WELCOME TO

The NHS Patient Flow Conference

Check Out Our Agenda Here...

SCAN ME

9th February 2023 - 08:00am – 16:00pm – etc.venues, Manchester

Conference hosted by Convenzis Group Limited

CONVENZIS

For Each Delegate Attending Our In-Person Event Today, we will be planting 1 tree with our Key Sustainability Partner

PLAY IT GREEN

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The Patient Flow Conference North 2023

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THE NHS PATIENT FLOW CONFERENCE 2023

Event Chair – Opening Address

Professor Maureen Baker

CBE

PRSB

Chair

THE NHS PATIENT FLOW CONFERENCE 2023

SPEAKING NOW

Ben Owens

Consultant in Emergency Medicine / UEC Division Clinical Chair ECIST
Clinical Associate - Sherwood Forest Hospitals

I will be discussing…

"Balancing Risk and Empowering Patients in Patient Flow"

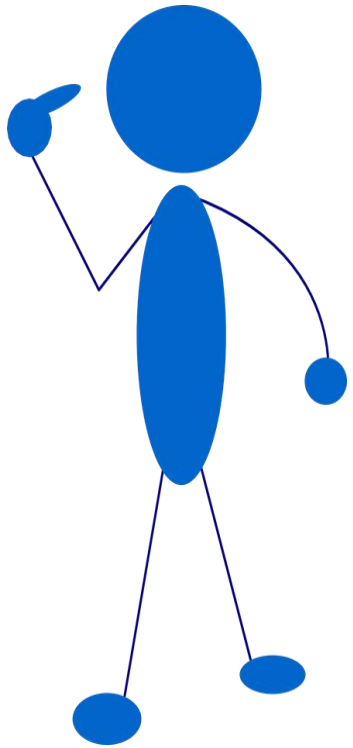
Balancing Risk and Empowering Patients in Emergency Flow

Dr Ben Owens

Consultant in Emergency Medicine

ECIST Clinical Associate

Who can be harmed when people are admitted unnecessarily or stay longer than necessary?



Ben Owens
@EmergMedCons

Appreciating that this is a difficult one and no option is ideal care Answering as a patient. If you/your relative were in significant pain/septic/having a possible heart attack/stroke/ head injury on blood thinners etc. would you rather have/be?

A long ambulance delay	2%
treated in an ED corridor	30%
In ED 2 to a cubicle	**68%**

606 votes · Final results

Ben Owens @EmergMe... · 07/01/2023

Follow on question. Also a poor but sadly too real choice (accepting that none of these are ok). Please RT if u answer. If you or your relative required hospital admission and were acutely sick (not ICU sick), been treated in ED & long waits for a bed would you rather be in?

An ED corridor	5%
ED 2 to a cubicle	18%
A post ED holding area	26%
Boarded 1 over on a ward	**51%**

276 votes · Final results

6,365 7 30 6

What are hospitals admissions for?

Problem

- No more Drs/nurses/beds/social care staff

Alternatives

- SDEC
- Hot clinics
- Community services
- Virtual ward
- 2ww clinics
- Primary care
- Safety netting

“She’s not safe!”

Falls Risk

- Each year 30% of those aged over 65,
- 40% over 80yo living in the Community
- 60% of nursing home residents will fall (Shaw 1996)
- Falls in Hospitals increases to 50 %
- Falls in Hospital – higher Hip #
- The rate of falls is increased in recently hospitalised patients with risk factors for falls

Behaviours we see that cause harm

- Unnecessary admissions
- Delayed discharges
- Home if bloods normal
- The “reassure-ogram”
- Refusal to do a hot week/review patients
- Refusal to board/sit out/use the discharge lounge
- Refusal to offload ambulances
- OT/PT reflex

Language

- “I’m not happy for you to go home”
- “But you might fall”
- “She's not safe”
- Its not safe to…..
- “I'm not happy to sign him off for the stairs”
- “I'm not risking my PIN/Registration”
- “The relatives might complain”

Drivers for these

- My patients
- I'm not responsible for ED/ambulances
- Might be sued
- Might be called to the coroner
- It’s not my job
- But I can’t see them and I can see the patient in front of me
- What we measure – falls IC rates

Risk of death in hospital inpatients

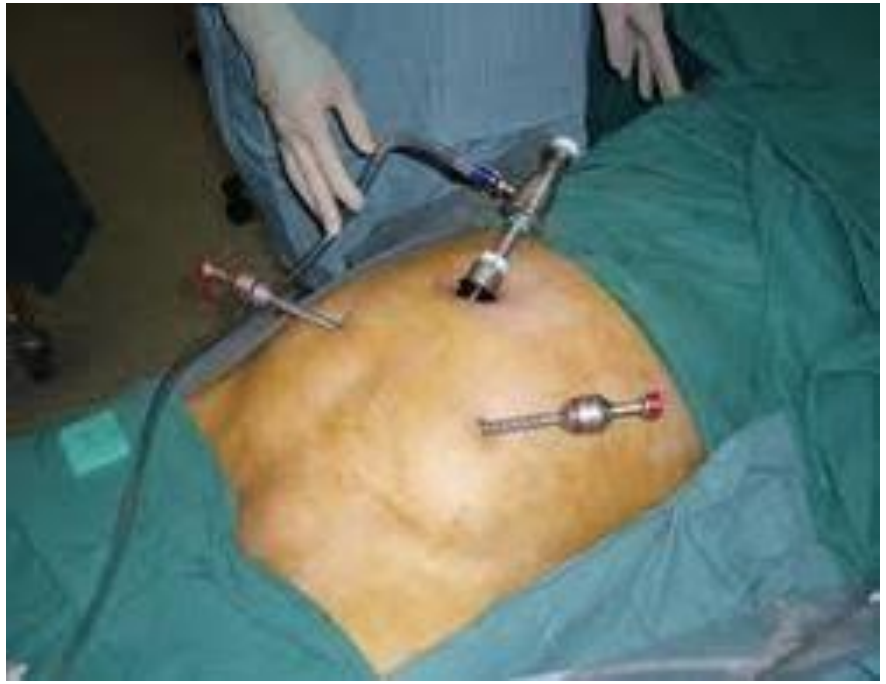
- 48% of people over 85 die within one year of hospital admission
- The elderly don’t fear death, they fear loss of independence
- What matters to me – not what is the matter with me

Real risk for the patients

- If you are admitted through a crowded ED you have a 43% mortality increase if admitted for 10 days or more
- If you are 80 you have a mean of 1000 days of life left – how many would you choose to have in hospital?
- Bed rest – 10-20% muscle strength lost per week – admission for > 3 days can convert an independent frail person to a dependant one
- If you are over 75 and in hospital for over 2 weeks you have a 13% mortality
- If you are over 85 and admitted to hospital 42% 1 year mortality

Last 1000 days of life

Why do we see process and behaviour differently to clinical treatment?



Phrases to stop/challenge

- “I’m risk averse”
- “My risk” or “I’m not taking the risk of discharging them”
- “Back to baseline”
- ”Medically fit for discharge”
- “Not safe to go home”
- “Failed physio” or “failed stairs assessment”
- “I’m not happy to sign them off as fit”
- “I’m here for my patients”

#NOF


The Wholly Frail
Henry Woodford
Emergency department...
Can I go home?
No, you're off your legs, we'll have to admit you
On the ward...
Can I go home?
No, you need to stay in bed or you might fall over
The following week...
Can I go home?
No, you're not back on your feet yet

Empowering patients – dementia?

- We should not ask relatives what they want
- Our obligation is to the patient
- Asking the relative what they want puts unfair pressure on them
- If they could rewind 20 years stand at the end of the bed and see themselves now what would they want us to do?

What can we learn from elective care?

- Consent for bypass and give a choice
- Why not for admission/discharge?
- For surgery we accept it documented in the notes why not in emergency care

Consent Form 1

Patient agreement to investigation or treatment

Patient details (or printed label)

Surname

First name

Date of birth

Male ☐ Female ☐

NHS Number

Responsible consultant

Job title

Special requirements *(eg. other language, communication method)*

Name of proposed procedure of course of treatment *Include brief explanation if medical term not clear*

Admission to hospital because it is 'safer' than going home

Statement of health professional

To be filled in by health professional with appropriate knowledge of proposed procedure as specified in consent policy

I have explained the procedure to the patient. In particular, I have explained:

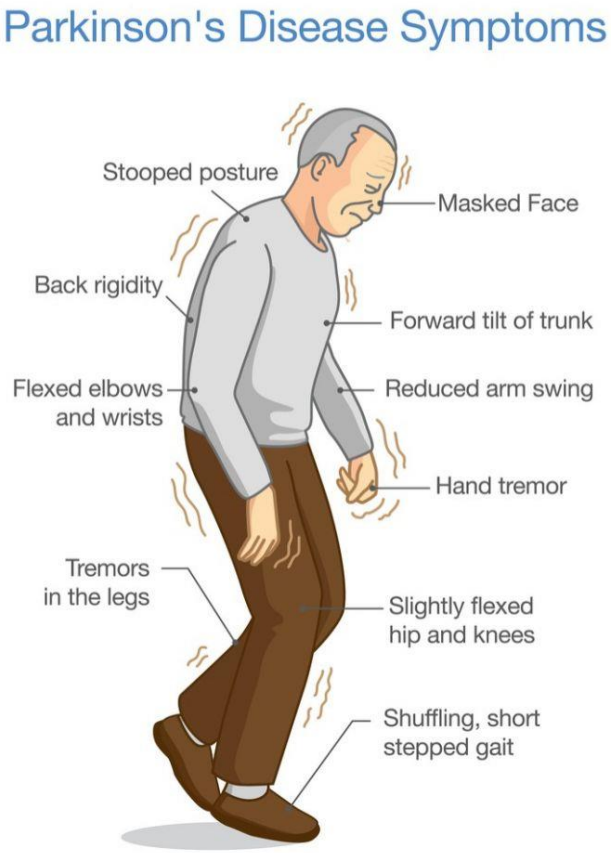
The intended benefits: Possibly early investigations; Not falling or collapsing with nobody there to help; having time to arrange better social circumstances / care

Serious or frequently occurring risks: Loss of confidence; loss of muscle power; loss of mobility; loss of sleep; increased confusion; increased risk of falling; risk of hospital acquired infection; not getting back to your own home ... ever.

Any extra procedures which may become necessary during the procedure

☐ Blood transfusion

Billy


Parkinson's Disease Symptoms
Stooped posture
Masked Face
Back rigidity
Forward tilt of trunk
Flexed elbows and wrists
Reduced arm swing
Hand tremor
Tremors in the legs
Slightly flexed hip and knees
Shuffling, short stepped gait

Empowering patients

- What are the pros and cons of admission/remaining in the hospital?
- Ask the patient what matters to them vs what is the matter with them
- Document it

Balance

- There is no “no risk” or “safe” just “safer” or lower risk”

How do we change this?

- Encourage staff to change the language they use, the approach to decision-making and the concepts of risk and who owns it and to empower patients.
- Liberate the ourselves from the false perception of personal risk they believe they have.
- Talk about the risks of admission/staying in
- Giving the patient the information about the risks, empowering and supporting them to make the decision they want

4 patient questions

Do I know what is wrong with me or what is being excluded?

The diagnosis

What is going to happen now, later today and tomorrow to get me sorted out?

The plan

What do I need to achieve to get home?

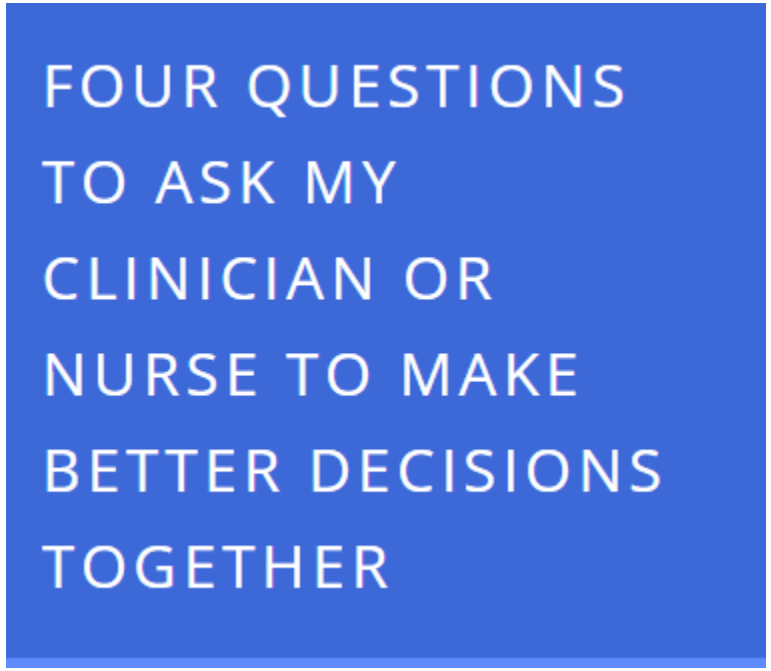
The clinical criteria for discharge

If my recovery is ideal and there is no unnecessary waiting, when should I expect to go home?

The expected date of discharge

BRAN tool for decision making

- Pushes us to consider alternatives and to see risk as something to balance for the patient
- [Shared decision making - Choosing Wisely UK]

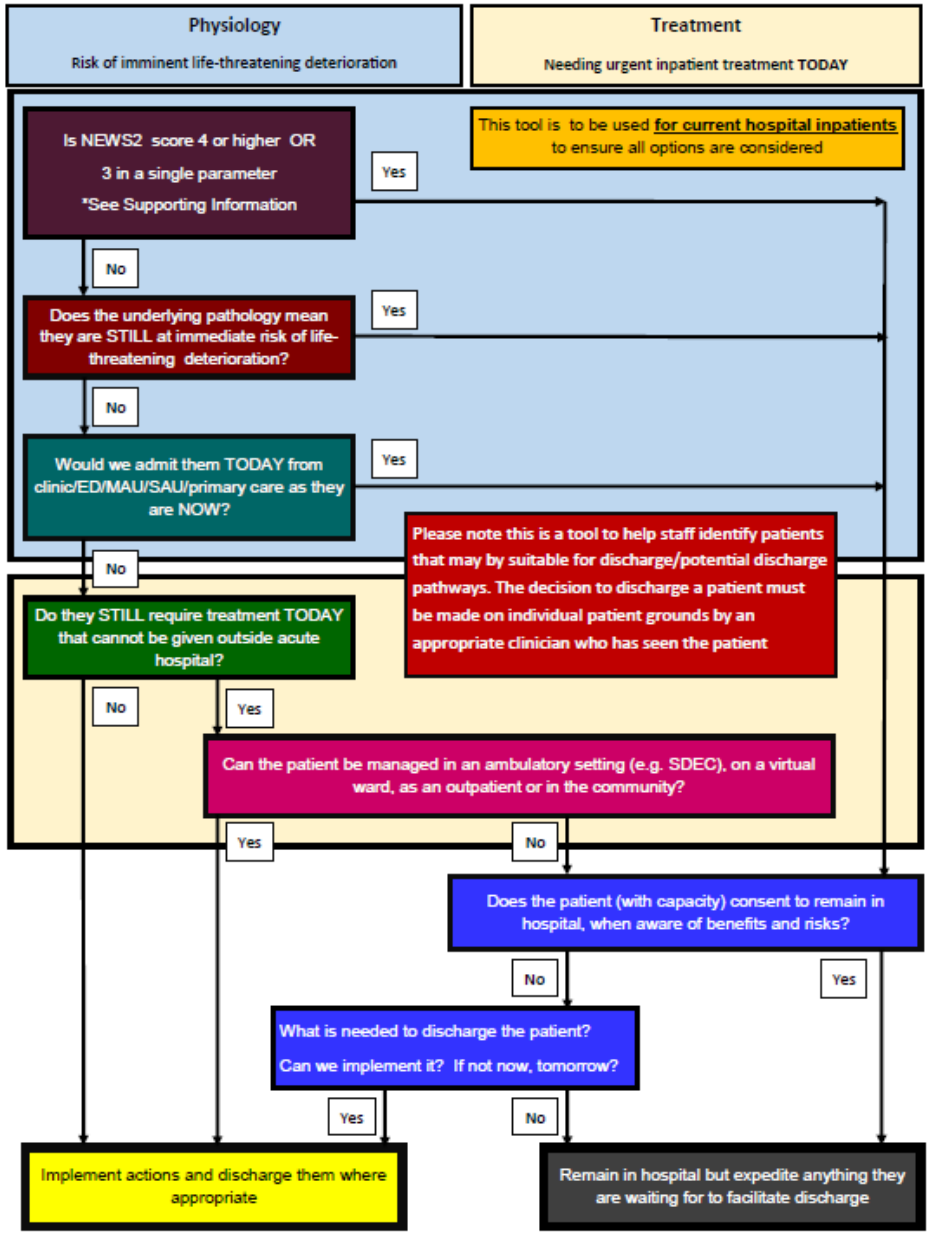


1. What are the **B**enefits?
2. What are the **R**isks?
3. What are the **A**lternatives?
4. What if I do **N**othing ?

Emergency Care Improvement Support Team
Safer, faster, better care for patients

Inpatient Discharge Decision Support Tool

NHS



Supporting information

Is the NEWS2 Score 4 or higher OR 3 in one parameter after treatment?

Example: Heart rate 130 after treatment

This only applies to *changes* in physiology. It is normal for some people to be confused or to require long-term oxygen

Mild delirium can be managed via SDEC / virtual ward or D2A pathway 1, or in other community settings.

Raised temperature alone with cause identified and treatment may not require inpatient care

Remember that not every patient with a low NEWS2 is suitable for discharge. High NEWS2 can be used to rule out discharge but low NEWS2 alone does not exclude admission.

There are situations when it may be appropriate to discharge a patient with a high NEWS2, such as at the end of life. Ask the patient what they want (explore previously expressed views if they are unable to communicate at that time) and involve a senior clinician to assist with planning.

Does the underlying pathology mean they are STILL at imminent risk of life-threatening deterioration?

Examples:

Sudden vascular deterioration (Life-threatening ischaemia, infarction or haemorrhage of any major body part), severe metabolic disorders, Rapidly progressive conditions

Do they STILL require treatment today that cannot be given outside acute hospital?

In some situations, a specific SpO2 target can be set, based on a patient's diagnosis and other clinical factors. If unsure seek senior advice.

There are situations when returning to a patient's usual place of residence is not possible because of a care or therapy need that cannot be met there at this time. There needs to be a balanced assessment of the benefits and risks of ongoing treatment away from home and where that treatment would best be delivered.

Work with patients and families to identify the best location for end of life care.

Can the patient be managed in an ambulatory setting (e.g. SDEC), on a virtual ward, as an outpatient or in the community?

Acute level care can be delivered by virtual wards hospital at home for conditions including (but not limited to):-
Improving AKI
Improving Heart Failure
Weaning oxygen in improving patients
Patients awaiting rapid imaging and other investigations

Medical issues monitored or re-assessed through non-admitted process, such as ambulatory area, outpatient intra-venous therapy, hot clinic, virtual ward.

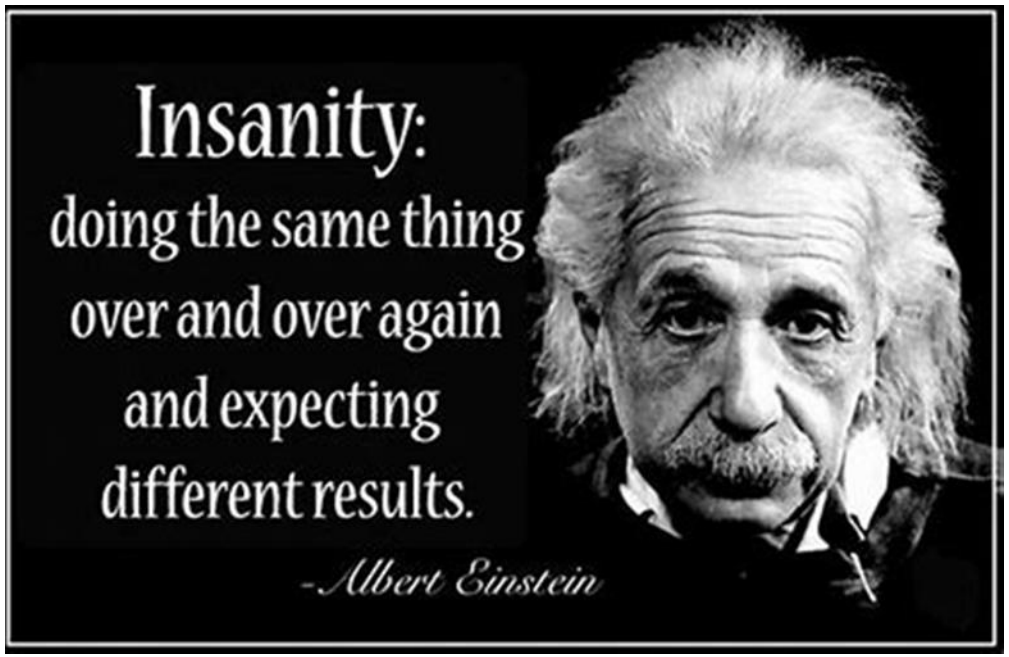
Does the patient (with capacity) consent to remain in hospital, when aware of benefits and risks?

Use BRAN in your discussions and documentation.

What are the **Benefits** of remaining in hospital?
What are the **Risks**?
What are the **Alternatives**?
What if we do **Nothing**?

What can we do differently?

- Talk to your teams - Talk about balancing risk and system ownership – the facts
- Alternatives to admission - Criteria to admit
- 4 Questions – use them and ask your patients
- Give risk to the patient and look at the system risk – disseminate the BRAN tool
- Clinical Early Discharge – inpatient decision support tool/criteria to reside – go and walk the wards weekly do the audit



If we risk nothing then our patients risk everything!

@EmergMedCons benjamin.owens1@nhs.net

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SPEAKING NOW

Mike Davidson

Care Group Manager - Medicine
University Teaching Hospital Southampton Foundation Trust

Mark Awad

Junior Doctor
Southampton General Hospital

We will discuss…

"The Use of Technology in Improving Flow"

NHS
University Hospital Southampton
NHS Foundation Trust

Flow Improvement - The UHS Way

January 2023

The challenge

University Hospital Southampton NHS Foundation Trust

16% Type 1 ED attendances

170 MOFD Patients

Capacity for Elective backlog

Staff sickness & morale

89 Covid inpatients

We needed to support our staff and patients through this challenge

The Trust was seeing unprecedented demand on our services with increased emergency department attendances, medically optimised for discharge patients and a need to treat our long waiting patients through our elective backlog. We had a significant number of Covid inpatients that we needed to treat as well as this affecting the availability of staff.

This was all at a time where our staff were stretched across escalation areas, tired from their efforts over the past 18 months and still impacted by covid related absence.

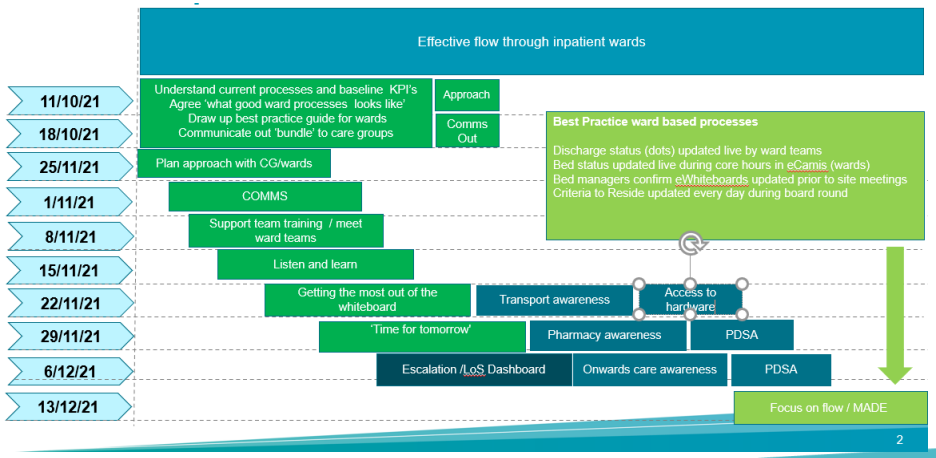
There was an immediate need to provide increased support to help our front line teams test and try new ways of working to improve staff and patient experience through this challenging period so that we can provide the care that we want to our patients.

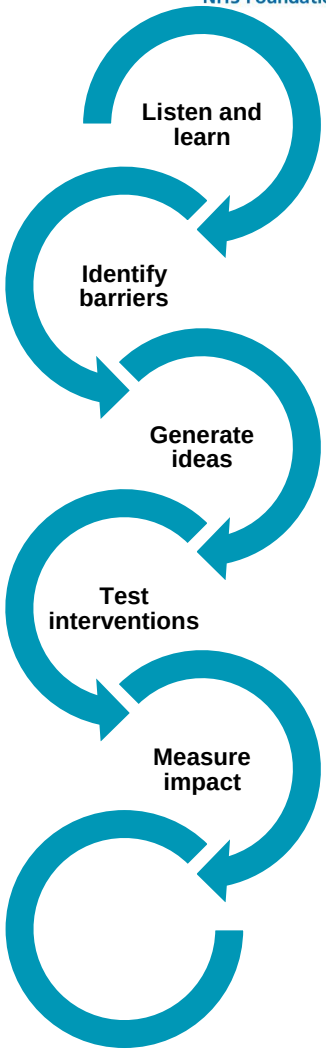
Response and approach

What did we do to start?

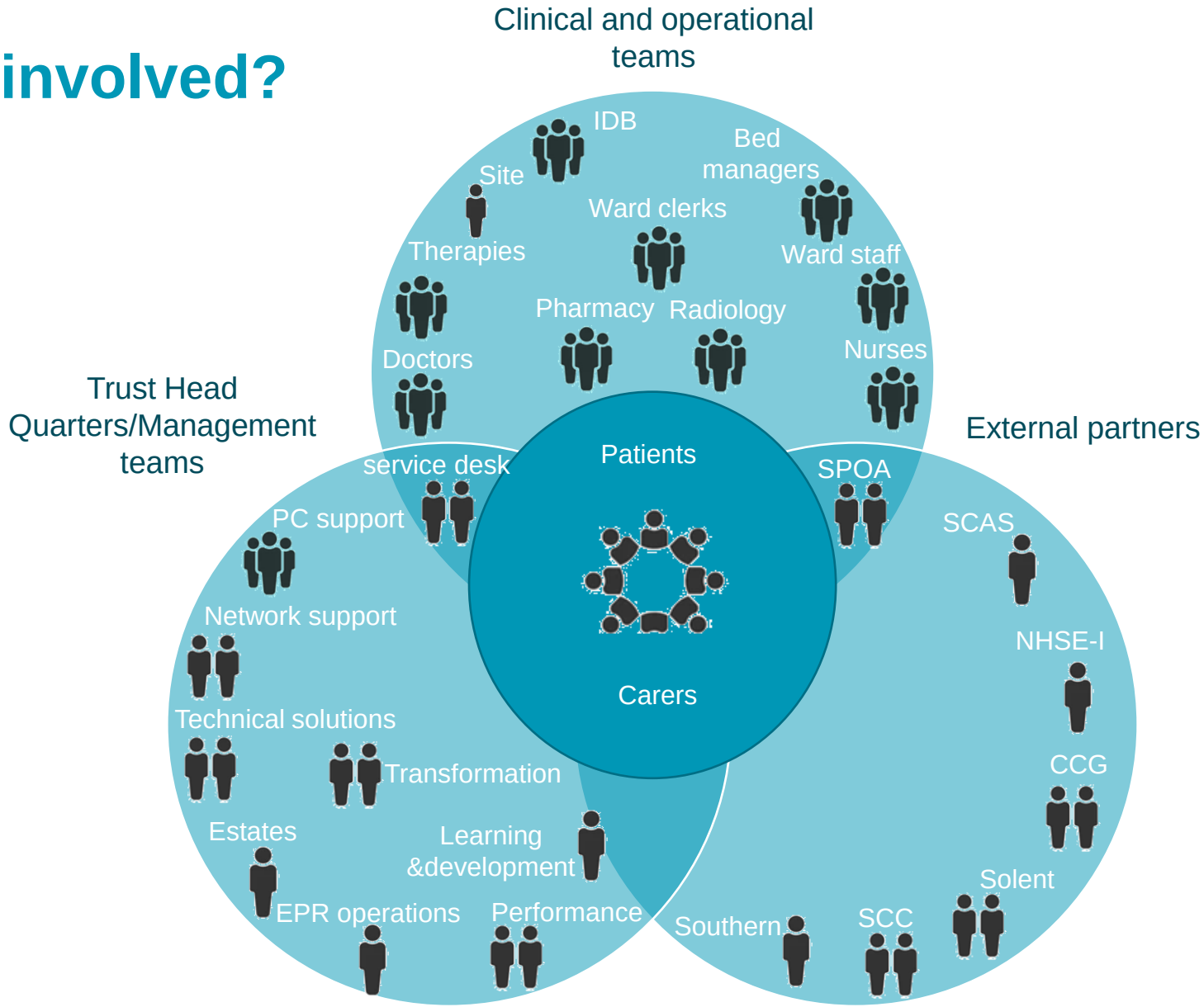
- A 4 week rapid improvement programme in Dec 2021 designed to:
  - Listen and learn from our front line teams
  - Identify current barriers and challenges to flow and discharge
  - Support ward staff to generate ideas and identify solutions to rapidly test and try new ways of working
  - Measure impact of interventions

- 20 change support staff were deployed to 40 wards
- Microsoft Teams eForms enabled real time digital feedback from patients and staff





Who was involved?



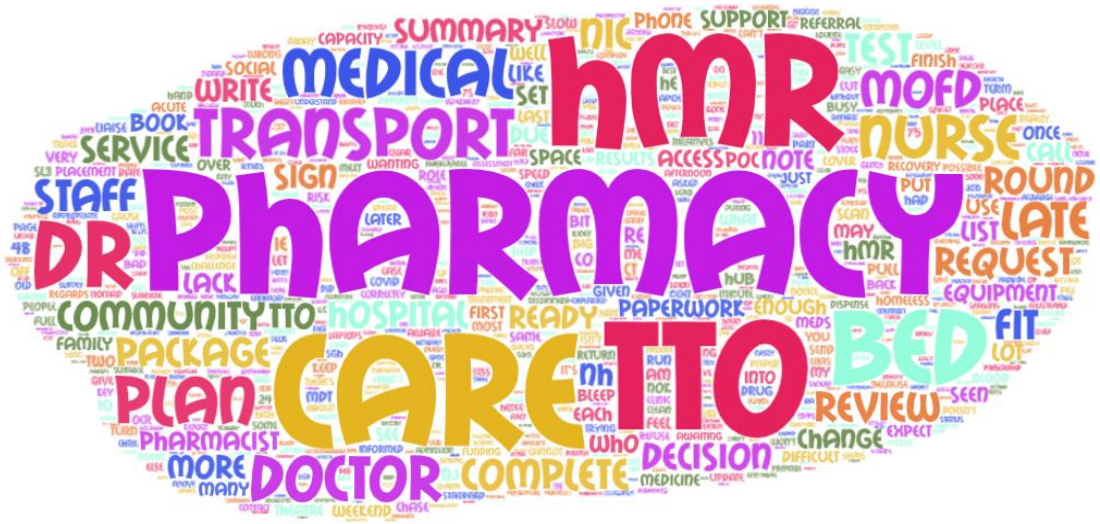
Listening……

to front line teams and patients

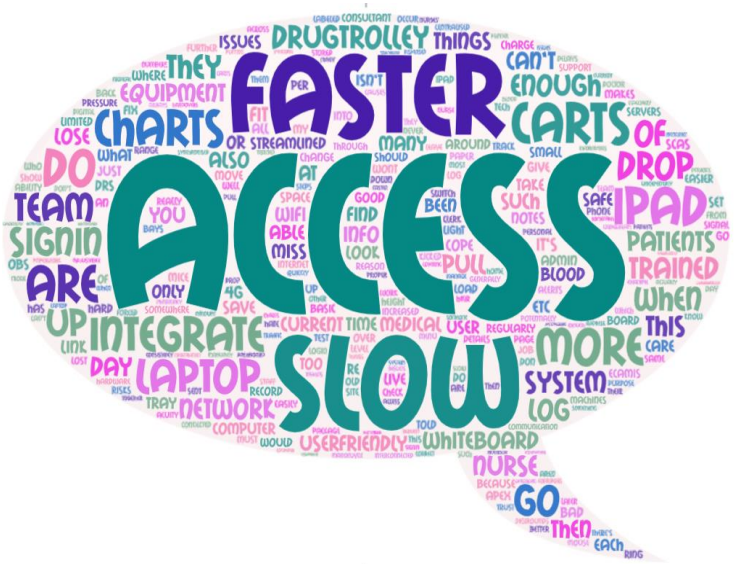
Listening to our ward teams

University Hospital Southampton NHS Foundation Trust

What are the biggest barriers to discharging patients?



What can we do to improve our current digital technology and processes?

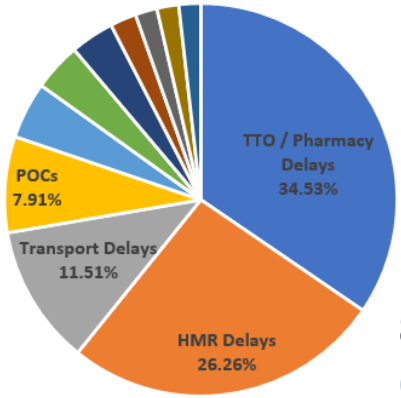


What did we get right when supporting you to leave hospital?

What could we have done better?

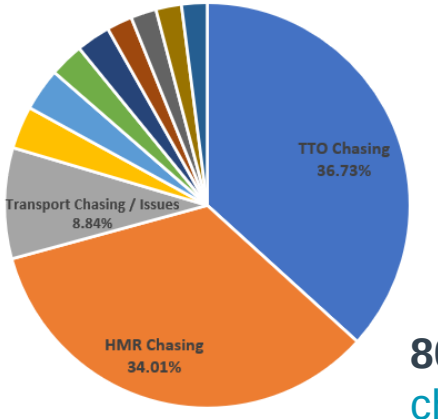
80% of **delays** to discharge reported to be due to:

Waiting for **TTO'S**
Waiting for **HMR**
Waiting for **transport**
Waiting for **POC**



80% of activities that teams felt were not a good use of time:

Chasing **TTO'S**
Chasing **HMR**
Chasing **transport**



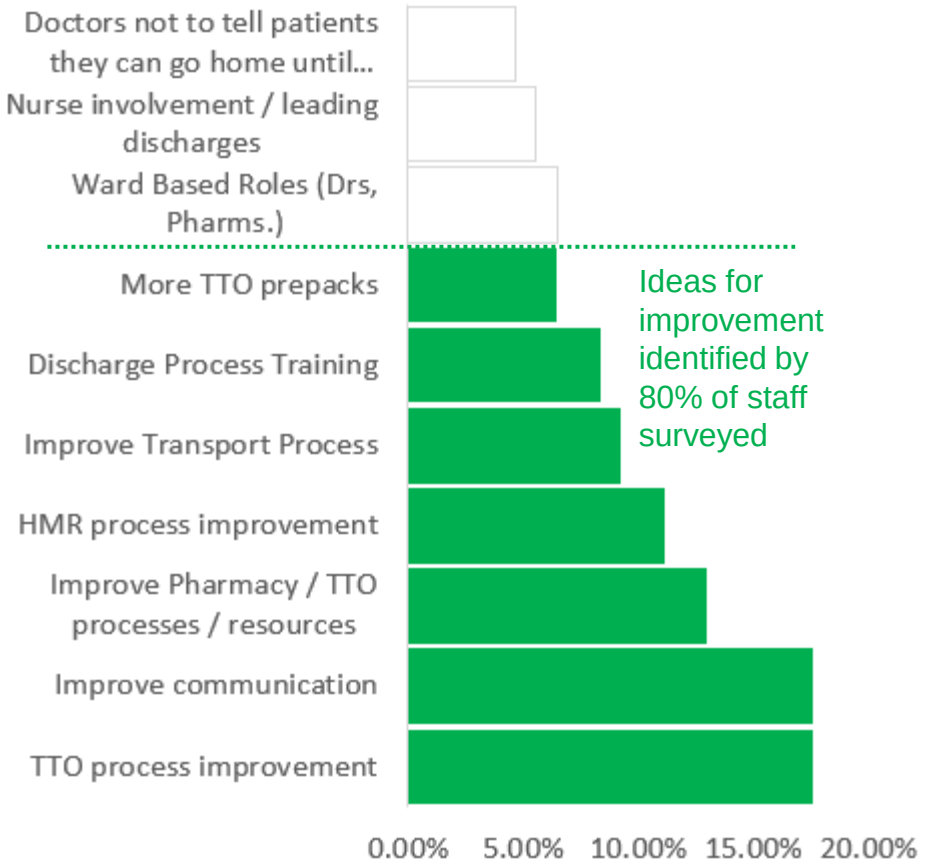
80% of reasons staff had not made changes themselves:

Not within their **control**
Lack of **staff**
Lack **time**
Lack of **Funding**
Permission
Nobody **listens**

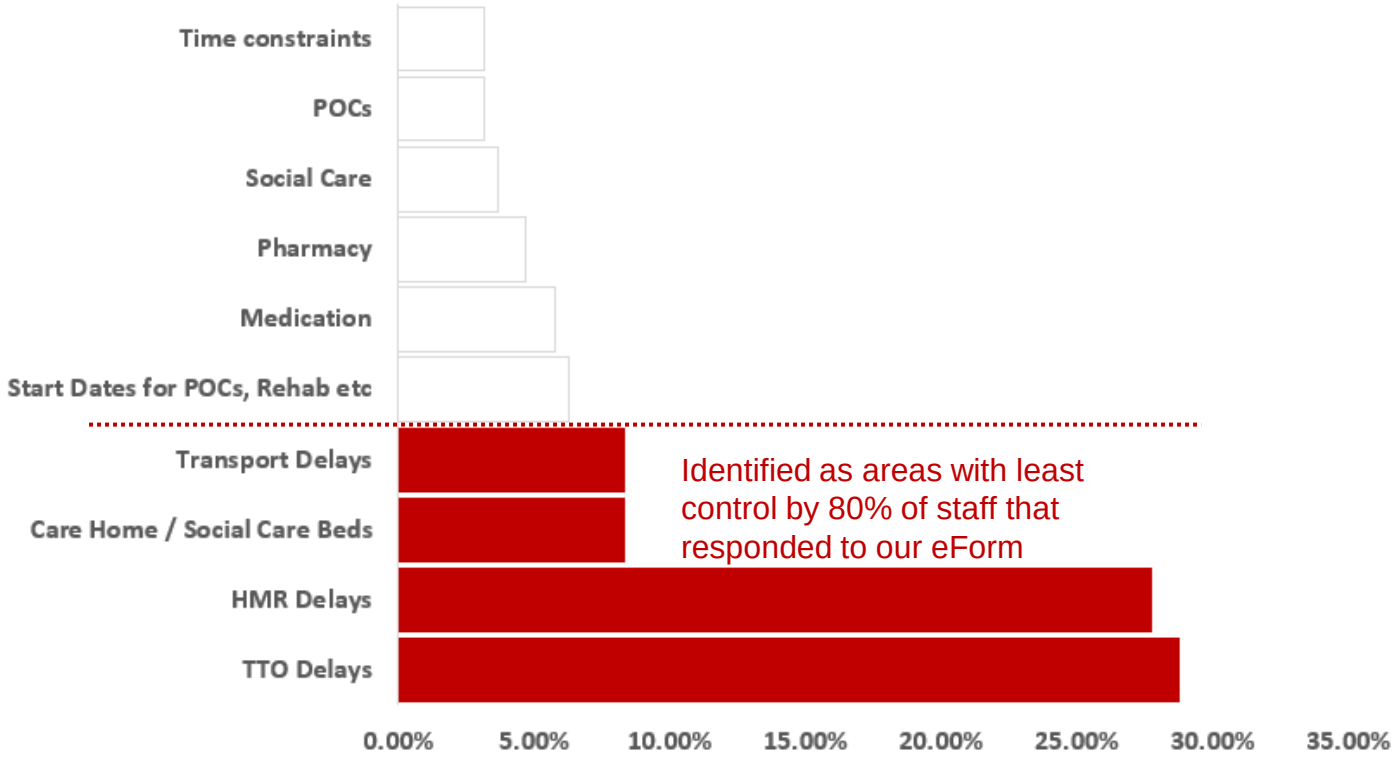
213 eForm responses from front line staff

University Hospital Southampton
NHS Foundation Trust

Pareto analysis to show ideas for improvement from front line teams



Pareto analysis to determine which parts of the discharge process teams feel they have least control or influence over



Interventions

Interventions to test and try

University Hospital Southampton NHS Foundation Trust

HMR Hit Squad

FP10 prescription

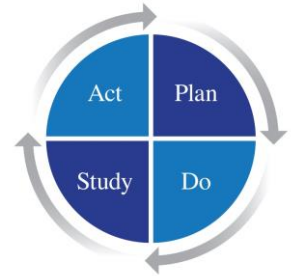
Junior Dr Laptops

Ward Based Doctors

HMR drop off

Pre-packs /
ward dispensing

TTO status



Measures

University Hospital Southampton NHS Foundation Trust

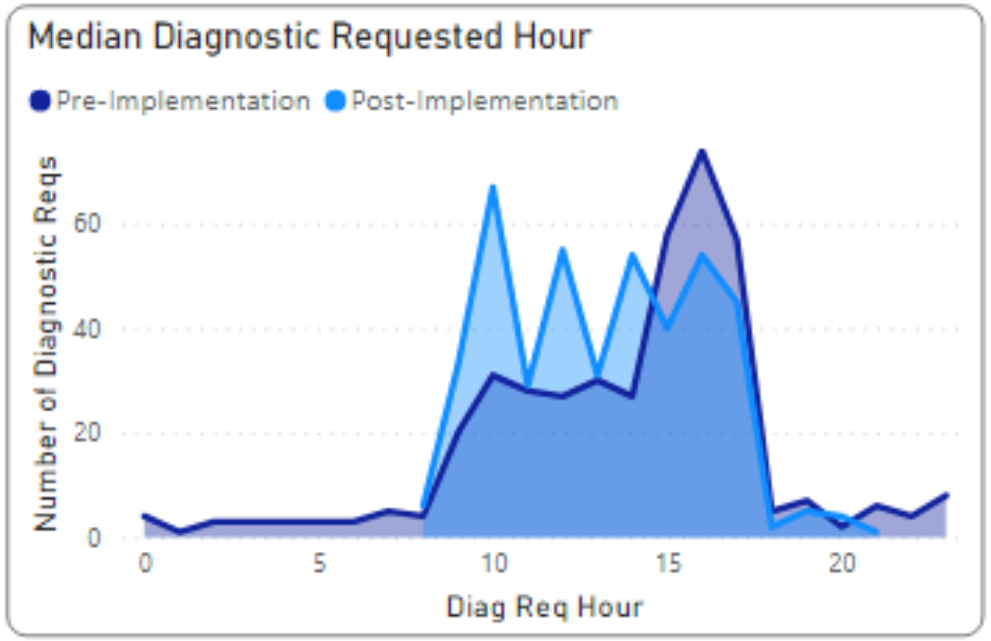
Junior doctors laptops	• <Average time TTO's pulled through • <Average time HMR completed • <Average time diagnostics requested • Balancing measures: Time from TTO requested to TTO ready, volume diagnostics requested
HMR hit squad & drop off / Ward based DR	• <Average time TTO's pulled through • <Average time HMR completed
TTO tracker	• Average time TTO's requested, completed, delivered
FP10 prescribing / pre-packs	• <Average time patients discharged from ward • Volume FP10's offered, accepted, given

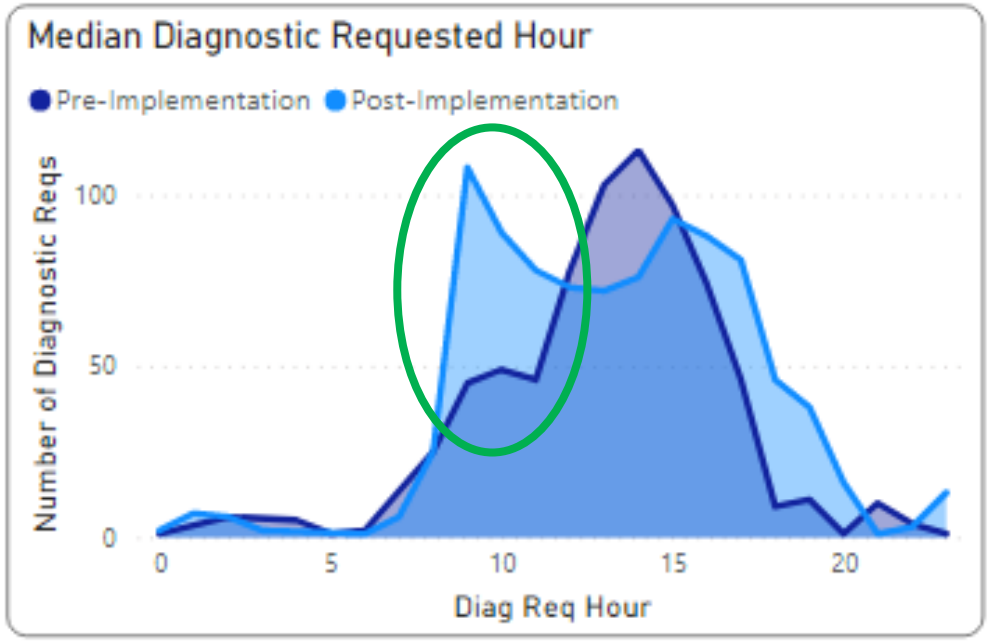
Impact

Junior doctor laptop intervention

University Hospital Southampton NHS Foundation Trust

Diagnostic test requests happened earlier - during ward round and on the go



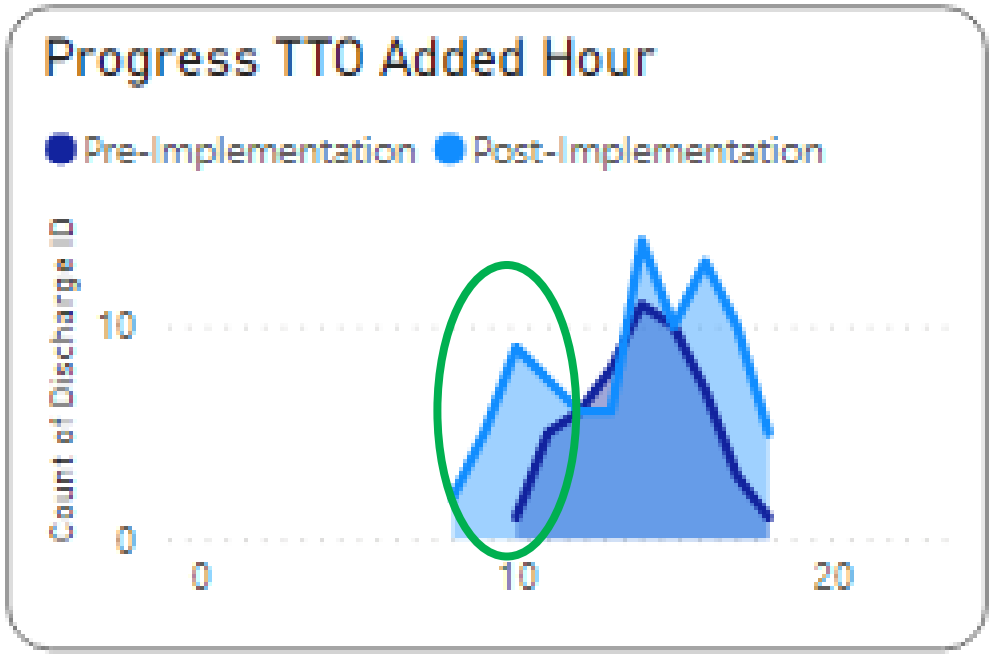


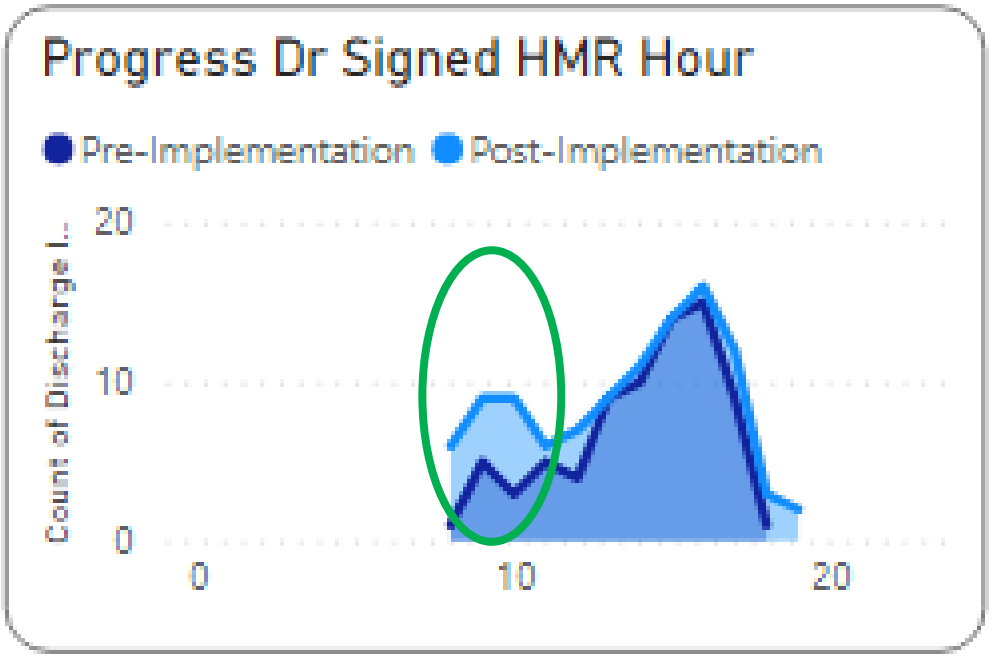
The time of day diagnostic tests are being requested has moved earlier in the day with the introduction of laptops for junior doctors

Junior doctor laptop intervention

University Hospital Southampton NHS Foundation Trust

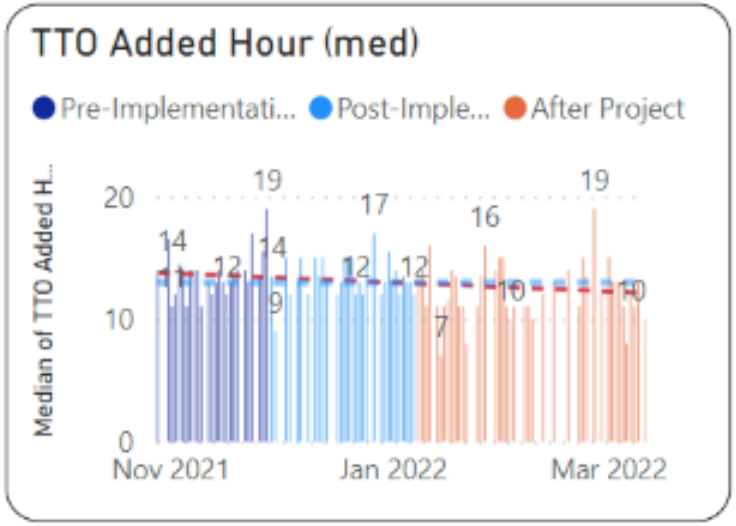
TTO requests and HMR singed earlier in the day

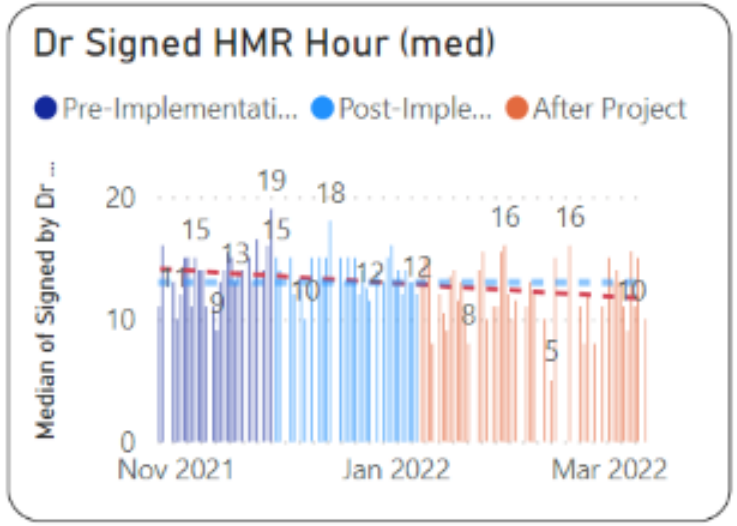


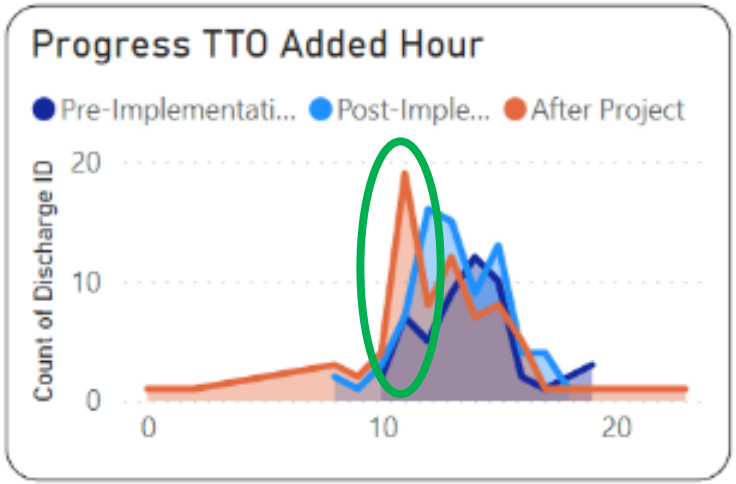


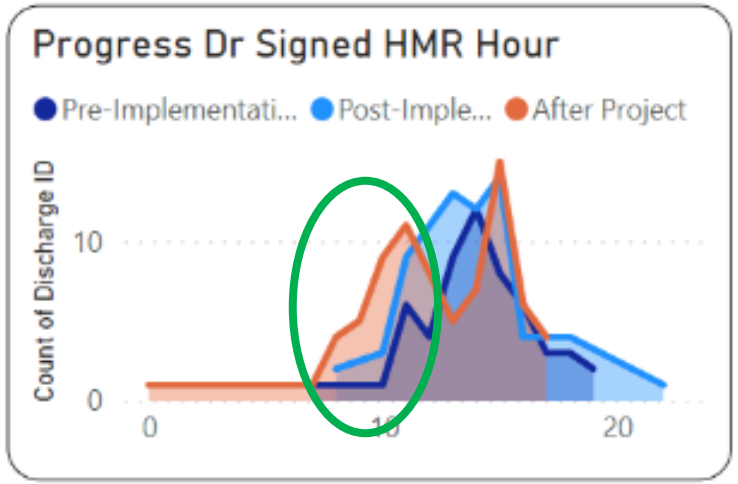
The time of day TTO's are being requested and HMR's signed requested has moved earlier in the day with the introduction of laptops for junior doctors

Junior doctor laptop intervention









Checking for sustainability…..

Junior doctor laptop intervention

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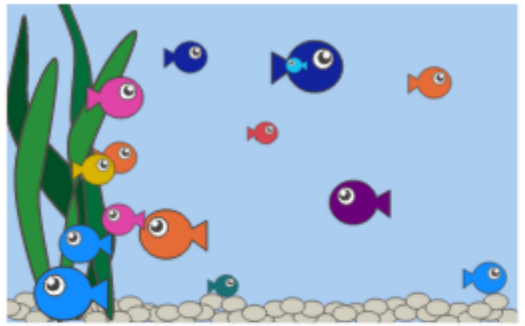
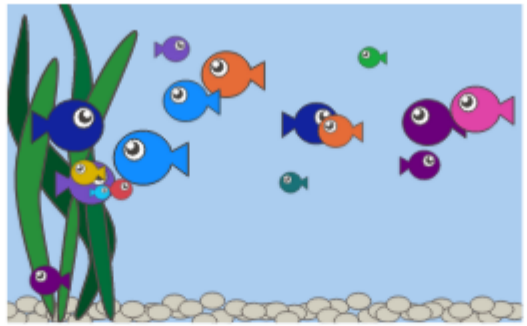
Drs with earlier added TTO hours (DISCHARGE)



Ward: All

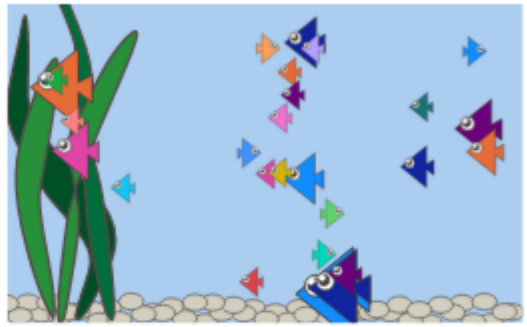
Name	Change in TTO Added Hr	Discharges
Maryam Al-Ezairej	-6	21
Nazish Javid	-6	3
Andrew Standing	-5	3
Victoria Beraud	-4	2
William Knibbs	-4	12
Alexander Lee	-3	7
Asha Nair Unnikrishnan	-2	29
James Dias	-2	23
Maimoona Zaheer	-2	31
Mohamed Abouelasaad	-2	6
Mohammed Dibas	-2	4

Drs with earlier signed HMR hours (DISCHARGE)



Name	Change in Signed Hr	Discharges
Mian Ahmed	-7	3
Alexander Lee	-7	7
Bianca Atena Panait	-5	11
Nazish Javid	-5	3
Victoria Beraud	-5	2
William Knibbs	-5	12
Asha Nair Unnikrishnan	-4	29
Musa Absi	-4	3
Mohammed Dibas	-3	4
Maryam Al-Ezairej	-3	21
Jessica Larwood	-2	38
Neha Datta	-2	11

Drs with earlier diagnostic request hours (DIAGNOSTICS)



Ward: All

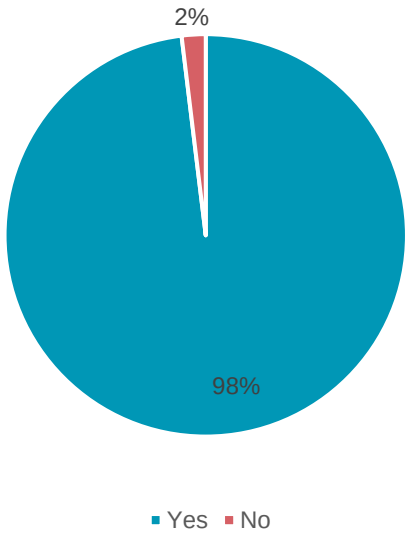
Name	Change in Req Hr	Requests
Ben Glover	-10	31
Nazish Javid	-7	173
Olivia Cox	-7	43
Callum Robins	-4	340
Victoria Beraud	-4	51
Nazek Abuhalaweh	-3	42
Peter Garus	-3	19
Chinaza Nwachukwu	-3	190
Kessaven Abayalingam	-2	185
Matthew Baldry	-2	201
Amar Mohammed Ali	-1	238
Bianca Atena Panait	-1	111
Bogdan Ciupe	-1	64

Using data in a fun way to motivate change in behaviour

The bigger the fish, the bigger the improvement

How did it feel for junior doctors?

Has having your own laptop improved your work flow?



4. Which tasks are you able to complete earlier in the day as a result of having a laptop?

More Details

TTO pulled through to HMR	44
HMR written	39
HMR signed	40
Diagnostic requests	50
Other	21

Ward rounds are faster and easier as we no longer have to wait to 'find' an empty computer space, and we can request things or do discharge summaries etc as we go which makes the day flow smoother and easier.

If the Trust doesn't wish to continue this initiative I will (somewhat sadly) happily sacrifice an appropriate amount of salary to continue having a laptop as it makes a real difference to my job.

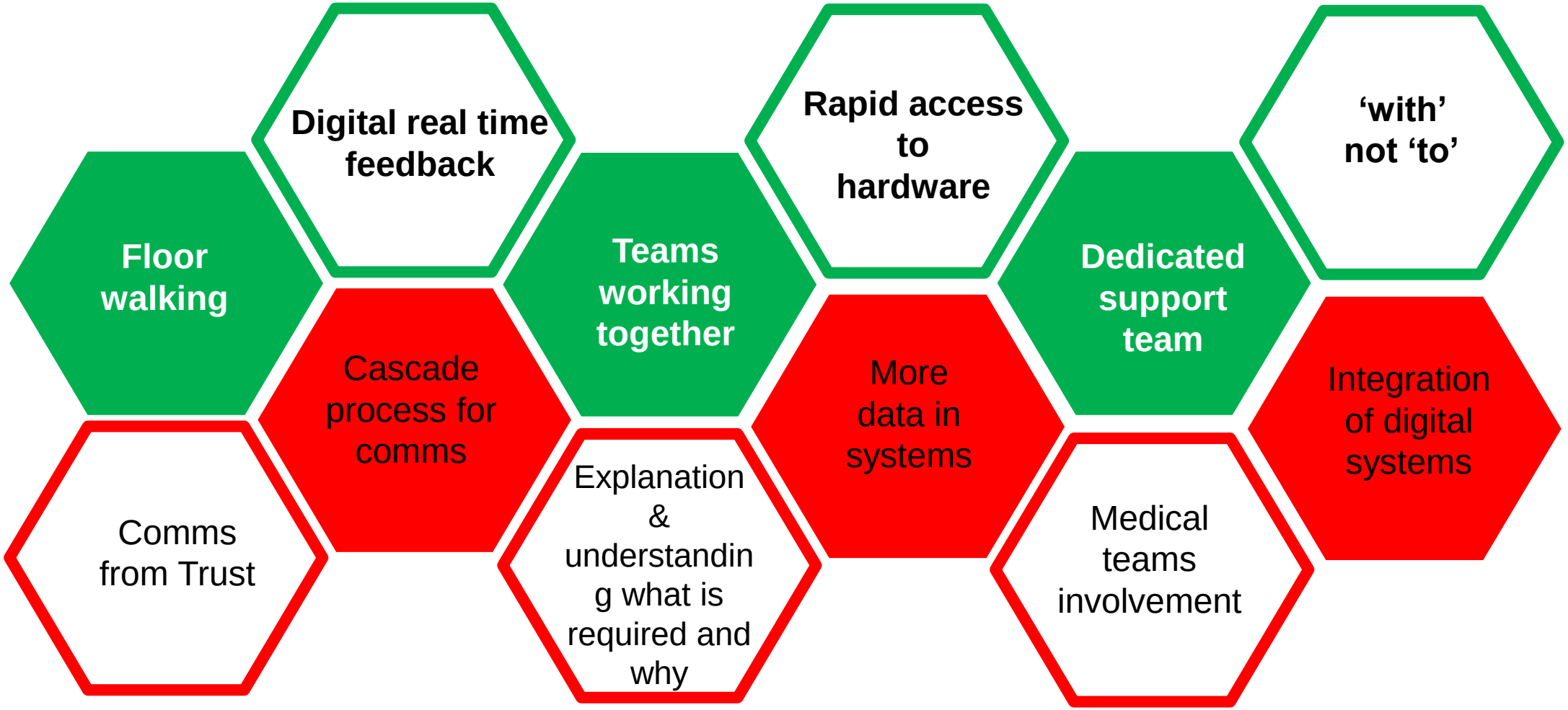
Able to do requests for bloods/changes to prescriptions as we have gone around the ward round, even whilst waiting in a queue for a parking permit!

The laptops have also allowed myself and other juniors I know to transition to solely using the electronic list, rather than faffing around printing a paper one

Has drastically improved workflow and significantly reduced delay in juniors leaving work late every day.

Learning

What went well

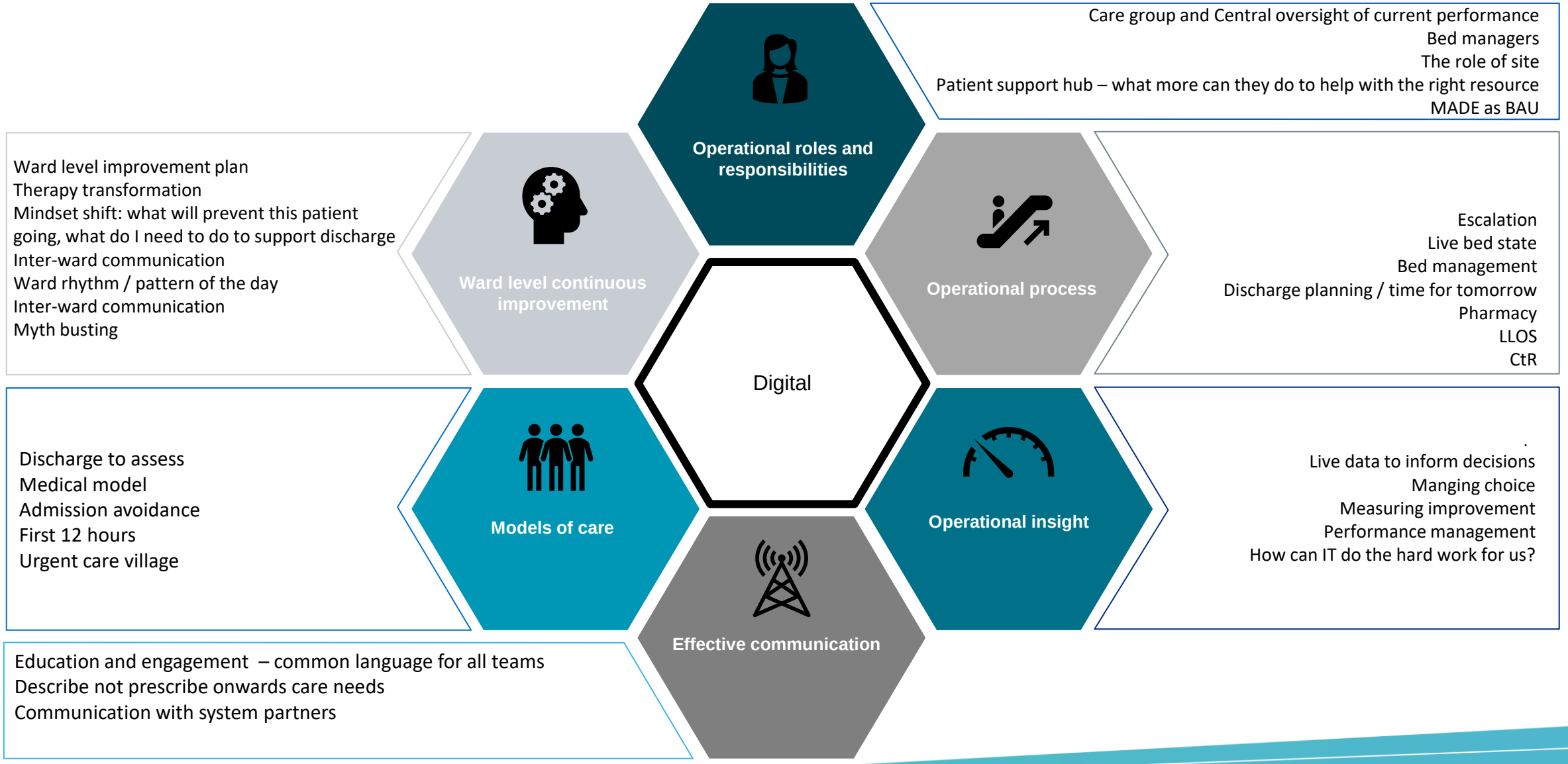


What could have been better

Building on our learning in 2022

Workstreams 2022

University Hospital Southampton NHS Foundation Trust



What have we achieved this year….

University Hospital Southampton NHS Foundation Trust

More patients have avoided admission

40% ambulatory surgery patients (9)
51% Specialty SDEC (37)
50%% Urology direct (40)

More patients leaving hospital

10% increase in weekly discharge

More patients leaving hospital sooner

7.4% reduction in P0 LoS

3136 Bed days saved

£941,039.28 NCR saving (3:1 ROI)

What will our focus be for 2023

University Hospital Southampton NHS Foundation Trust

Operational process

Accurate bed state
eWhiteboard upskilling of ward and clinical staff
Core data requirements
Support process design for Alcidion

Operational insight

Agree content for patient flow dashboard
Integrate existing dashboards
Create/Integrate MOFD dashboard
Create a Staffnet space for flow dashboard

MOFD processes

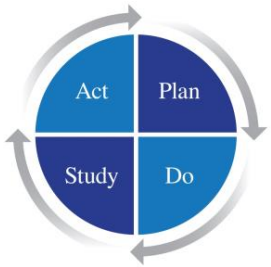
Content update on staffnet / PF website
Training and education videos
7 day working
MOFD reporting / improvement data
Improved patient information
MOFD improvement sustainability plan

Care groups prioritise interventions and resources, setting their own improvement aims, objectives and measures.

Reporting progress and learning to IPSG monthly and highlighting any issues to be unblocked

Care groups can choose from the ‘test and try’ interventions or design their own interventions

Interventions



NHS
University Hospital Southampton
NHS Foundation Trust

Doctors Administrators

Board Rounds

Audit of HB4L & discharges

Time for tomorrow - Huddle Optimisation

HMR/TTO Efficiency Improvements (process mapping)

5 Star Ward Rounds

Pre-packs / ward dispensing & FP10 prescription

Patient Information Flow/Work Duplication (observations)

eWhiteboard Training

Criteria Lead Discharge

Specialty SDEC

Hot clinics for admission avoidance

Virtual wards

Ambulatory theatres

eWhiteboard for assessment units

Thank you for listening

Any Questions…..?

Slido

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The Patient Flow Conference North 2023

SCAN ME

9th February 2023 - 08:00am – 16:00pm – etc.venues, Manchester

Conference hosted by Convenzis Group Limited

The Patient Flow Conference North 2023

THE NHS PATIENT FLOW CONFERENCE 2023

CONVENZIS

Q&A PANEL

Mike Davidson

Care Group Manager - Medicine: University Teaching Hospital Southampton Foundation Trust

Mark Awad

Junior Doctor Southampton General Hospital

Ben Owens

Consultant in Emergency Medicine/UEC Division Clinical Associate Sherwood Forest Hospitals

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THE NHS WORKFORCE CONFERENCE 2023

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MORNING BREAK, NETWORKING & REFRESHMENTS

THE NHS PATIENT FLOW CONFERENCE 2023

Event Chair – Chair Morning Reflection

Professor
Maureen Baker
CBE

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UP NEXT...

The Patient Flow Conference North 2023

THE NHS PATIENT FLOW CONFERENCE 2023

CONVENZIS

SPEAKING NOW

Dr Murray Ellender

GP and Co-Founder
eConsult

I will be discussing…

"eConsult Health - Digital triage to improve flow in the Emergency Department"

econsult

Digital Triage to Improve Flow in the Emergency Department

Patient Flow Conference

Dr Murray Ellender FRCGP MRCEM

9th February 2023

NHSX AI Award 2021

Digital Health London ACCELERATOR

HSJ 2017 AWARDS WINNER

thebmjawards FINALIST 2018

PATIENT SAFETY AWARDS 2018 Winner Information Technology

SBRI HEALTHCARE Award 2021

eConsult Health

Experts in digital triage

Primary Care

2,700+ practices

25m patients

33m+ eConsults

Urgent and Emergency Care

10 EDs or UTCs

700,000+ eTriages

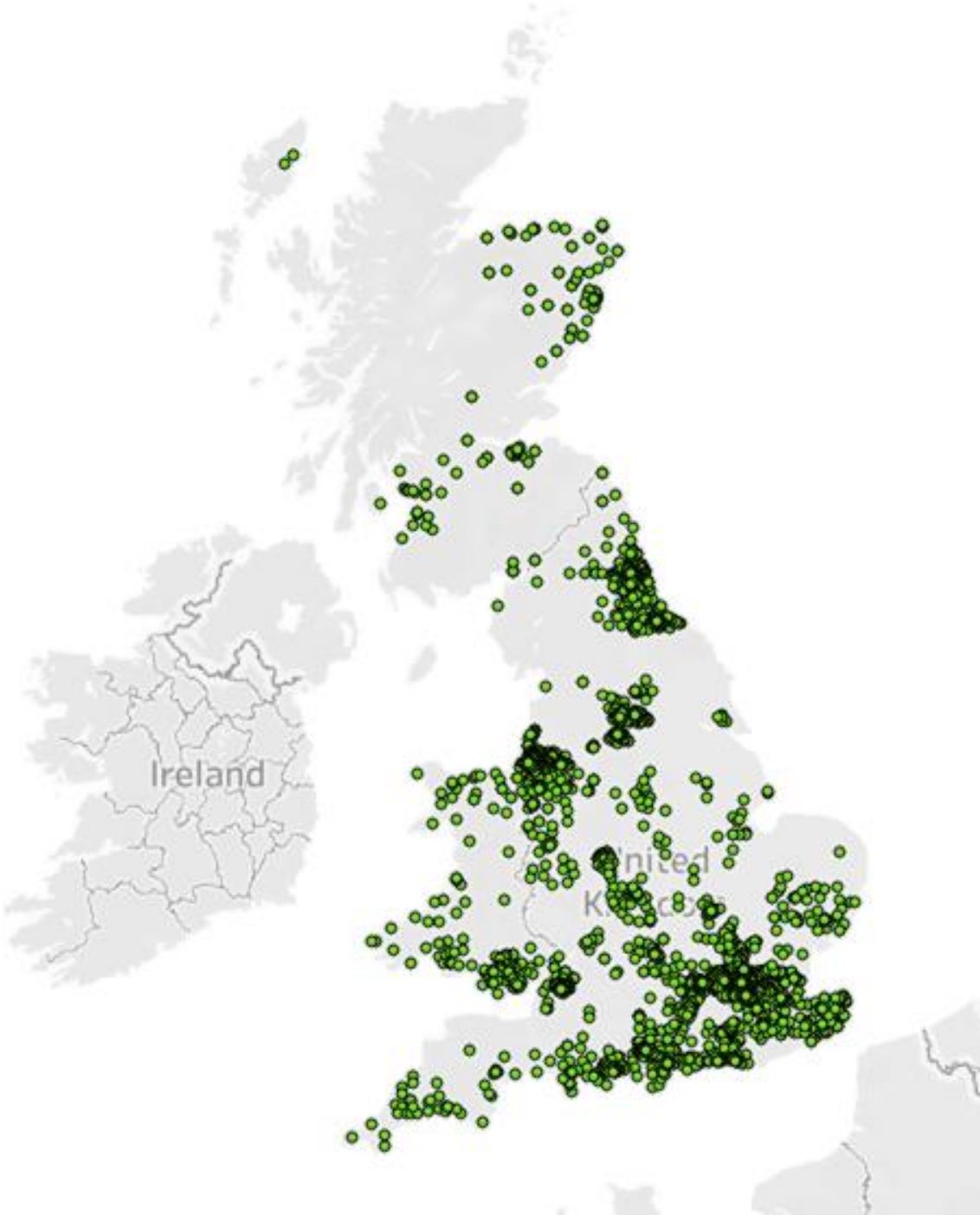
Live in 5 more by mid 2023

Outpatients

2 Trusts

40 Specialties

Partnership with Mid & South Essex NHS Trust



econsult

Founded in one practice in the NHS in 2014, eConsult is now live in over 2,700 GP practices and 10 Trusts across the UK

2014

2021

hurley group

NHS GP Partnership of 11 practices, 4 Urgent Care Centres, GP Out of Hours, 100,000 registered patients

First pilot with 20 practices, covering 130,000 patients. Tested 50 condition specific templates

TOWER HAMLETS

econsult

100+ condition specific, symptom led and admin templates

etriage

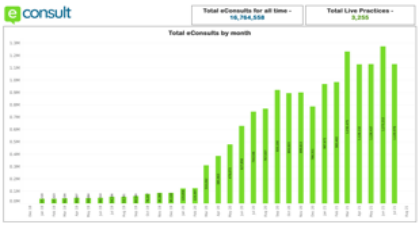
Launched in Bexley UCC

Centralised working model launched across Hurley Group practices

ehub

Adds video and SMS functionality

NHS app integration



2x practices 10x growth utilisation

Covid

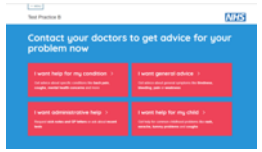
Primary care

Patient flow through eConsult in Primary Care

1m online consultations/month and >33m processed to date

Patient or parent/ guardian

NHS app or



GP practice website

✓Uses NHS login
✓Common journey
✓Available 24/7

- Self care
- Pharmacy
- Local services

Online consultation

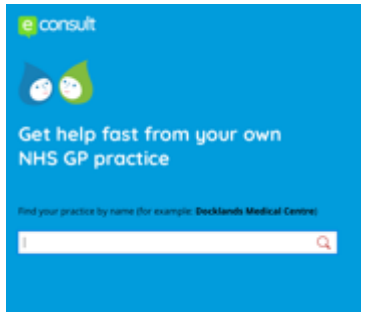
GP

Triage by team
Care navigator
Pharmacist
Admin
Physio
MHT
Physician Associate
GP

	Pre-Covid	effect
Remote closure	70%	90%
Message Prescription / advice	30%	40%
Phone	40%	48%
Video		2%
F2F appointment	30%	10%

Digital door into the general practice

Breaks down to four elements

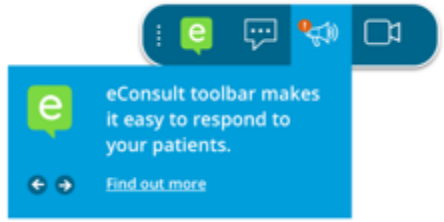


1. Patient journey ‘in’

- **Practice website**
- **NHS App**
- **eConsult webpage**

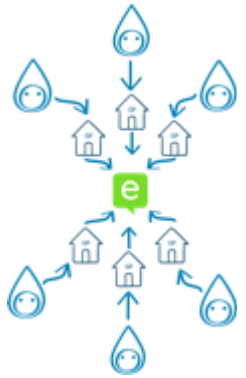
2. eConsult to clinician 👀

- **How we present the eConsult structured history**
- **Alongside patient’s medical record**



3. How clinician responds

- **Messaging response (SMS, email)**
- **Video/phone call**
- **Invite in for face-to-face**



4. How it works in networks

- **The “eHub”**
- **Sharing workload between practices, settings**
- **Routing to right clinician**

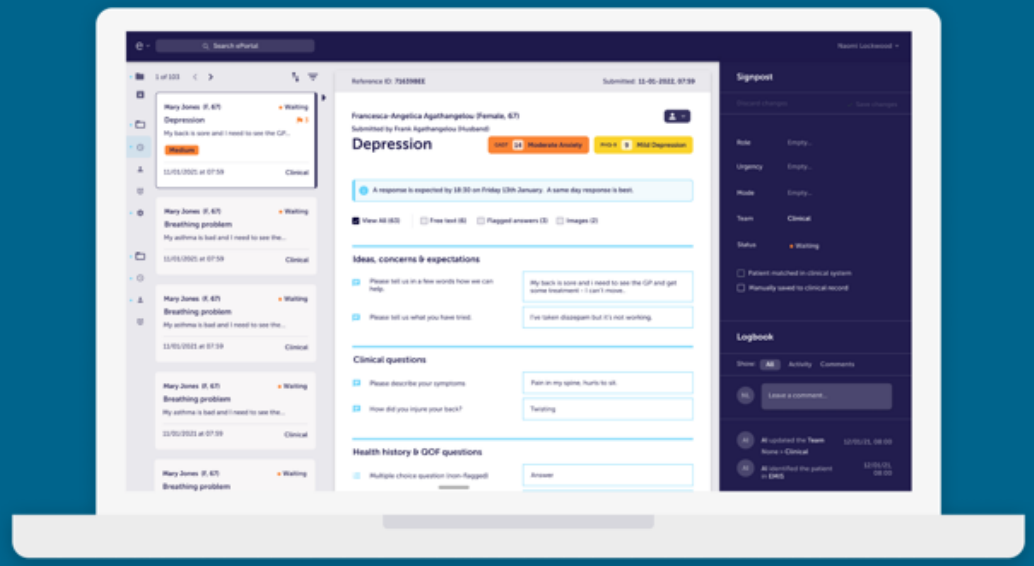
Patient experience ⟵ ⟶ **Clinician experience** ⟵ ⟶

econsult

Launched in 2022:
A smart eConsult inbox

Smart Inbox

Feature packed AI driven inbox optimised for triage speed and accuracy



econsult

eHub

Federated models enabled by our Smart Inbox for managing demand at scale

Urgent care

eTriage – intelligent triage for the Emergency Department

Patient enters demographics and history on eTriage

Patient arrives in Emergency Department or UTC

Auto PDS look-up to Mini Spine – check NHS number

NHS number into eConsult

Phase 2 remote obs

O_2

Clinical history auto-triaged into clinical system for clinician to review

Streaming nurse reviews patient consultation information – first F2F interaction with patient

- **Medical emergency**
- **Majors**
- **Majors/ minors**
- **Minors/ UCC/ redirection**
- **Pharmacy/ GP/ home**

- ✓ **Patient demographics**
- ✓ **NHS number**
- ✓ **Emergency care dataset Qs**
- ✓ **Acuity of patient**
- ✓ **Manchester Triage (colour-coded)**
- ✓ **Presenting history**

econsult

Pressure points in the patient journey

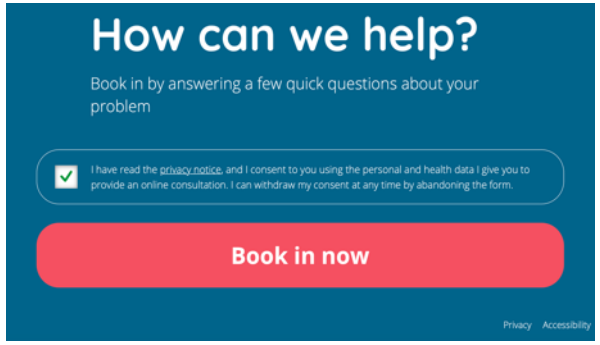
Book in → ***Wait 15 mins*** → **Triage nurse** → ***Wait ~4 hours*** → **Decision maker**

- Queue
- Non-clinical
- Reluctance in sharing clinical info
- Unless identified by reception, timings are static
- No clinical overview

- Manually capture history, observations and ECDS (Emergency Care Data Set - national mandatory data)
- Data capture may be inconsistent
- Potential for repetition
- First point where waiting times are considered based on need

econsult

The patient journey using eTriage:



- Medical emergency
- Majors
- Majors/ minors
- Minors/UCC/redirection
- Pharmacy/GP/home

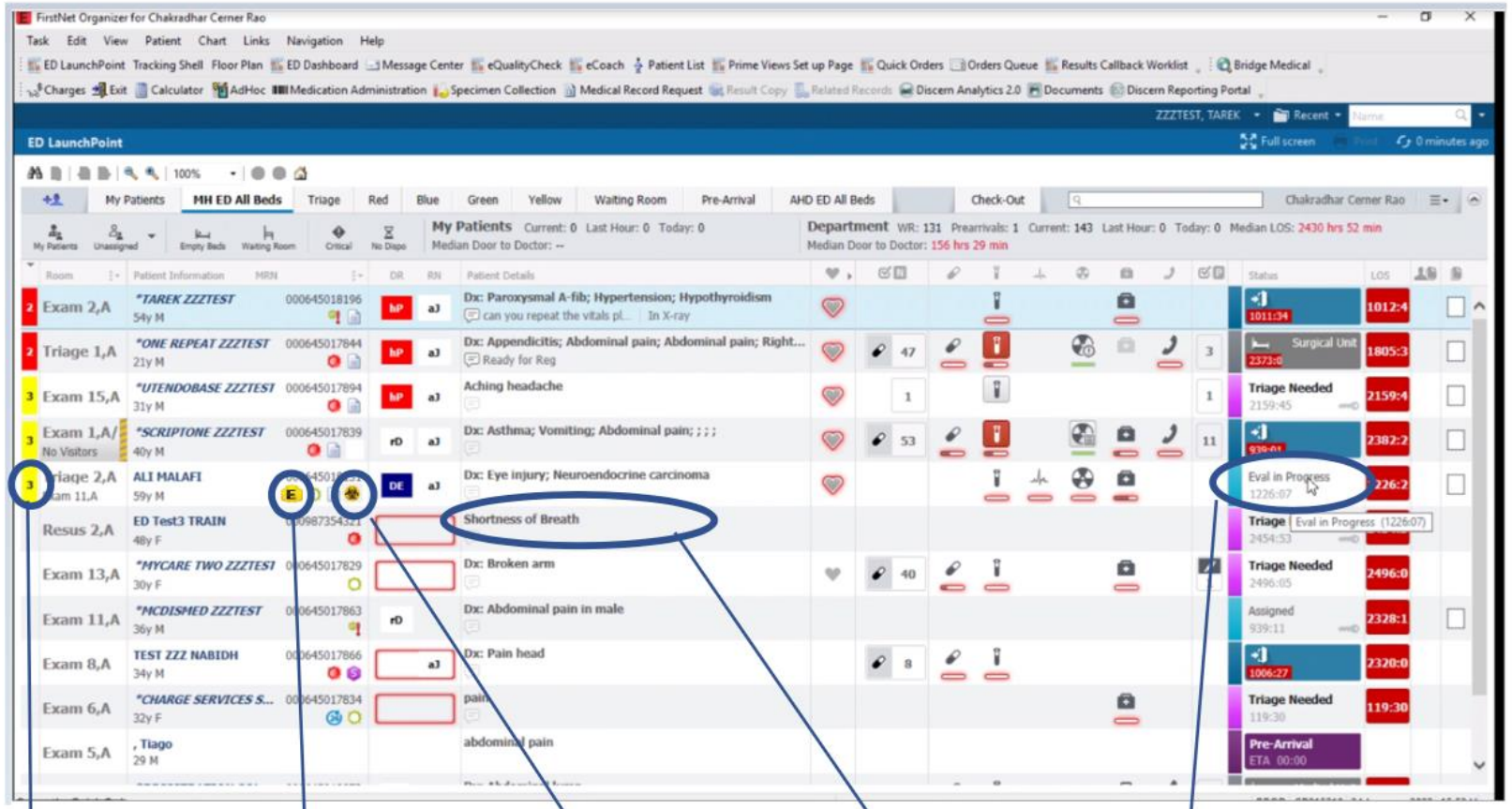
Digital check-in, history take, ECDS capture, and triage → **Automated risk stratification P1-P5** → **Route to appropriate care**

- No queues
- Consistent data capture (including ECDS)
- Patient involvement and dignity is respected
- Check-in and triage = 5 min
- Triage is clinically validated and standardised
- Data deposited directly to the EPR system

- Clinical overview of the waiting room
- Patients can be assessed based on acuity
- Triage nurse validates history and captures observations
- Direct patient to most appropriate care setting
- Can be customised to local workflows (Covid zones etc)
- Improvements in KPIs

econsult

eTriage within a Patient Tracker List



This 'Priority' value circled is the priority value calculated by the eTriage system and shared with Millennium via the interface.

This event Icon is a visual for the ED clinician to highlight the fact patient completed the eTriage process.

This event icon is conditional and displays if the patient has been flagged as a COVID risk via the eTriage process.

The 'Patient Details' column will display the presenting complaint captured in the eTriage system.

The Status Column is always set as 'Eval in Progress' when the patient has completed the eTriage process.

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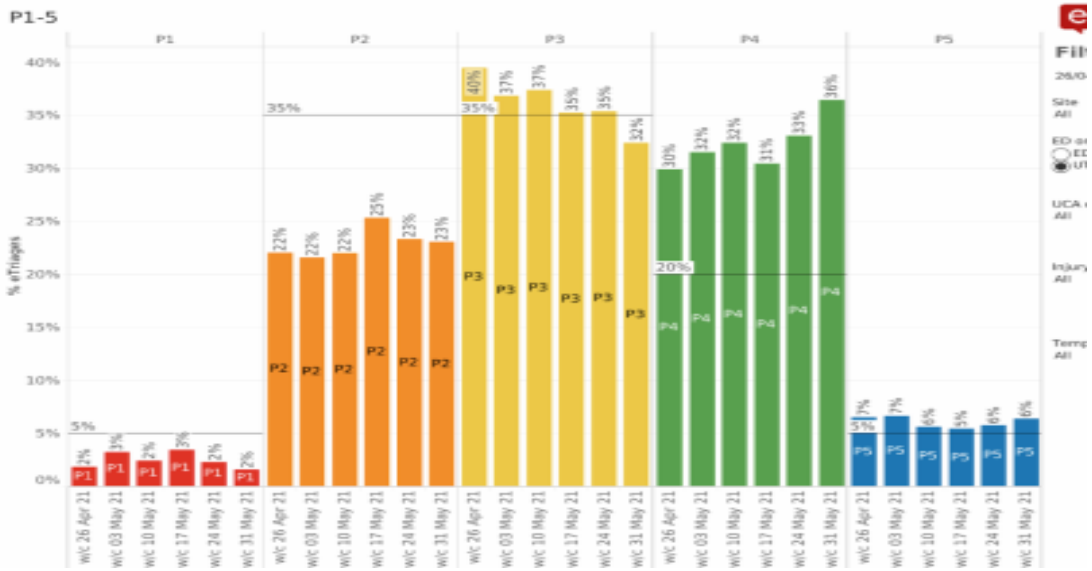
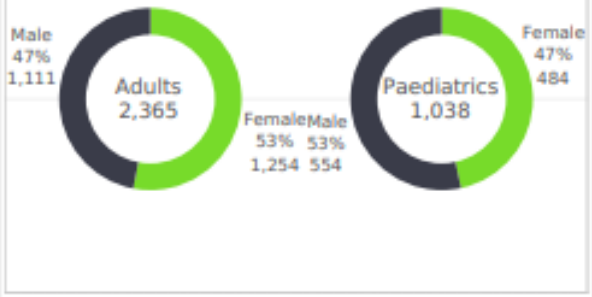
Customer implementation

- Consultative approach
- Supporting change management
- Baseline data studies
- Qualitative patient experience studies
- Baseline data to compare against KPIs
- Quarterly reviews and weekly data dashboards



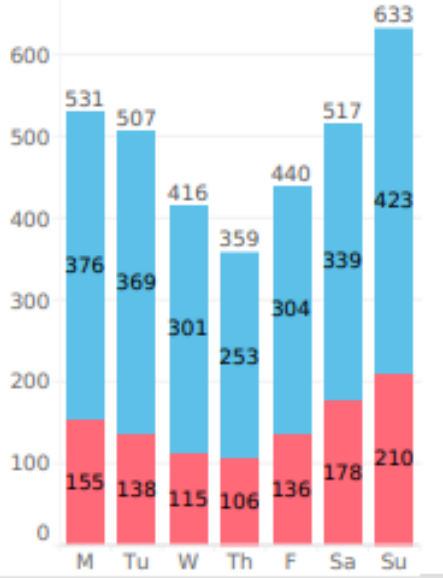
Total eTriages	Average time to completion
48,200	5.79 min

eTriages submitted - 3,403



Triage	Adults	Paediatrics
P1	11.3%	3.6%
P2	31.3%	56.6%
P3	32.9%	31.4%
P4	21.9%	6.8%
P5	2.6%	1.5%

Daily Trends



Top 20 Adult Templates		Top 20 Paediatric Templates	
1	Abdominal Pain	1	Cold Flu
2	Chest Pain	2	Unwell Child
3	Ankle Injury	3	Head Injury
4	Foot Injury	4	Vomiting or Diarrhoea
5	Cuts Wounds	5	Arm Injury
6	Arm Injury	6	Ankle Injury
7	Breathing problems	7	Rash, Spots and Skin Proble
8	Bruising and Haematomas	8	Finger Injury
9	Hand Injury	9	Foot Injury
10	Eye Problem	10	Hand Injury
11	Knee Injury	11	Unwell Baby
12	Back Pain	12	Wrist Injury
13	Finger Injury	13	Eye Problem
14	Head Injury	14	Earache
15	Lumps Bumps Skin	15	Leg Injury
16	Ear Problems	16	Mental health
17	Back Injury	17	Knee Injury
18	Eye Injury	18	Testicular Pain
19	Headache	19	Sore Throat
20	Mental health	20	Back Injury

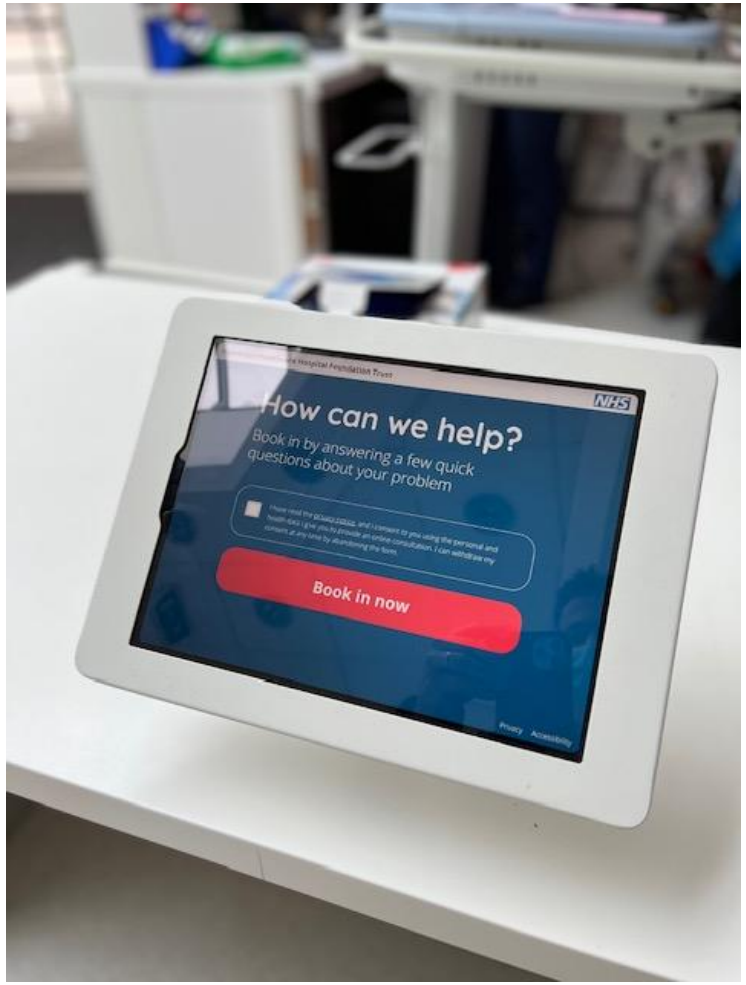
Age Demographics

16 and under	31%	1,048
17-24	11%	387
25-44	25%	837
45-64	21%	708
65-84	11%	376
85+	1%	47

10/1/2021 12:00:00 AM to 10.. Worthing Hospital

Homerton University Hospital, London

Emergency Department



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Homerton University Hospital Emergency Department

Improved Flow

Elimination of front door queues and reduced time *to check-in*

14% time saving *in triage assessment*

Straight to investigations *e.g. minor injuries to X-ray*

Better use of clinical resources

Reallocation of staff *Senior nurses moved from screening role, waiting room nurse reallocated back to floor*

Improved quality of care

Clinical visibility *of waiting room (undifferentiated > differentiated)*

100% of staff *felt eTriage had a positive effect on patient flow and safety*

Better quality of information *enables faster triage and frees up clinical time*

econsult

***92%** of patients felt their privacy improved when using eTriage*

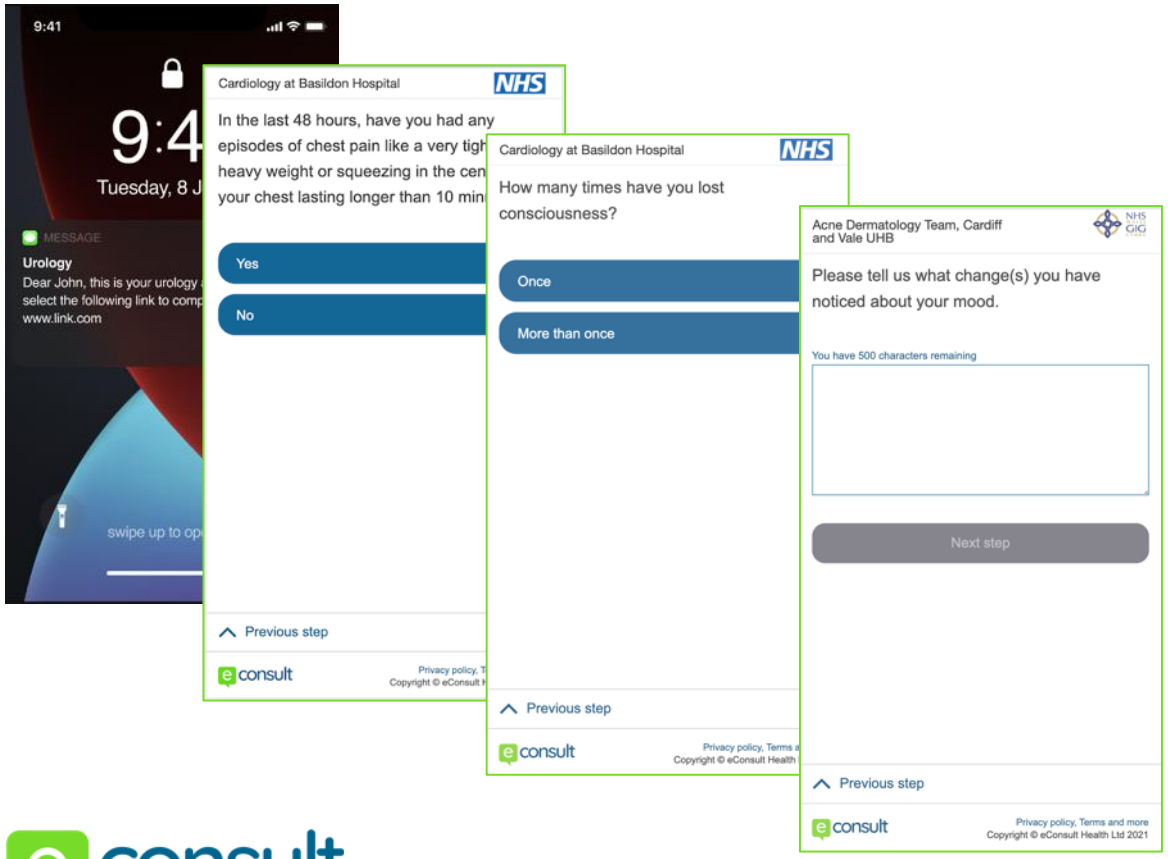
Full report coming soon

Specialist care

econsult

eConsult Specialist

Reducing waiting lists by improving patient pathways



econsult

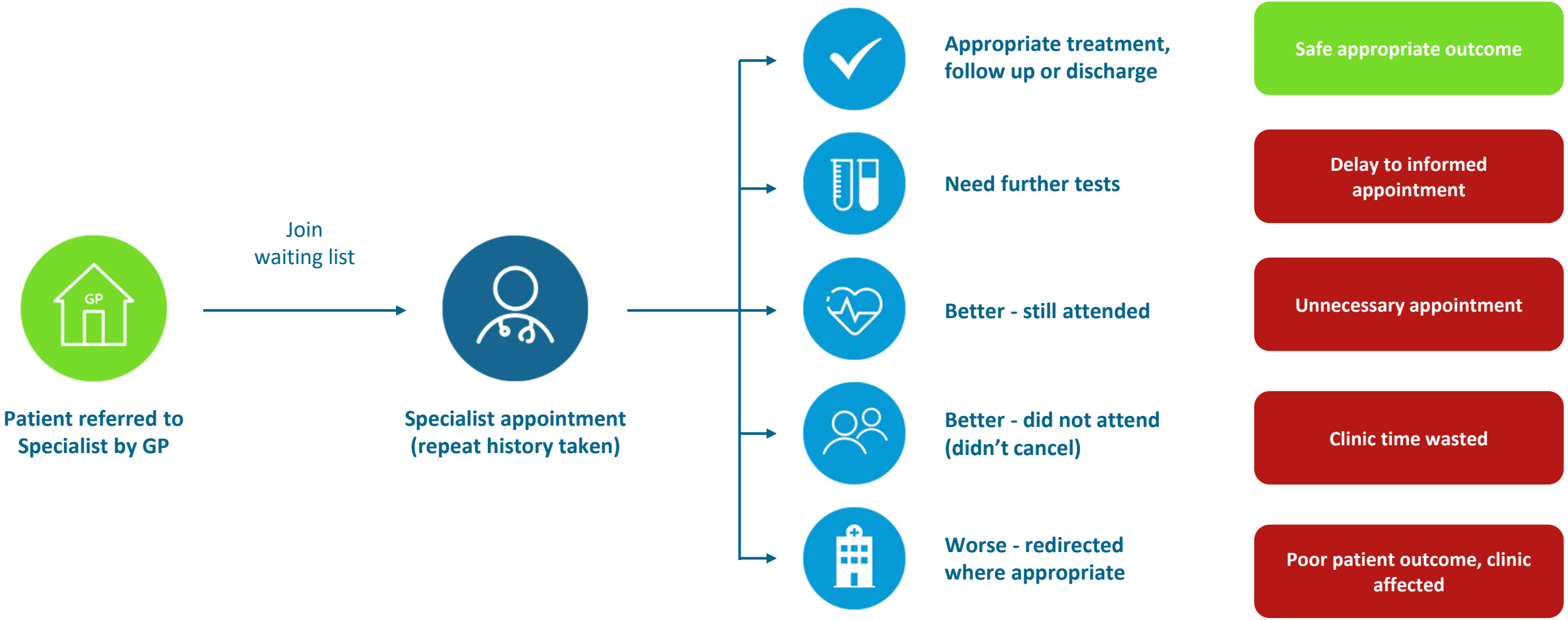
Outpatient triage and waiting list reduction solution

Benefits

1. **Identification and removal of unnecessary or inappropriate appointments (referral triage, pre-appointment, PIFU)**
2. **Optimisation of clinics themselves (DNA rate reduction, gathering history up front)**
3. **Enabling workforce delivery across geographies (remote consultation, networks)**

Significant waiting list and DNA reduction

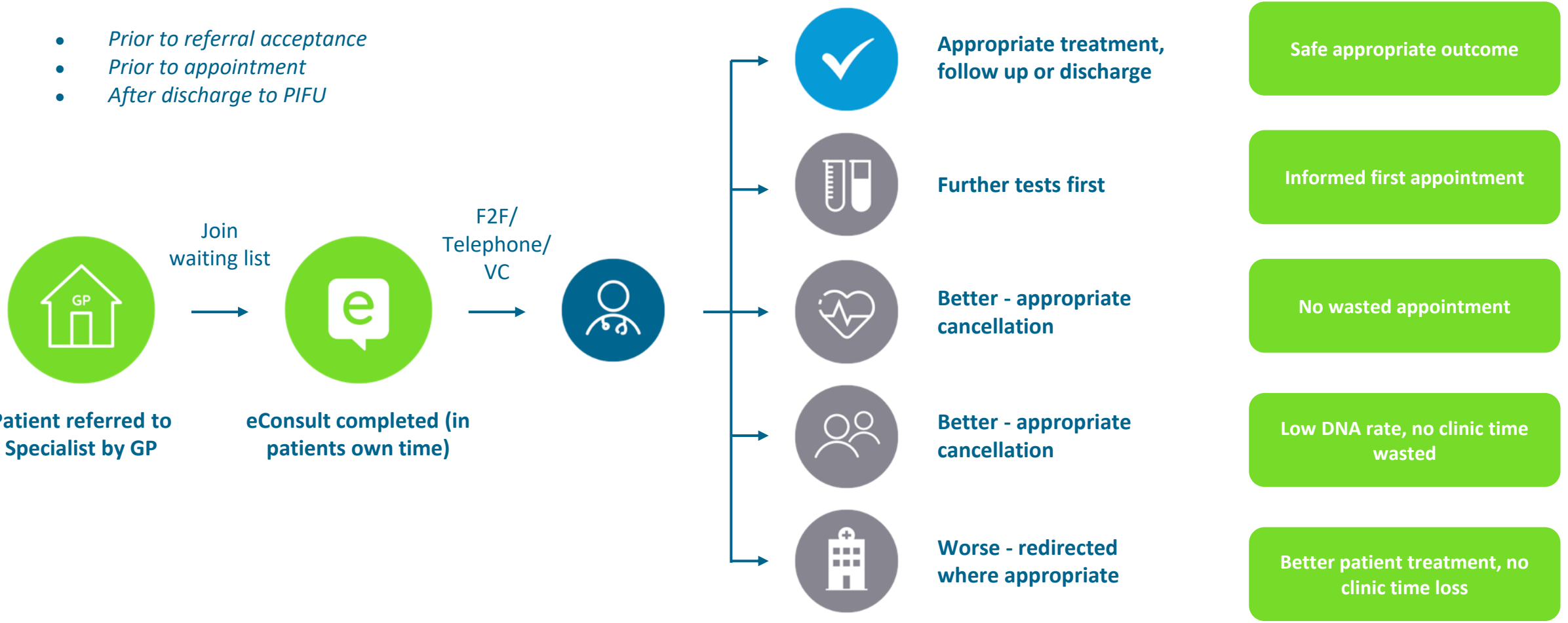
Traditional patient flow



econsult

eConsult enhanced patient flow

- *Prior to referral acceptance*
- *Prior to appointment*
- *After discharge to PIFU*



econsult

Mid and South Essex Foundation Trust

Gastro and MSK teams

One Gastro consultant saved over 33 clinical hours in 6 weeks

Potential saving of £12,000 per consultant per year

econsult

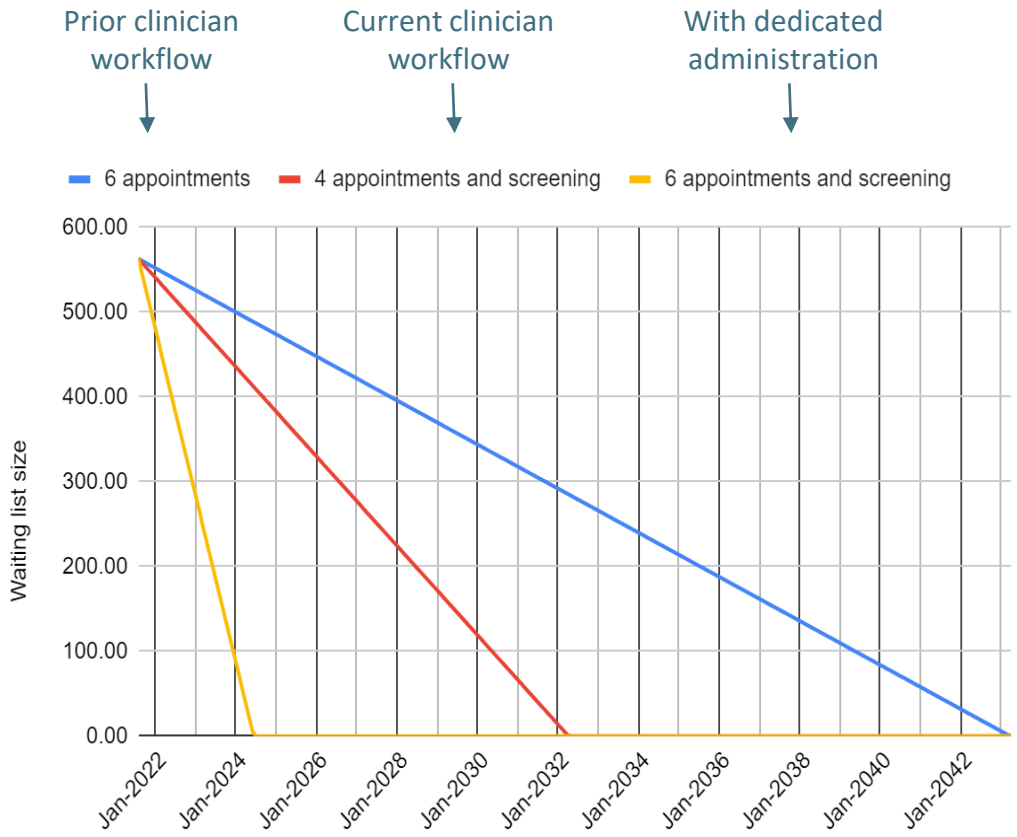
Teams report ability to make better clinical decisions

eConsult is proving an excellent tool. It takes 3 seconds to send out the questions

Christian Tam, Clinical Specialist Physiotherapist/ CATS Manager

University Hospital of Wales

Acne Clinic Pre-screening questionnaires



DNA rate 40% to near zero

Waiting list from 22 yrs to 10 yrs

"I'm not aware of any other quality improvement implementation to date in our Health Board that yields such marked efficiency savings."

Dr K Alden

econsult

Christian Tam

Trauma & Orthopaedics/MSK - Senior physiotherapist

*I was super impressed by how **easy** it is **to send questions to patients** and how easy it is **for them to respond**. The fact that their response is sent to us immediately with [Start Back for Spine] risk scores calculated and an indication of high/medium/low is brilliant.*

*…this **will save minutes from each referral** which really adds up. It might seem minor, but I'm so pleased with this ability and the difference it will make for us.*

econsult

Specialist content created by NHS trusts

Passed through eConsult's tried and tested Clinical Governance process

40 specialties commissioned across England and Wales

Implementation with existing specialties

- Consultative approach
- Supporting change management

Innovation partnership

- Governance sign off
- Baseline data to compare with KPIs
- Co-design with lead clinicians
- Clinical QA

The future

Individual doors

Primary Care

econsult

UEC

etriage

Outpatients

especialist

Join the doors

- History Capture
- Analysis of structured and unstructured data (NLP)
- Clinically scored summary
- Routing decision
- Clinical decision support
- Continual machine learning
- Best in Breed Partner API

Self help
Self referral
Physio
Pharmacy (CPCS)
Mental Health
Therapist

GP
Nurse
Admin

A&E
UTC
SDEC

Outpatients
Ambulatory care
2ww pathway

econsult

*NLP = Neuro-linguistic Programming
*2ww = 2 week wait

Project Butterfly: Digital eco-system

Primary Care ▸ Urgent Care
e.g. Route into Clinical Assessment Service

Urgent Care ▸ Primary Care
e.g. P5 redirects

Primary Care ▸ Specialist Care
e.g. 2 week wait cancer direct referral

Urgent Care ▸ Specialist Care
e.g. Same day emergency care routing

Driven by data

econsult

Any questions….?

murray.ellender@econsult.health

NHSX AI Award 2021

Digital Health London ACCELERATOR

HSJ 2017 AWARDS WINNER

thebmjawards FINALIST 2018

PATIENT SAFETY AWARDS 2018 Winner Information Technology

SBRI HEALTHCARE Award 2021

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UP NEXT...

The Patient Flow Conference North 2023

THE NHS PATIENT FLOW CONFERENCE 2023

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SPEAKING NOW

Clinton F Schick

Chief Executive
Strata Health

Charlotte Howard

Hospital Discharge Lead
Blackpool Teaching Hospitals NHS Foundation Trust

We will discuss…

"Your Patient Flow - Faster: Leveraging Digital Tools to Recover Productivity and Improve Whole System Flow"

Strata Health

Your Patient Flow – *Faster*

A single referral system across the ICS

Leveraging Digital Tools to Recover Productivity and Improve Whole System Flow

Who We Are

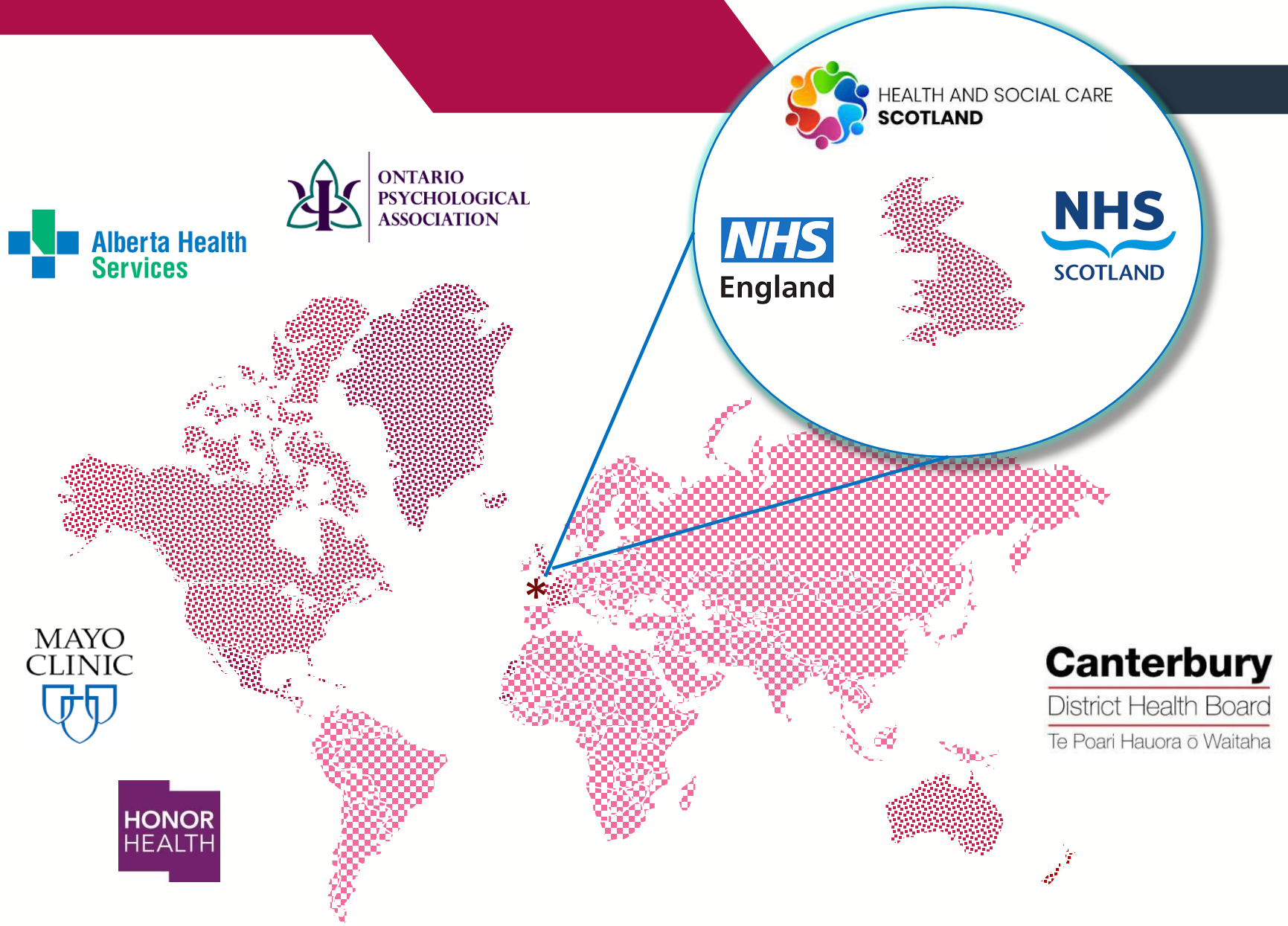
20+ YEARS

as industry leader in global system-wide patient flow

98% Customer Satisfaction Rate

95+% Retention Rate

Winner Lord Carter Award for Innovation 2018



A global footprint across the Commonwealth, the United States & New Zealand

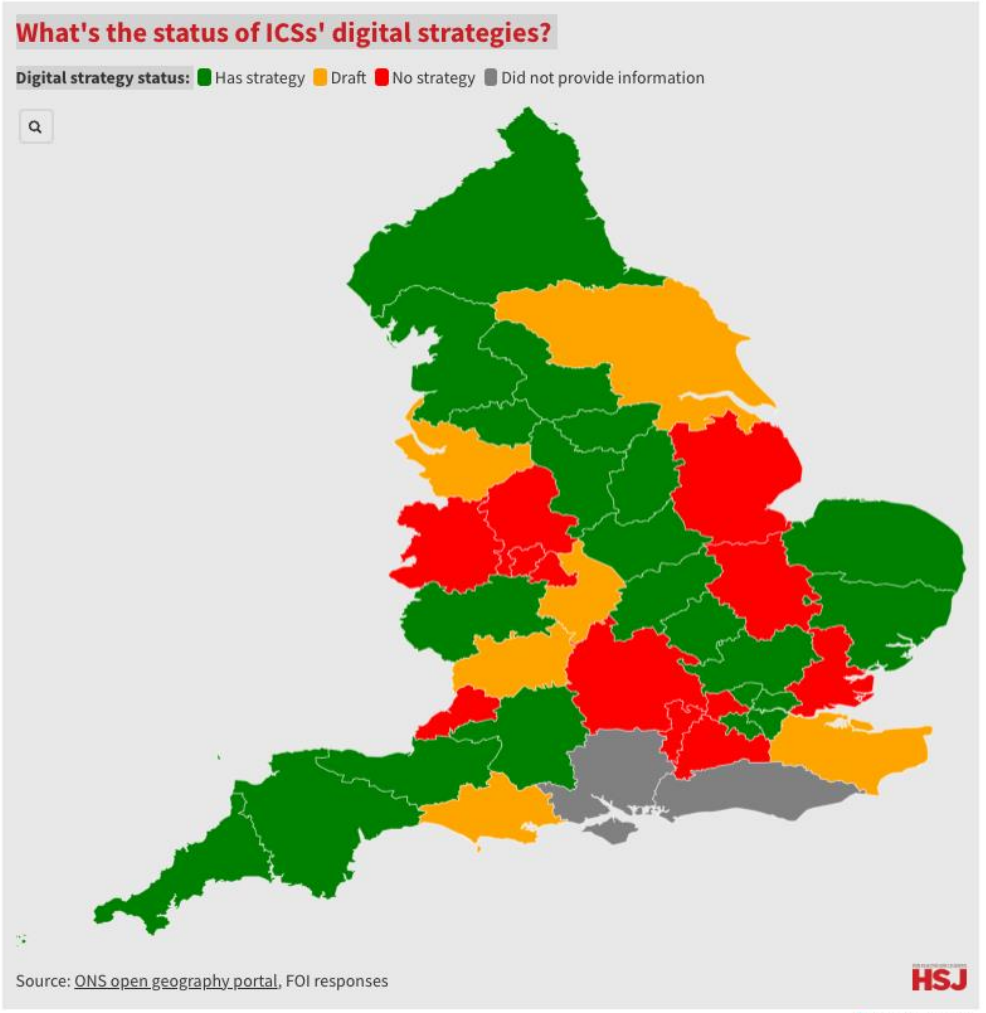
Strata Health

HSJ: 2 in 5 (40%) ICS's do not have a Digital Strategy*

- Best to take time, define a well suited strategy and get it right
- *NHSE's Transformation Directorate* aims to help recover performance in emergency and elective care via IT

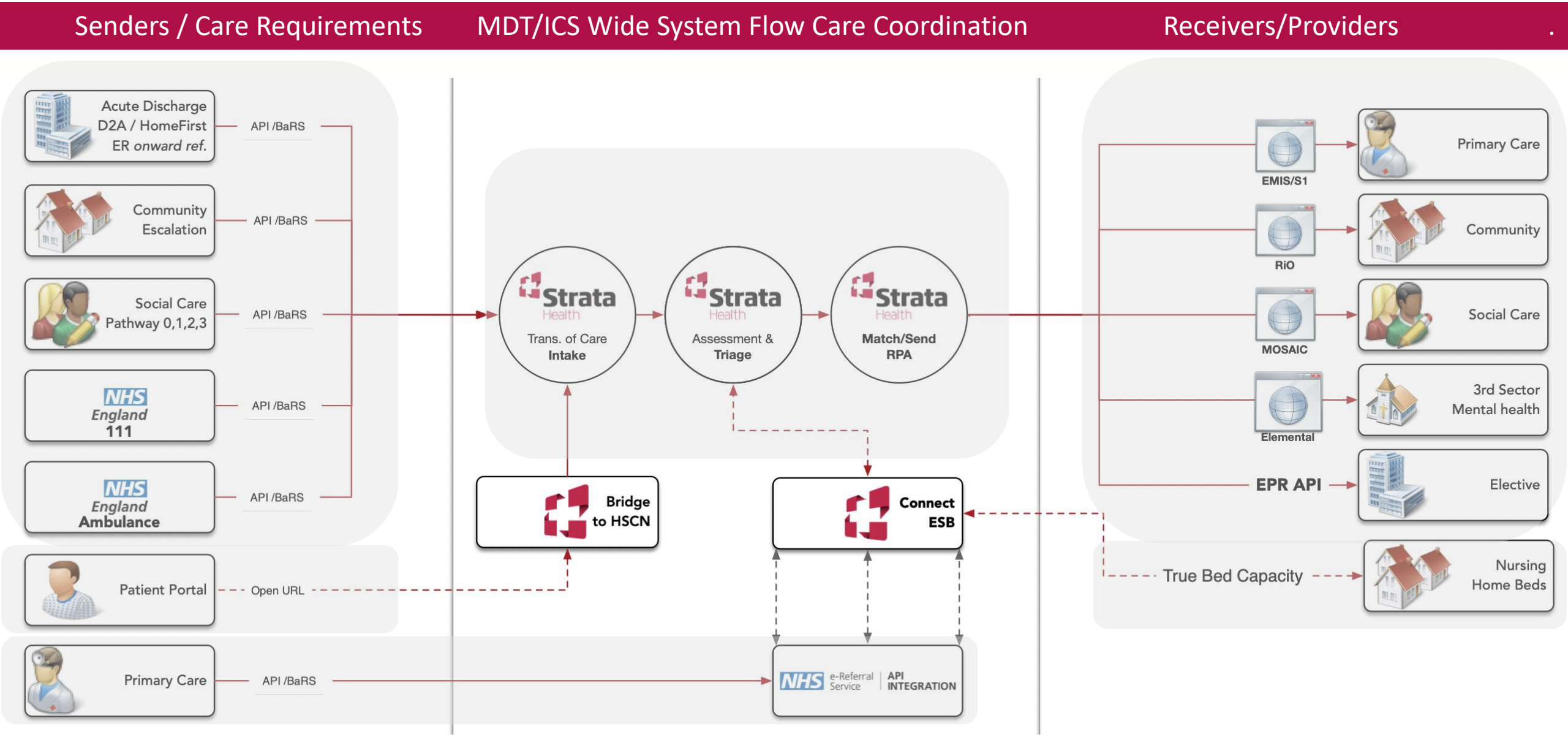
"ICSs "need to understand" the flow of patients across their system"

Adam Lavington, director of digital transformation at Hertfordshire and West Essex Integrated Care Board



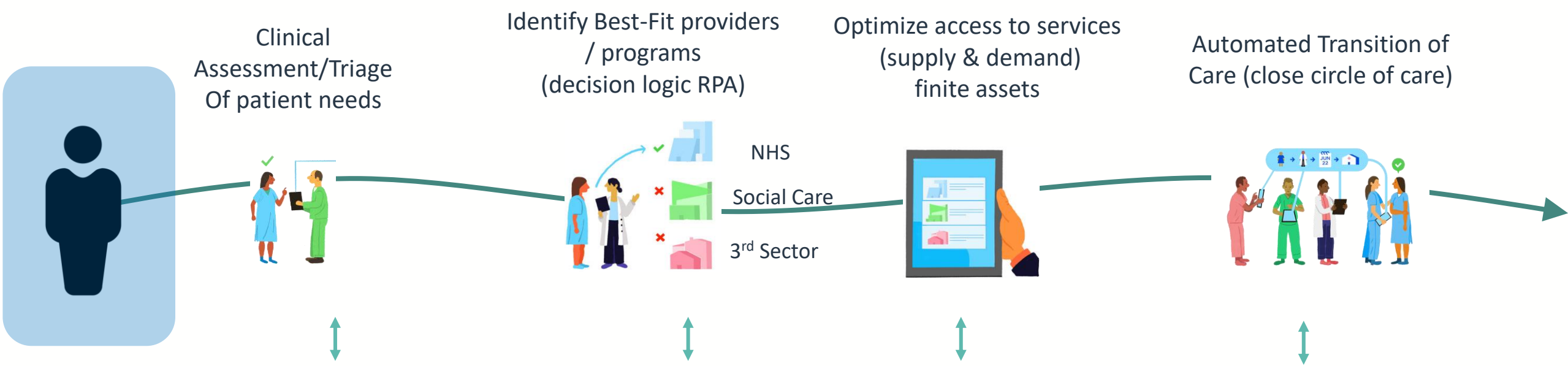
Strata Health

High-level LOGIC MODEL: Strata PathWays™ joins up patient transitions across the ICS



Also: Strata connects systems, produces matching and decision logic algorithms and digitally assists staff via RPA

From a Patient Centric view: Each patient transition has a digitized a workflow:
frontline staff deliver better care, to the right place, swiftly and consistently (audited)



Supporting your whole system EPRs (all systems) and shared care record digital strategy

Strata Health

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

The Fylde Coast's Integrated Discharge Journey

- Charlotte Howard
  Hospital Discharge Lead

- Emma Morrison
  Clinical Lead

Caring • Safe • Respectful

Blackpool Council
BUILDING A BETTER COMMUNITY FOR ALL

Lancashire County Council

NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Where we were

736 G&A beds

Evaluation of current discharge services

Confusion regarding remits & responsibilities

Inefficient processes & unnecessary delays

No collaboration between Health & Social Care

OPPORTUNITY

PROBLEM SOLVE

FUTURE

VISION

What We Did

Blackpool Teaching Hospitals NHS Foundation Trust

- Stakeholder workshops
- Single Point of Discharge (SPoD)
- Combine Health & Social Care Resources
- Integrated team of experts
- Trusted assessors for discharge services
- Strata to support digitalisation of pathways

Initial Outcomes

Blackpool Teaching Hospitals NHS Foundation Trust

- Pilot on 4 wards
- Triage - Discharge to Assess model
- Collaboration between Health & Social, Community & Acute
- Impact of Covid-19

Inappropriate referrals reduced from 30% to **2%**

Overall length of stay reduced by **4.6 days**

Increase in Home First discharges from 10 per week to **50**

Increase in monthly referrals from 452 to **711**

Transfer of Care Hub (TOCH)

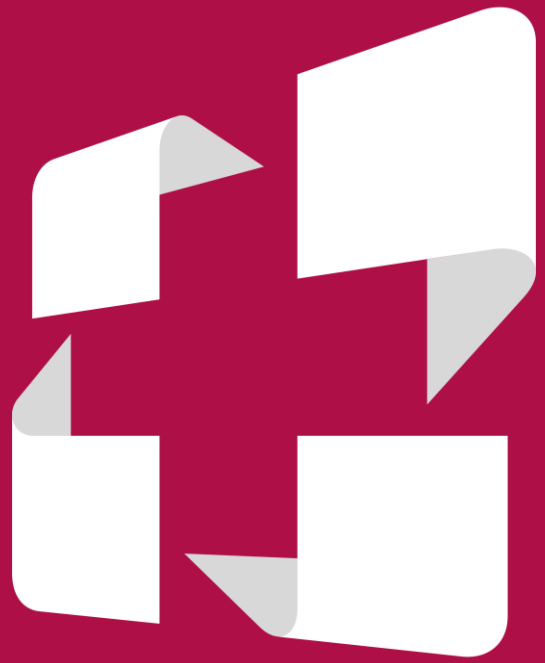
NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Discharge Facilitators	Triage Team	Complex Case Nurses	Residential Finding Services
Criteria to Reside Team	Home First	Homeless Link Workers	Patient Flow/Bed Managers/Site Matrons
Early Supported Discharge	Outreach	Transfer of Care Ward	Clifton Rehabilitation

Future Developments

Blackpool Teaching Hospitals NHS Foundation Trust

- Steps up/admission avoidance
- Mental Health Liaison Nurse
- Discharge Quality Matron
- Aim 16 Home First discharges per day
- Enhance links with Virtual Wards, SDEC, Frailty Unit
- Out of area pathways



www.stratahealth.com

Placeholder Slides

2023/24 priorities and operational planning guidance

Flow Deliverables

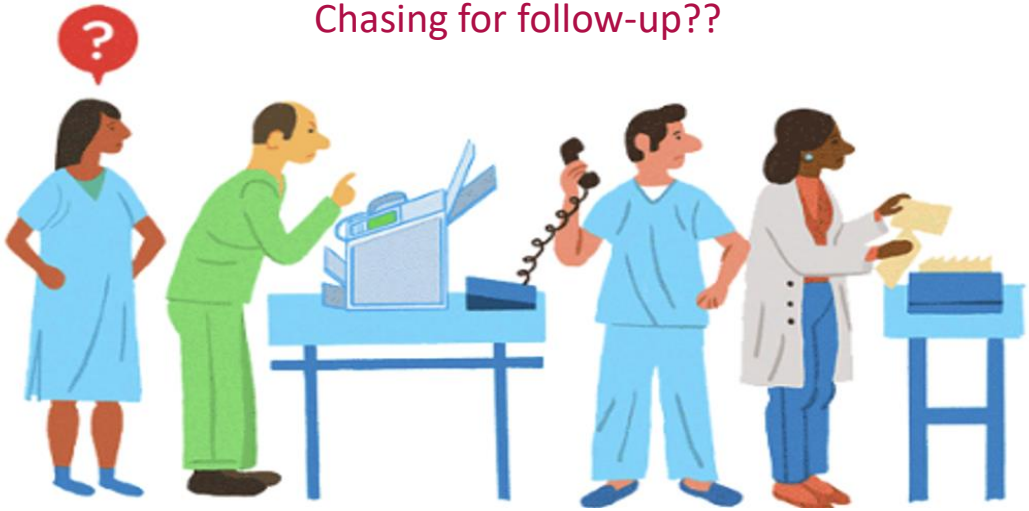
01	Reduce hospital occupancy <92%	D2A, ⬇ DTOC
02	Self-referral where GP not necessary	NHS 111 / Portal Access
03	Increase capacity in beds / resource (downstream)	Nursing Home / IC Real-Time Capacity
04	ToC Hubs & Interoperability to aid workforce	Triage eRS, 'GRFT'

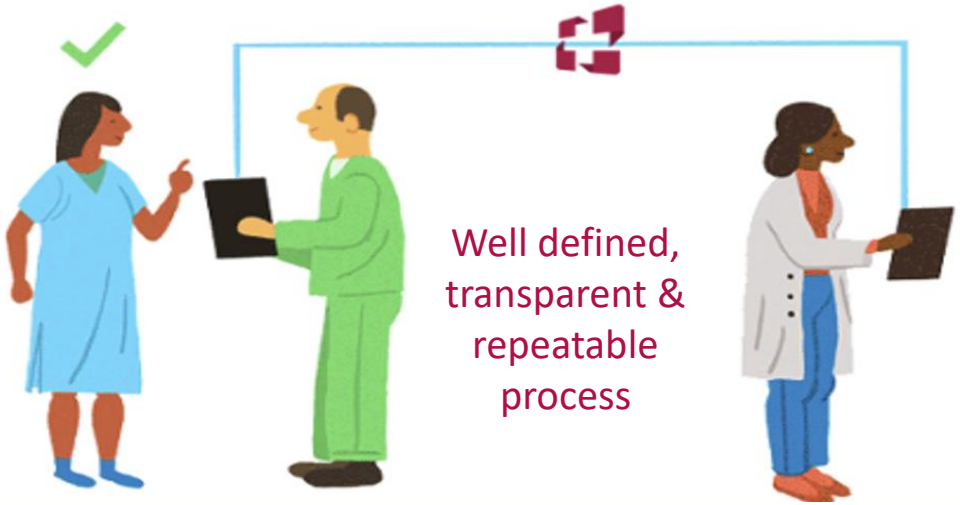
- ✓ Optimise System Capacity
- ✓ Improve Patient Outcomes
- ✓ Reduce Clinical Wait Lists
- ✓ Optimise Downstream Capacity
- ✓ Stop Inappropriate eRS referrals
- ✓ Enable 80/20 Rule on Triage
- ✓ Better System Flow

01 Reduce overall hospital occupancy <92%

Implement D2A; leverage system-wide access, placement and utilisation to reduce DTOC and achieve target occupancy.

Chasing for follow-up??



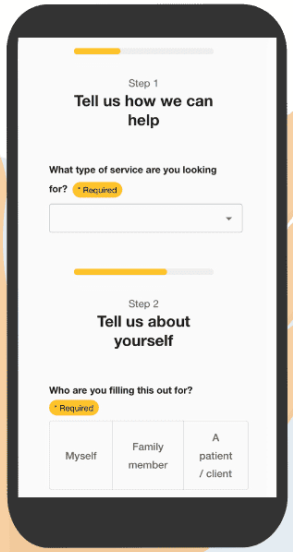


Well defined, transparent & repeatable process

Strata Health

02 Self referrals, if GP intervention not clinically necessary

- NHS 111 is evolving to enable actual referrals to either ED or urgent 2h in community - new BaRs compliance will make this happen
- Strata's patient portal (Ontario, Canada) allows self-referrals to be efficiently triaged and followed up across Pathways 0,1,2,3



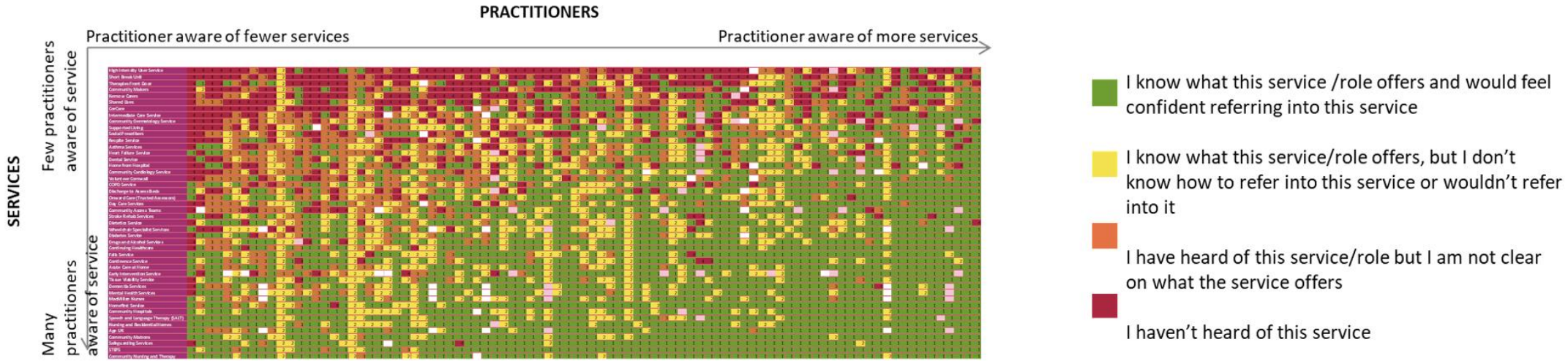
askforhelptoday .ca

"Strata's technology has enabled us to fill the access gap by creating better connections between health systems and psychologists and faster, more accurate referrals for people with mental health needs. People seeking treatment deserve to receive the right care the first time; with Strata Health, we deliver."

- Richard Morrison
CEO, Ontario Psychological Association

03 Increase capacity in community resource (beds)

- Strata enables real-time access to capacity within the community. How many services in your area are unknown (red)



"Clearly there are too many – hence the fundamental problem for hospital staff to support discharge planning. There needs to be one single point of access to support discharge planning navigation"

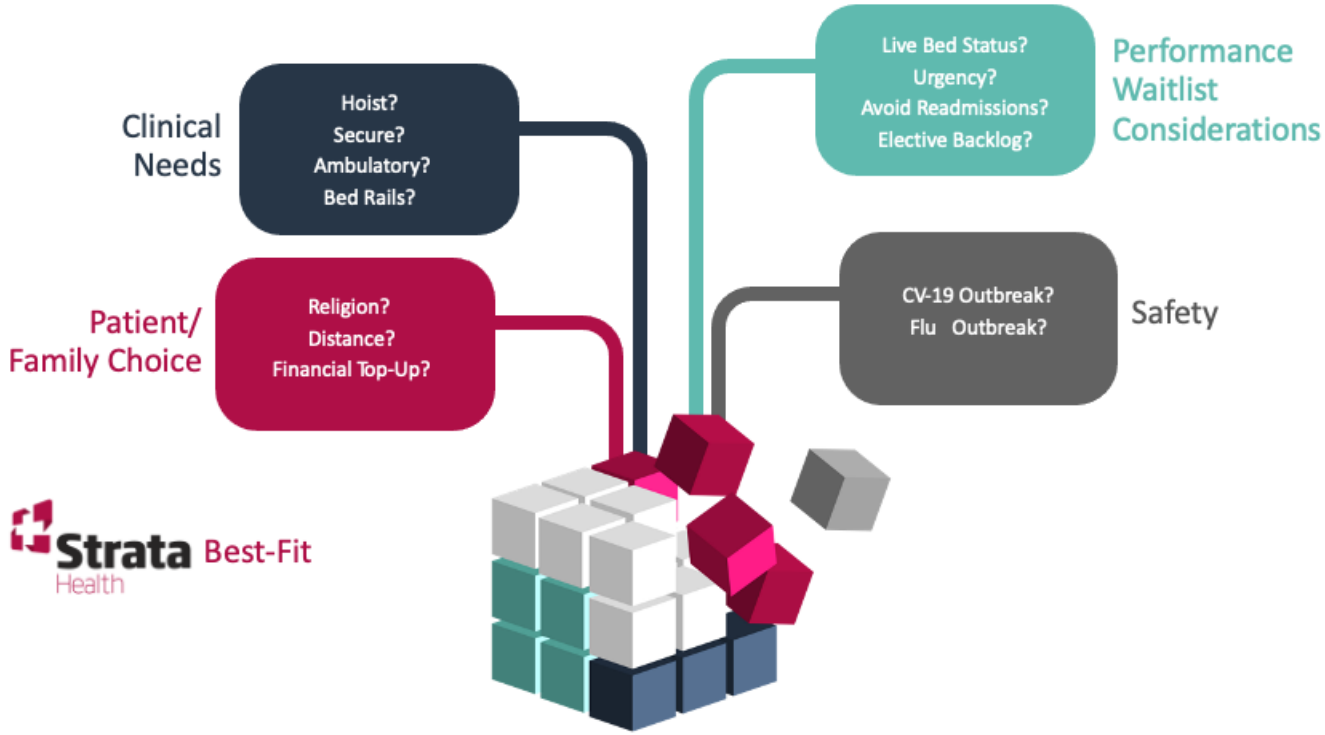
- Consultant Geriatrician

Strata Health

03 Matching RPA – key to reducing DTOC & re-admissions

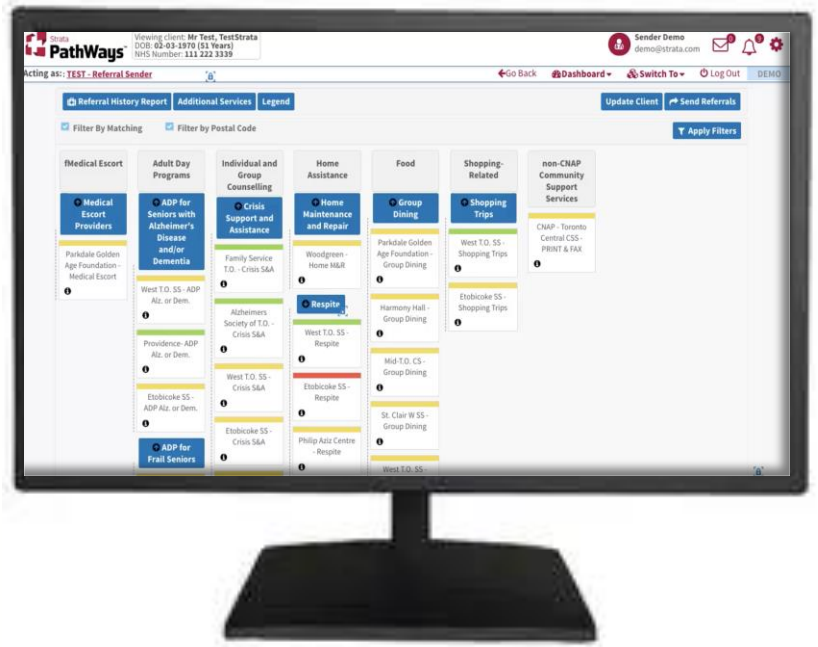
- Is a vacant beds enough information – as we certain the resources fits patient need?

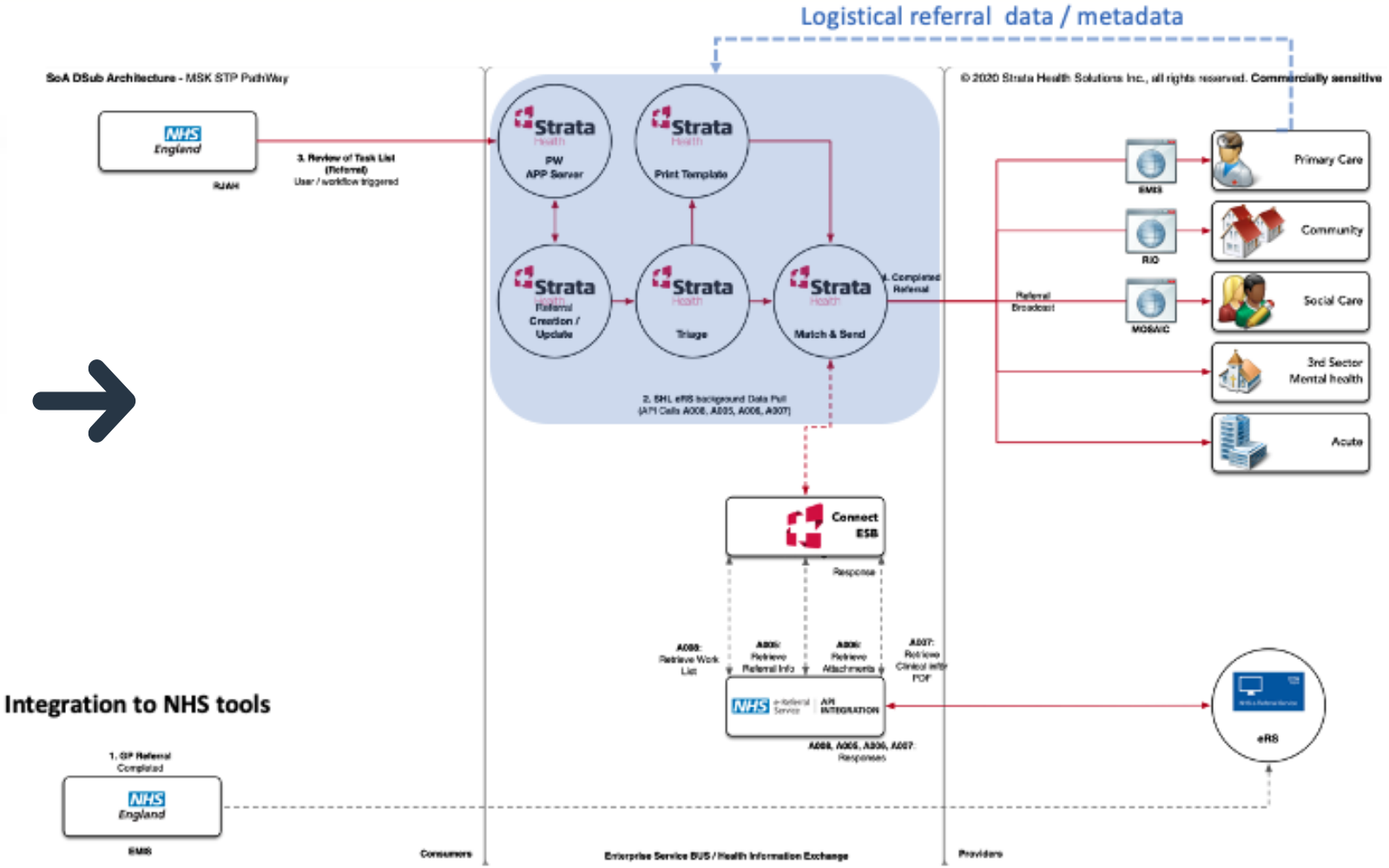
We need the DATA about the DATA for resource allocation and effective transfers of care



Strata Health

04 Matching RPA & interoperability supporting Transfer of Care Hubs - patient flow at the core!





Strata Health

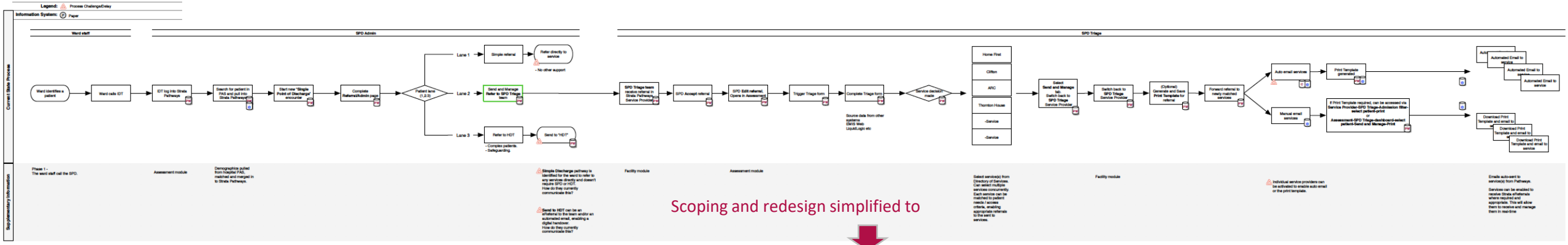
NHS
Blackpool Teaching Hospitals
NHS Foundation Trust

Case Study:

Peer Review: Single Point of Discharge

- The Trust provides a range of acute services to the 352,000 population of the Fylde coast health economy and the estimated 18 million visitors to the seaside town of Blackpool. Since April 1, 2012, the Trust also provides a wide range of community health services to the 445,000 residents of Blackpool, Fylde, Wyre and North Lancashire.
- The Trust is a provider of specialist tertiary care for Cardiac and Haematology services across this region.

[Blackpool Victoria]-[Single Point of Discharge]
Strata Project - Phase 1 - Current State



Scoping and redesign simplified to

Pilot Wards

Hospital nurse identifies patient with potential continuing needs post discharge.

Nurse enters eReferral into Strata Pathwa

Referral sent direct to SPoD Triage

Other Wards

Hospital nurse identifies patient with potential continuing needs post discharge.

Nurse calls SPoD and verbally hands over information

Single Point of Discharge

Multidisciplinary and multi agency access and process

Triage receive and manage the referral, adding information to it from other sources (i.e. GP and Community EMIS, LiquidLogic)

SPoD Match and send to receiving services

SPoD create eReferral and send to Triage team

Sending options

Email referral template to services

Automated email referral template to services i.e. Clifton, HomeFirst

eReferral within Strata Pathways (future)

Strata Health

Hospital Wide SPOD Peer Report

- Reduction of 4.1 days in LOS
- Increase utilization on ALL downstream services (load balanced)
- Reduced DTOC
- 50% increase in Home First (D2A and PW0)
- Response time <2hrs vs 24hrs+

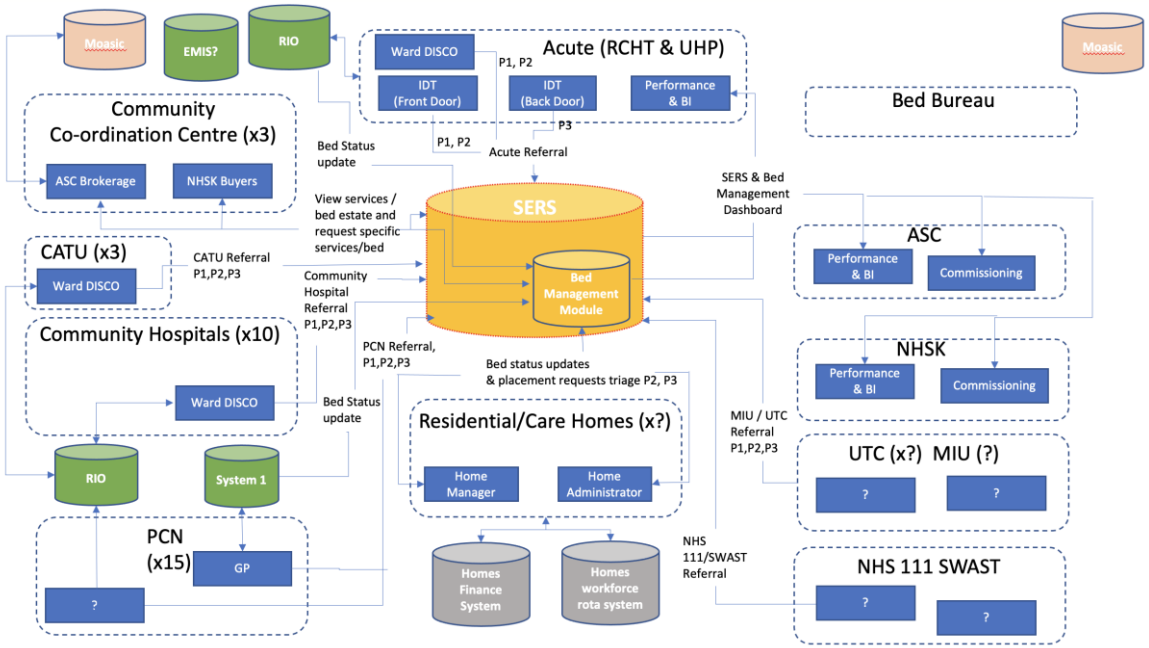
Charlotte Hamer
Assistant Lead for Hospital Discharge Service
Service Lead SPOD
Physiotherapist

Load balance downstream resources

Table 1:	% Distribution of Referrals	
Service	Pre-SPoD	Post SPoD
Clifton	78%	22%
ARC	2%	3%
Thornton House	1%	2%
ESD	5%	3%
Home 1st	14%	21%
Social Services (HDT & Community SW)	N/A	44%
Other	N/A	5%

Table 2	LOS at BVH (days)	
Service	Pre-SPoD	Post SPoD
Clifton	29.7	13.8
ARC	10.6	16.5
Thornton House	21.0	15.7
ESD	22.7	14.0
Home 1st	12.0	13.9
Social Services (HDT & Community SW)	N/A	16.5
All pathways combined	19.2	15.1

Where We Typically Start: Many Systems, Many Workflows

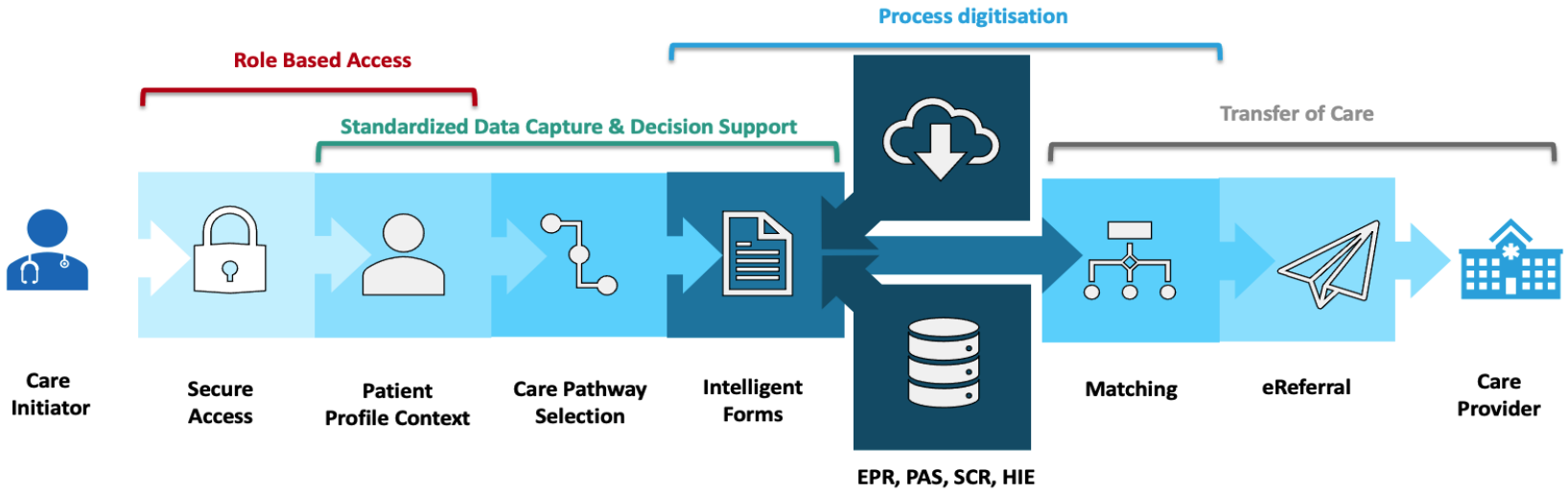


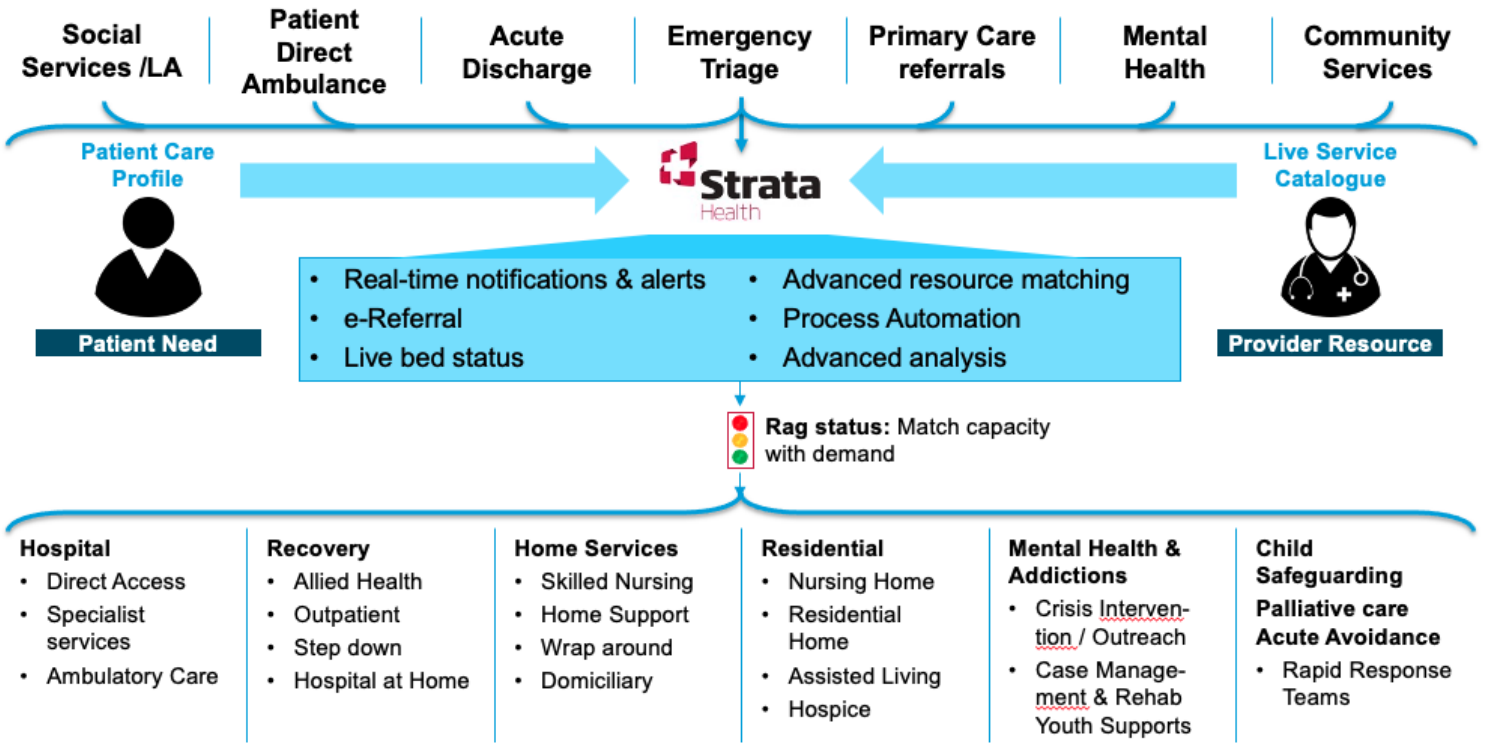
To a Single eReferral platform:
linking ‘data orchestration & workflow’

- **Orchestrate data** between desperate EPR’s/HIE’s (handshake API to API)
- Enable a bespoke dynamic *minimum data set to* flow across the ‘system’
- Link primary, secondary, community, local authority and 3rd sector

To a Single eReferral platform:
linking ‘data orchestration & workflow’

- **Workflow** & *r*eal-time capacity metadata
- Bi-directional flow, updates, alerts
- RPA to enable administrative efficiency





Any-to-Any system flow: Best practice underpinned by Strata

Each patient transition has a digitized a workflow: Frontline staff deliver better care, to the right place, swiftly and consistently (audited)

Clinical Assessment/Triage Of patient needs

Identify Best-Fit providers / programs (decision logic RPA)

Optimize access to services (supply & demand) finite assets

Automated Transition of Care (close circle of care)

Supporting your whole system EPR and shared care record digital strategy

Now also integrated with NHS eRS to enable triage, and NHS BaRS to enable added workflow optimisation with 111 and ED

Strata Health

Q&A

Strata Health

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UP NEXT...

ALCIDION

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SPEAKING NOW

Katy Cain

UK Chief Nursing Information Officer
Alcidion

I will be discussing…

"Balancing Patient Care and Service Demand with Flow Management"

ALCIDION

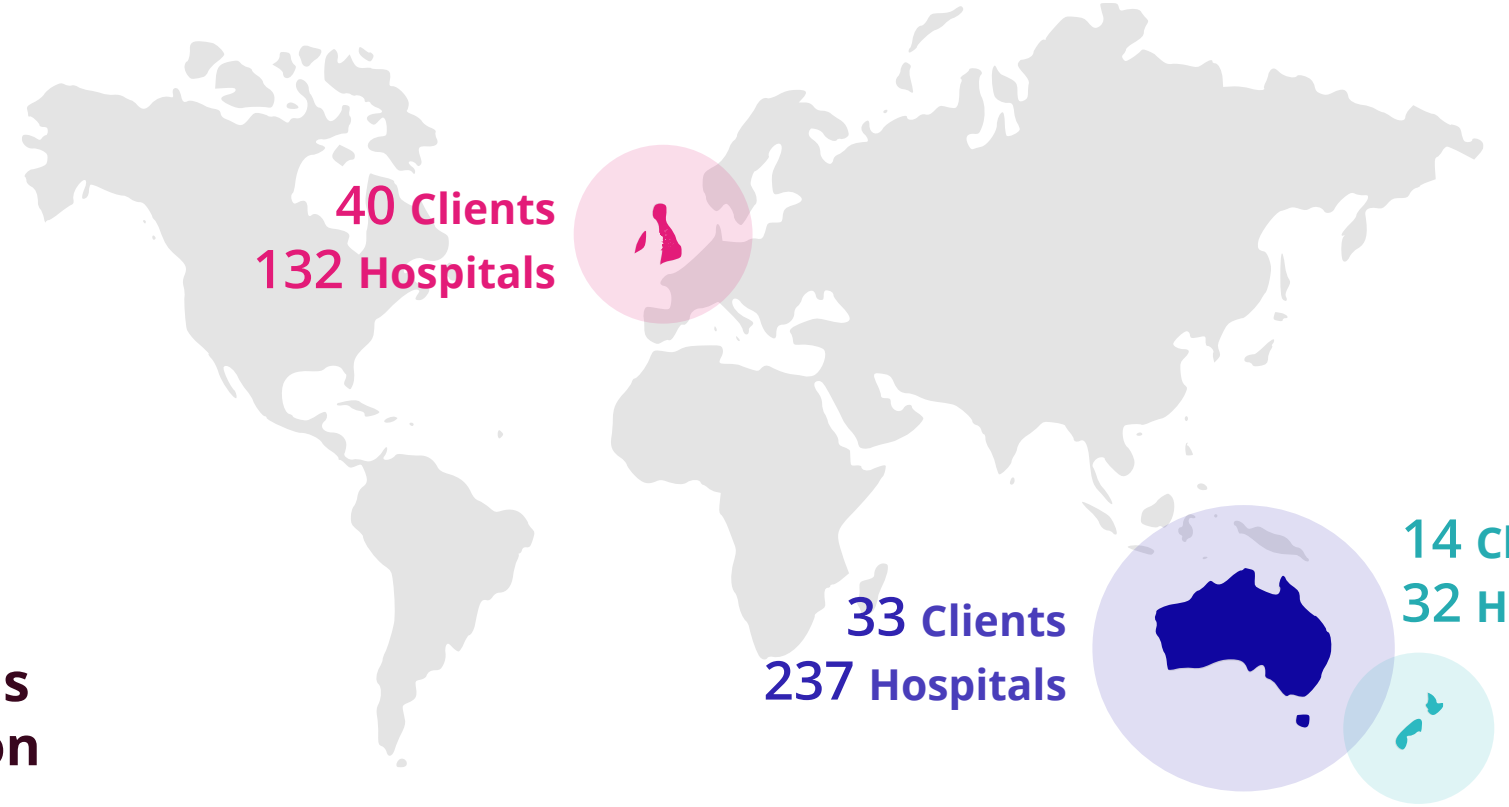
Balancing Patient Care and Service Demand with Flow Management

Alcidion
9 February 2023

ALCIDION

About Alcidion

- **ASX listed health informatics company**
- **Exclusive focus on healthcare technology**
- **100 clinical system implementations**
- **75+ complex system integrations**
- **15+ years' experience**
- **Leading edge, open standards platform & clinical application provider**



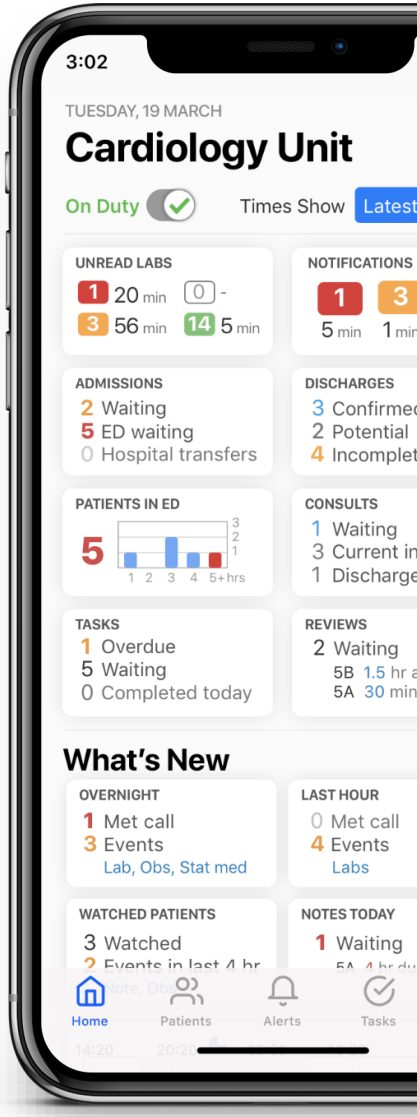
ALCIDION

Challenges We Seek to Address

- Patient Safety
- Clinical Productivity
- Patient Flow & Logistics
- Virtual/New Models
- Practice Variation
- Consumer Driven Care

Designed for Modern Healthcare

- Highly interoperable, built on open standards
- Designed to be an active participant in health care, not just a passive data store
  - Pathway Automation
  - Real-time CDS
- Adapts to different specialties and care settings
- Mobility for workflow integration
- A platform for safe innovation



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The Problem

- **Waiting list for UK treatment could reach 13 million in 2022, ~3x pre-pandemic level** *Economist Intelligence Unit, 2021*
- **Funding allocated to tackle waiting lists**
- **Answer = Patient Flow Management**

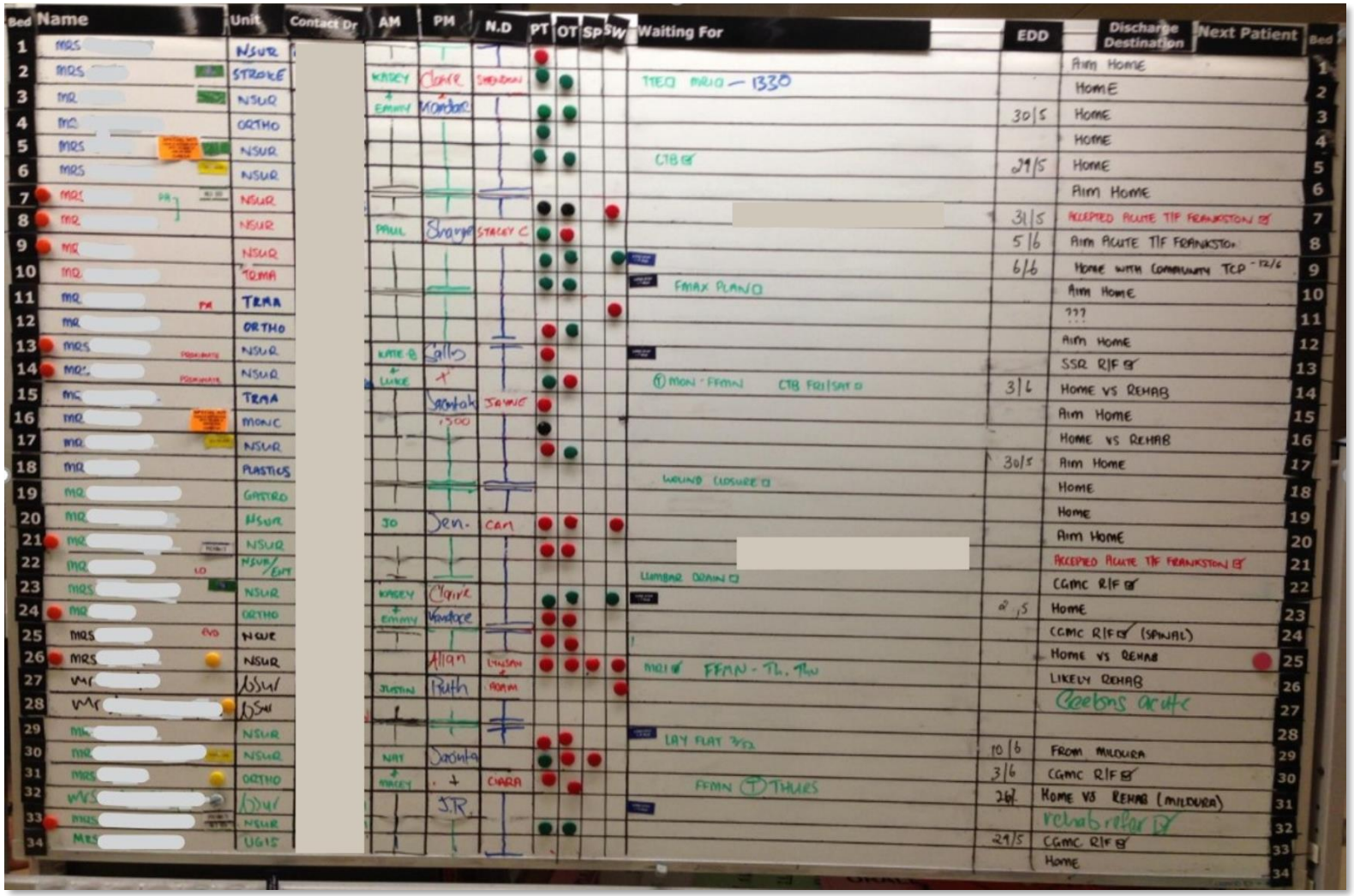
Health > News Health

CASH INJECTION NHS gets £5.9bn booster shot in Budget to tackle record waiting lists

ALCIDION

And local challenges . . .

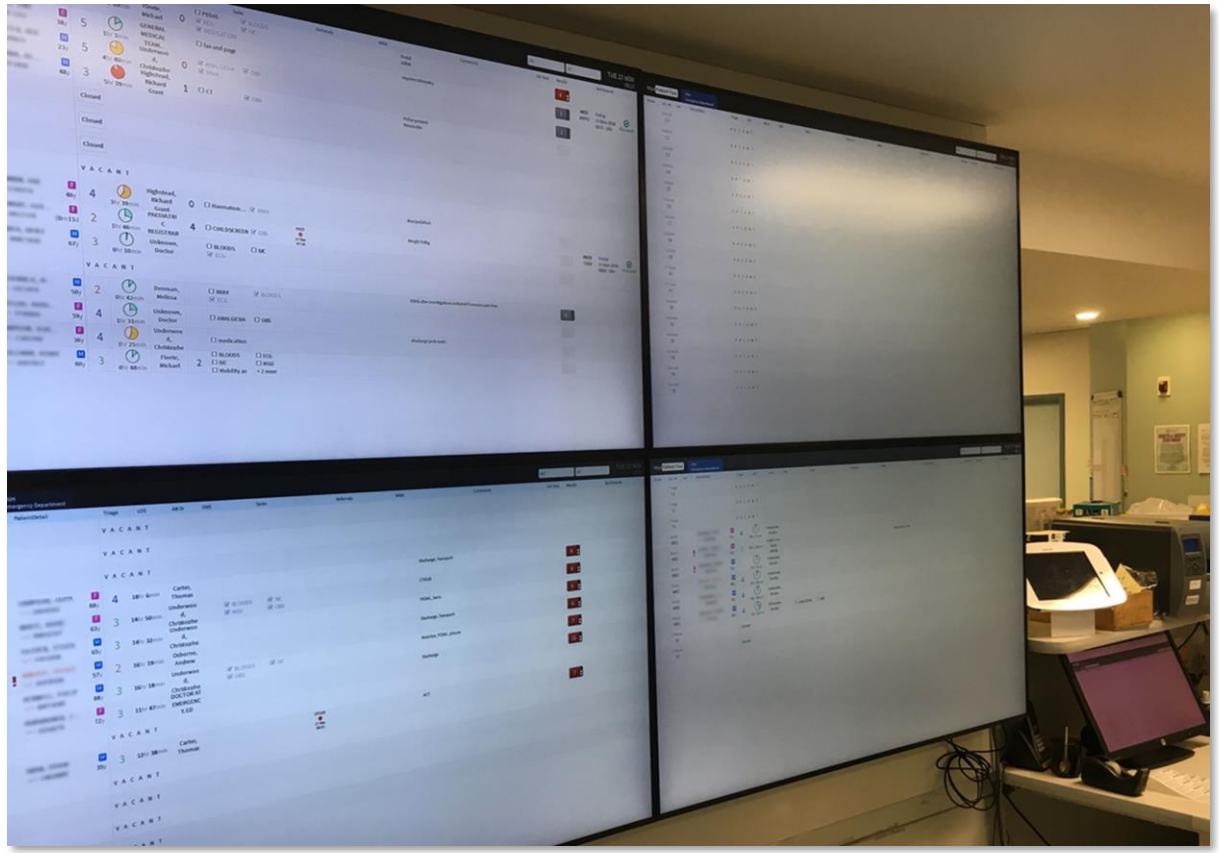
- Manually collected & maintained information
- Only available in one place – not shared with other systems
- Leads to inefficient patient journeys & unnecessary increases in patient length of stay
- Making great care first time harder



What is Patient Flow & what is important?

- **What is Patient Flow?**
  - Moving patients seamlessly around the entire system, not just the organisation
  - Improving flow, reducing length of stay, increasing satisfaction
  - Minimise manual data entry & duplication; remove phone calls & paper

- **What's important?**
  - Breaking down the walls of a hospital
  - View of the system across a region
  - Flow from ambulatory care through ED to inpatient to discharge
  - Identification & management of high-risk cohorts
  - Introducing new ways of working (virtual care, remote monitoring)



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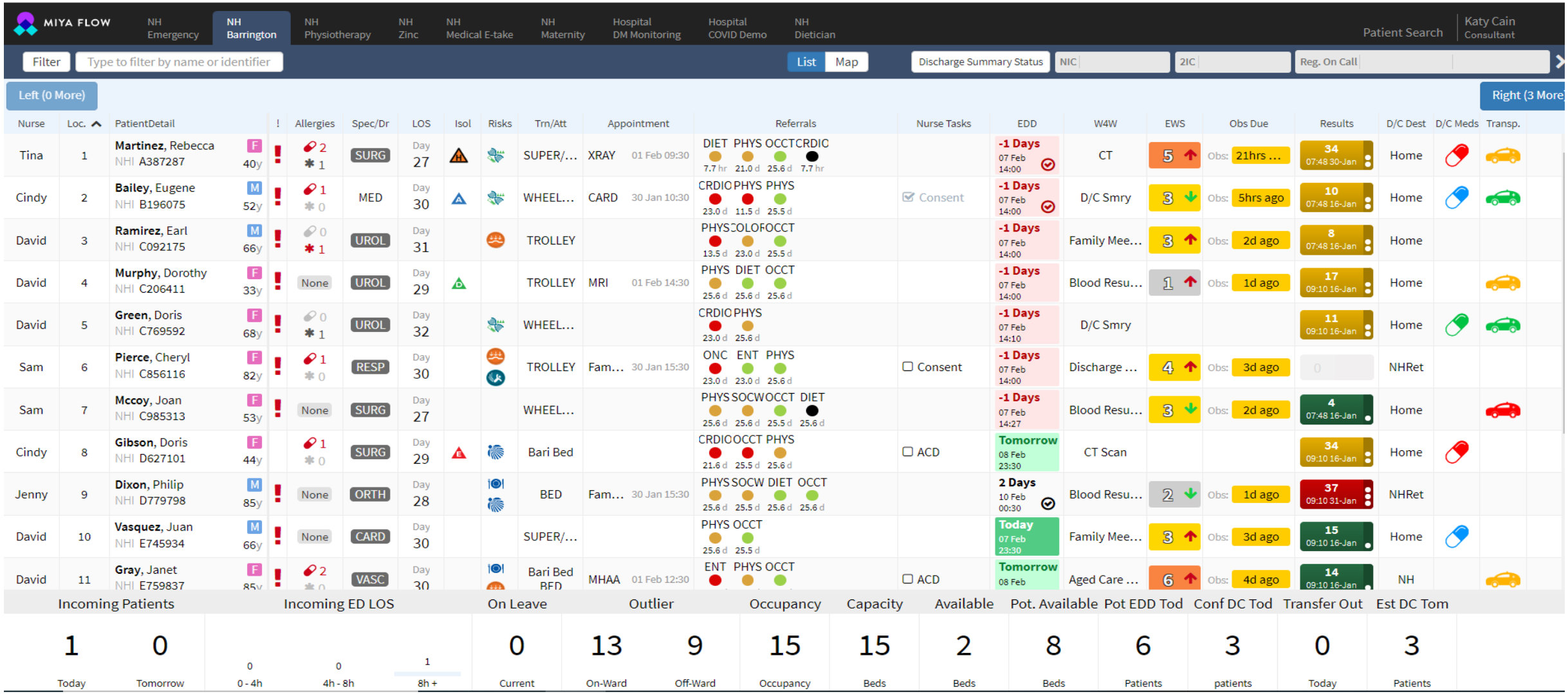
Miya Flow



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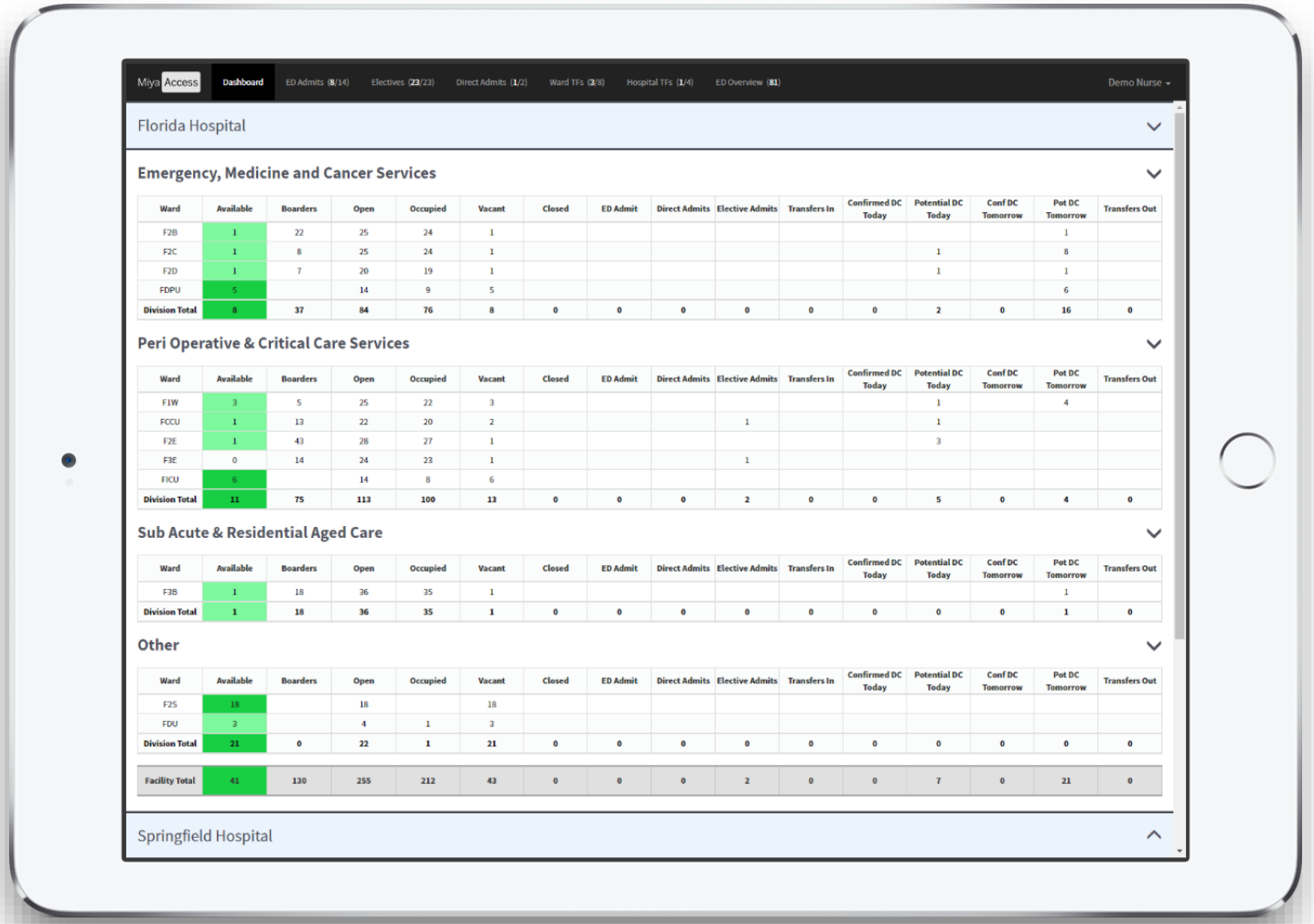
Miya Access

- Interactive user interface
- Enables pro-active allocation of patients to beds
- Provides current and projected occupancy aiding demand management
- Online bed requests promote capture of relevant information meaning allocation and capacity management is better aligned with clinical need.



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Miya Command

- **Dashboard to support operational decisions on capacity and flow.**
- **Real-time visualisation highlighting constraints in capacity**
- **Status indicators providing visual cues to highlight areas of potential over and under utilisation.**
- **Information supports all patient movements and episodes of care by utilising feeds from PAS, Miya Flow and Miya Access**

Examples of Miya Command Realtime dashboards :-
- Executive summary
- Hospital at a Glance
- Ward Snapshots
- Flow Trails

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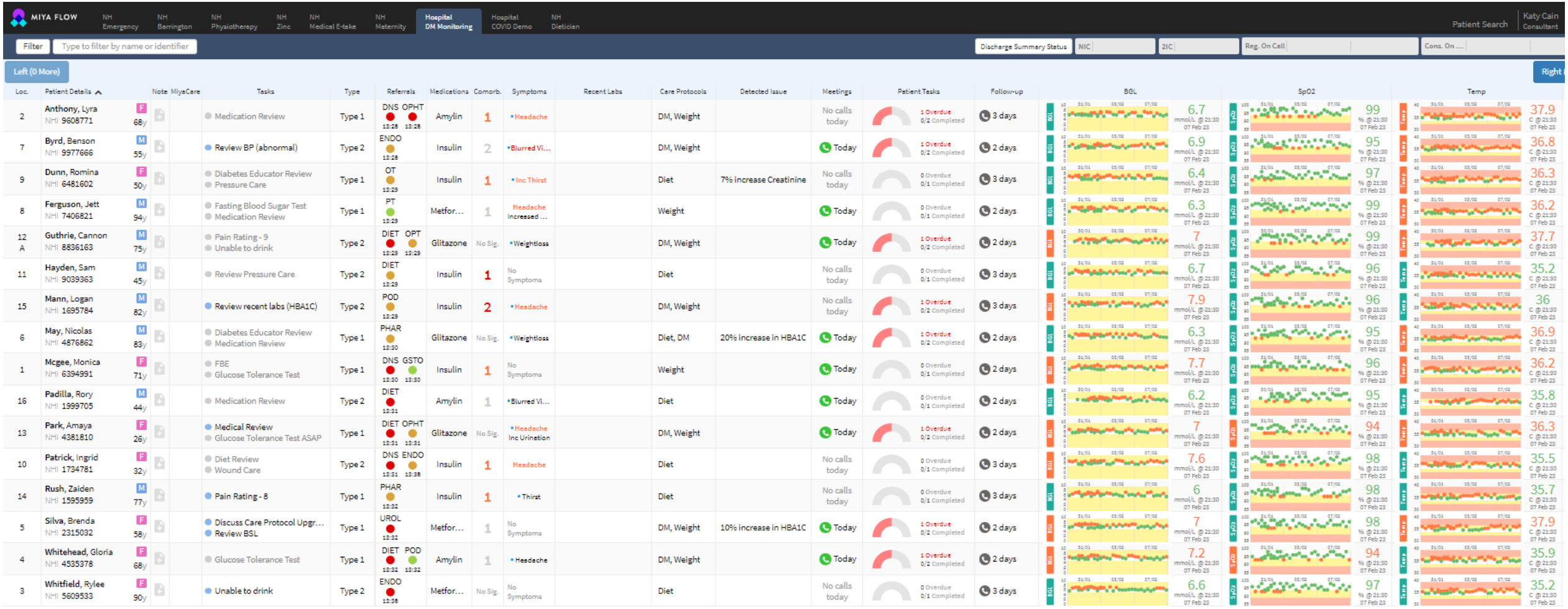
Fit for the future



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UP NEXT...

TECH IN CARE

PERSON CENTRED TECHNOLOGY

THE NHS PATIENT FLOW CONFERENCE 2023

SPEAKING NOW

Lorenzo Gordon

Director & Co-Founder
Tech in Care

I will be discussing…

"Enabling Patient Flow form Hospital To Community (and back again!)"

Enabling Patient Flow From Hospital To Community

PATIENT FLOW CONFERENCE 2023

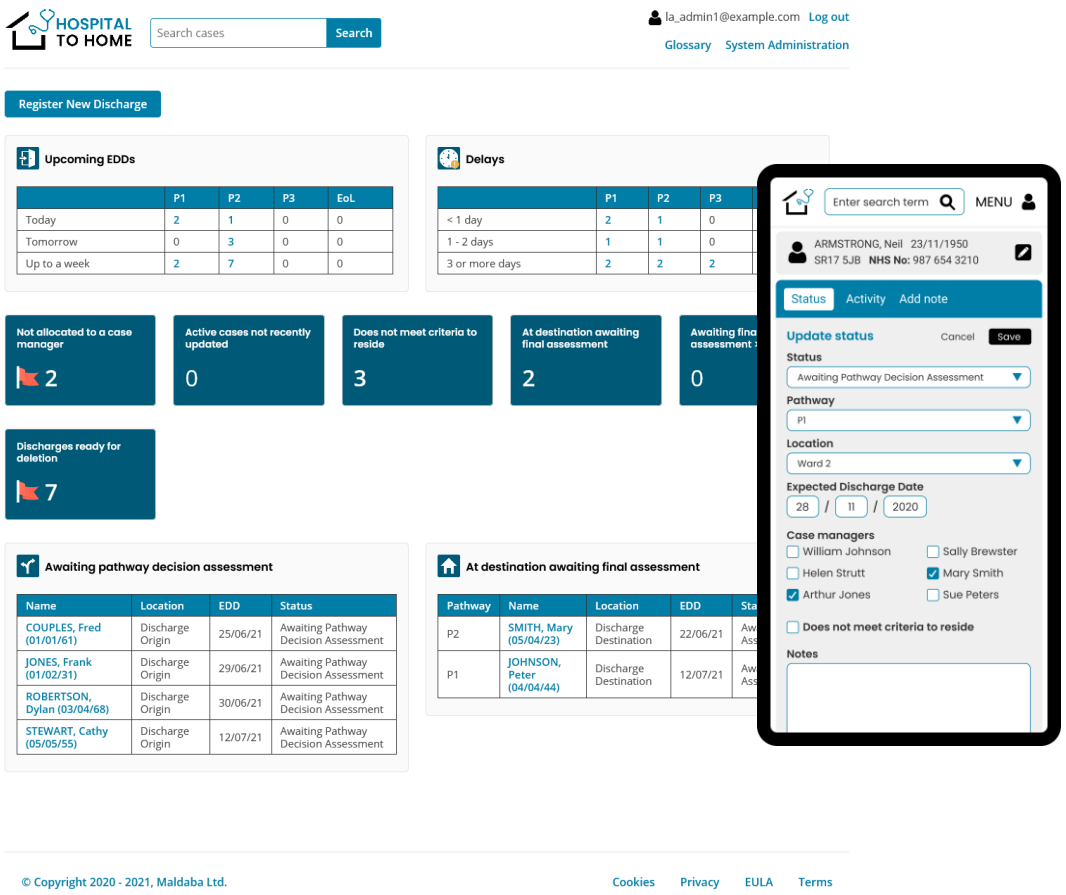
LORENZO GORDON - DIRECTOR - TECH IN CARE

HOSPITAL TO HOME

TECH IN CARE
PERSON CENTRED TECHNOLOGY

SCDIA Co-Fund

Hospital to Home – Discharge to Assess



Cookies Privacy EULA Terms

HOSPITAL TO HOME

TECH IN CARE
PERSON CENTRED TECHNOLOGY

Hospital to Home – Discharge to Assess

- Single version of the truth
- Released acute bed nights
- Email/SMS notifications
- Improved speed of discharge
- Clear communication

Hospital to Home – Discharge to Assess

30%

Administration reduction

£24.68

Local authority administration saving per D2A

1

Bed night saved every 2 D2A's

£200

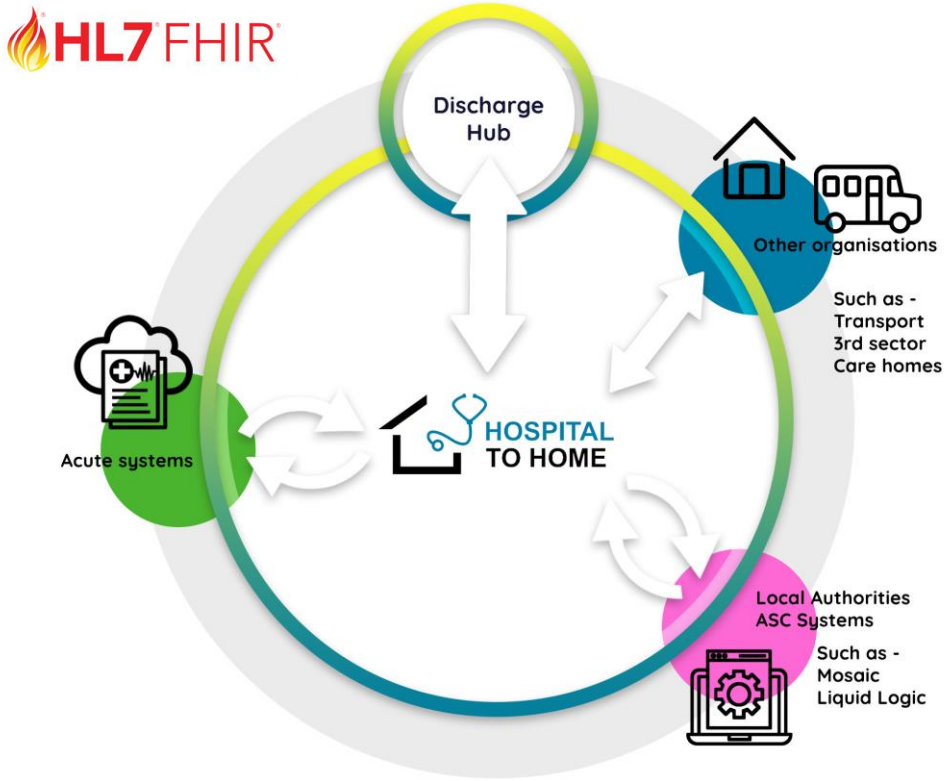
Saving of Acute Bed provision per D2A

HOSPITAL TO HOME

TECH IN CARE
PERSON CENTRED TECHNOLOGY

Hospital to Home – Intermediate Care

Hospital to Home – Interoperability



- Bespoke EPRs
- Partner Programmes:
  - Cerner
  - Liquid Logic
  - Epic
  - SystmOne
- Interoperability opportunity for all H2H customers, both current and prospective

Hospital to Home - Interoperability

An Offer

- 3 spaces for organisations to work with us to address their interoperability challenges
- First come, first served
- Get in touch:

lorenzo.gordon@tech-in-care.uk

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NETWORKING & LUNCH

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Event Chair – Chair Afternoon Address

Professor
Maureen Baker
CBE

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SPEAKING NOW

David Sgorbati

Chief Analyst
Health Economics Unit

I will be discussing…

"Population Health Management Implementation: From Statistics to Transformation"

Health Economics Unit

NHS
Midlands and Lancashire
Commissioning Support Unit

Population Health Management Implementation

david.sgorbati@nhs.net

https://healtheconomicsunit.nhs.uk/

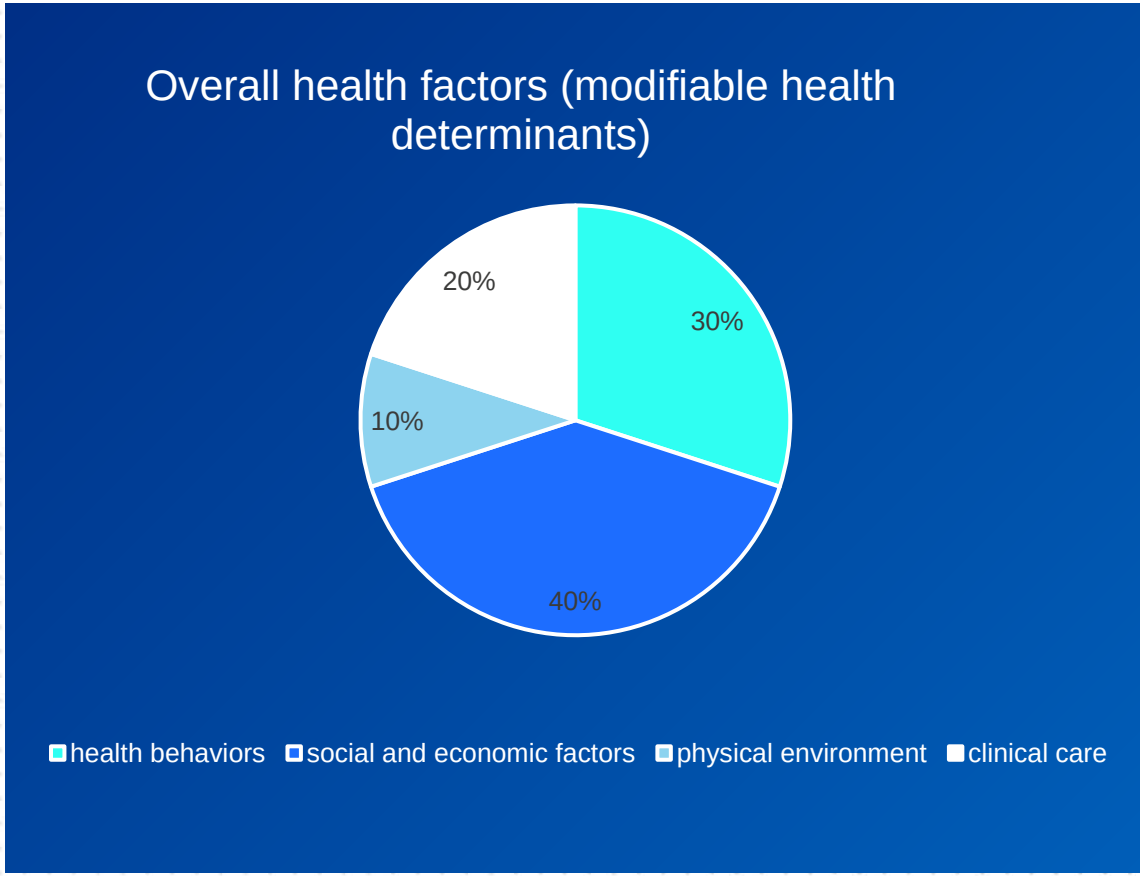
Hello, My Name Is David

- I work at the Health Economics Unit
  - Part of Midlands and Lancashire CSU
  - Data scientists, data engineers, and health economists
  - Work with NHS, academia, and commercial sector

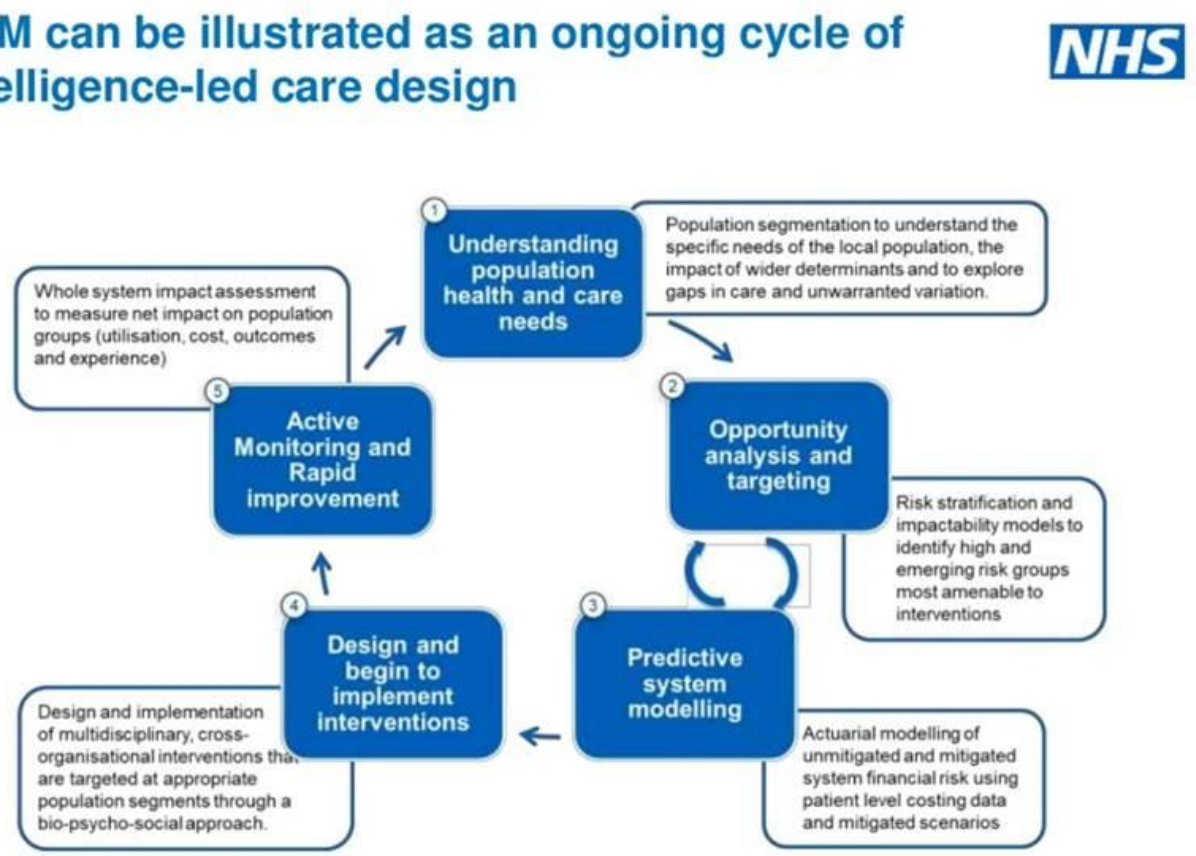
- I'm David
  - I'm a computer scientist
  - Start-up and NHS experience
  - I love my job

Population Health Management

- PHM is a set of frameworks and techniques which focus our planning on wider determinants of health
- It requires us to look at the healthy population, addressing inequalities in care and intervening more actively to promote wellbeing and prevent ill health, and focus on best use of resources

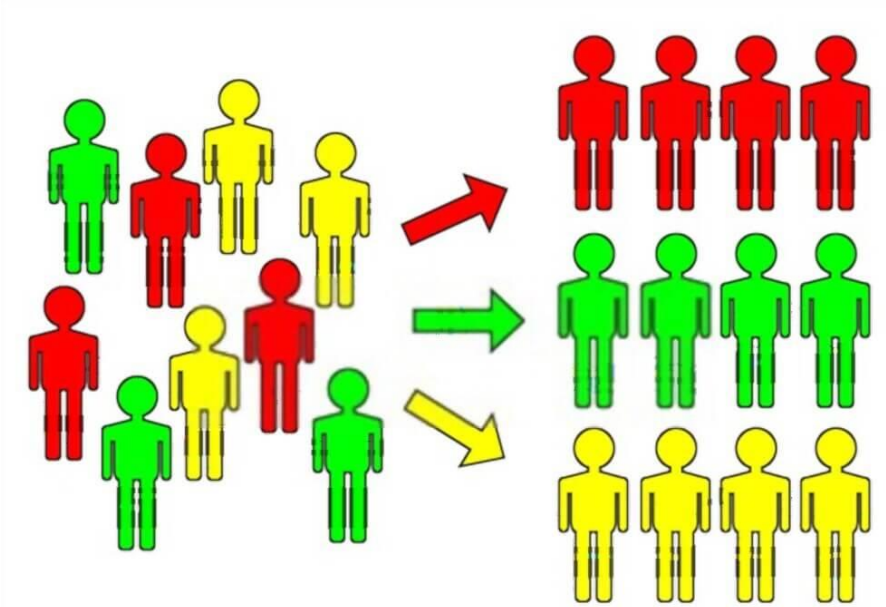


The PHM Cycle



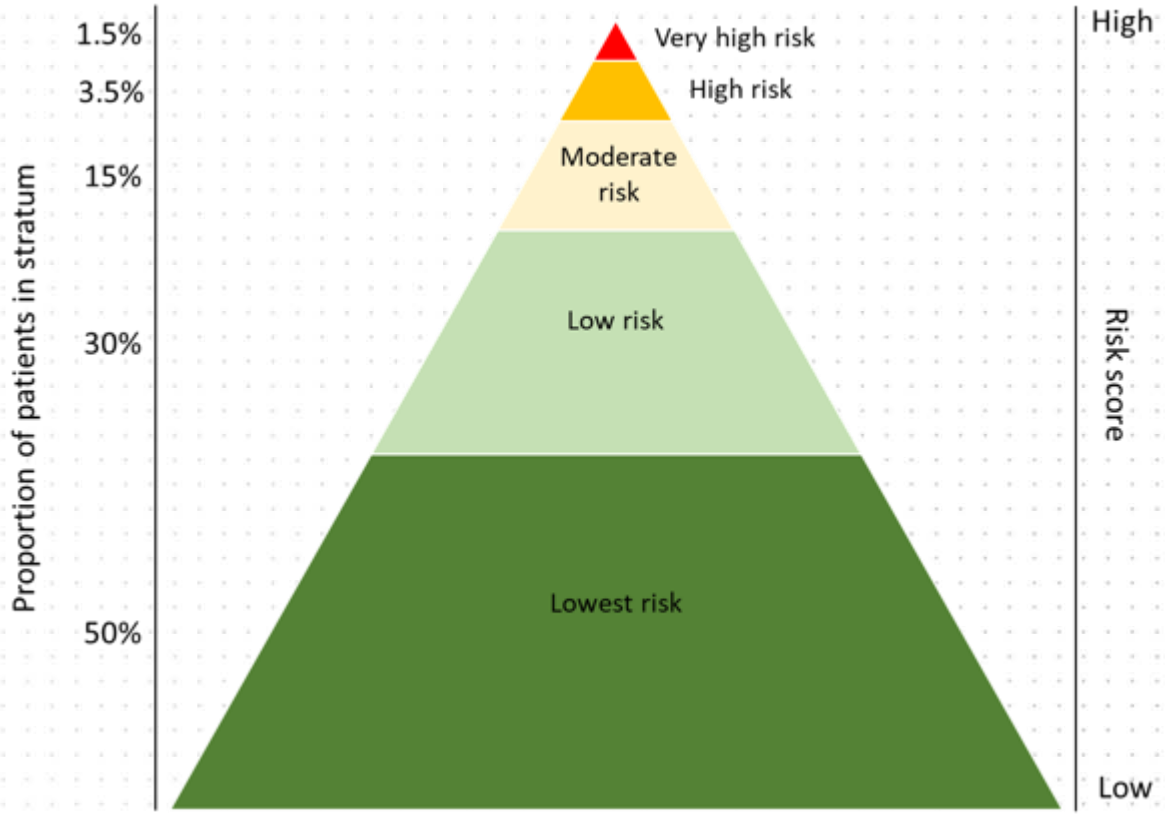
Population Segmentation

- Health metrics can often be adequately described by summary statistics
- However, the usefulness of summary statistics decreases as the complexity of a system and/or group increases
- Widely used in marketing as part of Segmentation → Targeting → Positioning strategies



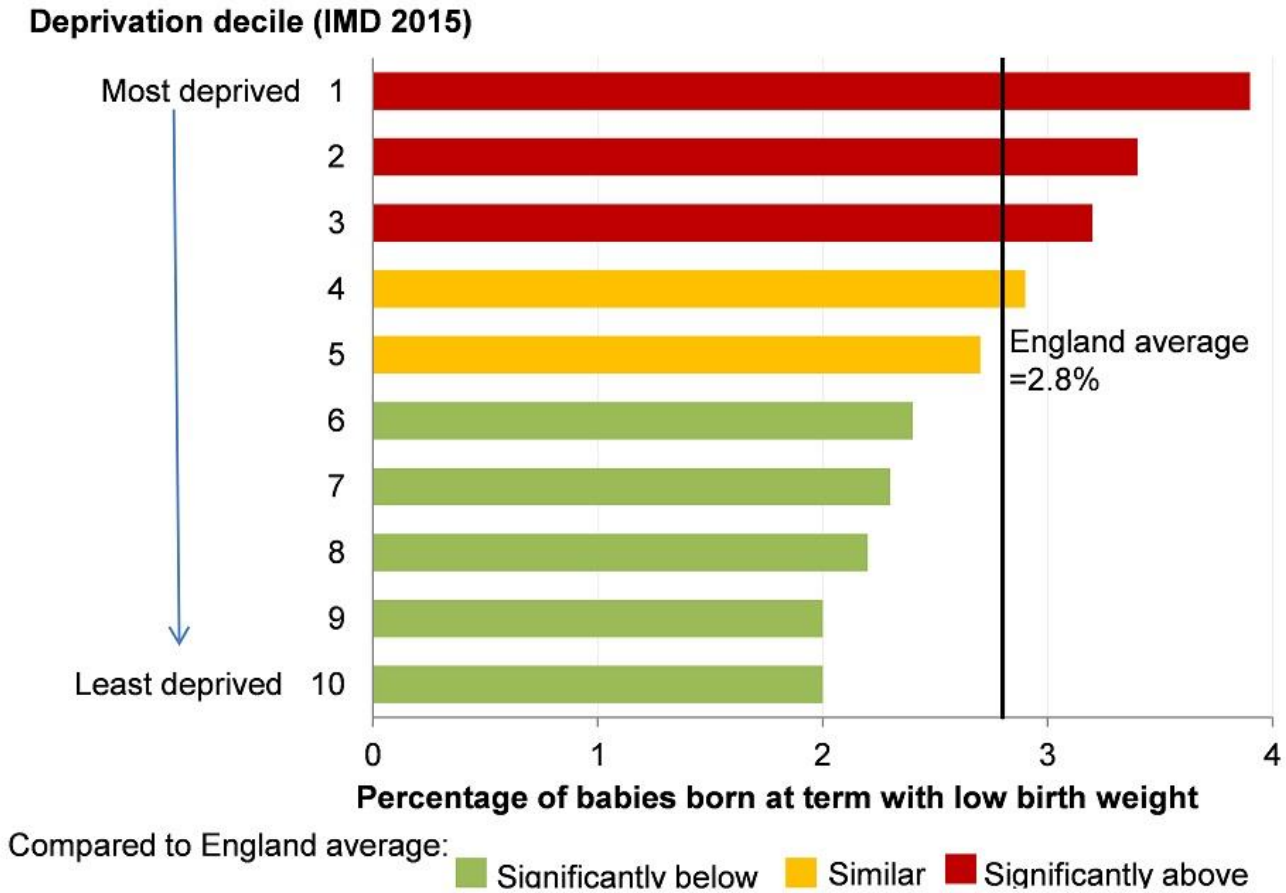
Risk Stratification

- The goal of risk stratification is to segment patients into distinct groups of similar complexity and care needs
- Risk stratification enables providers to identify the right level of care and services for distinct subgroups of patients
- At the individual level, a patient's risk category is the first step towards planning, developing, and implementing a personalised care plan



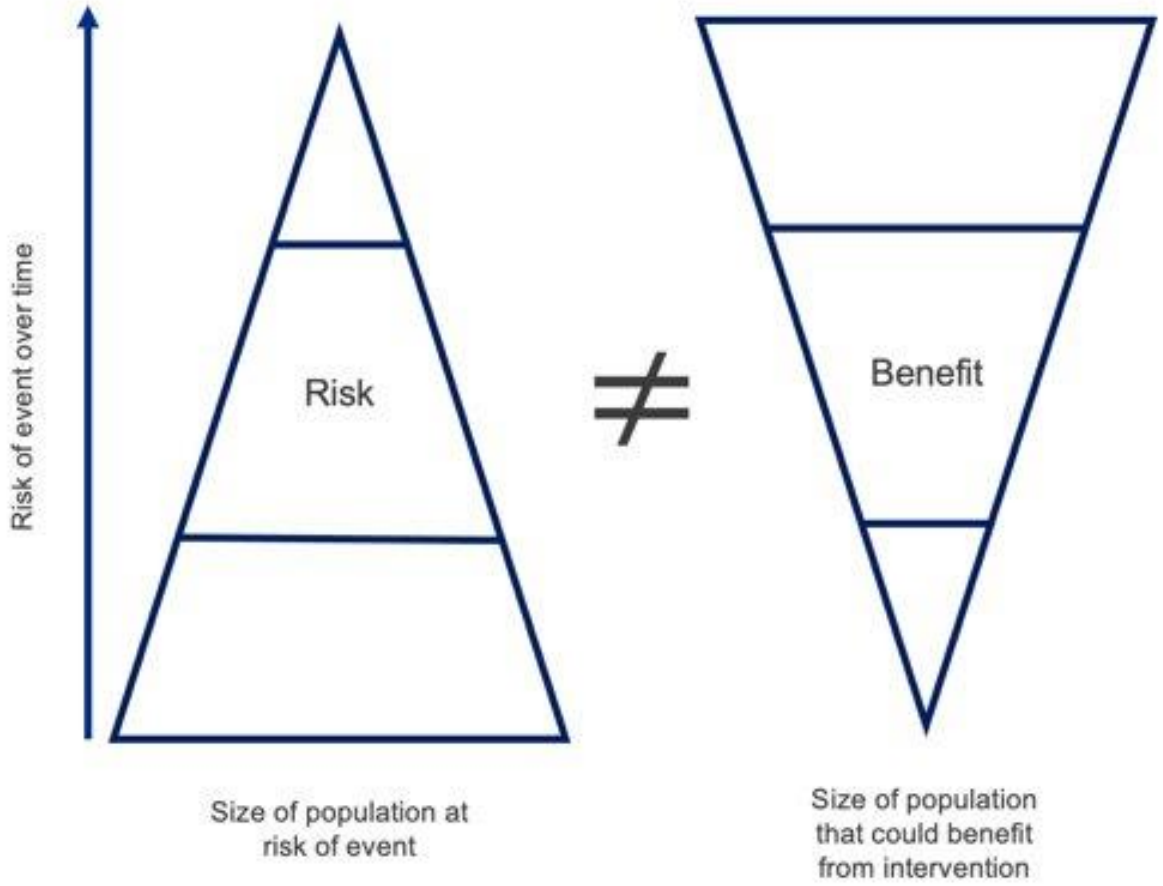
Sometimes We Talk A Lot and Say Very Little

- Deprivation is routinely discussed as a factor in poor health outcomes
- Summary statistics and predictive modelling will consistently show how people living in the most deprived areas are more likely to be ill and die earlier than people living in the most affluent areas
- But is this helpful?

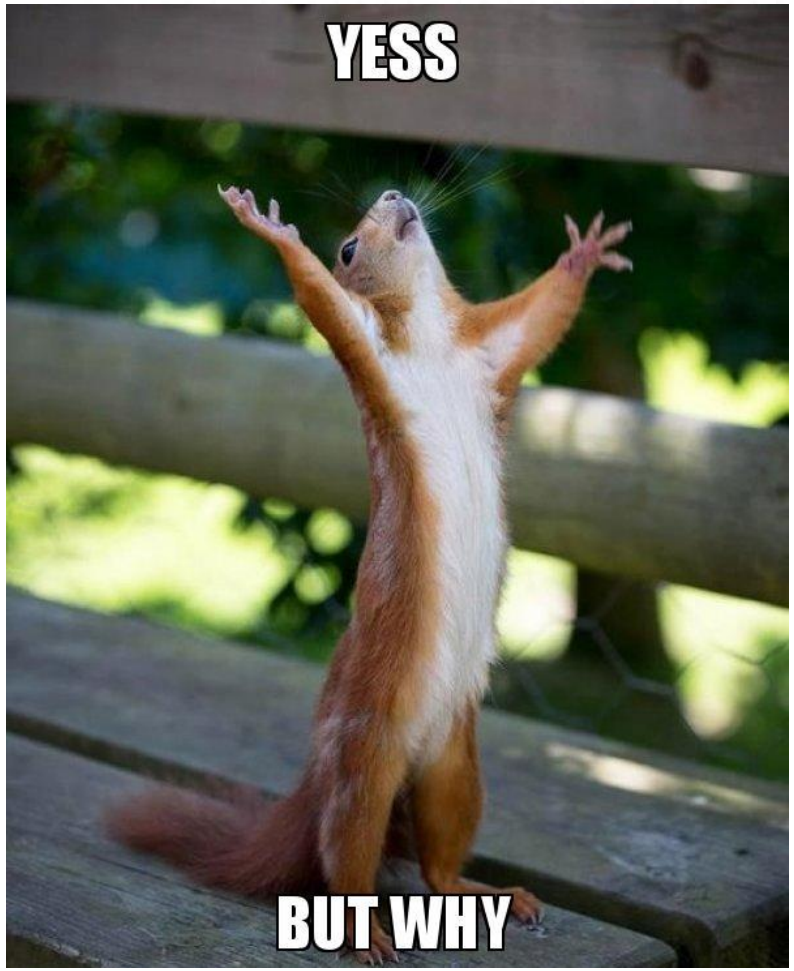


Sometimes We Look at Our Maths Upside Down

- Instinct: to put a lot of resources towards the patients at highest risk
- Practice shows this doesn't work, as that's not always where the opportunity to make a difference is
- What's the missing piece of the puzzle?



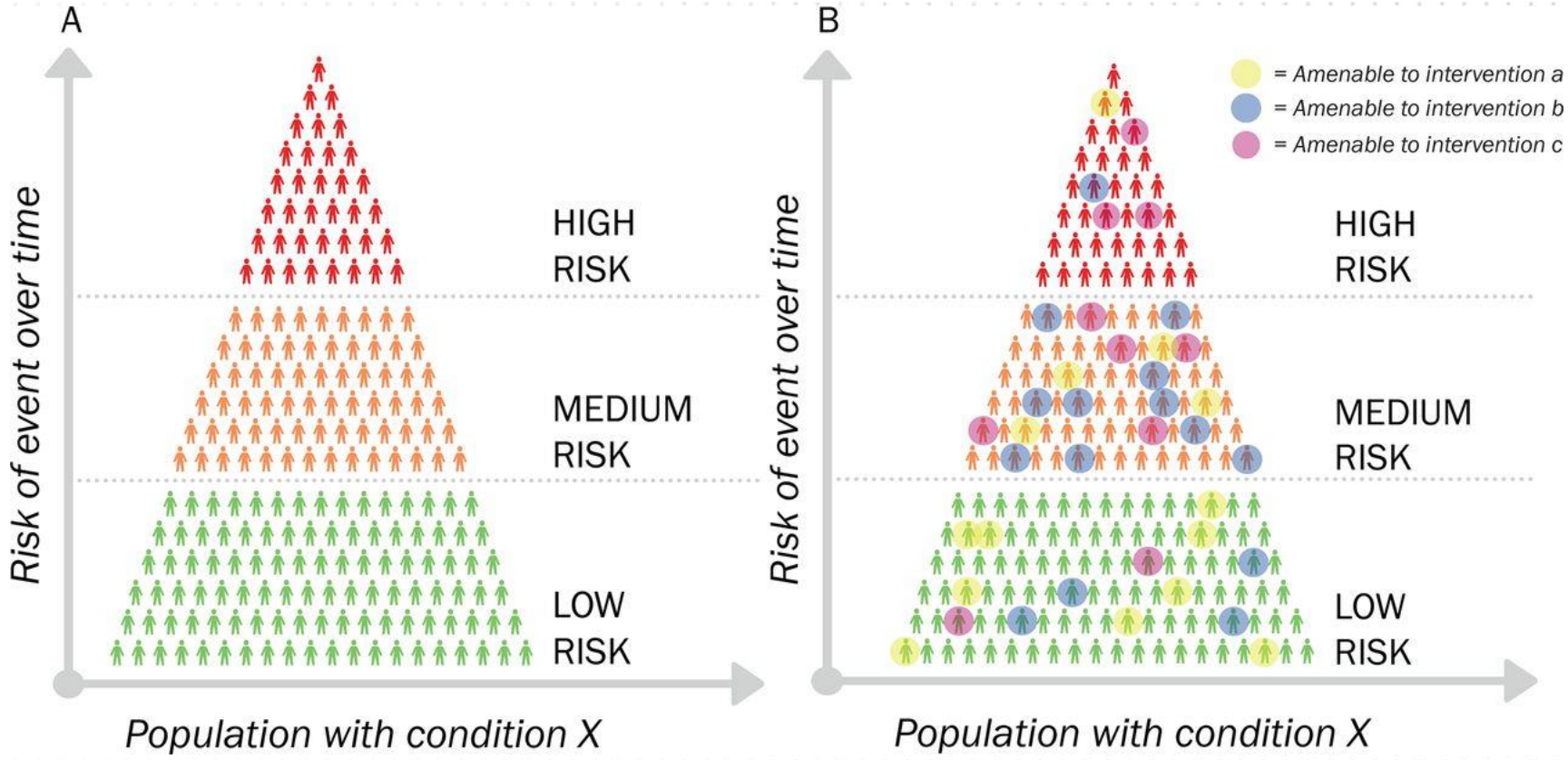
Why Does This Not Work?



- My job as an analyst is job is to improve decision quality
- Many times I have seen analysis not translating into action
- Admittedly, our analyses are not always adequate
- What is on the horizon?

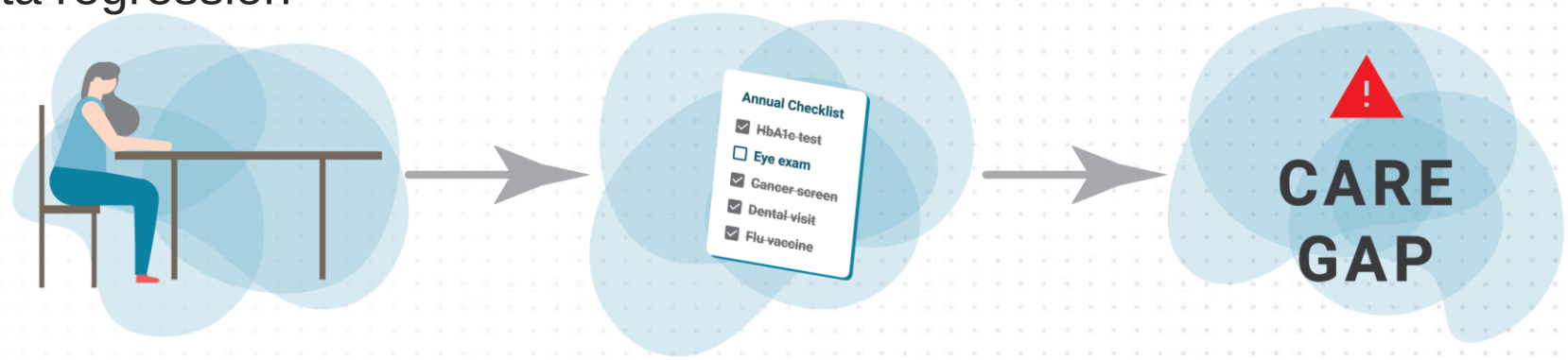
Impactibility Modelling - Definitions

- Impactibility is the likelihood that a patient will respond to an intervention and be willing to take part
- Impactibility analysis is a method of evaluating health interventions by measuring patients' responsiveness to said interventions

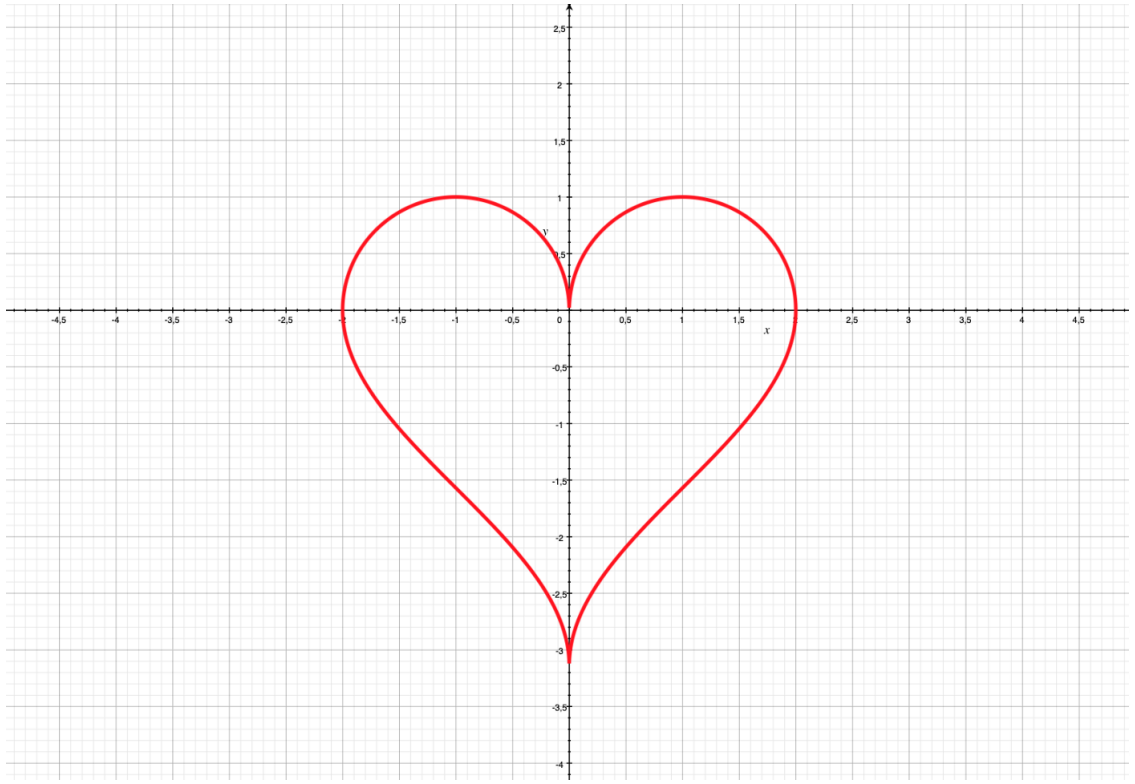


Impactibility Modelling Techniques

- Approaches to impactibility modelling include:
  - Health conditions amenable to preventive care
  - Health needs/gap analysis
  - Behavioural response models
  - Propensity to succeed models
  - Mediation analysis
  - Panel data regression



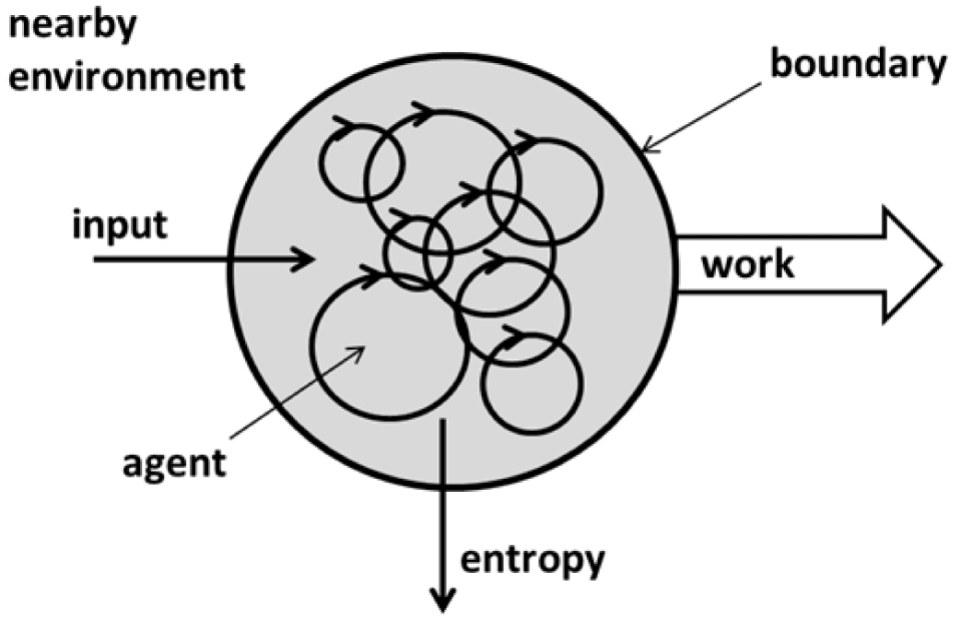
Are We There Yet?



- Sometimes, however, we have seen great analysis still not resulting in change
- Human behaviour is complicated

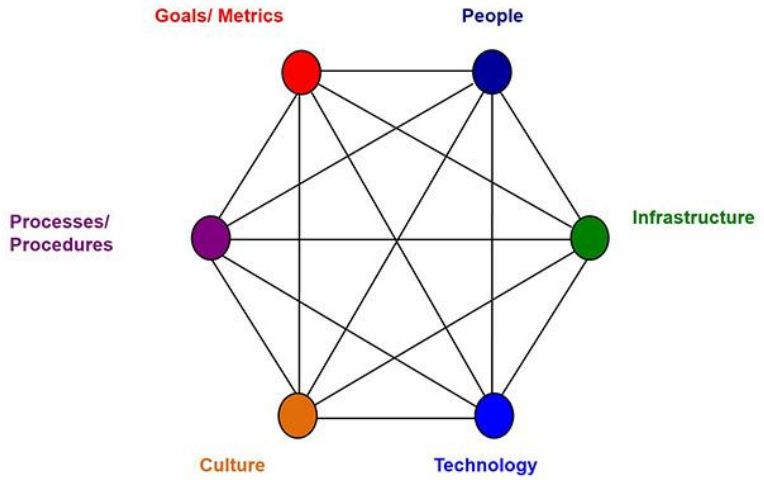
Complex Adaptive System

- The health and social care system is big and complex, with too many components to model precisely and dynamic non-linear interactions
- A lot of history, which influences our beliefs, behaviours, and choices
- The system components take relatively simple actions with partial knowledge of their consequences
- Different parts of the system have vastly different ability to adapt to change



Sociotechnical Approach

- Recognise unexpected behaviours will arise when parts of the system interact with new technologies
- Predicting the outcome of actions is challenging
- Reaching organizational objectives is not in the hands of any part of the system



Problem Structuring and Decision Conferences

- Decision conferencing is a way of “helping a group of key players to resolve important issues in their organization by working together, under the guidance of an impartial facilitator”
  - Rely on impartial facilitation
  - Evidence-driven when appropriate
- Problem structuring
  - Define the problem and scope
  - Define the key players
  - Define how the process will be taken forward following the project

I Hope You Enjoyed This Session

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UP NEXT...

ZIO®

BY iRHYTHM

THE NHS PATIENT FLOW CONFERENCE 2023

SPEAKING NOW

David Thorne

Director
Well Up North PCN

I will be discussing…

"The Importance of Technology and Processes Reducing Urgent Care in Cardiology - How Devices like Zio could help"

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SPEAKING NOW

Ruth Williams

Head of Intermediate Care
Sandwell Place

I will be discussing…

"Acute Hospital Care in the Front Room"

PATIENTS PEOPLE POPULATION

Sandwell Metropolitan Borough Council

NHS Sandwell and West Birmingham NHS Trust

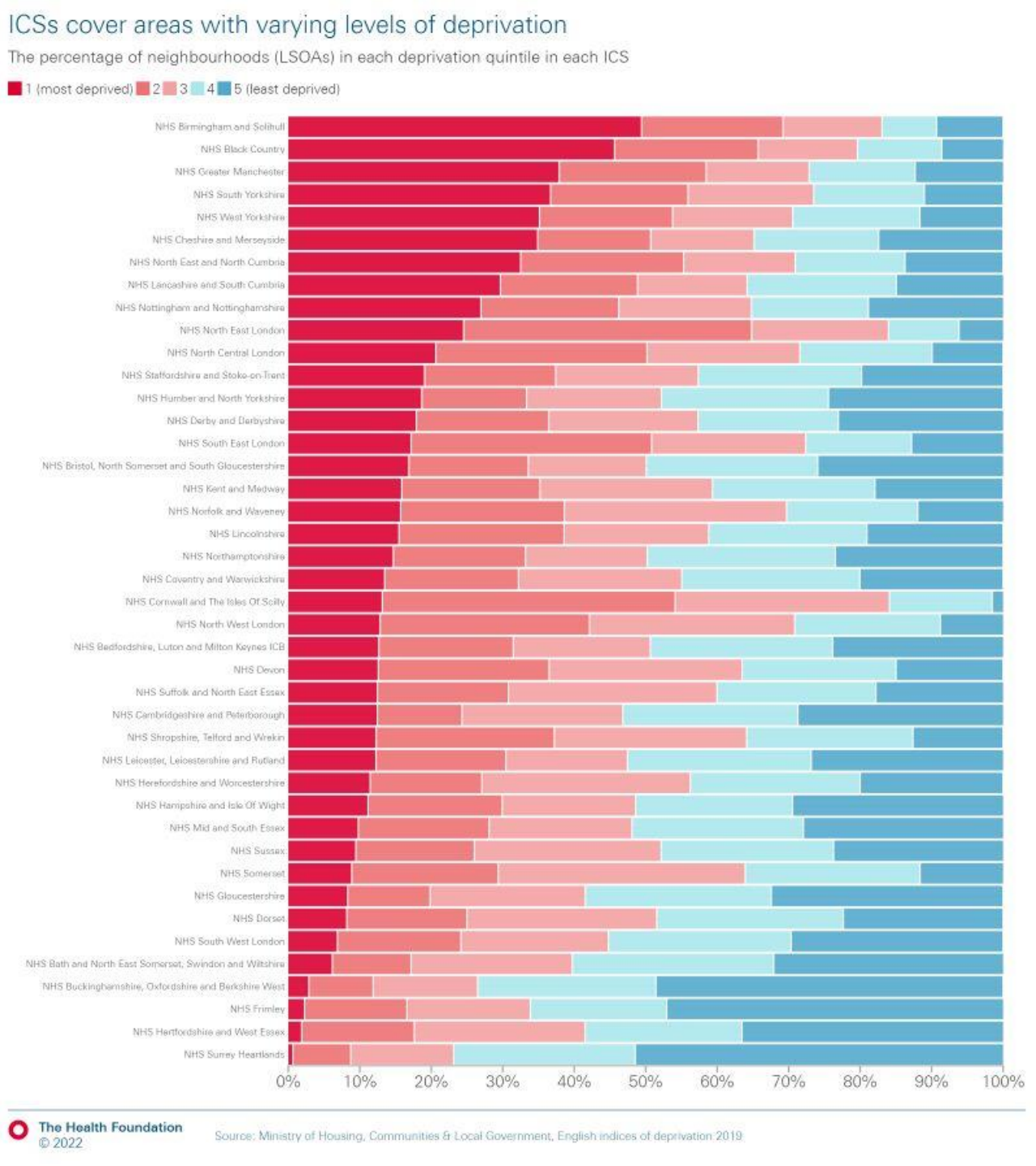
Acute Medicine in the Front Room

Ruth Williams, Head of Intermediate Care,
Sandwell Place

on behalf of

Dr Sarb Clare, Deputy Medical Director, SWBT
Integrated Care Services, SWBT
Sandwell Metropolitan Borough Council

Sandwell and West Birmingham NHS Trust



Mrs Kaur has had a fall

She presses her pendant alarm & speaks to Louise in Community Alarms

Louise talks to her and sends out Zee from the UCR 2 Falls team

Mrs Kaur's son arrives & reports she is not her usual self

No red flags so Mrs Kaur is assisted into her chair

Zee calls the Care Navigation Centre & talks to Dena an ACP

Dena triages the call and allocates for a UCR2 visit

ACP Mel arrives within 2 hours (2 hours 45 mins max time from fall)

Assessment

PATIENTS PEOPLE POPULATION

UCR2 Assessment

NHS Sandwell and West Birmingham NHS Trust

Mrs Kaur has capacity and wants to stay at home in her bungalow.

Usually formal carers 2 x 1, walks with a frame, no other adaptive equipment. Family live in same town and work full time.

Now unable to stand and walk, incontinent, not orientated, feels very fatigued

PMH: HTN
CKD3
HFePEF (BNP 1300+ 2021, recent 2/2/23 is 474)
PAF
MR
ILD
Falls

History of Presenting Complaint Both legs have been swelling in last few weeks despite taking furosemide 20mg x OD, more SOB than usual

Vital Signs
BP 160/96, P 72, RR 22,
Temp 35.6,
SPo2 99% on air

Admit via SPA?

Step Up?

Stay at Home?


Paramedic

PATIENTS PEOPLE POPULATION

Epicentre Hospital at Home

NHS Sandwell and West Birmingham NHS Trust

Mel, ACP, contacts Community Heart Failure Team who advise they are concerned about starting diuretic treatment with current renal function.
Mel contacts Dr Hagir in Epicentre for advice. Hospital at Home visit arranged with Acute Medicine Registrar and Community Nurse from UCR team.

POCT Bloods:

POCUS:

Assessment Findings: Treat as CCF (mild decompensation as not grossly SOB) / some element of ILD contributing too. AKI on CKD3

Plan:
Patient explained risk/benefits of treatment at home including can die.
Arrange for scales at home via Virtual Ward
Fluid restrict as currently doing 1-1.5 lit/day max
IV canula inserted & IV furosemide 50mg x stat given ……..

PATIENTS PEOPLE POPULATION

Wrap around offer

- Equipment from Joint Equipment Stores
- 72 hour wrap via Integrated Discharge Hub
- Virtual Ward monitoring including scales
- Reablement short term care package at end of 72 hour wrap
- Own Bed Instead rehabilitation to prevent deconditioning
- GP to start end of life planning
- Epicentre follow up visits and further IV diuretics as indicated over next 72 hours

NHS Sandwell and West Birmingham NHS Trust

Sandwell Metropolitan Borough Council

PATIENTS PEOPLE POPULATION

Epicentre Impact

Referrals Oct 22 – Jan 23	Step Down referrals	Av. Length of Stay (days)	Face to face contacts	Readmissions Oct 22 – Jan 23
85	17%	6	90%	9 (12.5%)

You listened to me

So relieved I didn't have to go into hospital

Cant believe I saw a doctor and got all that care within 2 hours of me pressing my alarm

Acute Medicine and Patient Flow

- We navigate the system not the patient
- Do what's right with the patient
- Track all the data
- Relentless focus on communication and proving the concept

Thank You and Further Information

Dr Sarb Clare, Deputy Medical Director, SWBT
@AcutemedSarbC

Integrated Care Services, SWBT
@icares_SWBH

Integrated Discharge Hub, SWBT,
@iDH_swb

Sandwell Metropolitan Borough Council

Professor Dan Lasserson, Warwick Medical School
@DanLasserson

Dr Tom Knight, PHD Student, Hospital at Home
@twh_knight

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SPEAKING NOW

Mrs Victoria Cardona

Head of Patient Flow Services
North Tees & Hartlepool NHS Trust

Mrs Vivienne Priestley

Service Lead Urgent & Emergency Care
North Tees & Hartlepool NHS Trust

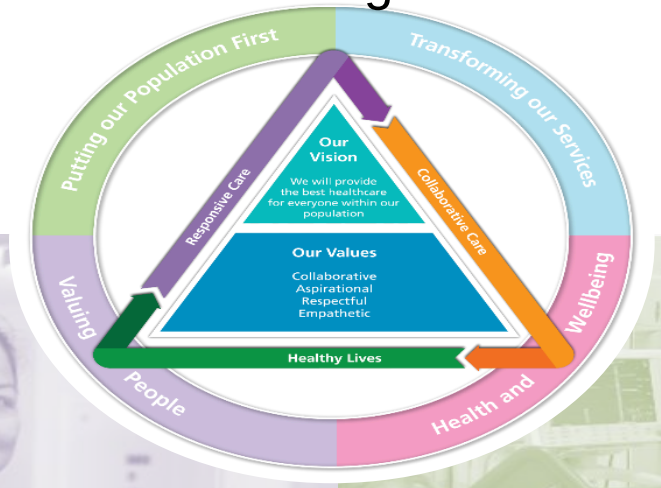
We will discuss…

"Integrated Coordination Centre - Improving Patient Flow and Discharge: A North Tees and Hartlepool Perspective"

Integrated Coordination Centre
“Improving Patient Flow and Discharge: A North Tees and Hartlepool Perspective”

Victoria Cardona - Head of Patient Flow Services

Vivienne Priestley - Urgent & Emergency Care Operational Manager



North Tees and Hartlepool NHS Foundation Trust

Covers a population of approximately 400,000 across Stockton, Hartlepool and parts of County Durham
The Trust employs around 5,700 staff across the Trust

2 main hospitals in Stockton and Hartlepool

545 Beds (G&A-483)

Cover 3 Local Authorities

The area is one of the most deprived in the country – amongst the worst for high levels of obesity, smoking and lack of physical inactivity. The Trust is committed working with local partners to tackling health inequalities in the community and, in doing so, helping reduce pressures on front of house health services. Close to half of our catchment population live in the 20% most deprived communities as defined by the index of multiple deprivation (IMD).

Focus for today:

- The implementation of an **Integrated Coordination Centre** and how this has supported prediction, planning and responding appropriately to patient flow
- How North Tees and Hartlepool optimise patient flow through a process of continuous dynamic interaction supported by **live up to date information** available to support decision making
- **Leadership** and “Command” Structure
- How teams work together from both acute and community, how **positive relationships** support patient flow.

Integrated Coordination Centre (ICC) – Our ICC brings together :

The Patient Flow Team (Bed Mangers/Site Managers) & the Discharge Team including a Discharged Transport Scheduler.

Our aim is that this integration brings about the biggest reward in regards to flow. In addition, we use our electronic systems to support this decision-making at the earliest opportunity to maximise our capacity and demand response.

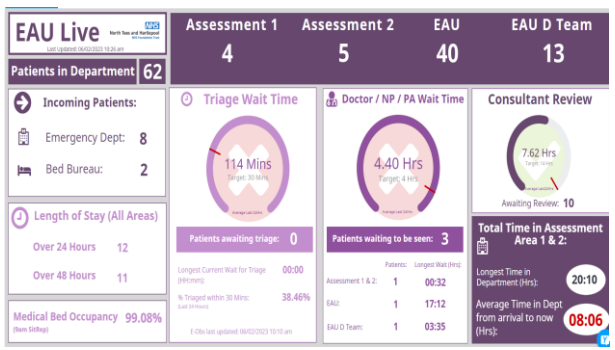
Visual Management in the Integrated Coordination Centre

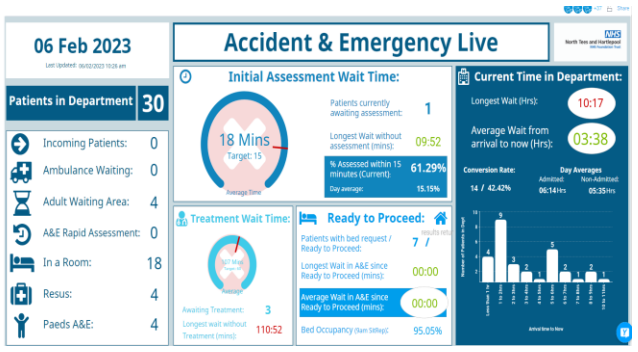
Visual management is an approach that communicates important information to those that need it in a visual and immediate manner.

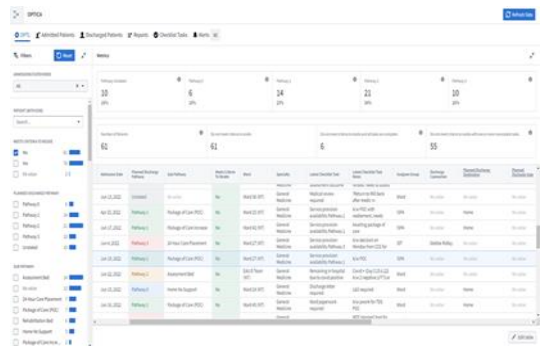
There are a number of systems we have to support all of which have associated action and escalation processes:

- Ambulance stack
- EPR
- Yellowfin BI
- OPTICA Discharge Tracker

This empowers the team to make specific patient-level plans based on 'live' rather than historic data.





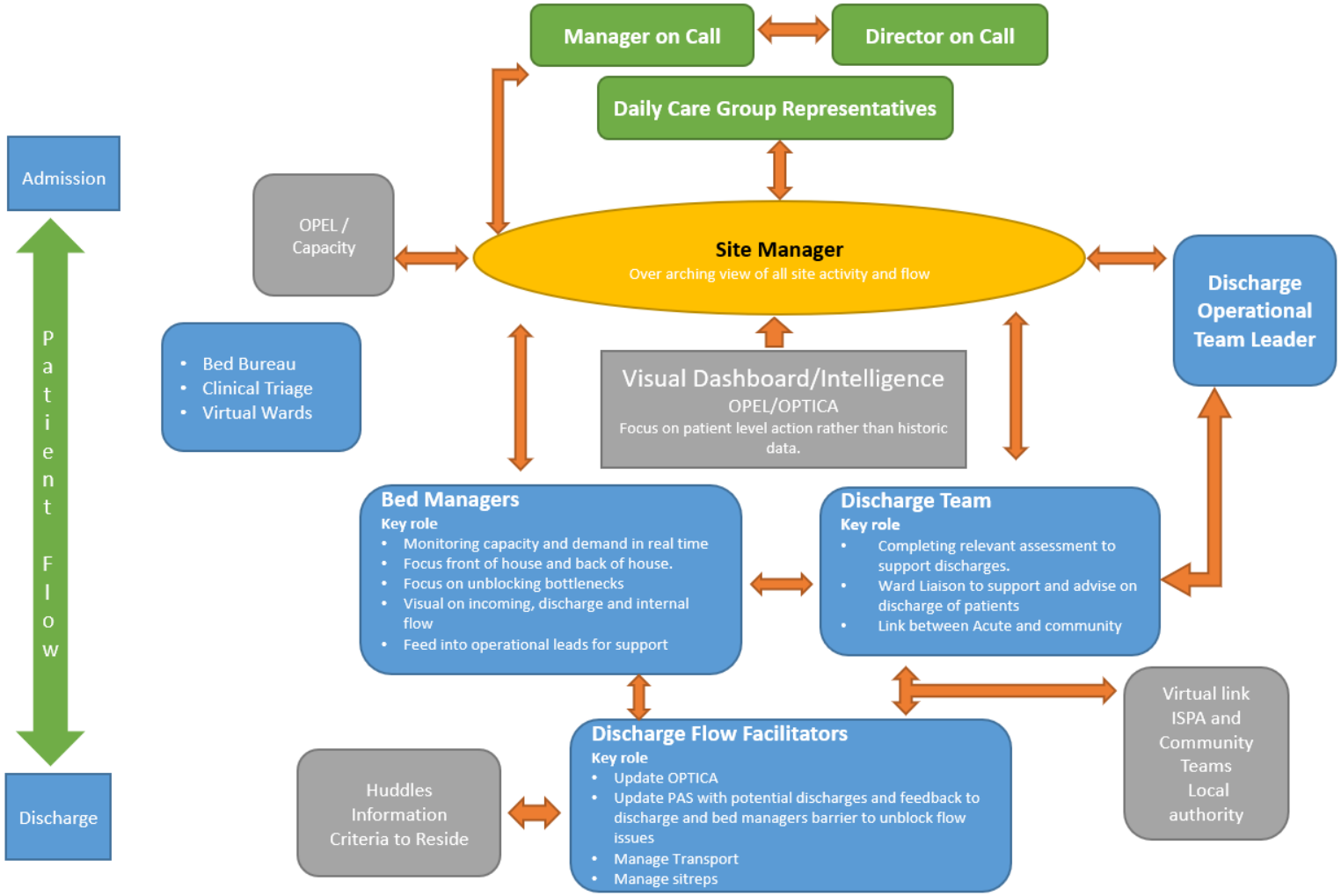


Leadership 'Command' Structure

- NTH have a leadership command structure with **designated communication channels** in place to enable efficient management and appropriate escalation of patient flow and discharge
- The Clinical Site Manager is responsible for operationally managing flow 24/7. They play a key leadership role working alongside the Discharge Team and Bed Managers within the Integrated Coordination Centre (ICC), and have an overarching view of the Trust's position regarding all site activity and flow.
- A designated Operational Lead from each of the 3 care groups provides support (Monday-Friday) to the Site Manager in unblocking beds, speeding up potential discharges and resolving challenges across the Trust from there speciality areas. There is a Manager on Call (Band 8b-8c) and Director of Call (Band 8d and above) available every day for escalation.

Integrated Coordination Centre: Team Structure

Figure 1 details the overall structure of the Integrated Coordination Centre, including leadership and operational elements, communication and escalation routes, meetings, and decision-making points.



Relationships

- Collaborative working relationships, underpinned by trust, open communication and respect are important for sustaining NTHs discharge performance. We place great emphasis on developing theses relationships with all key stakeholders
- Having all parties working together achieving the same end goal
- Built on the relationships developed during the COVID pandemic
- This is especially crucial when developing community services together

Community Services

We have been developing integrated community services in the Tees Valley for many years now. We have well established multidisciplinary teams who can provide safe and effective care without transporting a patient to hospital. We recognise that hospital is not an ideal environment for frail patients with multiple comorbidities, and aim to keep these patients in their normal place of residence whilst wrapping care and support around them.

The Trust has been working in collaboration with our colleagues in primary care, the GP federation and social care, as well as local secondary care trusts to develop new pathways of care: our vision is to ensure that every patient is offered the right care in the right place at the right time (virtual wards)

This means providing excellent quality care in patients own homes/care homes where this is appropriate, and ensuring that patients are only in hospital when that is the right place for them to be (2H UCR)

This requires a system wide approach, with equal focus being given to pre hospital, and alternatives to admission as much as flow at the front of house and discharge planning.

Schemes

- Co-located Urgent Care
- Established alternative pathways into hospital other than just ED
- Integrated Acute and Community Services
- ISPA 24/7 with clinical Triage
- Virtual Wards
- Ambulance Stack

North Tees and Hartlepool performance

NTH are well regarded for their continual positive patient flow performance despite a very difficult few years

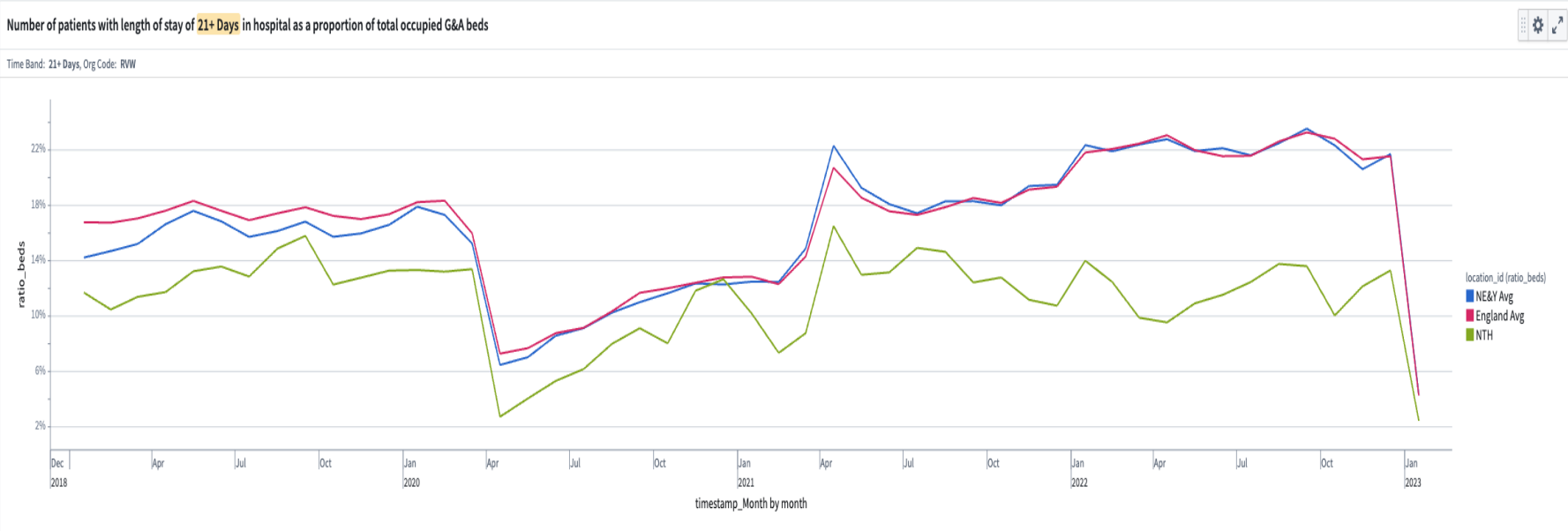
January 2023:

- Stranded Patients Occupied Beds (Avg) – performance is good.

> 7 days	41.28%
> 14 days	19.41%
> 21 days	10.79%

- Our current performance against the A&E four standard is within the top 5 of trusts nationally at 81.9 %
- Performance against average length of stay has seen a reduction from 3.5 days to 2.5 days. The average length of stay for patients not from our locality is 6 days
- We maintain elective activity and rarely P1 and P2 cancel elective procedures making full use of our University Hospital of Hartlepool capacity.

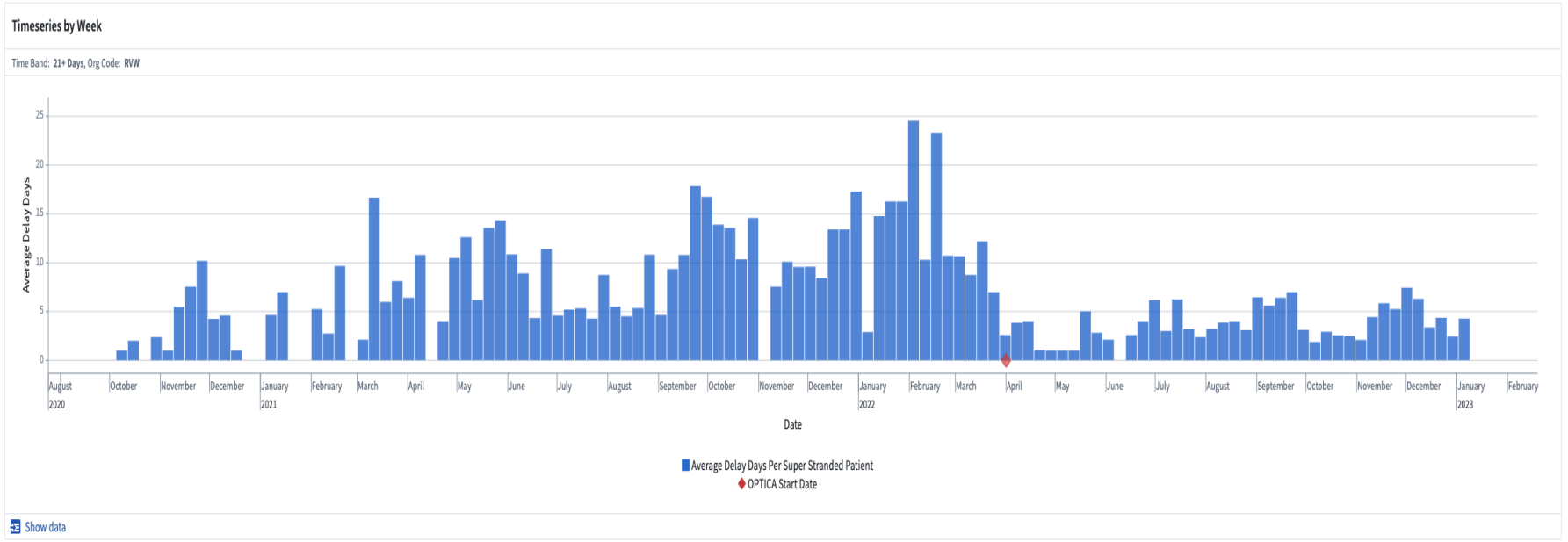
Length of Stay (21+)



The proportion of beds occupied by patients with length of stay of 21 or more days has stayed constant (˜10%) in average since the introduction of OPTICA and ICC in April 2022 while both ICS and England average numbers have increased (˜+4%).
21+ medically fit patients in NTH occupy **50% fewer beds** compared to the national and regional averages.

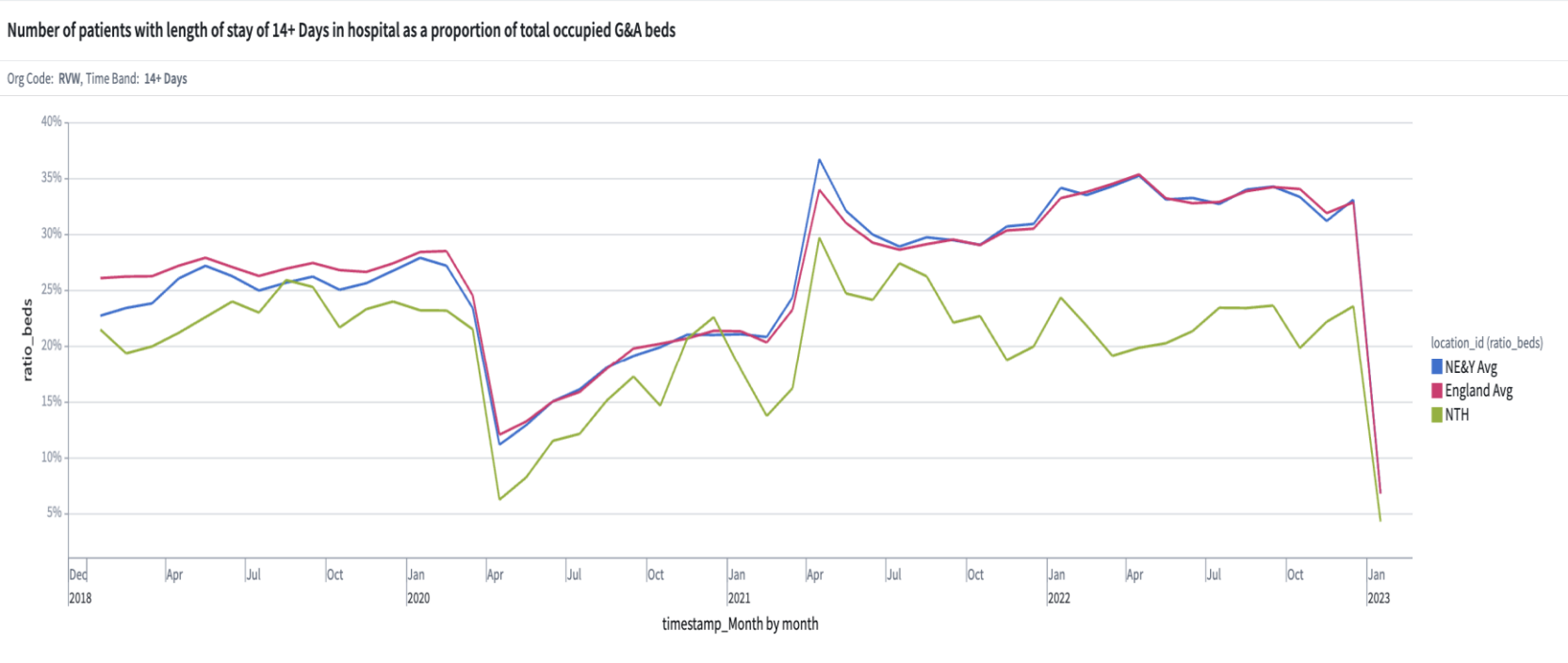
Length of Stay (21+): delay days

II. Of the total number of people who have a length of stay of 21+ Days and who have been assessed as not meeting the criteria to reside, the average number of additional days in total they have remained in hospital since not meeting the criteria to reside decision was made per person.



- The number of delays days for medically-optimized patients with length of stay of 21 or more days has significantly decreased since OPTICA ICC went live date. Number of delay days was kept under control in 2022 compared to the previous year despite a x3 increase in number of delayed patients

Length of Stay (14+)



The proportion of beds occupied by patients with length of stay of 14 or more days has stayed constant (˜20%) in average since OPTICA/ICC was fully implemented in April 2022 while both ICS and England average numbers have increased (˜+5% from 30 to 35%). 14+ medically fit patients in NTH occupy **43% fewer beds** compared to the national and regional averages.

home FIRST

NHS
North Tees and Hartlepool
NHS Foundation Trust

Is your patient ready for discharge?

Don't delay - Consider the Discharge or Transport Hub **now**.

Each discharge can help up to **five** patients.

Request a patient movement on TrakCare or ext. 46355 as soon as your patient is ready to leave hospital.


Any Questions?

Contacts

vivienne.priestley@nhs.net

victoria.cardona@nhs.net

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Q&A PANEL

David Sgorbati

Chief Analyst
Health Economics Unit

David Thorne

Director
Well Up North PCN

Ruth Williams

Head of Intermediate Care
Sandwell Place

Miss Victoria Cardona

Head of Patient Flow Services
North Tees & Hartlepool NHS Trust

Mrs Vivienne Priestley

Service Lead Urgent & Emergency Care
North Tees & Hartlepool NHS Trust

THANKS FOR ATTENDING

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