WELCOME TO

The NHS Patient Flow Conference 2022

Check Out Our Agenda Here...

Wednesday 6th July 2022- 08:00am – 15:30pm – Hatfield's Conference Centre

Conference hosted by Convenzis Group Limited

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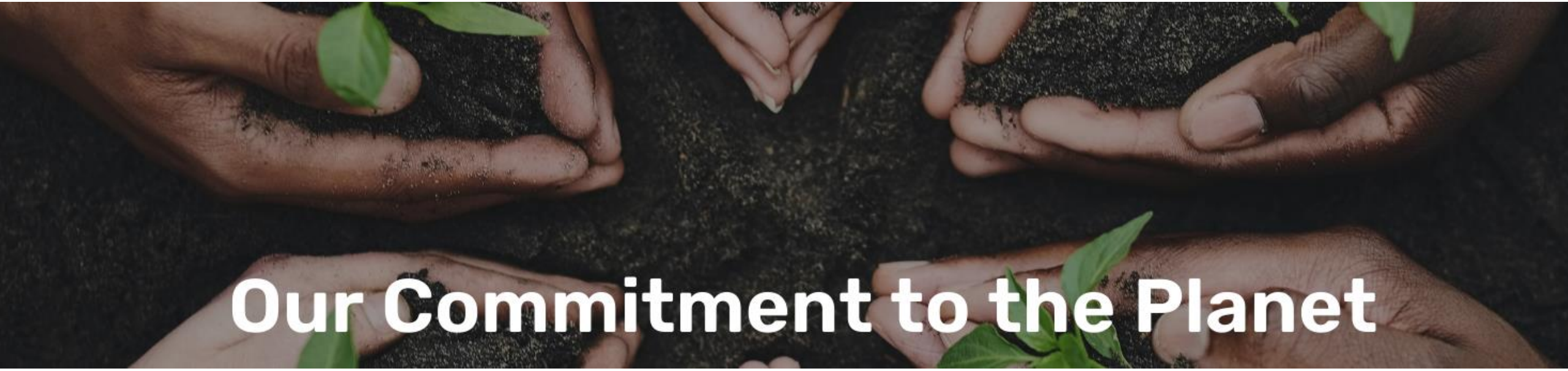

For Each Delegate Attending Our In-Person Event Today, we will be planting 1 tree with our Key Sustainability Partner

PLAY IT GREEN

Slido

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

The Patient Flow Conference 2022

SCAN ME

Wednesday 6th July 2022- 2022- 08:00am – 15:30pm – Hatfield's Conference Centre

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The Patient Flow Conference 2022

The NHS Patient Flow Conference 2022

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Event Chair – Opening Address

Douglas Hamandishe

"Alcidion Clinical Consultant and Broadcaster – Centric Health Media"

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SPEAKING NOW

Jenny Keane

Director for Hospital Discharge & Community Rehabilitation – NHS England

I will be discussing…

"Putting Patients at the centre of community services: how do we transform community services to support more people to stay well & independent at home?"

Patient flow

Jenny Keane, Director
Hospital Discharge and Rehabilitation
NHS England

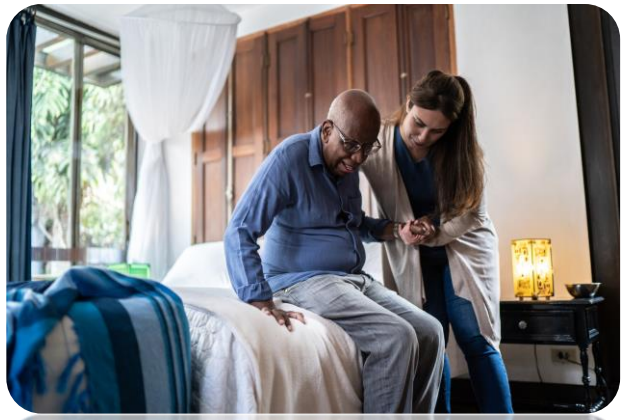
Patient flow

Jenny Keane, Director
Hospital Discharge and Rehabilitation
NHS England

Tonight, across England, over 10,000 people will spend the night in an acute hospital who should be sleeping in their own bed at home, or in other more appropriate bed-based settings in the community

The majority of these people are still in hospital due to a delay in accessing post-discharge services in the community; this is ultimately down to a lack of capacity in both health and social care ‘step-down’ or ‘intermediate care’ services

Vision


Enable more people to recover
and rehabilitate in community services
and in their normal place of residence

#supportpeopletolivetheirbestlives

Our ambitions

Support more people to stay well and independent at home, wherever they call home, so that they can live their best lives.

When people do need be treated in hospital, community health services are crucial to supporting timely discharge, enabling people to recover at home. For those people who need ongoing care and support in the community, this assessment should be done at the place they call home, including care homes.

Funding for people's care arranged by the NHS is provided through NHS Continuing Healthcare. Local health and care systems also have access to funding through the Better Care Fund, bringing health and social care budgets together.

We are working with local systems to develop new models of care, including the expansion of virtual wards, urgent community response, anticipatory care and enhanced health in care homes

Enablers


Community capacity & capability
Legislation & Policy
Investment
Integration
Transformation
Identity
Societal Change

Discharge Taskforce

- In support of continued focus on discharge processes, a **national discharge taskforce**, supported by the Government, has been initiated to provide strategic oversight of hospital discharge initiatives.

- This has included the development of **4 distinct but interrelated workstreams across health and care**, underpinned by identification of a number of systems of focus.

- These areas have been identified through regional and national discussions and data analysis and are being supported through virtual and in-persons visits to identify key actions to support further improvements.

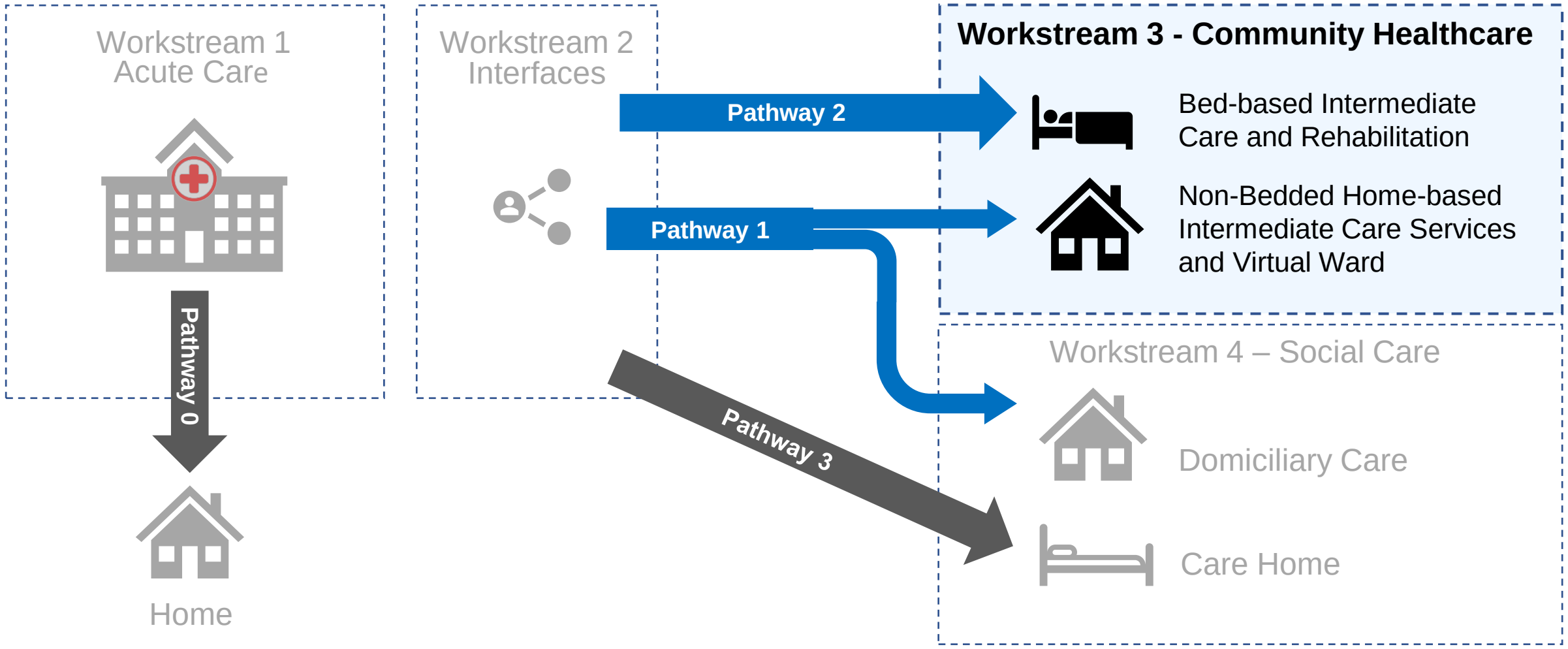
Workstream 1
Hospital Only Discharge

Workstream 2
Discharge Interfaces

Workstream 3
Community Healthcare

Workstream 4
Social Care

Patient flow



National priorities

Virtual Wards

- we expect systems to have completed the comprehensive development of virtual wards towards a national ambition of **40–50 virtual beds per 100,000 population** by December 2023
- up to £200 million will be available in 2022/23 and up to £250 million in 2023/24.

UCR

- full geographic coverage 12 hours a day, 7 days a week in virtually every community from April 2022
- providers required to achieve a minimum threshold of reaching 70% of 2 hour crisis response demand within 2 hours by end of December 2022

Anticipatory Care

- proactive and personalised health and support for people with multiple long-term conditions
- systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 in line with forthcoming operating framework for AC

National priorities

EHCH

- systems need to ensure consistent and comprehensive coverage of Enhanced Health in Care Homes in line with the national framework. These are minimum requirements. Systems are encouraged to implement the EHCH framework in full
- in 22/23 there will be a framework refresh and stronger links to Virtual Wards

Digital & data

- ensure all providers can access the Local Shared Care Record as a priority in 2022/23, to enable urgent care response and virtual wards
- deliver radical improvements in quality and availability against national data requirements and clinical standards, including the priority areas of urgent care response and musculoskeletal (MSK)

Waiting lists

- systems must develop and agree a plan for reduction of community service waiting lists and ensure compliance of national sitrep reporting.
- they must develop a trajectory for reducing their community service waiting lists and significantly reduce the number of patients waiting for community services

Virtual wards

A virtual ward is a safe and efficient alternative to NHS bedded care that is enabled by technology.

Virtual wards support patients who would otherwise be in hospital to receive the acute care, monitoring and treatment they need in their own home.

This includes either preventing avoidable admissions into hospital, or supporting early discharge out of hospital.

The NHS has an ambition to extend virtual wards to more people across the country so that by December 2023 there are 40–50 virtual beds per 100,000 population.

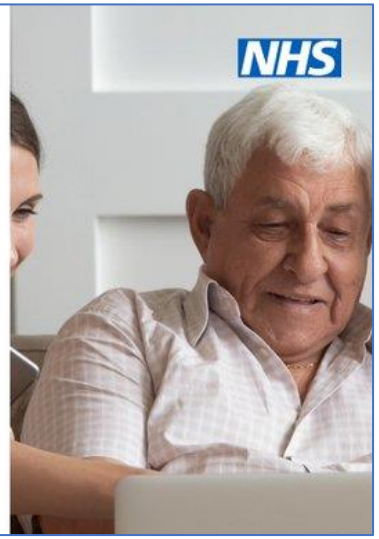
Better for people

- People receive high quality care from a multidisciplinary team but in the comfort of their own home
- People are supported to be as independent as possible, helping to avoid deconditioning sometimes seen in a hospital environment.
- People can have visitors at a time that's convenient to them, eat their favourite foods and have their family and pets around them.

"It's a truly amazing feeling, when we treat someone with delirium at home with IV fluids and they improve within the hour, being **back to themselves**.

"Patients are so thankful to us for being able to stay in their own homes. It **means the world to them**."

Trainee
Virtual ward in east Kent



Join our Virtual Wards workspace on FutureNHS to share resources, and discuss learning from those expanding or setting up virtual wards. To find out more please email england.virtualward@nhs.net

Anticipatory care

Proactive and personalised health and support for people with multiple long-term conditions of any adult age

Systems need to work with health and care providers to develop a plan for delivering AC from 2023/24 in line with forthcoming operating framework for AC

"We are embarking on the largest cultural change seen in a generation, moving from reactive, single disease-based fragmented care to proactive joined-up care, personalised to the individual.

This is anticipatory care and our simple goal is to ensure that people can be happy, healthy and living independently for as long as possible.

No-one can challenge this aspiration but it takes a concerted and focused approach to achieve this for older people with a medical diagnosis of frailty, who are not as physiologically robust as a fit and well person of a similar age."

GP David Attwood, GP Partner and Clinical Lead for integrated care of older people in West Devon

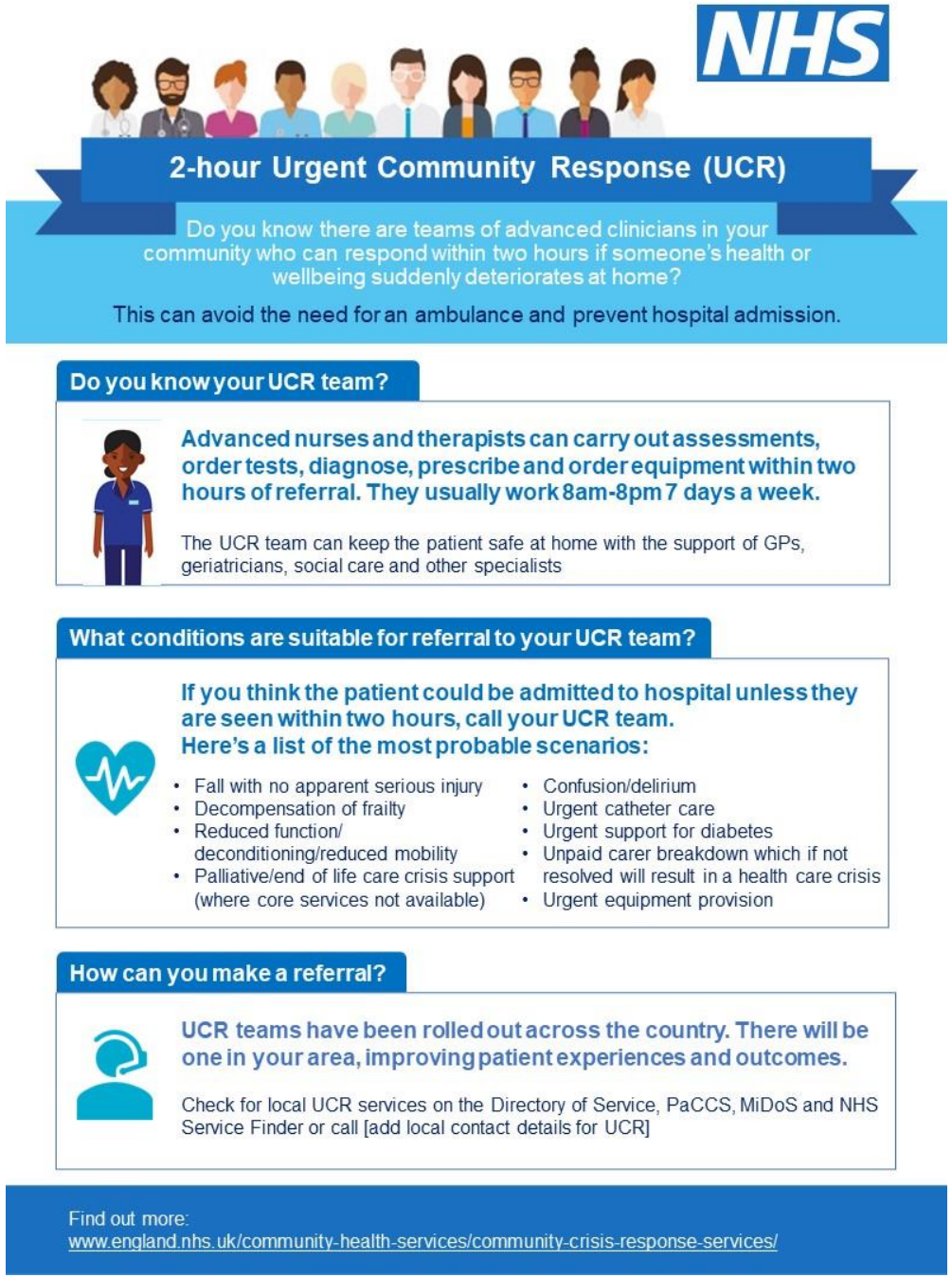
2-hour urgent community response

Two-hour UCR teams provide assessment, treatment and support to people over the age of 18 in their own home or usual place of residence who are experiencing a health and/or social care crisis and who are at risk of hospital admission within the next 2-24 hours.

There are now UCR teams covering virtually every community in the country.

For 2022/23 systems and providers are expected to:

- maintain full geographic rollout and continue to grow services to reach more people
- increase the number of referrals from all key routes, with a focus on Urgent and Emergency Care (UEC), 111 and 999, and increase care contacts
- ensure workforce plans support increasing capacity and development of skills and competencies in line with service development
- providers required to achieve, and ideally exceed in the majority of cases, the minimum threshold of reaching 70% of 2-hour UCR demand within 2 hours from the end of December 2022
- improve capacity in post-UCR services to support flow and patient outcomes including avoiding deterioration into crisis again or unnecessary admission



Rehabilitation

Every person who requires and will benefit from non-acute rehabilitation are able to receive high quality, timely care and as close to home and community as possible.

We will embed rehabilitation as a core community offer that supports individuals and populations with recovery and restoration, maintenance and prevention or deterioration of health and wellbeing.

Objectives:

- Optimising bedded and home models of care
- Developing digital and virtual models
- Improving data recording and reporting
- Strengthening the offer through community assets and levers

england.communityrehab@nhs.net

Community Rehabilitation 22/23 priorities

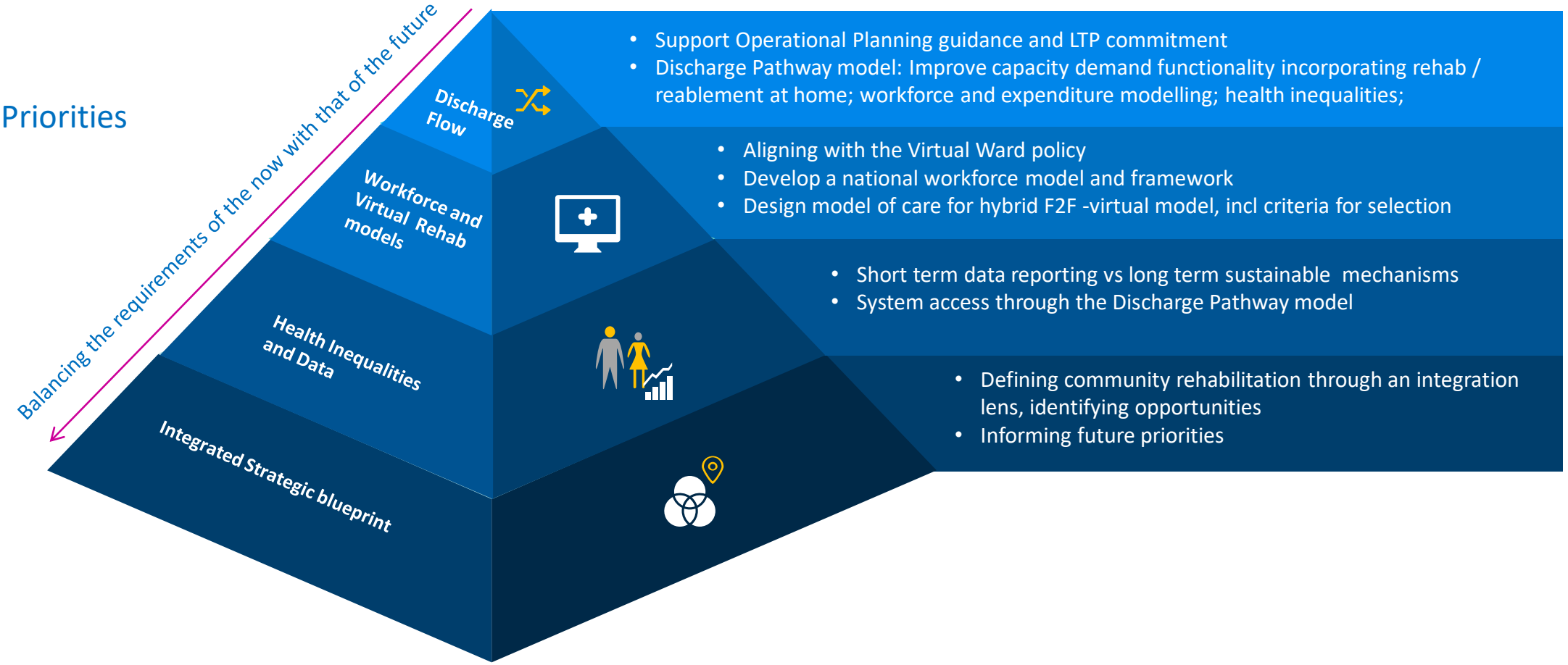
Levers

NHSE CHS Policy: Discharge, BCF, Virtual Wards

NHSE strategic levers: LTP, Elective Recovery Plan

Legislation: Health and Care Act, Integration White Paper

22/23 Priorities



Optimising bedded and home care post discharge

Current model → **Optimising bed & home pathways** → **Improving outcomes**

- Various issues affecting current model:
- **Variation in bedded capacity** affected by various drivers: geography, estates, behaviours, funding, systems maturity
- Access to **home care** is varied and subject to workforce availability and maturity in system integration
- Variation in **local models** with no clear outcome measures hinders understanding of where it may be working and what good looks like
- **National oversight and benchmarking** of variation and inequalities in access is challenging without improvement in data quality and reporting

Data model

Bedded and non-bedded stratification

Standards and Outcomes

Workforce

Timely access to care when required and in the right setting

LOS, flow / timely discharge

Reduced ongoing care needs and readmission rates

Restoration and waiting lists

Over 900,000 patients are waiting for community services

Systems must develop and agree a plan for reduction of community service waiting lists and ensure compliance of national sitrep reporting.

Specifically, systems are asked to:

- develop a trajectory for reducing their community service waiting lists
- significantly reduce the number of patients waiting for community services
- prioritise patients on waiting lists
- consider transforming service pathways and models to improve effectiveness and productivity.

> The waits for musculoskeletal conditions in the community are the highest for any condition in every region of the country. The Best MSK health programme has developed a comprehensive toolkit to support the management of back pain, shoulder pain and hip and knee OA , providing evidence-based resources and clear guidance on referral optimisation to support recovery of services and delivery of high quality care.

Chris Mercer
Consultant Physiotherapist
Clinical Lead, NHSEI Best MSKHealth

Enhanced health in care homes

People living in care homes should expect the same level of support as if they were living in their own home.

EHCH provides a framework for delivering health care to residents through the support of a multi-disciplinary team (MDT) including primary care, specialists, community-based care services and care home staff.

Requirements included in:

- 2020/21 Network Contact DES and associated guidance for primary care networks (PCNs)
- NHS Standard Contract for community health services and other NHS providers

Every care home should have access to:

- a weekly ‘home round’ or ‘check in’ with residents based on the MDT’s clinical judgement
- a personalised care and support plan within 7 days of re/admission to a care home
- Structured Medication Reviews for residents who would benefit from the review.

Patient flow

Jenny Keane, Director
Hospital Discharge and Rehabilitation
NHS England

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SPEAKING NOW

Jyothi Nippani

National Clinical Lead
NHHE/I Emergency & Elective Improvement

I will be discussing…

"Impact of Managing Frailty on Patient Flow"

Frailty – Impact on Emergency patient flow

Rachel Williams
Associate Director of Operations
South Warwickshire University Foundation Trust

Jyothi Nippani
Foundation Group AMD - South Warwickshire NHS FT
Clinical Director – NHSI (Elective and Emergency Improvement)
National Clinical Lead – Hospital Transformation

Today…

Why frailty? Impact on flow – some facts

Latest PDSA and recommendations…

Headlines

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NEWS

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England | Local News | Regions | Norfolk

East of England Ambulance boss sorry after waiting patient dies

4 days ago

Ambulance and trolley waits soar to record levels

By Alison Moore, Matt Discombe | 11 November 2021

8 Comments

- Heart attack and stroke patients face waits of nearly an hour despite 18-minute target
- Trolley waits in A&Es top 7,000 in October amid worst ever performance levels

Ambulance response times hit new lows last month, leaving heart attack and stroke patients waiting nearly an hour to be reached on average, despite the system having an

News

Exclusive: Ambulance service will collapse by August, predicts its nursing director

25 May 2022

A struggling ambulance trust could face a ‘Titanic moment’ and collapse entirely this summer if the region’s worsening problems with hospital handover delays are not taken more seriously, its nursing

News

Multiple deaths due to care delays highlighted in damning CQC report

27 May 2022

Dozens of patients died or suffered ‘severe harm’ after long waits for ambulances during a three-month period in a health system facing ‘extreme pressure’ on its emergency services.

Who can be harmed when patients are admitted unnecessarily?

Working backwards through the chain of events leading to admission

The patient waiting at home
Pts at home waiting for an ambulance…

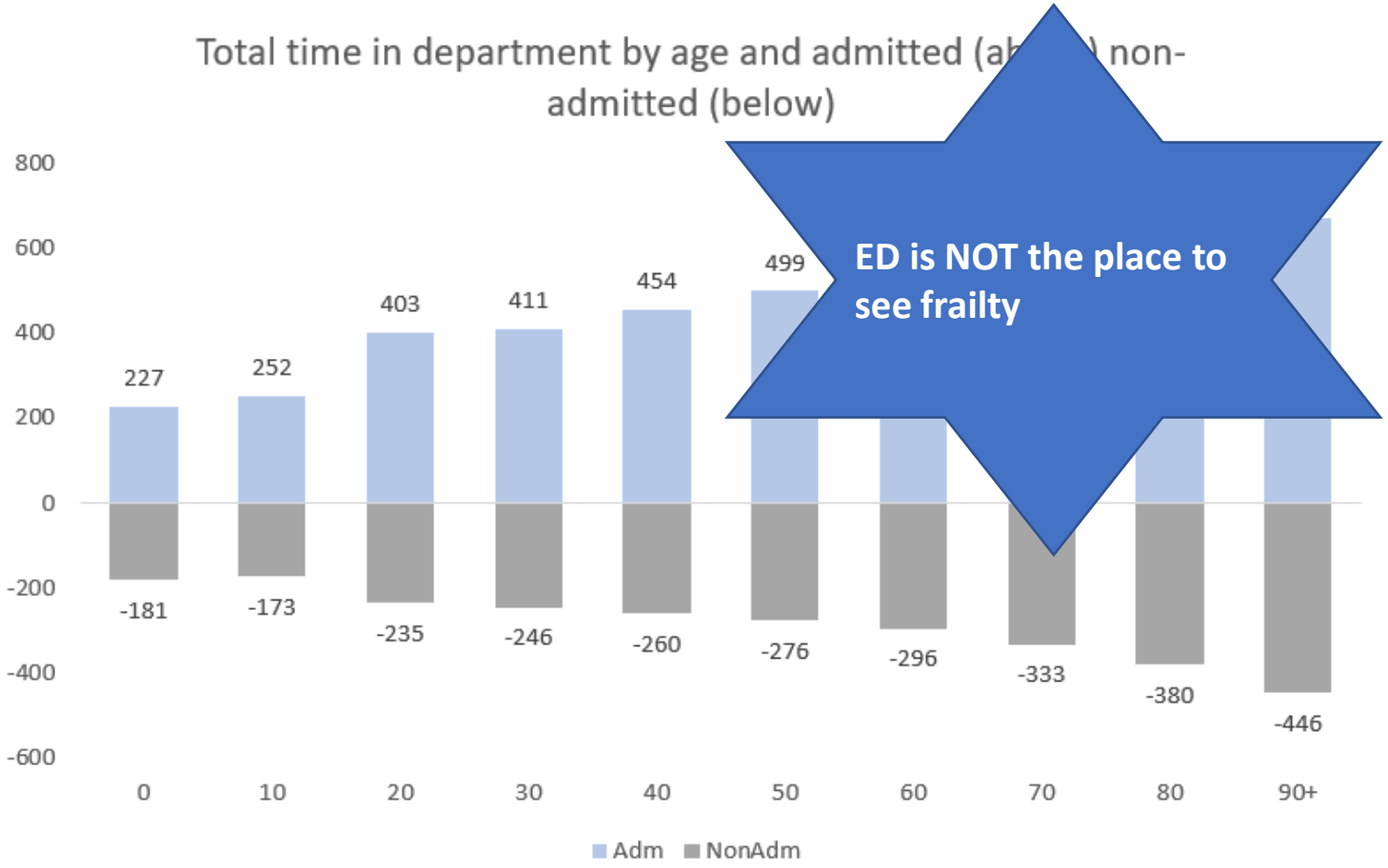
The patient waiting to be handed over
Cant be off loaded
No access to treatment

The patient waiting for a bed
Sub optimal care
>12hrs – significant harm

The admitted patient
Deconditioning
LloS
Nosocomial infections
Death

National picture

- Admitted/speciality pathways spend more time in ED
- Older patients spend 10-11hrs if admitted and 6-7 hrs if not admitted

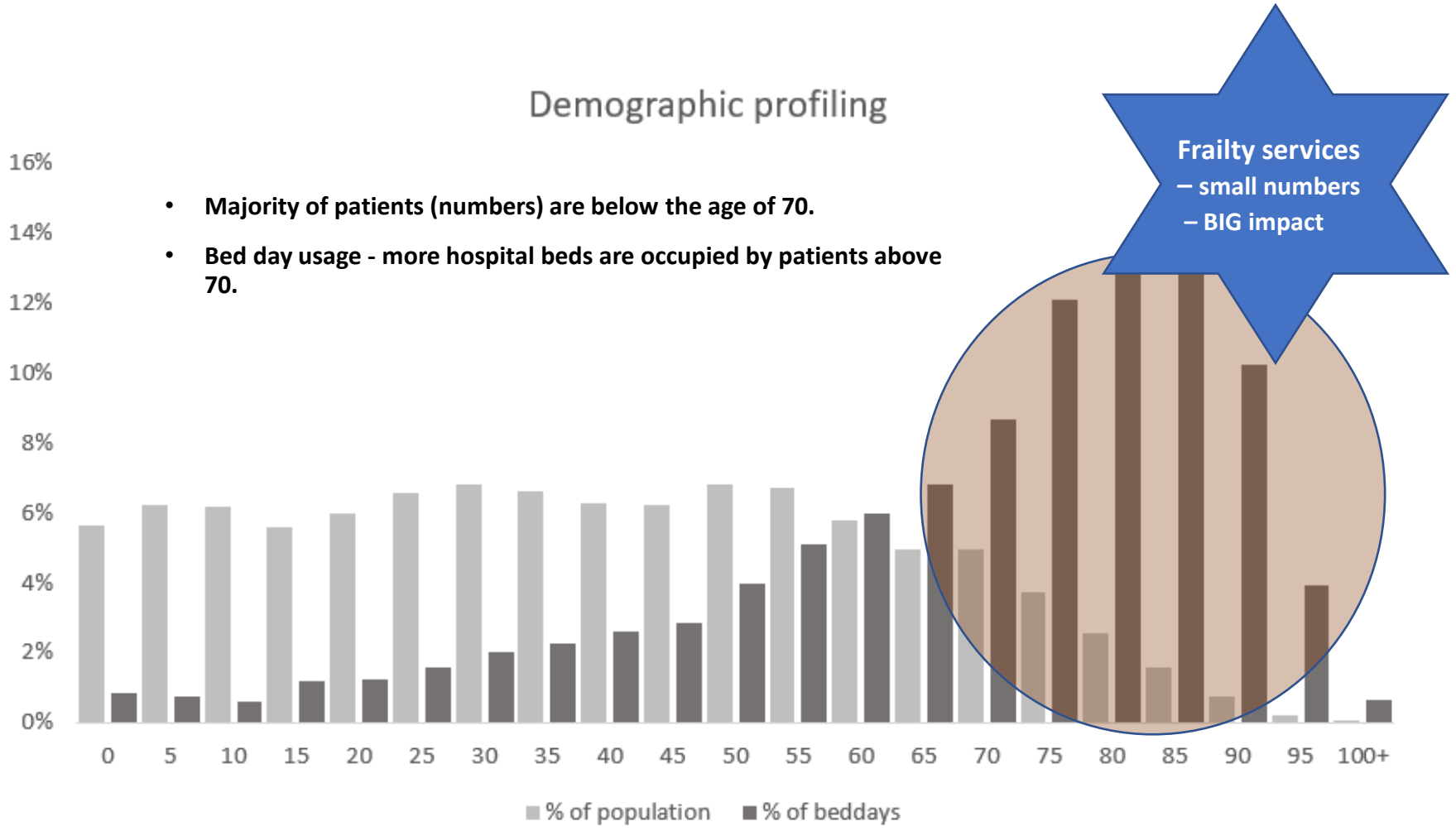


Emergency care bed-day usage

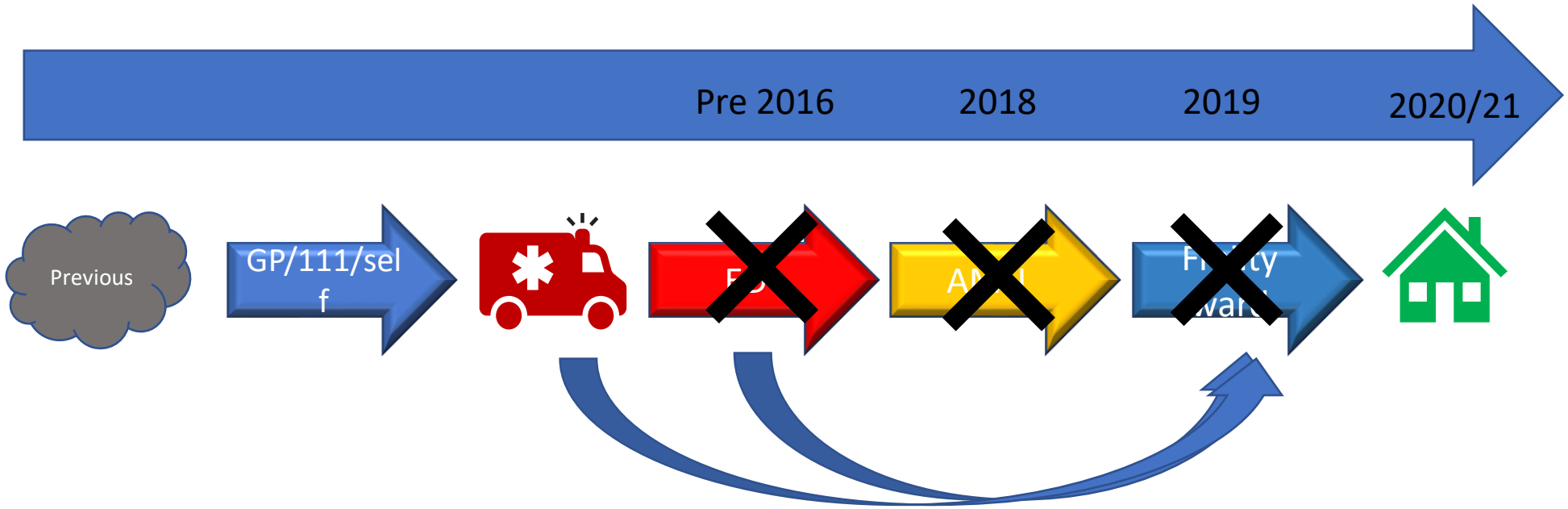
Over 70s

- Population **13.5%**,
- Attendances **22%**
- Time in ED **30%**
- Beds **66%**

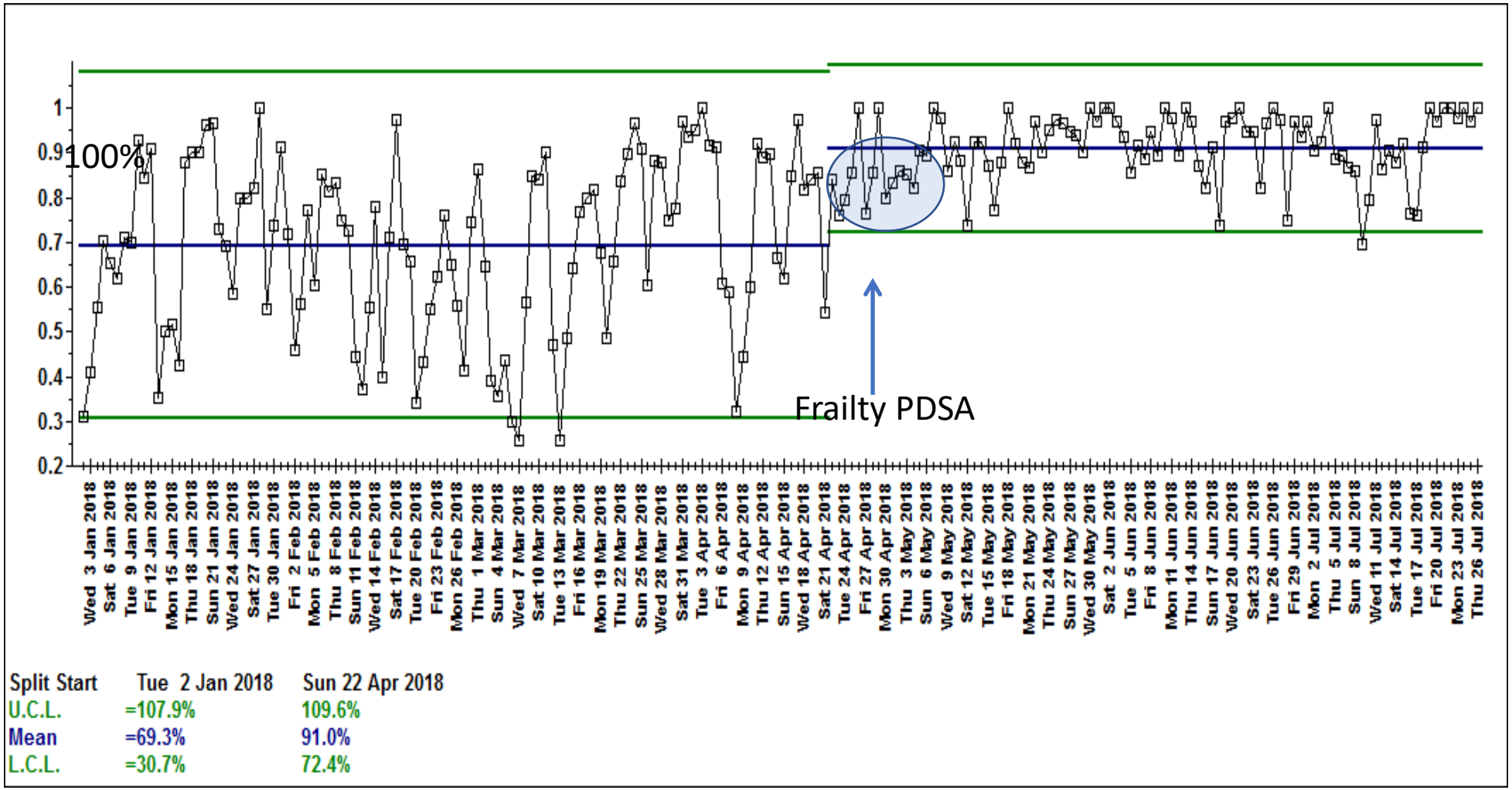
- **Majority of patients (numbers) are below the age of 70.**
- **Bed day usage - more hospital beds are occupied by patients above 70.**



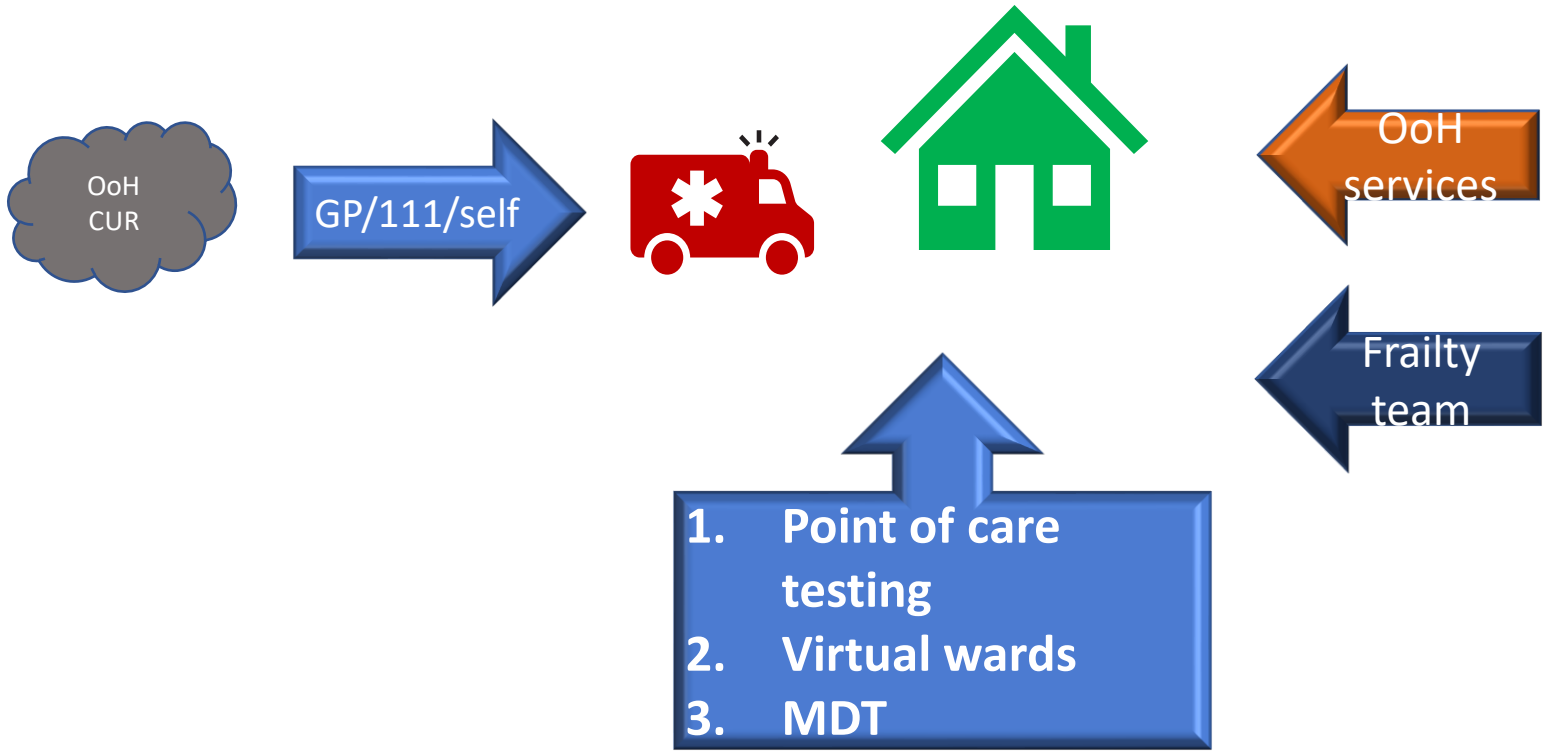
SWUFT - Frailty Journey



A&E 4 Hour Performance for over 75's – Pre Covid



Frailty Journey – 2021/22



Why Frailty?
Impact on Elective and Emergency Flow

Age group	Proportion of beds occupied in SWFT	Proportion not meeting CtR within the age group
<18	1%	0%
19-74	42%	21%
>75	57%	34%

More than 50% occupied by older patients

A third of these don't need to be here

A significant number – don't need admission

Should not been conveyed to sec. care.

Most of them did not want to leave home

Getting frailty right – best patient experience AND will release inpatient capacity

The Problem…

However referred, majority of older patients come to sec. care via an ambulance

- Ambulance services have three options when on site with a patient.

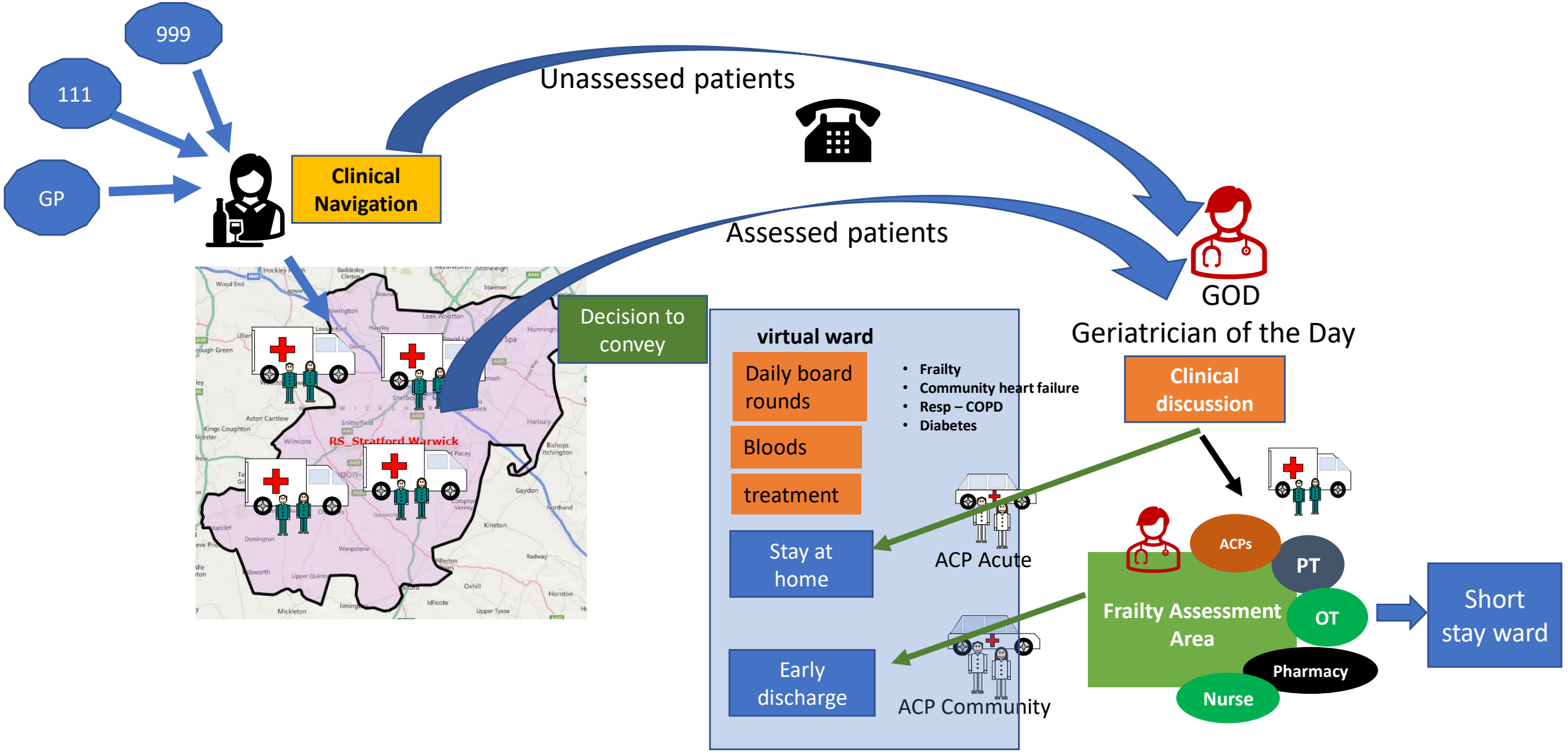
1. See and Treat
2. See and convey to ED
3. See and find an alternate

Seen as a safe option when 3 fails. The path of least resistance is often the path of most potential harm

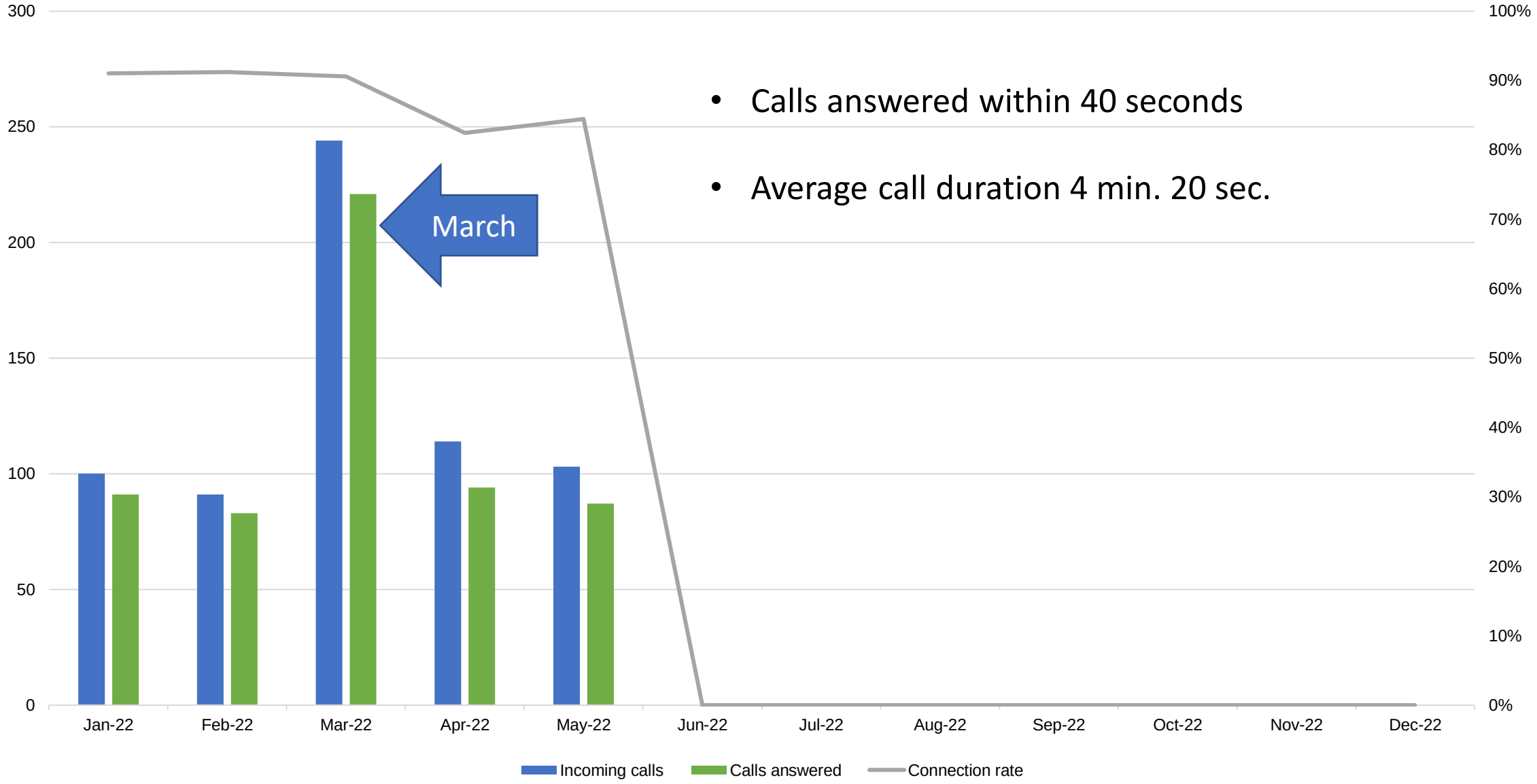
- The third option of ‘see and find an alternate pathway’ is often unreliable and so is used inconsistently leading to a vicious cycle of conveyance, admission, long hospital stays, deconditioning needing increasing packages of care and exit blocks, which in turn lead to delayed ambulance handover times.

PDSA and criteria

- Patients
  - over 75 yrs age
  - frail and under 75
  - SW postcode
- All categories of WMAS patients
  - Assessed and Unassessed patients
  - 0800- 2000hrs
- Dedicated consultant taking the calls – high quality decision making

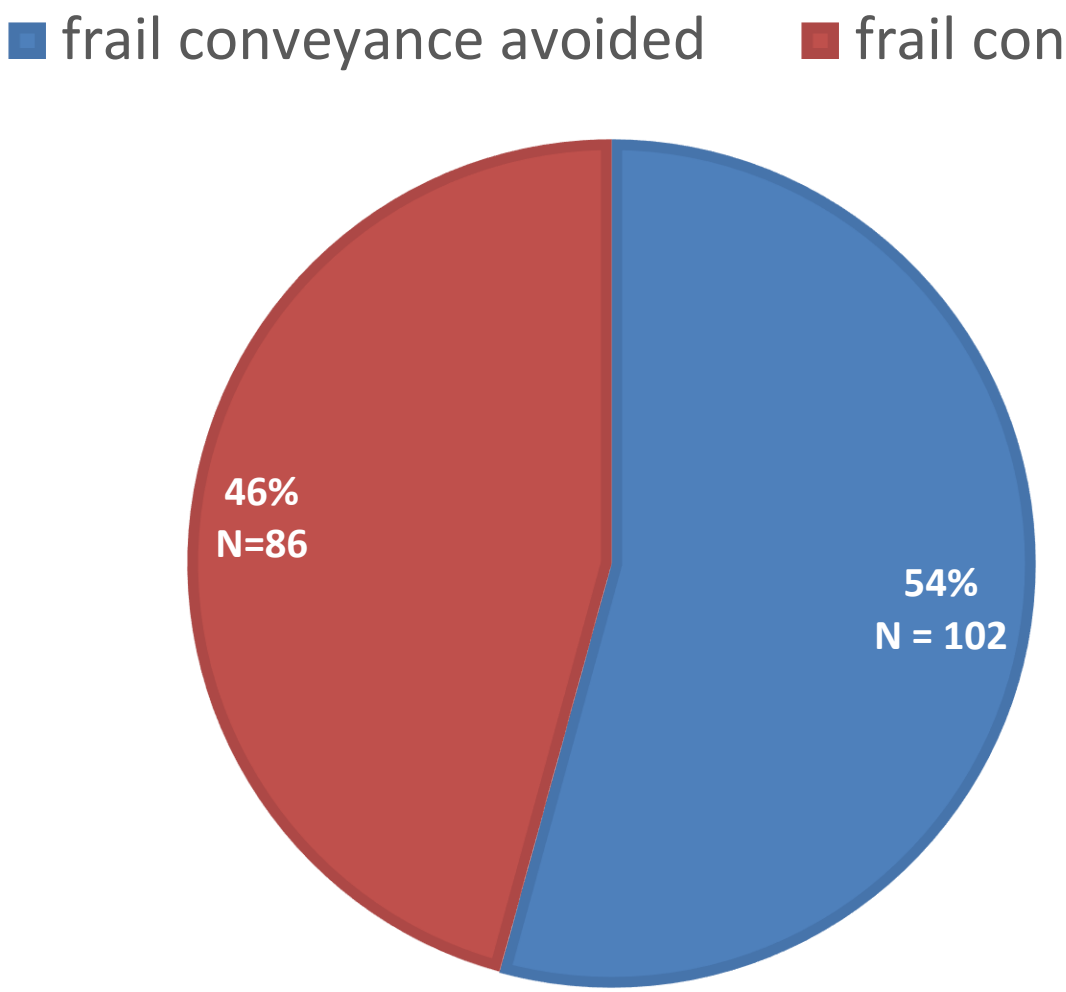

999
111
GP
Clinical Navigation
Unassessed patients
Assessed patients
Decision to convey
RS_Stratford Warwick
GOD
Geriatrician of the Day
virtual ward
Daily board rounds
Bloods
treatment
Frailty
Community heart failure
Resp – COPD
Diabetes
Stay at home
Early discharge
ACP Acute
ACP Community
Clinical discussion
ACPs
PT
OT
Pharmacy
Nurse
Frailty Assessment Area
Short stay ward

Consultant connect – calls



- Calls answered within 40 seconds
- Average call duration 4 min. 20 sec.

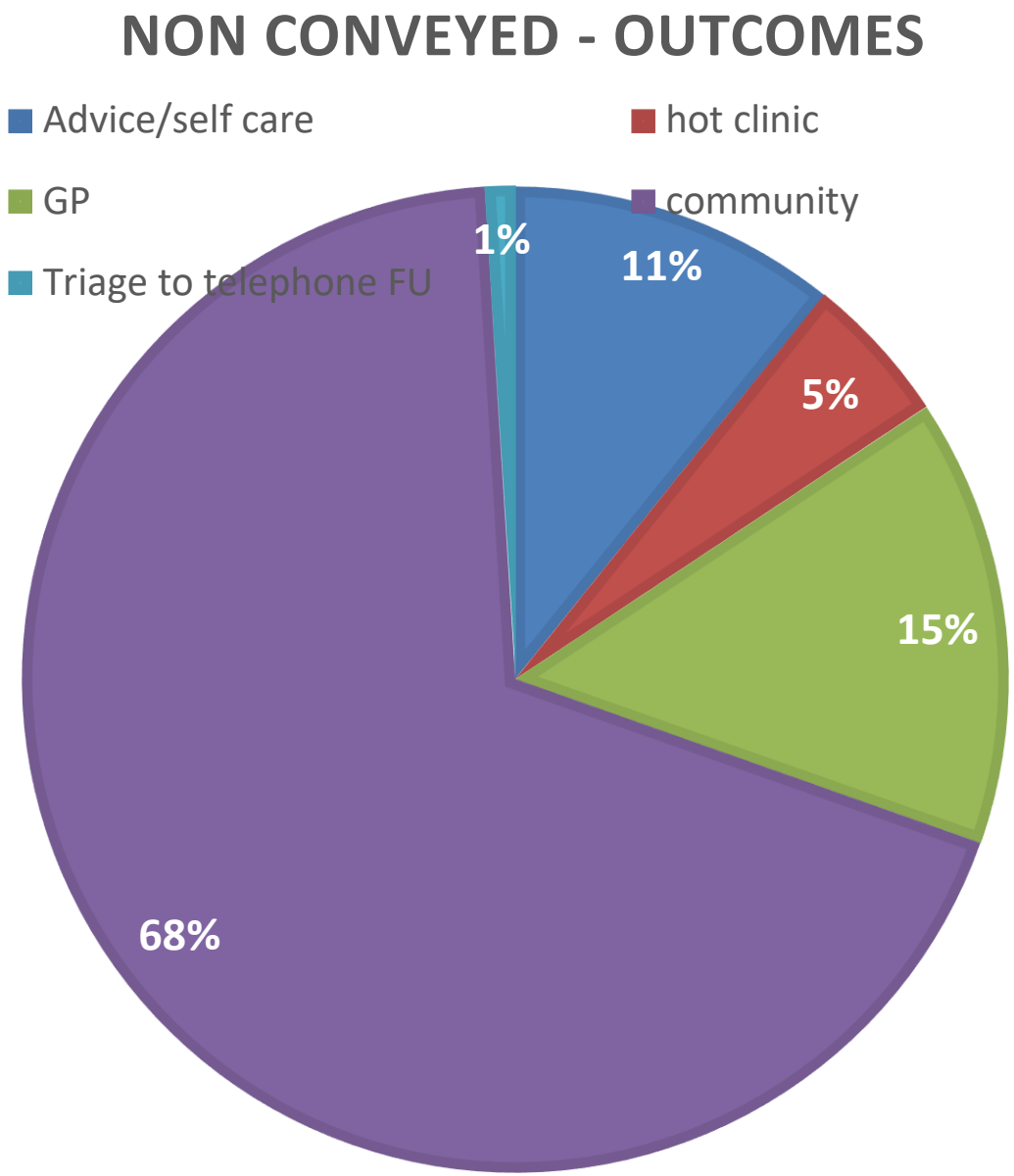
FRAIL - CONVEYANCES AVOIDED – 54%



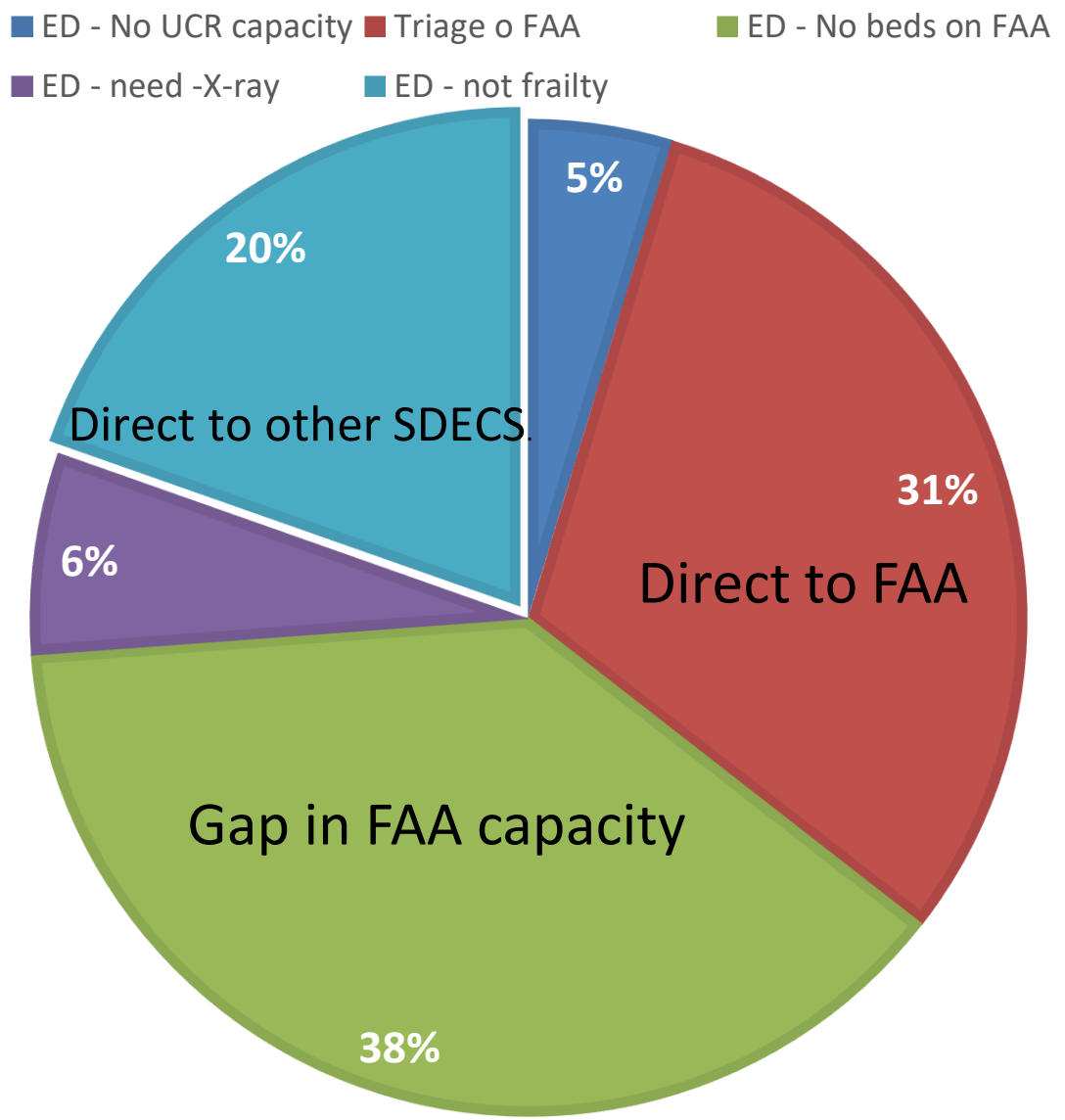
Of the 209 patients over 75 yrs – 21 not frail

102 patients not conveyed out of the remaining 188

SWUFT over 75's conversion rate is 63%

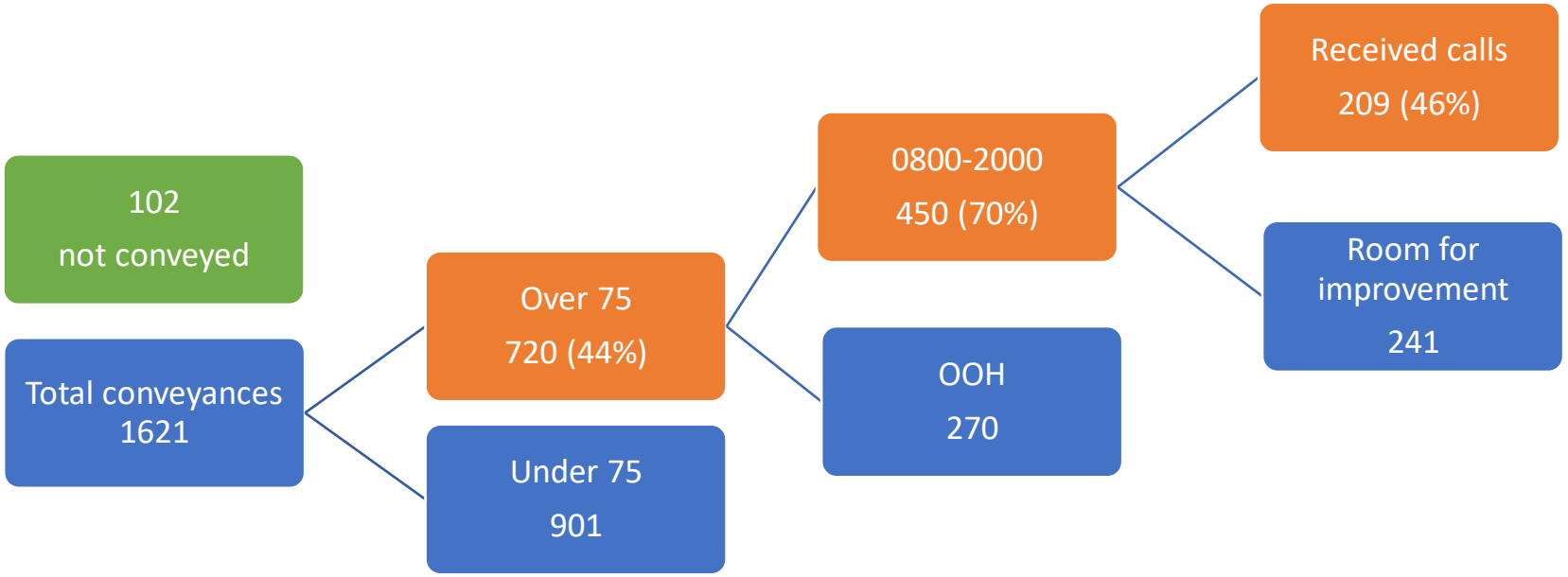


CONVEYANCES – TRIAGE DESTINATIONS



Only 11% potentially left in ED

March 2022- SWFT – WMAS conveyance data

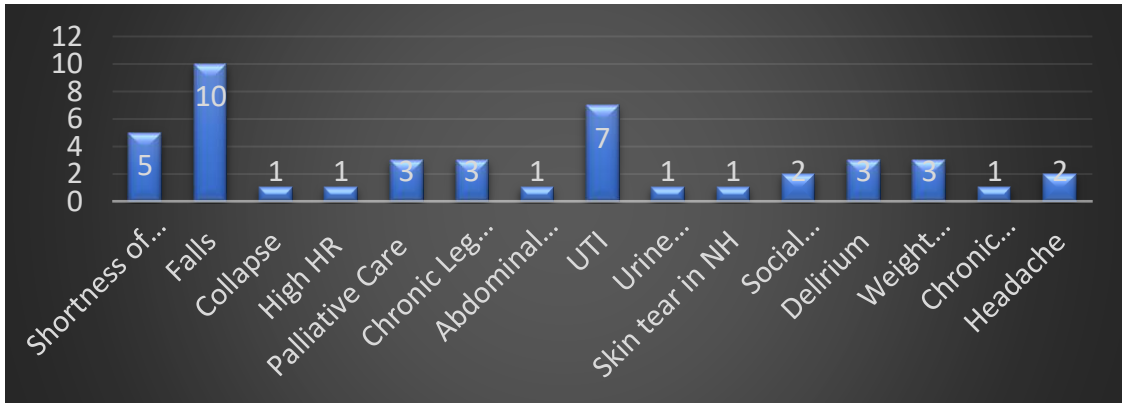


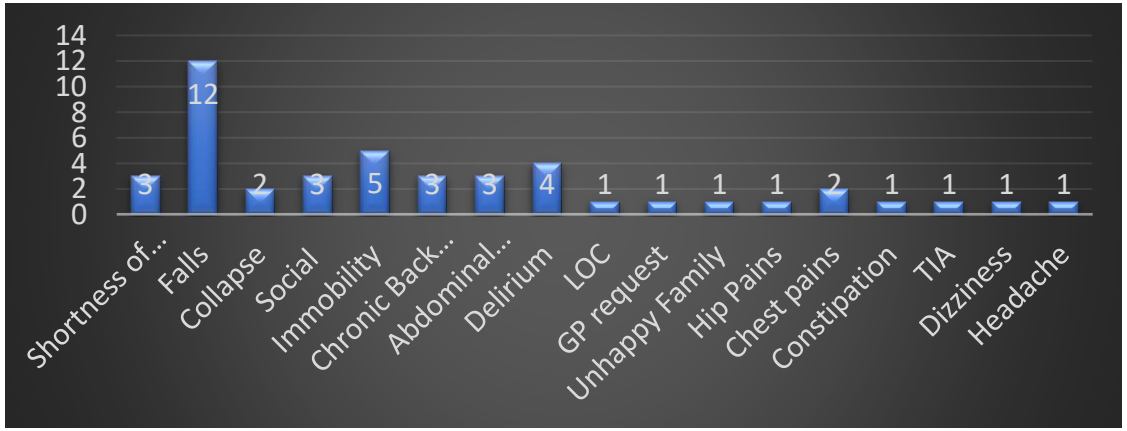
450 patients over the age of 75 were conveyed to SWFT, instead of 552 (450 +102)

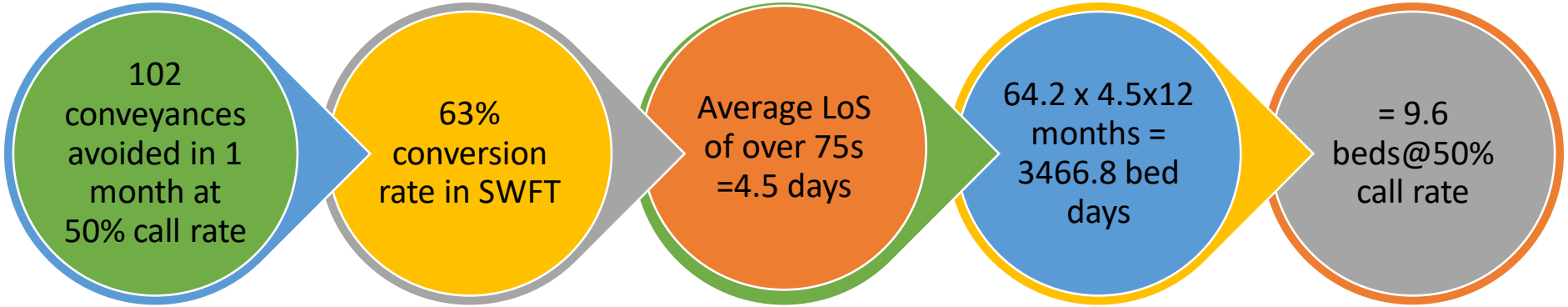
Comparing symptoms - non conveyed and conveyed

Presentation	Non conveyed	Conveyed
Shortness of breath	5	3
Falls	10	12
Collapse	1	3
High HR	1	
Palliative Ca		
Chronic Leg pai		4
Abdominal pains		4
UTI		
Skin tear in NH		
Social prob		1
Delirium	3	4
Wt. loss	3	
Chronic /Chest pain	1	2
Headache	2	
Immobility		5
GP request		1
headache	2	1
TIA/dizziness		2

What makes the difference is having someone at home 24/7 to keep an eye on the patient





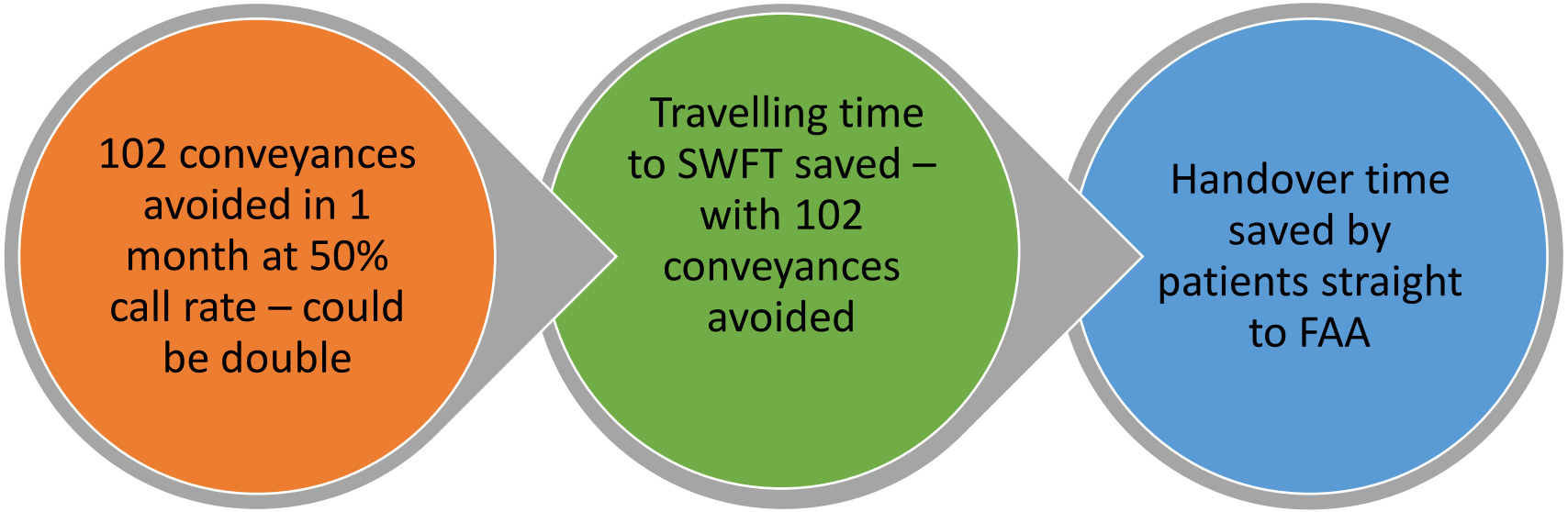


Current conveyances avoided	3.4 patients per day	9.6 bed days saved
If calls doubled	6.8 patients per day	19.2 beds saved

Potentially saved 10-20 acute beds while doing the right thing for the patients.

Potential Quality improvement for WMAS

Refer- current national headlines slide



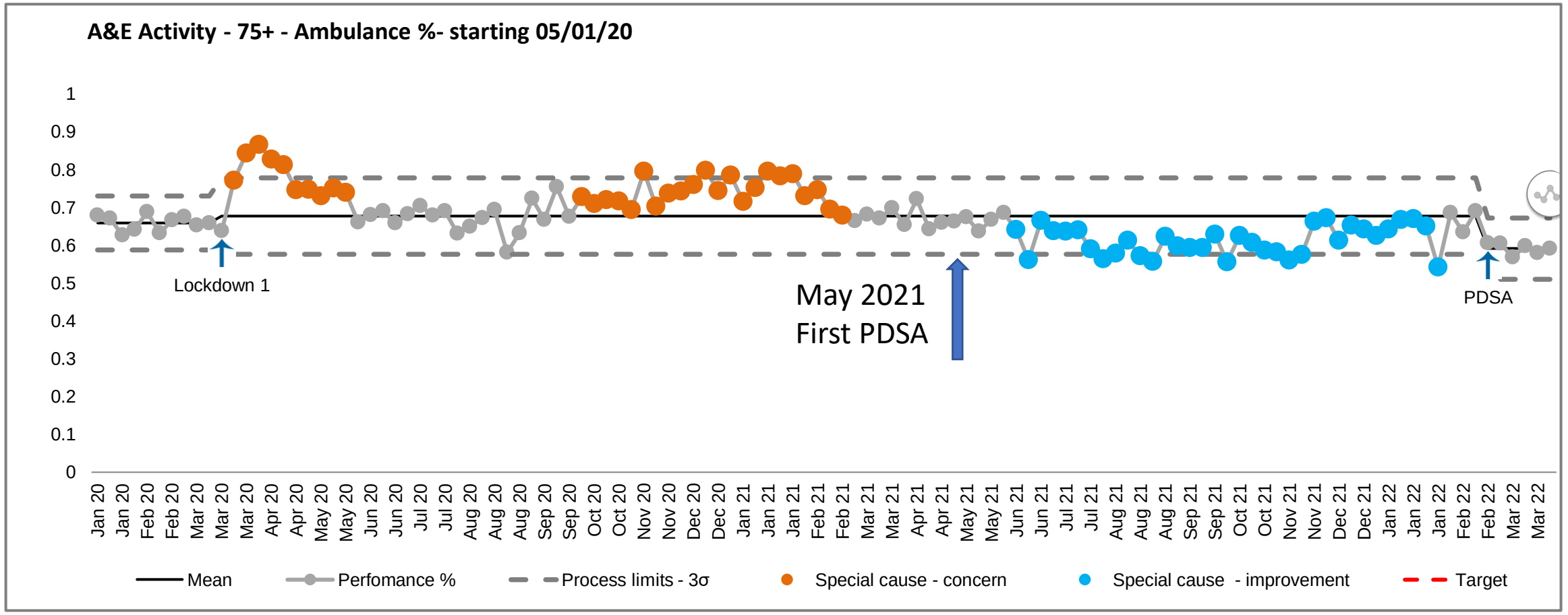
Not about money, but time back to WMAS

- Load to handover time in Warwick – 90 minutes
- Average ambulance unit hour cost - £500
- 102 conveyances avoided
- **102 x750 = 76.5K**
- spent ?? out of the 50K - saved - 76.5K in one month alone through non conveyance.
- Waiting time also reduced through direct drop in FAA rather than ED

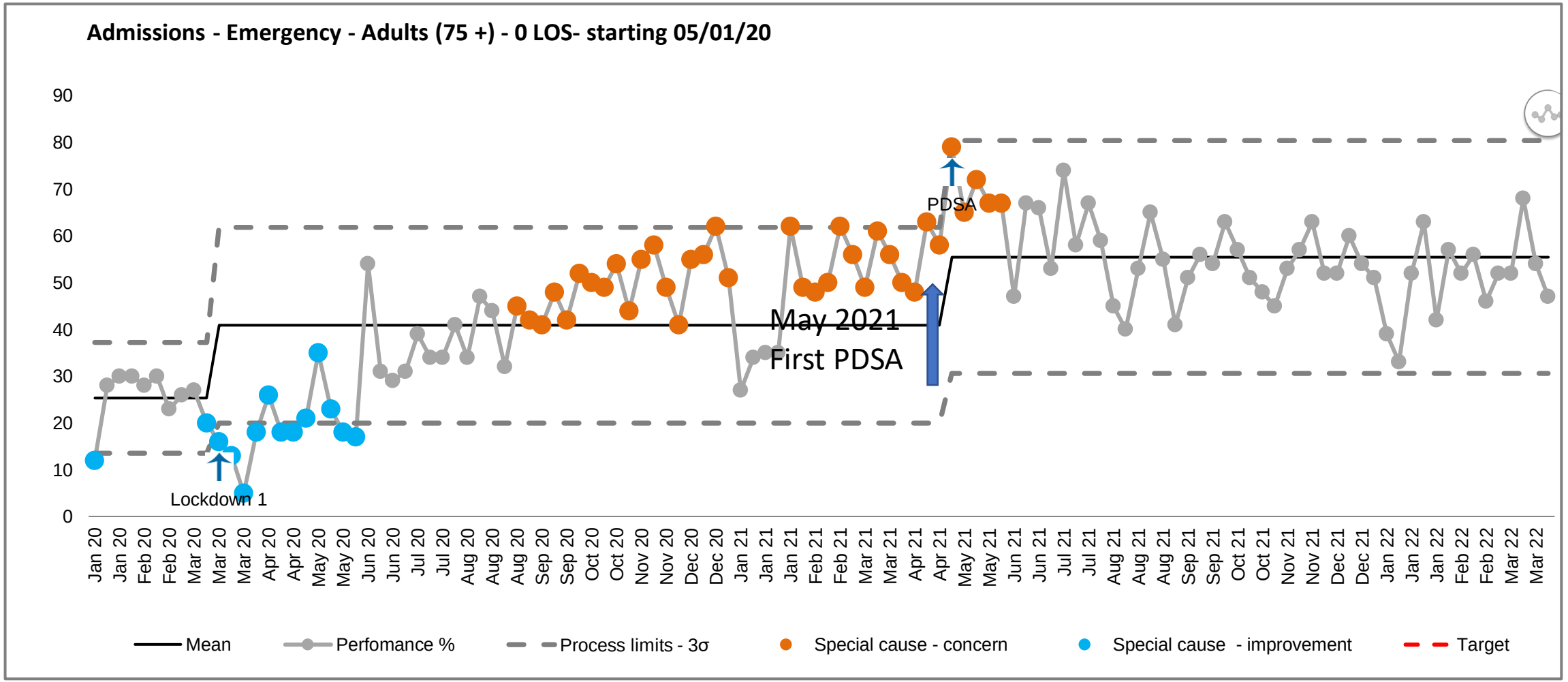
Some Myths on ‘barn door conveyances’

Long lies –more than 4 hrs need bloods	**We can do the bloods at home and treat appropriately**
Short of breath – saturations < 90%	We can provide treatment and monitoring at home – worth a discussion
Need CT /Xray	If well enough can be brought in the following morning for CT
Frailty unit full – no point calling	Even greater need for calling as we may be able to • Avoid an admission • Arrange to be seen the following day • Seen in ED by the frailty team which still avoids delay
GP called for the ambulance – has been treating for UTI, now needs investigations	These are most suitable for management at home on a virtual ward

Proportion of ambulances to SWFT with over 75s



SDEC activity in the over 75s



Hospital to Home
Warwickshire Fire Rescue Service

- **Commissioned by Warwickshire County Council**
- **Transport patients home**
  - **Wheel chair crews**
  - **2 man chair**
- **Not just a taxi service**
  - **Safety checks**
  - **Fit smoke alarms**
  - **Assess for Trips and falls**
  - **Multiagency Hoarding**
  - **Assess for vulnerability**
  - **Food in the fridge**
  - **Can refer to District nursing/Age UK/CERT**
- https://youtu.be/EYozOCOQ-uw
- Warwickshire Fire and Rescue Service Hospital to Home | Fab NHS Stuff

Key messages for Frailty

Avoid	Using 999 where possible – call local frailty services directly
Avoid	Conveyance where possible – hospital@home /virtual ward
Avoid	ED and Acute Medicine where possible – direct to frailty unit

Questions?

The Patient Flow Conference 2022

The NHS Patient Flow Conference 2022

SPEAKING NOW

Dr Katherine Henderson

President of the Royal College of Emergency Medicine
Royal College of Emergency Medicine

I will be discussing…

"Facing up to Reality in Emergency Care"

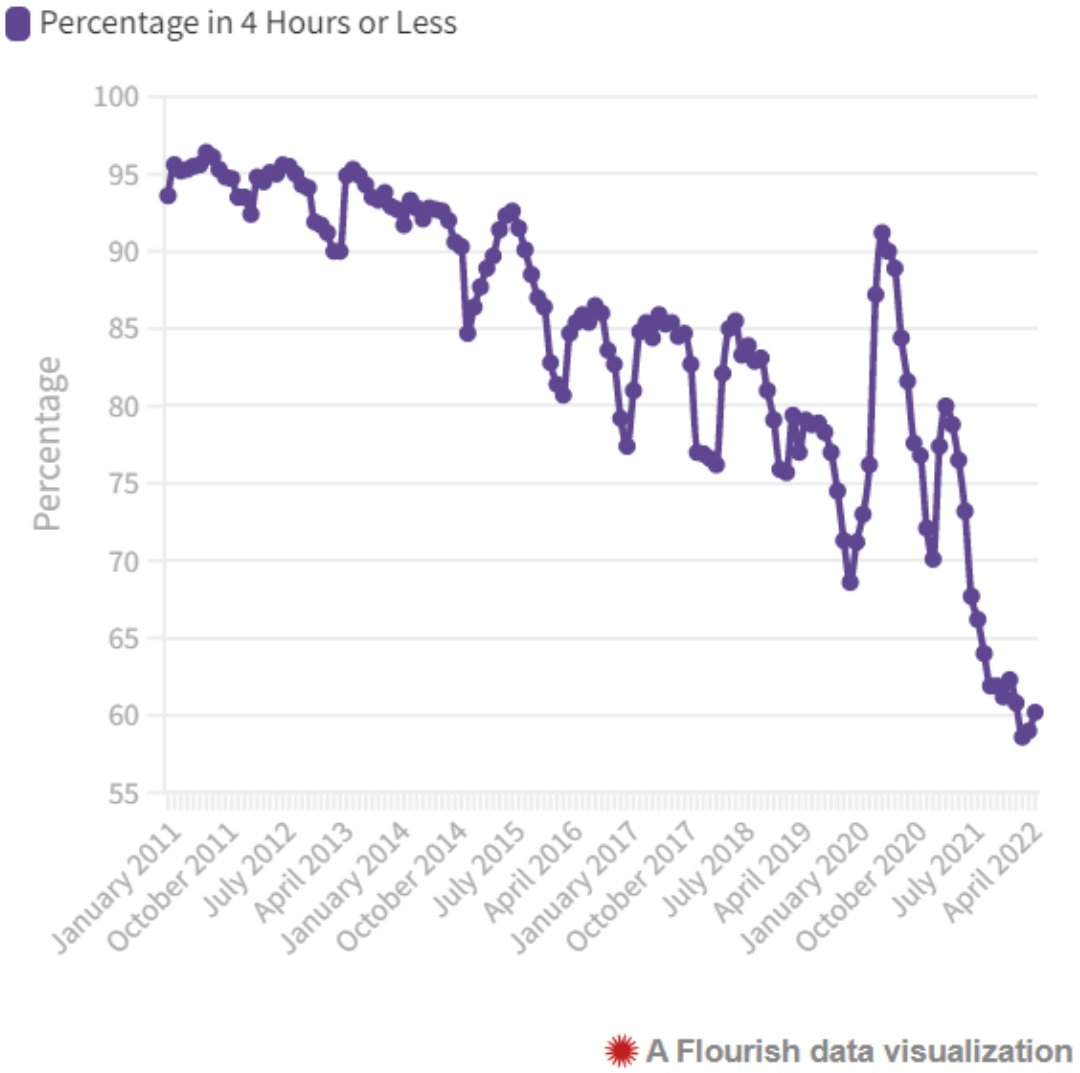
Facing up to the Reality of Emergency Care

Dr Katherine Henderson

President RCEM UK

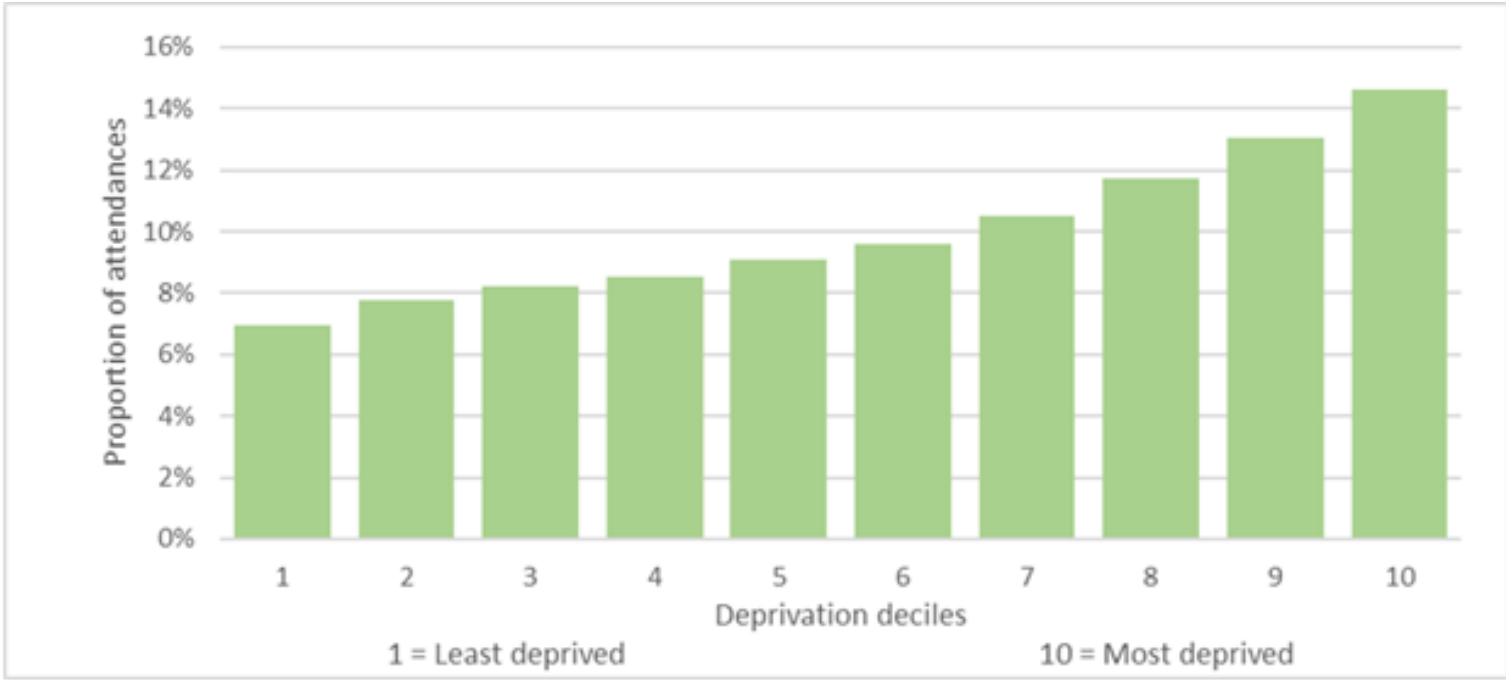

July 2022 Emergency Care - Reality - How we all feel at the moment

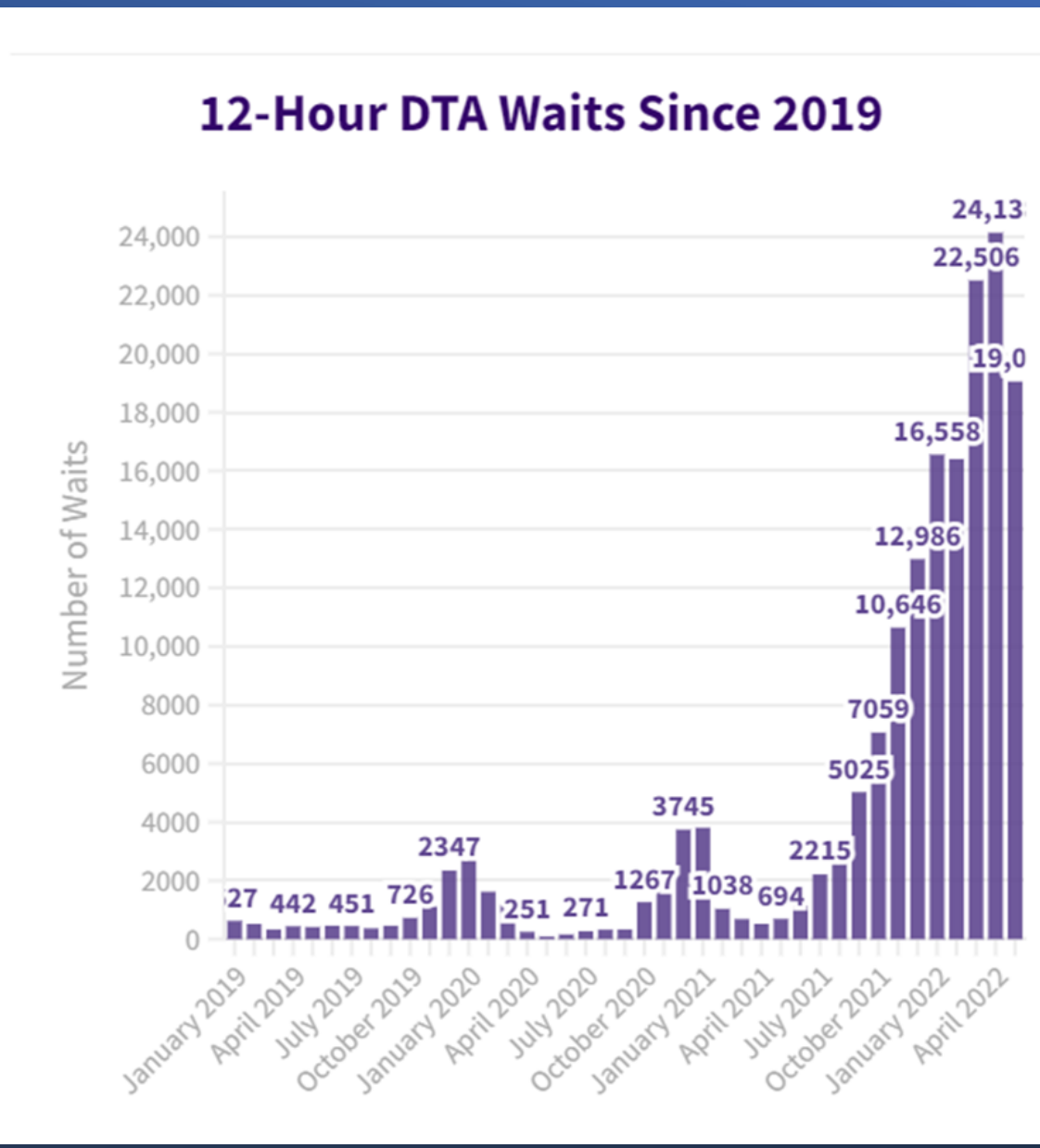
4-Hour Target in Type 1 EDs



Emergency Medicine

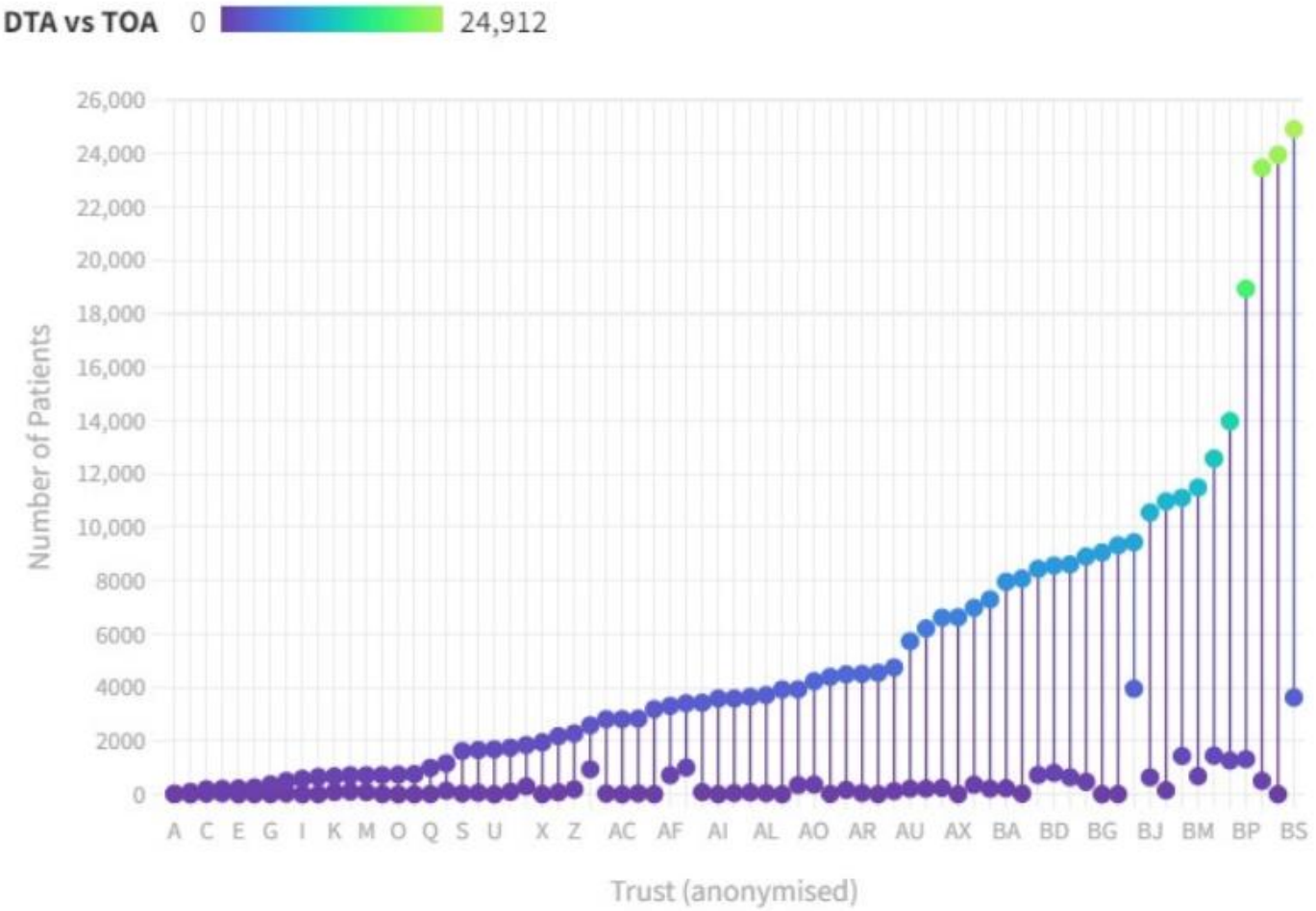
Proportion of ED attendances by level of deprivation




12-Hour DTA Waits Since 2019
Number of Waits
24,000
22,000
20,000
18,000
16,000
14,000
12,000
10,000
8000
6000
4000
2000
0
27
442
451
726
2347
251
271
1267
3745
1038
694
2215
5025
7059
10,646
12,986
16,558
22,506
19,0
24,13
January 2019
April 2019
July 2019
October 2019
January 2020
April 2020
July 2020
October 2020
January 2021
April 2021
July 2021
October 2021
January 2022
April 2022

Comparison of 12 Hour Figures by Trust

2021 yearly aggregate of 12 Hour from Decision to Admit VS. 12 Hour from Time of Arrival

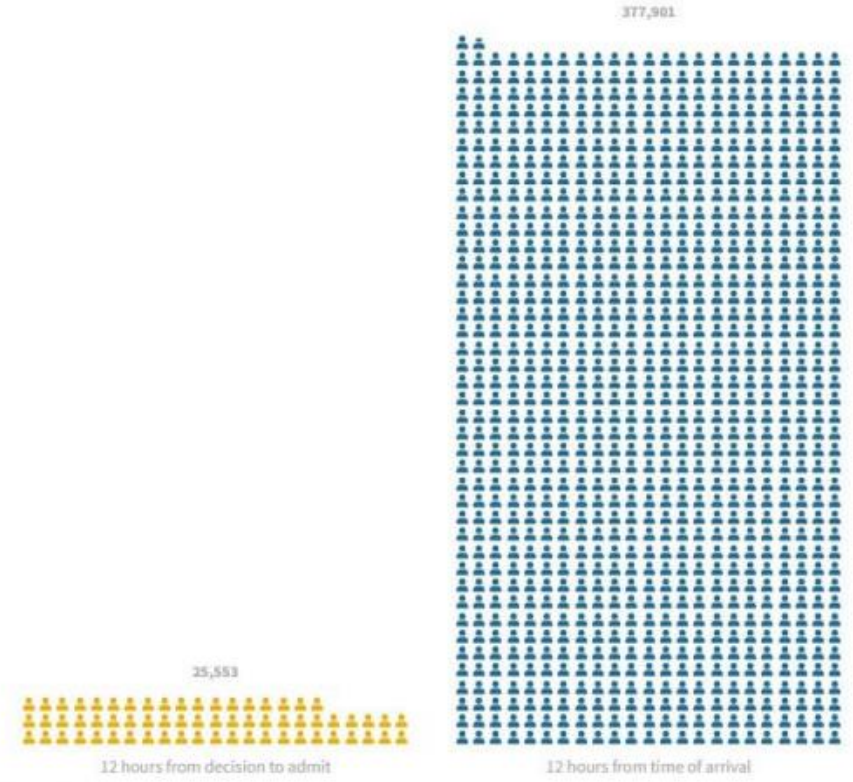


The Tip of the 12 Hour Iceberg

Patients waiting 12 hours from the decision to admit them to hospital, versus the number of patients waiting 12 hours from their time of arrival

Each Icon represents 400 patients who waited in an ED in 2021.

= 400 12 hours from time of arrival
12 hours from decision to admit



Most people do not plan an Emergency Department visit

but

everyone is a potential patient

The 10 point plan Sept 2021

Commitment	Assessment	Status
Supporting 999 and 111 services	This commitment was backed by £150 million funding to support 999 and 111. The time taken to answer NHS 111 calls was lower in the first three months of this year than the preceding three months and the proportion of calls abandoned also fell. However, this did not help to ease crowding in EDs. Ambulance response times continue to exceed national standards although in May only 387 patients waited 10 or more hours for hospital handover down from 700 in March 2022. There should be none over 60 mins.	
Supporting primary care and community health services to help manage the demand for UEC services	Capacity needs to be expanded to allow primary care to take ownership of unscheduled patients that do not require urgent or emergency treatment. The plan did not detail steps the NHS would take to expand capacity in the primary care service and the size of the GP workforce is falling. Community health teams have not been adequately supported as data published on urgent response services for April 2022 revealed huge regional variation in the number of referrals for a two-hour response.	
Supporting greater use of Urgent Treatment Centres	Attendances to UTCs increased when compared to winter 2020/21, however they were still well below pre-pandemic levels. Despite this, 4-hour performance declined, raising questions about the role and suitability of UTCs in increasing slack in the UEC system.	
Increasing support for Children and Young People	Although there has not been a significant increase in mental health presentations for children aged 5-14, young patients presenting to EDs with mental health concerns requiring admission continue to endure long stays in the inappropriate environment of a busy ED.	
Using communications to support the public to choose services wisely	There is no indication of whether the communication campaigns helped the public make informed decisions about where to access urgent and emergency care. Furthermore, even if patients were successfully informed, this does not mean that there are services available.	
Improving in-hospital flow and discharge	The plan failed to address and improve patient flow through hospitals. This winter, average bed occupancy stood at 91.9%, six percentage points higher than the year before. This winter also saw the highest numbers of long stay patients in hospital for seven, 14 and 21 days or more since winter 2017/18. There was a substantial increase in ambulance handover delays. By week 13 of the Winter Sit Reps, delays as a proportion of arrivals were 2.7 times higher than the previous year.	
Supporting adult and children's mental health needs.	Mental health patients continue to endure long stays in the ED. There is no transparency on whether commitments were met and no indication whether NHS England shared data with providers and ICS' on total attendances and 12 hour waits in ED for mental health patients. If this commitment was met, the data was not published. This was intended to bring transparency and identify systems with highest mental health pressures for the first time.	
Reviewing Infection Prevention and Control (IPC) measures to ensure a proportionate response.	Despite the plan outlining an expectation of no corridor care, in March 2022, NHS England reported the largest monthly increase on record for the number of 12-hour waits from decision to admit, with an increase of more than 6,000 from the 16,404 recorded in the previous month. Most IPC measures have now been removed, yet EDs continue to experience high instances of corridor care. Any future UEC strategy must tackle the root causes of crowding by eliminating exit block. High numbers of covid associated admissions is adding to staffing and capacity pressures.	
Ensuring a sustainable UEC workforce.	The Secretary of State's workforce plan is yet to be published, which presents a major barrier for UEC recovery, impacting staff morale and capacity in the system. Same Day Emergency Care (SDEC) can help to prevent unnecessary admissions and ease workload pressures on already strained staff. RCEM's November 2021 Snap Survey of Clinical Leads revealed only 10% had wide ranging SDEC in place for 12 hours a day, seven days a week. 81% of Trusts that responded had limited or no effective SDEC in their department.	

The 10 Point Action Plan has failed in its aims to mitigate against current pressures and improve performance in all settings. The plan itself acknowledged that full recovery of the UEC pathway "will take time and require actions


Emergency care in trouble
Patient Safety is compromised

*NHSE CEO Amanda P*ritchard speech

- Frankly, the situation we see at the moment in emergency departments and ambulance services is as challenging as any winter before the pandemic. To those colleagues …..who are immersed in this every day, let me assure you… …when you tell us about the immense pressure you are under, we hear you.
- April was the busiest ever for ambulance services in terms of calls and Category 1 incidents, and the second busiest for Accident and Emergency Departments.
- But demand isn't the whole story here.
- **The unacceptable rise in 12 hour waits for admission from A&E underlines that the issue is, as you know, flow**.
- **You can trace the line from delayed discharges… …to A&E crowding… …all the way through to slower ambulance response times**.

https://www.healthpolicyinsight.com/nhs-england-ce-amanda-pritchards-speech-to-nhs-confedexpo-2022/

Team EM and the future

Face up to the 12 hour data and act on it

The Patient Flow Conference 2022

The NHS Patient Flow Conference 2022

CONVENZIS

UP NEXT...

DNV Imatis

The Patient Flow Conference 2022

The NHS Patient Flow Conference 2022

CONVENZIS

SPEAKING NOW

Michael Fjelstad

Solution Consultant
DNV Imatis AS

I will be discussing…

"Case Study Haraldsplass Diaconal Hospital"

C.F. Møller Architects, Fotograf Jørgen True

Haraldsplass – a Journey

Real-Time Clinical Operations Management

A “must” in every new hospital

Michael Fjeldstad
Product consultant DNV Imatis

Haraldsplass
Diakonale Sykehus

About Haraldsplass Diaconal Hospital

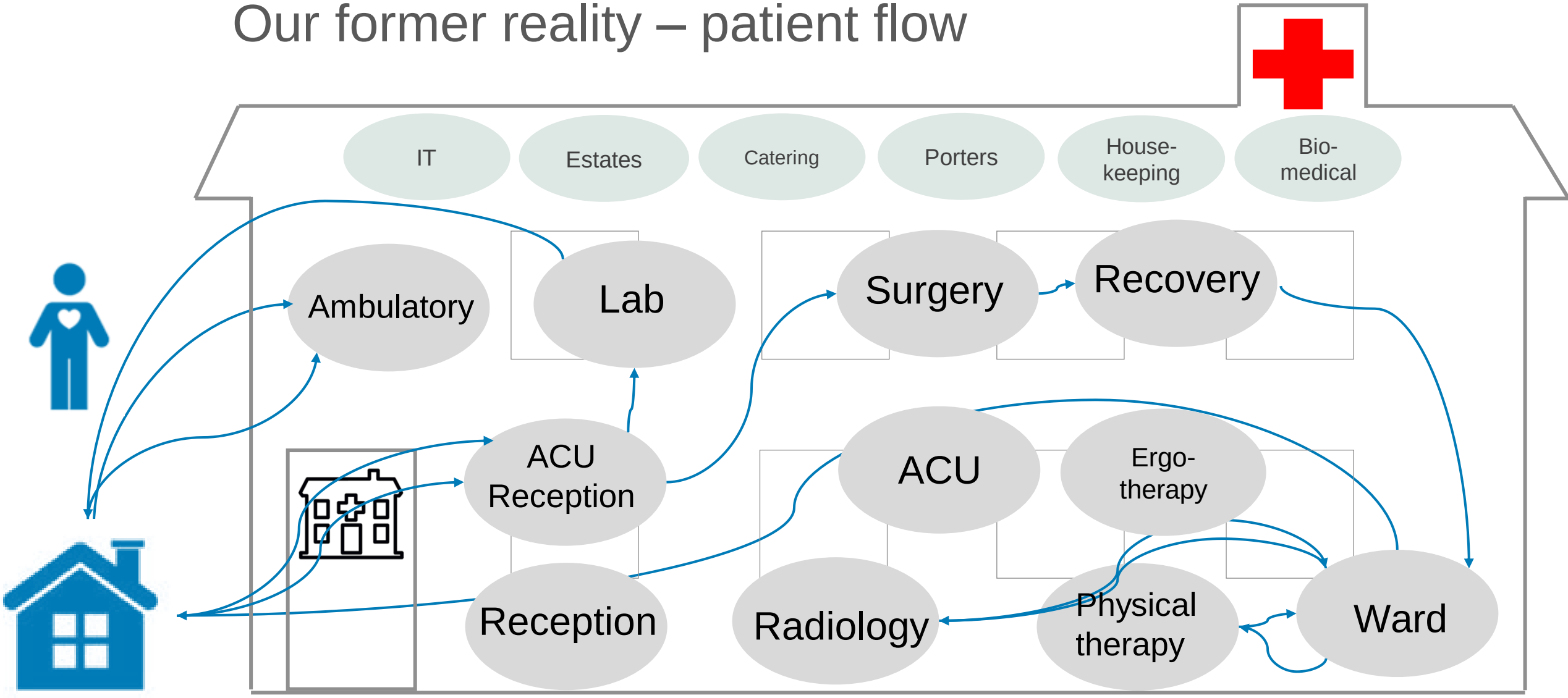
Acute Care Hospital

- Internal medicine hospital for 145.000 inhabitors
- 1200 employees
- Part of region Helse Vest
- 33.000 employees

- High competence in advanced knee, shoulder and prosthetic surgery

100.000 visits a year

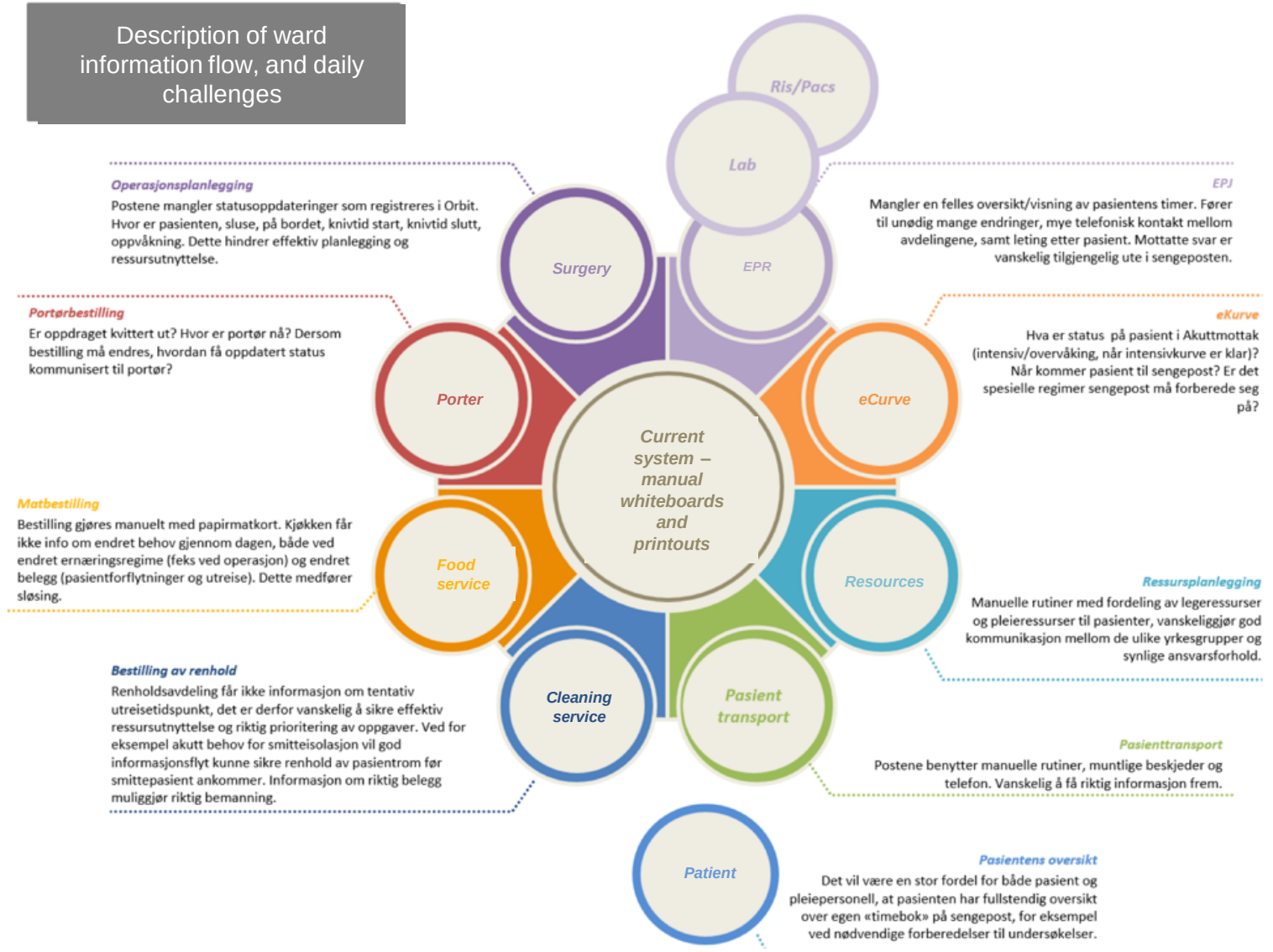
Our former reality – patient flow



Our former reality – systems in silos

- Many systems
- Manual workflows
- Time to obtain information
- Quest for resources (people, equipment)
- Time for coordination

Description of ward information flow, and daily challenges

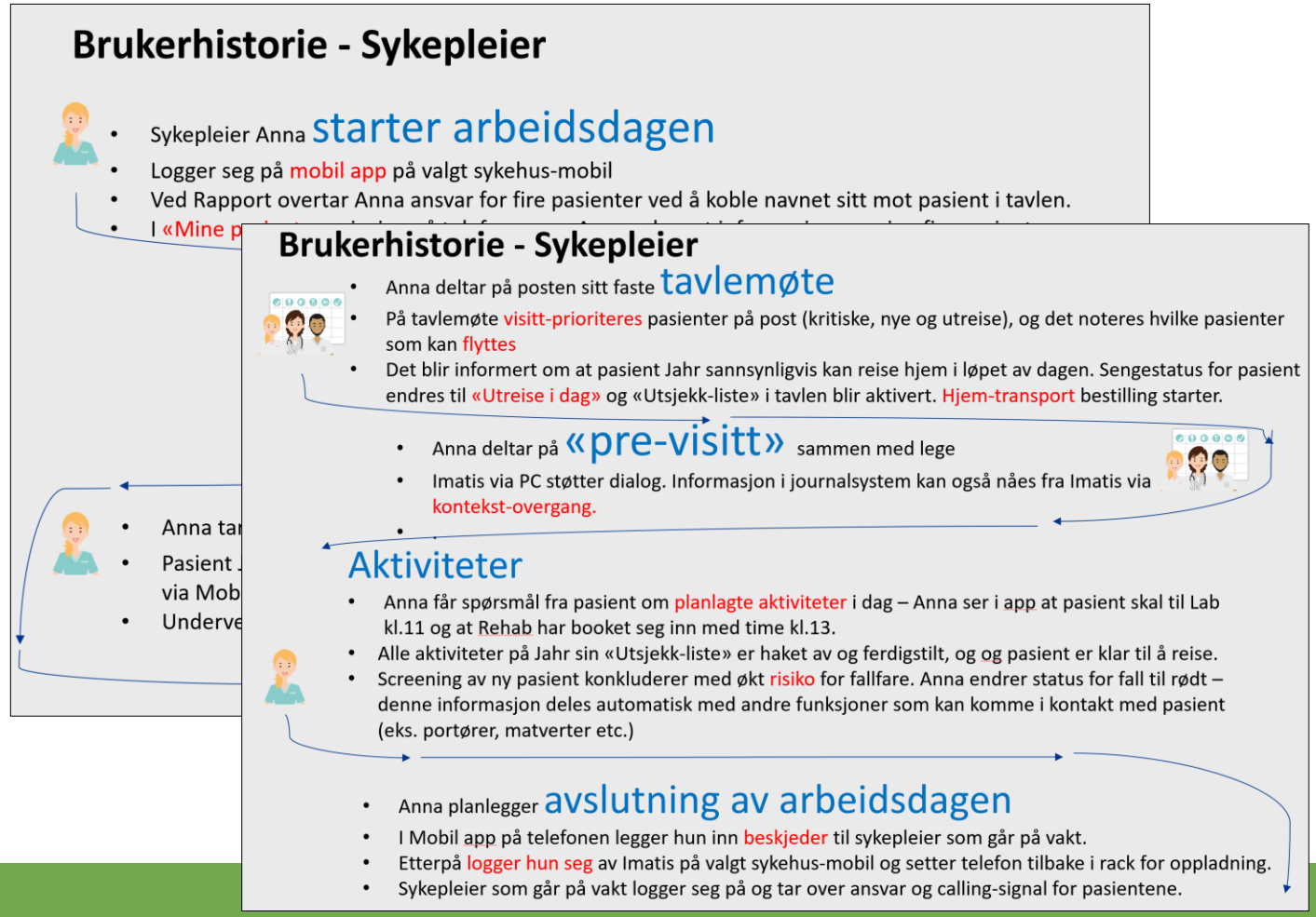


Haraldsplass
Diakonale Sykehus

How would we like it to be?

How did we found out what we wanted?

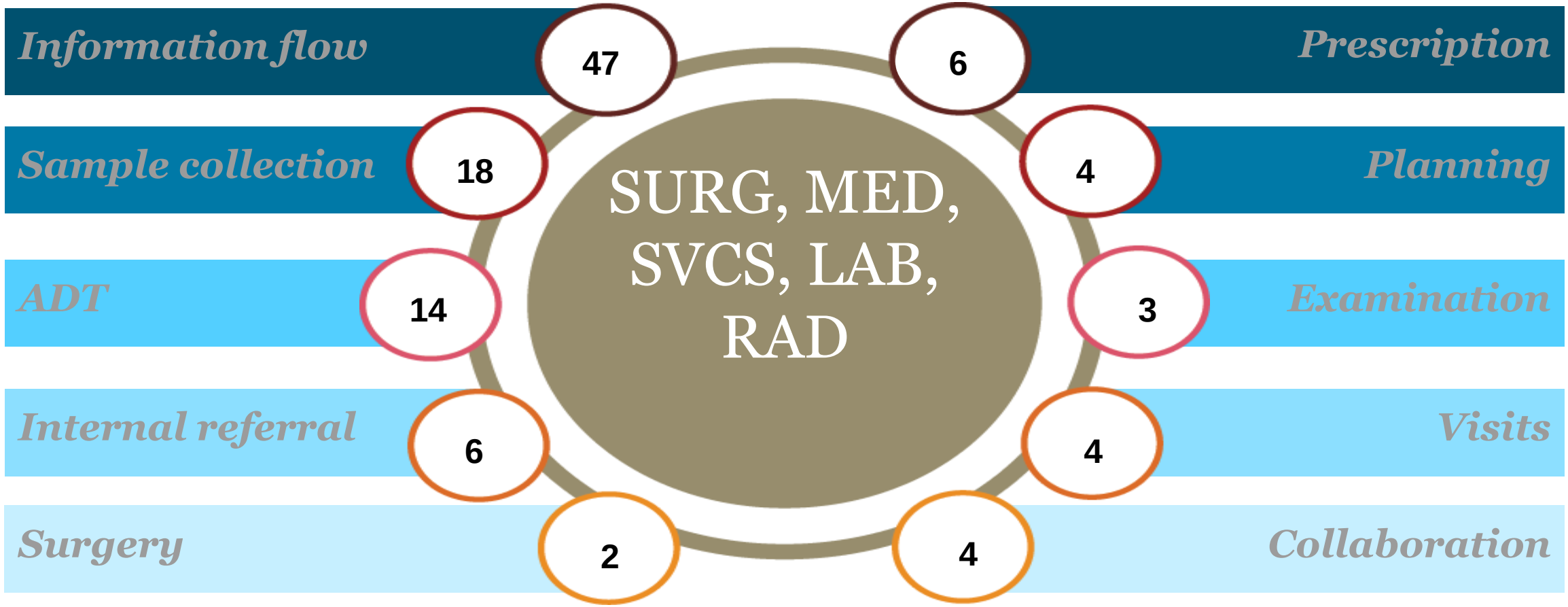
- We collected a lot of user stories (84 pages)
- How we work today and what is our “dream scenario”
- Met with all professional groups
- Observed how they work
- Documented



How did we found out what we wanted?

We looked at old, unsolved projects

We identified 104 issues that were unsolved



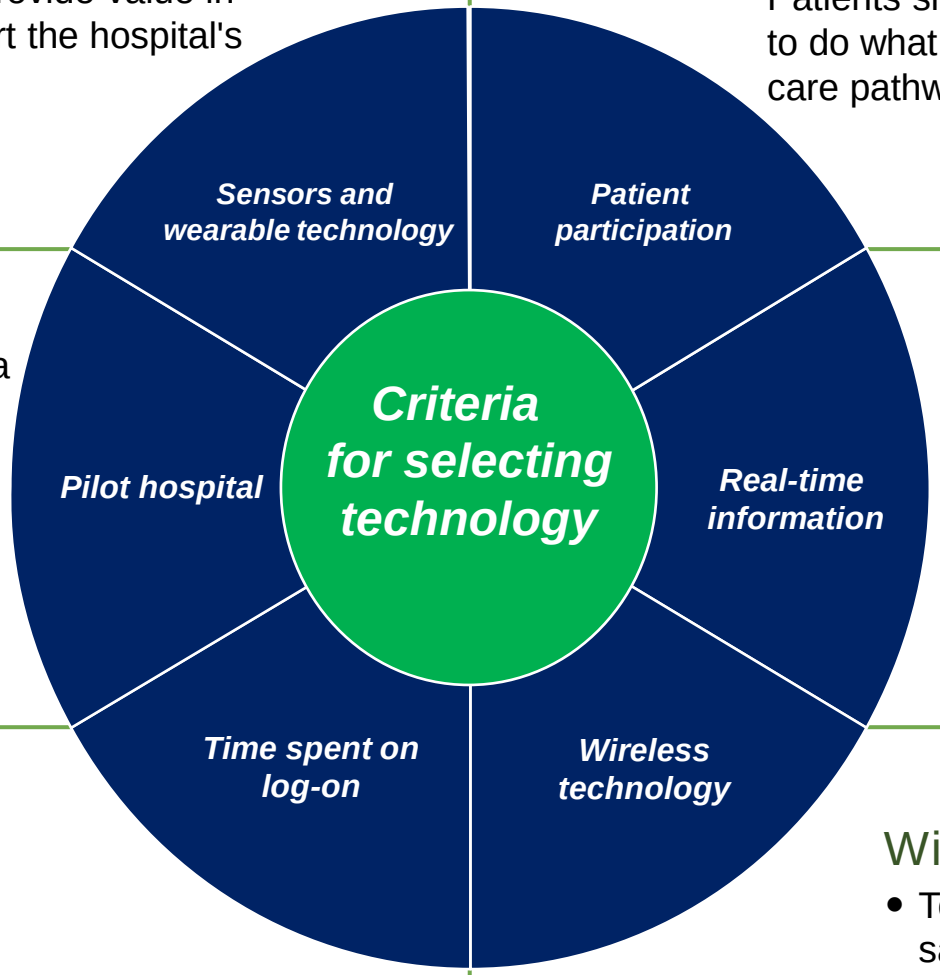
Guidelines for technology selection

Sensors and wearable technology

- To be used where this can provide value in patient treatment and support the hospital's objectives

Patient participation

Patients should be encouraged and enabled to do what they can themselves through the care pathway



Pilot hospital

- In priority areas, we will work to be a pilot hospital by introducing technological solutions in Helse Vest region
- Efforts will be made to choose "off-the-shelf solutions" and well-proven technology

Real-time information

- Capture data at the source
- Record once
- Double registration shall end
- Retrive information when and where needed

Time spent logging in

- Shall be minimised

Wireless technology

- To be used where it delivers satisfactory, and sound functionality and safety

Pre-requisite: We have built a new digital foundation...

- A mature reliable WiFi network throughout the hospital (also old in buildings)
- Fully developed reliable wired network throughout the hospital
- Prepared for “electronic door signs” at all patient rooms as well as TVs
- Internal mobile network, separate base stations from with a passive distribution network
- 600 iPhones have largely replaced DECT, landlines and calling
- Prepared for nursecall via DNV Imatis (Silent hospital)
- Regional pilot hospital for management of patient flow and resources in HV

Haraldsplass Diakonale Sykehus

What does it take to succeed?

- A management team that wholeheartedly support the project
- Establish and communicate **clear goals** at the organization level, why do we do this change in the hospital
- Strong management **commitment** at all levels is crucial to ensure a good implementation
- **Composition** of project team, access to good interdisciplinary competence in the project team both with healthcare and technology professionals
- **Enough resources** for good project implementation
- Good collaboration with all the participants
- ***Understand that changing working methods and processes takes time***

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Most important success factor:
Commitment, find the 2%

"Departments introduced the new system before we expected because they wanted it and saw the value it brings"

- Petter Thornam quality director Haraldsplass Diaconale Hospital

DAGENS Medisin

Nyheter Debatt Pharma DM Arena

NYE SMARTTAVLER: Avdelingsleder Elisabeth Mjøs og lege Alf-Olav Haukelid kan lettere dele informasjon med den nye samhandlingstavlen.

SPESIALISTHELSETJENESTE

Slik jobber de på nye Haraldsplass sykehus

Smarttelefoner til alle, storskjermer med samtidsdeling av informasjon og moderne legemiddeltraller har skapt en ny hverdag for de ansatte ved Haraldsplass diakonale sykehus.

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Målfrid Bordvik
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Del: Del 535 Tweet Share Mail Skriv ut

Leading Norwegian medical publication

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Diakonale sykehus

What have we accomplished?

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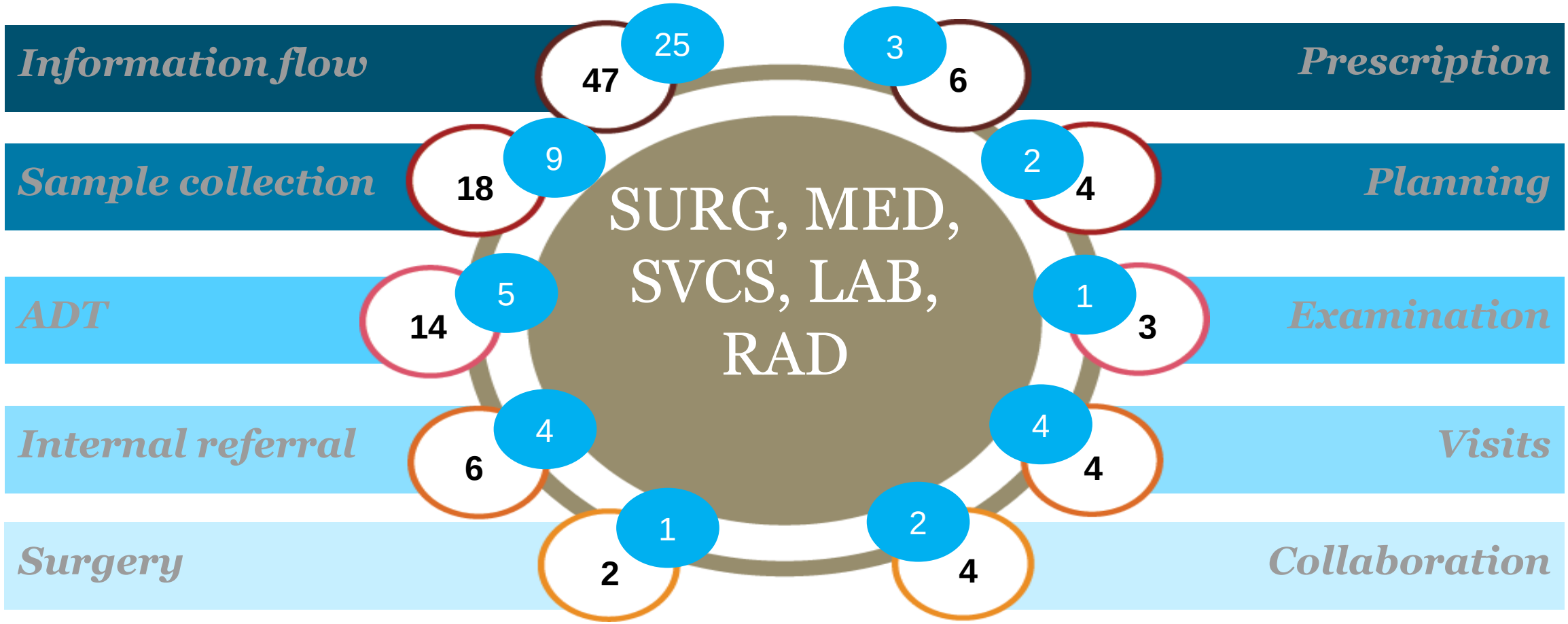
DNV Imatis solves 56 of the 104 identified issues without any customisation



Patient flow mngt

- Patient – where to?
- Is sample collected?
- Is the porter ordered?
- Patient day schedule
- Where is the patient?
- Is a patient being examined?
- Plan for the stay?
- Is the x-ray taken?

Resource management

- Who is the responsible support resource?
- Who is the responsible nurse?
- Which nurse is available
- Which doctors are available
- Who is the treating physician

Notifications

- Waiting for lab results
- Nurse call
- Calling
- Motion detection
- Critical alerts
- Waiting for imaging results

Patient safety

- Triage 1 2 3
- Safe surgery
- In safe hands 24/7
- Treatment plan
- Patient pathway

DNV Imatis' solution involves, the right information for the right person at the right time…

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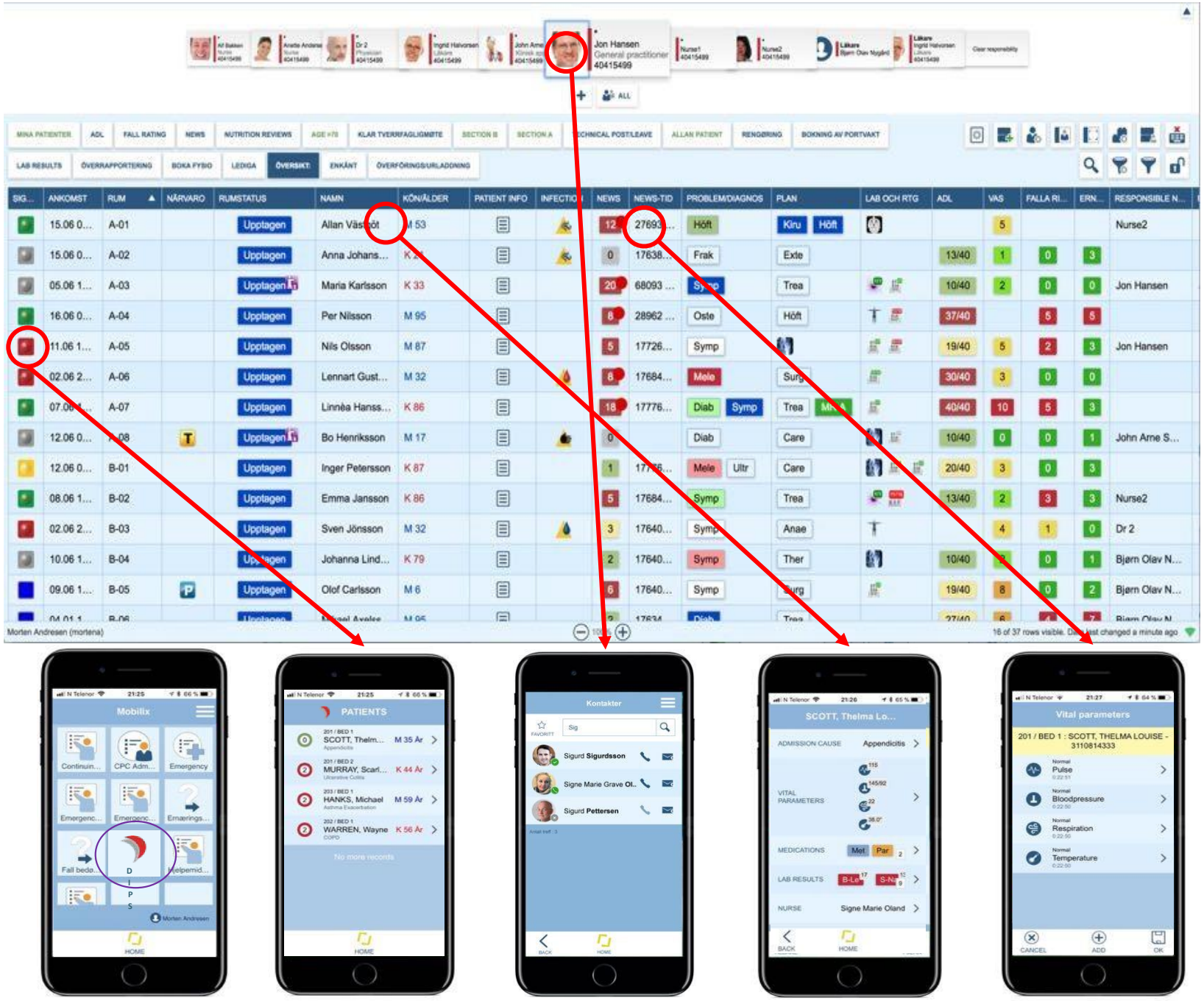
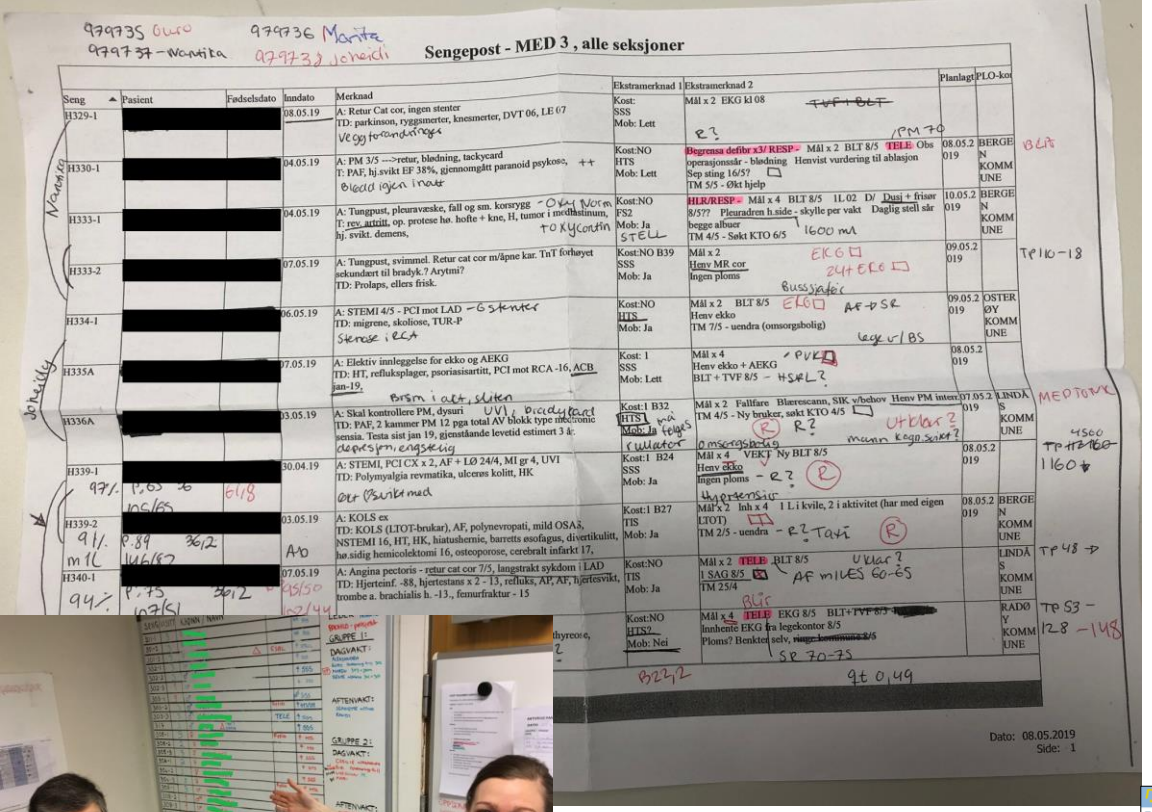
Seamless connection on all platforms

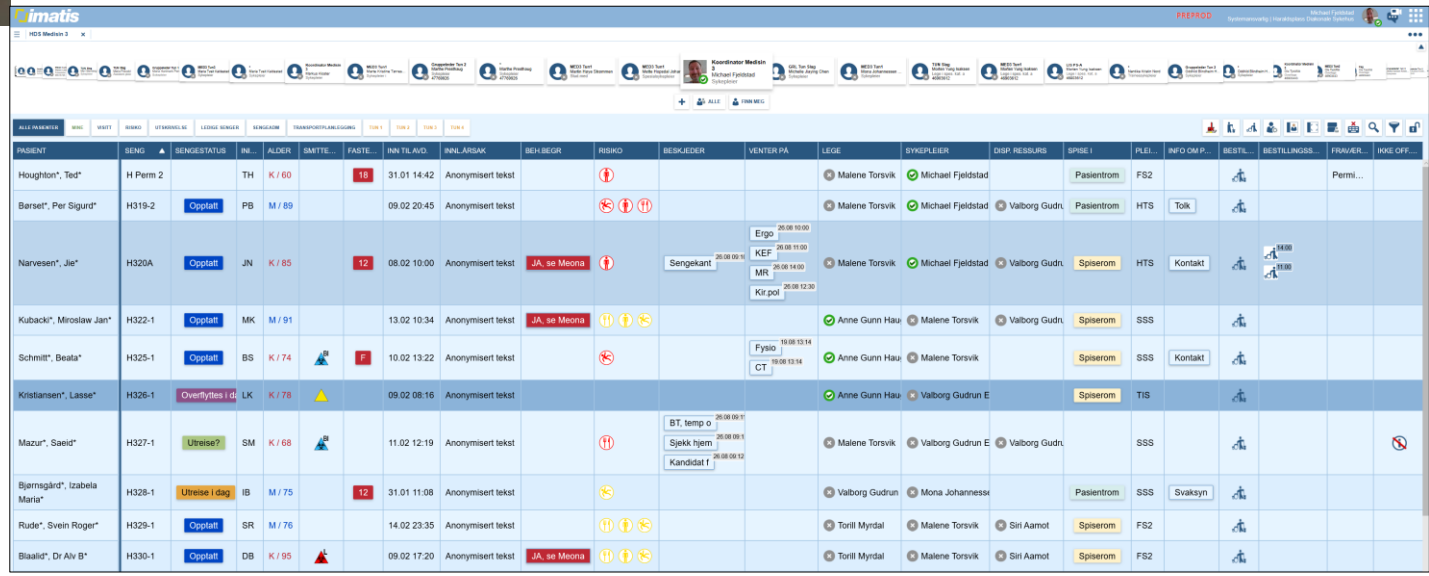
- ***See*** who is the responsible resource
- ***Call*** directly to the responsible resource
- ***Send*** a message directly to responsible resource
- Get ***alerts*** on "my" patients
- Simple ***registrations*** on the “move”
- ***Find*** the patient, regardless of department





From paper and manual whiteboards …

…to real-time information sharing



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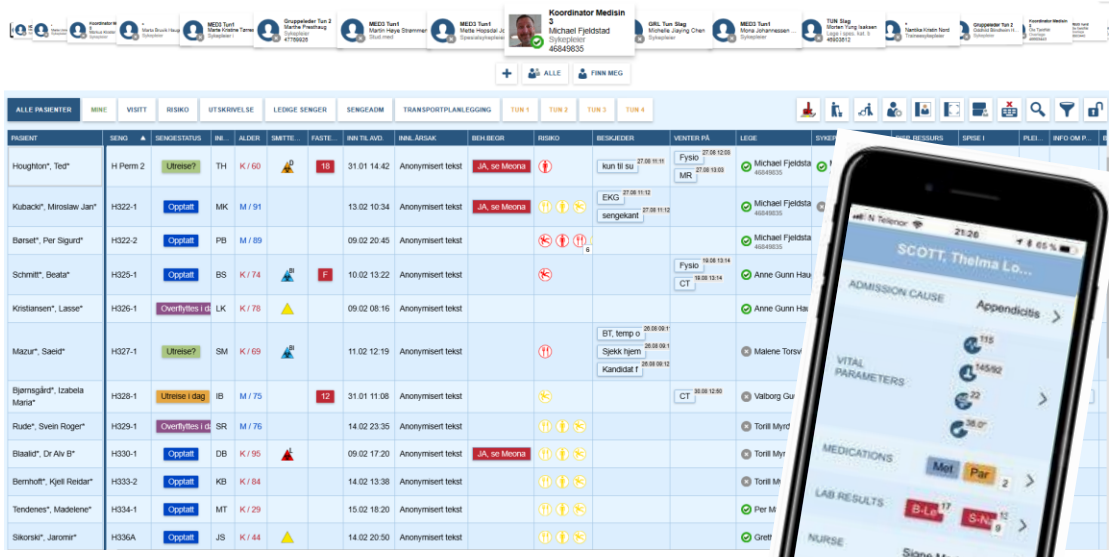
Digital WB

- Real-time overview
- Overall display of important information
- Regardless of platform
  (touch screen / PC / tablet / mobile)
- Adapted needs for each ward based on a template
- Context transition to the EPR
- Anonymous



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Cleaning services

- Complete, automated cleaning solution
- Closed loop
- The cleaner logs onto a mobile device

- Priority rooms are cleaned first
- Avoid washing rooms before discharge
- Know about infection regimen and whether the patient is "dangerous"

imatis

HDS Beleggsoversikt | HDS Medisin 3 | HDS Resepsjon | HDS Portør oppdragsoversikt | HDS Renhold faste oppdrag

ALLE GJENSTÅR I DAG | ALLE I DAG | ALLE UTFØRT I DAG | ADMIN | OMRÅDE: H4 | FØLGES OPP

R. ▲1	ROM ▲2	ROM BESKR.	SENGESTATUS	SMITTEREGIME	KVITT.	RENHOLDSPLAN	SIST RENGJ.	NESTE RENGJ.	INFO. OM...
H4	H Korr-1	Seng	Opptatt		✔	7 d/u	05.08 14:24	09.08	
H4	H416-1	Seng	Opptatt		✔	7 d/u	06.08 07:10	09.08	
H4	H419-1	Seng	Opptatt		✔	7 d/u	06.08 07:10	09.08	
H4	H420A	Seng	Opptatt		✔	7 d/u	06.08 07:09	09.08	
H4	H422-1	Seng	Opptatt			7 d/u	23.08 10:37	24.08	
H4	H422-2	Seng	Opptatt			7 d/u	23.08 10:37	24.08	
H4	H425-1	1-seng	Opptatt			7 d/u	05.08 12:58	06.08	
H4	H426-1	1-seng	Opptatt			7 d/u	06.08 07:09	07.08	
H4	H427-1	1-seng	Opptatt			7 d/u	06.08 11:49	07.08	
H4	H428-1	1-seng	Opptatt			7 d/u	06.08 12:03	07.08	
H4	H430-1	1-seng	Opptatt			7 d/u	05.08 12:37	06.08	
H4	H433-1	Seng	Opptatt			7 d/u	05.08 07:14	06.08	

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Porters

- Complete automated information
- Able to “turn the trip“ with a few taps
- Porters receives information about infection status and fall risk
- Nurses have real-time overwiew

ALLE (SISTE 24T) | BESTILT | PÅGÅR | UTFØRT (SISTE 24T)

EN…	TIDSPU… ▼	KATEG…	STATUS	PRIORITET	SMITTE…	FRA	TIL
	04.09 10:38	Pasient	Utført	Normal	BI	Medisinsk klinikk\Medisin 3\H325-1 (1-seng)	Fagavdeling
	04.09 10:16	Pasient	Utført	Normal		Medisinsk klinikk\Medisin 3\H322\H322-2 (1,5-seng)	Bygglokasjoner
	04.09 10:13	Pasient	Utført	Normal	D	Medisinsk klinikk\Medisin 3\H Perm\H Perm 2 (Permisjonsseng)	Fagavdeling

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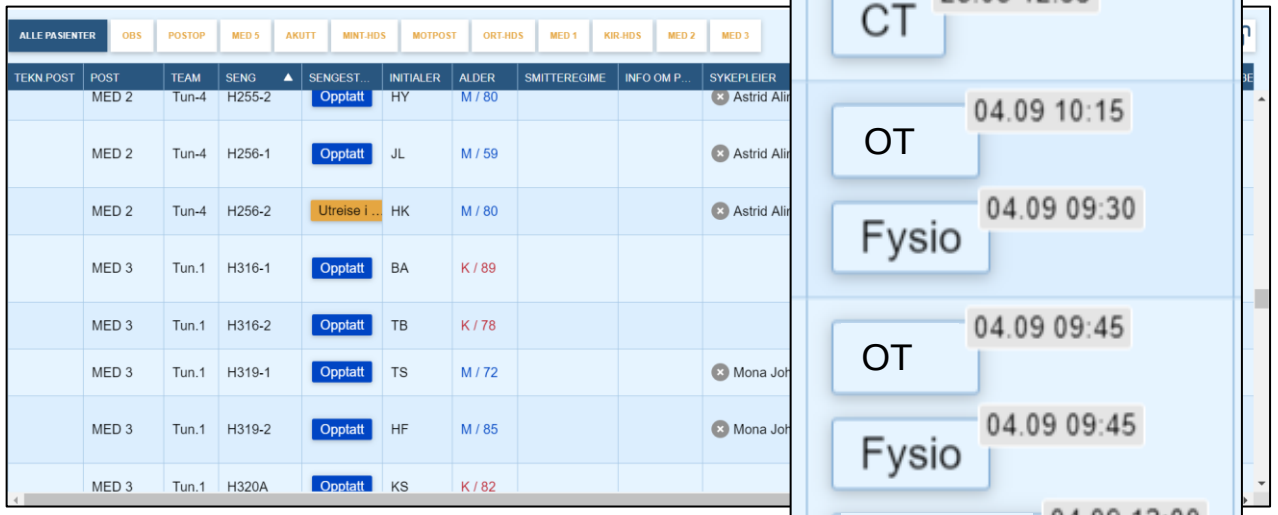
“Waiting on”, plan for the day

- Wards request required support services
- Support services generate "plan for the day" (X-ray, PT, OT, speech therapist, outpatient clinics, etc.)
- Radiology department can advise and give an appointment faster (no need to call)
- Easier to schedule inspections
- Fewer “road trips”
- Easier to inform the patient at "bedside" about the plan for the day



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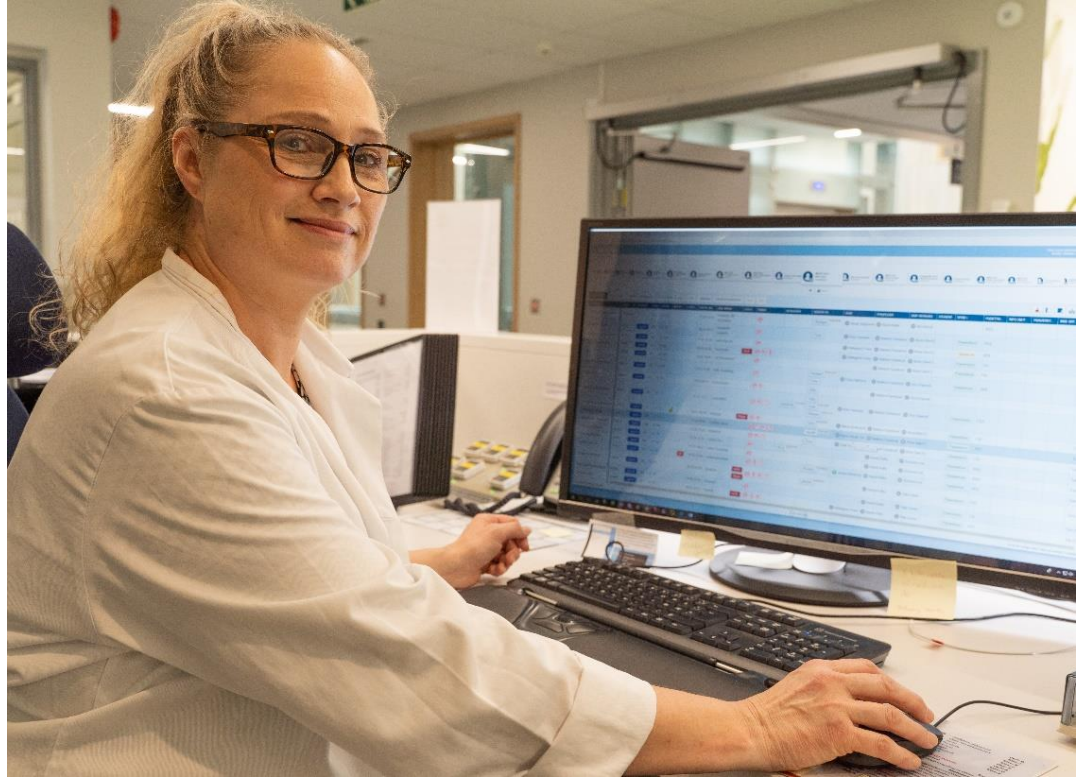
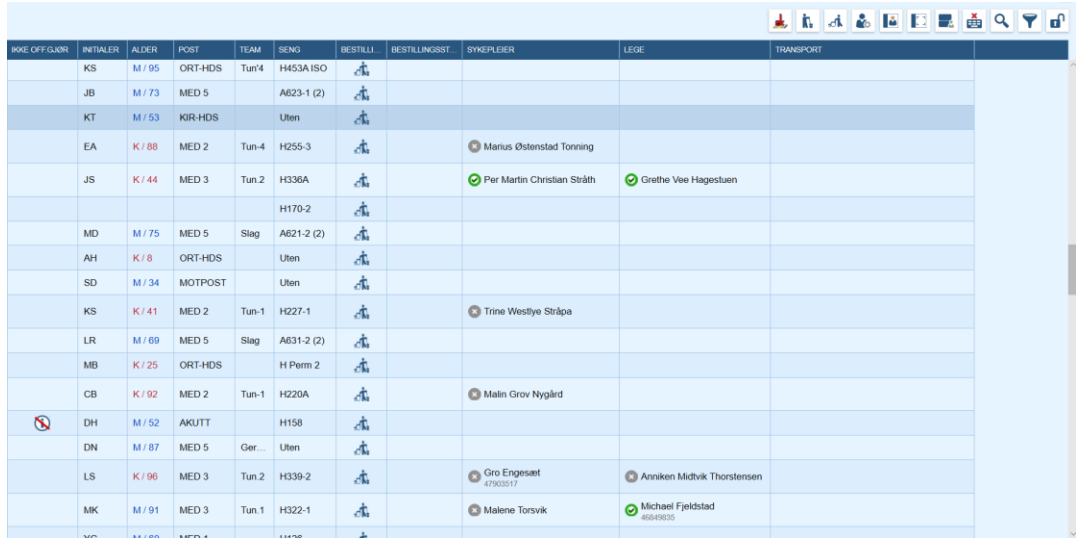
Anonymous reception view

- For the main reception
- For floor reception
  - Search for patient by name
  - Shows where the patient is
  - Who is responsible
  - If transport has been ordered
  - Important during Covid





IKKE OFF.GJØR	INITIALER	ALDER	POST	TEAM	SENG	BESTILLI...	BESTILLINGSST...	SYKEPLEIER	LEGE	TRANSPORT
	KS	M / 95	ORT-HDS	Tun'4	H453A ISO					
	JB	M / 73	MED 5		A623-1 (2)					
	KT	M / 53	KIR-HDS		Uten					
	EA	K / 88	MED 2	Tun-4	H255-3			Marius Østenstad Tonning		
	JS	K / 44	MED 3	Tun.2	H336A			Per Martin Christian Stråth	Grethe Vee Hagestuen	
					H170-2					
	MD	M / 75	MED 5	Slag	A621-2 (2)					
	AH	K / 8	ORT-HDS		Uten					
	SD	M / 34	MOTPOST		Uten					
	KS	K / 41	MED 2	Tun-1	H227-1			Trine Westlye Stråpa		
	LR	M / 69	MED 5	Slag	A631-2 (2)					
	MB	K / 25	ORT-HDS		H Perm 2					
	CB	K / 92	MED 2	Tun-1	H220A			Malin Grov Nygård		
	DH	M / 52	AKUTT		H158					
	DN	M / 87	MED 5	Ger...	Uten					
	LS	K / 96	MED 3	Tun.2	H339-2			Gro Engesæt 47903517	Anniken Midtvik Thorstensen	
	MK	M / 91	MED 3	Tun.1	H322-1			Malene Torsvik	Michael Fjeldstad 46849838	

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4 times as many patients

in an orthopedic outpatient clinic

Before the change:

- Long queues (<2500 patients)
- Great frustration
- High sickness absence
- Angry patients
- Poor collaboration between professional groups

After a new flow via DNV Imatis:

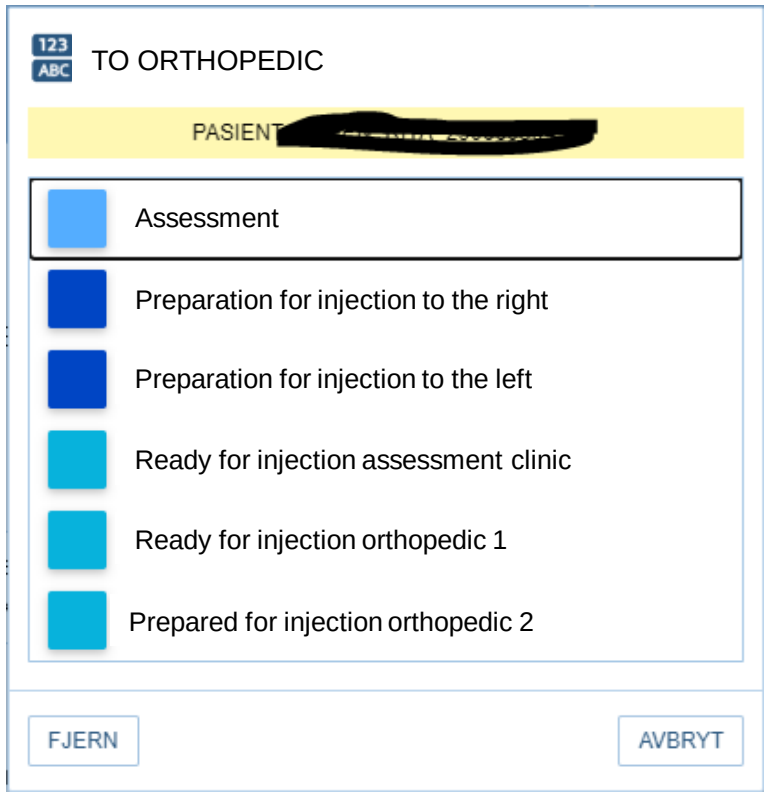
- 4 times as many patients every day
- The queues eliminated
- Declining sickness absence
- Patients come to the appointment quickly
- Major change in collaboration between professional groups

How we did it:

4 Physical therapists

1 Orthopedic doctor

1 Nurse

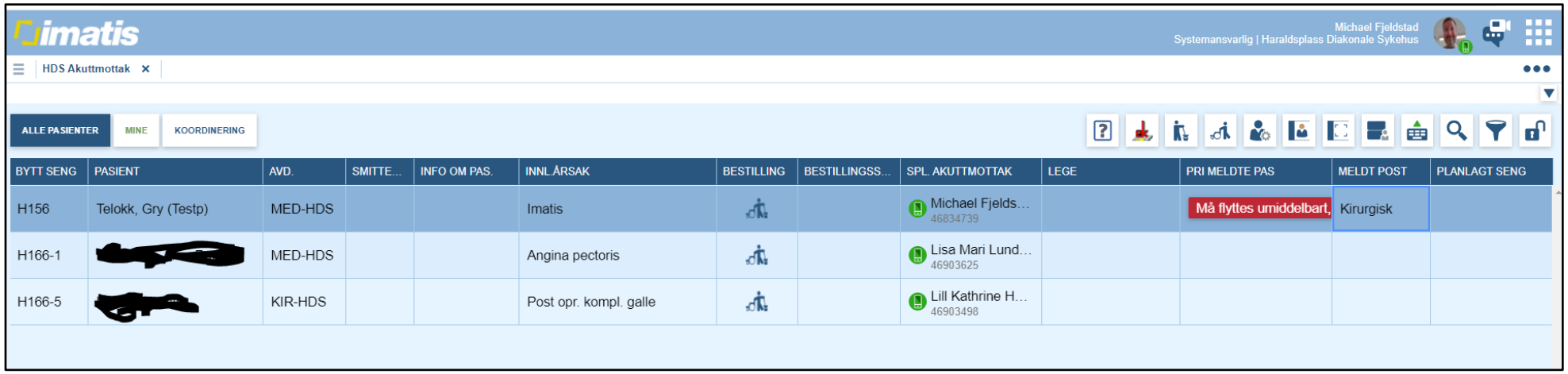


Automated messages have been set up about who and what to do

+ Flow automation
+ No need to look for each other
+ More time for the patient
+ Simplification of work process

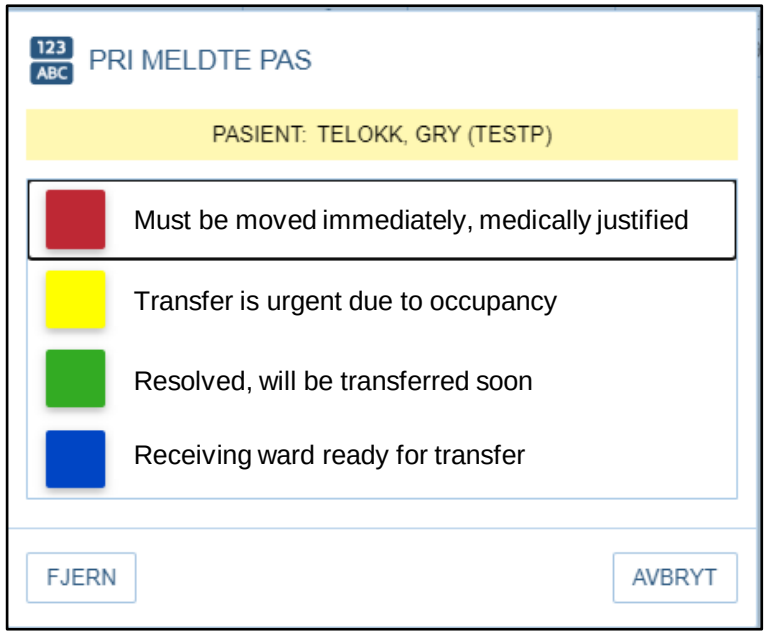
Success factor:
Committed users who clearly convey what is the best flow

Admitting patients from A&E to the ward



We notify the ward about A&E patients' admissions via DNV Imatis

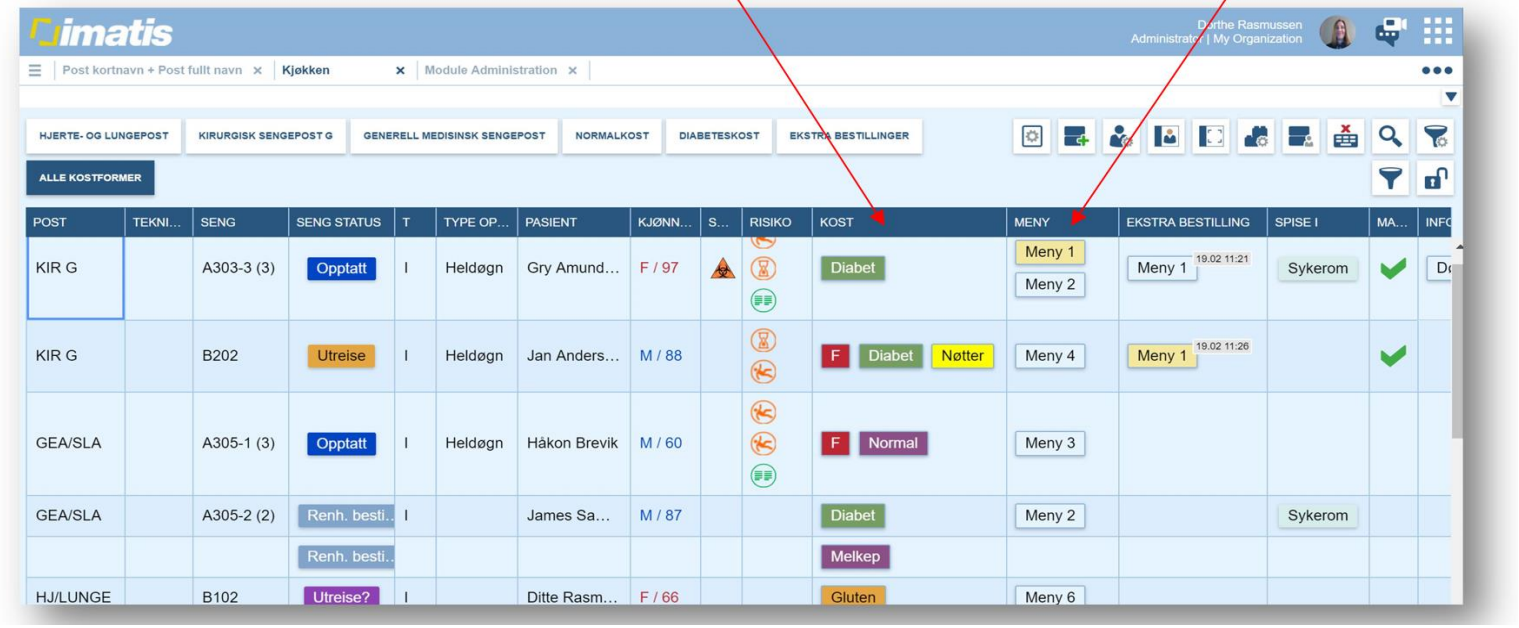
- Automated process:
- Who should report
- What information to share
- Who receives the confirmation in admissions
- Only by 1 touch



Food ordering in DNV Imatis

- Digital food cards
- Separate view for nurse, dietitian and kitchen
- Enter food requests in Mobilix “bedside”
- Always updated food wishes
- Significantly reduced food waste

22.07.2021					Dinner overview												12:48								
Post	Meny 1	Meny 2	Meny 3	Meny 4	Meny 5	Meny 6	Meny 7	Meny 8 diett	Meny 9 diett	Meny 10 diett	Meny 11 diett	Meny 12 diett	Meny 13 puré	Meny 14 puré	Meny 15 puré	Meny 16 puré	Meny 17 kraft	Meny 18 kraft	Meny 19 kraft	Meny 20 kraft	Dessert 1	Dessert 2	Dessert 3	Dessert 4
Kir/Ort	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0
Obs / Med 1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Med 2	0	1	0	2	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	0
Med 3	4	1	0	1	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	3	1	0	1
MIPO / Med 5	1	1	1	1	2	0	0	0	0	0	0	1	0	0	0	1	0	0	0	0	2	4	0	2



Haraldsplass Diakonale Sykehus

Overall occupancy overview HDS

03.11.2021		Occupancy overview			10:16	
Ward	No. pat. (w/o leave)	Patients on leave	Discharge?	Discharge today	Transfer patients	Suspected pandemic	Confirmed pandemic
Akuttmottak Med	7	0	0	0	0	2	0
Akuttmottak Kir/Ort	4	0	0	0	0	1	0
Observasjon (10)	11	0	0	3	0	0	0
Med 1 (5)	5	0	0	0	0	0	0
Med 2 (31)	32	0	2	0	0	0	2
Med 3 (29)	31	0	11	0	0	0	0
Med 5 (24)	24	0	5	0	0	0	0
Intensiv (6)	3	0	0	0	0	0	1
Preoperativ (KODA)	1	0	0	0	0	0	0
Postoperativ Kir/Ort	6	0	0	0	0	0	0
Kirurgisk (20/15)	14	0	0	1	0	0	0
Ortopedisk (17/10)	17	0	3	2	0	0	0
Totalt	153	0	21	6	0	3	3

- Staff planning
- Patient flow planning
- Overview of Covid 19 patients
- Used by
  - Directors
  - Managers
  - Coordinators
  - Nurses
  - etc.

DNV Imatis - out patient

- Fully automated flow for outpatient patients through the hospital.
- The patient is notified one hour before arrival, with information on where he is going.
- The patient can choose whether they want to check in by phone or vending machine.
- In the waiting zones, there are anonymous waiting room boards that display your reference number for the day.
- When it's your turn, you will receive a message on your phone and on the waiting room screen about which room you are going to

Haraldsplass
Diakonale Sykehus

Haraldsplass
Diakonale Sykehus

What would we do differently?

Lessons learned

- We think we chose the right implementation strategy → step-by-step implementation
- BUT with step-by-step implementation it is not possible to have full effect right away
- We underestimated the information needs: What does the hospital want with this?
- Especially important in relation to the experience of benefit and gain: Gains are often asymmetrical and indirect, i.e., that someone must do something for others to gain
- Too much information on the boards at the beginning → in a pilot everyone wants everything. It is important to test and adjust, before expanding

Haraldsplass Diakonale Sykehus

What we have: Committed employees!

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The Patient Flow Conference 2022

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Wednesday 6th July 2022- 2022- 08:00am – 15:30pm – Hatfield's Conference Centre

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The NHS Patient Flow Conference 2022:

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Q&A Panel

Michael Fjeldstad

Solution Consultant
DNV Imatis AS

Dr Katherine Henderson

President of the Royal College of Emergency Medicine

Jyothi Nippani

National Clinical Lead
NHHE/I Emergency & Elective Improvement

Jenny Keane

Director for Hospital Discharge & Community Rehabilitation

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MORNING BREAK, NETWORKING & REFRESHMENTS

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Chair Morning Reflection

Douglas Hamandishe

"Alcidion Clinical Consultant and Broadcaster – Centric Health Media"

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UP NEXT...

CATALYST BI

BRINGING PEOPLE AND DATA TOGETHER

The Patient Flow Conference 2022

The NHS Patient Flow Conference 2022

SPEAKING NOW

Jenni Woods

Health & Business Intelligence Lead
NHS Tayside – Alongside Catalyst BI

Susan Paterson

Associate Director – NHS Tayside
Alongside Catalyst BI

I will be discussing…

”Helping Predict Demand & Manage Patient Flow in the NHS”

CONVENZIS

Predicting and Managing Patient Flow

Barney Ulyatt

Business Development Manager – Catalyst BI

Jenni Woods

Health & Business Intelligence Lead – NHS Tayside

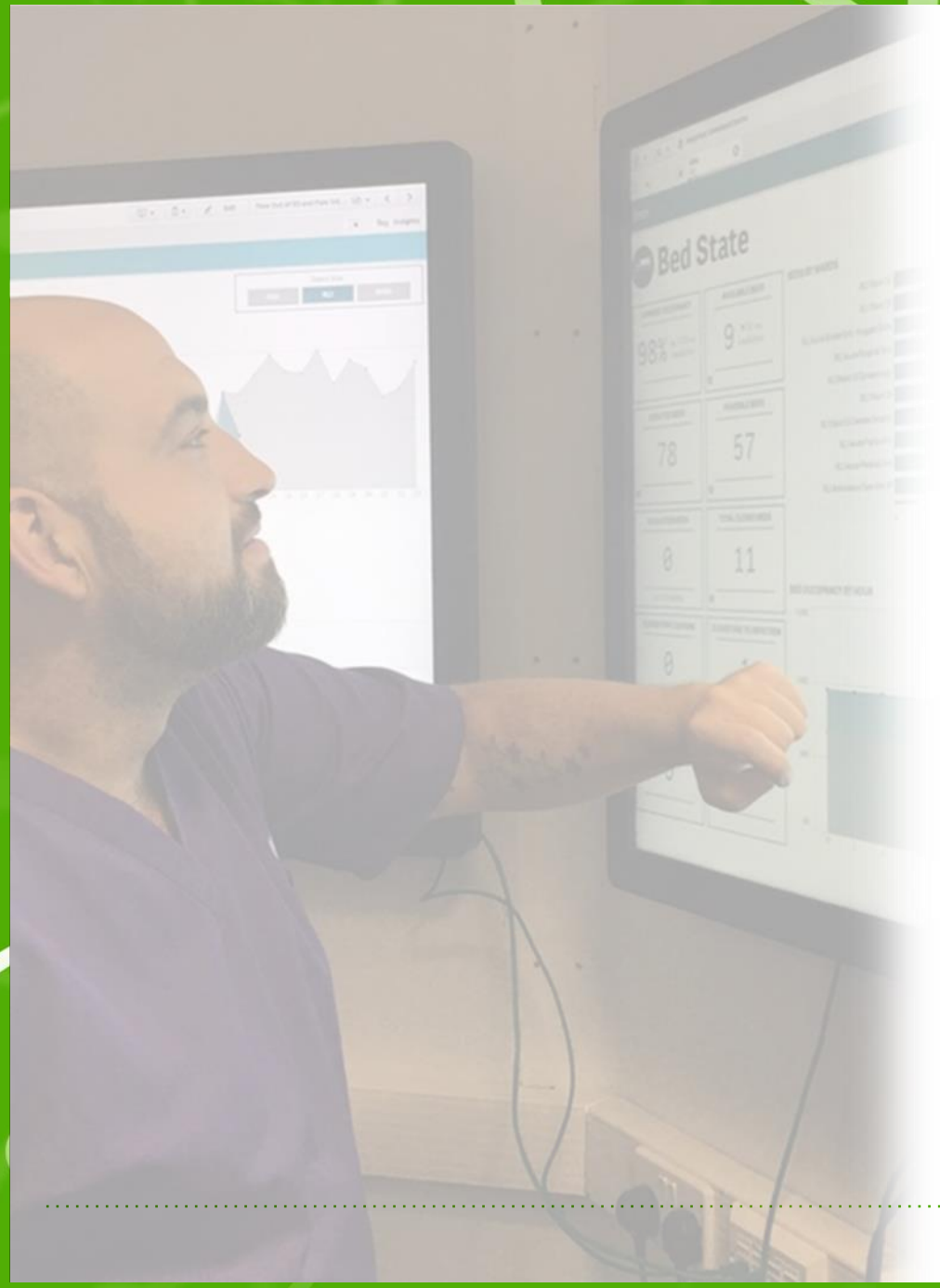
Susan Paterson

Associate Director – NHS Tayside

NHS Tayside

CATALYST BI

BRINGING PEOPLE AND DATA TOGETHER



Over to Jenni and Susan

Thank You

Jenni Woods

Health & Business Intelligence Lead – NHS Tayside
Jennifer.Woods@nhs.scot

Susan Paterson

Associate Director – NHS Tayside

Barney Ulyatt

Business Development Manager – Catalyst BI
Barney.Ulyatt@catalyst-it.co.uk

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UP NEXT...

The Patient Flow Conference 2022

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SPEAKING NOW

Dr Simone Lester

Medical Director
Sodexo Medical Advisory Board

I will be discussing…

"How to Create Positive Patient Outcomes with Integrated Facilities Services that help Improve the flow within your Hospital"

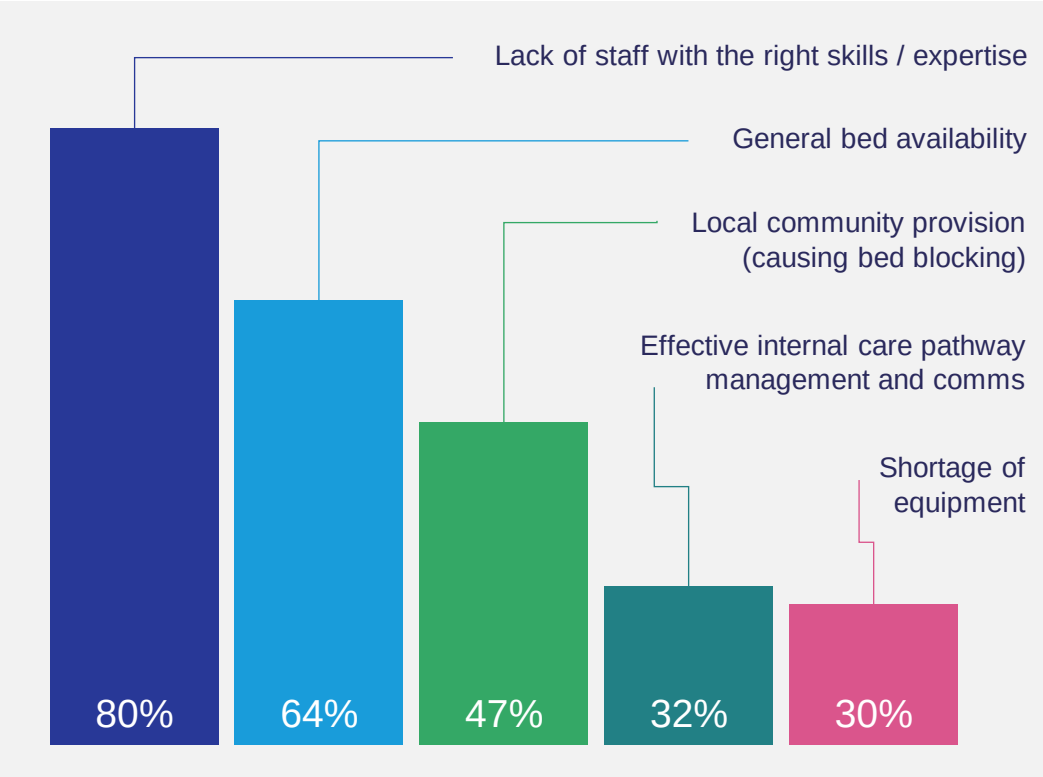
Harnessing non-clinical interventions to improve patient flow

Dr Simone Lester
Medical Director
Sodexo Health & Care

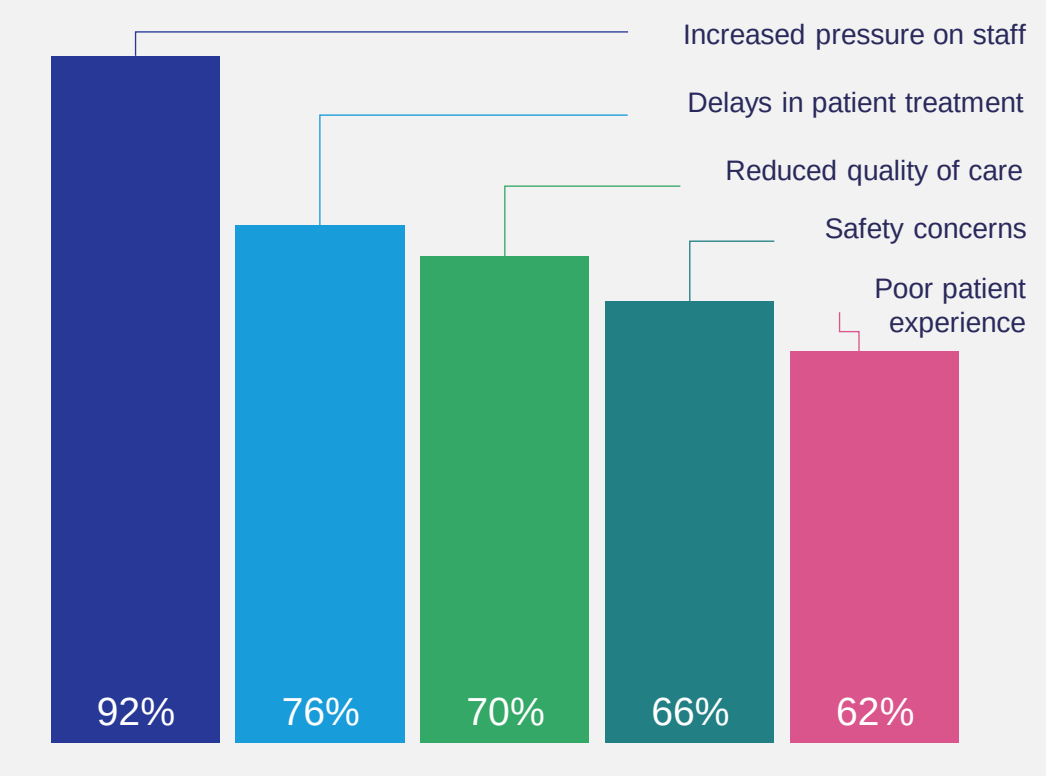
What NHS staff and patients told us about their experience

What you told us about patient flow in your organisation

What factors in particular are limiting the capacity at your hospital or Trust?



What are the main consequence(s) of working at capacity within your organisation?



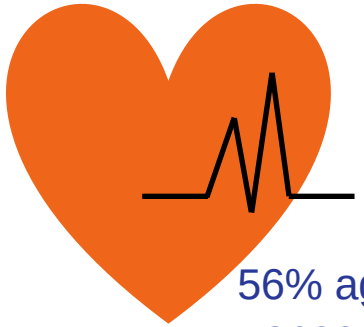
sodexo HEALTH & CARE

Source: Sodexo Health & Care OnePoll Hospital Staff Survey - JC S 2705 HS – 250 respondents - June 2022

What solution(s), if any, do you think could help improve patient flow within your organisation?

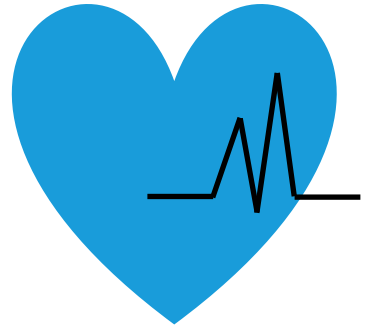
Increased staffing / recruitment	**90%**
Additional / improved community services	55%
Out of hospital treatment	50%
Adding more beds / building more hospitals	49%
Improved training / skill creation	42%
New processes and ways of working	40%
New or additional equipment	31%
Improved configuration of existing estates	21%

What, if anything, could be a benefit(s) of working with a third party to help address patient flow/capacity challenges?



57% agree it frees time to focus on patient care

56% agree it improves the speed of service delivery



Integrates services more effectively	38%
Adds new/additional skills and ideas	38%
Improve cost efficiency/ free up budget	37%
Greater visibility of service performance	29%
Adds human resource	28%

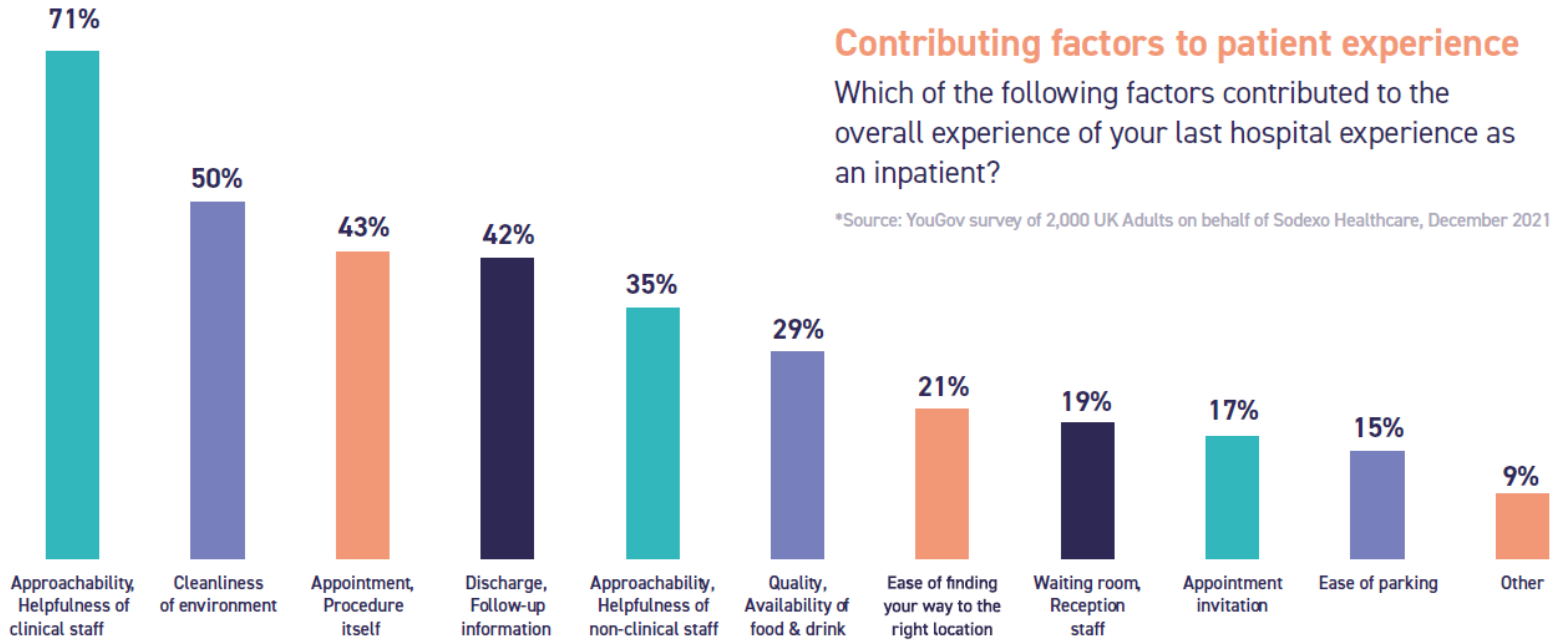
sodexo HEALTH & CARE

Source: Sodexo Health & Care OnePoll Hospital Staff Survey - JC S 2705 HS – 250 respondents - June 2022

Why patient experience matters when it comes to improving flow

According to new research*, **93%** of inpatients believe they are more likely to get better quicker and leave hospital sooner if they have had a positive experience.

Non-clinical interactions play a huge role in this. In fact, **50%** say the cleanliness of their environment is a key contributing factor to their experience, making it more important than the appointment itself.



Contributing factors to patient experience

Which of the following factors contributed to the overall experience of your last hospital experience as an inpatient?

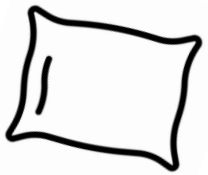
*Source: YouGov survey of 2,000 UK Adults on behalf of Sodexo Healthcare, December 2021

sodexo HEALTH & CARE

How can getting on your bike keep your hospital moving?

Multiple small changes can make a big difference

Painted the inside of the team truck white to spot little bits of dust that would normally slip by unnoticed but could degrade the performance of the finely tuned bikes.



Determined the type of pillow and mattress that led to the best night's sleep for each rider.

Hired a surgeon to teach each rider the best way to wash their hands to reduce the chances of catching a cold.

Between 2007-2017 British cyclists won 178 world championships, 66 Olympic or Paralympic gold medals and 5 Tour de France victories.

Source: https://jamesclear.com/atomic-habits

sodexo HEALTH & CARE

CASE STUDIES

Improving patient flow through non-clinical interventions

CASE STUDY #1
Increasing portering productivity at North Devon District Hospital

TRUST
Royal Devon University Healthcare NHS Foundation Trust

OPENED
23 November 1979

HOSPITAL TYPE
District General

BEDS
300 Inpatient Beds

EMPLOYEES
3392 Trust Employees
350 Sodexo Employees

FIRST PARTNERED WITH SODEXO
April 1997

SERVICES PROVIDED
- Catering
- Cleaning
- Portering
- Helpdesk
- Reception
- Security
- Courier Services

sodexo HEALTH & CARE

SIGNIFICANTLY INCREASING PRODUCTIVITY

26.1%
Increase in completed tasks against the previous year

14%
Improvement in task response time

9%
Increase in average completed tasks per hour

66%
Increase in porter's productivity

"I can't think of going back to our old system. It's increased our workflow and has enabled us to use the porters more effectively and efficiently.
It has made such a vast improvement not just for the department but also our patients. We loved that we could follow the whole process on screen and see the location of each porter.

Jude Roome, Superintendent Radiographer

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CASE STUDY #2
Adopting technology to act on patient feedback at Manchester NHS Foundation Trust

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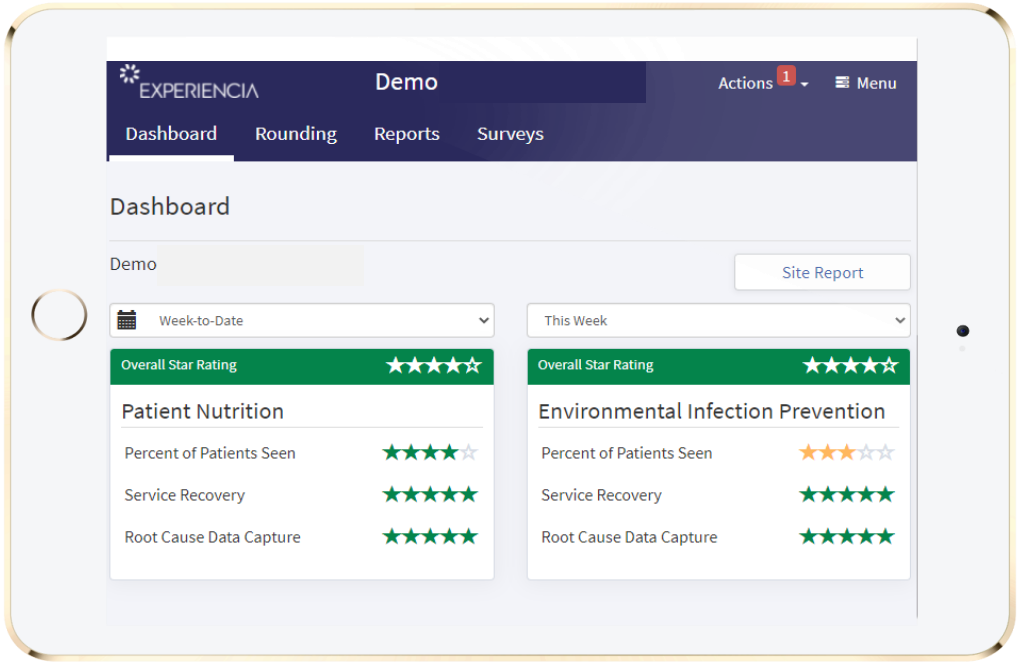
Improving patient experience in real-time

Helen Hitchen
Patient Ambassador
at Manchester Oxford
Road Campus



Experiencia Dashboard
Real-time data and insights enable teams to mitigate problems before the patient has left

sodexo HEALTH & CARE

> Never underestimate the power of listening to people.

Linda Whitehead, Facilities Matron, Sodexo Health & Care

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Final thoughts

The role of non-clinical interventions matters

Inpatient research shows that six out of the top ten factors contributing to patient experience are non-clinical

The NHS needs support to improve patient flow

88% of healthcare professionals we interviewed agreed that there would be benefit to working with a third party to address patient flow / capacity

Sodexo Health & Care can help

We provide controlled delivery and empowered experiences that keep health and care flowing every day

sodexo HEALTH & CARE

Thank you

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The NHS Patient Flow Conference 2022

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SPEAKING NOW

Stuart Hosking-Durn

Head of Resilience & Patient Flow
University Hospitals of Morecambe Bay NHS Foundation Trust

I will be discussing…

"Learning from Crisis: Innovation & Results in Emergency Care"

We are UHMBT

Together, we are creating a great place to be cared for and a great place to work

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Learning from Covid-19 to improve patient flow

Stuart Hosking-Durn, Head of Resilience & Patient Flow

Learning from COVID-19 to support improvements in patient flow

- Measure what's important
  - Data metrics
  - Timely & accurate information
- Setting the right agenda
  - Action FOCUS
- Co-locating decision makers
  - Establish a place
  - Make use of technology to create virtual places
- Continuing the journey
  - There's always room for improvement

Morecambe Bay setting the context

- Integrated Care Trust
  - 3 acute hospital sites
  - 2 community bedded sites
  - 50+ community team location
  - c 8,500 staff
  - c 370,000 citizens
  - 1,000 sq miles
  - NMC2R currently accounts for 22% of G&A beds
  - Future boundary changes due to LA split could increase this area leading to more challenges

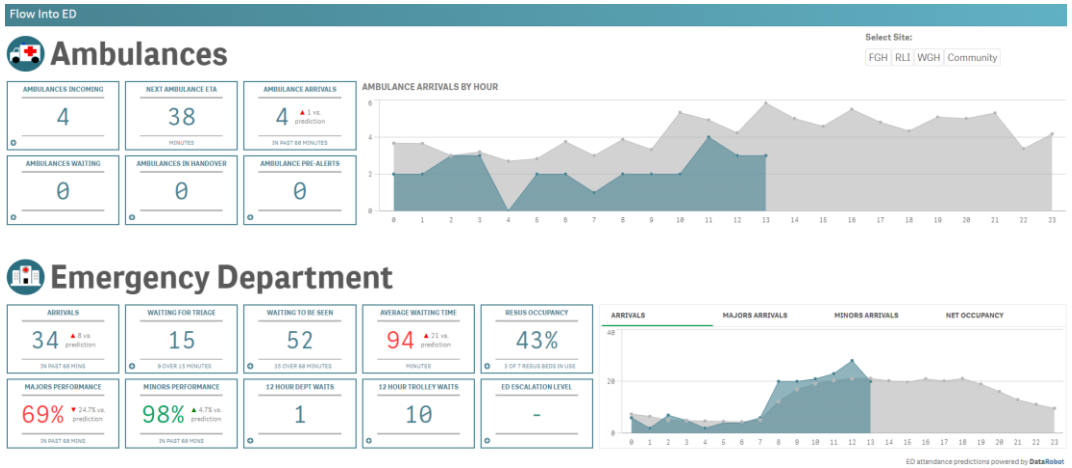
Metrics

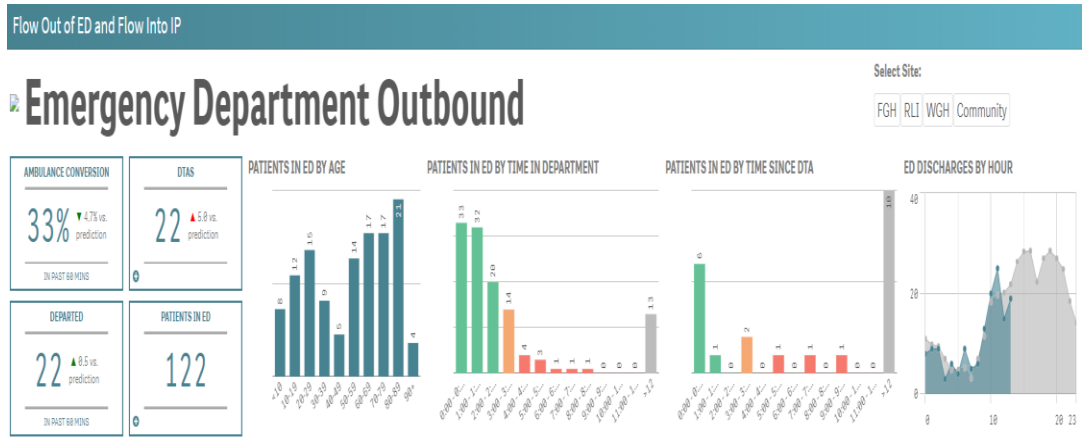
- Measuring pressure can be very subjective without clear and measurable metrics which help frame the discussion.
- Patient safety & experience must be and is at the heart of the assessment of pressure both in ED and across the system.
- Computer AI systems can calculate a “number”, but does it tell the true story?
- Transparency in the metrics gives confidence that escalation/de-escalation is being managed consistently

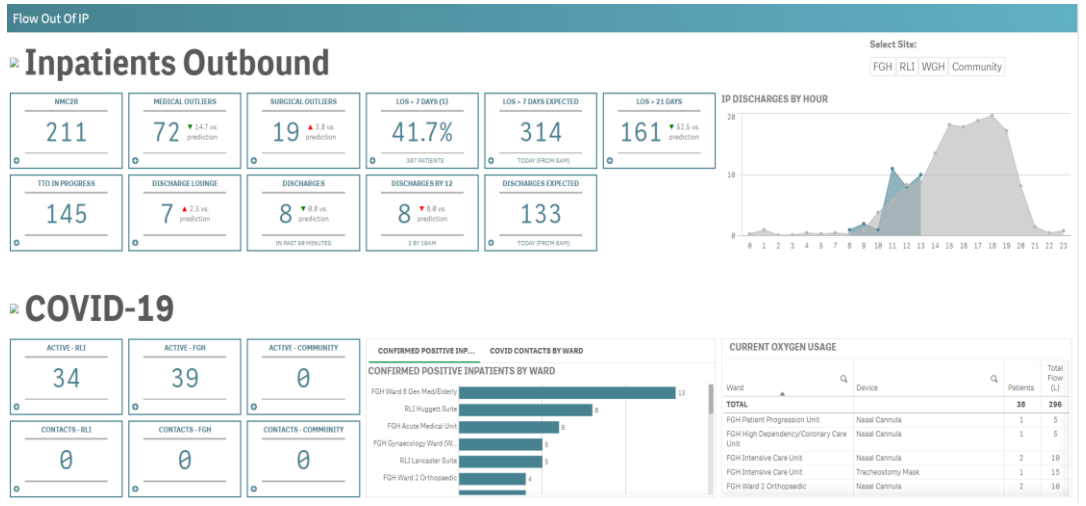
ED Escalation status	Emergency Department Escalation Triggers							
	Total patients in ED (x1.5 weighting)	Number of ambulance waits	Resus spaces available	Isolation cubicles available	Attendance in last hour	Current triage wait time	Current wait to be seen by a clinician	Patients with DTA >30 mins waiting for a bed
4	41 or more	5 or more	0	0	16 or more	>46 mins	>120 mins	5 or more
3	31-40	3-4	0	1	11-15	21-45 mins	90-119 mins	3-4
2	21-30	1-2	1	2	6-10	16-20 mins	61-89 mins	1-2
1	20 or less	0	2 or more	3 or more	5 or less	15 mins or less	60 mins or less	0

Trigger	OPEL 1	OPEL 2	OPEL 3	OPEL 4
ED escalation level	1	2	3	4
Patients spending more than 12hrs in ED	<1% of attendance	<2% of attendance	2-4% of attendance	>4%
Critical Care capacity	<80% occupied	80-100%	All formal capacity occupied and planned overflow in use	Mutual aid plan implemented
G&A bed occupancy	RLI <85% FGH <90%	Up to 95%	95-100%	Is above 100%
Planned additional bed capacity	Available and on standby	Escalation capacity in use but below 80%	Escalation capacity in use up to 100%	All additional escalation beds opened and in use, Full Capacity Protocol initiated
Expected capacity v expected demand	Capacity is equal to or greater than forecast demand for the next 24 hours	There is an expected capacity deficit of less than 20% for the next 24 hours	There is an expected capacity deficit between 20-40% for the next 24 hours	The expected capacity deficit is >40% for the next 24 hours
Beds in assessment areas	Beds in assessment areas are less than 90% occupied	Beds in assessment areas are 90-99% occupied	No assessment beds available within the next 3 hours	No assessment beds available >3 hours
Infection Prevent & Control	No loss of admission beds due to IP factors	Between 1-3% of G&A beds trapped	Between 4-10% of G&A beds trapped	More than 10% 0f G&A beds trapped
Staffing	Planned safe staffing place	Actual staffing levels >90%	Actual staffing levels 80-90%	Actual staffing <80%
Not Meeting Criteria to Reside	>11% of G&A bed capacity	Between 11-14% of G&A bed capacity	Between 14-17% of G&A bed capacity	>17% G&A bed capacity

Get access to timely data







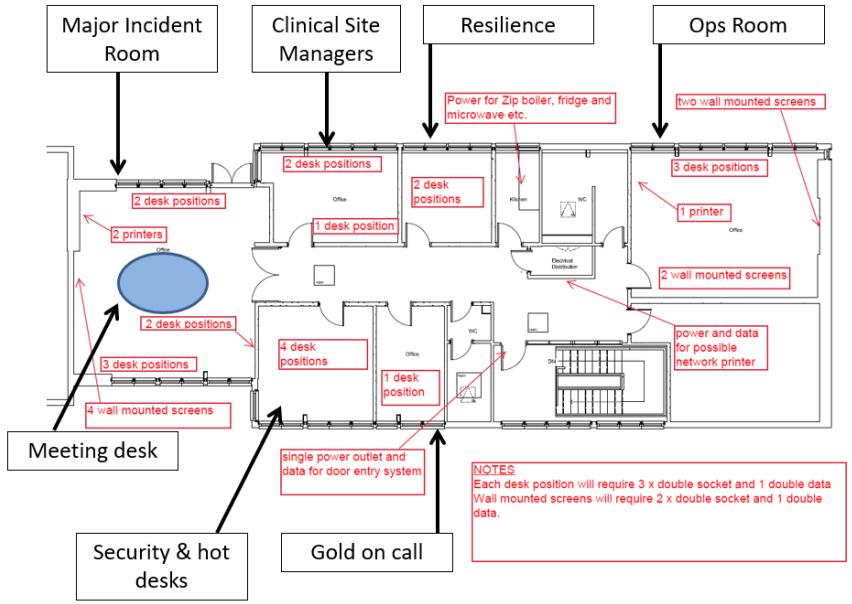
Managing patient flow agenda

- Meeting agenda
  - Action not debate – what, by whom, by when?
  - ECIST – FOCUS
  - The FOCUS Model - a set of guiding principles to help teams standardise operational site management | Fab NHS Stuff
- Manage attendees
  - Avoiding the “cast of thousands”
  - Align to OPEL
- Setting the “battle rhythm”
- Declaring OPEL 4
  - Be bold but be sure

Patient flow meeting agenda	08:00	12:00	16:00	20:00
Handover from previous night – Tactical on-call	X			
Review of outstanding actions	X	X	X	X
Patient safety & welfare – including any significant harm events	X	X	X	X
Staff safety & welfare – safe staff & incidents involving staff who may need support	X	X	X	X
ED • triage time • WTBS • resus & majors’ capacity • DTA patients over 4 & 12hrs • instances of corridor care, ambulance handover delays • mental health patients for escalation • Actions & support needed • ED escalation level	X	X	X	X
Bed position • Now, later, possible, net beds against current predictor • Speciality beds – ICU, stroke, CCU, PPU etc • Issues affecting discharge & Care Group plan to meet current DTAs • ICU step downs, repats from other hospitals and patients waiting primary transfers to tertiary centres • Closed/trapped beds and outbreak update • Paeds/Maternity/SCBU/Neonates including internal diverts • Community services • WGH position	X	X X X X	X	X
DoLS numbers & security reviews		X		
NMC2R numbers and discharge plans (P1, P2 & P3)		X		
Discharge plans for the following day			X	
Covid situation – including positive & vent numbers	X		X	
Agree actions & log – What is needed? Who is doing it? By when?	X	X	X	X
Evening plan and handover for Tactical & Strategic			X	
Review and confirm overnight plan				X

Co-locating flow & EPRR

- Consider creating a permanent “place”
  - ICC, EOC, PFCC etc
- Choose the right location
  - Security implications during a major incident
- Resiliency & redundancy
  - Power (n+1), data (WannaCry), fall-backs (Storm Desmond)
  - Remote capability
- Welfare
  - Ice cream freezer



Rooms with a view

Continuing the journey

- Stroke
- Oxygen
- Moving the data forward

Stroke Tracker - Last App Reload Time = 04/07/2022 14:43:49

Highlight Rows Requiring Action

Highlight Rows That Are Overdue

Select Site

CURRENT STROKE PATIENTS	BRAIN SCAN NOT REQUESTED	BRAIN SCAN NOT COMPLETED	NEED DYSPHAGIA SCREENING	THROMBOLYSED PATIENTS	NOT ON A STROKE WARD	NOT SEEN BY NURSE	NOT SEEN BY CONSULTANT
46	2	3	7	3	8	7	6
VIEW DETAIL	VIEW DETAIL	VIEW DETAIL	VIEW DETAIL	VIEW DETAIL	VIEW DETAIL	VIEW DETAIL	VIEW DETAIL

Stroke Tracker | Stroke Tracker - Flag Mimics | Patients Triaged as Suspecte...

Arrived Date/Time	Time Since Arrival	RTX Number	Initials	Current Location	Brain Scan Requested	Brain Scan < 1 Hour	Dysphagia Screen < 4 Hours	Thrombolysis Status	Stroke Ward Admission < 4 Hours	Seen By Stroke Nurse < 24 Hours'	Seen By Stroke Consultant < 24 Hours
04/07/2022 14:21:00	22 Mins	RTX0559622	SL	RLI ED	Requires Action	Requires Action	Requires Action	No Thrombolysis Recorded	Requires Action	Requires Action	Requires Action
04/07/2022 14:19:00	24 Mins	RTX0463359	DS	RLI ED	Requires Action	Requires Action	Requires Action	No Thrombolysis Recorded	Requires Action	Requires Action	Requires Action
04/07/2022 13:22:00	1 Hours 21 Mins	RTX0534395	IH	RLI ED	Complete	Complete	Requires Action	No Thrombolysis Recorded	Requires Action	Requires Action	Requires Action
04/07/2022 12:35:00	2 Hours 8 Mins	RTX0446962	CS	RLI ED	Complete	Complete > 1 Hour	Requires Action	No Thrombolysis Recorded	Requires Action	Requires Action	Requires Action
04/07/2022 12:24:00	2 Hours 19 Mins	RTX1075282	SW	FGH ED	Complete	Complete > 1 Hour	Requires Action	No Thrombolysis Recorded	Requires Action	Requires Action	Requires Action
04/07/2022 11:51:00	2 Hours 52 Mins	RTX8707317	AJ	RLI ED	Complete	Complete	Requires Action	No Thrombolysis Recorded	Requires Action	Requires Action	Requires Action
03/07/2022 20:07:00	18 Hours 36 Mins	RTX3062068	GW	RLI Huggett Suite	Complete	Complete	Complete	No Thrombolysis Recorded	Complete > 4 Hours	Complete	Complete
03/07/2022 15:29:00	23 Hours 14 Mins	RTX8018646	JO	RLI Huggett Suite	Complete	Complete	Complete	No Thrombolysis Recorded	Complete	Complete	Complete
02/07/2022 19:27:00	1 Days 19 Hours	RTX8707197	SL	RLI Huggett Suite	Complete	Overdue	Complete	No Thrombolysis Recorded	Complete	Complete	Complete

Flow Out Of IP

CURRENT OXYGEN USAGE

Ward	Device	Patients	Total Flow (L)
TOTAL		**37**	**285**
FGH Patient Progression Unit	Nasal Cannula	1	5
FGH High Dependency/Coronary Care Unit	Nasal Cannula	1	5
FGH Intensive Care Unit	Nasal Cannula	2	10
FGH Intensive Care Unit	Tracheostomy Mask	1	15
FGH Ward 2 Orthopaedic	Nasal Cannula	1	5
FGH Ward 2 Orthopaedic	Simple Face Mask	1	15
FGH Ward 4 General Surgery	Nasal Cannula	1	5
FGH Ward 4 General Surgery	Venturi Mask 35%	1	8
FGH Ward 5 General Surgery	Nasal Cannula	1	5
FGH Ward 6 Gen Med/Elderly	Nasal Cannula	3	15
FGH Ward 7 Gen Med/Elderly	Nasal Cannula	4	20
FGH Ward 9 and Coniston Suite	Reservoir Mask	1	15

We are UHMBT

Together, we are creating a great place to be cared for and a great place to work

NHS
University Hospitals of Morecambe Bay
NHS Foundation Trust

Thank you

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BY iRHYTHM

The Patient Flow Conference 2022

The NHS Digital Hospitals Conference 2022

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SPEAKING NOW

Dr Nolan Stain-Montalvo

Principal Clinical Scientist leading on networked cardiology and non-invasive cardiac diagnostics - Barts Health NHS Trust, London

I will be discussing…

"Introducing Patch Technology in a Stroke"

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Q&A Panel

Dr Nolan Stain-Montalvo

Principal Clincial Scientist
Barts Health NHS Trust - iRhythm

Stuart Hosking-Dawn

Head of Resilience & Patient Flow

Andrew Davies

Medical Director
Sodexo Medical Advisory Committee

Baldur Johnsen

Health & Business Intelligence Lead
NHS Tayside – Catalyst BI

The Patient Flow Conference 2022

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NETWORKING & LUNCH

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Chair Afternoon Reflection

Douglas Hamandishe

"Apprenticeship Relationship Manager – Health Education England"

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SPEAKING NOW

I will be discussing…

"The Burden of Hyperkalaemia: Maintaining Normal Potassium in Acute & Recurring Patient"

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LOKELMA®
Sodium zirconium cyclosilicate
powder for oral suspension

K+ALIBRE
WHAT SCIENCE CAN DO

The Burden of Hyperkalaemia: Maintaining Normal Potassium in Acute and Recurring Patients

Wednesday 6th July 2022

For UK healthcare professionals only

This promotional meeting is organised and funded by AstraZeneca.

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AstraZeneca

Document number: GB-37322

Date of preparation: June 2022

Our speakers

Ruby Chumber
Advanced Cardiology Practitioner, Queens Medical Centre

Dr Amir Jehangir FRCP
Consultant Acute & General Internal Medicine
University College Hospital London
Honorary Clinical Associate Professor
UCL Medical School

Speaker disclosures

Ruby Chumber - Advanced Cardiology Practitioner, Queens Medical Centre

- Speaker honorarium – AstraZeneca

Dr Amir Jehangir FRCP

Consultant Acute & General Internal Medicine
University College Hospital London
Honorary Clinical Associate Professor
UCL Medical School

- Speaker fees received from BMS/Pfizer, Menarini, Pharmacosmos, Alexion and AstraZeneca

LOKELMA®▼ (sodium zirconium cyclosilicate)[1]

5 g powder for oral suspension | 10 g powder for oral suspension

Therapeutic indications

LOKELMA is indicated for the treatment of hyperkalaemia in adult patients.

Posology

Adults, including the elderly

Correction phase

The recommended starting dose of LOKELMA is 10 g, administered three times a day orally as a suspension in water.
When normokalaemia is achieved, the maintenance regimen should be followed.

Maintenance phase

When normokalaemia has been achieved, the minimal effective dose of LOKELMA to prevent recurrence of hyperkalaemia should be established. A starting dose of 5 g once daily is recommended, with possible titration up to 10 g once daily, or down to 5 g once every other day, as needed, to maintain a normal potassium level. No more than 10 g once daily should be used for maintenance therapy.

Patients on chronic haemodialysis

For patients on dialysis, LOKELMA should only be dosed on non-dialysis days. The recommended starting dose is 5 g once daily.
To establish normokalaemia (4.0–5.0 mmol/L), the dose may be titrated up or down weekly, based on the pre-dialysis serum potassium value after the long interdialytic interval (LIDL). The dose could be adjusted at intervals of one week in increments of 5 g up to 15 g once daily on non-dialysis days.

Please refer to the LOKELMA SmPC for full details.

LIDL=long inter dialytic interval; SmPC=Summary of Product Characteristics.

1. AstraZeneca. LOKELMA® (sodium zirconium cyclosilicate): Summary of Product Characteristics. Accessed June 2022

LOKELMA®▼
Sodium zirconium cyclosilicate
powder for oral suspension

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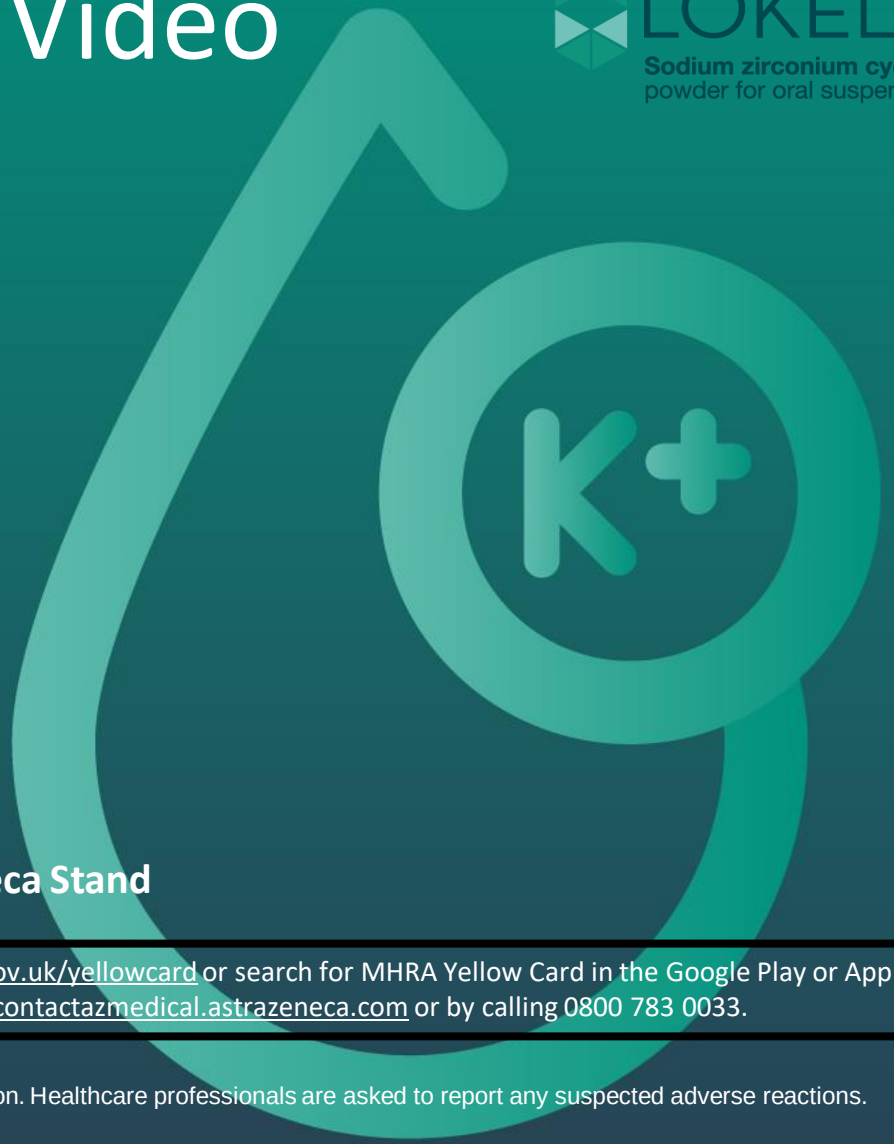
Lokelma Mode of Action Video

LOKELMA®
Sodium zirconium cyclosilicate
powder for oral suspension



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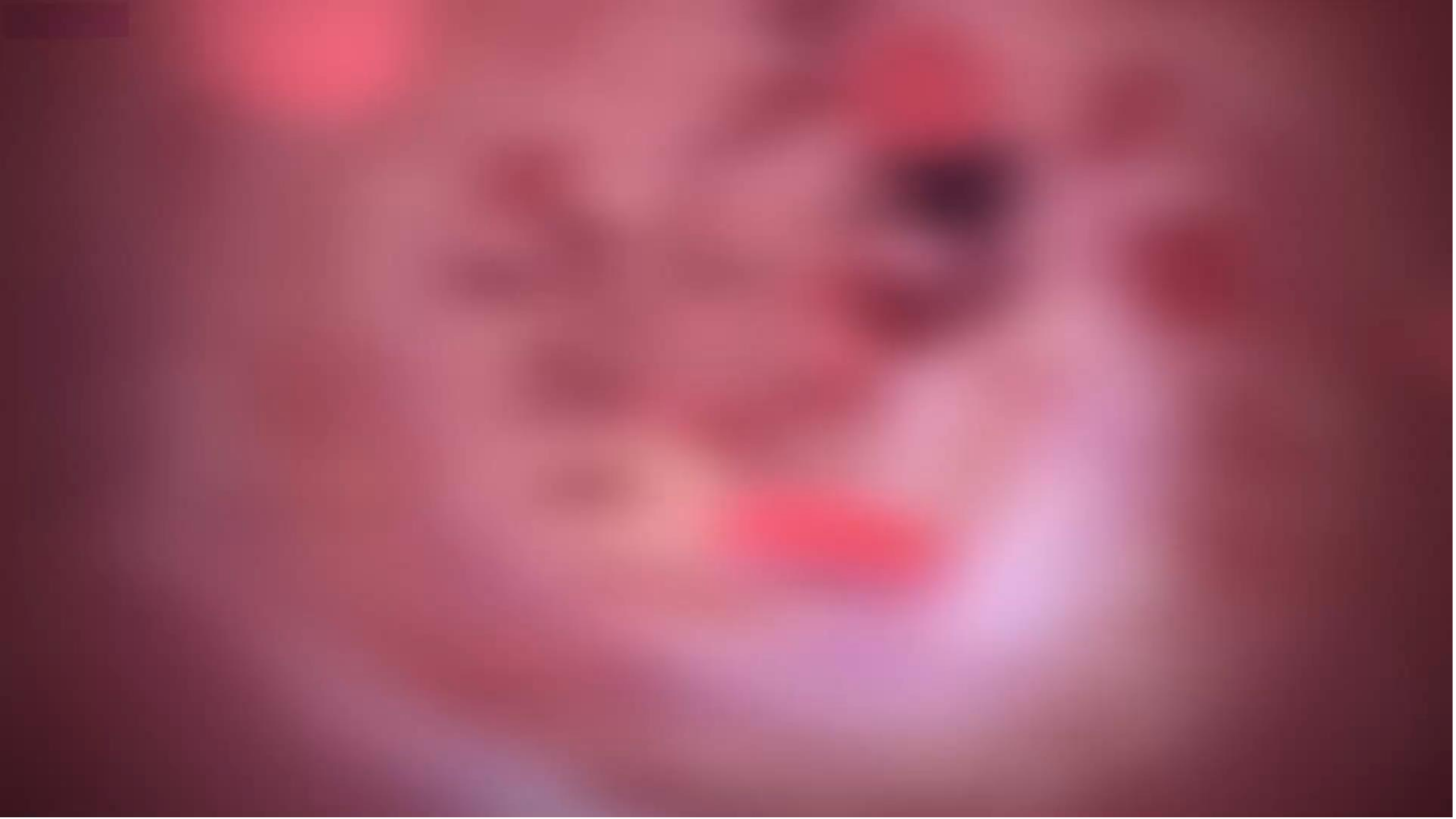

Safety and tolerability profile[1]

- 5.7% of patients receiving LOKELMA reported oedema-related events;* the events were more commonly seen in patients treated with 15 g
- 4.1% of patients receiving LOKELMA developed hypokalaemia (serum K^+ level <3.5 mEq/L), which resolved with dosage adjustment or discontinuation of LOKELMA
- LOKELMA is not systemically absorbed or metabolised by the body
- LOKELMA can be co-administered without spacing of dosing times with oral medications that do not exhibit pH-dependent bioavailability
- LOKELMA contains approximately 400 mg sodium per 5 g dose, equivalent to 20% of the WHO recommended maximum daily intake of 2 g sodium for an adult. LOKELMA is considered high in sodium. This should be particularly considered for those on a low-salt diet

LOKELMA is not to be used in place of emergency treatments; emergency treatment may require other temporary agents.

Please refer to the LOKELMA SmPC for full safety information.

LOKELMA® ▼
Sodium zirconium cyclosilicate
powder for oral suspension

***Includes generalised and peripheral oedema.**
K^+=potassium; SmPC=Summary of Product Characteristics; WHO=World Health Organisation.

1. AstraZeneca. LOKELMA® (sodium zirconium cyclosilicate): Summary of Product Characteristics. Accessed: June2022

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WHAT SCIENCE CAN DO

Panel discussion

LOKELMA®
Sodium zirconium cyclosilicate
powder for oral suspension

Ruby Chumber &
Dr Amir Jehangir FRCP

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PRESCRIBING INFORMATION

LOKELMA® ▼ (sodium zirconium cyclosilicate) 5g & 10g POWDER FOR ORAL SUSPENSION

Consult Summary of Product Characteristics before prescribing.

Indication: Lokelma is indicated for treatment of hyperkalaemia in adults.

Presentation: 5g or 10g powder for oral suspension. Each sachet contains 5g or 10g sodium zirconium cyclosilicate.

Dosage and Administration: **Correction phase:** Recommended starting dose for adults and elderly is 10g, administered orally, three times a day as a suspension in water, with or without food. When normokalaemia is achieved the maintenance regimen should be followed. Typically, normokalaemia is achieved within 24 to 48 hours. If patient is still hyperkalaemic after 48 hours of treatment the same regimen can be continued for an additional 24 hours. If normokalaemia not achieved after 72 hours of treatment other treatment options should be considered. **Maintenance phase:** Establish the minimal effective dose to prevent recurrence of hyperkalaemia. Recommended starting dose of 5g once daily, with possible titration up to 10g once daily, or down to 5g once every other day, as needed, to maintain normal potassium level. No more than 10g once daily should be used for maintenance therapy. Monitor serum potassium levels regularly during treatment. Monitoring frequency will depend on factors such as other medications, progression of chronic kidney disease and dietary potassium intake. Discontinue and re-evaluate patient if severe hypokalaemia occurs. No clinical data available for treatment beyond one year. **Patients on chronic haemodialysis**: Patients on dialysis should only be dosed on non-dialysis days. Recommended starting dose is 5g once daily. To establish normokalaemia (4.0 - 5.0 mmol/L), the dose may be titrated up or down weekly based on the pre-dialysis serum potassium value after the long inter dialytic interval (LIDI). The dose could be adjusted at intervals of one week in increments of 5g up to 15g once daily on non-dialysis days. Monitor serum potassium weekly while the dose is adjusted. Once normokalaemia is established, monitor potassium regularly (e.g. monthly, or more frequently based on clinical judgement including changes in dietary potassium or medication affecting serum potassium). **Renal/hepatic impairment:** No dosage adjustment required. **Paediatric population:** Safety and efficacy has not been established in children and adolescents (<18 years).

Contraindications: Hypersensitivity to the active substance.

Warnings and Precautions: **Serum potassium levels:** Monitor serum potassium levels when clinically indicated, including after changes are made to medicinal products that affect the serum potassium concentration (e.g. renin-angiotensin-aldosterone system (RAAS) inhibitors or diuretics) and after Lokelma dose is titrated. **Hypokalaemia:** Hypokalaemia may be observed. To prevent moderate to severe hypokalaemia dose titration (maintenance posology) may be required. Discontinue and re-evaluate treatment in patients with severe hypokalaemia. **QT Prolongation:** During correction phase, a lengthening of QT interval can be observed as the physiologic result of decline in serum potassium concentration. **Risk of interaction with X rays:** Sodium zirconium cyclosilicate may be opaque to X-rays, keep in mind if patient has abdominal X-ray. **Intestinal perforation:** Risk of intestinal perforation unknown. Special attention to be paid as intestinal perforation has been reported with polymers that act in the gastrointestinal tract. **Sodium content:** Lokelma is considered high in sodium. This should be particularly taken into account for those on a low salt diet. **Severe hyperkalaemia:** Limited experience in patients with serum potassium concentrations greater than 6.5 mmol/L.

Drug Interactions: No expected effects of other medicines on sodium zirconium cyclosilicate as it is not absorbed or metabolised by the body. Sodium zirconium cyclosilicate can transiently increase gastric pH and can lead to changes in solubility where co-administered medicinal product has pH-dependent stability and therefore should be administered at least 2 hours before or 2 hours after oral medications with clinically meaningful gastric pH dependent bioavailability (e.g. azole antifungals, a number of anti-HIV drugs, and tyrosine kinase inhibitors). Sodium zirconium cyclosilicate can be co-administered without spacing of dosing times with oral medications that do not exhibit pH-dependent bioavailability.

Pregnancy and Lactation: Preferable to avoid use during pregnancy. Can be used during breast-feeding.

Ability to Drive and Use Machines: Lokelma has no or negligible influence on the ability to drive and use machines.

Undesirable Events: **Consult SmPC for full list of side effects.** Common: Hypokalaemia, oedema related events (including fluid overload, fluid retention, generalised oedema, hypervolaemia, localised oedema, oedema, oedema peripheral, peripheral swelling).

Legal Category: POM.

Marketing Authorisation Numbers: **Great Britain:** PLGB 17901/0332, PLGB 17901/0331. **Northern Ireland:** EU/1/17/1173/002-004

Presentation and Basic NHS Cost: 5g x 30 pack: £156; 10g x 3 pack: £31.20; 10g x 30 pack: £312.

Marketing Authorisation Holder: **Great Britain:** AstraZeneca UK Ltd., 600 Capability Green, Luton, LU1 3LU, UK. **Northern Ireland:** AstraZeneca AB, SE-151 85 Södertälje, Sweden.

Further Information is Available From: AstraZeneca UK Ltd., 600 Capability Green, Luton, LU1 3LU, UK.

Date of preparation 04/2022

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The Patient Flow Conference 2022

SCAN ME

Wednesday 6th July 2022- 2022- 08:00am – 15:30pm – Hatfield's Conference Centre

Conference hosted by Convenzis Group Limited

The Patient Flow Conference 2022

The NHS Patient Flow Conference 2022:

SPEAKING NOW

Dr Michael Watts

Associate CCIO
University Hospitals of Derby & Burton NHS Trust

I will be discussing…

"Digitalising Patient Flow – The Barriers & How to Overcome them"

Digitalising Patient Flow

A Junior Doctors Story

Aims

- Optimising patient flow
- The benefits of digital
- Understanding technology's impact on patient flow
- How to implement digital and it's barriers

Who needs to hear this talk

- Thought leaders and clinical Innovators
- Change enthusiasts
- NHS intrapreneurs
- NHS leaders

Introduction

My Why

On a mission to create patient-centric, safe and impactful healthcare through digitalisation

- **NHS Doctor**
- **Associate CIO, University Hospitals of Derby & Burton**
- **Co-founder and Managing Director of a Digital Health SME**
- **NHS England Clinical Entrepreneur and Mentor**
- **MBA Student**

Dr Michael Watts MBChB BSc (Hons)

The perfect flow

Understanding Patient Flow

The Benefits

- **Minimising waiting times and delays in care**
- **Improving clinical outcomes and patient experience**
- **Increased efficiency, less duplication**
- **Reduced costs (less overtime, waiting list initiatives, locums)**

The ultimate benefit to the NHS is **REPUTATION**

The digital patient flow

The Benefits

- **Centralised data storage**
- **Improved auditability**
- **Accelerated communication**
- **Reduced paper usage**

SaaS

The Benefits

- **Data-driven decision making**
- **Clicks and mortar organisation**
- **Improved communication**
- **Staffing support**

Robotic process automation

The Benefits

- **Limiting variation and human error**
- **Eradicates behavioural biases (eg operational vs clinical)**
- **Automatic reporting**
- **Improved interoperability**

Predictive analytics

The Benefits

- **Trend recognition**
- **Decision-support algorithms**
- **Predict number of admissions / transfers / discharges**
- **Predict resource requirements**

The Risks

- **Decision-support risks**
- **Accountability**
- **Managing adaptive technologies**

Case Study

Thank you

michael.watts5@nhs.net

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UP NEXT...

The Patient Flow Conference 2022

The NHS Patient Flow Conference 2022:

SPEAKING NOW

Ash Thornley-Davies

Healthcare Account Executive
Zoom

I will be discussing…

"Why the NHS Choose Zoom: Harnessing Zoom Integrations for Improved Patient Outcomes"

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SPEAKING NOW

CONVENZIS

Sian Wimbury

Deputy Chief Operating Officer
Greater Manchester Mental Health Foundation Trust

Simon Glover

Patient Flow Strategic Lead
Greater Manchester Mental Health Foundation Trust

I will be discussing…

"Why the NHS Choose Zoom: Harnessing Zoom Integrations for Improved Patient Outcomes"

THANKS FOR ATTENDING

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