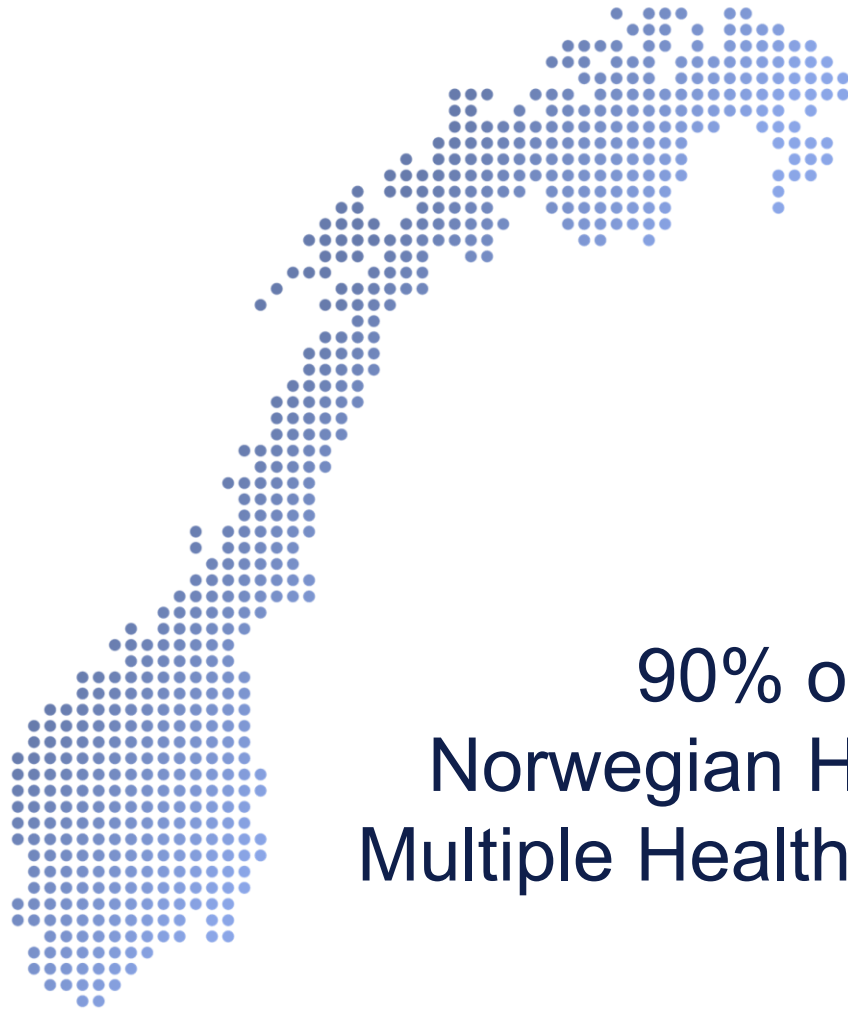
50,227,000 Patients



46 300

Professional Users

A Deep Data Set DNV Imatis



90% of
Norwegian Hospital
Multiple Health Regions



18 Hospitals



21,600,000 Patients



34,600
Professional Users

Improving
productivity
in healthcare
operations
by 15-20%



Patient Flow



Admission

Imaging

Transfers

Labs

Visitors

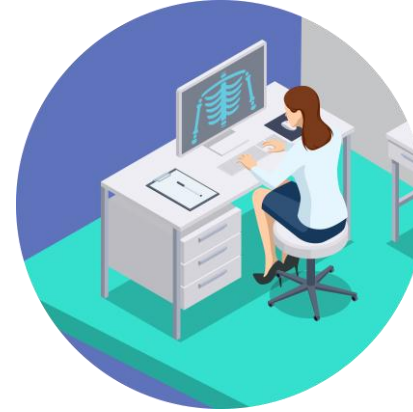
Medication

Housekeeping

Porters

Discharge

A Systems Approach...



Efficient

Patient centered

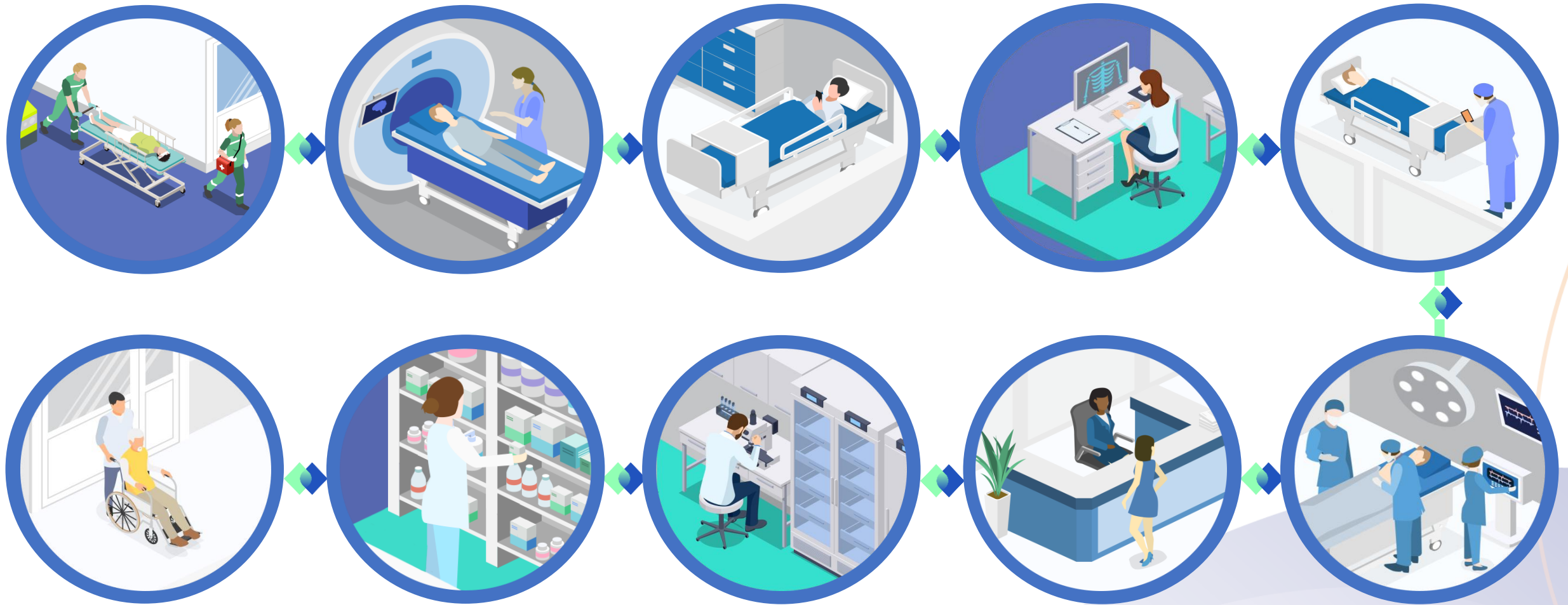
Staff friendly

Audited

Secure

Joined up

Digital Coordination...



Powered by  **DNV Imatis** solutions

The System

Secure mobile apps | Powerful dashboards | Interactive screens



Smart alarm management
and event notifications



Real-time patient and bed
management



Coordinated task
management



DNV Imatis Fundamentum



Chubb



wandsworth
HEALTHCARE

PHILIPS
Healthcare



KONE

Epic



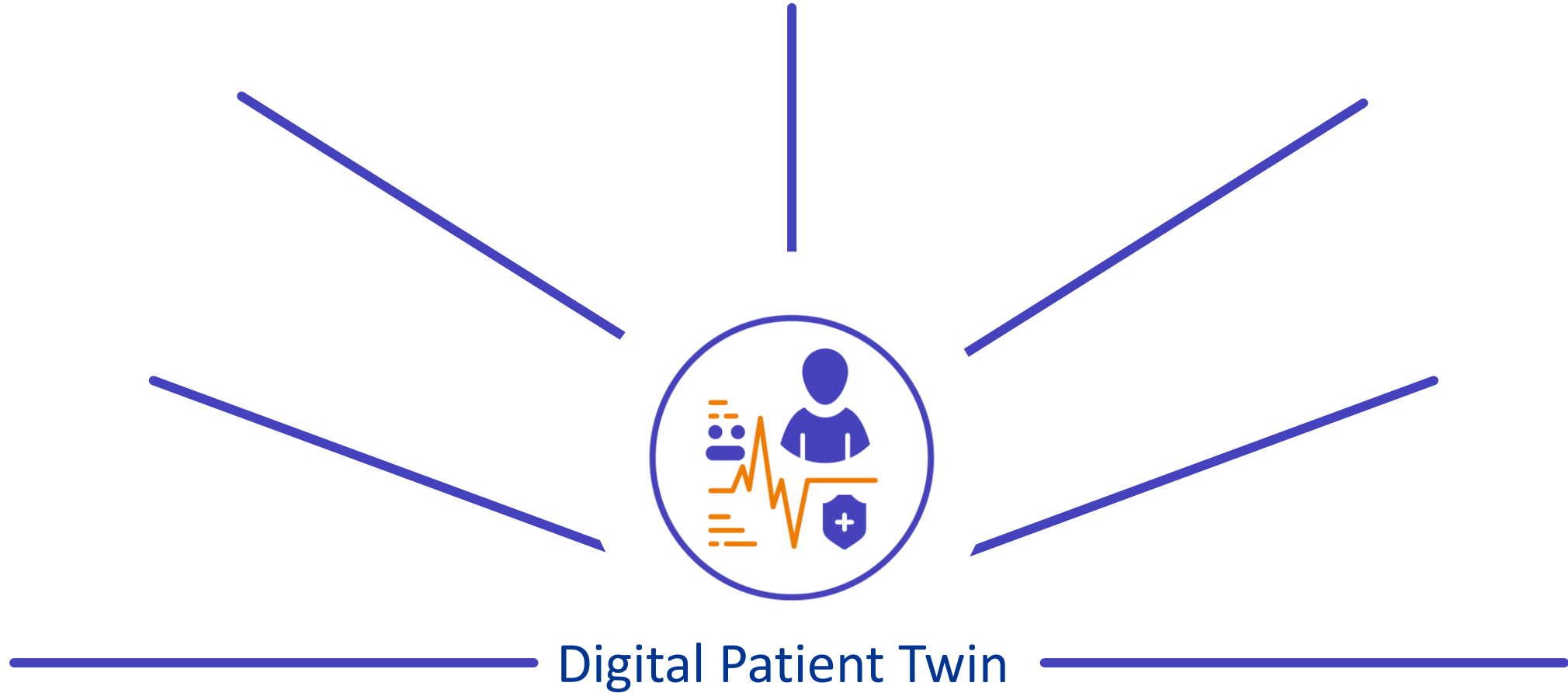
Microsoft
Active Directory

The **Tools** (applications)

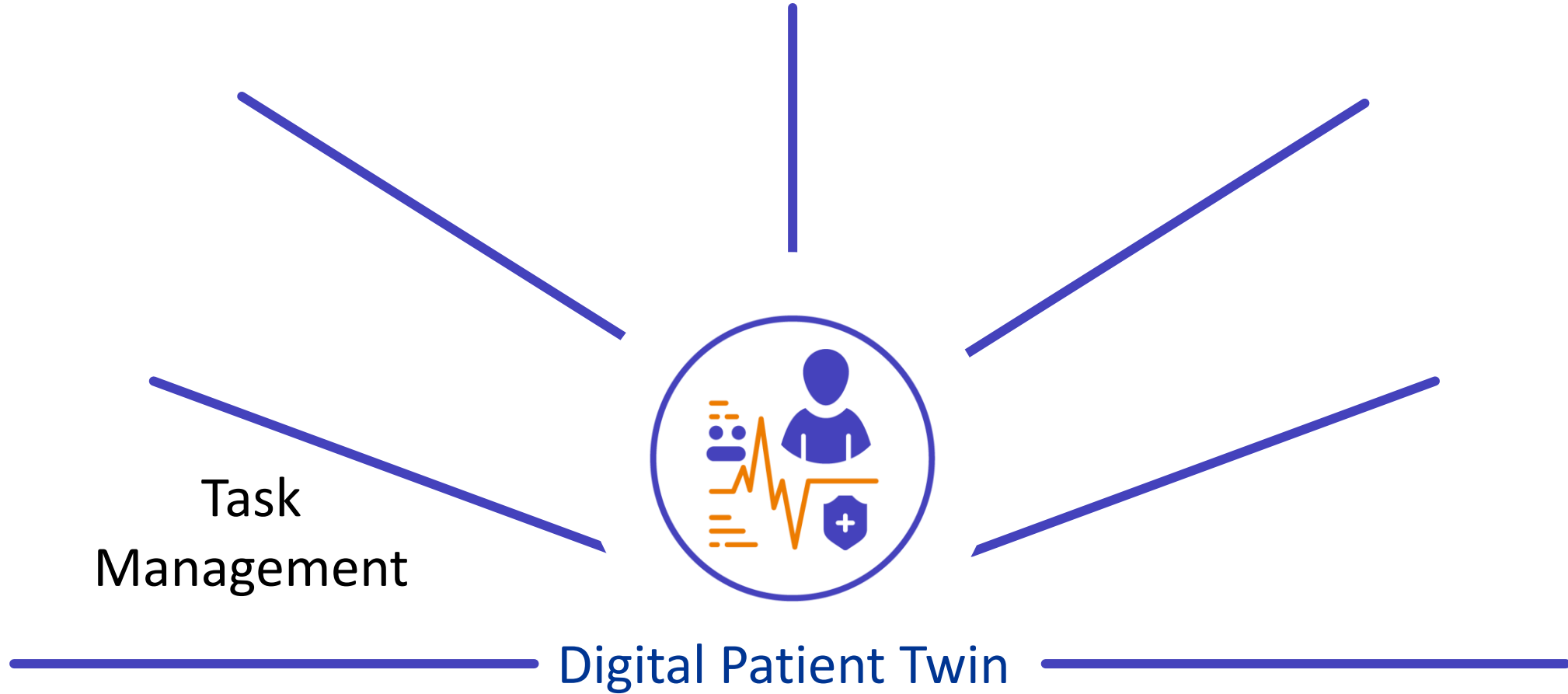
The **Platform**

The **Ecosystem**

The Heart of the System



Workflow First Approach



NC	BED	LINKS	INFECTION	NAME	BED STATUS	ARRIVAL	EPR	PRESCRIPTIONS	LEVEL OF CARE	RESPONSIBLE NURSE	DOCTOR	EDD	DISCHARGE READY	TASK STATUS
	Day Room			Jane Doe	Occupied	03/11 11:53 AM		Tramadol	II	Nurse 1 07785926582	Doctor 1			
	Room A1				Available					Nurse 1 07785926582				
	Room B1			Maggy Nesium	Occupied	03/11 11:53 AM		Amoxycillin	I	Nurse 1 07785926582	Doctor 1	06/11	Not ready	
	Secure Room				Available					Nurse 1 07785926582				
	Treatment Room			Christopher Betts	Occupied	19/10 12:26 PM		Amoxycillin Paracetamol	II	Nurse 1 07785926582	Doctor 1	06/11	Not ready	
	Bed Space 02			Arther Right	Occupied	03/11 11:53 AM		Morphine	III	Nurse 1 07785926582	Doctor 1	07/11	Not ready	
	Bed Space 03				Pending cleaning					Nurse 1 07785926582				

NC	BED	LINKS	INFECTION	NAME	BED STATUS	ARRIVAL	EPR	PRESCRIPTIONS	LEVEL OF CARE	RESPONSIBLE NURSE	DOCTOR	EDD	DISCHARGE READY	TASK STATUS
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	Room A1				Available					 Nurse 1 07785926582				
	Room B1			Maggy Nesium	Occupied	03/11 11:53 AM				 Nurse 1 07785926582	 Doctor 1	06/11	Not ready	
	Secure Room				Available					 Nurse 1 07785926582				
	Treatment Room			Christopher Betts	Occupied	19/10 12:26 PM				 Nurse 1 07785926582	 Doctor 1	06/11	Not ready	
	Bed Space 02			Arther Right	Occupied	03/11 11:53 AM				 Nurse 1 07785926582	 Doctor 1	07/11	Not ready	
	Bed Space 03				Pending cleaning					 Nurse 1 07785926582				

LINKS

Treatment Room | Christopher Betts

 Patient log

 Update patient info

 NEWS

 qSOFA

 Bedsores

 Fall

 Nutrition

 Meal order

 Surgery

 Send task

 Porter request

CANCEL

Wandsworth Portage: New task

Location

Location (Required)
Wandsworth/Medical Department × ▾

Location details

↕

Destination (Required)

Search locations

Wandsworth

▸ A&E Department

▸ Medical Department

▸ Radiology Department ✓

▸ Support Services Department

Task details

Category (Required)
Patient × ▾

Bed

Chair ✓

Walking

Patient first name (Required)
Christopher

Patient surname (Required)
Betts

Responsible for patient
Nurse 1 | 07785926582

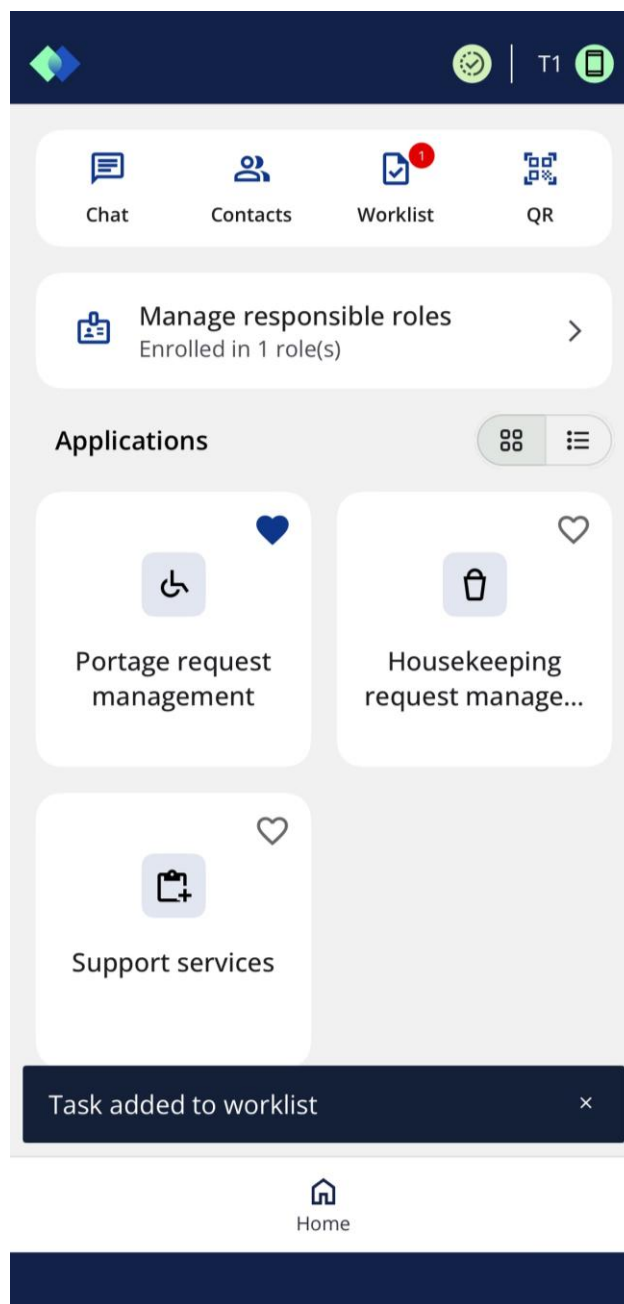
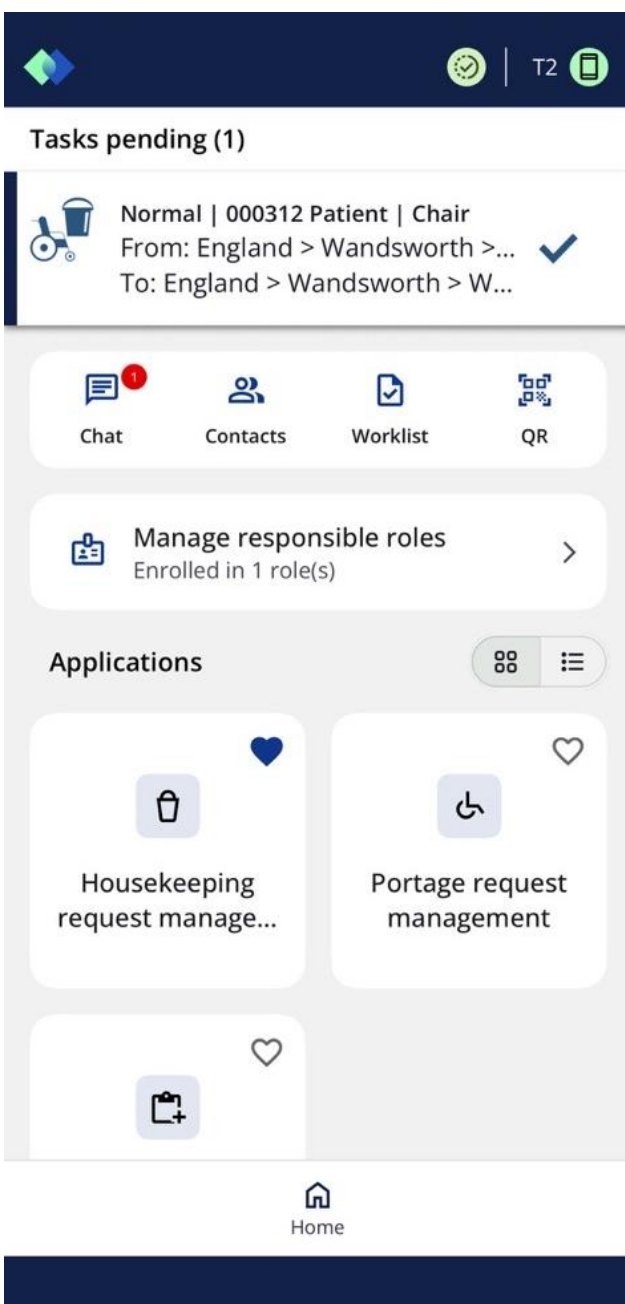
✓ Infection

Infection type (Required)
Airborn × ▾

Cancel

Create task

NC	BED	LINKS	INFECTION	NAME	BED STATUS	ARRIVAL	EPR	PRESCRIPTIONS	LEVEL OF CARE	RESPONSIBLE NURSE	DOCTOR	EDD	DISCHARGE READY	TASK STATUS	
	Day Room			Jane Doe	Occupied	03/11 11:53 AM		Tramadol	II	 Nurse 1 +447523730650	 Doctor 1				
	Room A1			Mat Holliday	Occupied	03/11 11:53 AM		NSAIDs	II	 Nurse 1 +447523730650	 Doctor 1		Ready	 13/11/2025 10:22 AM	
	Room B1			Maggy Nesium	Occupied	03/11 11:53 AM		Amoxycillin	I	 Nurse 1 +447523730650	 Doctor 1	06/11	Not ready	Por (Registered)	
	Secure Room				Available					 Nurse 1 +447523730650					
	Treatment Room			Christopher Betts	Occupied	19/10 12:26 PM		Amoxycillin Paracetamol	II	 Nurse 1 +447523730650	 Doctor 1	06/11	Not ready		
	Bed Space 02			Arther Right	Occupied	03/11 11:53 AM		Morphine	III	 Nurse 1 +447523730650	 Doctor 1	07/11	Not ready		
	Bed Space 03				Pending cleaning					 Nurse 1 +447523730650					



NC	BED	LINKS	INFECTION	NAME	BED STATUS	ARRIVAL	EPR	PRESCRIPTIONS	LEVEL OF CARE	RESPONSIBLE NURSE	DOCTOR	EDD	DISCHARGE READY	TASK STATUS	
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	Room A1			Mat Holliday	Occupied	03/11 11:53 AM		NSAIDs	II	Nurse 1 +447523730650	Doctor 1		Ready	3/11/2025 10:22 AM	
	Room B1			Maggy Nesium	Occupied	03/11 11:53 AM		Amoxycillin	I	Nurse 1 +447523730650	Doctor 1	06/11	Not ready		
	Secure Room				Available					Nurse 1 +447523730650					
	Treatment Room			Christopher Betts	Occupied	19/10 12:26 PM		Amoxycillin Paracetamol	II	Nurse 1 +447523730650	Doctor 1	06/11	Not ready		
	Bed Space 02			Arther Right	Occupied	03/11 11:53 AM		Morphine	III	Nurse 1 +447523730650	Doctor 1	07/11	Not ready		
	Bed Space 03				Pending cleaning					Nurse 1 +447523730650					

DNV Imatis

Demo Room

Wandsworth | Wandsworth

Medical Inpatient Dashboard

Medical Inpatient Whiteboard

Porter Request Dashboard

Wandsworth Cleaning Request Dashboard

Porter | Task Dashboard

Friday, 14 November 2025

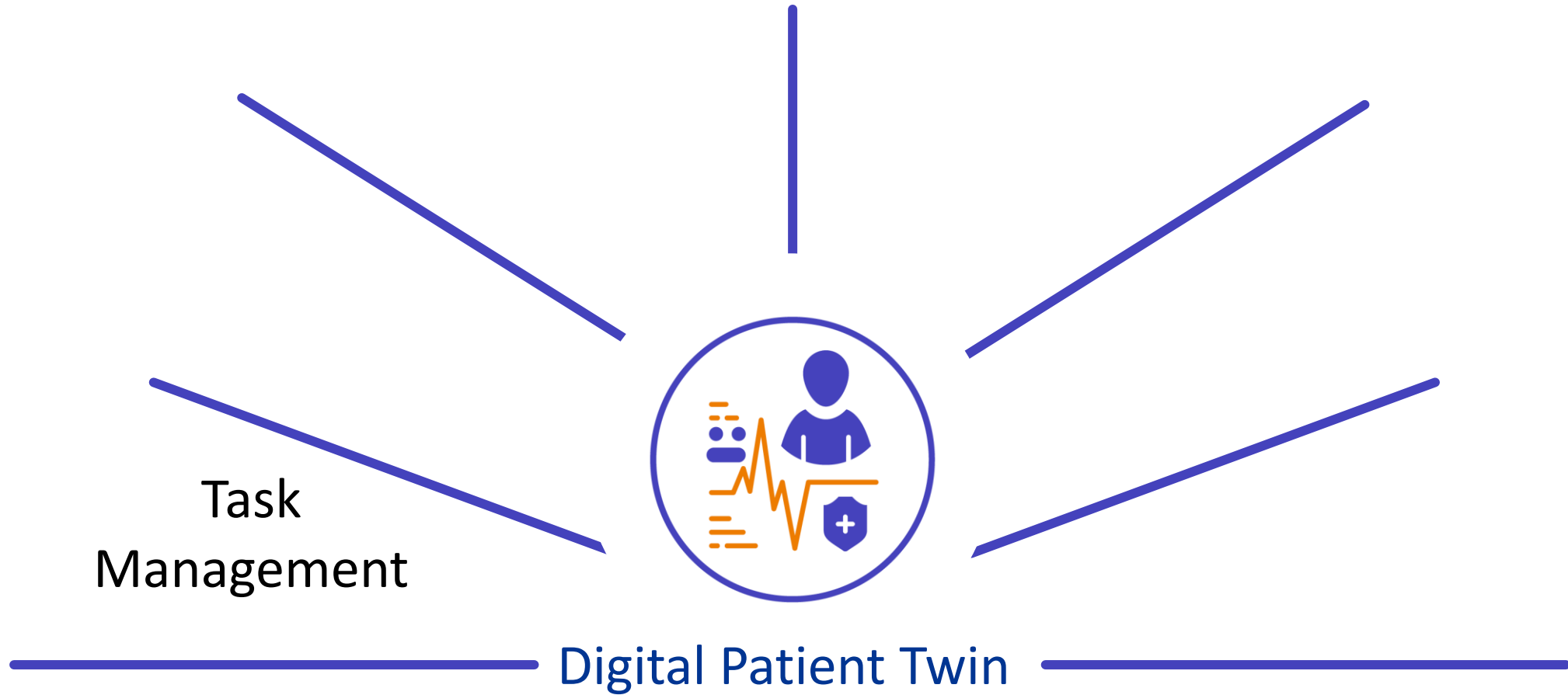
12:12:48

All tasks	Registered tasks	Max waiting time	Active tasks	Missed tasks	Completed tasks
16	4	10mins	2	0	10

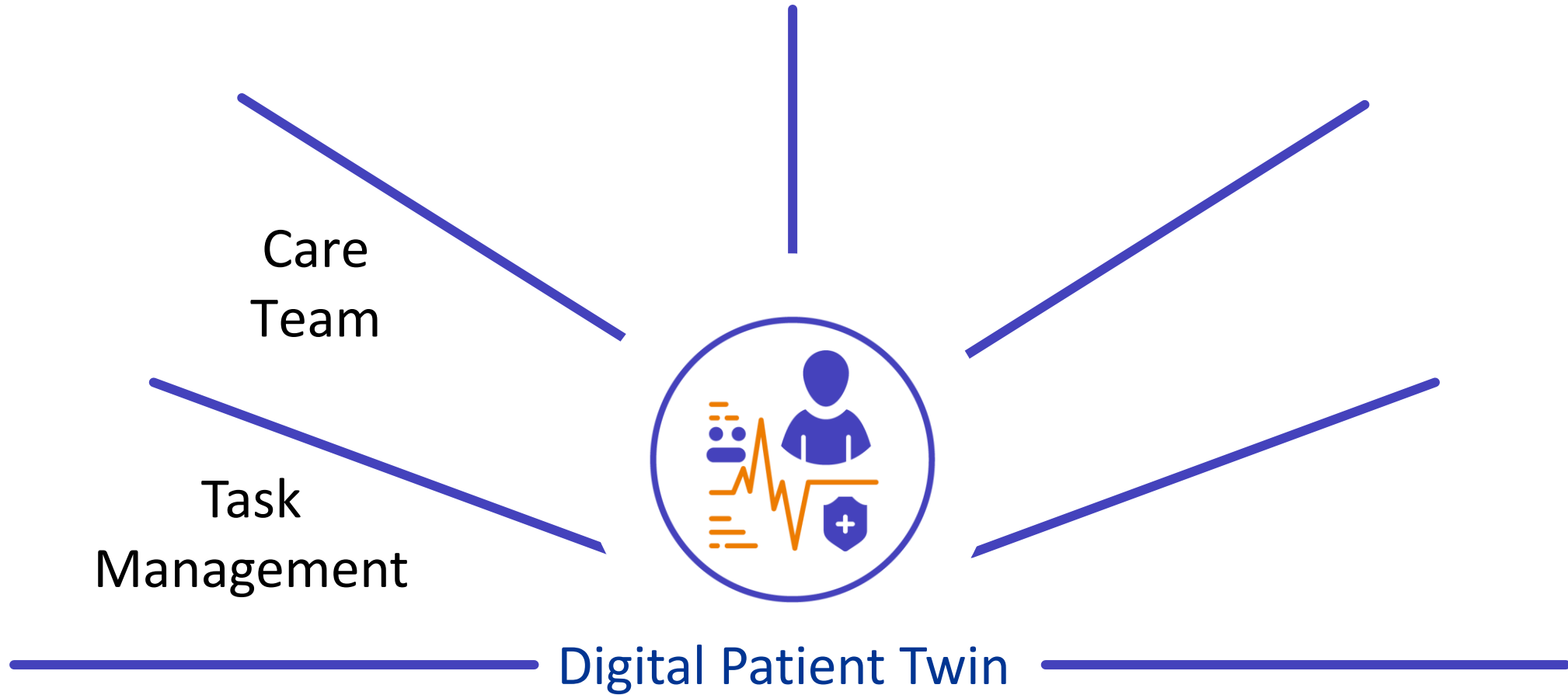
Emergency patients	Ward transfer	Registered tasks	Max waiting time	Active tasks	Missed tasks	Completed tasks
5	3	2	6mins	1	0	6

Medical wards patients	Discharge today	Registered tasks	Max waiting time	Active tasks	Missed tasks	Completed tasks
3	2	2	10mins	1	0	4

Workflow First Approach



Workflow First Approach



NAME	NC	BED	LINKS	INFECTION	BED STATUS	ARRIVAL	EPR	MEDS REC	PRESCRIPTIONS	RESPONSIBLE NU...	DOCTOR	LOS	EDD	DISCHARGE R...	DISCHARGE
Jane Foster		Maybury Ward			Occupied	05/11 12:1...						6d 1h 25m		Ready	9/9
Jane Doe		Day Room			Occupied	03/11 11:5...			Tramadol	 Nurse 1 +447523730650	 Doctor 1	3d 7h 2m			0/9
Maggy Ne...		Room B1			Occupied	03/11 11:5...			Amoxycillin	 Nurse 1 +447523730650	 Doctor 1	2d 12h 10m	06/11	Not ready	0/9
Mat Holliday		Secure Room			Occupied 	03/11 11:5...			NSAIDs	 Nurse 1 +447523730650	 Doctor 1	3d 1h 25m		Ready	0/9
Christophe...		Treatment Room			Occupied	19/10 12:2...			Amoxycillin Paracetamol	 Nurse 1 +447523730650	 Doctor 1	1d 1h 5m	06/11	Not ready	0/9
Arther Right		Bed Space 02			Occupied	03/11 11:5...			Morphine	 Nurse 1 +447523730650	 Doctor 1	1h 25m	07/11	Not ready	0/9

12:39

74

Treatment Room Christopher Betts

D1

All

NEWS

Discharge

Infection

Bed status

Occupied

Arrival

19/10 12:26 PM

Prescriptions

Amoxicillin

Paracetamol

Level of care

II

Responsible nurse

Nurse 1
07785926582

Doctor

Doctor 1
07311277822

Task status

11/14/2025 12:00 PM

Porter task

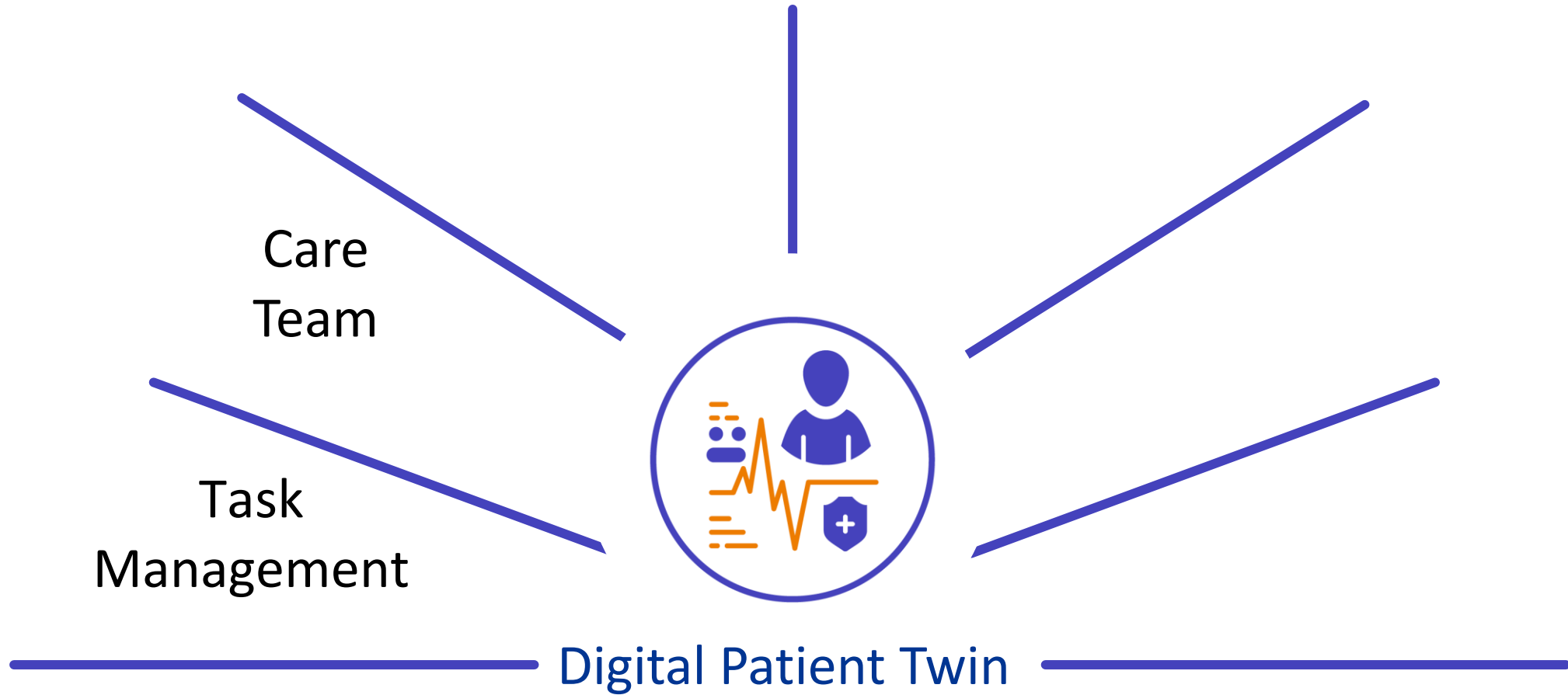
Back

Home

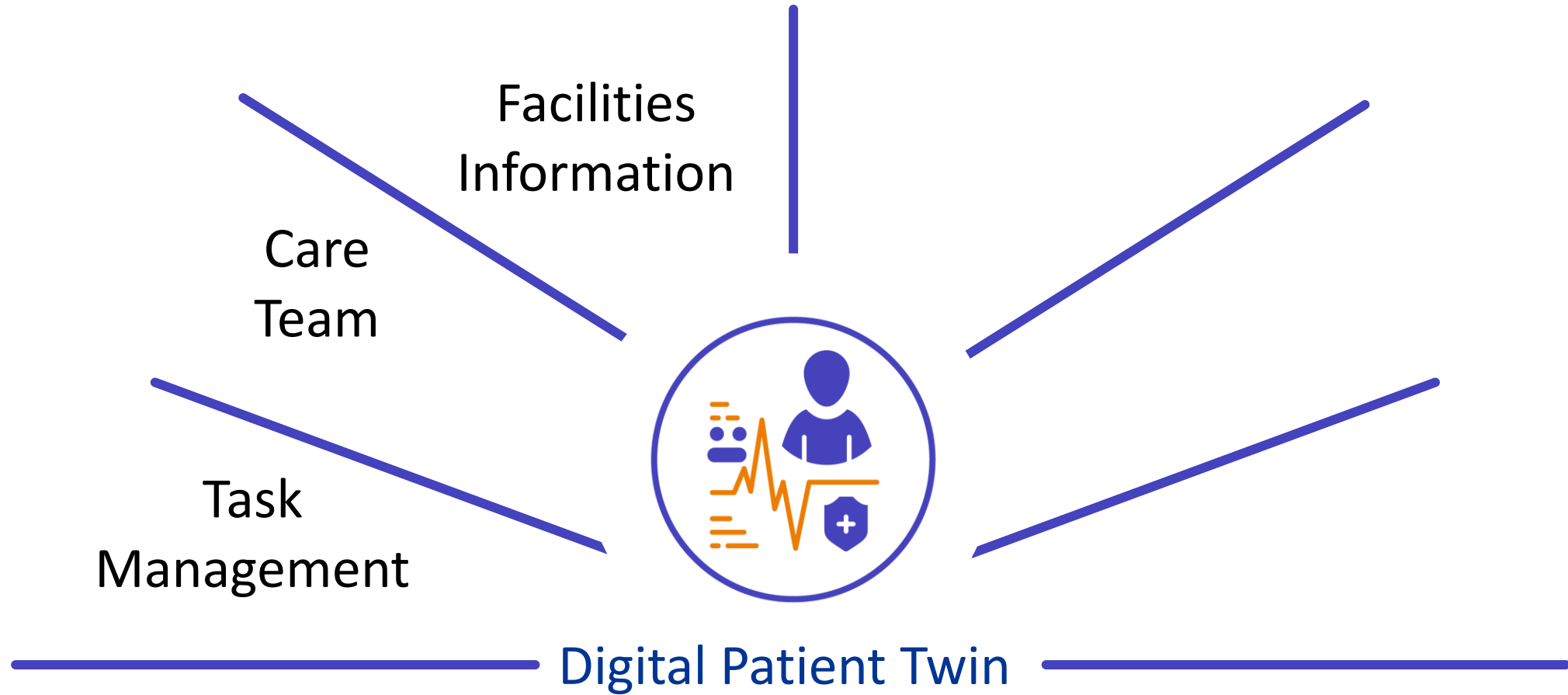
ALL	MY PATIENTS	ARRIVING	NEWS	DISCHARGE	BEDSORES	FALL	NUTRITION	QSOFA	REQUEST SUPPORT SERVICES							
NC	BED	LINKS	INFECTION	NAME	BED STATUS	ARRIVAL	EPR	PREScriptions	LEVEL OF CARE	RESPONSIBLE NURSE	DOCTOR	EDD	DISCHARGE READY	TASK STATUS		
	Day Room			Arther Right	Occupied	08/07 11:46 AM		Paracetamol	II	 Nurse 1 07785926582	 Doctor 1	13/07 12:00	Not ready			
	Room B1			Maggy Nesium	Occupied	08/07 11:02 AM		Fentanyl	II	 Nurse 1 07785926582	 Doctor 1					
	Secure Room			Mat Holliday	Pending cleaning	08/07 11:02 AM			III	 Nurse 1 07785926582	 Doctor 1					
	Treatment Room			Hus Patel	Occupied	08/07 08:07 AM		Codeine Paracetamol	III	 Nurse 1 07785926582	 Doctor 1					
	Bed Space 01				Available					 Nurse 1 07785926582						
	Bed Space 02				Available					 Nurse 1 07785926582						
	Bed Space 03				Available											
	Bed Space 04			Bluey Heeler	Occupied	08/07 11:02 AM			I	 Nurse 1 07785926582	 Doctor 1	10/07 15:00	Not ready			

NC	BED	LINKS	INFECTION	NAME	BED STATUS	ARRIVAL	EPR	PRESCRIPTIONS	LEVEL OF CARE	RESPONSIBLE NURSE	DOCTOR
	Day Room			Arther Right	Occupied	08/07 11:46 AM		Paracetamol	II	Nurse 1 07785926582	Doctor 1
	Room B1			Maggy Nesium	Occupied	08/07 11:02 AM		Fentanyl	II	Nurse 1 07785926582	Doctor 1
	Secure Room			Mat Holliday	Pending cleaning	08/07 11:02 AM			III	Nurse 1 07785926582	Doctor 1
	Treatment Room			Hus Patel	Occupied	08/07 08:07 AM		Codeine Paracetamol	III	Nurse 1 07785926582	Doctor 1
	Bed Space 01				Available					Nurse 1 07785926582	
	Bed Space 02				Available					Nurse 1 07785926582	
	Bed Space 03				Available						
	Bed Space 04			Bluey Heeler	Occupied	08/07 11:02 AM			I	Nurse 1 07785926582	Doctor 1

Workflow First Approach



Workflow First Approach



DNV Imatis

Demo Room

Wandsworth | Wandsworth

Medical Inpatient Dashboard

Medical Inpatient Whiteboard

Porter Request Dashboard

Wandsworth Cleaning Request Dashboard

ALL

MY PATIENTS

ARRIVING

NEWS

DISCHARGE

BEDSORES

FALL

NUTRITION

QSOFA

NC

BED

LINKS

INFECTI...

NAME

Maybury Ward

Jane Foster

Day Room

Jane Doe

Room B1

Maggy Nesiu

Treatment Room

Christopher B

Bed Space 02

Arther Right

Meal Order

Treatment Room | Christopher Betts

Diet

Diet

Available elements

Bland diet

Fat free diet

Fat reduced

Gluten free diet

Halal

Kosher

Selected elements

Gluten free diet

Food allergies

Input freetext

Add

Food allergies

Available elements

Almonds

Apple

Celery

Selected elements

Celery

* REQUIRED FIELDS

OK

CANCEL

FINAL SCREE...

NUTRITIONAL...

SEVERITY OF ...

NUTRITION TI...

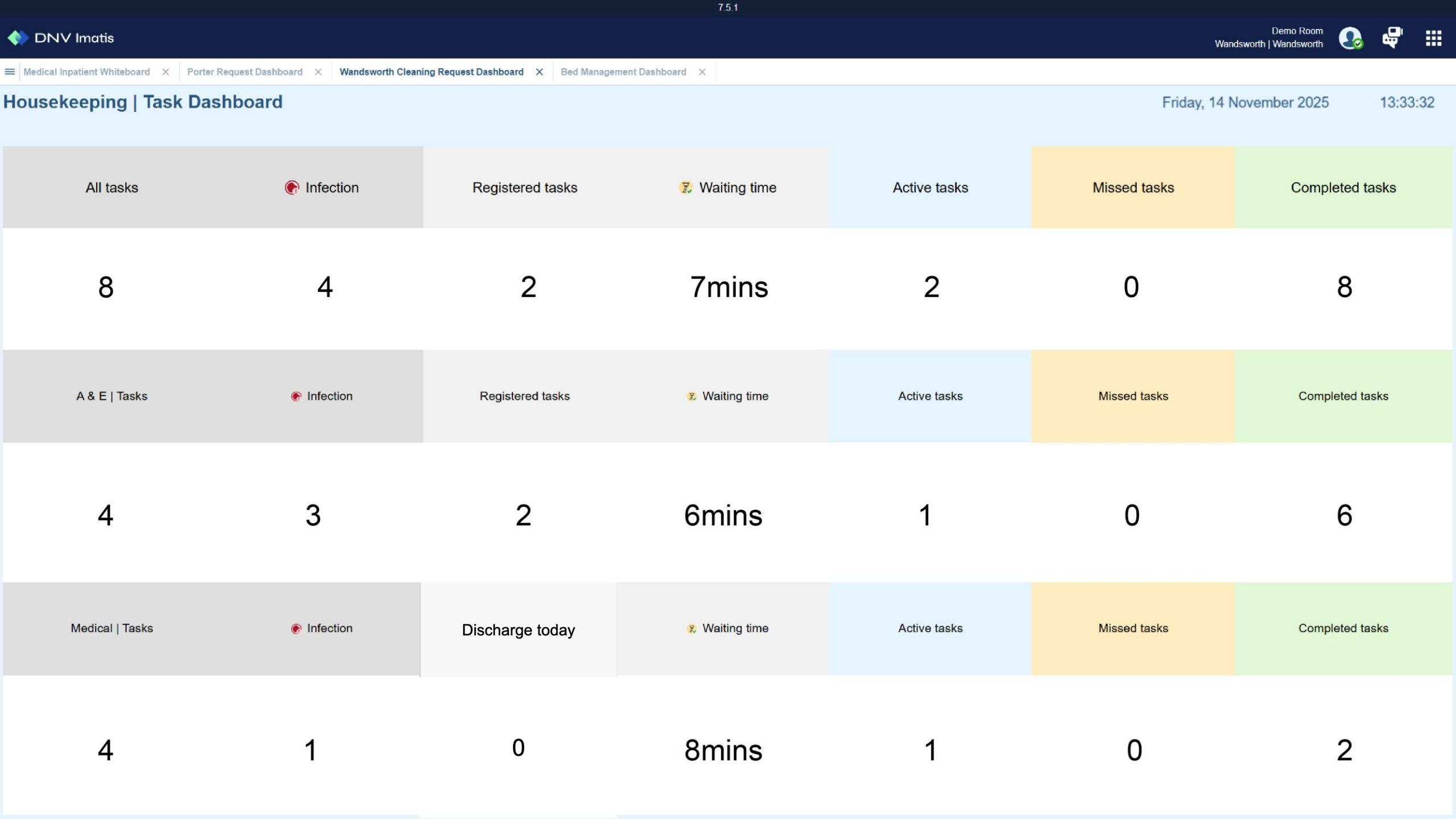
COI

NO

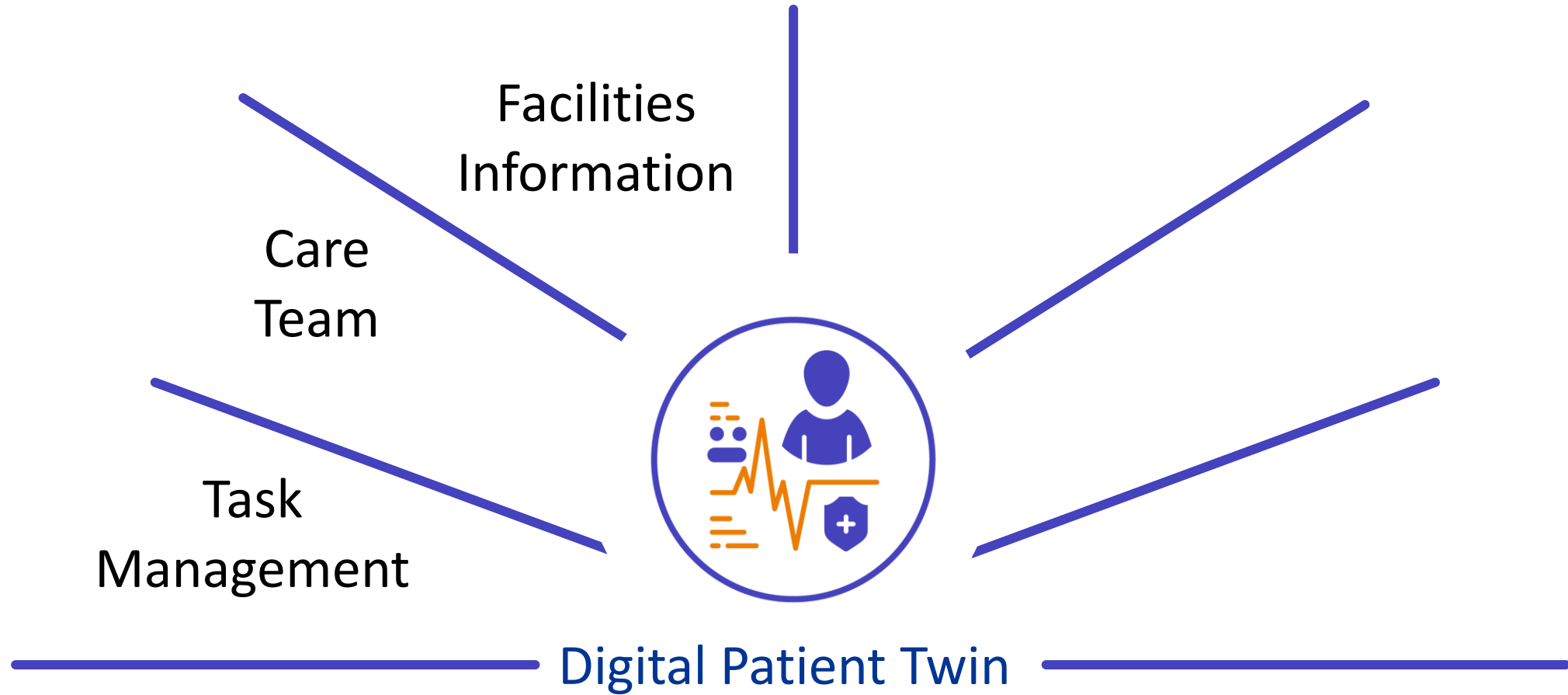
YES

5 of 8 rows visible. Data last changed a minute ago

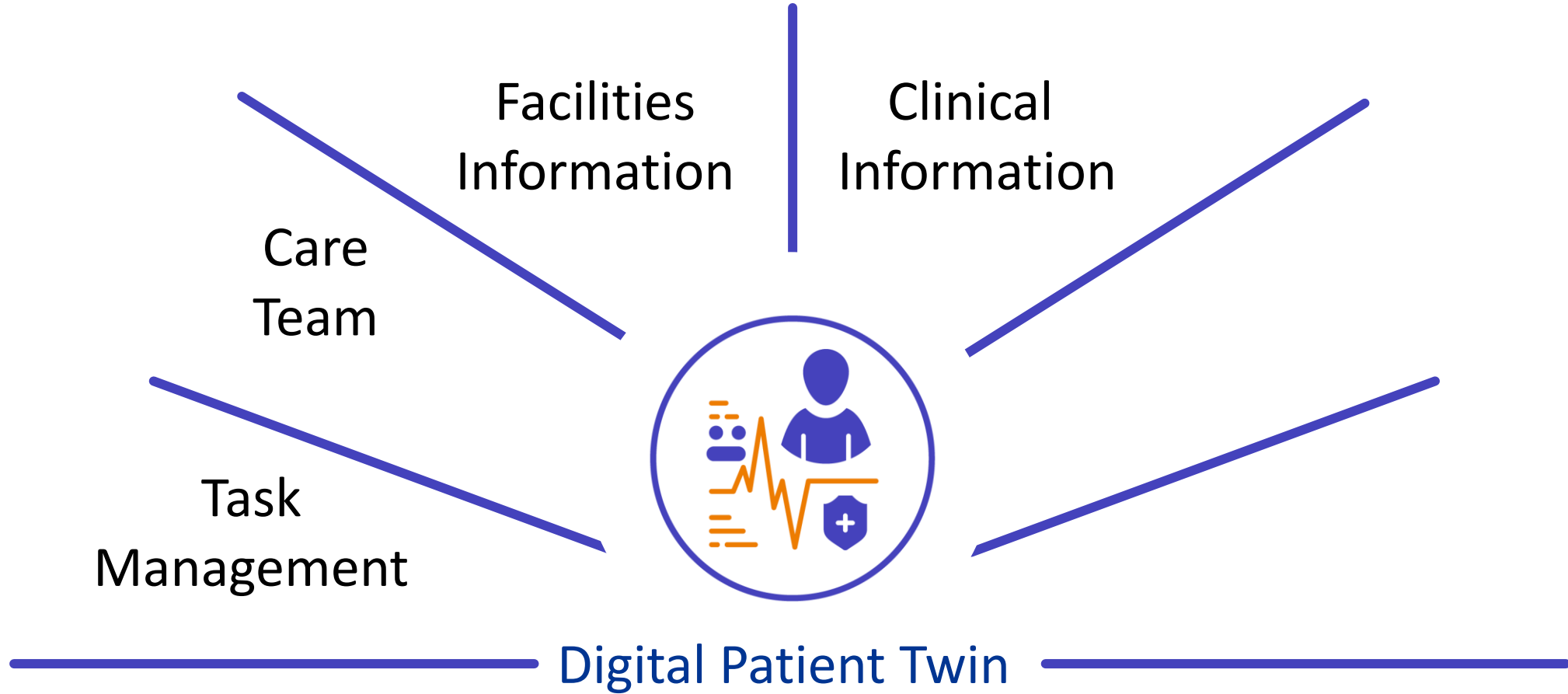
NC	BED	LINKS	INFECTI...	NAME	EPR	NUTRITION	NUTRITION S...	BMI	WEIGHT LOSS	REDUCED DIE...	ICU	FINAL SCREE...	NUTRITIONAL...	SEVERITY OF ...	NUTRITION TI...	COI
	Maybury Ward			Jane Foster												
	Day Room			Jane Doe												
	Room B1			Maggy Nesium												
	Treatment Room			Christopher Betts				YES	NO	YES	NO	YES				
	Bed Space 02			Arther Right												



Workflow First Approach



Workflow First Approach



NC	BED	INFECTION	NAME	EPR	NEWS SCORE	RESPIRATION	HYPERCAPNIC RES...	SPO2 1	SPO2 2	O2	SYSTOLIC BP	PULSE	CONSCIOUSN...	TEMPERATURE	COPY
	Maybury Ward		Jane Foster		7↑	2	NO	2	----	0	1	1	0	1	
	Day Room		Jane Doe		6↑	2	YES	----	1	0	1	1	0	1	
	Room B1		Maggy Nesium		9↑	1	YES	----	2	2	2	1	0	1	
	Treatment Room		Christopher Betts		8↑	2	NO	2	----	0	2	1	0	1	
	Bed Space 02		Arther Right		0=	0	NO	0	----	0	0	0	0	0	

Secure Room Mat Holliday

D1

All

NEWS

Discharge

X

Links

Patient log

Update patient info

NEWS

qSOFA

Bedsore

Fall

Nutrition

Meal order

Surgery

Send task

Porter request

<

Back

Home

Secure Room Mat Holliday

D1

qSOFA

Respiration *

Is respiratory rate greater than or equal to 22 breaths per minute?

1

YES, respiratory rate is greater than or equal to 22 breaths per minute

0

NO, respiratory rate is NOT greater than or equal to 22 breaths per minute

Systolic BP *

Is systolic BP less than or equal to 100 mmHg?

1

YES, systolic BP is less than 100 mmHg

0

NO, systolic BP is NOT less than 100 mmHg

* REQUIRED FIELDS

OK

CANCEL

<

Back

Home

NC	BED	INFECTION	NAME	EPR	NEWS SCORE	RESPIRATION	HYPERCAPNIC RES...	SPO2 1	SPO2 2	O2	SYSTOLIC BP	PULSE	CONSCIOUSN...	TEMPERATURE	COPY
	Maybury Ward		Jane Foster		7↑	2	NO	2	----	0	1	1	0	1	
	Day Room		Jane Doe		6↑	2	YES	----	1	0	1	1	0	1	
	Room B1		Maggy Nesium		9↑	1	YES	----	2	2	2	1	0	1	
	Treatment Room		Christopher Betts		8↑	2	NO	2	----	0	2	1	0	1	
	Bed Space 02		Arther Right		0=	0	NO	0	----	0	0	0	0	0	

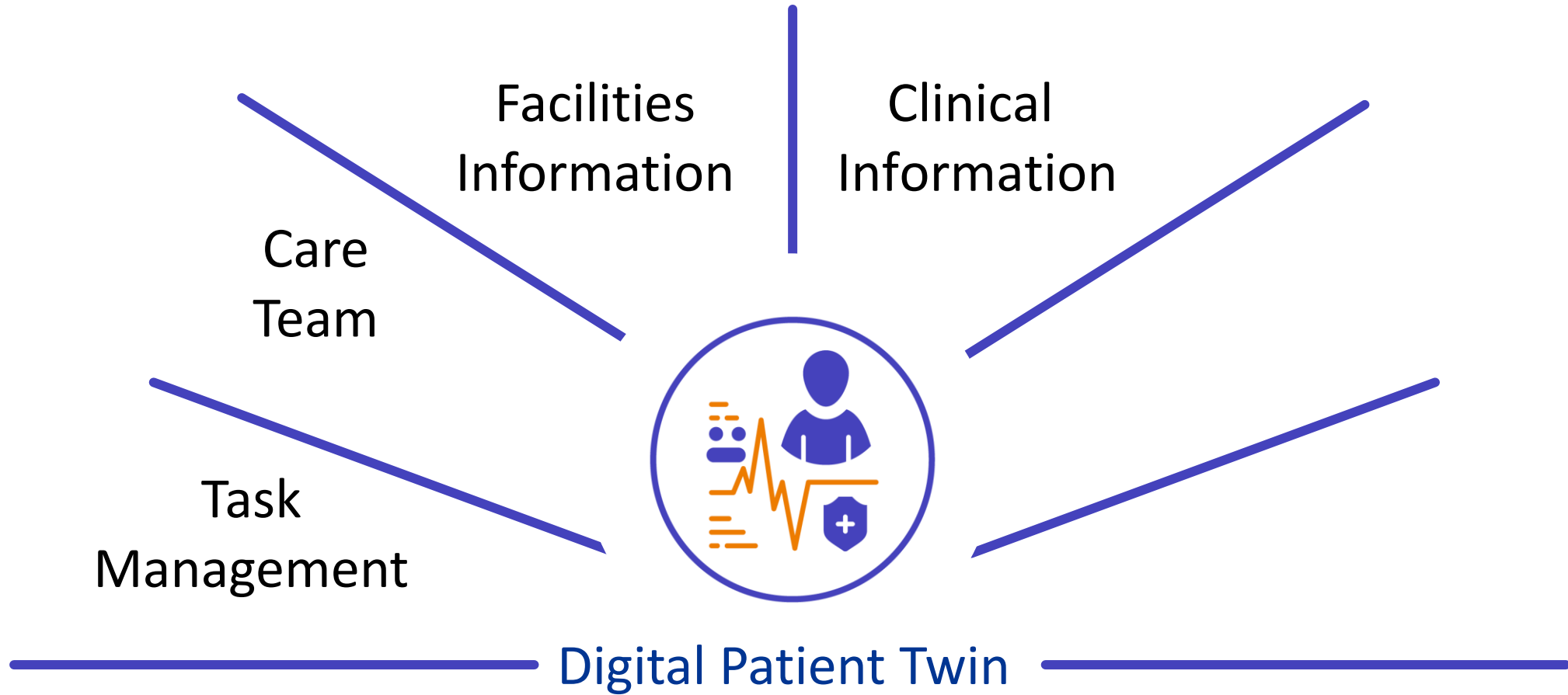


QSOFA

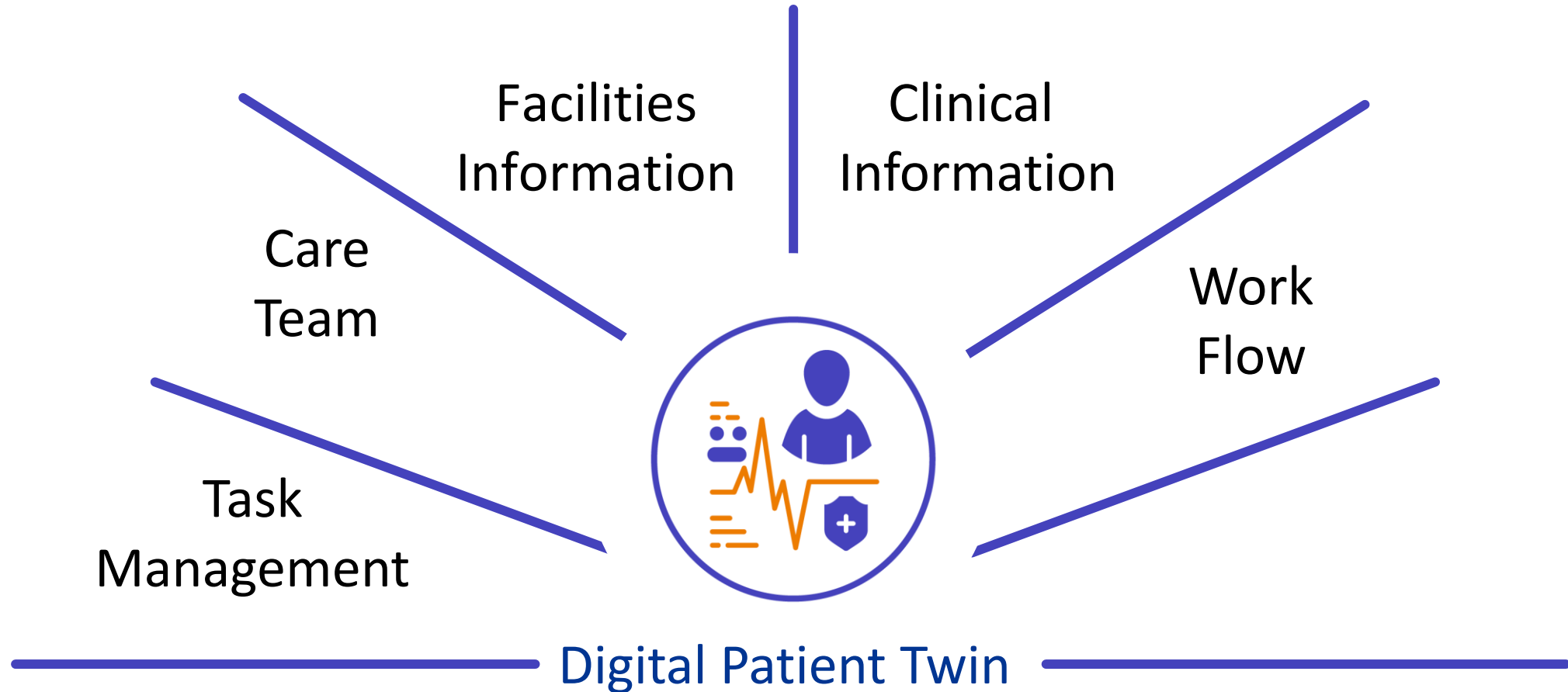


	NEWS SCORE	RESPIRATION	HYPERCAPNIC RES...	SPO2 1	SPO2 2	O2	SYSTOLIC BP	PULSE	CONSCIOUSN...	TEMPERATURE	COPY
	7 [↑]	2	NO	2	----	0	1	1	0	1	
	6 [↑]	2	YES	----	1	0	1	1	0	1	
	9 [↑]	1	YES	----	2	2	2	1	0	1	
	8 [↑]	2	NO	2	----	0	2	1	0	1	
	0 ⁼	0	NO	0	----	0	0	0	0	0	

Workflow First Approach



Workflow First Approach



NAME	NC	BED	LINKS	INFECTION	BED STATUS	ARRIVAL	EPR	MEDS REC	PRESCRIPTIONS	RESPONSIBLE NU...	DOCTOR	LOS	EDD	DISCHARGE R...	DISCHARGE
Jane Foster		Maybury Ward			Occupied	05/11 12:1...						6d 1h 25m		Ready	9/9
Jane Doe		Day Room			Occupied	03/11 11:5...			Tramadol	Nurse 1 +447523730650	Doctor 1	3d 7h 2m			0/9
Maggy Ne...		Room B1			Occupied	03/11 11:5...			Amoxycillin	Nurse 1 +447523730650	Doctor 1	2d 12h 10m	06/11	Not ready	0/9
Mat Holliday		Secure Room			Occupied	03/11 11:5...			NSAIDs	Nurse 1 +447523730650	Doctor 1	3d 1h 25m		Ready	0/9
Christophe...		Treatment Room			Occupied	19/10 12:2...			Amoxycillin Paracetamol	Nurse 1 +447523730650	Doctor 1	1d 1h 5m	06/11	Not ready	0/9
Arther Right		Bed Space 02			Occupied	03/11 11:5...			Morphine	Nurse 1 +447523730650	Doctor 1	1h 25m	07/11	Not ready	0/9

NAME	NC	BED	LINKS	INFECTION	BED STATUS	ARRIVAL	EPR	MEDS REC	PRESCRIPTIONS	RESPONSIBLE NU...	DOCTOR	LOS	EDD	DISCHARGE R...	DISCHARGE
Jane Foster		Maybury Ward			Occupied	05/11 12:1...						6d 1h 25m		Ready	9/9
Jane Doe		Day Room									Doctor 1	3d 7h 2m			0/9
Maggy Ne...		Room B1									Doctor 1	2d 12h 10m	06/11	Not ready	0/9
Mat Holliday		Secure Room									Doctor 1	3d 1h 25m		Ready	0/9
Christophe...		Treatment Room									Doctor 1	1d 1h 5m	06/11	Not ready	0/9
Arther Right		Bed Space 02									Doctor 1	1h 25m	07/11	Not ready	0/9

EDD

Secure Room | Mat Holliday

DATE

13/11/2025

TIME

< November 2025 >

Wk Mon Tue Wed Thu Fri Sat Sun

44 27 28 29 30 31 1 2

45 3 4 5 6 7 8 9

46 10 11 12 13 14 15 16

47 17 18 19 20 21 22 23

48 24 25 26 27 28 29 30

49 1 2 3 4 5 6 7

TODAY

1 : 23

AM

PM

NOW

CLEAR

OK

CANCEL

NAME	NC	BED	LINKS	INFECTION	BED STATUS	ARRIVAL	EPR	MEDS REC	PRESCRIPTIONS	RESPONSIBLE NU...	DOCTOR	LOS	EDD	DISCHARGE R...	DISCHARGE
Jane Foster		Maybury Ward			Occupied	05/11 12:1...						6d 1h 25m		Ready	9/9
Jane Doe	☐	Day Room									Doctor 1	3d 7h 2m			0/9
Maggy Ne...	☐	Room B1									Doctor 1	2d 12h 10m	06/11	Not ready	0/9
Mat Holliday	☐	Secure Room									Doctor 1	3d 1h 25m	13/11	Ready	0/9
Christophe...	☐	Treatment Room									Doctor 1	1d 1h 5m	06/11	Not ready	0/9
Arther Right	☐	Bed Space 02									Doctor 1	1h 25m	07/11	Not ready	0/9

 DISCHARGE

Secure Room | Mat Holliday

DISCHARGE CHECKLIST (5/9)

▼ Discharge checklist (5/9)

COMPLETE GROUP ☐

TASK	NOTE	MODIFIED BY	COMPLETE
The patient (and/or next of kin) informed		Demo Room	☒
Possessions returned		Demo Room	☒
Discharge consultation complete		Demo Room	☒
Patient has received all necessary prescriptions		Demo Room	☒
Discharge envelope		Demo Room	☒
Discharge summary complete and sent			☐
Community care notified			☐
Ready from nurse			☐
Ready from doctor			☐

EDIT

OK

CANCEL

NAME	NC	BED	LINKS	INFECTION	BED STATUS	ARRIVAL	EPR	MEDS REC	PRESCRIPTIONS	RESPONSIBLE NU...	DOCTOR	LOS	EDD	DISCHARGE R...	DISCHARGE
Jane Foster		Maybury Ward			Occupied	05/11 12:1...						6d 1h 25m		Ready	9/9
Jane Doe	☐	Day Room									Doctor 1	3d 7h 2m			0/9
Maggy Ne...	☐	Room B1									Doctor 1	2d 12h 10m	06/11	Not ready	0/9
Mat Holliday	☐	Secure Room									Doctor 1	3d 1h 25m	13/11	Ready	0/9
Christophe...	☐	Treatment Room									Doctor 1	1d 1h 5m	06/11	Not ready	0/9
Arther Right	☐	Bed Space 02									Doctor 1	1h 25m	07/11	Not ready	0/9

☒ DISCHARGE

Secure Room | Mat Holliday

DISCHARGE CHECKLIST (9/9)

▼ Discharge checklist (9/9)

COMPLETE GROUP ☒

TASK	NOTE	MODIFIED BY	COMPLETE
The patient (and/or next of kin) informed		Demo Room	☒
Possessions returned		Demo Room	☒
Discharge consultation complete		Demo Room	☒
Patient has received all necessary prescriptions		Demo Room	☒
Discharge envelope		Demo Room	☒
Discharge summary complete and sent		Demo Room	☒
Community care notified		Demo Room	☒
Ready from nurse		Demo Room	☒
Ready from doctor		Demo Room	☒

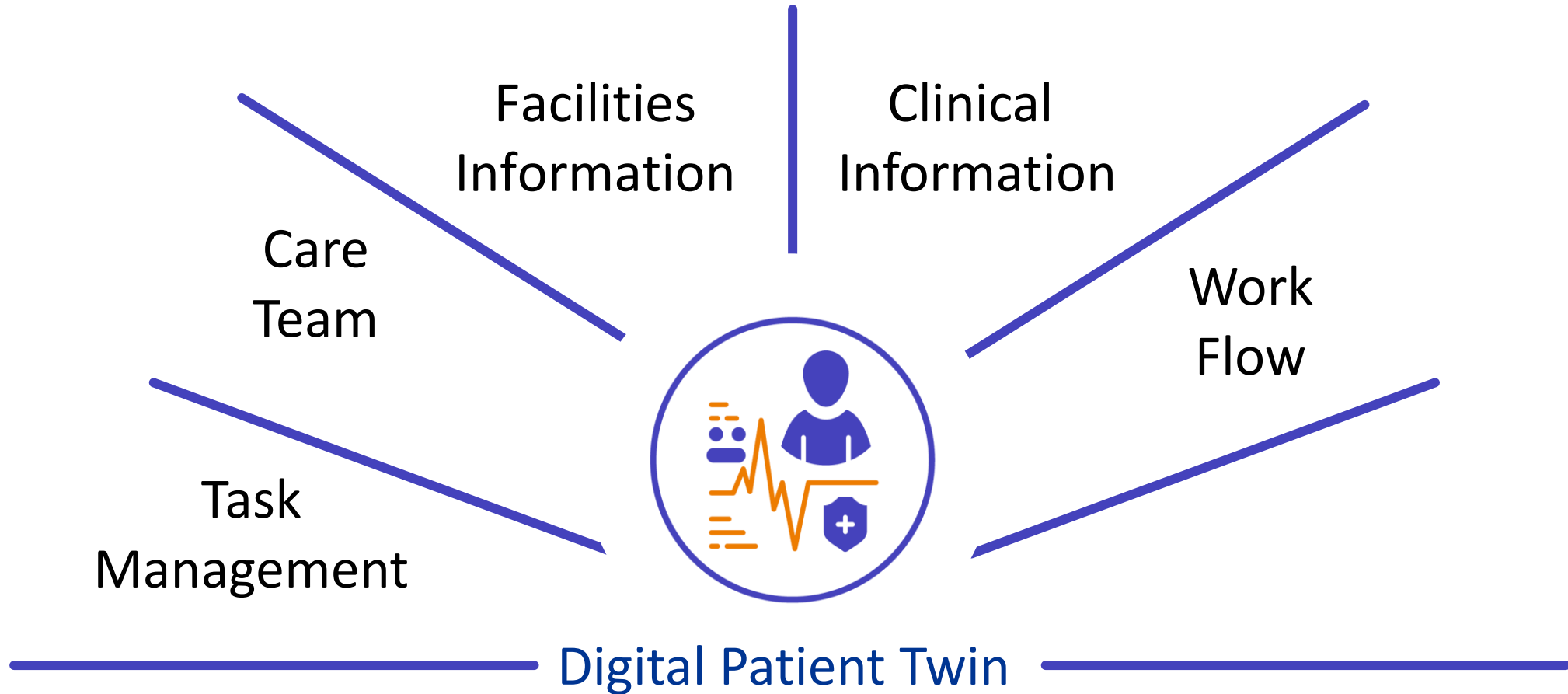
EDIT

OKCANCEL

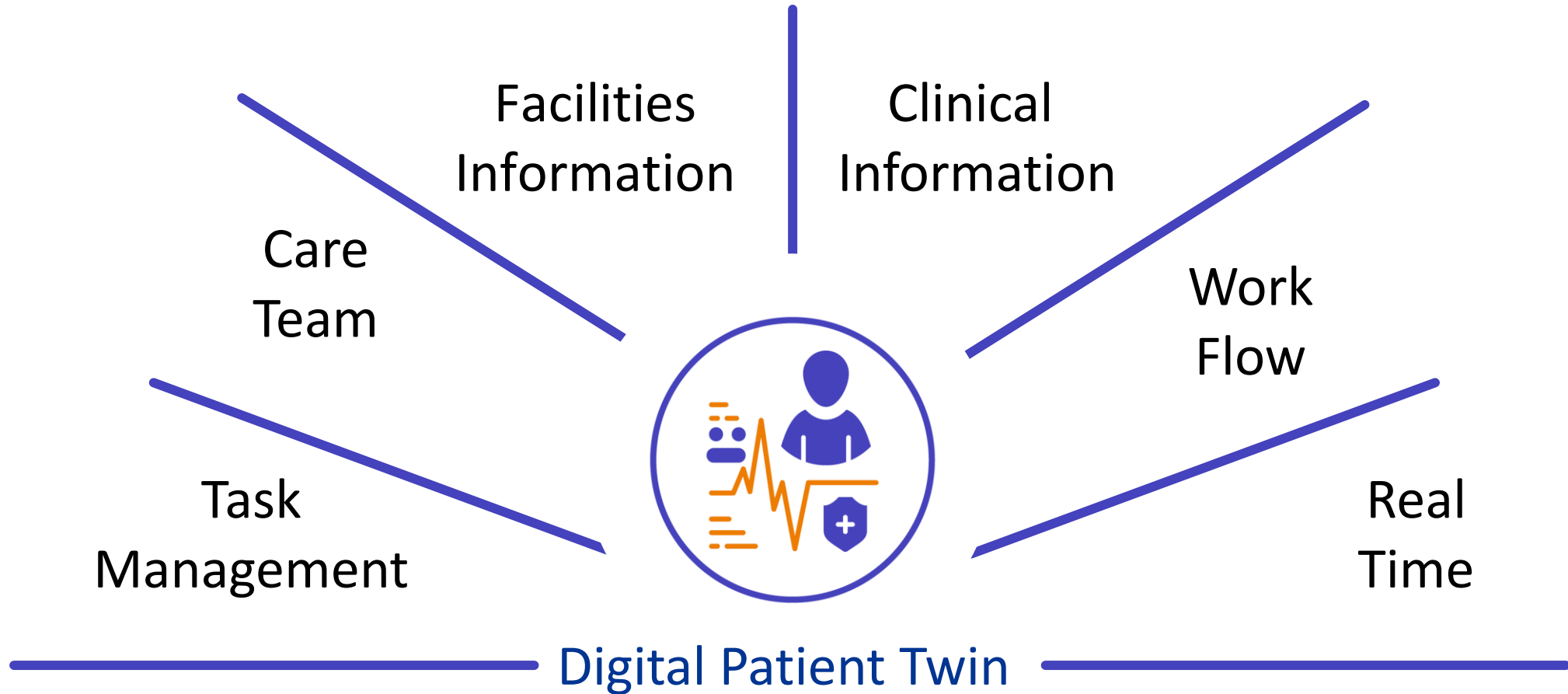
ALL TASKS

PRI.	TIME ▲	INFECTION TYPE	FROM	TO	CATEGORY	BOOKER
	11:32 am				Discharge cleaning	Maybury

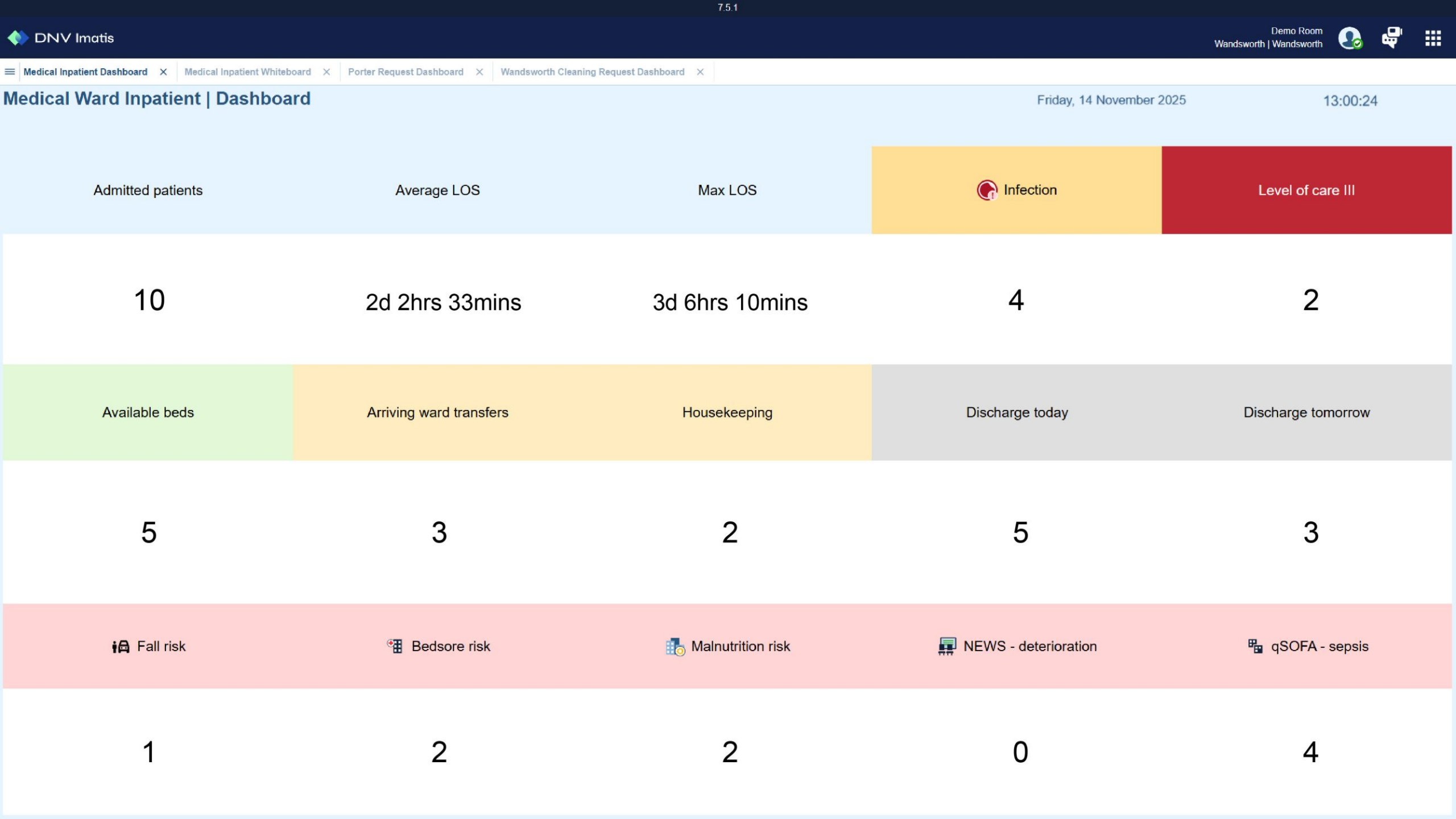
Workflow First Approach



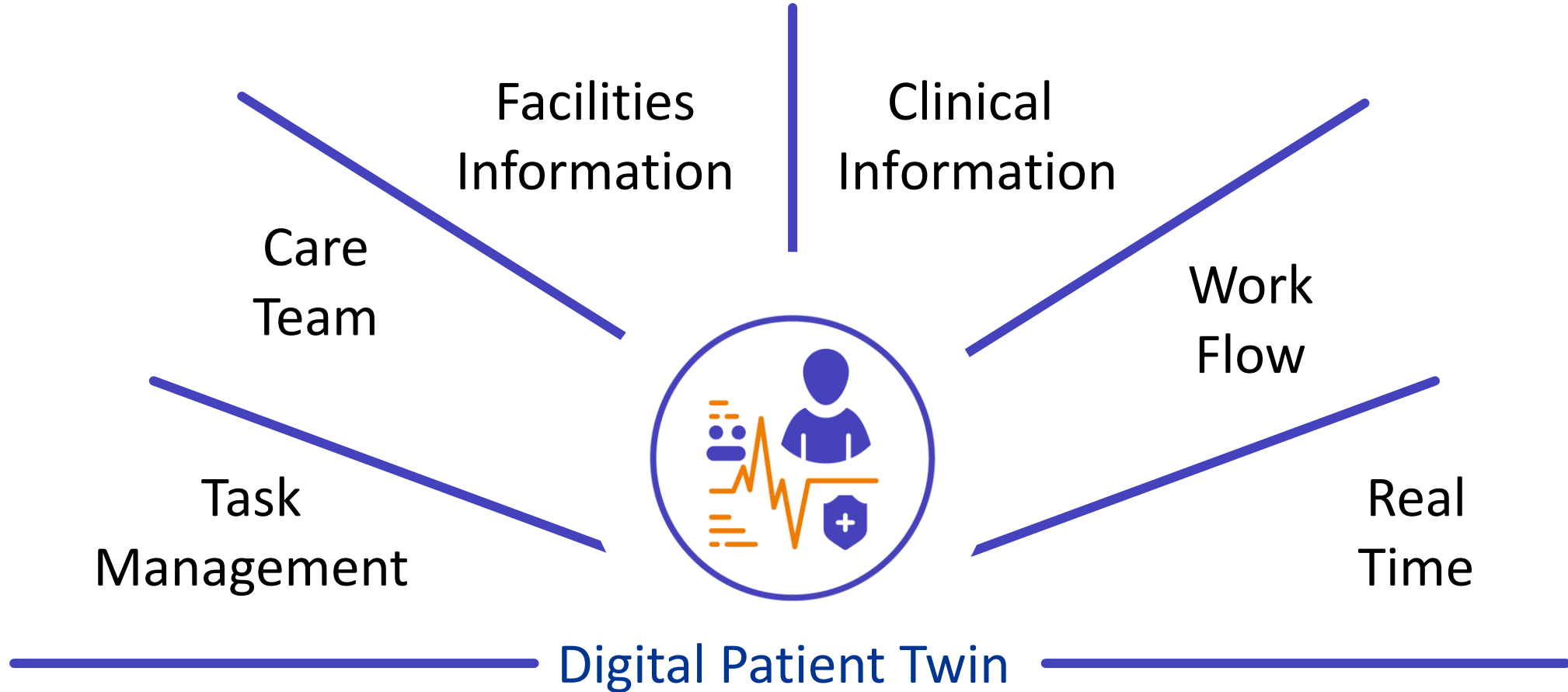
Workflow First Approach



DNV Imatis 7.5.1 Demo Room Wandsworth Wandsworth						
Medical Inpatient Dashboard Medical Inpatient Whiteboard Bed Management Dashboard Porter Request Dashboard Wandsworth Cleaning Request Dashboard Cleaning Task Manager Hospital Bed Management Friday, 14 November 2025 11:28:03						
	Total no. of beds	Inpatients	Planned Discharges	Housekeeping	Available beds	Arriving patients
Total	20	10	5	4	5	5
Emergency Dept	7	4	2	2	2	1
Medical Ward	6	5	1	0	1	1
Surgical Ward	7	3	2	1	4	3



Real-World Benefits



Real-World Benefits



The emergency department at Haraldsplass diaconal hospital: from bottleneck to flow

Transferring patients from the emergency department to the ward is time-consuming and resource-intensive at most hospitals, potentially creating a bottleneck for the patient flow. Haraldsplass diaconal hospital is among the hospitals that have extensively used digital tools to ease the transfer. Through a pilot project, a solution for seamless transfer of patients through digital bed management boards was developed. The solution enabled more efficient communication that reduced time consumption and human errors, while providing a better basis for effective resource allocation. The new bed management solution proved successful and is now in daily use throughout the hospital.



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About the hospital

Haraldsplass diaconal hospital (HDS) is a local hospital in Bergen, Norway. It is a private, non-commercial hospital with around 1250 employees. Specialist health services are offered in internal medicine, surgery, orthopaedics, and radiology, along with associated outpatient activity. The hospital has approximately 170 beds and most patients are admitted through the emergency department. On average, 40 patients go through the emergency department daily, of which about 90% of these need immediate help.

Troublesome transfers

HDS was early in adopting digital solutions. As early as 2018, they introduced digital boards from DNV Imatis on all wards to achieve a better overview of patients and staff resources. With all patient information available in the digital board, the next step was to look at how the transfer between the emergency department and the wards could be improved.

The emergency department had systems that worked well internally in the department but lacked a tool for transferring patients. One of the biggest challenges was that the shift leader in the emergency department had almost

all responsibility for patient flow. The shift leader had to call the wards to find out who they should talk to, and then verbally share all the information that was already registered in the digital board from DNV Imatis verbally. This took precious time, both for the shift leader and for the coordinator at the receiving ward. In addition, important information that was often written down on yellow notes could disappear, which in turn created unnecessary time use and confusion. Verbal communication became a source of error.

Time-saving and precise communication

To improve internal communication in the transfer of patients, the hospital set up a project group that involved employees on both the ward and the emergency department. After mapping the flow, a new solution was designed that was named "Reported to" in the existing boards. The solution was first piloted between the emergency department and the surgical ward.

In the new solution, patients were reported directly to the post from the board at the emergency department. The shift leader had a complete overview of the ward and

could assign patients directly based on the overall situation. Instead of giving verbal messages through several people to get to the right person, communication was given through standardised messages. Notification that the patient was reported to the ward went directly to the mobile of the responsible nurse, who could assign the patient a bed and a responsible resource. Then the responsible person could press one button to notify the emergency department that they were ready to receive the patient. The information was also not lost, as it was available at all times - all through the same board.

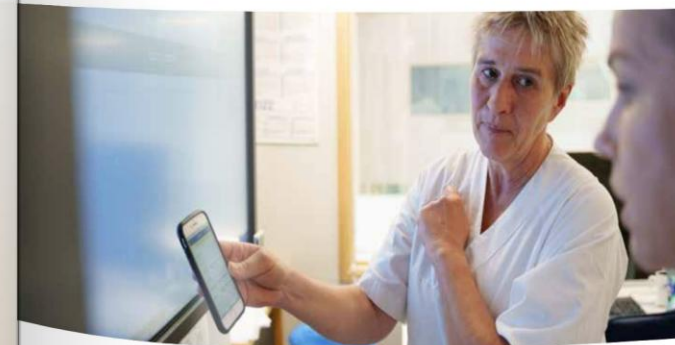
"An interesting observation was that we thought it was extremely important to have verbal discussions. We assumed that conversations were the key to effective communication. However, it turned out that this was not always the case, especially when it came to the large volume of patients to be transferred."

- Former system manager HDS, Michael Fjeldstad

By utilising the functionality of the boards in the transfer of patients, the information was available to all involved parties. When the emergency department reported the patient to the surgical ward, they agreed on the same information about the patient, which reduced discussions and time for clarifications. The porters were informed about which room the patient was to be transported directly to so that the patient did not have to lie in the hallway waiting for the responsible nurse.

From pilot to successful operation

During the pilot, two important prerequisites were identified for the logistics from the emergency department to the wards to work as well as possible. The first was that the shift leader in the emergency department had a comprehensive occupancy overview. It was made available in the shift leader's overview by collecting key figures/real-time data on occupancy from all wards. The second was that all patients were classified with level of care so that the overall care demand per department was available. This meant that the shift leader could distribute the load more evenly between the wards. This degree of planning required that the wards, on their part, actively updated the status of their patients on their ward boards.



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CASE STUDY



DNV Imatis
Bed Management at Østfold Hospital
In 2015 Østfold Hospital, located southeast of Oslo, opened a new hospital with 5,000 beds and 20 beds and 21 operation rooms. The hospital became the first in Norway to receive HIMSS Level 3 certification. This is a key factor in the hospital's success.

Previously, the hospital relied on manual routines involving various forms, which took time during patient visits. Interdepartmental communication was also time-consuming, often requiring manual calls to multiple locations to reach the right person. Vital information was sometimes written on whiteboards, paper, or sticky notes, leading to outdated or forgotten details. The lack of

A photograph of a hospital ward, showing several beds with orange headboards and metal frames, some with white linens. Medical equipment like IV stands and monitors are visible. The ward has a light-colored floor and walls, with a long corridor leading into the distance. The image is tilted and partially obscured by text on the left and right sides of the page.

Interaction across wards is crucial to make the best possible use of the hospital's capacity. Overcrowding and pressure on wards is common, but with interaction

Because all inpatient wards have the same real-time information, patient flow has improved, work processes have been simplified and communication between wards is easier. In addition, the digital whiteboards have helped to focus on logistics and highlighted bottlenecks.

Patient acuity is carried
who estimate treatment
the patient's treatment
a patient may have

15-17 hours saved

per shift per day on coordination
and manual routines >

**€4,400 saved
per bed**

annually as a result of coordinated
workflows, real-time decision support
and role-based task management >

50% reduction

in bed turnaround time
by coordinating cleaning and
discharge >

**Two hour
reduction**

in lab result turnaround time >

**£3,000 saved
per bed**

as a result of digitising and
silencing nurse calls >

Missed orderly tasks
down by 2-7%

Fewer unnecessary porter trips
and improved task flow >



€130,000 saved

in yearly improvements as a result
of improved communication and
digital cleaning coordination
>

**50% noise
reduction**

and 12% increase in sleep quality
as a result of a Silent Hospital
approach >

Cost savings estimated to

€8.5 million

by smoother patient flow with
digital check-in and queue
management >

**15-20%
productivity
gains**

by streamlining administrative and
logistical coordination >

“

The use of interactive digital whiteboards and interaction
with other departments helps staff to easily visualise and
act on potential bottlenecks. We have a better overall
overview of our occupancy rate, and we can more easily
predict how the next 24 hours will be.

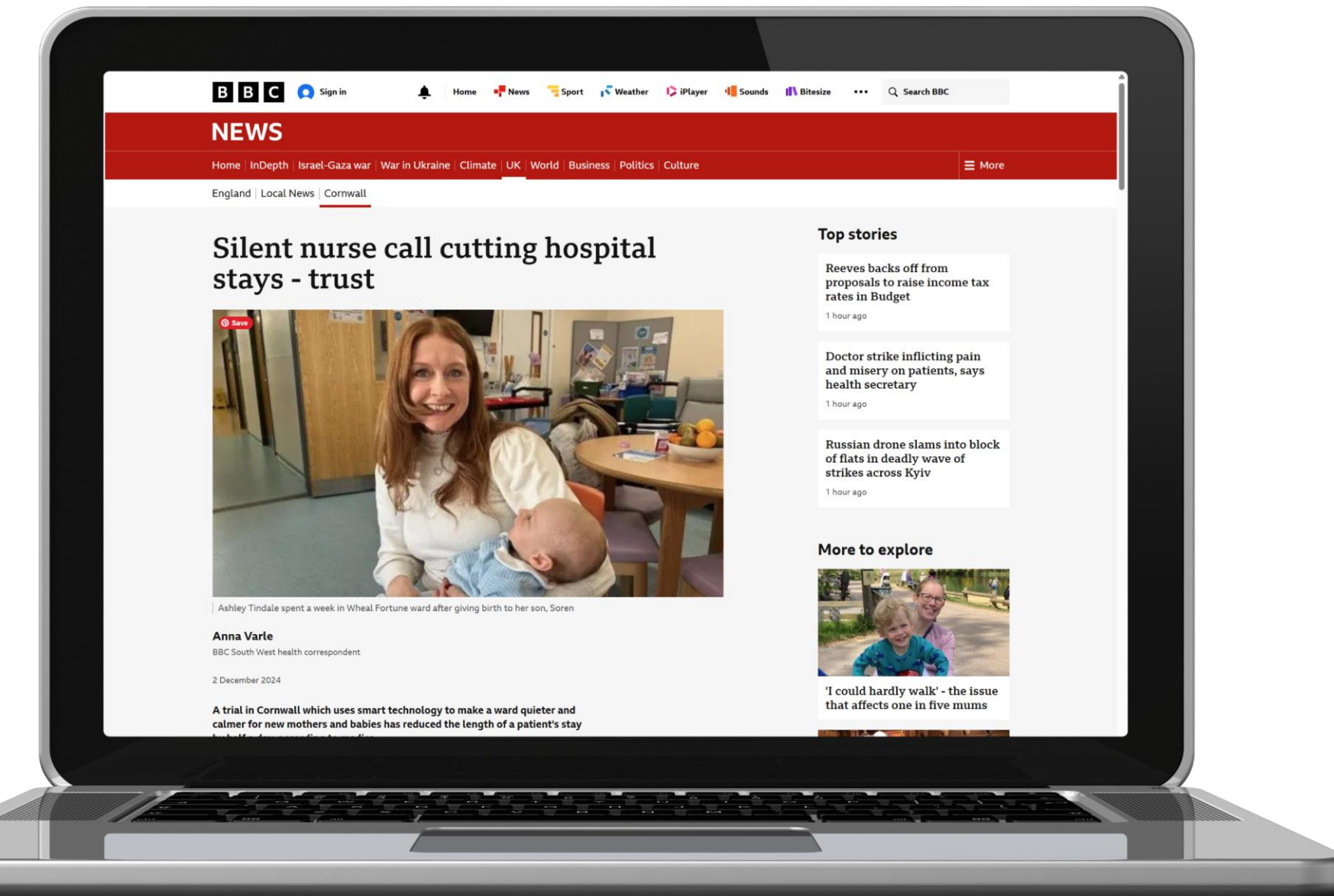
Anette Siebenherz, Østfold Hospital Trust, Norway >

No-show rate

cut by 34%

with digital appointment reminders
and self-check-in >

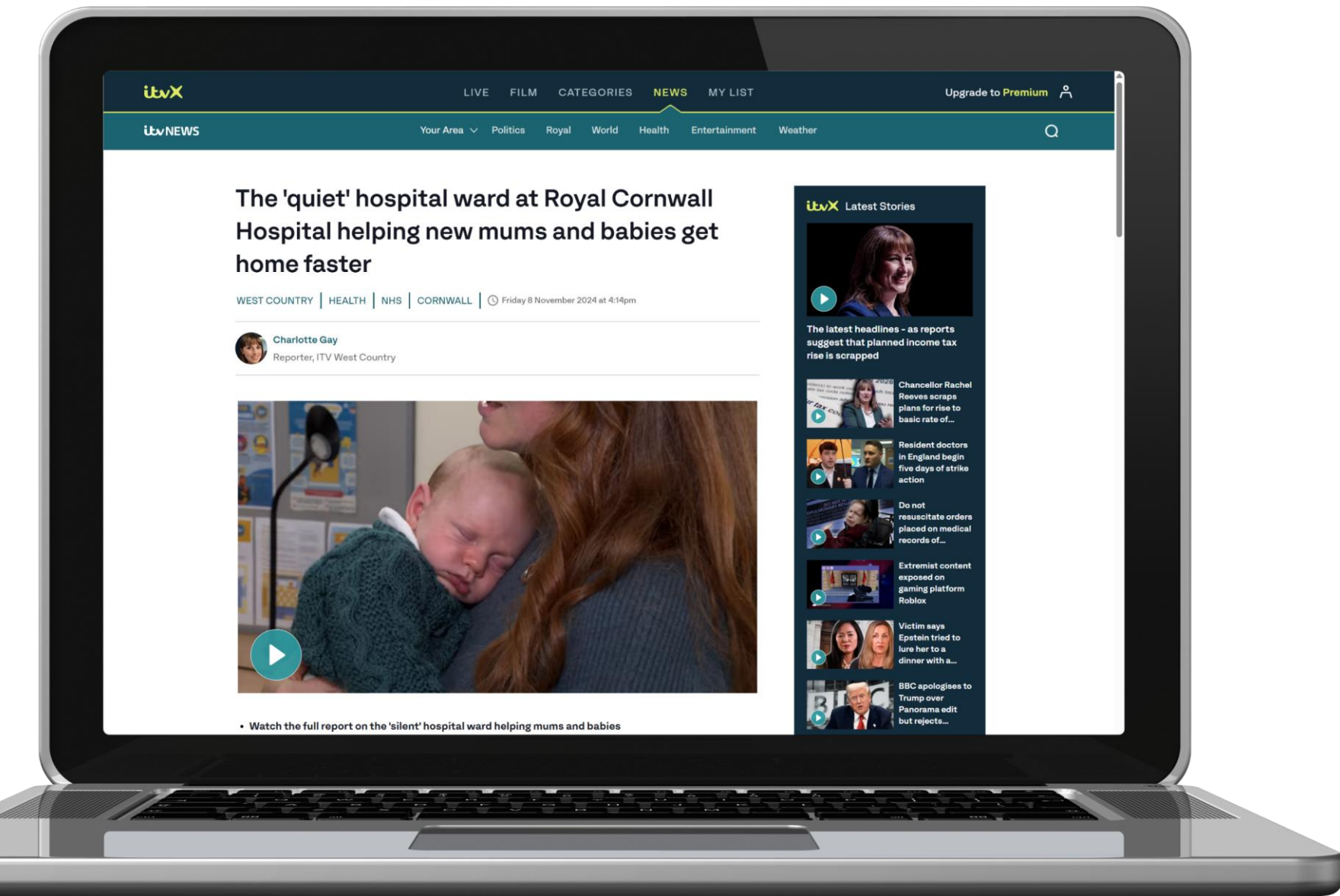




Royal Cornwall Hospitals

NHS Trust





NHS

Royal Cornwall Hospitals

NHS Trust





4.3.3 Benefit 3: Reduce the Average Length of Stay (ALOS)

Benefit Type: Non-Cash Releasing Benefit

It was proposed that reducing noise levels on the ward might lead to faster recovery times and enable a reduction in the ALOS. The implementation of the DNV Fundamentum platform on the ward did result in a statistically significant reduction in ALOS which was measured by tracking the ALOS for the patients during trial period and comparing that figure with the ALOS for the previous 2 years (baseline). Historical data was used to identify any seasonal trends which may occur and to seek to confirm that the reduction in ALOS was because of the project.

The findings on ALOS were:



A reduction in average length of stay of 0.5 days per post-natal patient was measured over the 6-month pilot. This could result in a non-cash releasing benefit of circa £75k for a 25-bed ward over a 12-month period.

There was a large site wide network disruption on 16 June 2024 which caused disruption across the network infrastructure and RCHT digital systems. The pilot was suspended, and the nurse call

system reverted to audible call bells while the network issues were resolved. Analysis of the data during this period shows a spike in ALOS for patients on the ward during the return to audible call bells, with ALOS reducing again once the silent operation of call bells resumed. This potentially demonstrates the positive effect the silent call bell system had on the ALOS however it is recognized that the increase in ALOS might be due to the more general impact of the IT outage on patient care. The extension of the trial through 2025 provides the opportunity to verify under more controlled conditions that the observation is causation rather than correlation.

Graph 2



4.3.4 Benefit 4: Improved measurement of call bell response times

Benefit Type: Unmonetisable

With the implementation of DNV Fundamentum, the Ward Manager on Wheal Fortune Ward was able to collect and interrogate data, for the first time, on the time taken for staff to answer the call bells.

The assumption supporting this benefit is that having the ability to record and analyse call bell response activity will lead to improved call bell response times and greater staff accountability for the delivery of care. Being able to track call bell response times also provides important clinical governance data which could be used when responding to complaints or investigations.

The findings on call bell response times were that there was a continuation of response time aligned with results and data from pre-pilot audible bells. There was a qualitative impact that showed improved responses from staff resulting from nurse calls being routed to the primary care giving enabling higher quality initial care.

4.3.5 Benefit 5: Reduction in the number of patient safety incidents

This benefit was retired due to insufficient data to show either improvement or worsening from the baseline data for patient safety incidents on Wheal Fortune Ward.



Royal Cornwall Hospitals
NHS Trust



Questions?

Digital Patient Journey Experience Centre



Refreshments & Networking



Chair Morning Reflection



Chris Morrow-Frost

National Clinical Advisor to Secondary Care
NHS England





Case Study



Case Study



Rob Hurrell

Senior Business Development Manager – Health
Enovation UK Limited





Complex Discharge, Simpler Handovers

A Digital Transfer of Care Approach

You already know the challenge...



Patient Transfer



Why the NHS still wastes billions on patients who don't need to be in hospital

12 January 2026

Share  Save 

 Add as preferred on Google



Nick Trigg

Health correspondent

As ambulances queued in front of Royal Berkshire Hospital in Reading last week, corridors full of patients were waiting for a bed on a ward. Emergency department consultant Omar Nafousi was at his wit's end.

"We've no space," he told the BBC last week. "This is not what I signed up for when I became a doctor."

It is a scene that is being repeated in hospitals up and down the country as winter viruses and cold weather add to the pressures on the health service.

Currently nearly 4,000 beds in England alone are taken up by patients with flu, Covid and the vomiting bug norovirus, according to NHS England, and the situation is on a similar scale in the rest of the UK.

But that is dwarfed by another pressure – the patients who should not be in hospital.

Every day there are more than 13,000 people whose treatment has been completed who are still in hospitals in England, the latest figures from NHS England suggest. Plus there are a further 4,000 around the rest of the UK - which means around one in eight beds are occupied by people who don't necessarily need to be there.

Many of these "delayed discharge" patients are older and may be frail and living with multiple health conditions who need support in the community.

<https://www.bbc.com/news/articles/c394vjm7n4vo>

What delayed discharge looks like, every day

Patients waiting to go home

AVERAGE PER DAY

22,396

patients no longer meet the criteria to reside

OF THOSE READY

59.3%

Are not discharged on the day they could be

AVERAGE PER DAY

13,291

Remain in hospital, despite being fit for discharge

TOTAL COST OF DELAYED BED DAYS, ENGLAND

£ 231.6m per month

May 2026 – 412,026 additional bed days

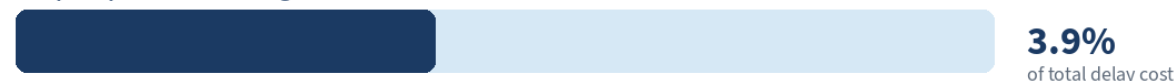
Care transfer hub and referral delays

Of that £231.6m, £41.9m, nearly one pound in every five, is directly attributable to care transfer hub and referral coordination delays.

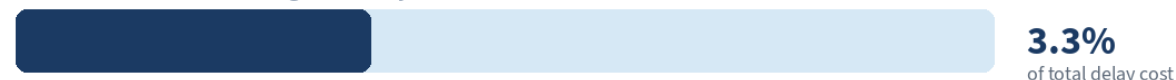
Care transfer hub: confirming care needs and pathway



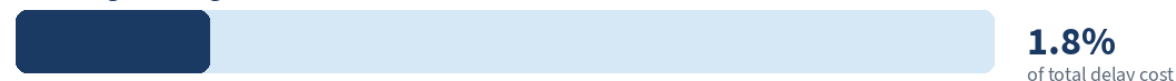
Hospital process: awaiting referral to care transfer hub



Care transfer hub: awaiting necessary referrals



Wellbeing: discharge destination readiness issues



Source: NHS England Daily Discharge Sitrep, monthly data, May 2026

Why it's hard



Discharge historically seen as the end of the pathway: *'get patients out of hospital'*



Lack of collated information about ongoing care needs



Lack of system integration means discharge notes are 'sheets in the wind' – **clinical risk**



Lack of information about **capacity** leads to the dreaded 'call round'.

The Perspective from The Netherlands



The Perspective from The Netherlands

enovation

enovation point

King 06-06-1950 (73) BSN: 759937850 Transfer ID: 788057

Forms

Phases

Characteristics

Search file

Dashboard

File

Patient record

Request Follow-up care

Nurse Handover

Communication journal

Additional file

Attachments

Assessment

Transfer Lounge

Actions

Print

Phase 0	WN	Record patient data	24-01-2024 16:36
Phase 1	WN	Fill in application form	24-01-2024 16:59
... Phase 2	TL	Review File by TL	
Phase 3	TL	Send CARE/Assessment Centre	
Phase 4	AC	Review File AC	
Phase 4.1	AC	Record the AC Assessment decision	
Phase 5	CofE	Review File Specialist CofE	
Phase 5.1	CofE	Record CofE Result Triage	
Phase 6	CARE	Review File CARE	
Phase 7	CARE	Record CARE decision	
Phase 7.1	TL	Assess CARE decision	
Phase 8	WN	Send nurse handover	
Phase 9	TL	Close File	

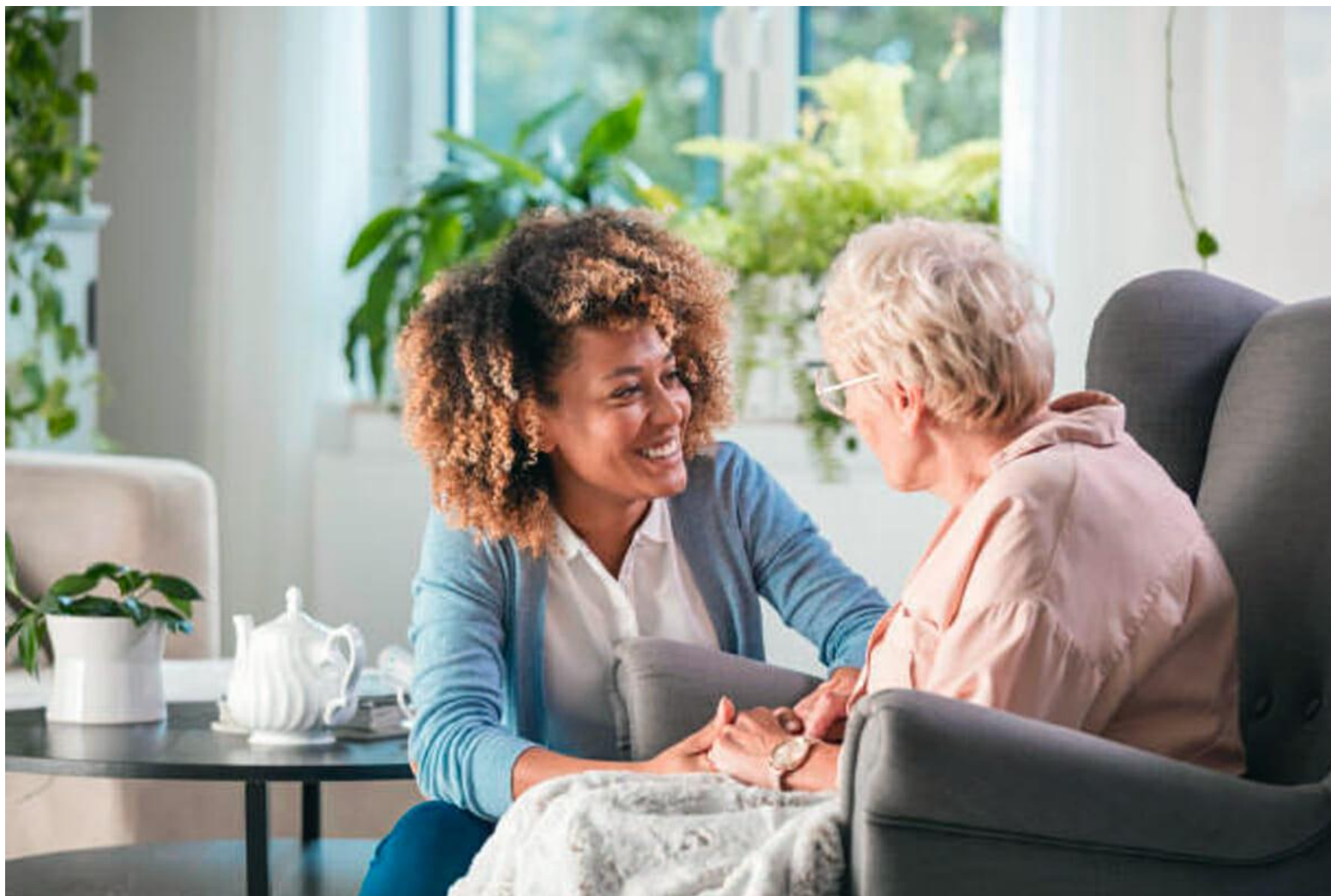
The Perspective from The Netherlands



Regional Transfer of Care collaboration



Lessons



Lessons



Seamless digital Transfer of Care is **achievable today**.



It depends on **strong regional collaboration and commitment**.



Start small – one hospital, one care home – and scale from there.



We've delivered this across multiple healthcare providers and regions for **over 15 years** and can help you take the next step.

The Opportunity

Be our first UK regional partner - one ICB, Trust, or system ready to shape how digital Transfer of Care works here.



The Opportunity

*“If you want to go fast, go alone; if you want to go far,
go together.”*



Questions?





Case Study

gama
healthcare



Case Study



Kris Khambhaita

Director Infection Prevention and Control
Dartford and Gravesham NHS Trust



Our Improvement Journey (so far), in Optimising Patient Flow whilst keeping Infection Prevention

Kris Khambhaita

Director of Infection Prevention & Control
Dartford and Gravesham NHS Trust (DGT)



Keynote Presentation

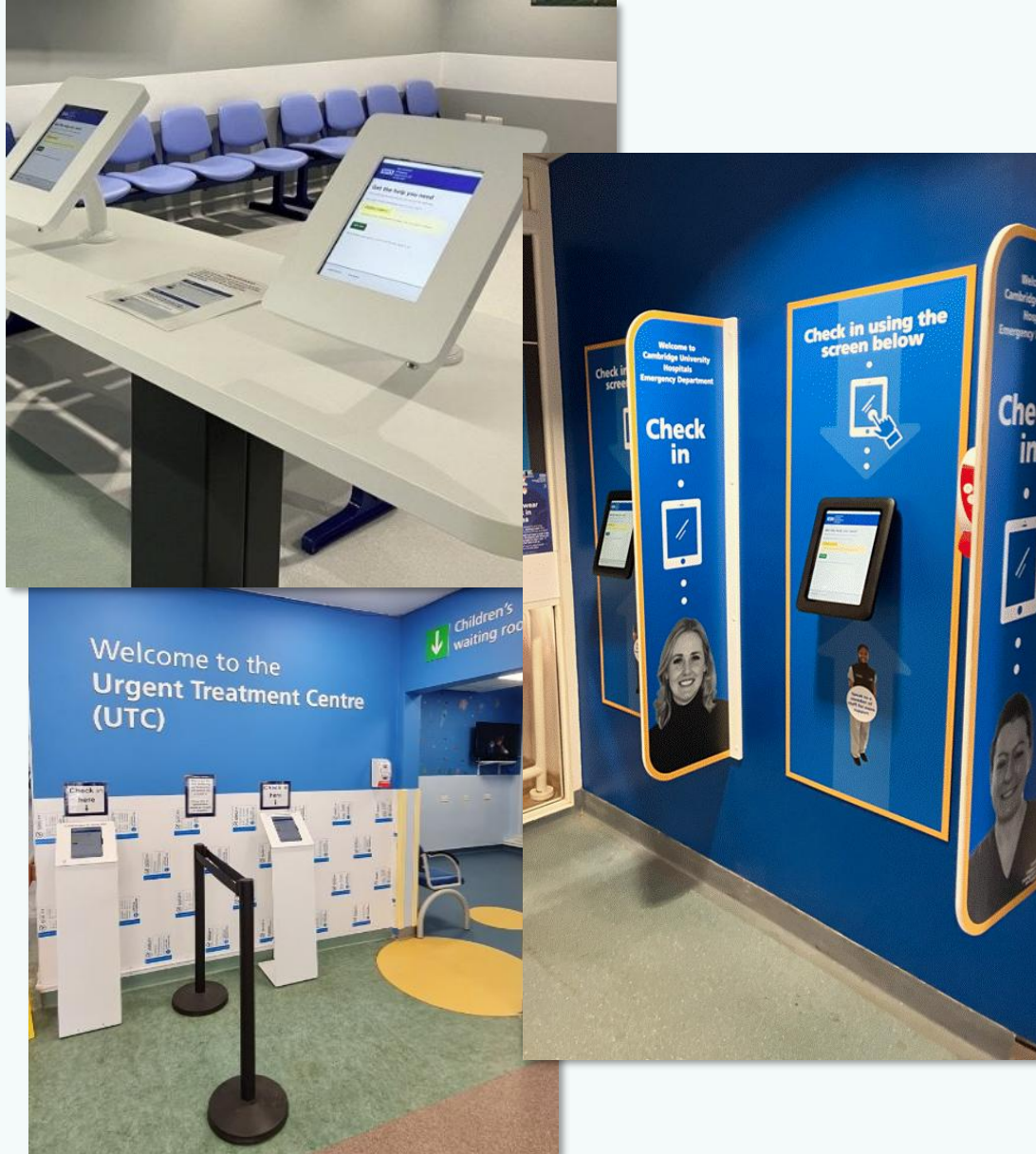


Emily Godfrey
Implementation and Business
Change Manager
NHS England



Peter Richardson
Senior Product Manager
NHS England



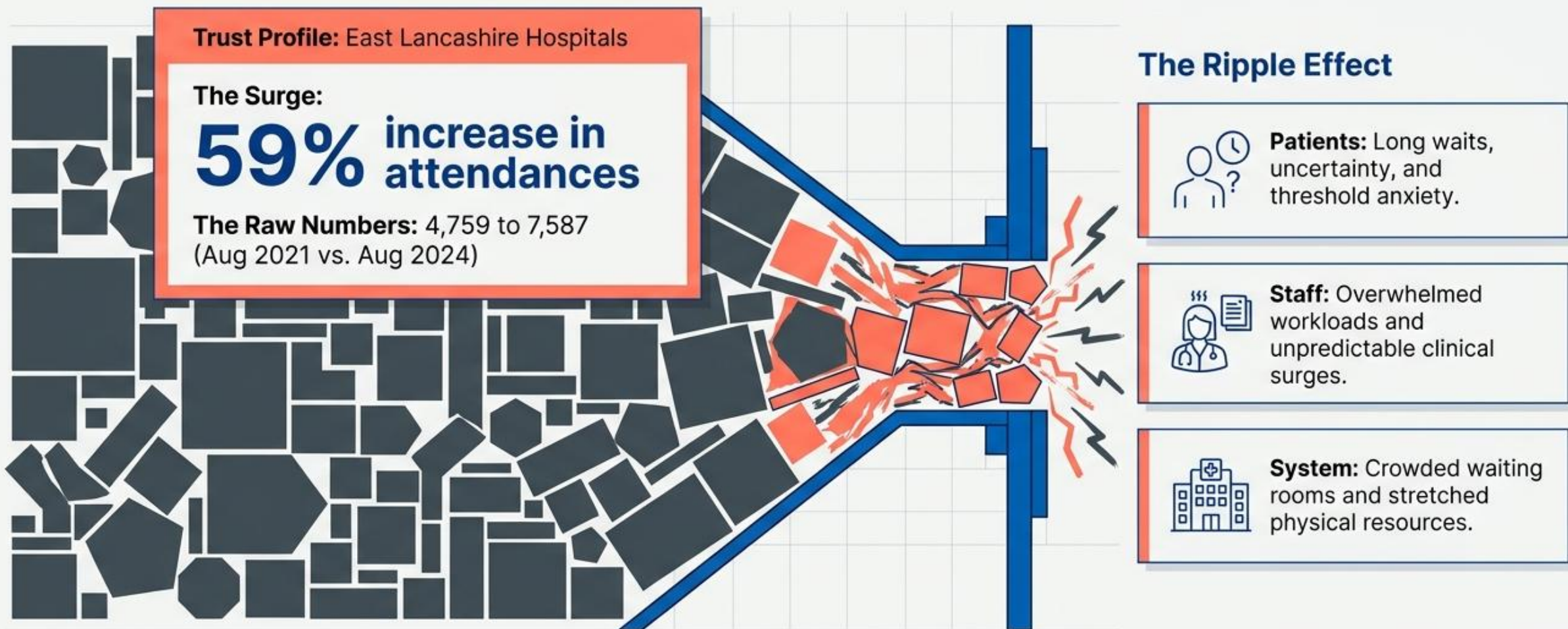


The Digital Front Door:

The Case for Streaming and Redirection in Urgent and Emergency Care

Transforming flow, safety and patient experience across the NHS.

We cannot keep doing more of the same.



We need a front door that is safer, faster, and smarter.

The Digital Front Door: Streamlining Emergency Triage

Arrival & Clinical Assessment

Digital Self-Triage

Patients complete a guided clinical assessment via a kiosk upon arrival.



Instant Prioritisation

The system automatically ranks patients by clinical need using a validated model.

Smart Streaming & Redirection



Strategic Redirection

Patients are directed to suitable alternatives such as Pharmacy First or SDEC.



Scheduled Care

Non-urgent patients can be scheduled for later appointments instead of waiting.

A Platform That Adapts to Your Operational Model

Check-in:
Captures demographics, NHS number lookup, and ECDS fields.

Prioritisation:
Delivers P1-P5 acuity outcomes, instantly prompting early investigations (e.g., ECGs).

Virtual Waiting Rooms (VWR): Books same-day return appointments. **Over 70%** of UTC patients can be booked to return later.

Streaming (Internal): Directs patients to SDEC, ambulatory care, maternity, mental health crisis, or minor injuries.

Redirection (External): Routes flow out of the hospital to Pharmacy First, primary care, dental, CAS, or community eyecare.

Hybrid Models: Mature sites blend all modules maximum departmental benefit.

Impact: Addenbrookes Hospital

90 seconds saved
per patient



7 hours saved
per day



50 Hours
saved every single week

Mechanism: Demographic information flows seamlessly and directly into the Electronic Patient Record (EPR), eliminating manual data entry and allowing resources to be redirected back to patient care.

Emergency Department: Streaming & Redirection (S&R) Model

The Patient Journey



1. Patient Walks In

The patient arrives at one of the four front doors (ED or UTC) requiring rapid initial assessment.



2. Initial Assessment Nurse Review

A nurse performs a "meet and greet" to provide clinical oversight and begin the assessment process.



3. S&R Tool Implementation

The digital tool is used to assign an acuity level (1–5) and determine the most appropriate care pathway.

4. Defined Outcomes

Patients are directed to the Emergency Department, Urgent Treatment Centre (Booked Appointment), Primary Care, or Streamed Away.

S&R Tool Outcome Distribution



Clinical Safety & Accuracy

56%

Triage Accuracy with Built-in Safety Net



Clinical audits of **640** episodes show that while **56%** of triages are "correct," a significant **38%** are over-triaged to act as a safety mechanism for high-acuity cases.



Improved Clinical Oversight

The model provides better monitoring of waiting areas during surges, reducing the risk of un-triaged patients waiting in crowded rooms.



Superior Low-Acuity Assignment

The S&R tool is more accurate at assigning lower acuity levels (3-5) than manual processes, removing staff reluctance to redirect patients.

Impact & Productivity Gains

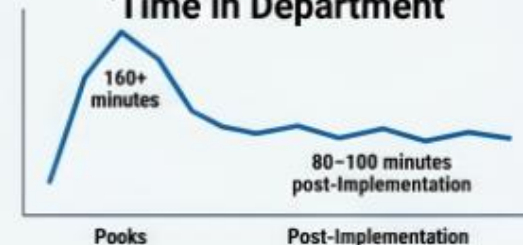
566% Increase in Booked Appointments

The number of booked appointments rose from **6** per site to approximately **40** per site following implementation.

118,642 Total Users

Since June, the tool has processed **69,108** users at Royal Bournemouth Hospital (RBH) and **49,534** at Poole General Hospital (PGH).

Significant Reduction in 'Time in Department'



High Patient Satisfaction

The model and electronic registration estate are well-received by patients for their efficiency and clarity.

Transforming Urgent Care: The East Lancashire Digital Triage Model

EAST LANCASHIRE FRONT DOOR TRANSFORMATION

Following the implementation of the new digital triage model with BaRS as a key enabler



178
MINS
Avg. Time in Dept.

87.71%
4-Hour Performance

4,759
Total Attendances



94
MINS
Avg. Time in Dept.

94.94%
4-Hour Performance

7,587
Total Attendances

IMPACT ON PATIENTS



SEPSIS IDENTIFICATION IN <18 MINUTES

Rapid identification and treatment protocols at Royal Blackburn Hospital ensure patient safety.

"It saves hanging around for hours"



Scheduled appointments



"Excellent service... I was called five minutes early"



Scheduled appointments



IMPACT ON STAFF



GETTING THE
RIGHT CLINICIAN
TO THE RIGHT
PATIENT

"Staff report more effective workload management and appropriate clinical matching."



STRESS



A MUCH MORE PLEASANT
WORK ENVIRONMENT

MOVE AWAY FROM
"FIRST COME,
FIRST SERVED"



Clinicians prefer the acuity-based scheduled system over traditional queuing models.

IMPACT ON SERVICES



263
CLINICIAN
HOURS SAVED

Time recovered (July–Aug 2024) by redirecting patients to suitable alternative services.

525 SUCCESSFUL
SERVICE REFERRALS

CLINICAL ASSESSMENT
SERVICE (CAS)

378

SAME DAY
EMERGENCY
CARE (SDEC)

99

DENTAL
CALLBACK

48

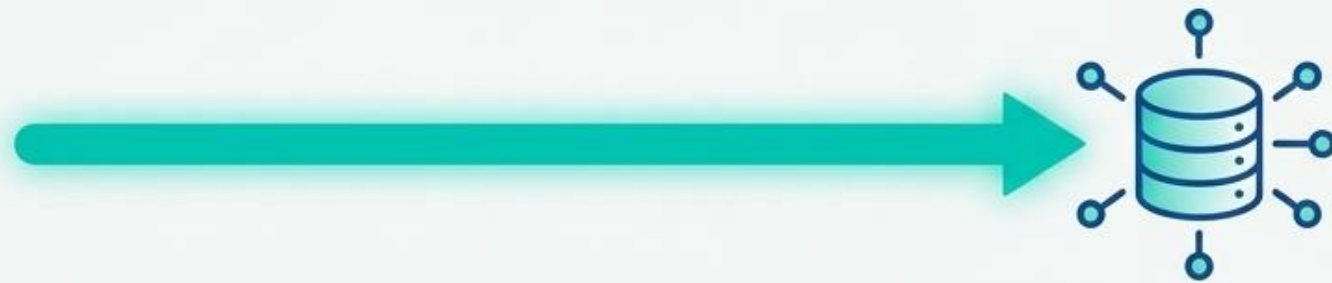


The BaRS Enabler: Fixing the Digital Friction

The Fragile Past – Legacy ITK/Email



The Robust Present – BaRS Integration



- ✓ **<5-second** transmission.
- ✓ Direct Electronic Patient Record (EPR) integration.
- ✓ **24/7** monitoring and automated fault isolation.
- ✓ Nationally consistent onboarding.

BaRS is the difference between a digital front door that works, and one that fails silently.

“ Personal obsession of mine is how we bring order into Urgent Care with more schedule and more appointment times and more hot clinics, better SDEC. More accessible, other dispositions rather than queuing in a busy ED for hours. And frankly, also from our colleagues’ points of view in there, them being unable to see risk in a crowded department. ”

Sir Jim Mackey
Chief Executive Officer of NHS England

Speaking at NHS Confed 2026



Slido

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





Case Study





Emergency care in crisis - doing more with less
by process optimisation

Overview

- Where are we now
- The chest pain problem
- Speeding up diagnosis
- What is point of care testing
- Evidence of benefit
- The way ahead

Where are we now



This kills patients.

ED overcrowding

The Landmark NHS Study (2022)

Size

Over 5 million NHS patients in England between 2016 and 2018.

Threshold

A statistically significant, linear increase in all-cause 30-day mortality begins after 5 hours from the initial time of ED arrival.

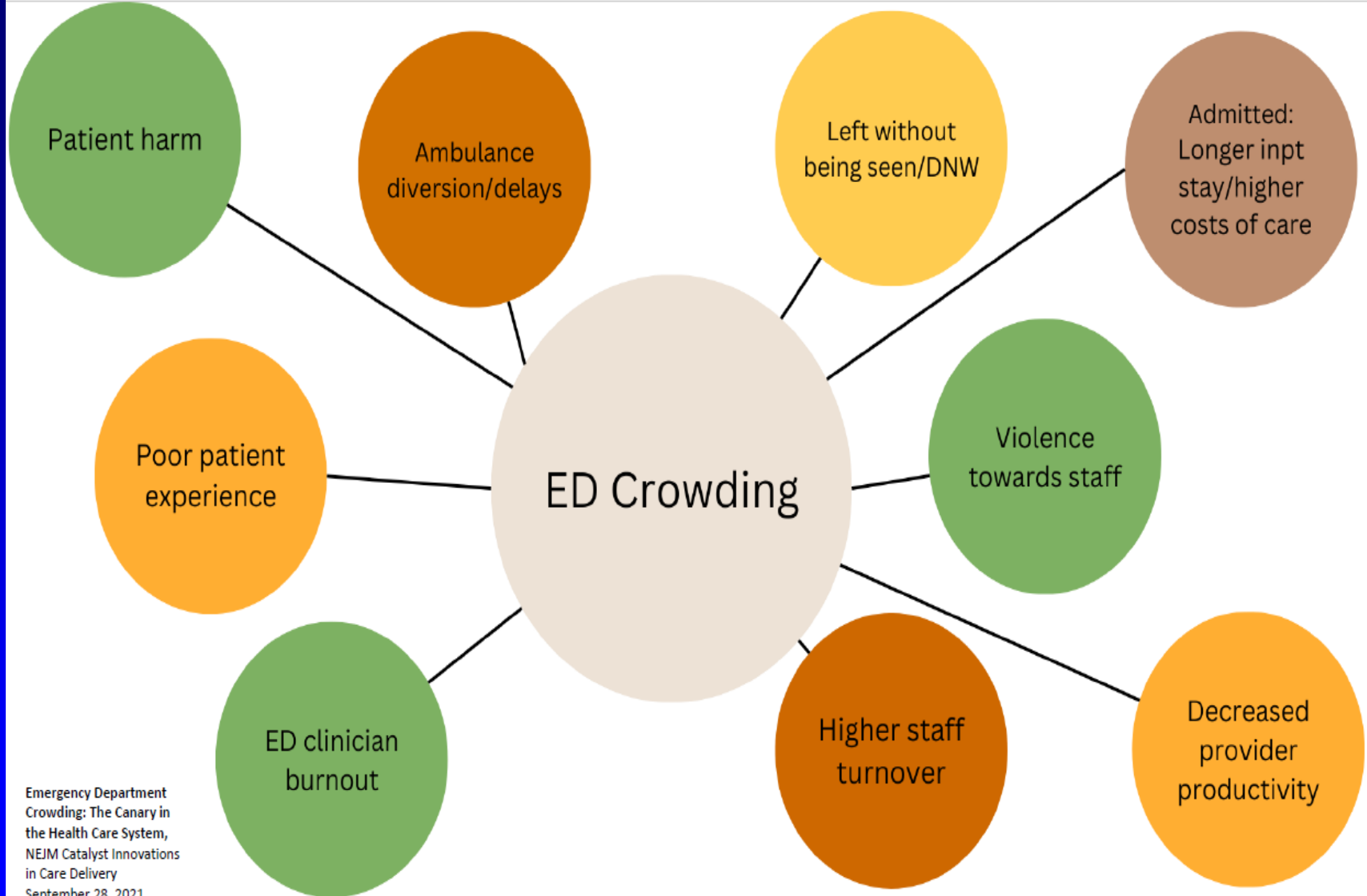
Harm Metric

For every 82 patients whose transfer to an inpatient bed is delayed beyond 6 to 8 hours, one extra death occurs

– EMJ 2022 ; 39:168-73

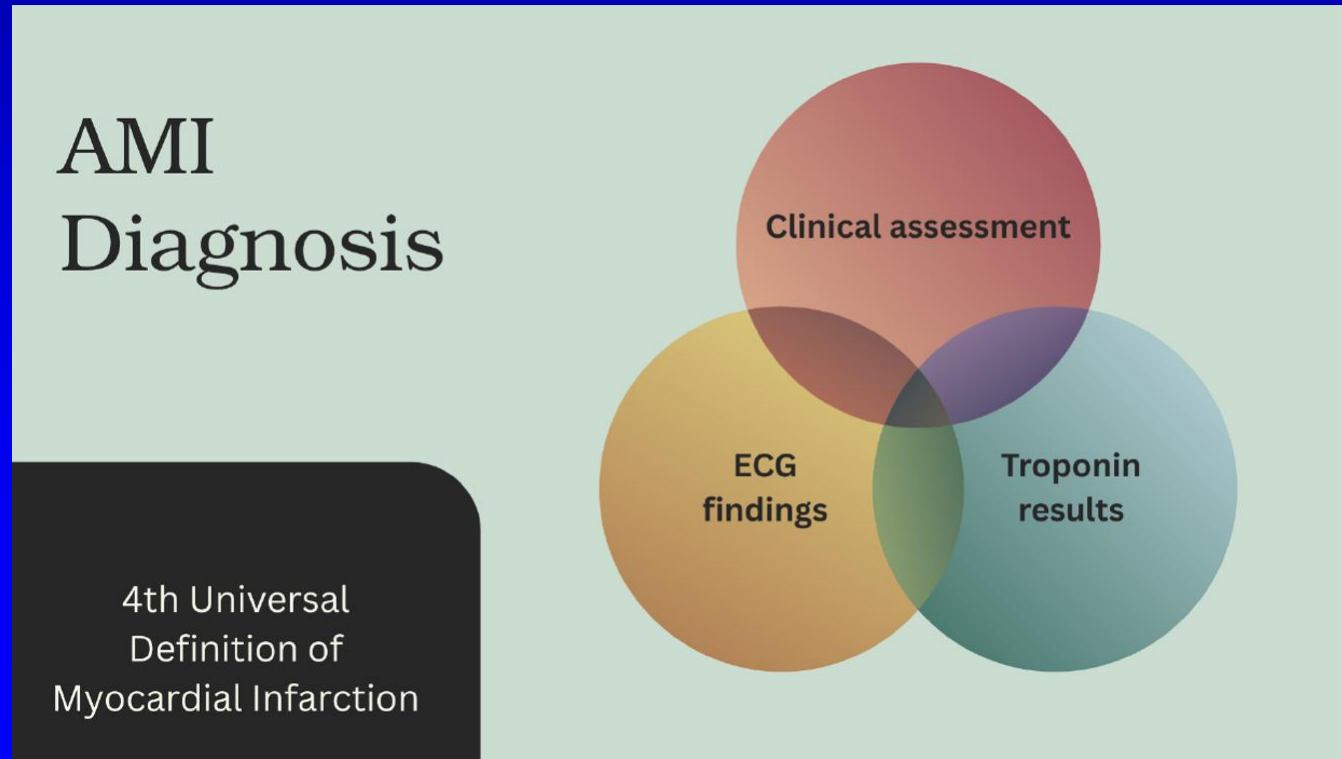
ED overcrowding

- Increased In-Hospital mortality
 - 5% greater odds of in-patient death
 - » Sun et al Ann Emerg Med. 2013;61:605611.e6.
- Short-Term Post-Discharge Risk
 - ED crowding elevates the 10-day mortality rate, even for non-admitted, low-acuity patients who are discharged home
 - Eidsto et al Intern Emerg Med. 2023 Aug 22;19(1):175–181
- Condition-Specific Risks:
 - Research indicates that crowding significantly raises 28-day mortality rates for specific acute presentations, such as community-acquired pneumonia.
 - McKenna Clin Exp Emerg Med. 2019 Jul 12;6(3):189–195



The chest pain problem

- Chest pain is the largest single cause of ED presentations
- Only 5-15% have a final diagnosis of acute myocardial infarction (heart attack)



The chest pain problem

- All patients need a troponin measured by a high sensitivity method
- Why
 - Evidence based review of the published studies supports their use.
 - <https://www.nice.org.uk/guidance/dg40>
 - Westwood et al ME Clin Chem 2021; 67:237-44.
 - Its in all the guidelines
 - It improves care and costs less
- This is done by the hospital laboratory

ALL ROADS LEAD TO THE EMERGENCY DEPARTMENT

AT HOME
Sudden chest pain



GP PRACTICE
Seen by GP –
chest pain needs
further assessment



**AMBULANCE
SERVICE**
999 calls and
emergency
responses



We're here
24/7 for
life-threatening
chest pain
and serious
conditions

**URGENT
TREATMENT
CENTRE**
For urgent but
not life-threatening
chest pain



PHARMACY
Advice given –
chest pain
needs urgent
assessment



**WORKPLACE
OR PUBLIC
PLACES**
Sudden chest pain



Symptoms: Chest Pain

- ✓ Pressure, tightness or heaviness
- ✓ Pain may spread to arm, jaw, neck or back
- ✓ May be with breathlessness, sweating, nausea or dizziness

IF IT'S A LIFE-THREATENING EMERGENCY
CALL 999

CARE HOME
Chest pain in
residents



Speeding up diagnosis

Speeding up diagnosis

- Using high sensitivity troponin measurements it is possible to
 - Send someone home immediately from the ED on the basis of a single blood test at the time of arrival at the ED (Up to 60% of all patients with chest pain, one and done)
 - Complete the entire diagnostic process in the ED within 1-2 hours instead of waiting for a 3 hour blood test result as was previously recommended
 - This strategy is recommended by the European Society of Cardiology
 - It is diagnostically efficient and it is safe

What is the MACROS-2 Trial?



MERSEY ACUTE CORONARY
SYNDROME RULE OUT
STUDY



PRAGMATIC, NON-
INFERIORITY RANDOMISED
CONTROL TRIAL AIMED TO
ASSESS THE SAFETY AND
FEASIBILITY OF THE ESC 0/1-
HOUR CHEST PAIN PATHWAY
VS CONVENTIONAL 0/3-
HOUR CHEST PAIN PATHWAY.



2 SITES IN LIVERPOOL,
UK (AINTREE UNIVERSITY
HOSPITAL AND ROYAL
UNIVERSITY HOSPITAL)



IN A NESTED SUB STUDY OF
THE TRIAL, OUR GOAL IS TO
EVALUATE THE CLINICAL
AND ANALYTICAL
PERFORMANCE OF POC
ASSAY (TRIAGETRUE ASSAY).

PRE-SPECIFIED CRITERIA
FOR SSRO+ADPS

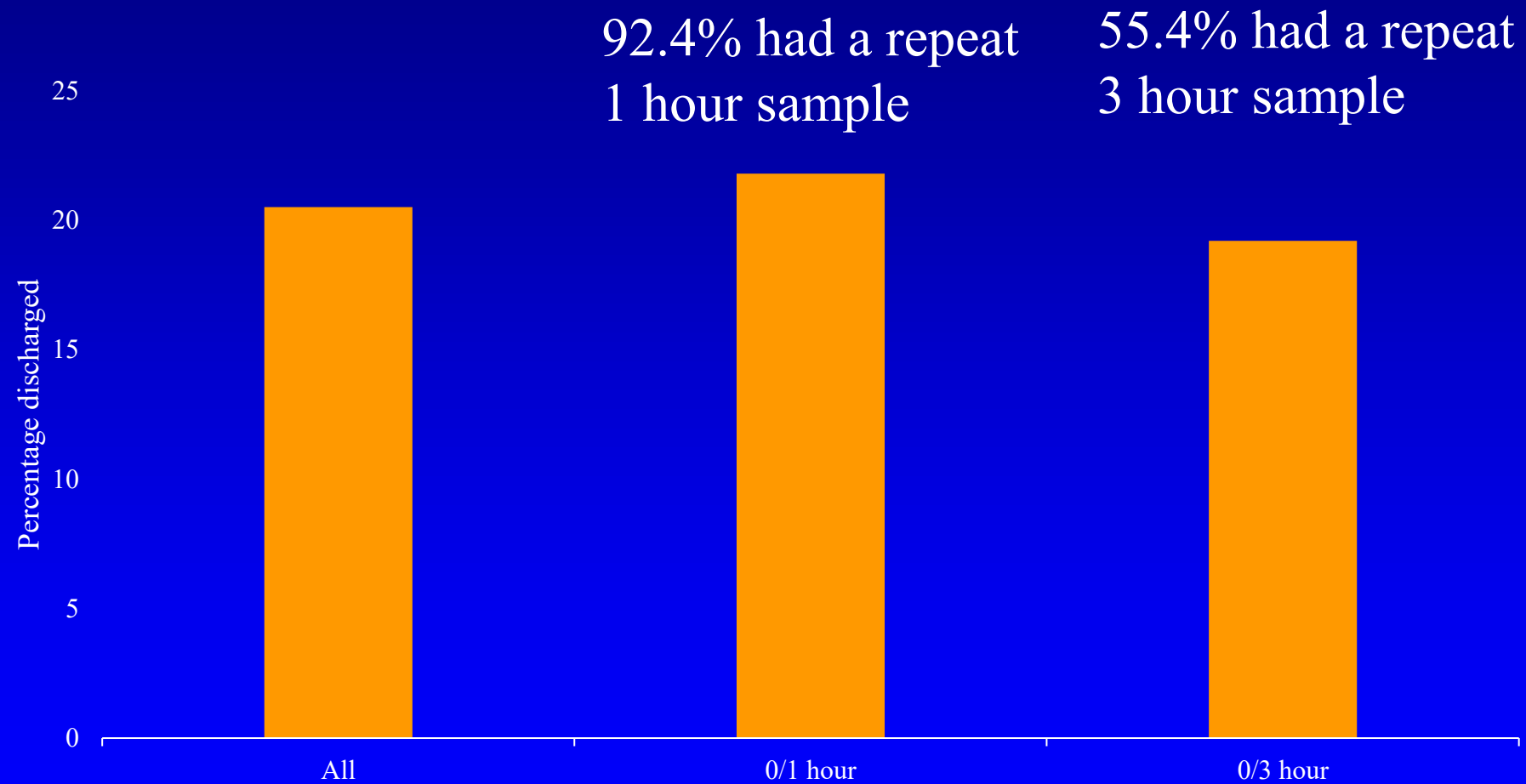
PRE-SPECIFIED SAFETY
CRITERIA FOR RULE OUT
≥98% (TYPE1+2 MI)



EACH SAMPLING POINT:

- 1) HS-TNT ROCHE ELECSYS
- 2) SIEMENS ATELICA AND
ABBOTT ALINITY HS-TNI
- 3) TRIAGETRUE WB AND
PLASMA

Proportion of patients discharged within 4 hours for each pathway.				
Clinical Decision	Total	0/1 hour	0/3 hour	p-value
	n = 3543			
Discharged within 4 hours (%)	725 (20.5)	384 (21.8)	341 (19.2)	0.06



Ooops

Why.

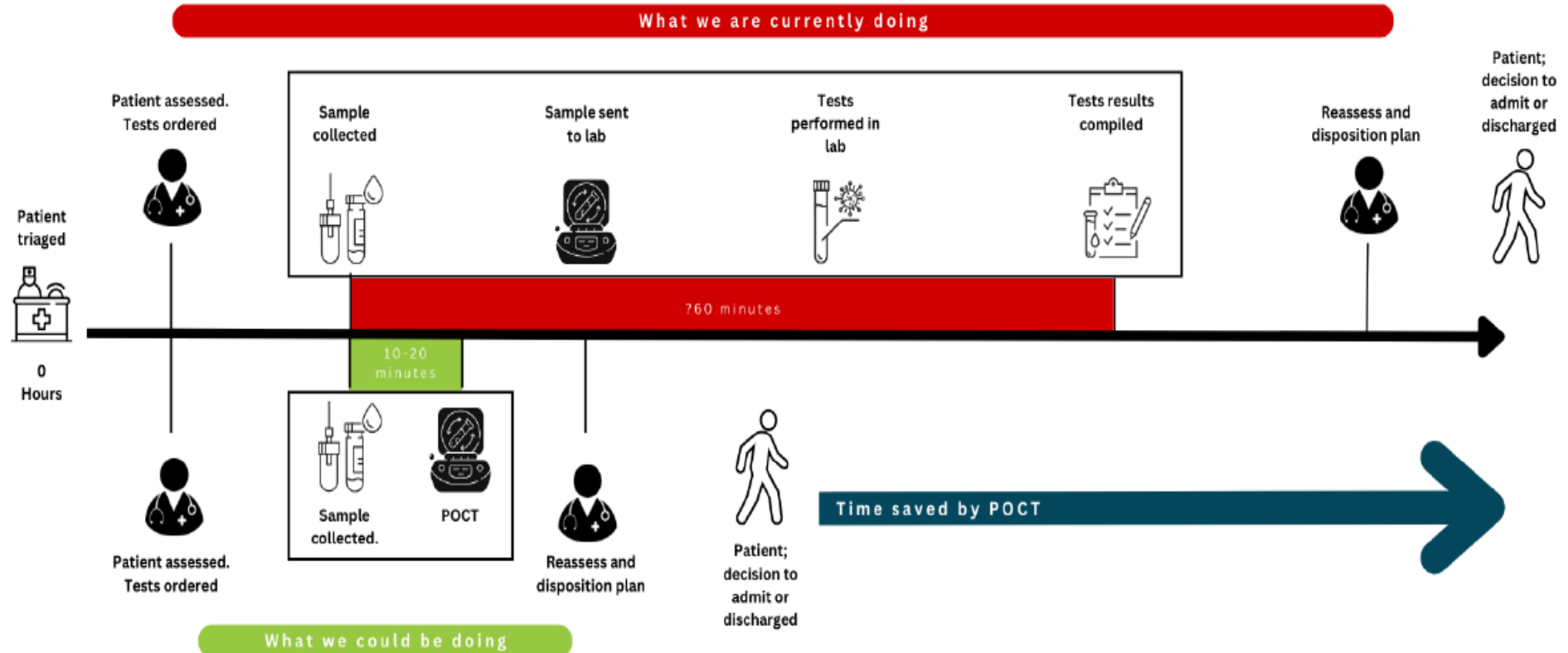
- Laboratory TAT is a barrier as the second sample is taken before the first result is available. For successful implementation in a laboratory based setting, 0-2 hours is the only practical option.
- Measure the nose length of the laboratory director before and after you ask them the laboratory turn around time for troponin and they tell you its less than 60 minutes.
- Then ask the ED staff what it REALLY is.

- Option appraisal
 - Do nothing
 - The situation will get worse
- Increase existing capacity with more beds and health care professionals
 - They don't exist
 - They may take a long time to train anyway
 - It's a very expensive option
- Point of care testing
 - More expensive than laboratory based testing but much cheaper than other options
 - Supports process change and avoids hospital attendance

What is point of care testing (POC)

Rationale for POC

- Results are provided in a more, timely manner directly to the clinician responsible for immediate patient care.
- Testing occurs close to the patient without the need for transfer of samples, allowing testing in a range of healthcare environments including ambulances and rural healthcare/clinics.



Evidence of benefit

With thanks to Professor Martin Than



Improving CARE By FASTER risk-STratification through use of high sensitivity point-of-care troponin in patients presenting with possible acute coronary syndrome in the EmeRgency department: a stepped-wedge cluster randomized trial

PI | Professor Martin Than | Emergency Department, Christchurch, New Zealand

Co-authors: John W Pickering, Laura R Joyce, Vanessa Buchan, Christopher M Florkowski, Nicholas Mills and the ICare-FASTER Investigation Team



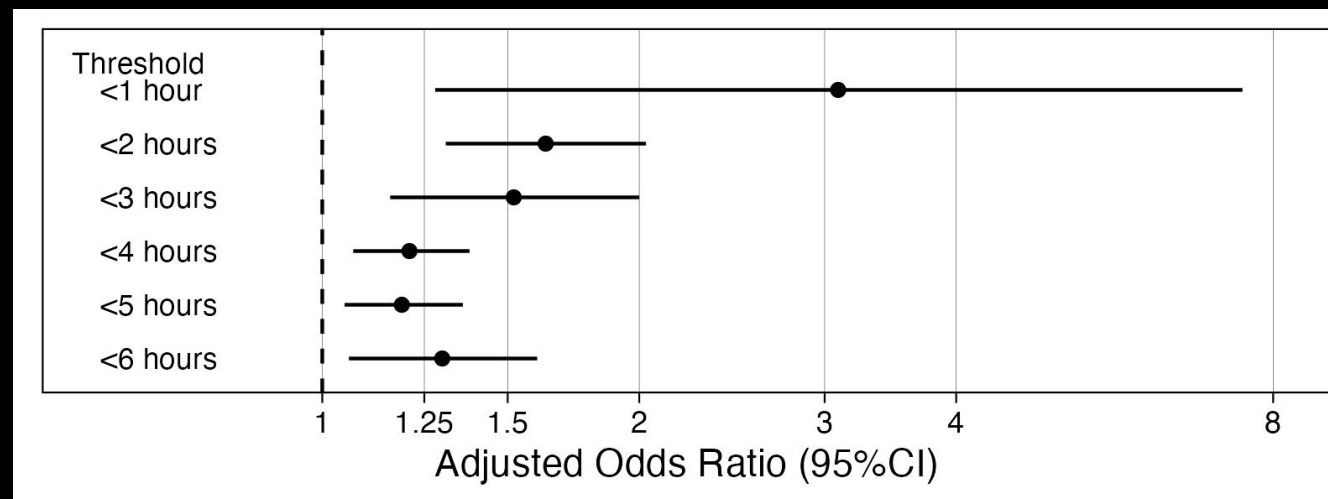
Funding: Health Research Council of NZ | Emergency Care Foundation | Siemens Healthineers (product support)

#AHA25

PRIMARY OUTCOME: Change in mean ED length of stay (LOS) after implementation of the POC as default test

LOS was reduced by 13% (95%CI 9 to 16%; $p < 0.001$)
- corresponds to a 47-minute (95%CI: 33 to 61 minutes) reduction from the control arm's mean LOS of 376 minutes.

Chance in odds for discharge according to time from arrival



The way ahead

- Only patients at high risk, which is detected by the electrocardiogram (ST elevation MI, STEMI) and clinical assessment need an immediate hospital transfer and a cardiac catheterisation.
- The majority of patients even those with a final diagnosis of MI without electrocardiographic changes can have definitive treatment deferred by up to 72 hours ONCE THE DIAGNOSIS IS ESTABLISHED.
- Inappropriate treatment of patients without MI causes harm.

The way ahead

- Whole blood high sensitivity troponin measurement in a technology suitable for use in a range of different clinical care environments, which has been proven to be analytically equivalent to the central laboratory.
- Evidence base that the chosen technology can be used in these environments and is clinically diagnostically equivalent to the laboratory based approach.
- Change in process



Change – Yes we can





Eoin Madigan



Healthcare needs are changing and we need improved solutions



1 in 10

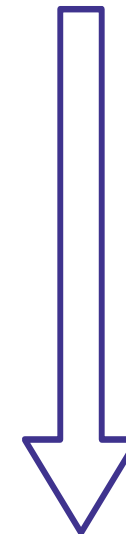
patients spent over
12 hours in A&E in
2025.¹

15,000+

deaths due to long
A&E waits in 2025.²

2,000+

Patients experiencing
Corridor Care - May
2026³



97%

of clinical leads
described the
situation as
unsustainable.⁴

60%

of clinical leads
described their
department as
moderately
understaffed.⁵

¹One in 10 A&E patients waited over 12 hours in 2025 - BBC News (Accessed 24/06/2026)

^{2,4,5}RCEM_SoEM_England_A4_0326-UPDATED-FINAL.pdf (Accessed 24/06/2026)

³Statistics » Corridor Care – Urgent and Emergency Care Daily Situation Reports (Accessed 24/06/2026)

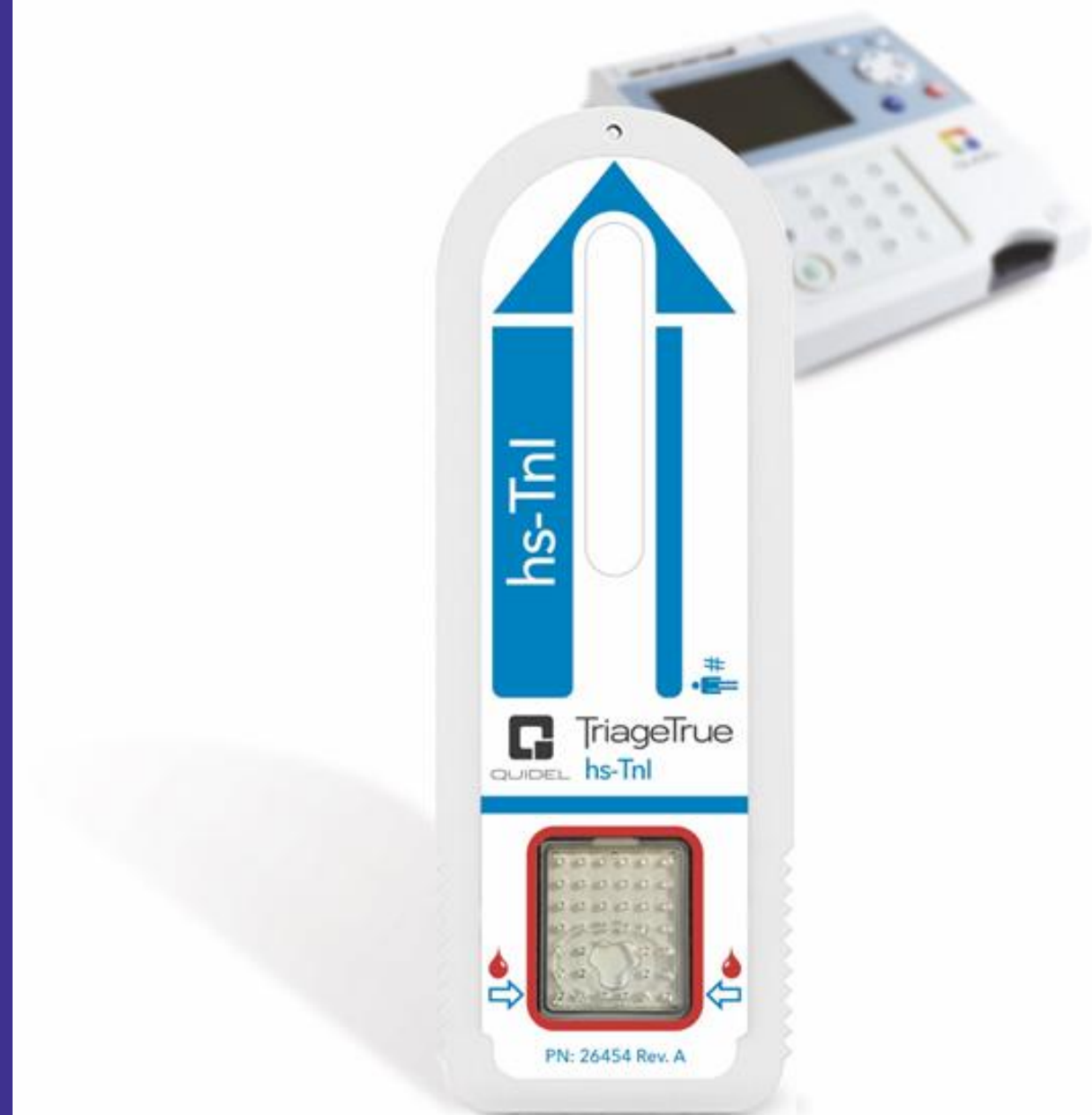
Let's take control of the change...

What if

Reimagine normal

- What would happen if those results were available during initial assessment?
- Can you imagine compressing the time to decision making?
- What would be the downstream impacts on the patient and department?

Faster time to results may contribute to faster patient disposition, reduced length of stay, and increased ED throughput.



Triage True - hsTropI

Where it is needed most...

- Over 1,400 customers across 40 countries globally.
 - >400 Routine Hospitals implemented
 - >1,000 GP customers
- Successful evaluations and implementation across different healthcare environments:
 - Emergency Primary Care Clinics (Norway)
 - Accident & Emergency Departments (U.K & Ireland)
 - Ambulance Services (Netherlands)
- The only true point-of-care high-sensitivity troponin test that:
 - Is included in the European Society of Cardiology 0/1-hour algorithm
 - Meets IFCC and NICE recommendations, in accordance with IFCC-CCB criteria
- 65% rule-out rate when used within recommended chest pain pathways

Hospitals

Cardiology Clinics



Other Decentralised Settings



Nursing Homes



Private Labs



Triage cardiac biomarkers are suitable for centralised and decentralised settings

Core Labs



Pre-Hospital



Emergency Services



Doctors' Offices



Remote Clinics



Community Testing Centres



QuidelOrtho™

One test. Far-reaching impact.

**Visit our stand to see how it
could transform your Emergency
Department.**



Lunch & Networking



Chair Afternoon Address



Chris Morrow-Frost

National Clinical Advisor to Secondary Care
NHS England



NHS Deep Dive



Towhid Imam
Consultant Geriatrician
Croydon Health Services



Improving support for people with frailty through proactive and integrated care

Dr. Towhid Imam

Front Door Frailty Lead/Department Lead, Croydon Health Services

NHS England Advisor – Frailty Collaborative

SWL Clinical Lead for Frailty

Thank you for listening

towhid.imam@nhs.net

Keynote Presentation



Lindsey Mclean
Urgent Care Programme Manager
Wye Valley NHS Trust





Compassion • Accountability • Respect • Excellence

Wye Valley NHS Trust

UEC Transformation

The Ownership Effect

Lindsey Mclean, Urgent Care Programme Manager

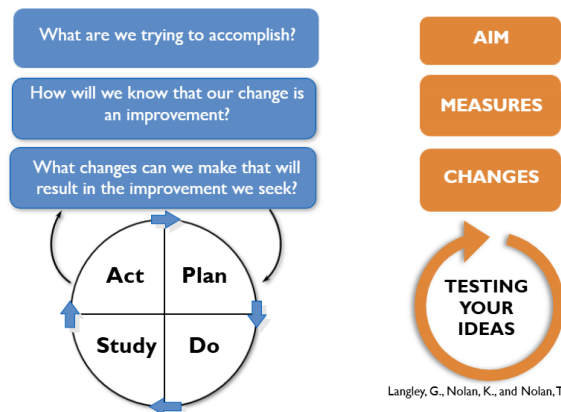
What were the problems?

- UEC pathway challenges **spanned across teams/areas/departments/divisions**
- Rare occasions to be **face to face** with colleagues
- Lack of ***adequate* time to stop** and understand the problems
- A need to **deliver changes at pace.**
- Opportunity to allow true **clinical and operational design/ownership** in improvement



Design – Executive/Transformation - ToC

- Designed **3 weekly Workshops**
- Committed to commence **Tests of Change 1 week after Workshop 3**
- Identified **Learning and/or Launching** Tests of Change
- Utilised the **Model for Improvement**
- Daily **30-minute PDSA Review** meetings for 4 weeks:
 - Encourages **cross- scheme engagement**
 - **‘All in it together’** environment
 - **Celebrate** the wins; **support** the challenges early.



Aims of the Workshop



Aim

By the end of the workshops we will have co-designed our measurable tests of change to be delivered between 16th June – 11th July

1. **Improve streaming** and navigation away from ED
2. **Reduce the time** for patients in ED / Reduce congestion
3. **Improve our Ward based flow** processes and reduce on-going reliance on the high use of TES / Escalation beds

Workshop 1 – Current State & Future State



Head space away
from the day to day
operational
pressures



Understand some of the
challenges we face across the
whole WVT pathway



An expectation to think
big about some of the
solutions (short,
medium and long term)

Workshop 2 – Ideation & prototyped ideas



Work on tables to document the changes they wanted to make

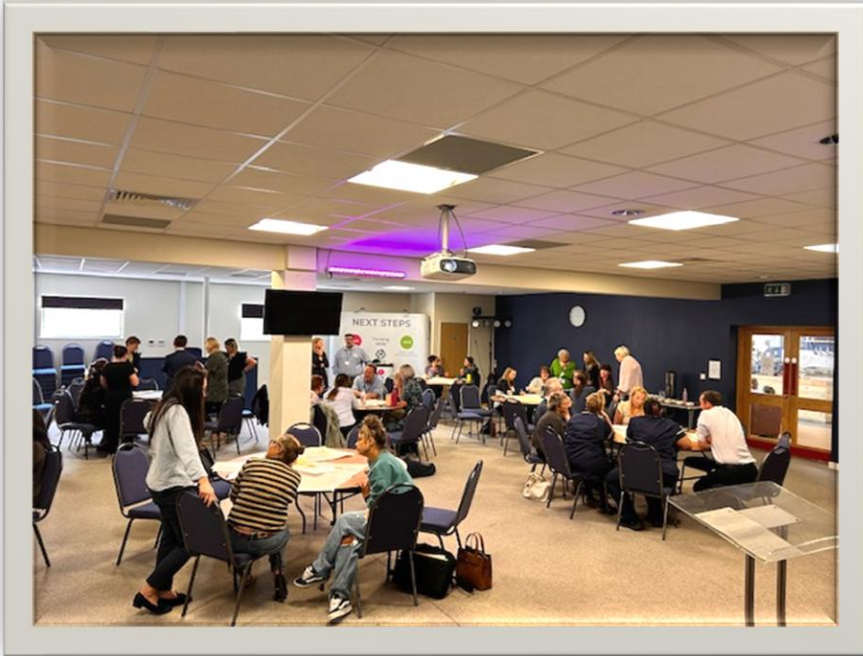


Refer back to current state to understand the problems/challenges and opportunities



Use all the knowledge in the room to start to design the changes they wanted to make

Workshop 3 – Mfl measurable Tests of Change



Created our Test of Change plans including our actions and stakeholder engagement plans

17 Tests of Change – to be commenced between 16th June – 11th July

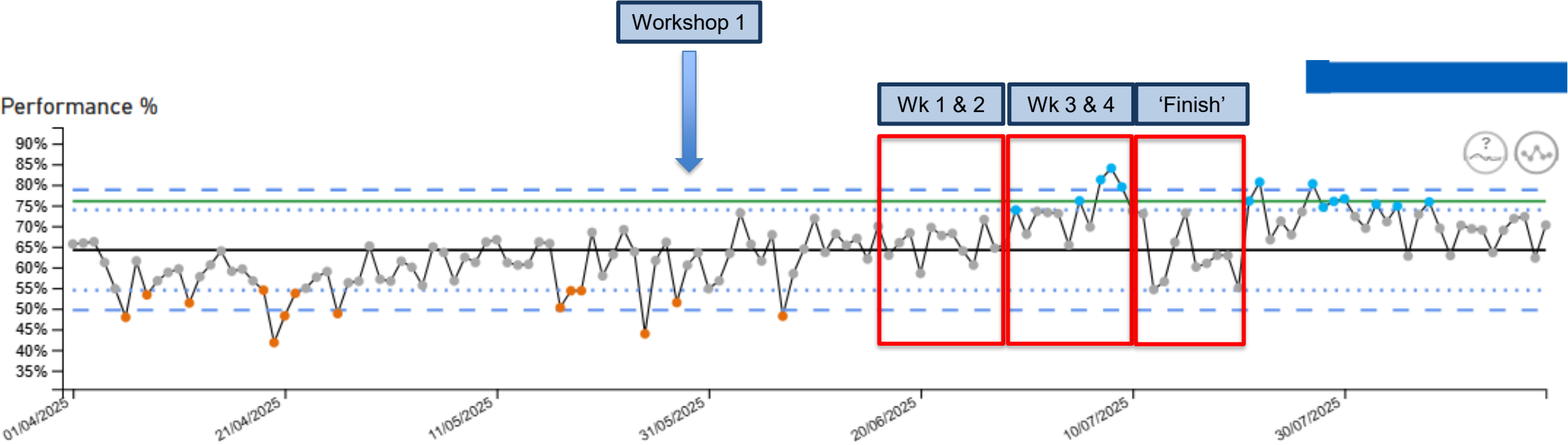
Valuing Patients Time – Test of Change

Title	Patients on wards that are being discharged early in the day, will leave the hospital without delay reasonably location
Lead (incl email addresses)	
Test of Change Type	Launch ☒ Learn ☐
Aim	Achieve no delay from PT not being ready. Transport does not get delayed/aborted - pt gets to destination
Measure	Feedback from transport that delays have been avoided.
Test of Change	Check IP CN - to ensure check EOD - Liaise with PTSC - re booked day before - Use appendage from SOP to encourage prep of pt
What changes will you make that will result in the improvement?	
How will we know if the change is an improvement?	
Additional notes	What delays have caused about or delay of transport who was informed.

17 (+ 4) Tests of Change

1. Developing an Acute Surgical Unit & Improving Surgical Flow
2. WMAS Offload
3. Patients on wards that are being discharged early in the day leave the hospital without delay
4. Transfer of patients to Community Hospitals without handover or EDS
5. Femoral Fracture Pathway improvements (Frailty)
6. All patients travelling to Powys Care Homes or hospitals with patient transport will leave no later than 1pm
7. PitStop – Define what will always happen and implement
8. Midnight Multi-speciality Huddle in ED
9. Maximise Nurse Navigator role in ED
10. Use of Pharmacy volunteers to support EDS flow for discharge lounge
11. Revise Acute Oncology pathway – reducing use of SDEC/ED unless “emergency”
12. Reduce delays in access to inpatient MRI
13. Roll out Handover Process SOP to facilitate timely patients transfer from ED to wards
14. Putting the Acute back in AMU (creating 4 bedded bay for GP expected/sick patients)
15. Introduce the Bed Management Module in Maxims
16. Positioning a limited therapy resource to maximise therapeutic impact in the acute
17. Pharmacy access the transport tracker in order to prioritise discharges
18. *Create a ‘booking system/TCI’ list for SDEC expected patients*
19. *Test the use of Heidi AI on ward rounds (reduce the time taken to create an EDS)*
20. *Gynae SDEC/direct flow to Women’s Health ward*
21. *Dinmore – keep their own beds*

4hr Emergency Access Standard (to 19th Aug 2025)



Learning (at week 10)

- **Co-design the approach** and outcomes across operational, nursing and medical executive leadership team (not UEC lead for the organisation)
- Dividing into **Launch and Learn** Tests of Change worked really well (with flexibility/conversion during the ToC too)
- Kept the **workshops open** for more people to attend throughout the 3 weeks
- **1x workshop per week** worked really well to maintain momentum but allowed reflection/conversations/team feedback in between
- **Mfl templates enough for governance** (no re-typing up, just photos of each template)
- **DON'T call it Test of Change month** if you have launches to continue at day 32
- Start Tests of Change **1 week after workshops**
- **First 2 weeks were rocky** – stick with it
- **Say yes** to additional schemes if momentum has grown
- Continue **attention for 9-12 weeks** (still experimenting)



Workshop 4 – Celebration & Phase 2



Created our Test of Change plans including our actions and stakeholder engagement plans

14 Tests of Change – commenced between Sept - Nov



WYE VALLEY NHS TRUST STAFF SURVEY

NHS STAFF SURVEY RESULTS 2026

How we rank against all NHS trusts in England

These results show our league table position for key questions from the NHS Staff Survey 2026, across the five People Promise sub-themes.

**NHS****Wye Valley****NHS Trust**

People Promise in action



Our league table position

This shows where our Trust ranks out of all NHS trusts in England.



No.1 in England

We are the highest ranking trust in England for this question.

Rankings are out of all NHS trusts in England.

Source: NHS Staff Survey 2026
published March 2026

People Promise theme	Survey question	Wye Valley NHS Trust Rank (out of all trusts)
 Shared purpose and vision	2a: I look forward to coming to work	4
	2b: I am enthusiastic about my job	1 No.1
	7a: The team I work in has a shared set of objectives	8
	8a: Teams within this organisation work well together to achieve their objectives	21
	25a: Care of patients/service users is my organisations top priority	38
	25c: I would recommend my organisation as a place to work	22
 Investing in culture and people	24a: This organisation offers me challenging work	12
	24b: There are opportunities for me to develop my career in this organisation	8
	24c: I have opportunities to improve my knowledge and skills	5
	24d: I feel supported to develop my potential	11
	24e: I am able to access the right learning and development opportunities when I need	20
 Building leadership behaviours	9a-i: My immediate manager (six questions)	3 – 8
 Building improvement capability and capacity	3d: I am able to make suggestions to improve the work of my team/department	1 No.1
	3e: I am involved in deciding on changes introduced that affect my work area	1 No.1
	3f: I am able to make improvements happen in my area of work	2
	5b: I have a choice in deciding how to do my work	6
	7d: Team members understand each other's roles	20
 Using quality management system	6a: I feel that my role makes a difference to patients/service users	3
	25b: My organisation acts on concerns raised by patients/service users	40
	25e: I feel safe to speak up about anything that concerns me in this organisation	16
	25f: If I spoke up about something that concerned me, I am confident my organisation would address my concern	30



Thank you

These results reflect your dedication, teamwork and commitment to providing the best possible care. Together, we are making a difference.



Your voice. Your ideas.

Listening to you helps us improve our workplace and the care we provide for our patients.



People Promise in action

These results show the power of working together to create great places to work and deliver outstanding care.



Compassion • Accountability • Respect • Excellence

Thank you

Lindsey.mclean@wvt.nhs.uk

 **Lindsey.Mclean**

Breakout Skill Clinic



Catherine Withers

Senior Leadership Coach &
Partner
Praxis Consultancy Limited



Karen Heng

Senior Leadership Coach & Partner
Praxis Consultancy Limited



Skill Clinic



Zella King

Senior Research Fellow
University College London (UCL)



Claire Tucker

Senior Information Analyst
University College London
Hospital (UCLH)

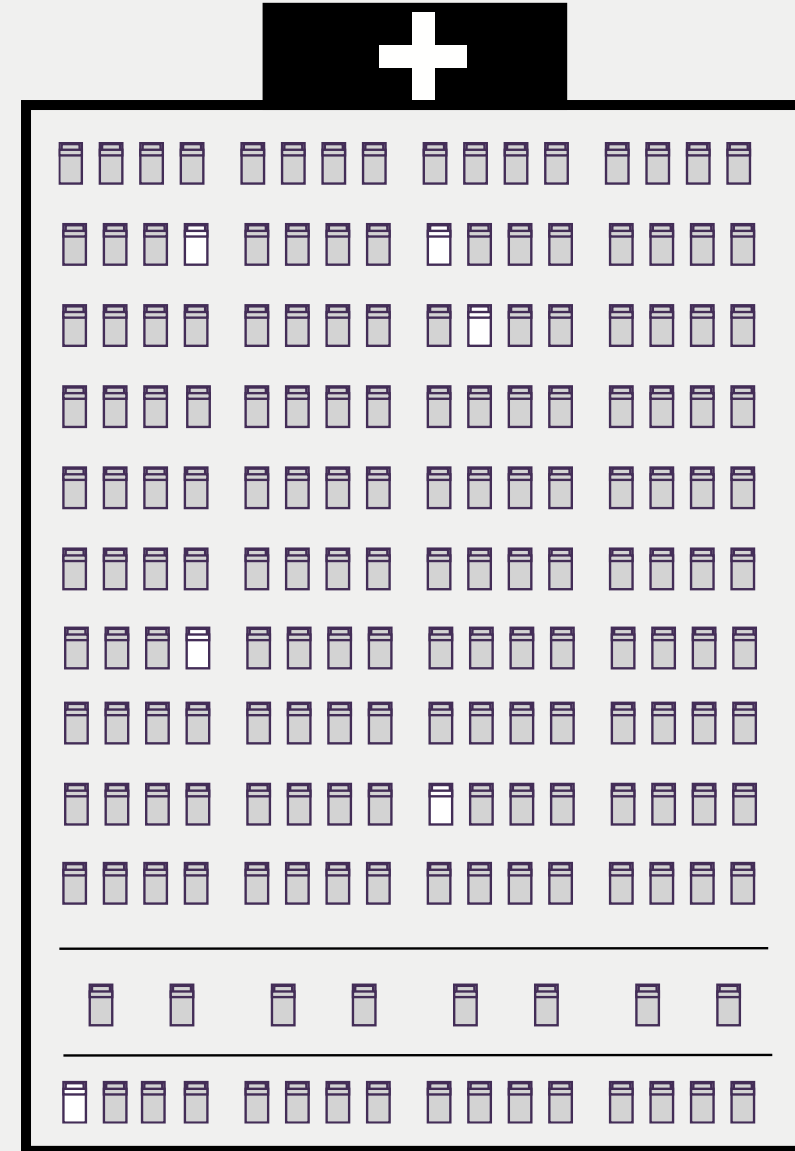
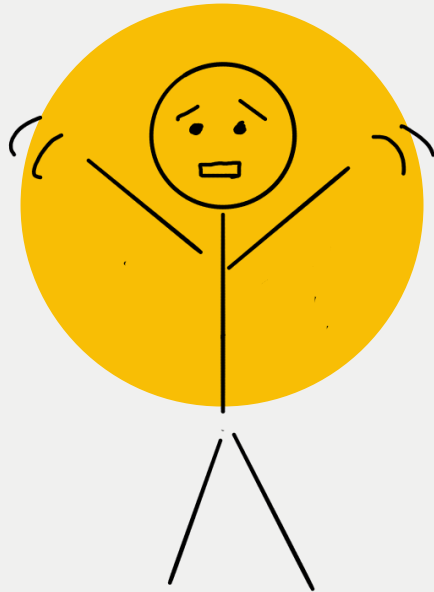


Getting ahead of demand: Real-time patient flow prediction at UCLH

Dr Zella King, Senior Research Associate, Clinical Operational Research Unit, UCL

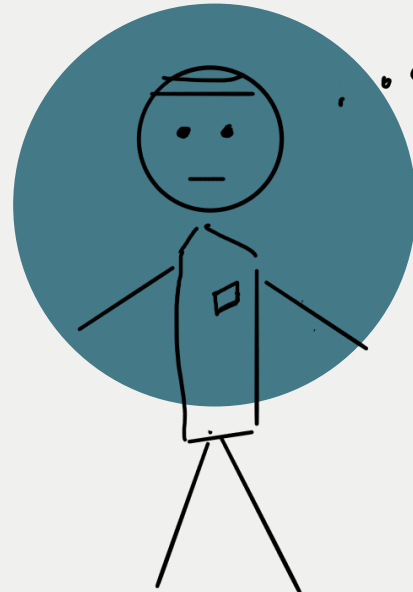
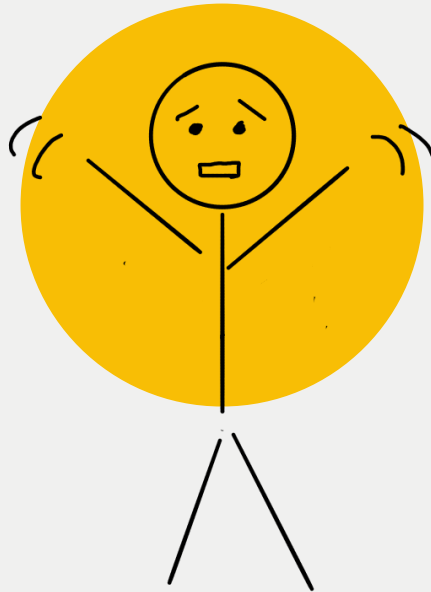
Claire Tucker, Senior Information Analyst, UCLH

10 patients
waiting for
beds in ED



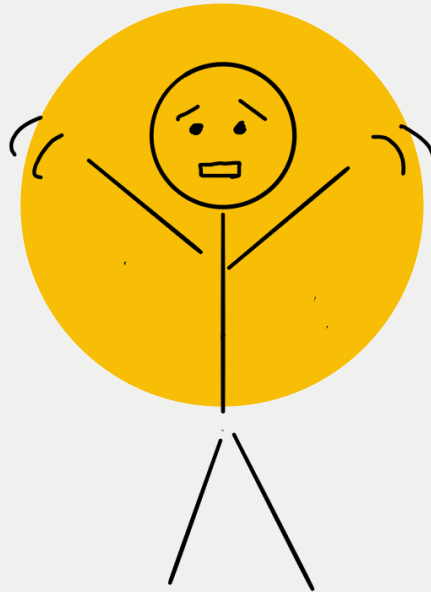
10 patients
waiting for
beds in ED

GI WARD
|||| ||||
|||| ||||



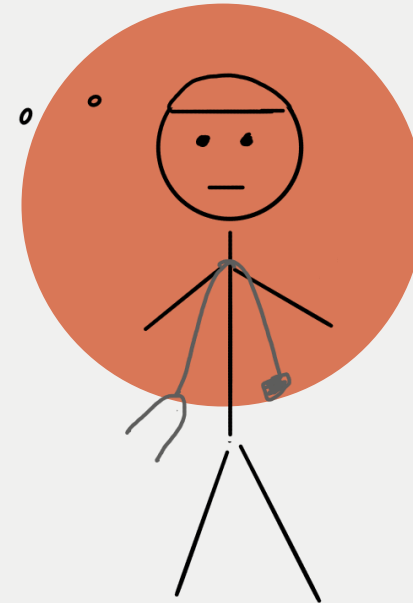
Ward is full.
Patients need us,
or can't leave.
Staff are busy.

10 patients
waiting for
beds in ED



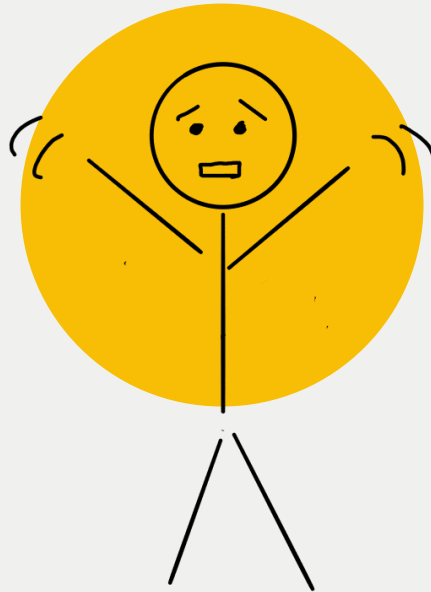
LIST - GET LOWER

La la la la.
I'm focused
on the
patients
on my
list



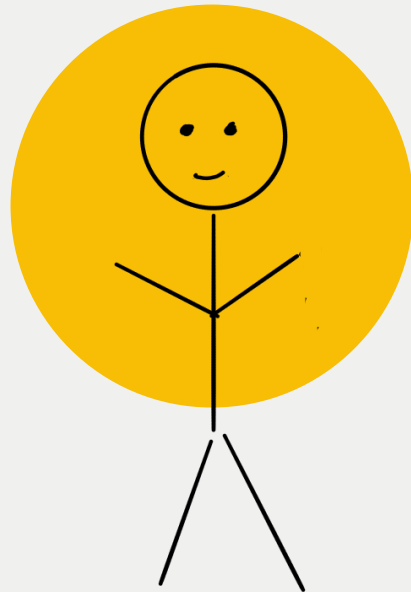
What if we could go from this ...

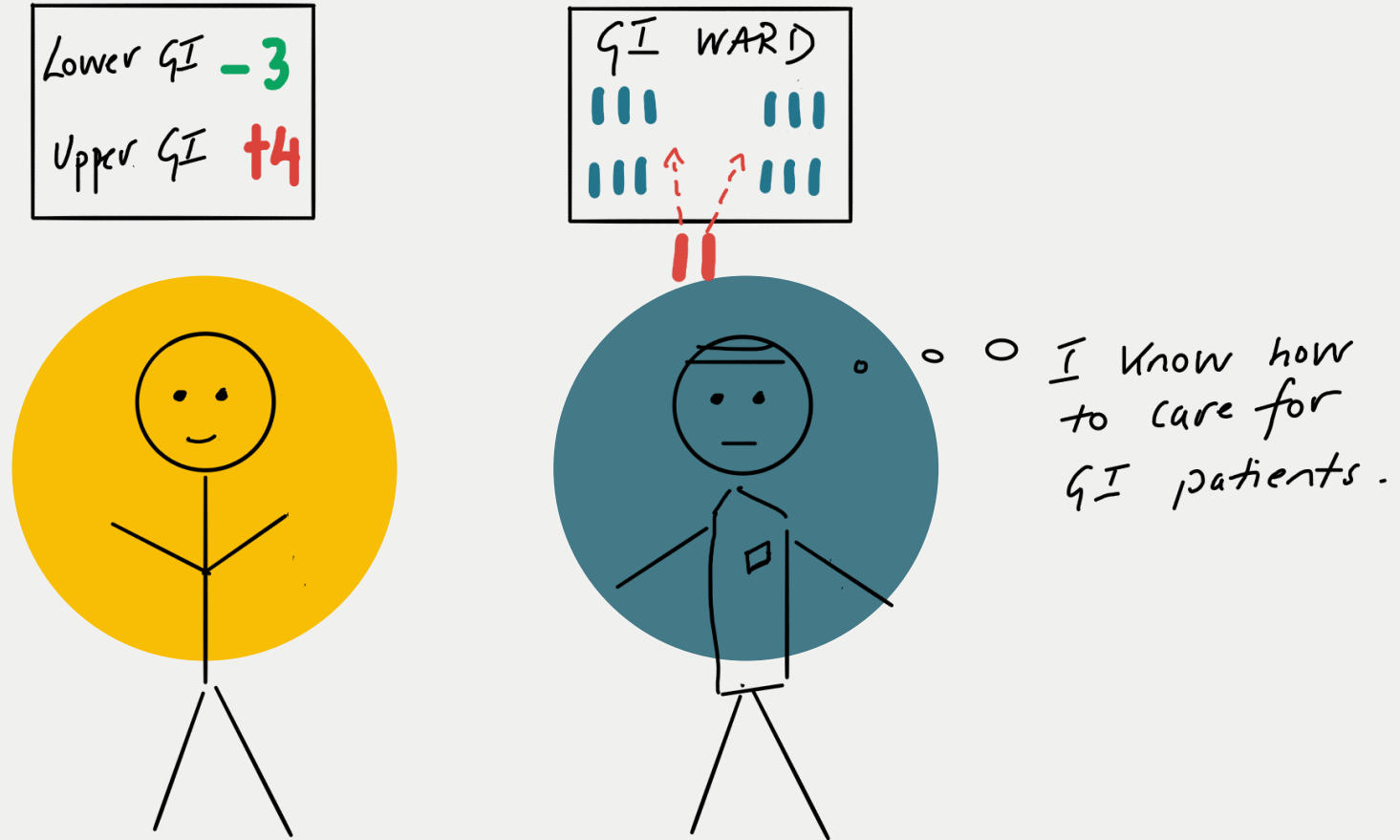
10 patients
waiting for
beds in ED



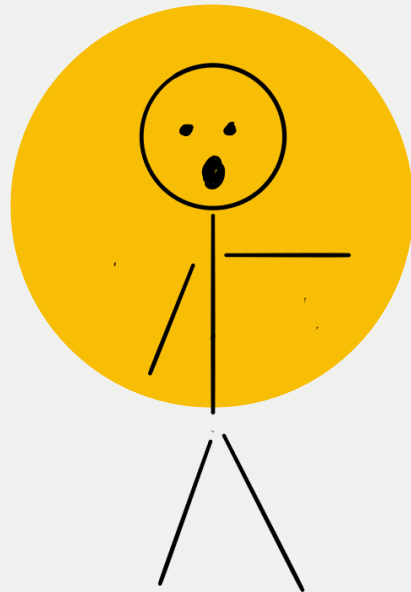
... to this

Lower GI	-3
Upper GI	+4





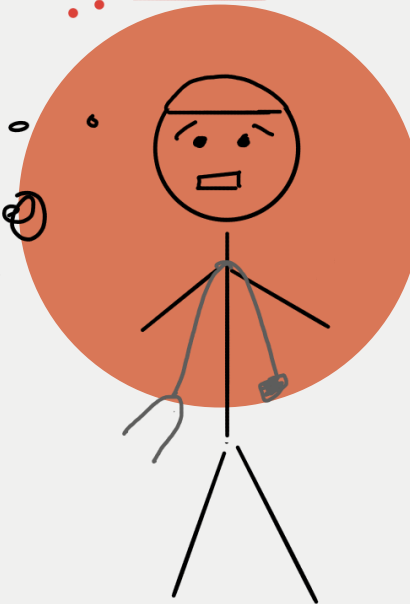
Lower GI -3
Upper GI +4



Ahoy there,
Upper GI!
The tide
is rising

UPPER GI LIST

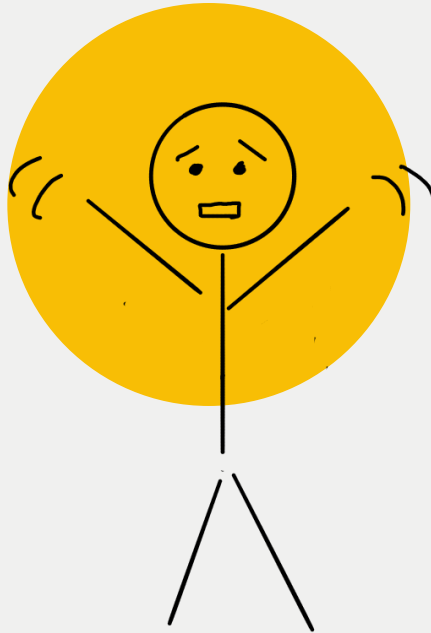
!!
!!



+4 !*!@
Let's get
some
patients
home
today

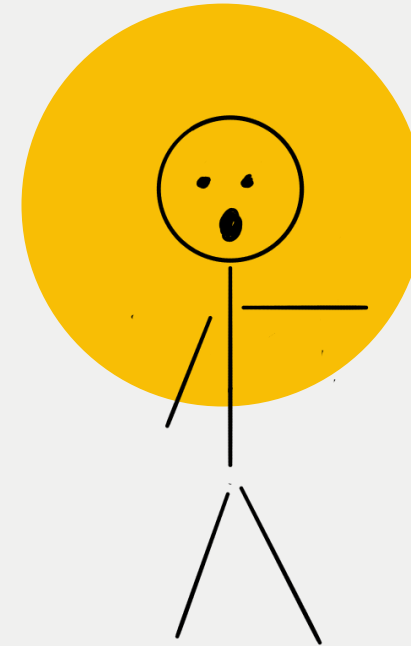
How do we get from this ...

10 patients
waiting for
beds in ED



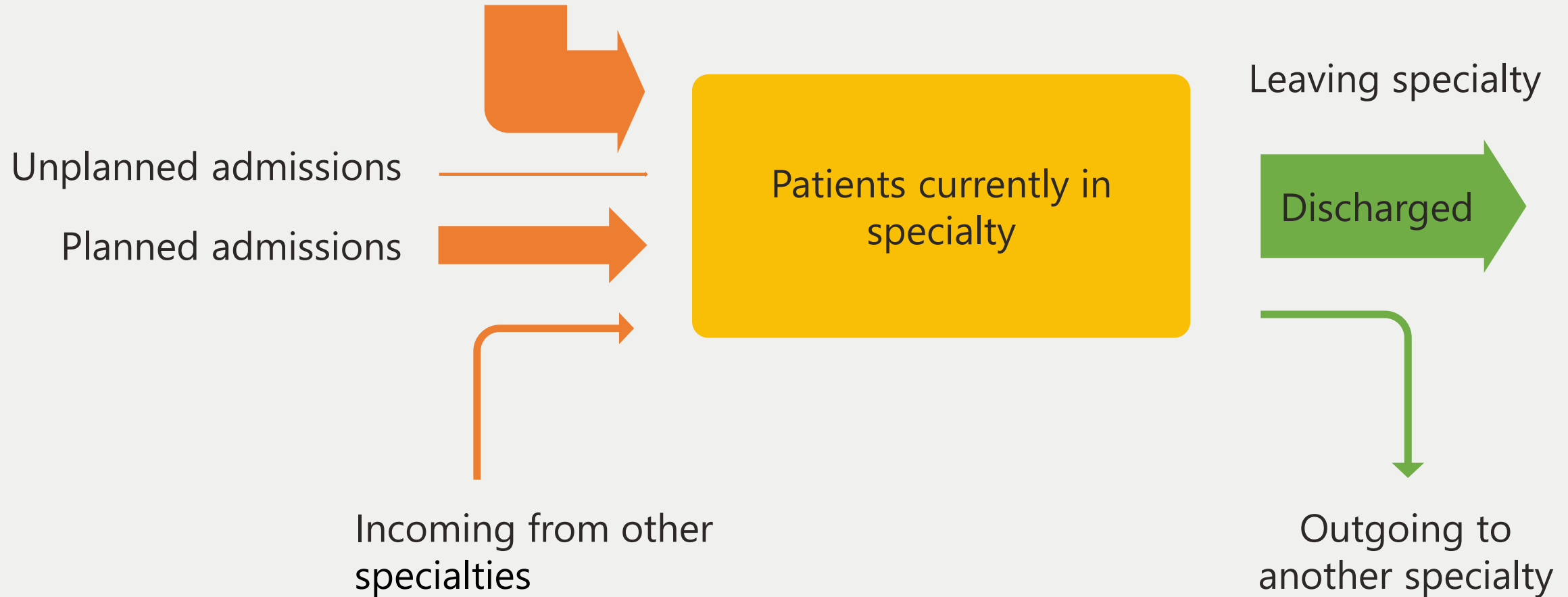
... to this?

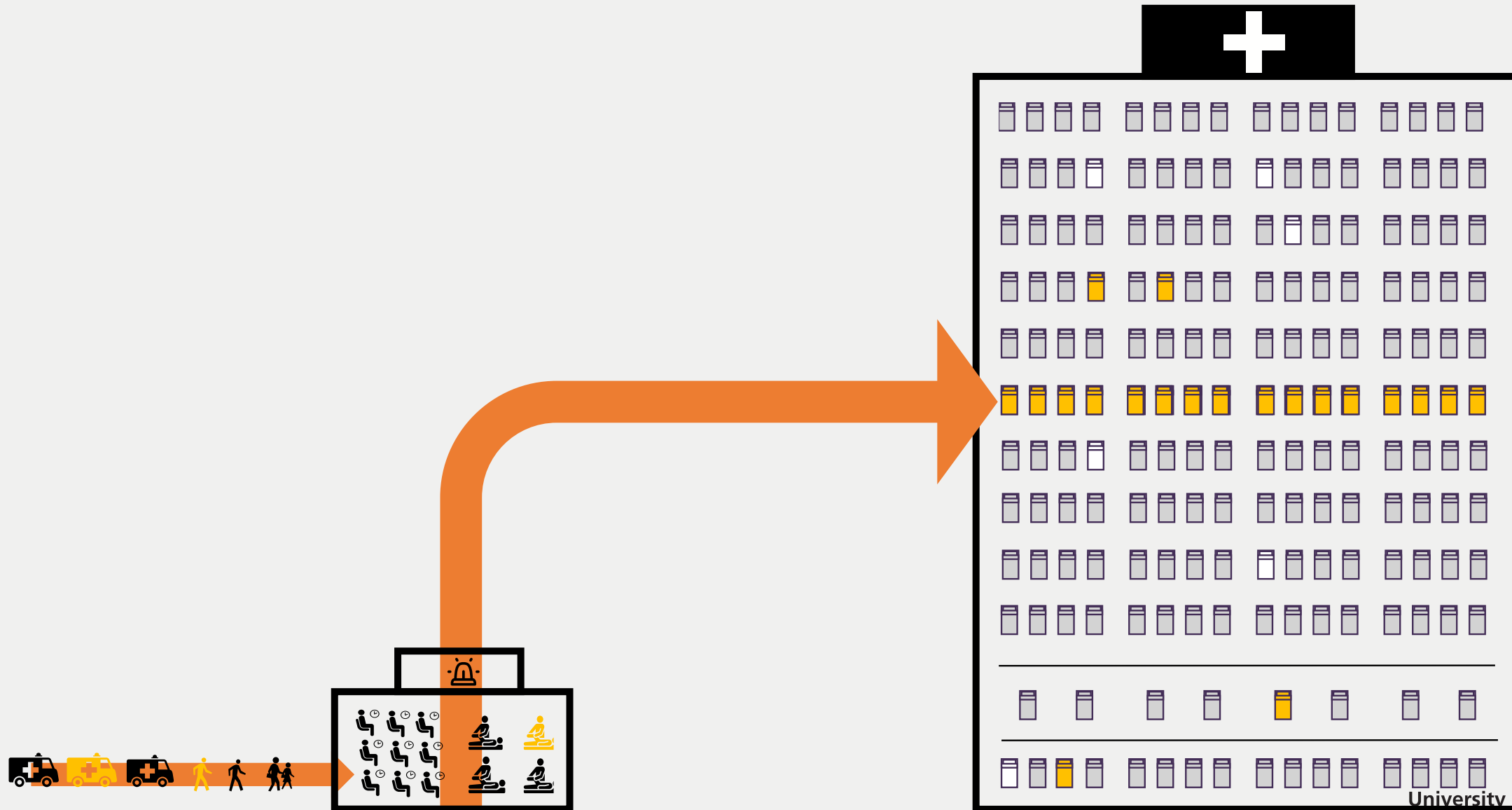
Lower GI -3
Upper GI +4

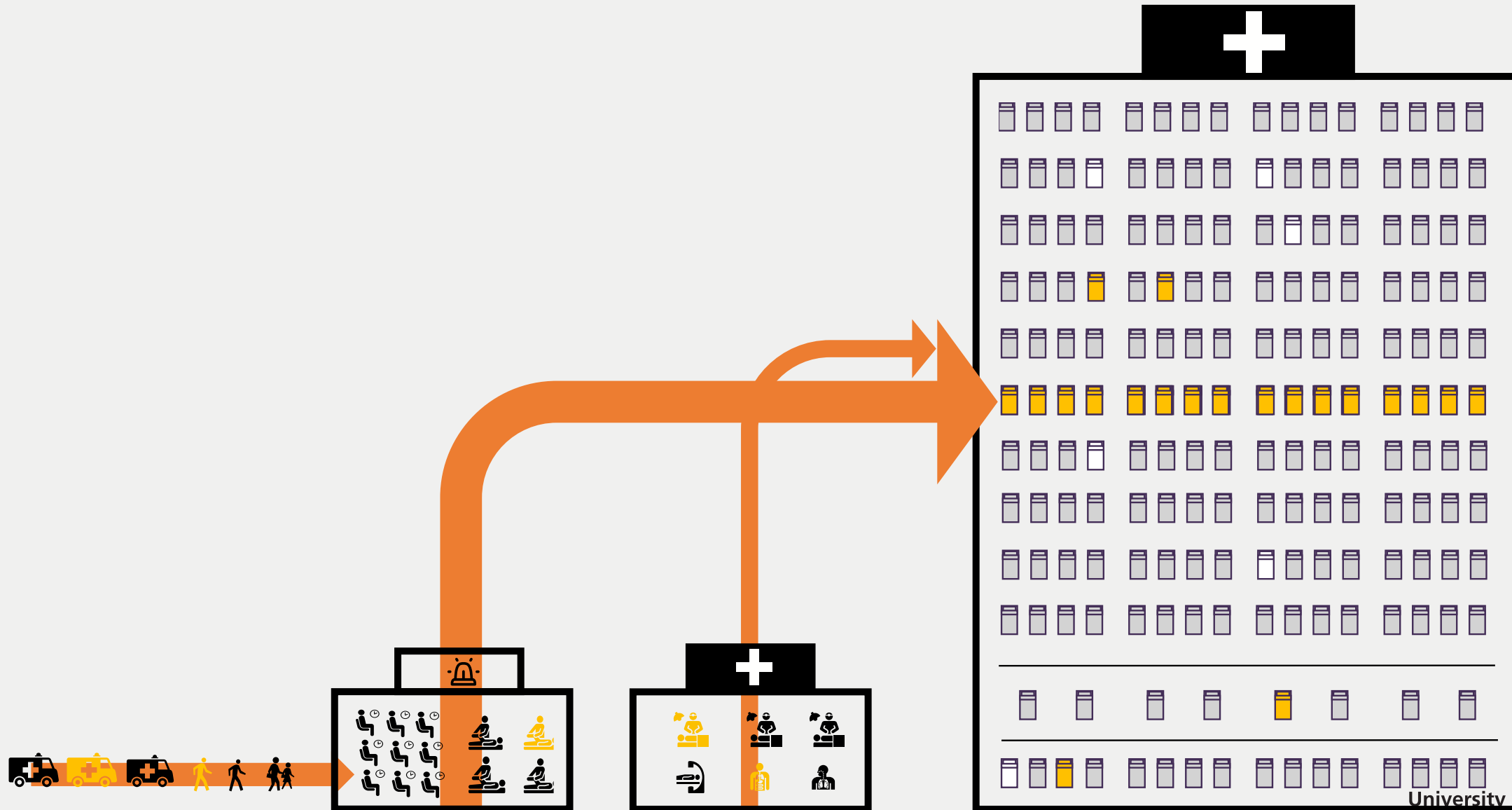


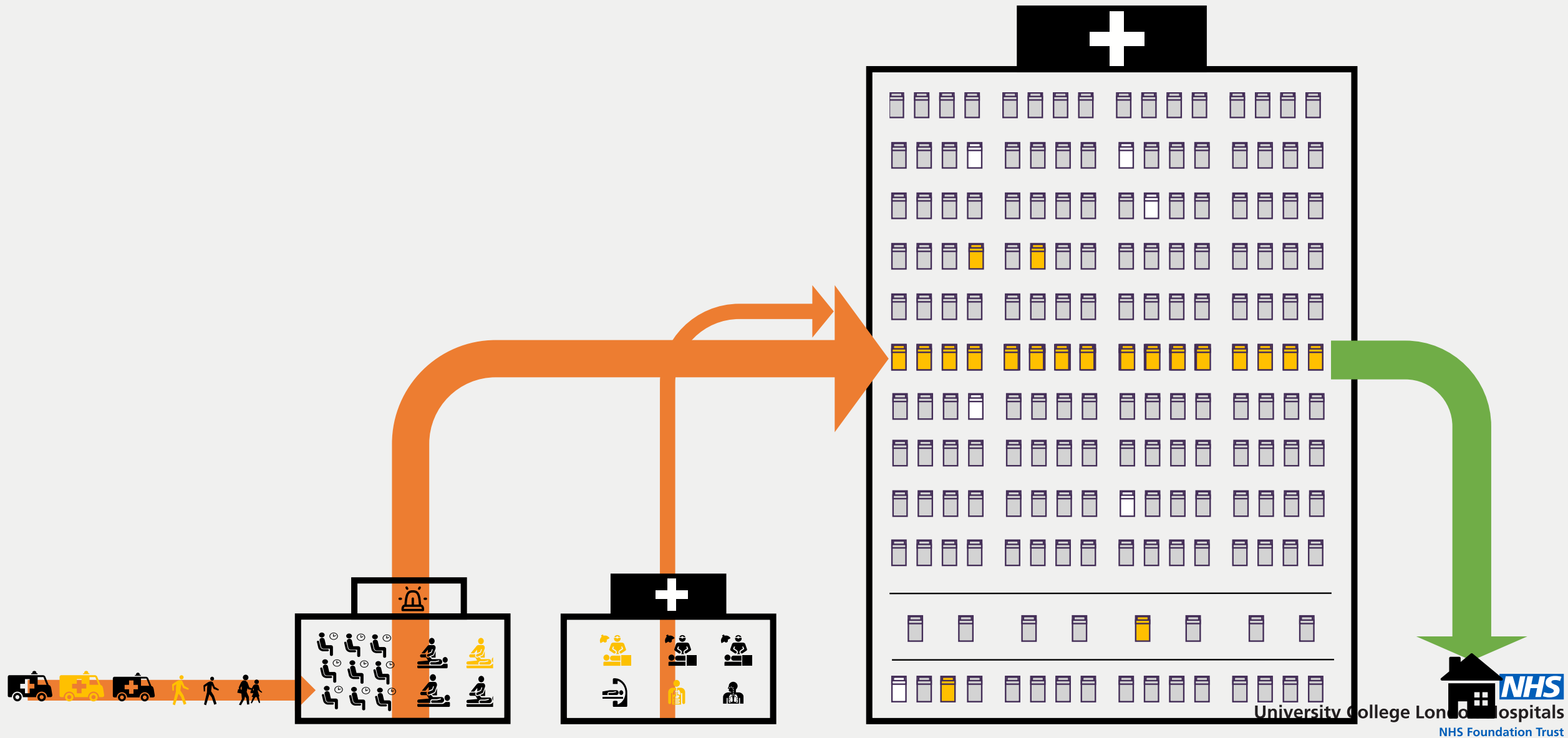
Ahoy there,
Upper GI.
The tide
is rising

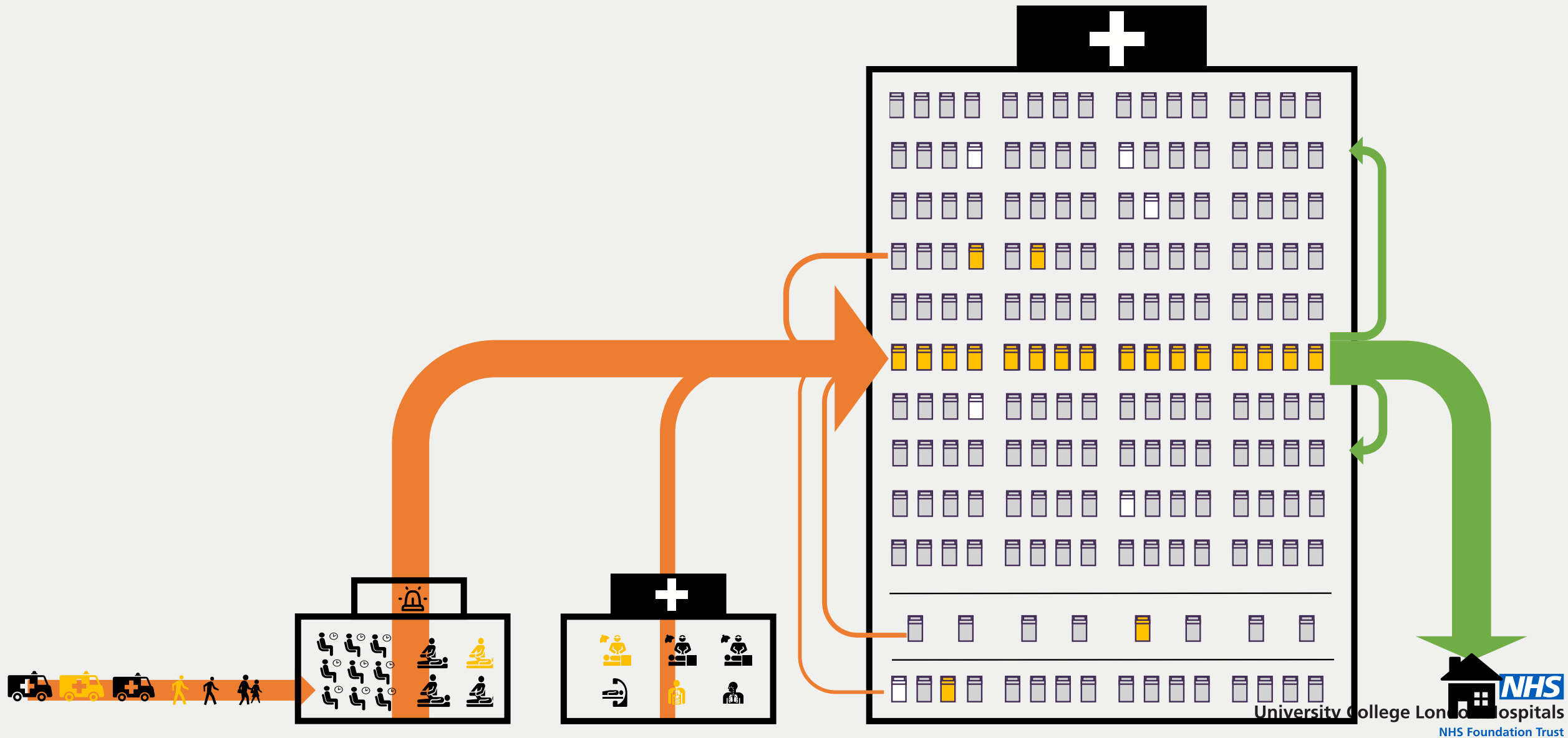
Admissions via ED



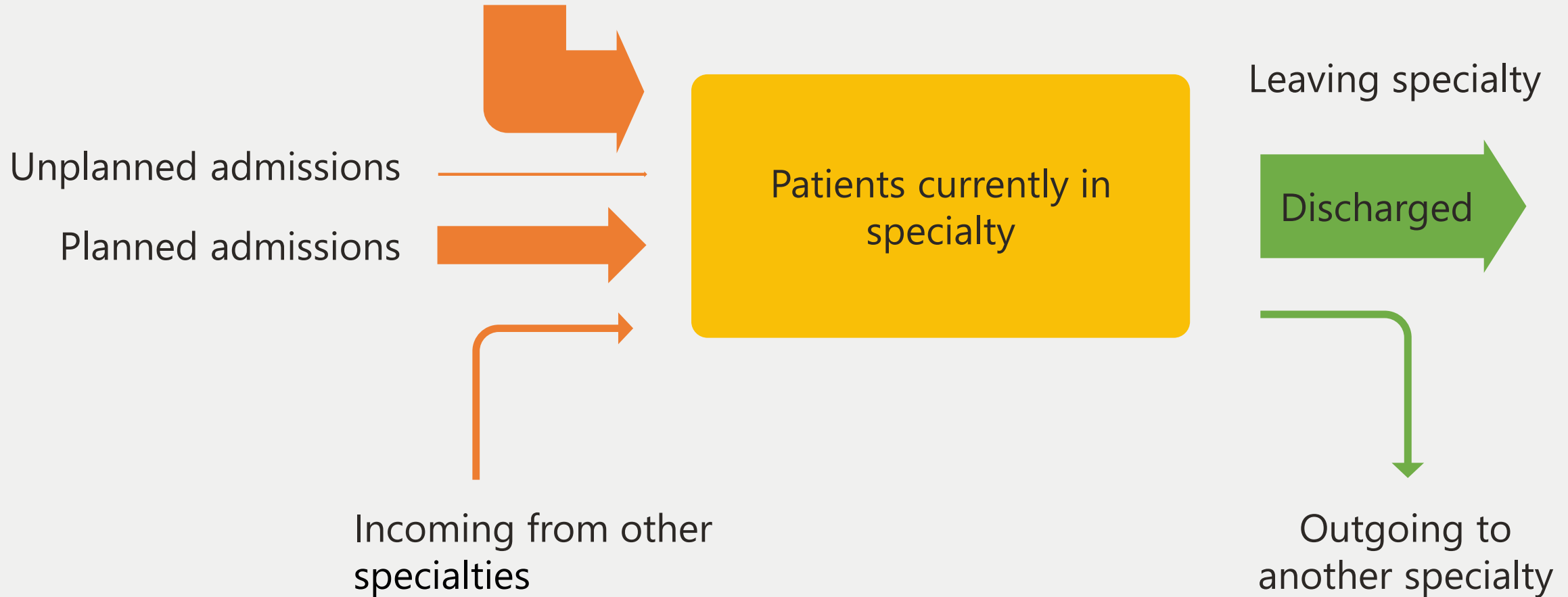


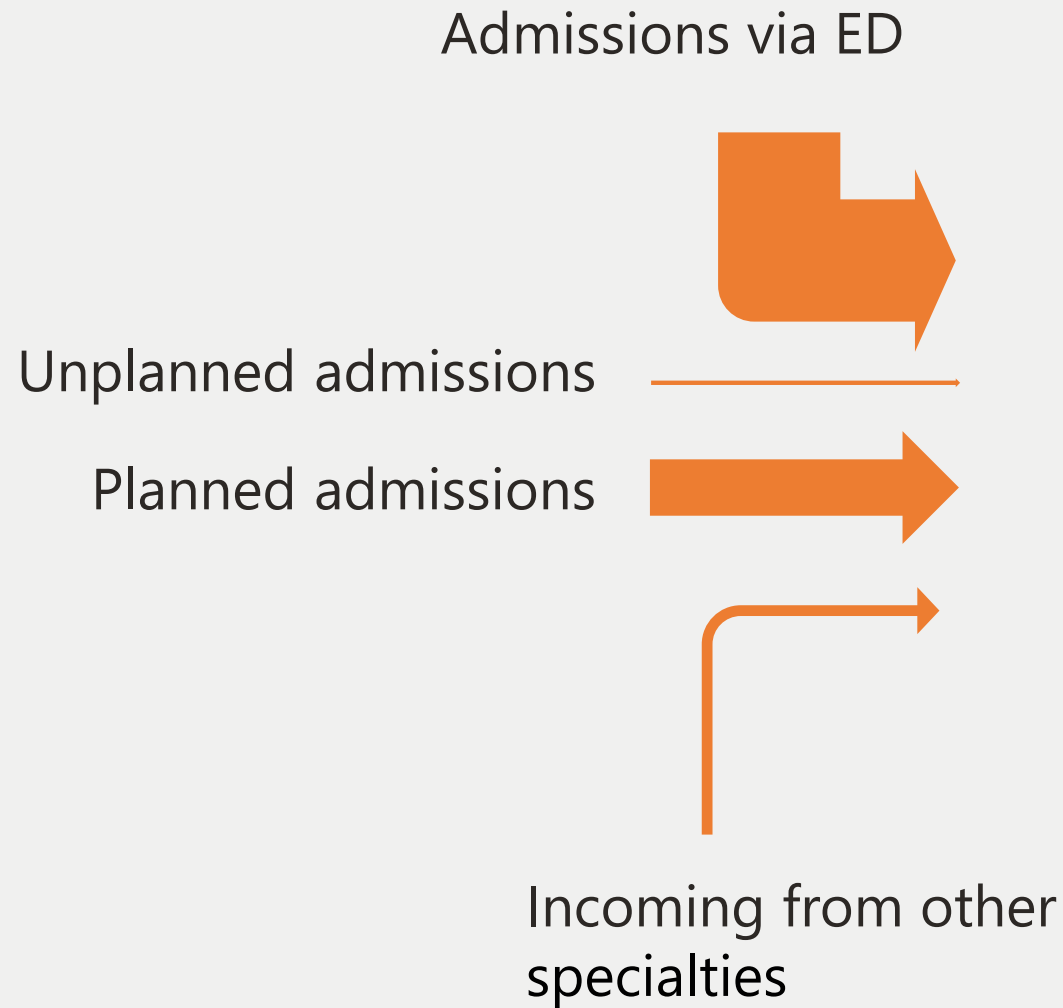




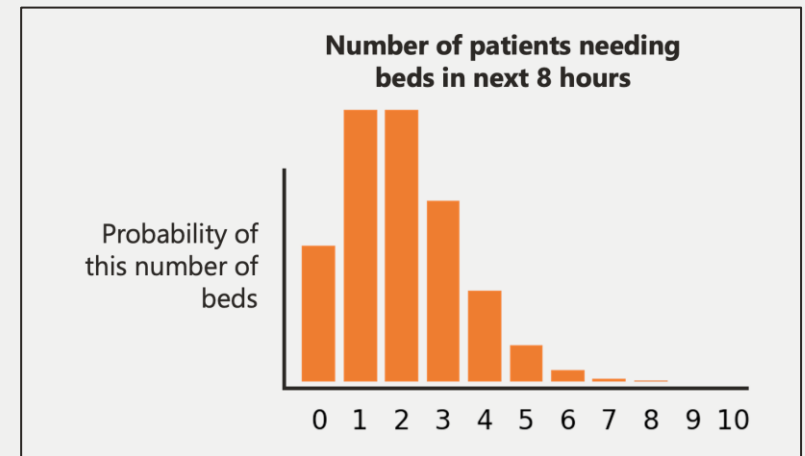


Admissions via ED





The demand predictions assume that ED 4-hour targets will be met



To predict demand for patients currently in the ED

Admissions via ED



Probability of a patient being admitted at the end of the ED/SDEC visit

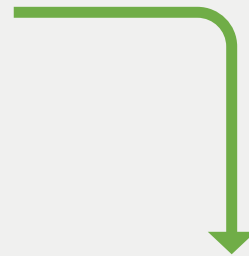
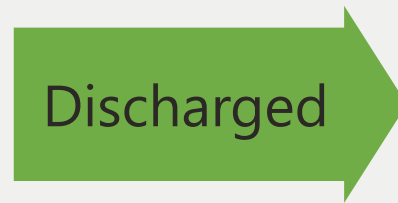
- Age, arrival method
- Locations visited in ED (eg Resus, UTC)
- Triage scores, pain levels, consciousness
- Numbers of observations and lab orders
- Vital signs
- Lab orders
- Lab results
- Whether patient has consult order

Probability of a patient being admitted to specialty if admitted

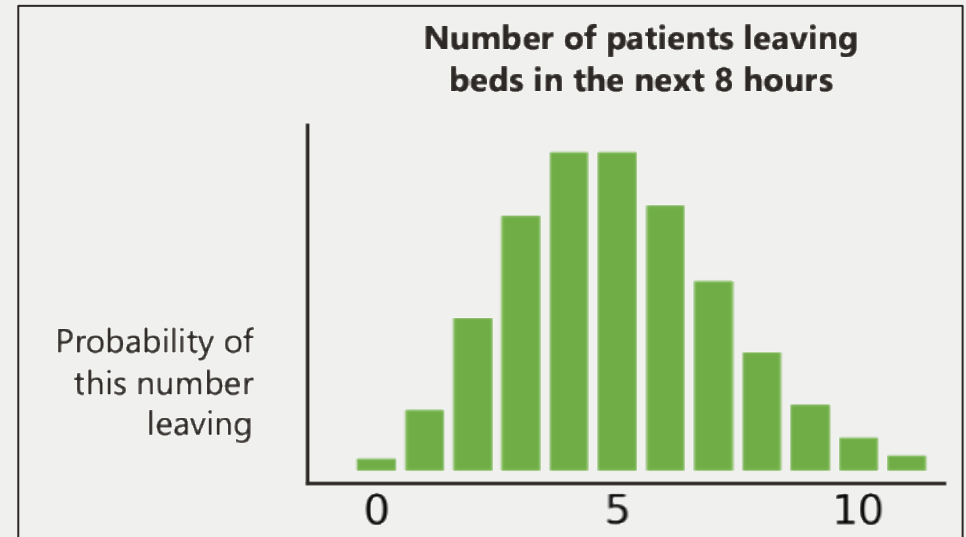
- Specialty associated with consult order while patient in the ED

To predict discharge from specialty

Leaving specialty

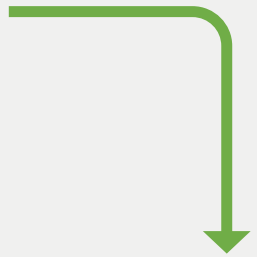


Outgoing to
another specialty



To predict discharge from specialty

Leaving specialty

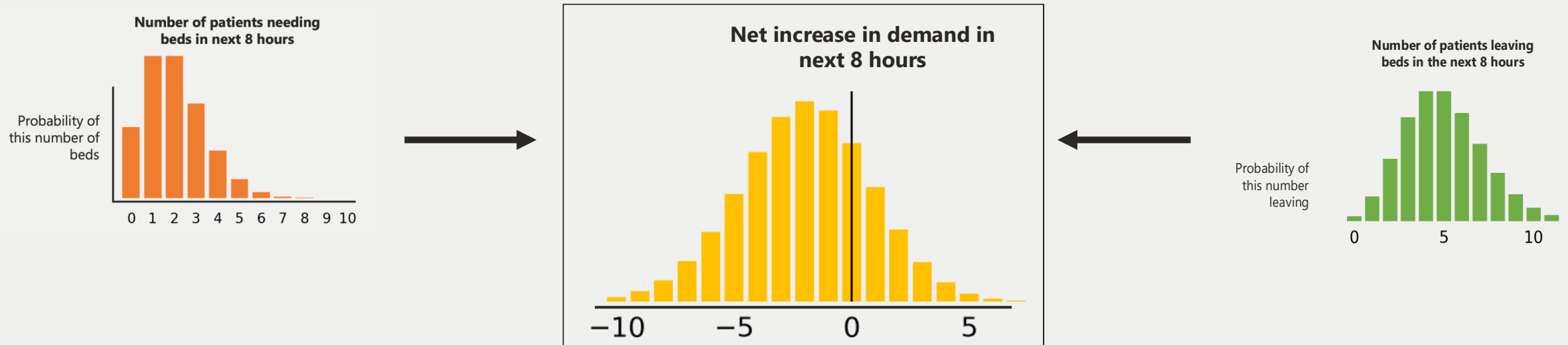


Outgoing to
another specialty

Probability of a patient
being discharged from a
specialty within the
prediction window

- Time of day
- Day of week
- Current specialty
- Length of stay to date in this specialty
- Patient having confirmed/query discharge
- Safe Patient Discharge Assessment score
- Patient's Discharge To Assess pathway
- Progress on discharge targets for patient
- Other signals of staff activity around the patient

Combining these predictions gives a net increase in the next 8 hours

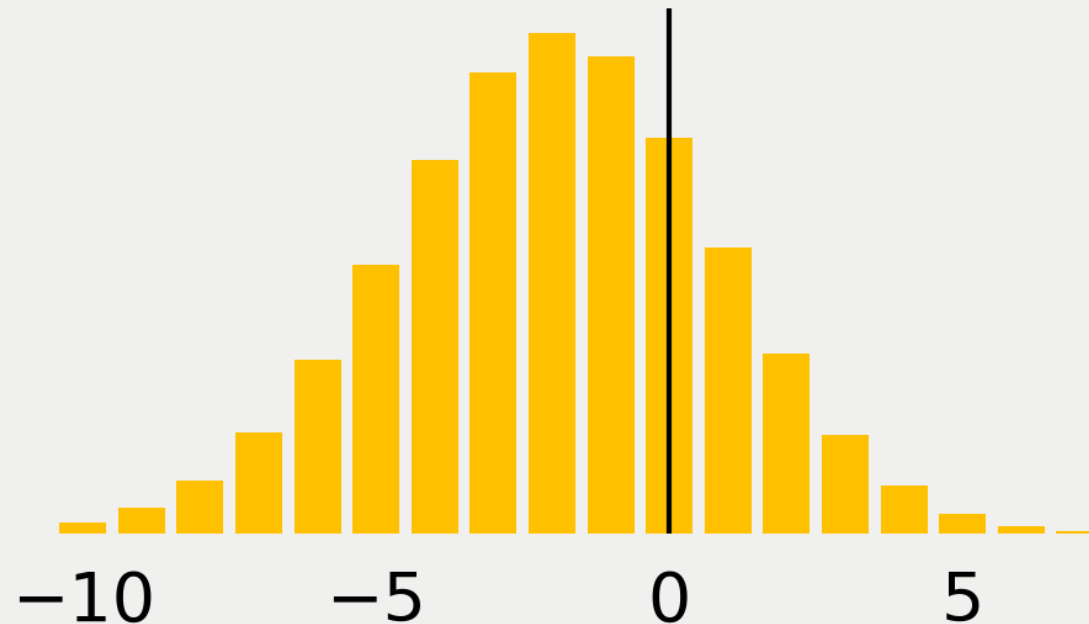


The demand predictions assume that ED 4-hour targets will be met

Is the tide rising or falling?

Net increase in demand between now and
end of prediction window

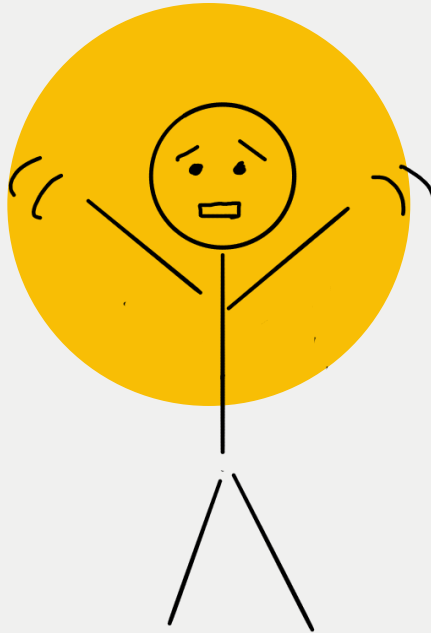
Probability of this
number of beds



Here the number leaving is expected to be greater than
number arriving → demand for beds expected to reduce

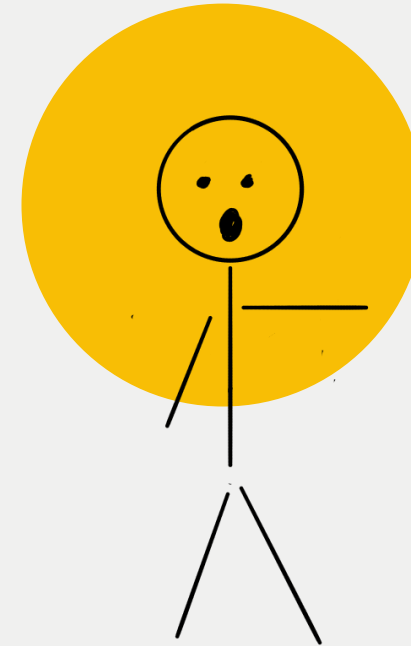
That's how we get from this ...

10 patients
waiting for
beds in ED



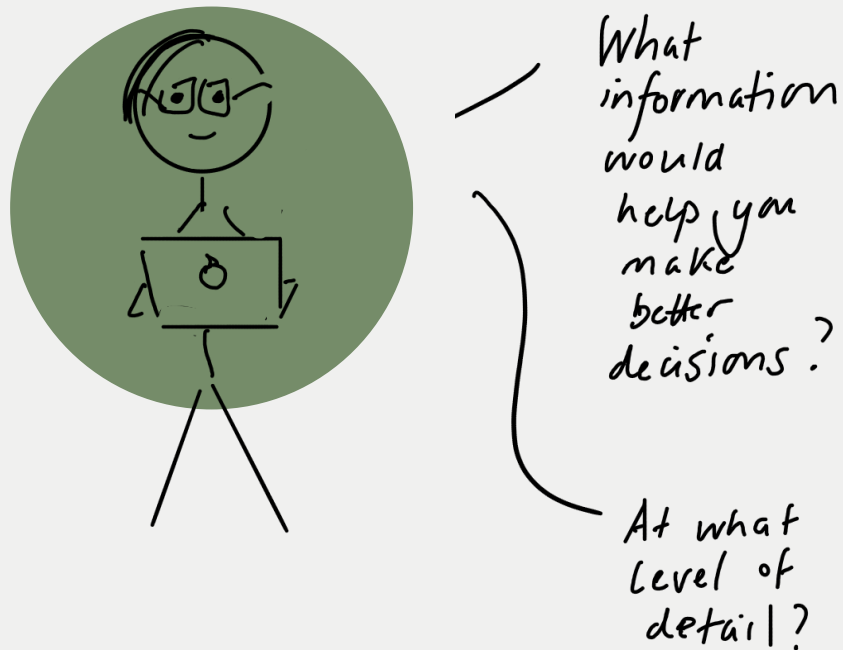
... to this

Lower GI -3
Upper GI +4

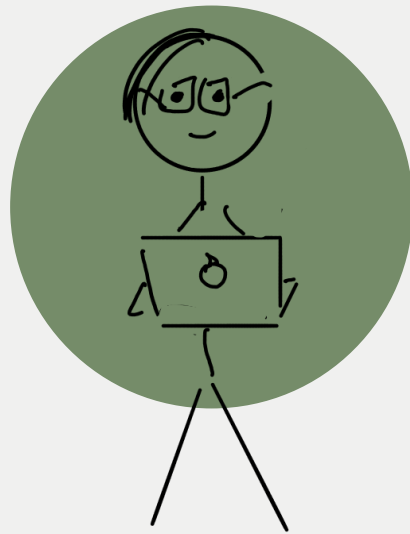


Ahoy there,
Upper GI.
The tide
is rising

Who might use this information and for what?



Who might use this information and for what?

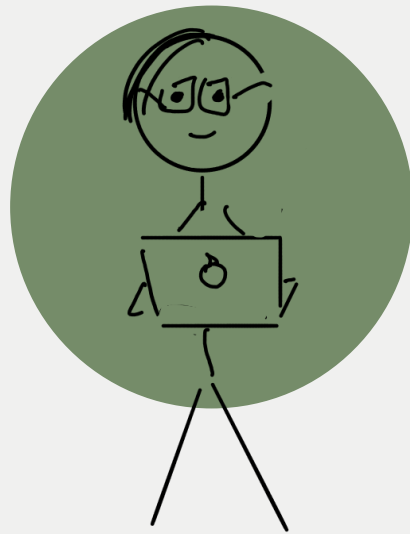


What
information
would
help you
make
better
decisions?

At what
level of
detail?



I want
to
know
everything
every where
all at
once



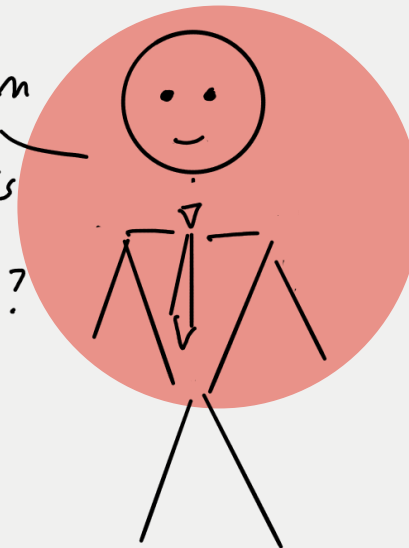
What information would help you make better decisions?

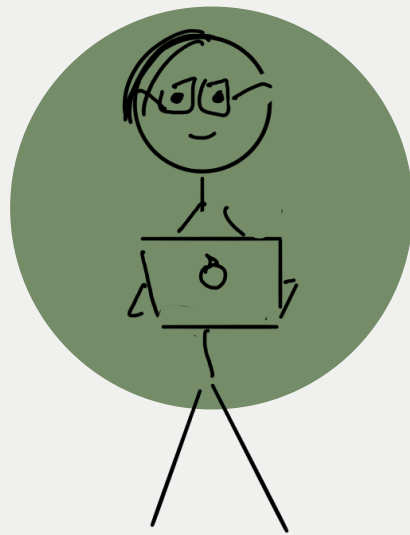
At what level of detail?

DIRECTOR OF
OPS FOR ELECTIVES

At 3.15 pm
what is
tomorrow's
elective
demand?

At
subspecialty
level

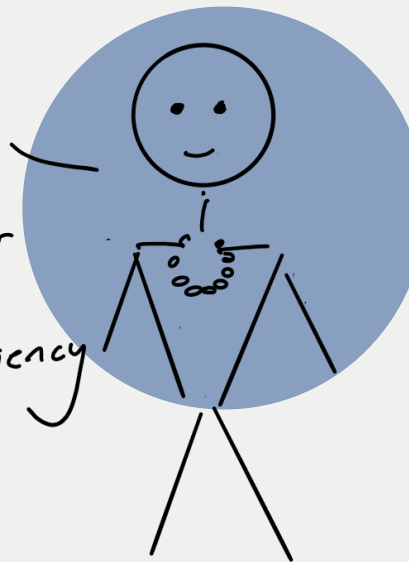




What information would help you make better decisions?

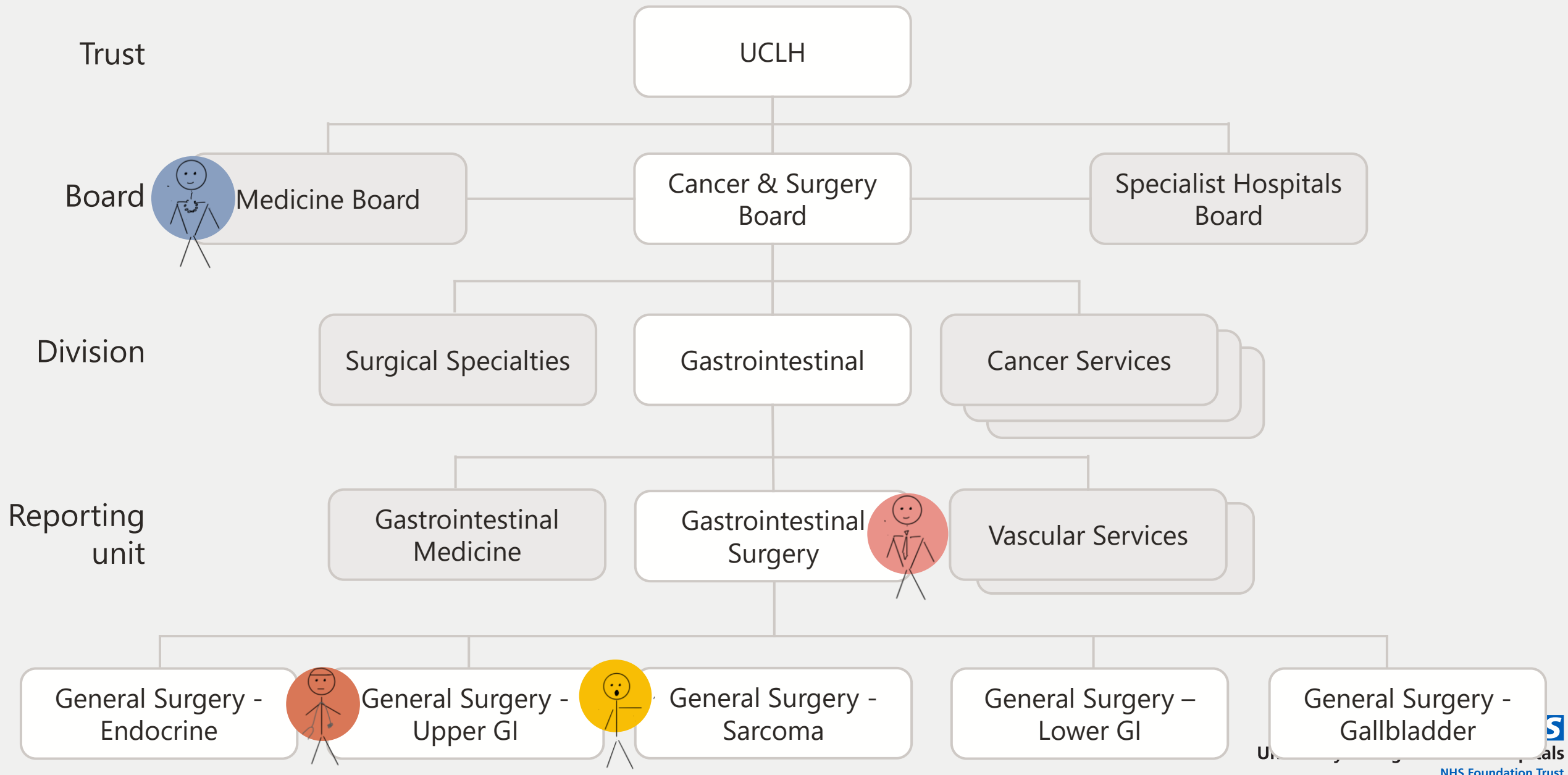
At what level of detail?

DIRECTOR OF OPS FOR MEDICINE



Net change in demand.
Balance of elective v. emergency

At board level



Reporting unit

Gastrointestinal
Surgery

General Surgery -
Endocrine

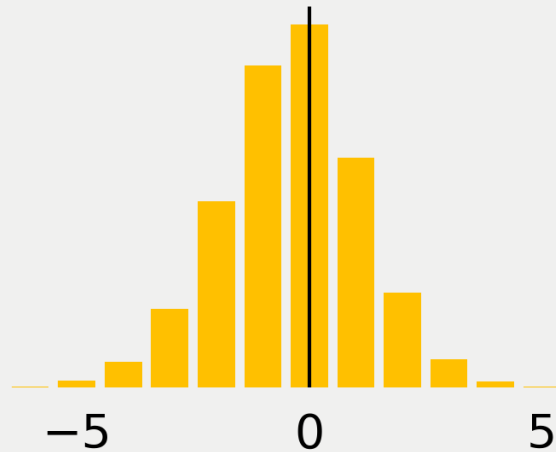
**General Surgery -
Upper GI**

General Surgery -
Sarcoma

General Surgery -
Lower GI

General Surgery -
Gallbladder

Net flow expectation = -0.42



Reporting unit

Gastrointestinal
Surgery

General Surgery -
Endocrine

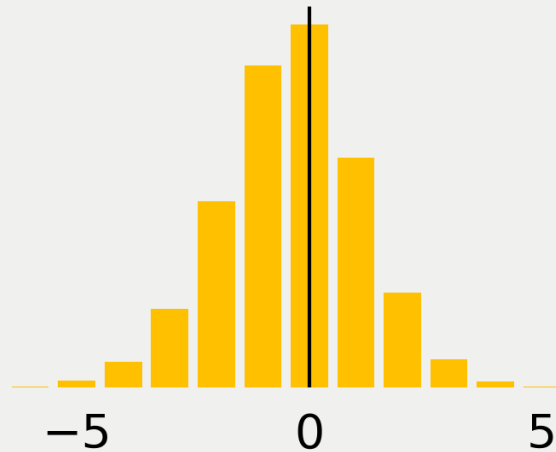
**General Surgery -
Upper GI**

General Surgery -
Sarcoma

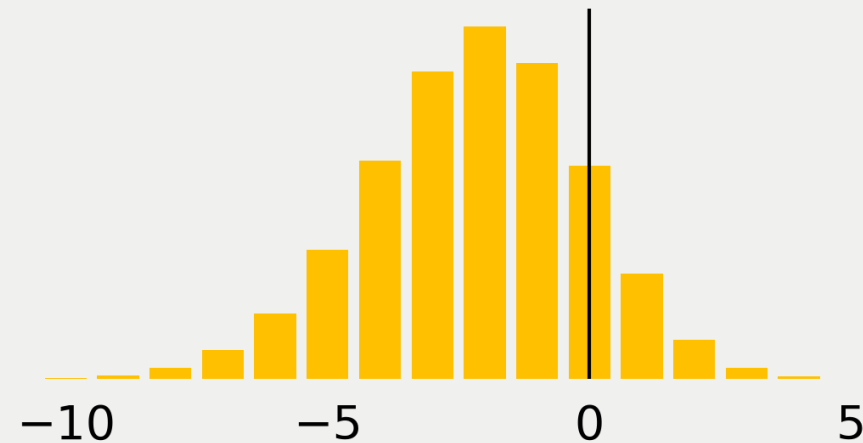
**General Surgery -
Lower GI**

General Surgery -
Gallbladder

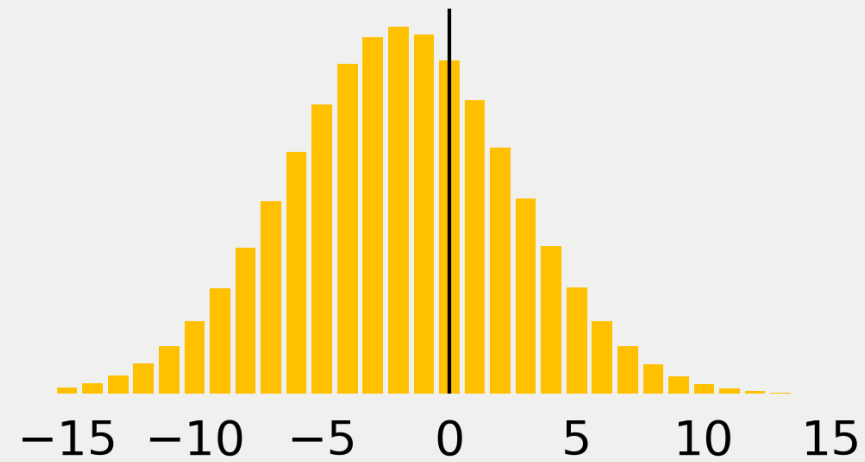
Net flow expectation = -0.42



Net flow expectation = -2.2



Net flow expectation = -2.22



Reporting unit

**Gastrointestinal
Surgery**

General Surgery -
Endocrine

General Surgery -
Upper GI

General Surgery -
Sarcoma

General Surgery -
Lower GI

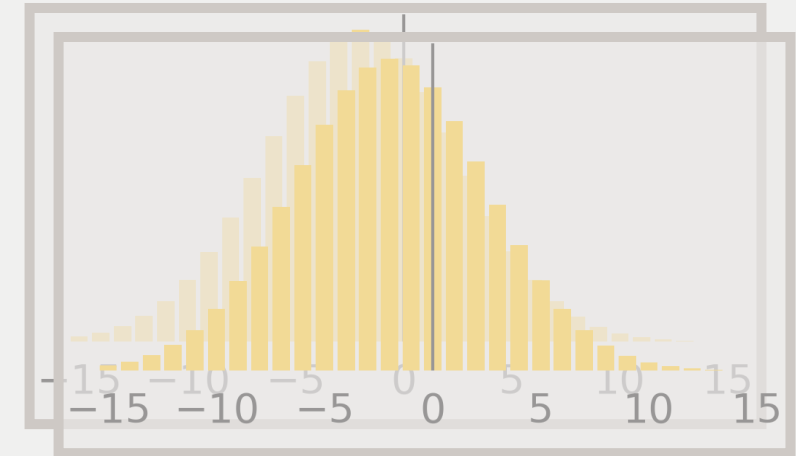
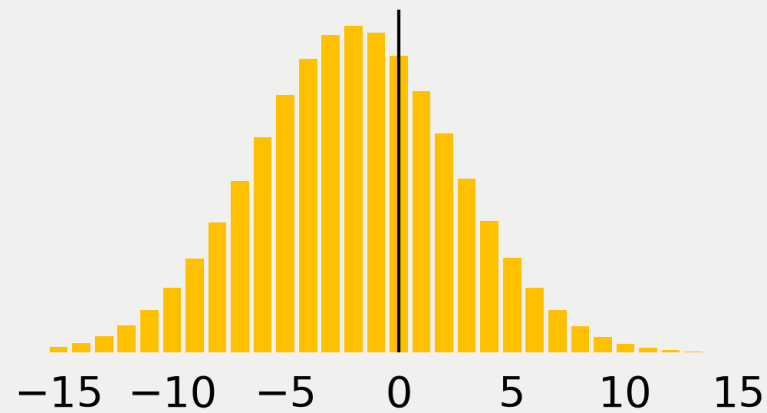
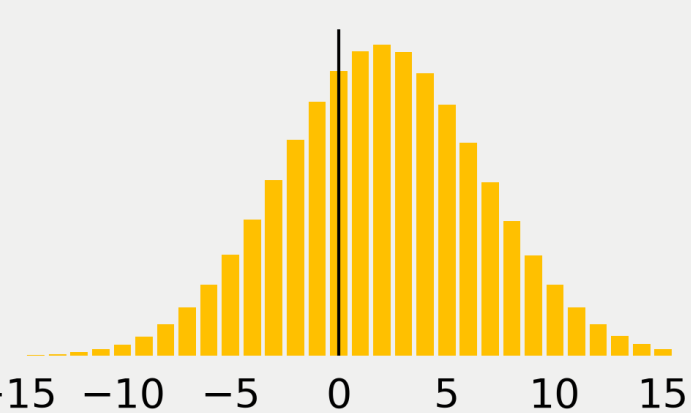
General Surgery -
Gallbladder

Gastrointestinal

Gastrointestinal
Medicine

Gastrointestinal
Surgery

Vascular Services



What this looks like in practice

Current situation

Reporting Unit	Bed base	Number of inpatients	Number waiting in ED/SDEC	Number over bed base	Number outlying from this service	Number of inliers hosted for other services
Gastrointestinal Medicine	19	32	0	13	24	11
Gastrointestinal Surgery	48	54	1	7	23	17
Obesity Services	0	2	0	2	2	0
Vascular Services	0	1	0	1	1	0



Gastrointestinal division is exceeding its bed base in all reporting units

What is coming?

Current situation

Reporting Unit	Bed base	Number of inpatients	Number waiting in ED/SDEC	Number over bed base	Number outlying from this service	Number of inliers hosted for other services
Gastrointestinal Medicine	19	32	0	13	24	11
Gastrointestinal Surgery	48	54	1	7	23	17
Obesity Services	0	2	0	2	2	0
Vascular Services	0	1	0	1	1	0

What is coming?

Emergency patients

Predicted Emergency Flows		
Arrivals	Departures	Net Flow
1 to 3	2 to 4	-2 to 0
2 to 4	3 to 5	-3 to 1
0 to 0	0 to 0	0 to 0
0 to 0	0 to 0	0 to 0



Arrivals



Departures



Net flow

Current situation

Reporting Unit	Bed base	Number of inpatients	Number waiting in ED/SDEC	Number over bed base	Number outlying from this service	Number of inliers hosted for other services
Gastrointestinal Medicine	19	32	0	13	24	11
Gastrointestinal Surgery	48	54	1	7	23	17
Obesity Services	0	2	0	2	2	0
Vascular Services	0	1	0	1	1	0

What is coming?

Emergency patients

Elective patients

Predicted Emergency Flows		
Arrivals	Departures	Net Flow
1 to 3	2 to 4	-2 to 0
2 to 4	3 to 5	-3 to 1
0 to 0	0 to 0	0 to 0
0 to 0	0 to 0	0 to 0

Predicted Elective Flows		
Arrivals	Departures	Net Flow
1 to 4	1 to 2	0 to 2
1 to 2	4 to 6	-5 to -2
0 to 0	0 to 1	-1 to 0
0 to 0	0 to 0	0 to 0



Arrivals Departures **Net flow**

Current situation

Reporting Unit	Bed base	Number of inpatients	Number waiting in ED/SDEC	Number over bed base	Number outlying from this service	Number of inliers hosted for other services
Gastrointestinal Medicine	19	32	0	13	24	11
Gastrointestinal Surgery	48	54	1	7	23	17
Obesity Services	0	2	0	2	2	0
Vascular Services	0	1	0	1	1	0

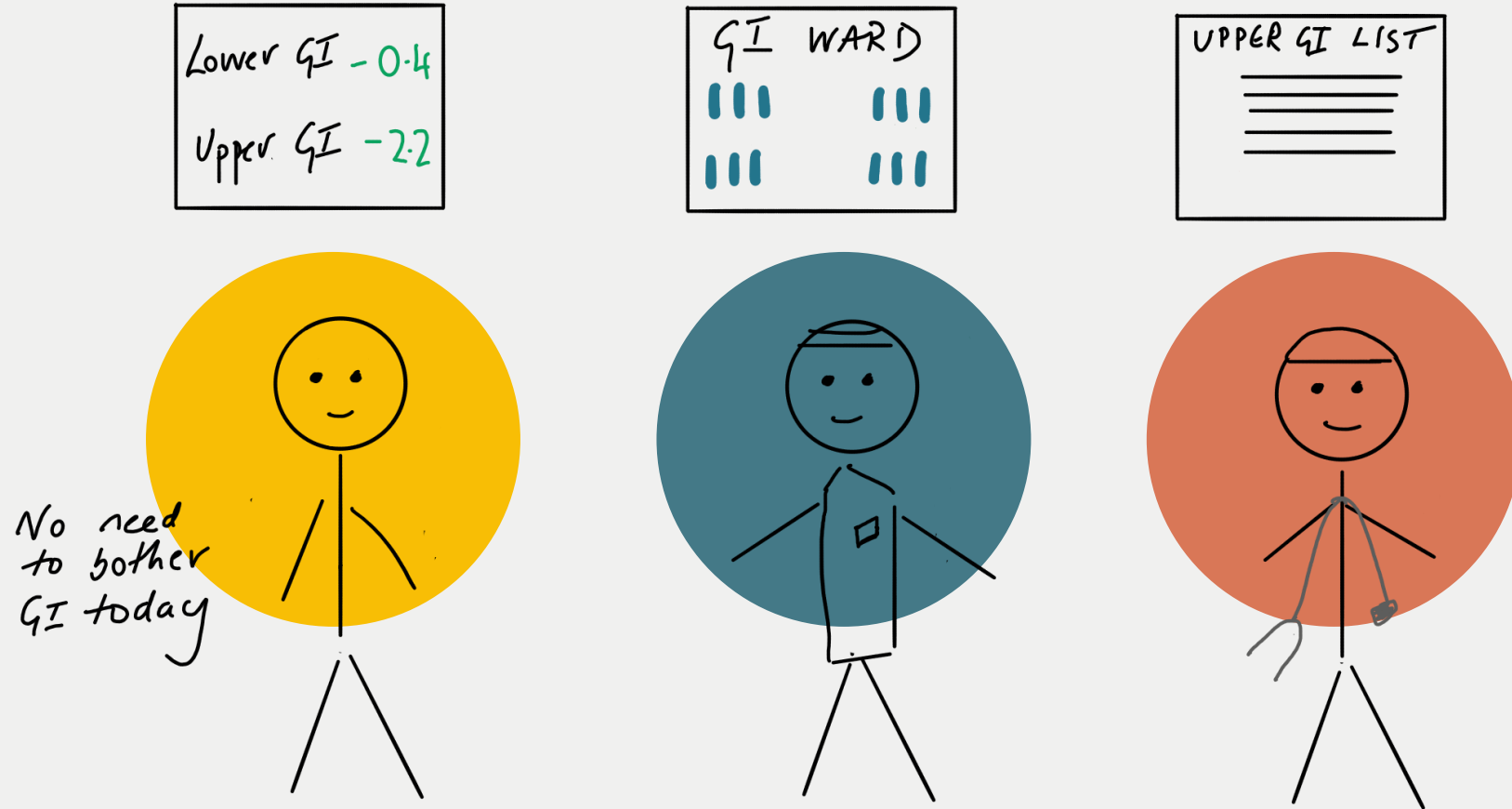
What is coming?

Emergency patients Elective patients

Predicted Emergency Flows			Predicted Elective Flows			Predicted change with respect to bed base
Arrivals	Departures	Net Flow	Arrivals	Departures	Net Flow	
1 to 3	2 to 4	-2 to 0	1 to 4	1 to 2	0 to 2	11 to 15
2 to 4	3 to 5	-3 to 1	1 to 2	4 to 6	-5 to -2	0 to 5
0 to 0	0 to 0	0 to 0	0 to 0	0 to 1	-1 to 0	1 to 2
0 to 0	0 to 0	0 to 0	0 to 0	0 to 0	0 to 0	1 to 1



Position is improving for Gastro Surgery

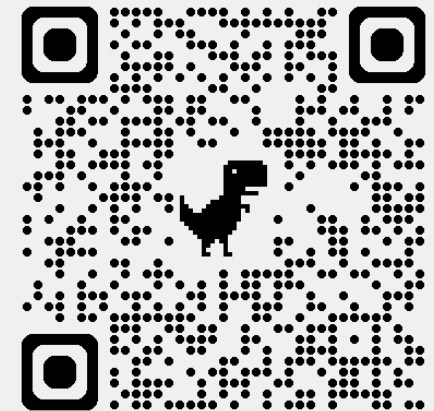


The modelling code is open source

Now being adopted by four other hospitals in England and Sweden



patientflow code



How the tool is being used at UCLH



06.00

09.30

12:00

15:30

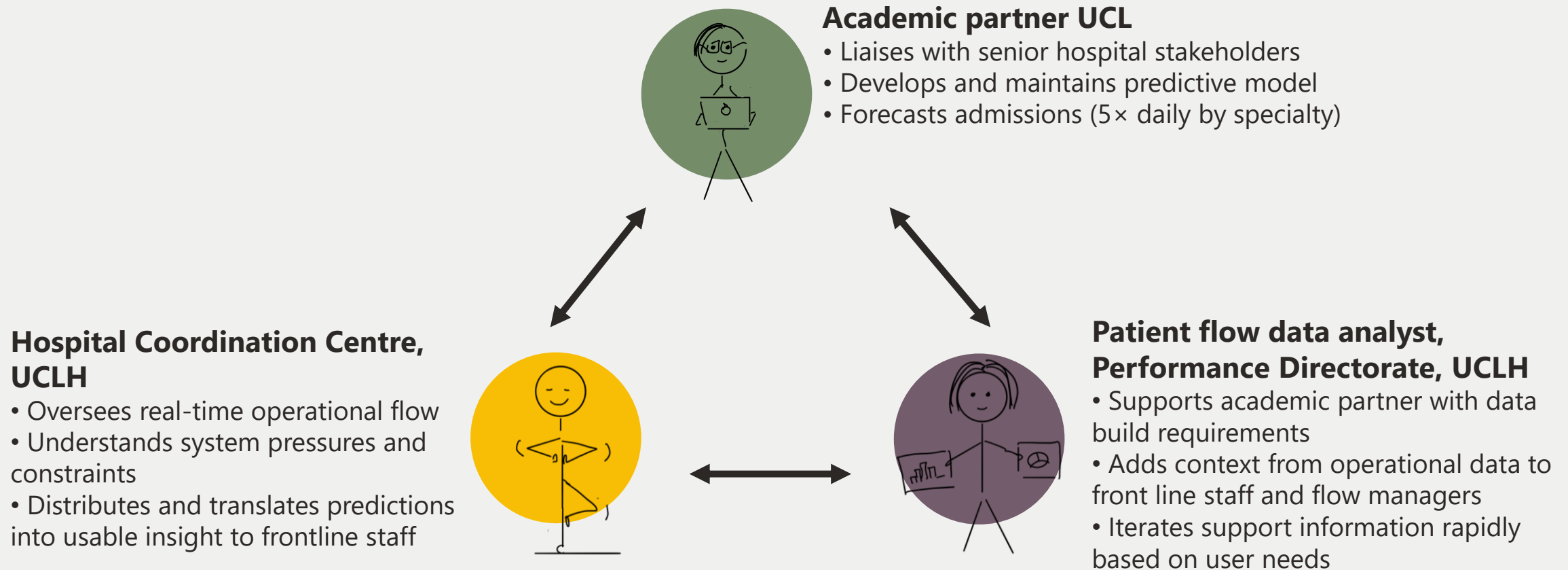
22:00

07:59



Predictions to 07:59 the next day

Combining prediction, operational coordination, and analytical context



Turning predictions into operational decisions

Building a relevant environment	Bringing in real-world limits	Supporting change
Provide a joined-up data environment combining operational and predictive data Enable users to explore demand from multiple perspectives (specialty, pathway, activity type) Continuously refine metrics and views as understanding evolves	Bring together capacity, flow, and patient complexity data alongside predicted demand Show how available capacity varies across services and time Identify where mismatches between demand and capacity are emerging	Support development of operational targets and performance benchmarks Provide insight to support discharge and flow decisions Deliver rapid analysis in response to emerging issues Connect relevant teams quickly when operational pressure requires coordinated action

How can you implement this? Key areas to focus on

Leadership and organisational support

- Active senior clinical and operational leadership buy-in and clear stakeholder engagement
- Regular presence in operational and governance forums at all levels

Embedded analytical capability

- Dedicated analyst capacity and built-in recognition of the analytical role
- Time protected for proactive and preventative analysis

Collaborative working internally

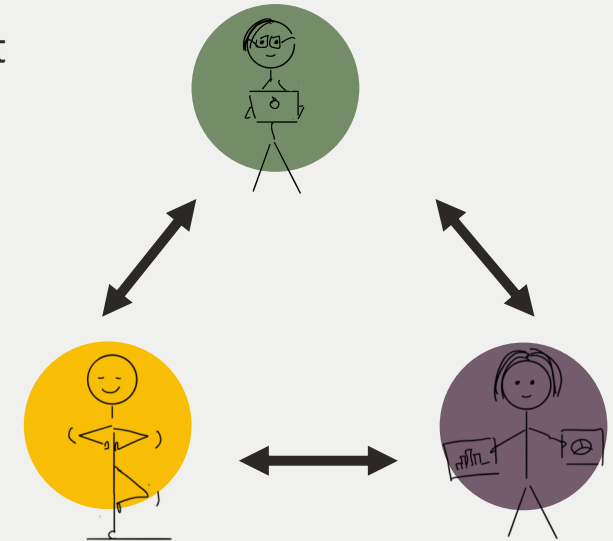
- Informal huddles to enable rapid testing and refinement and strong feedback loops
- Close day-to-day collaboration to ensure outputs remain relevant and usable

Developing & sharing what we know

- Use of quantitative and qualitative data sources with ongoing focus on data quality, including data entry training
- Use of evolving analytical methods to improve interpretation and communication of insight

Tapping into academic and peer expertise

- Work with existing academic partners to develop and refine ideas – what resources are already available?
- Build informal networks to share and learn from each other



Contact

Zella King

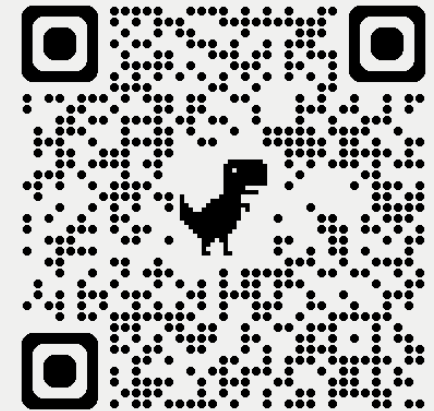
zella.king@ucl.ac.uk

zella.king1@nhs.net

Claire Tucker

claire.tucker@nhs.net

patientflow code



Countess of Chester hospital

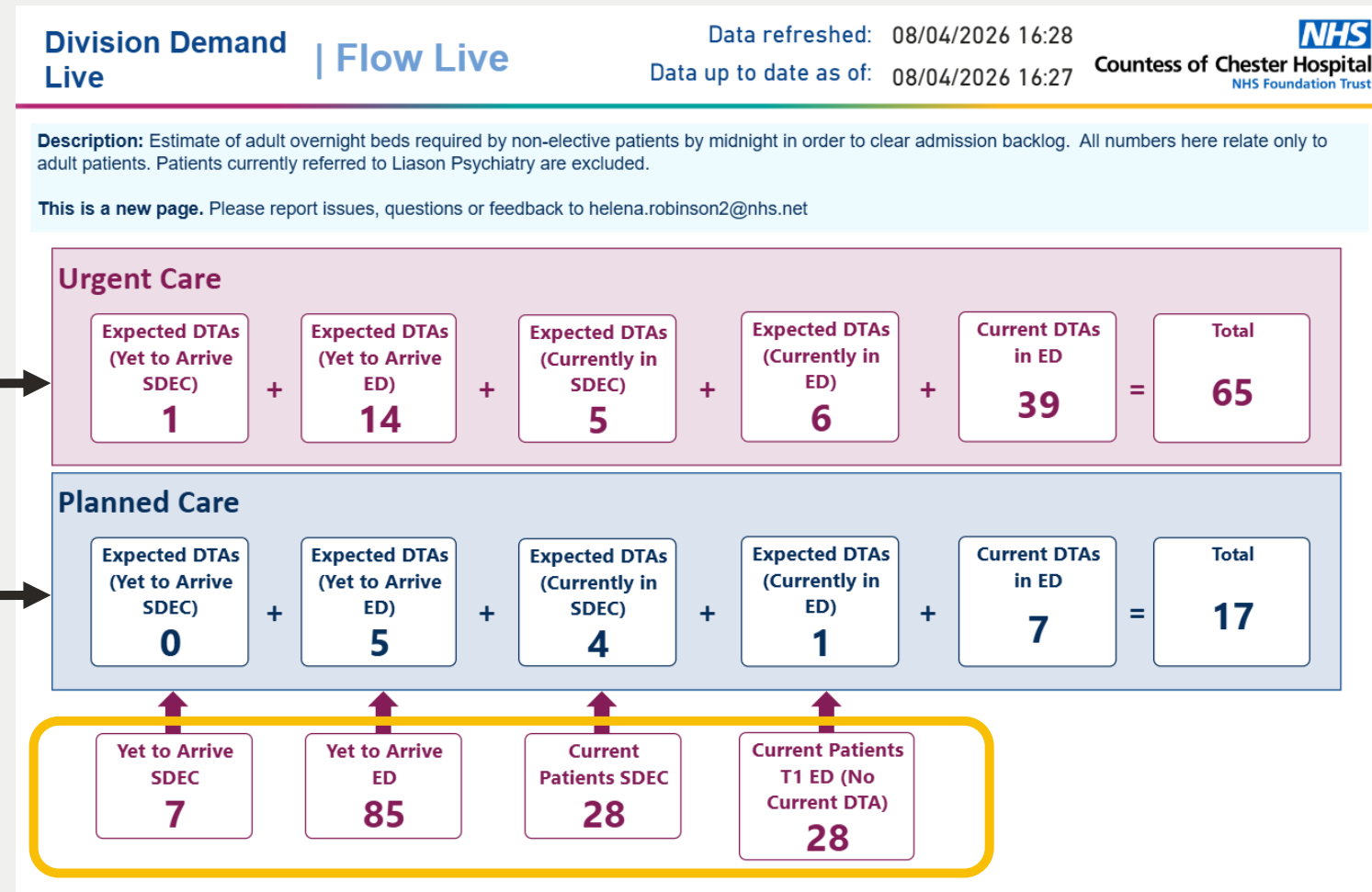


Countess of
Chester Hospital
NHS Foundation Trust

Medical →

Surgical →

Forecast additional
attendances before
midnight





Scan here for the next NHS Patient
Flow Conference...



4th November 2026
etc.venues, Manchester, 8th Floor, 11
Portland Street, M1 3HU

