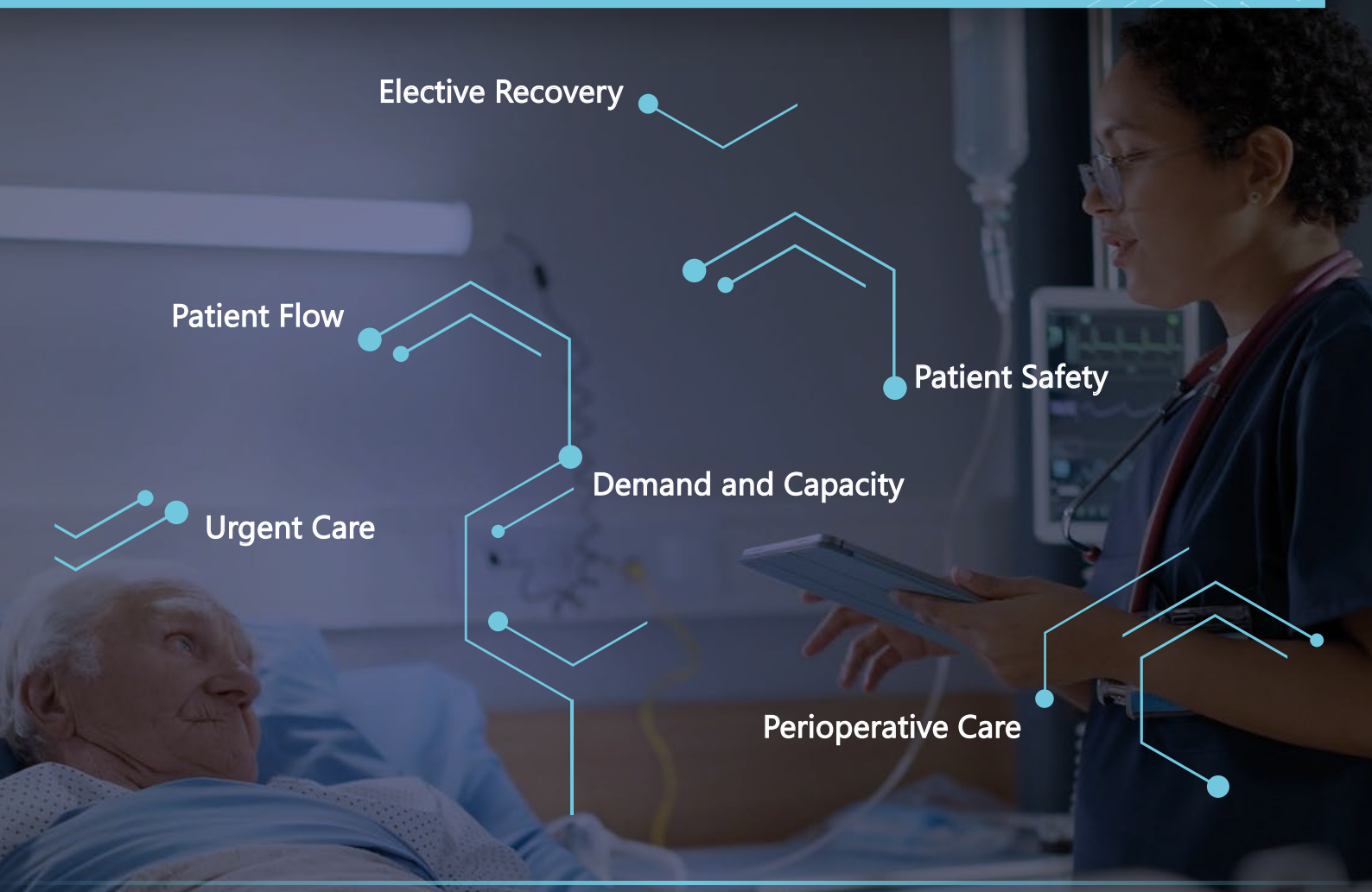
vitalhub
United Kingdom

Patient Flow Transformation 2023

Patient Flow Transformation 2023 Report



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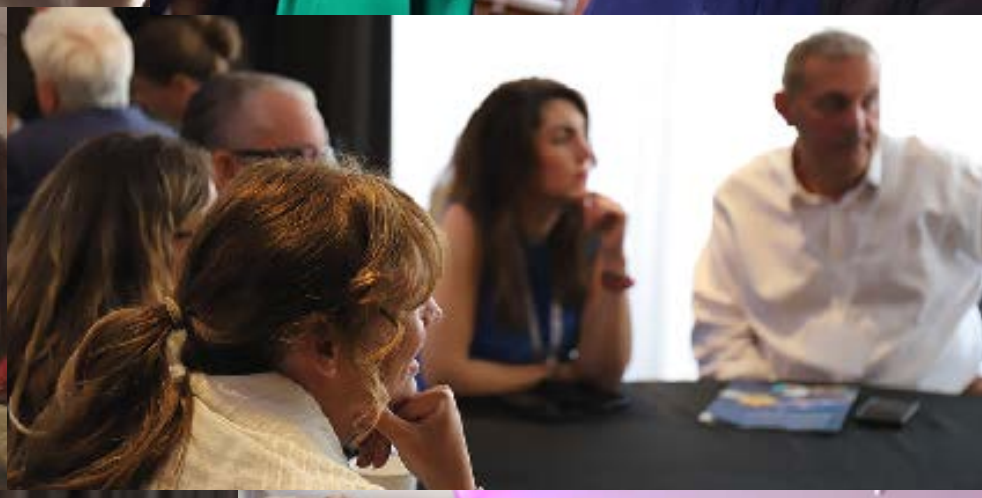



Empowering Patients
Through Technology
vitalhub
Patient Flow
Transformation
2023

Welcome

On July 18th, VitalHub UK hosted its annual Patient Flow Transformation 2023 (PFT23) event at County Hall, in the heart of London.Overlooking the Parliament of Westminster, St Thomas' Hospital and the London Eye, this year's PFT23 event sought to take centre stage in the UK healthcare conversation. With an outstanding 23 leading NHS speakers, all at the forefront of healthcare decision making, innovation and problem solving, PFT 2023 was curated by our team to break down barriers on difficult topics, explore complex problems, and evaluate digital solutions for the most salient issues in healthcare.

Speakers included directors of service from NHS England, King's College Hospital, NHS Kent & Medway, Hampshire Isle of Wight, Cardiff & Vale, Buckingham and Dorset, to name a few.

Kick-starting the day, renowned motivational speaker Gavin Oattes presented a brilliant opening session to set the tone for a day of proactive problem solving and forward-thinking discussion, with attendees primed for an agenda that included 6 breakout sessions, in which partners, delegates and VitalHub UK representatives could explore challenges and solutions on numerous pertinent healthcare topics.

The day was interactive, informative, and collaborative and included not one, but two, live command centres showing the real-world workings of whole system visibility solutions. SHREWD and Beautiful Information products were on show in a live pop-up System Control Centre demonstrated by the tactical command team from Kent and Medway, and separately we had Visionable's Ambulance Control Centre solution in another room.

Presentations throughout the day covered topics from ambulance handover delays, managing and reducing waitlists, reimagining Elective Care Hubs, improving discharge processes and what the healthcare sector can do to empower patients. Engagement at the Q&A of each presentation, managed through the online platform SLIDO, showed the event tapped into the pulse of the sector's concerns, with delegate interaction garnering 10-15 questions for most sessions. Conversations were expanded on in the roundtable sessions, in which delegates and industry leaders could map through the issues of the day and forge new ideas in an environment designed to foster expansive thinking. These were concluded with the reveal of our ConfedExpo Interactive Wall insights, which sealed the session as a huge success.

23 Leading NHS Speakers

Of attendees surveyed, **100%** would recommend the event

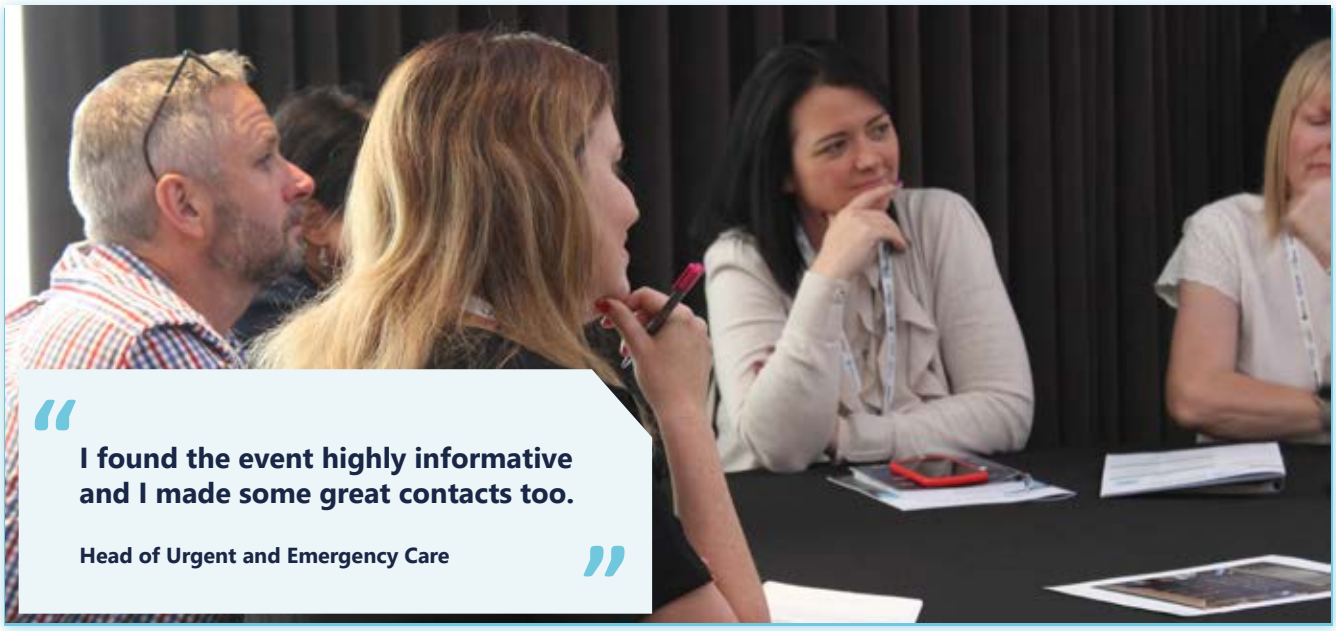
100% of attendees surveyed said they would attend next year

Delegates from over **57** NHS Organisations

Roundtable Hosts

- **Helen Lancaster**
  Dir. of System Transformation,
  Coventry and Warwickshire
  ICB
- **Richard Samuel**
  Prog. Director Outpatients
  Recovery and Transformation,
  NHS England
- **Martin Riley**
  Managing Director,
  Medway Community Healthcare
- **Jonathan Lofthouse**
  Site Chief Executive,
  Princess Royal University Hospital
  and South Sites. King's College
  Hospital NHS Foundation Trust
- **Dave Ashford**
  Regional Head of UEC,
  NHS Midlands
- **Paul Cleeland-Smith**
  Head of UEC Operations
  NHS England, East of England
- **Paul Vinters**
  Snr UEC Operations Manager,
  NHS England
- **Professor Matthew Cooke**
  Chairman,
  Opto Health
- **Dr Marc Farr**
  Chief Analytical Officer,
  East Kent Hospitals
  NHS Foundation Trust
- **Jonathan Wright**
  Head of Patient Access,
  University Hospitals Dorset
  NHS Foundation Trust
- **Pete Gordon**
  Head of Elective & Emergency
  Care Improvement,
  NHS England
- **Jacqui Sarakbi**
  Director of Urgent &
  Emergency Care,
  NHS Kent and Medway
- **Jaz Dhaliwal**
  Lead Partner, Digital Health
  KPMG
- **Lisa Riley**
  Deputy CEO, VP of Strategy & Sales
  VitalHub UK
- **Stuart Jeffery**
  Management Consultant,
  The Cernunnos Centre

Roundtable Session Review



As part of our interactive and collaborative approach to our event this year, we introduced a roundtable session, inviting delegates and industry leaders to come together to break down barriers on difficult topics, explore complex problems, and evaluate digital solutions for the most salient issues in healthcare.

Breakout sessions throughout the day covered topics from ambulance handover delays and reducing waitlists to improving discharge processes and what the healthcare sector can do to empower patients.

Conversations were expanded on in the roundtable sessions, in which delegates and industry leaders were able to map through the issues of the day and forge new ideas in an environment designed to foster expansive thinking.

We asked attendees to centre their discussions around the barriers to effective patient flow within the healthcare system, with several key challenges being identified, including data access and transparency, siloed working, and a lack of coordination across different healthcare departments. Additionally, the need for a patient-centred approach and better integration of technology to improve patient flow were highlighted.

Roundtable Outcomes - Key Challenges to Effective Patient Flow

Below is a round-up of some of these key challenges along with recommendations made by attendees:

Data Access and Transparency:

A major issue hindering patient flow is the lack of seamless access to patient data across various healthcare providers and departments. The absence of transparent and easily accessible data makes it difficult for healthcare professionals to make informed decisions and optimise patient flow.

Recommendations:
• Implement centralised and interoperable data systems to enable real-time access to patient information.
• Develop standardised protocols for sharing data between different healthcare entities.

Siloed Working and Lack of Coordination:

The attendees emphasised the significance of breaking down silos and promoting collaboration among health-care teams and organisations. Siloed working leads to inconsistent treatment approaches and delays in patient care.

Recommendations:
• Foster a culture of collaboration and teamwork to improve communication and coordination among healthcare providers.
• Encourage the sharing of best practices and treatment protocols across departments.

Inefficient Use of Capacity and Resources:

Limited capacity in intermediate care facilities and inadequate use of available resources can impede patient flow. The leaders stressed the importance of optimising room capacity and utilising resources more effectively.

Recommendations:
• implement capacity management strategies to ensure rooms and resources are utilised optimally.
• Explore the potential for a more fluid work-force not restricted by budgets, allowing professionals to work in multiple settings.

Breakout Sessions / Q&A Responses

Breakout - Improving Ambulance Handover Delays

Paul Cleeland-Smith
Head of UEC Operations,
NHS England

Paul is regional Head of UEC Operations for the East of England and is passionate about patient care and developing innovative and integrated UEC services. Commencing his NHS career in 1994 working for Surrey Ambulance Service, he's held a variety of roles within the NHS Ambulance Service, including clinical, educational and managerial roles. Paul is a State Registered Paramedic and maintains clinical practice. He has also held roles managing NHS 111, Out-of-Hours, treatment centres, paediatric retrieval services, and the medical services at large public events.

Paul Vinters
Snr UEC Operations Manager,
NHS England

Paul Vinters is a motivated healthcare leader with 12 years of NHS Operational leadership. He is skilled in driving performance and motivating teams to achieve results. Paul has a proven track record of success in fast-paced environments and has demonstrated emotional intelligence and effective communication skills. Presently, as the Senior Urgent Emergency Care Operations Manager at NHS England - National Integrated Urgent Care team, Paul adeptly manages operational demands, collaborating closely with internal and external stakeholders to accomplish strategic objectives while prioritising patient experience and safety.

Q&A with Paul Vinters

How do you encourage providers to load balance risk?

PV "Visibility of metrics throughout the whole region amongst ICBs provided the best encouragement for this to occur. Systems would often use it to compare their current position to neighbouring systems."

Did you get push back from anyone about putting in a new system - and why?

PV "The actual sharing of metrics was not widely declined. The biggest issue faced was providers being able to prioritise this amongst other power BI and requests to information and IT teams. There was some resistance to the principle around parity of escalation and actions undertaken. There was also some push back regarding the metrics opted for not aligning to local provider surge and escalation."

Can you share which metrics are used, and which ones have been initially used but ditched due to learning, and why?

PV "ED: OPEL status, patients in resus, patients in majors, wait to be see, average wait time dept, patients with a DTA, attendances rolling 60. Ambulance conveyances, patient arrival to handover delays, total enroute, total at hospital, cohorting # and longest, 999 patients outstanding in community, patients in C2 category outstanding # and longest, resource with response at scene and enroute, outstanding HCP referrals (expected conveyances), # patient arrival to handover delays by 15, 30, 60 min, C1-4 performance – NHS111 metrics. Unable to advise as to those roved as project property remains with East of England Ambulance Service NHS Trust."

Where are the strategic levers in the system? How can we use the predictions to act and prevent escalation, if everything is already at max escalation level?

PV "Predicted conveyances should allow this to happen but behaviourally, at an operational level, it was difficult for people to accept the validity of this information."

Are there plans to develop SHREWD use further at a regional level?

PV "Not at this time."

Is this tool used 24/7, or is this switched on by a decision maker? If so, who makes the decision and how is the decision captured?

PV "Monitored 24/7 by EEAST and embedded within their SOPs. Used by region to review ICB status at a high level."

Why do you think some of the other regions are reluctant to promote intelligent conveyancing? How can NHSE teams differ?

PV "It could be seen as an easy go to option instead of addressing the root cause of patient arrival to handover delays."

How do we track the second order consequences to see if IC is the best option and make intelligent decisions?

PV "Governance around patients who were "displaced" from their local acute were monitored by EEAST. For any of the second order consequences that occurred, it was [relatively] straightforward at an individual patient level to determine if an unintended consequence for specific patients arose from an IC decision. There were plans to develop and map the catchment areas of hospitals to automate this process as East of England had a low proportion of sites that were one-to-many receiving units. This would have taken the requirement for workforce to manually flag displaced patients."

How do you avoid certain organisations becoming net exporters and others importers?

PV "SHREWD did not have the ability to perform this and required other data to be reviewed and tracked for trends and analysis. This was taken forward by a number of ICBs into their planning and subsequently funding considerations. So whilst not necessarily preventing it, it allowed for movement within an ICB to be taken into consideration."

Are there any plans/conversations with surrounding regions especially given, for example, those hospitals on the borders or systems which aren't using SHREWD?

PV "IC was always a within region consideration. It was utilised when informing cross-border support but no plans for movement out of region."

Short-Term Crisis Management vs. Long-Term Planning:

Limited capacity in intermediate care facilities and inadequate use of available resources can impede patient flow. The leaders stressed the importance of optimising room capacity and utilising resources more effectively.

Recommendations:
• implement capacity management strategies to ensure rooms and resources are utilised optimally.
• Explore the potential for a more fluid work-force not restricted by budgets, allowing professionals to work in multiple settings.

Cultural and Behavioural Challenges:

Cultural resistance to change and risk aversion were identified as barriers to effective patient flow. Over-coming these challenges requires clinical champions who are willing to drive change and adapt to new ways of working.

Recommendations:
• Encourage a culture of innovation and continuous improvement in healthcare organisations.
• Foster a learning environment that encourages healthcare professionals to embrace new approaches and technologies.

Conclusion

The insights from the roundtable discussions highlight the critical issues affecting patient flow in healthcare. By addressing these barriers and implementing the recommended strategies, healthcare systems can enhance patient flow, improve resource utilisation, and provide more patient-centred care. Collaboration, data-driven decision-making, and a focus on long-term planning will be instrumental in overcoming these challenges and achieving effective patient flow across the healthcare continuum.

Have you undertaken any analysis on common conveyance to sites not the closest to the patient e.g. section 136 cases

PV "S136 was an contraindication for IC."

Were there any unintended consequences (good or bad)? What were they and how did you manage / mitigate them?

PV "Inter-hospital transfer and inter-ICB discharge delays were two areas that were highlighted by ICBs to be very difficult for ICBs to manage when a patient was imported to them."

What did you learn about the routines and behaviours / ways of working required to make implementation of the system a success?

PV "During the implementation there was a much higher bearing on chief information officers and their teams than operations.
ICBs learnt to utilise the tool within their own surge and escalation processes but equally there was a high need for the ambulance services to own the conveyance of patients and actively ensure they were undertaken when IC was actioned."

Why do you think the adoption of Vantage hasn't had a big impact on performance? Has it helped address any barriers to making improvements?

PV "There were many factors that were directing performance, IC was seen as a action for patient safety."

How did you ensure that Acutes who are willing to take higher internal risk actions, aren't being victims of offloading ambulances quicker?

PV "It was often that such actions would be indicated by the A&E dashboard. There was an ability to mitigate this further operationally through the attendance of ICB representatives from potentially "importing" systems onto systems considering or reviewing IC."

System Control Centre – An Exemplar Site

Jacqui Sarakbi
Director of Urgent & Emergency Care,
NHS Kent & Medway

Jacqui started her career in clinical research and worked for many years in hospitals and universities both within Australia and the UK before joining the NHS. She has held roles within providers; commissioning roles at place, system and regional levels prior to joining the national NHSE UEC team. She recently returned to NHS Kent and Medway to take up her role as Director of Urgent and Emergency Care working across UEC commissioning, transformation and improvement as well as the Kent and Medway Operational Control Centre.

Kevin Cairney
Deputy Director of Operations & Performance, National UEC
NHS England

Kevin is the Deputy Director of Operations & Performance, National UEC, reporting to the National UEC Clinical Director and NHSE DCOO for delivery of Programme 1 within the UEC Recovery Plan 23/24. With 25 years in the NHS, starting as a Nursing Auxiliary and with roles ranging from emergency and critical care, the British Army Joint Medical Group, Head of Nursing for Site Operations at Croydon, and a number of senior manager roles, Kevin joined NHS England in September 2022. As a healthcare leader, Kevin's guiding principle is about finding ways to maximise the 'time to care' for our frontline as by doing so, patients will reap the benefit.

Q&A with Jacqui Sarakbi and Kevin Cairney

Do you track access and outcomes according to people's socio-economic background/ethnicity/disabilities, etc, in your control centres?

KC "The SCC project has completed an EHIA in its project phase to ensure that this is within the scope of the end product. The specification makes clear which BI access the SCC team should have access to when operating shifts or prospective planning.

The SCC, by equalising specifications alongside a standardised OPEL system, will also facilitate transparent operational status between providers within systems. In essence, those hospitals used to operating in socio-economically deprived communities tend to desensitise their OPEL over time. By putting them on the same 'playing field' as those who operate in better resourced areas, there may be the potential for better mutual aid and support."

What's stopping you getting all the missing data from some ICBs

KC "This is more about the objectivity and standardisation of "the ask" rather than being able to get the data."

Can't you just buy SHREWD for the rest of the country - save time!?

KC "We are not able to commit to one vendor but the more homogenous system that meets the digital specification and links to NHSE, the better."

The OPEL status seems to be heavily acute focussed. Huge importance of using this as a whole system and including community services. Has this been considered?

KC "We see emergency care as the end point of a community pathway and so the acute system is the surrogate for system safety and risk mitigation. The OPEL policy is national which means that we would expect systems and providers to adopt the specification or report by exception as why not. We do have a number of other providers actions that we think merits the focus of the SCC and can work with other localised surge policies."

Does the visibility of real-time data at a very senior and minister level lead to reinforcement of reactive knee-jerk behaviours?

KC "No. The first being that we are very rarely able to 'triple click' down to site level focus and intervene. Even then, the new NHS operating protocol means that we would expect ICB to intervene on imminent or emergent safety issues followed by NHSE region. The OPEL framework makes clear the level of escalation from system to region and region to national based on objective parameters that remove most of the human factor (and behaviour). NHSE has also moved into a much more supportive position through PMO, resourcing and transformation. OPEL and SCCs are not designed to performance manage, but the NHS constitution remains. Providers must demonstrate exceptional narrative where there are non-compliant with this or assure NHSE that they have a plan to recover, improve or maintain performance (and therefore patient safety)."

How can we be confident that the visibility of such level of detail by national doesn't lead to systems or acutes being micromanaged by the national team?

KC "The national OPEL framework is clear on the ToR for daily engagement or intervention for systems that are refractory to NHSE regional intervention. "

An ICB and region are more than just acutes, when can we expect other areas to be included?

KC "The OPEL policy works on the knowledge that acute sites (and ambulance Trusts) is where the most pressure is concentrated. By measuring these, we are focusing on surrogate markers of system acuity. This does not mean that systems should not use these local surge protocols and their actions, but NHSE will largely focus on the Acute pathway. NHSE has a vision that in 24/25 we will bring primary care, mental health, community, maternity and CYP into the OPEL umbrella more formally and then in 25/26 we will seek to establish a 'system OPEL' that remains comprehensive without losing comprehensibility."

Empowering Patients Through Technology

Paul Griffiths
Former Head of Delivery, Digital Care Models, NHS England

Paul is a director in a consultancy team specialising in transformation, improvement and leadership development in healthcare. Until June 2023 Paul worked as Head of Delivery for Digital Care Models at NHS England and has more than 20 years of experience in a range of operational, quality improvement, transformation, and senior leadership roles across NHS organisations. Paul has led work that has received national and international recognition and has helped shape national policy for digital transformation in the NHS.

Dr Jane Turton
Associate Specialist, Cardiff and Vale UHB

After training to be a GP and completing an MSc in computer science, Dr Turton returned to hospital medicine and has spent over 25 years in her chosen specialty of geriatric medicine and metabolic bone disease. Dr Turton is active in clinical research in rare bone diseases and the use of AI in medicine.

Sam Chapman
Urgent & Emergency Care Prog. Associate Director, Hampshire and Isle of Wight ICS

Sam has worked in the Hampshire and Isle of Wight System in its various forms over a 10-year NHS career. A specialist in urgent and emergency care, he has contributed to the coordination of the UEC programme for the ICB, and the implementation of integrated urgent care, 111 First, System Control Centre, and importantly, the live data systems used to manage and monitor them. Sam has followed up an undergraduate degree with a master's in Leadership and Management in Health and Social Care and is currently finishing up a master's in Business Administration.

Q&A with Dr Jane Turton and Paul Griffiths

With the example of staff reviewing video, or the osteoporosis App, are there any learnings to reflect on about staff adopting and integrating into workflow?

PG "The use of the osteoporosis app has allowed improved scheduling of communication to patients; as offering replies to enquiries doesn't rely upon the patient being available on the telephone, so contact only has to be made once. We recognised that extra administrative support was needed to manage the telephones so we bid for and received a small increase from our organisation."

Jane - has there been any "pushback" from clinicians perceiving extra workload due to being always contactable (via app)? Is it extra work or actually less?

JT "Our patients were already contacting us and leaving voicemail. The workload is unchanged and communications are more secure. We are able to leave answers on the App."

How do you address inequities of care access/outcomes that might be exacerbated by use of patient digital tools?

PG "The simple answer is to pay attention to it, talk to patients who may not be able / want to access digital tools to understand why (and help them if required) and ensure alternative methods to access the same care pathway are available. I think teams sometimes get held back from pursuing digital solutions by the worry of inequity, however, I would strongly encourage teams to press on with digital solutions and talk to patients about the developments and possible impacts, but not get held back.

JT "Within osteoporosis services the App is an addition, those who have no digital access are contacted in the traditional fashion, face to face in clinic or on the telephone."

To all panellists: What would your advice be for engaging patients and getting feedback quickly to fail fast/improve processes at pace?

PG "Get them in to your projects and programmes as early as possible. Can you get patients into working groups, are there existing patient groups you can access to help co-design the digital solutions. Use patients to test out solutions, understand what works and what doesn't and then refine and iterate as you go. Always remember that the new digital pathways are designed to benefit patients, so talk to them about how this will happen in practice and test, refine, test, refine, test etc...

JT With the osteoporosis services, we asked the patients for ideas, they asked for the APP. We also spoke with patient support groups."

What are the bridging options for patients that do not have access to devices or can't use technology?

PG "We continue to use letters, telephone and face to face interactions"

Q&A with Dr Jane Turton and Paul Griffiths

How do we influence digital investment given the rapid evolution of tech enabled care post Covid? Sometimes it's challenging to get stakeholder engagement.

PG "Ensure your clinical leads are at the forefront of the conversation, so it doesn't become a managerial / financial debate that gets stuck in finding a return on investment. Many digital solutions may take years to have a financial saving, so focus on helping the clinical teams design lean, value adding pathways, enabled by technology and make the case for investing in designing the pathways this way. Focus on care quality, experience, safety and outcome for patients and staff to make the case. A strong clinical lead supported by operational experts and patient representatives can create a powerful and compelling team. Patient safety always comes first. The major benefit of improving IT is secure and personal communication. It allows care closer to home and avoids admission."

Jane, what additional pathways have needed to be put in place to ensure PT don't miss the medication etc? What risks have been highlighted?

JT "The app we are testing sends alerts for safety blood tests and a reminder to take the medication. We have a member of staff who checks by telephone with the patient that medication is taken, as our main concern was patients stopping treatment and not telling us."

How can we encourage patients to engage with technology more?

PG "Communicate with patients, use local radio, TV, bus adverts, have digital helpers on hand when patients are onsite. Ensure the solutions are well designed, user friendly and meet a clear need, so that when patients do use them, they see value and continue to use them. Don't be afraid to seek feedback on solutions and improve them where you can.

JT Show that it is safe, give more information about their care."

We have a proliferation of really fantastic Apps for patients. How much extra admin and digital support behind the scenes is needed?

PG "Overtime well designed digital solutions should save time. In the set up / implementation phase, there could be work to create the new pathway, but be clear on how the solution should reduce or remove admin, and if you cant find this, then maybe think about if the solution is the right one?"

Elective Care Hubs Reimagined

Lisa Riley
Deputy CEO & VP of Strategy & Sales, VitalHub UK

For Lisa's bio, see Panel Session - Patient Flow Transformation.

Paul Griffiths
Former Head of Delivery, Digital Care Models, NHS England

For Paul's bio, see Breakout 4 - Empowering Patients Through Technology.

Q&A with Lisa Riley and Paul Griffiths

What do you think are the main barriers currently stopping this reimagined patient journey and how can any gaps be filled?

PG "The main barriers are; commitment to investment and capacity to transform. Within provider organisations there is often limited capacity and funding to innovate, so the key is prioritising the pathway(s) that will be redesigned and transformed via digital solutions, and then be realistic about the time, team and money needed to do it; do this at the outset. In my experience, the teams that do well also use a clear method for change and apply this rigorously through the process.

LR "Head space; the teams on the ground, or in the thick of all the activity and pressures out there, are the ones often needed to see the vision, support requirement gathering, redesign pathways, put a business case together for funding, rally around the teams needed to be engaged, support deployment and implementation and do the change management functions also required; they don't have the time or support.

It's often the case that people just don't know what they don't know. There's a lot out there and often its piecemeal, so one solution for this part, another for something else etc. Sometimes people need ideas presented to them but they don't have the time, and often lots of providers contact them to sell them things, so there's a lot of doubt about what's real and what's sales talk. They're not sure how one bit fits together with another."

Are there solutions that help match the right patients to appointments that become available due to patient cancellation?

PG "Yes, there are these on the market but they need to work in tandem with provider systems to make it easy to identify appropriate patients."

In Lisa and Paul's experience, what are the major challenges in Elective care and is there a national focus to address these?

PG "Yes, there is national focus (broadly) and funding available to support new and innovate elective pathways for elective hubs, patient portals and digital pre-op assessment tools as examples. There are also a wide range of case studies, support guides, policy documents and strategic statements that show national intent. However, it is down to local systems and providers to work out which solutions will have impact for the patient population they care for and be relentless in execution of these solutions using change and transformation processes."

LR Competitiveness is also a barrier, in my opinion. There is currently not enough incentive for trusts to work more collaboratively with other trusts or private providers."

How can the referral process be improved?

PG "There is a range of solutions that can help automate and enhance referrals, through gaining more information at the point of referral and using AI to triage and ensure onward referral to the right team first time. These work best when designed with the clinical teams across an ICS to ensure the ideal pathway can be designed into the digital solutions."

LR "Here are many ways referrals into elective care can be improved, often focused around process management and comms. Often there are a lot of services out there that could be an alternative to traditional hospital referrals – but how on earth are primary care teams meant to keep up to date with all the different services – that change, the different pathways that are often created, the various teams and organisations often involved and not to mention all of the different criteria applied to access everything out there. There is a system that can be plugged into primary care to auto populate referrals and also sign post the most appropriate service using criteria-based rules. At VitalHub we have our own MCAP tool that is currently being used to assess referrals sitting on waiting lists to ascertain whether they are appropriate and if not where would the most appropriate onward care be better provided, using clinical criteria in built into the system."

Given the breadth of tools available, where do you think the NHS could best start from where we are today?

PG "Focus on patients being able to actively book OP appointments (and amend or cancel) via a patient portal. This needs hospital systems to enable this, so that it works well. So much time is spent arranging OP care, if patients could do this themselves it would empower them and free up staff to work on other aspects of care provision. In addition, patient portals could easily be used to gain pre-appointment information via messaging or questionnaires to ensure the appointment adds the most value when it takes place."

LR "Knowing the situation in real time, for me, is the most important place to start – you can then start to look at pressures, where they are already, where they are building, and what opportunities you have available and capacity elsewhere in your own pathway, service, team, trust, ICB or even more widely. SHREWD provides real time oversight of capacity and demand – it could be used to have a single version of the truth and without multiple spreadsheets, from multiple stakeholders, all in one place."

What's the main reason for cancelling elective appointments and how do you think this can be changed?

PG "From my experience the main reason in outpatients is to do with the availability of the clinician (for example they have been moved to do other activity or have taken leave). The first step to solving this is to ensure that any unnecessary OP appointments are removed (e.g. introduce patient initiated follow up, implement digital pathways and virtual appointments, ensure all appointments add value, so not bringing back patients whose diagnostics haven't been done). Then once this is done, this should free up capacity to ensure the clinical teams have the time and capacity to deliver OP care as planned, therefore reducing the need to cancel and rebook.

The first step in improving the pathway should be to remove the waste that is in there now, and go from there."

LR "Inefficient or ineffective processes is the common theme I see. Insisting on face-to-face appointments, using paper that gets lost or delayed, or leaving things to the last minute, such as pre-assessments on the morning of surgery that then potentially picks up an anomaly that then delays the procedure, and therefore delays treatment, wastes the patients time, the teams time and theatre allocations."

If you could pick one technical solution to solve these issues (existing or not), what would it be?

PG "Patient portals to manage OP pathways; these could really help revolutionise the way OP care takes place through being able to communicate with teams, make and change appointments, send images, share care records and so on."

LR "For me its SHREWD – ICB wide – to support Elective Hubs and aid and encourage the ability to be able to see more widely than the four walls of each individual hospital."

Breakout - Managing and Reducing Waiting Lists

Jonathan Wright
Head of Patient Access,
University Hospitals Dorset
NHS Foundation Trust

Jonathan is Head of Patient Access at University Hospitals Dorset (UHD) NHS Foundation Trust and is an experienced senior NHS manager in secondary healthcare. Jonathan started his career in the NHS as a diagnostic radiographer and has held general divisional manager roles across elective and emergency clinical services. He has also had experience of leading regional and local services in Wiltshire & Dorset. His current priorities include elective care recovery and the Digital First Clinical Validation Programme. Jonathan was also the UHD project and budget manager for the Outpatient Assessment Clinic at Dorset Health Village.

Peter Cnudde
Orthopaedic Surgeon,
Hywel Dda University
Health Board

Dr Peter Cnudde is a fellowship-trained orthopaedic surgeon who specialises in joint replacement surgery of the knee and the hip. He studied Medicine at Leuven University (Belgium) and graduated in 1995 with honours. Dr Cnudde was appointed consultant in Hywel Dda Health Board (UK) in 2003. In 2021, he was awarded the prestigious Rothman-Ranawat Travelling Fellowship. Dr Cnudde was also awarded an Honorary Professor appointment in the Faculty of Medicine, Health and Life Science at Swansea University.

Caroline Pritchard
Lead Anaesthetist,
Buckinghamshire
Healthcare NHS Trust

Caroline trained in Medicine at Cambridge university, followed by Imperial Medical School. After a period of general medical training, she completed her anaesthetic training at the Central London School of Anaesthesia. She has been a consultant anaesthetist in Buckinghamshire (BHT) for the last 12 years, during which time she has set up and run the perioperative medicine and the pre-assessment service, to prepare patients for surgery. This includes the Cardio Pulmonary Exercise Testing service, for which she is accredited.

Q&A with Jonathan Wright and Caroline Pritchard

Jonathan, how was the increase in patient volume achieved? Was this a change of pathway, referral criteria, etc. as well as a high street presence?

JR "Yes a change in pathways with support to redesign to maximise use of resources and space and allow staff to operate at the top of their licenses or bands. Maximising use of volunteers and navigator to flow patients through the facility."

Jonathan, what if anything would improve the process further? You mentioned MVP - what's next?

JR "We continue to focus on increasing activity and redesigning more pathways to include more diagnostics. For example we are due to commence high volume Gynaecology ultrasound clinics to reduce direct referrals to the gynae service"

How has connected care insight also helped plan for discharge pathways? Is there evidence linked to improved package of care.

CP "We can highlight high risk patients at risk of delayed discharge, so enhanced recovery team can be involved yes. We do also have sight of who is already known to community services in advance, so in future this could be used to help plan. Frailty dashboard – separate entity now to identify severely frail patients for admission avoidance/ SDM discussions"

Has this helped improved surgical appointment slot utilisation?

CP "Not yet, but is work in progress, as has the potential for this yes."

PC Still in early phases. No data available, but not bringing patients back unnecessary will free up time.

How has connected care informed your risk management of PIFU?

CP "POA doesn't use PIFU by the very nature of the service. We would have to trial the patients on the non admitted pathways to see if our gold / green patients would be suitable."

PC It would still be the same risk management but moving from a traditional system to a digital one. Because in a digital world, there is better traceability/recording it should reduce the risk

Connected Care insight, was there any challenge with primary care sharing information and seeing this as a supportive collaborative approached?

CP "All data sharing and IG put in place during dashboard development, undertaken at the ICB level to enable population insights and service planning. I would have to check details with our digital teams, but not aware of any particular issues."

Connected care insights, what advise would you give to help support a mind set change around working in partnership around sharing care records?

CP "Talk to your digital leads in the trusts, and ICS. Data should be following the patients and accessible regardless of boundaries/PCNs etc..
Obviously records are only shared when clinically needed, run some patient events to ask what patients want, ask them about how many times they have to repeat the same information to different teams, think about clinical risks everytime you have a manual transcription as this causes errors. Etc etc"

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Caroline, how have you reduced pre-op numbers for fit patients in a safe way/balancing risk, etc. And how have patients/healthcare reacted?

CP "10% reduction of nurse POA clinic slots based on the golden patients. Tested the SOP carefully with whole team. Anyone mis – categorized simply gets re booked into a nurse clinic. Team now very happy to run the process. "

How have you overcome digital skills inequalities with both patients and staff?

CP "This is not relevant for patients. Staff – the dashboard is very intuitive, very little training needed to use. People can filter by anything on the w/l with anything in the GP record. More work is needed to change pathways and processes really. "

Jonathan - could you please expand on how you achieved the risk stratification to direct suitable patients to the clinic on the high street?

JR "Through the use of clinical review of back log to identify suitable pathways for the facility & with a Digital first validation approach."

For Caroline: Was community data part of the management system pls?

CP "Our community data is on rio, and this is not fully connected. We only have those known to services/ living in Nursing home".

Is it important to integrate with EHR's and theatre systems to improve surgical performance, integrating the surgical journey within hospital on day of surgery

CP "Yes –and this is a slightly different issue - a 1:1 direct integration of medical information , using a standard set of API from GP record directly into the patients EPR."