THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Welcome to The National NHS Patient Flow Conference!

6th November 2024
15 Hatfields Conference Centre,
London SE1 8DJ

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Chair Opening Address

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

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Slido

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

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Keynote Presentation

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

Transforming Patient Flow:
The national perspective

National Clinical Adviser – Hospitals Programme

Hospitals team, Integrated Urgent and Emergency Care, NHS England

The Why:

Access to Emergency Care

Original research

Association between delays to patient admission from the emergency department and all-cause 30-day mortality

Simon Jones [1,2], Chris Moulton [3,4], Simon Swift [2,5], Paul Molyneux [2], Steve Black [6], Neil Mason [2], Richard Oakley [2], Clifford Mann [3,7]

Handling editor Simon Carley

[1]Department of Population Health, New York University School of Medicine, New York, New York, USA
[2]Methods Analytics, London, UK
[3]The "Getting It Right First Time" programme, NHS Improvement, London, UK
[4]Emergency Department, Royal Bolton Hospital, Bolton, UK
[5]Index Unit, University of Exeter Business School, Exeter, UK
[6]Black Box Data Science Ltd, Biggleswade, UK
[7]Emergency Department, Musgrove Park Hospital, Taunton, UK

Correspondence to Dr Chris Moulton, Emergency Department, Royal Bolton Hospital, Bolton, UK; Chris.Moulton@boltonft.nhs.uk

Clifford Mann deceased

Received 30 April 2021
Accepted 15 November 2021

ABSTRACT

Background Delays to timely admission from emergency departments (EDs) are known to harm patients.

Objective To assess and quantify the increased risk of death resulting from delays to inpatient admission from EDs, using Hospital Episode Statistics and Office of National Statistics data in England.

Methods A cross-sectional, retrospective observational study was carried out of patients admitted from every type 1 (major) ED in England between April 2016 and March 2018. The primary outcome was death from all causes within 30 days of admission. Observed mortality was compared with expected mortality, as calculated using a logistic regression model to adjust for sex, age, deprivation, comorbidities, hour of day, month, previous ED attendances/emergency admissions and crowding in the department at the time of the attendance.

Results Between April 2016 and March 2018, 26 738 514 people attended an ED, with 7 472 480 patients admitted relating to 5 249 891 individual patients, who constituted the study's dataset. A total of 433 962 deaths occurred within 30 days. The overall crude 30-day mortality rate was 8.71% (95% CI 8.69% to 8.74%). A statistically significant linear increase in mortality was found from 5 hours after time of arrival at the ED up to 12 hours (when accurate data collection ceased) ($p<0.001$). The greatest change in the 30-day standardised mortality ratio was an 8% increase, occurring in the patient cohort that waited in the ED for more than 6 to 8 hours from the time of arrival.

Conclusions Delays to hospital inpatient admission for patients in excess of 5 hours from time of arrival at the ED are associated with an increase in all-cause 30-day mortality. Between 5 and 12 hours, delays cause a predictable dose–response effect. For every 82 admitted patients whose time to inpatient bed transfer is delayed beyond 6 to 8 hours from time of arrival at the ED, there is one extra death.

Key messages

What is already known on this subject

- Small studies from Canada and Australia have indicated that there is an increased mortality rate among patients who experience delays in admission to an inpatient bed from the emergency department (ED).
- Counterfactual modelling has shown reduced patient mortality as a result of the NHS 4-hour operational standard. The NHS Benchmarking Network found a coefficient of determination (R^2 value) of 0.07 between time greater than 4 hours in the ED and a hospital's Summary Hospital-level Mortality Indicator.

What this study adds

- This study of over five million NHS patients shows an increase in all-cause 30-day mortality that is independently associated with delays to hospital admission from the ED rather than with crowding alone.
- The standardised mortality rate starts to rise from 5 hours after the patient's time of arrival at the ED.
- The increasing effect of long stays in the ED before inpatient admission can be measured and represented as a number needed to harm metric: after 6–8 hours, there is one extra death for every 82 patients delayed.

Linked

► http://dx.doi.org/10.1136/emermed-2021-212106

Check for updates

© Author(s) (or their employer(s)) 2022. No commercial re-use. See rights and permissions. Published by BMJ.

To cite: Jones S, Moulton C, Swift S, *et al*. *Emerg Med J* Epub ahead of print: [*please include* Day Month Year]. doi:10.1136/emermed-2021-211572

INTRODUCTION

In England, by the end of the 20th century, demographic changes and reduced numbers of acute hospital beds had resulted in crowded emergency departments (EDs) and long delays for patients. In consequence, the NHS 4-hour operational standard was introduced in 2004 and shortly thereafter, the other nations of the UK and several other countries, such as Canada and Australia, introduced similar standards for ED waiting times.[1–5] (The 4-hour standard is a binary time threshold for discharge, admission or transfer; it starts when the patient arrives at the ED, and time in the ED beyond 4 hours is a 'breach' of the 'target'.)

For more than a decade, the 4-hour standard served both patients and the NHS well but, during the past few years, further increases in the demand for urgent and emergency care have exacerbated long waits for hospital admission.[6] By 2019–2020, over 3.2% of all ED patients waited in the ED for more than 12 hours from their time of arrival.[7] Long ED delays are most often caused by 'exit block' due to a lack of available inpatient beds. This was demonstrated using data collected from all English EDs over a 90-day period by an NHS economics team. They showed that higher inpatient bed occupancy was correlated with longer ED waiting times, but with a non-linear association.[8]

Emerg Med J: first published as 10.1136/emermed-2021-211572 on 18 January 2022. Downloaded from http://emj.bmj.com/ on January 29, 2022 at Royal College of Emergency Medicine. Protected by copyright.

Mortality

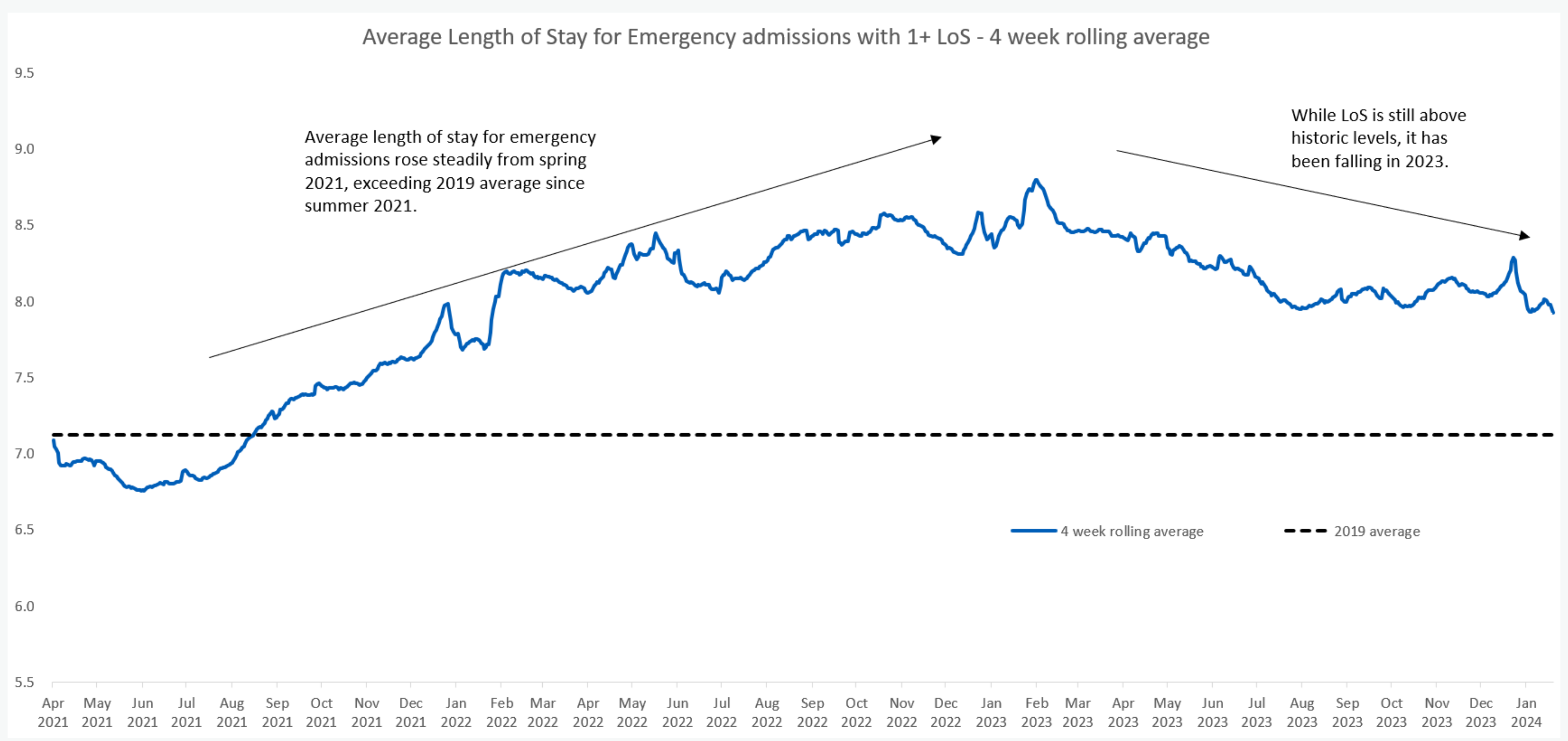
Deconditioning

Morale

Time

Productivity

Mean emergency length of stay in the English NHS has not returned to pre-pandemic levels



We have increased our permanent general and acute hospital bed stock by 5000

We now have 12,500 Virtual Ward beds seeing 30,000 patients a month

But further change is still needed to deliver care we can all be proud of

Delivery plan for recovering urgent and emergency care services

January 2023

The What:

Delivery of:
The Right Care
At the Right Place
In the Right Time
By the Right Professional

The How:

- **UEC Service planning**
- **Signposting, streaming & redirection**
- **Care and clinical input closer to home aligned to patient demand**
- **Developing advanced roles and innovative workforce models**
- **System working and accountability**

Putting the how into practice – The Acute UEC Flow Model

Acute flow principles
Contents
Principle 1
We involve our patients, their carers and families in their care and keep them informed
Involving people means focusing on what matters
Applicable to all our teams – not just those providing direct care
Key initiatives can help deliver the principle
Four questions to help us know we are valuing patients' time
We need to know we are making a difference both qualitatively and quantitively
Getting it right makes a big difference to everyone
A few references to support this principle
Principle 2
We ensure every step adds value
Value can mean a lot of different things to different people
There is value in every interaction and transaction we make with patients and families, and between staff
Some key initiatives help ensure every step is both valuable and adds value
Key initiatives can help deliver the principle
Getting it right makes a big difference to everyone
We need to know we are making a difference both qualitatively and quantitively
A few references to support this principle
Principle 3
We ensure our patients get to the right team at the right time
Patients being seen by the right team at the right time shortens their time away from home
Getting patients to the right team at the right time is a whole team effort
Key initiatives can help deliver the principle
We need to know we are making a difference both qualitatively and quantitively
Getting it right makes a big difference to everyone
A few references to support this principle
1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20

Enablers:

- Leadership & Culture
- Our Patients and Staff
- Wealth of national policy, evidence based best practice, communities of practice and learning networks
- Digital Advancements
- Improvement support teams, including data analytics

Thank You

@nhsengland

company/nhsengland

england.nhs.uk

THE NATIONAL NHS PATIENT FLOW CONFERENCE

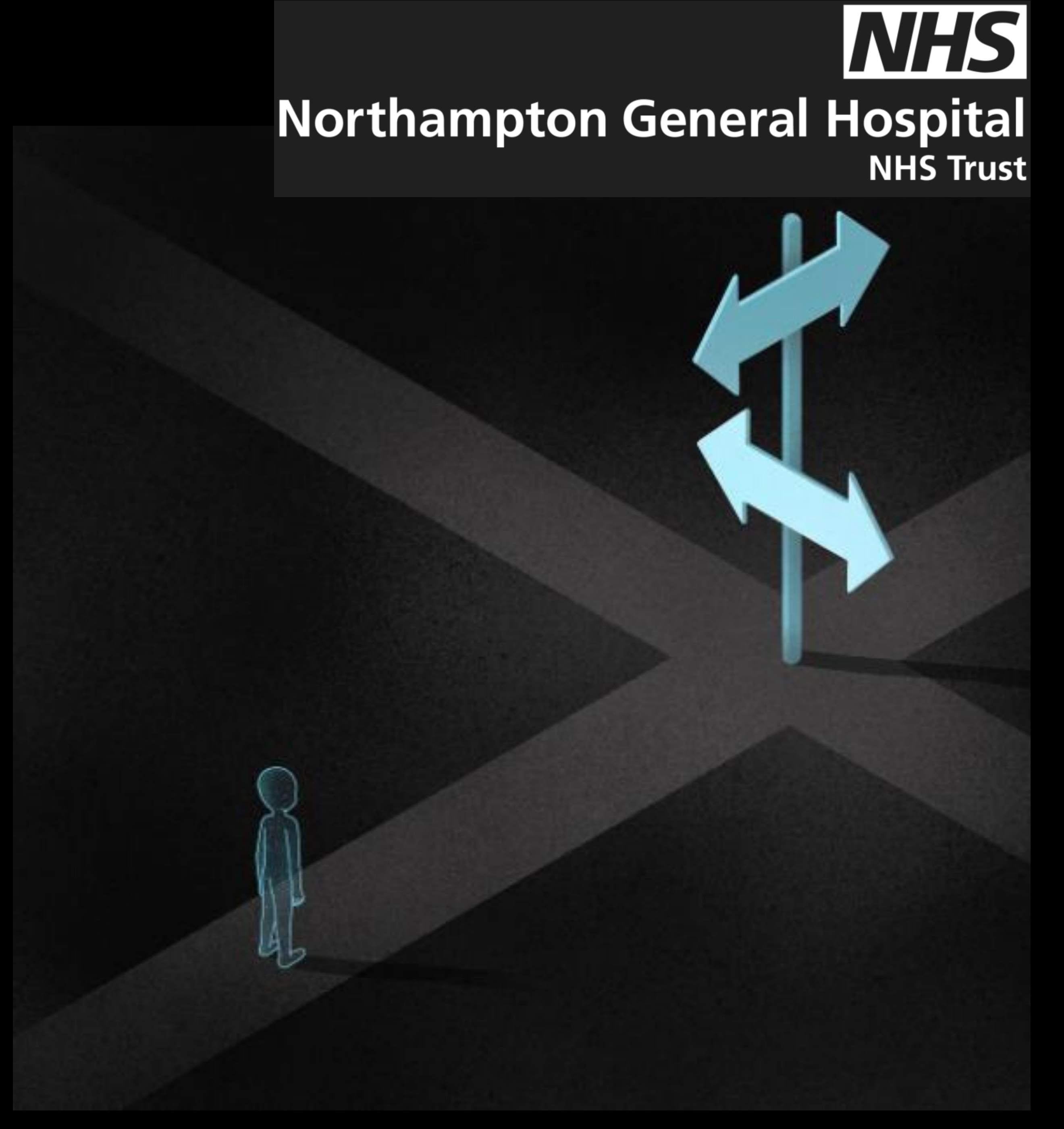
Improving NHS Pathways

Keynote Presentation

Chris Johnson
Head of Patient Experience & Engagement
Northampton General Hospital

Poor patient flow from the patient's perspective.

Chris Johnson, Head of Patient Experience & Engagement, Northampton General Hospital



Agenda

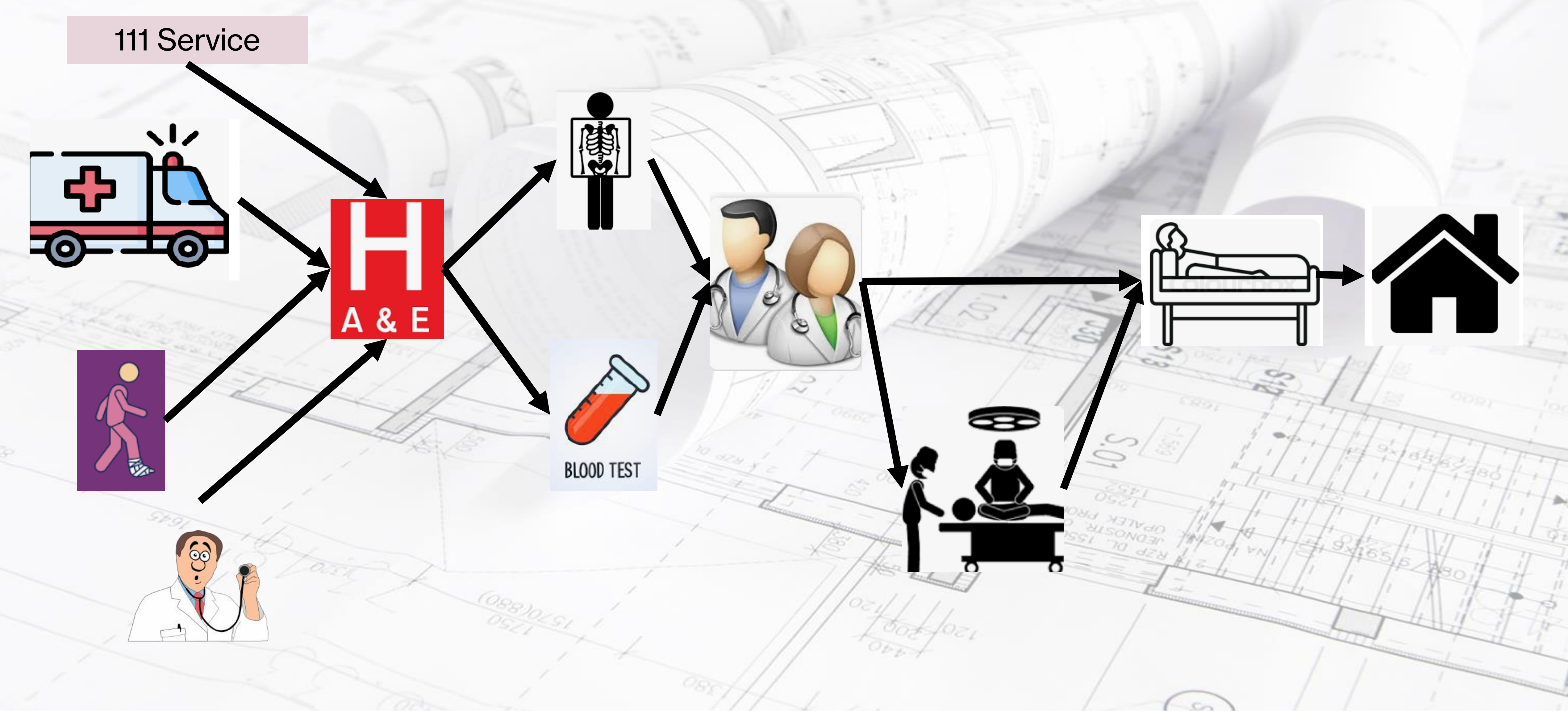
- **Patient’s feedback on:**
  - **The experience at the ‘front door’**
  - **The implications of multiple ward moves**
  - **Trying to get home**

The Value of Patient Feedback

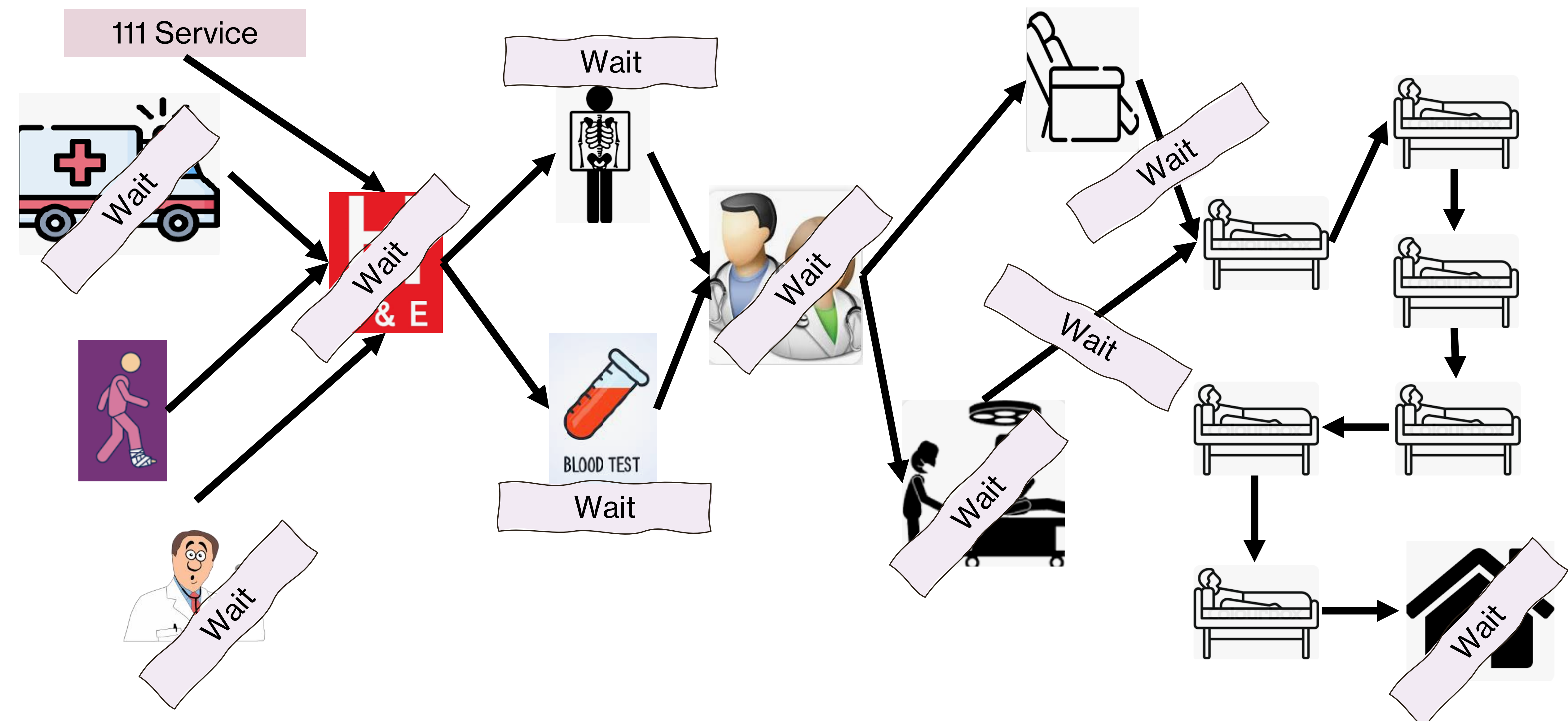
- **The Service Users Voice – A Powerful Driver for Change**
- **Supports Service Development**
- **Measurement of Service Performance**
- **Most importantly –**

It puts the patient at the centre of the system

Emergency Pathways – All the best made plans…!



The Reality For Too Many Patients



Patient's Experience of 'the front door'

Common Patient Feedback Themes

"Waiting hours to be seen by anyone clinical."

"I spent days in a recliner in the corridor before I got to a ward"

"Sat in uncomfortable, cramped waiting areas feeling vulnerable and exposed"

"I had to continuously chase for my results and the next steps."

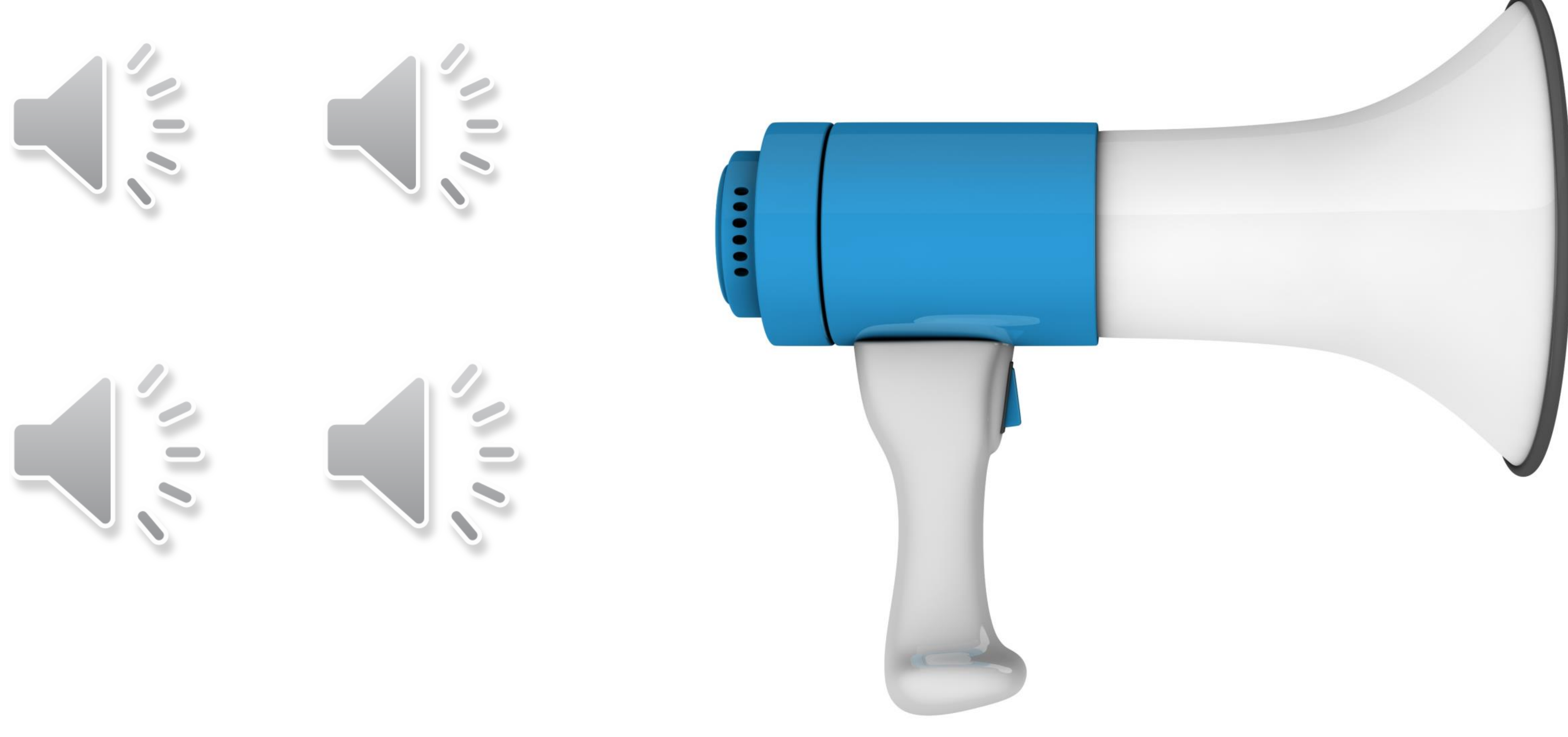
"It felt like no one had an idea of what was going on."

"Handed over from one person to another and had to repeat my whole history all over again"

"Sent home with no pain relief and ended up back in A&E again."

"I had to be treated in the waiting area as there was no space in the next section."

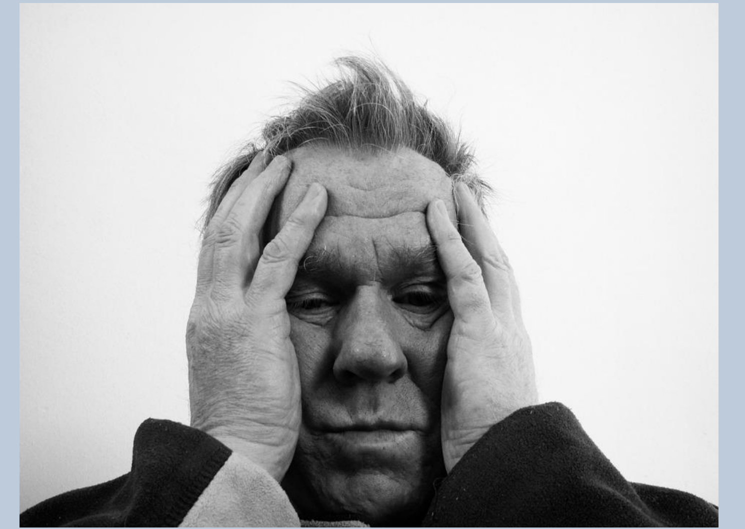
The Patient & Relative’s Voices



Eureka – Finally in a ward bed!

But.....

It’s not the right bed for the patient's specialty



Multiple ward move risks

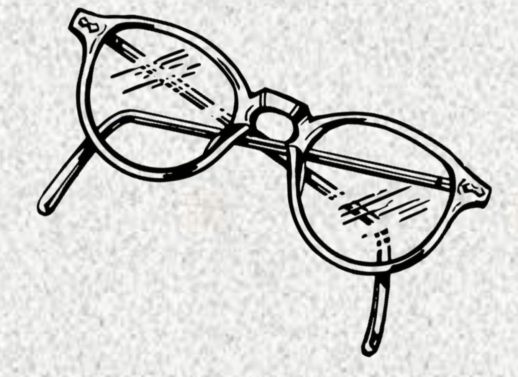
- Increase risks of falls – unfamiliar environment
- Extended length of stay
- Increased risk of patient deterioration
- Inappropriate ward specialty for the patient’s condition
- Patient confusion & family frustration
- Lack of continuation of care
- Potential hand over communication failures
- Patient property losses

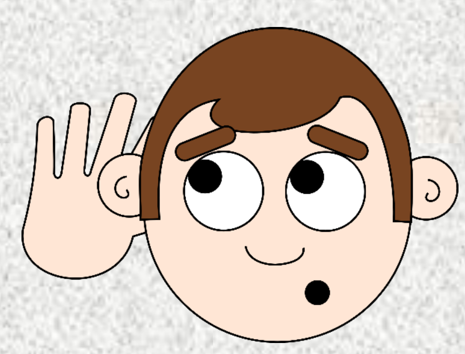
The effect of losing patients property during multiple ward moves

In addition to the financial cost to the hospital for lost property claims, consider what it must be like to:

Loss of a family sentimental piece of jewellery

Unable to read without your spectacles





Not be able to hear if you do not have your hearing aids

You cannot eat, smile or talk properly because your dentures have been lost

Feedback from just one patient who was moved multiple times:

- Nearly every time I was moved it was 10, 11 o’clock at night, sometimes it was gone midnight.
- I would not get any advance warning, sometimes being woken up to be moved.
- You just get to know the staff and then you get moved on to another ward.
- Although the next ward would have my notes, it still felt like the new ward team didn’t know much about my health problems and what the next plan was supposed to be.
- I felt that each time I was moved, my continuity of care suffered.
- I truly believe my hospital stay was longer, and my recovery was made worse because of all the ward moves I endured.
- I regularly got someone else's meals.
- I found it very distressing and annoying, and my family were hugely frustrated.

The Challenges of Discharge Planning

Complex discharge

Package of Care

Waiting for non-emergency transport provision

Co-ordination with families

Awaiting discharge medication

Home assessment

Waiting the doctor's review / decision

Care home placement

When am I going home?

Discharge procedure is appalling. Patients are told they're going home today but with no indication at all of what time.

Unfortunately, the discharge procedure lets down the very good experience.

Eventually getting home at midnight wasn't good for a 75 Yr old.

I have been discharged without appropriate pain relief and am considering returning to A&E tonight.

Staff work so hard & are lovely to patients, but waiting hours after discharge for meds only to be told pharmacy is closed, so I have no meds

The transport never arrived so I ended up in the discharge suite all night which had no facilities like the ward did.

Discharge takes so long, I was told at 10am I could go home, and I am still here at 5pm, so frustrating when you just want to go home.

The Family…

My mother was due to be discharged on **Tuesday 20th August 2024**. But due to a requirement that her medication needed to be in blister packs, we were told that her discharge would be delayed for 48 hours. So, her discharge was set to be **22nd August 2024**. However, due to trying to get my mother some home support organised, she remained in hospital until **Tuesday 27th August.** All the time I had no idea what to plan to take time off work and organise my own family commitments.

Ironically, the medication she was sent home with was not in blister packs which was the reason for the initial delay!
But she is my Mum and I am just glad to have her home.

My final thought...

Has the NHS become so tolerant of all the poor process flow issues, that we have got to the point that they have become normalised?

Any Thoughts or Questions

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Case Study

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Slido

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

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Case Study

Mike Cawthorn
MD
Catalyst IT

Noel Watson
Senior Pre-Sales Consults
Catalyst IT

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Chair Morning Reflection

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

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Case Study

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Slido

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

Case Study

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Michael Fjeldstad
Solution Consultant
DNV Imatis AS

Christopher Betts
Business Development and Sales Leader - DNV Imatis

We streamline and automate the hospital flow

Chris Betts – Business development and sales leader
Michael Fjeldstad – Clinical solution specialist, RN

We streamline and automate the hospital flow

10:23

Real-time integration and visualisation of your healthcare operations, accessible anywhere

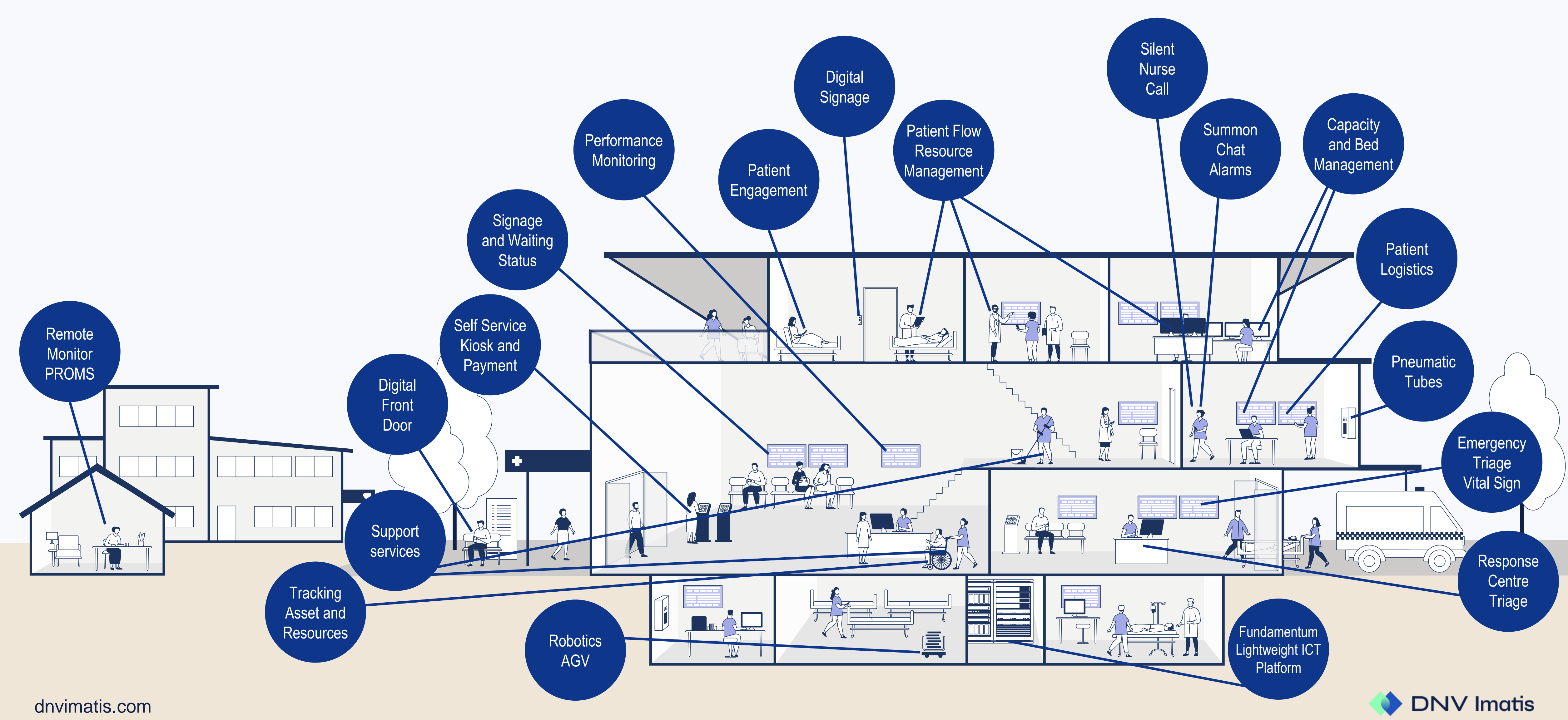
Patient flow

Resource management

Task management

Alarm management & communications

DNV Imatis in short



4 challenges
and results

1: Patient flow - eBCMS

Østfold Hospital Trust, Norway

Managing patient flow within hospitals and between the emergency department and ward

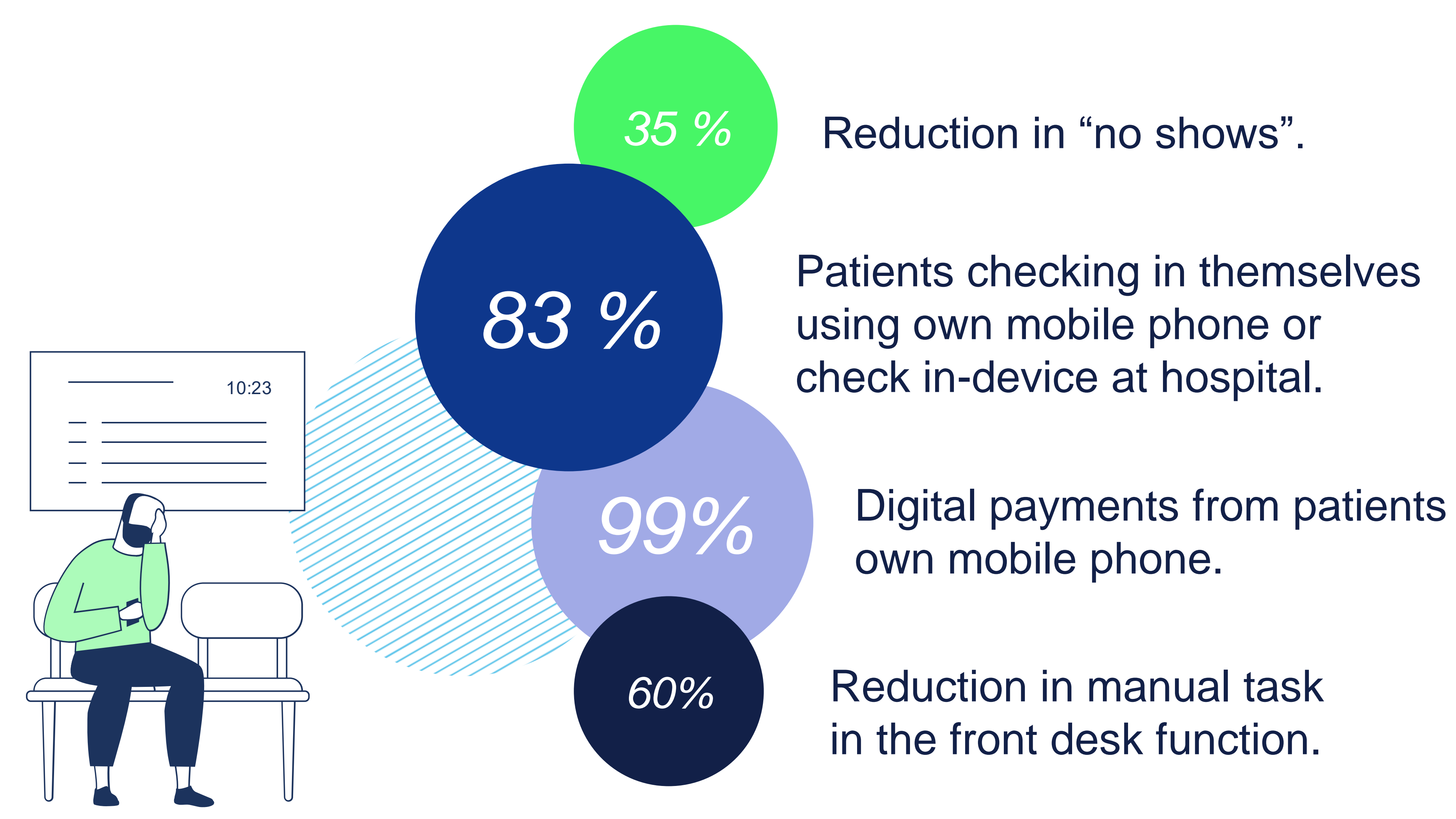
eBCMS flow

Bed Management at Østfold Hospital Trust, Norway

2: «No-shows»

South-Eastern Norway Regional Health Authority

High no-show rates at outpatient clinics, leading to long waiting lists and surgery delays


35 %
Reduction in “no shows”.
83 %
Patients checking in themselves using own mobile phone or check in-device at hospital.
99%
Digital payments from patients own mobile phone.
60%
Reduction in manual task in the front desk function.
10:23

3: Task management

Haraldsplass Diaconal Hospital, Norway

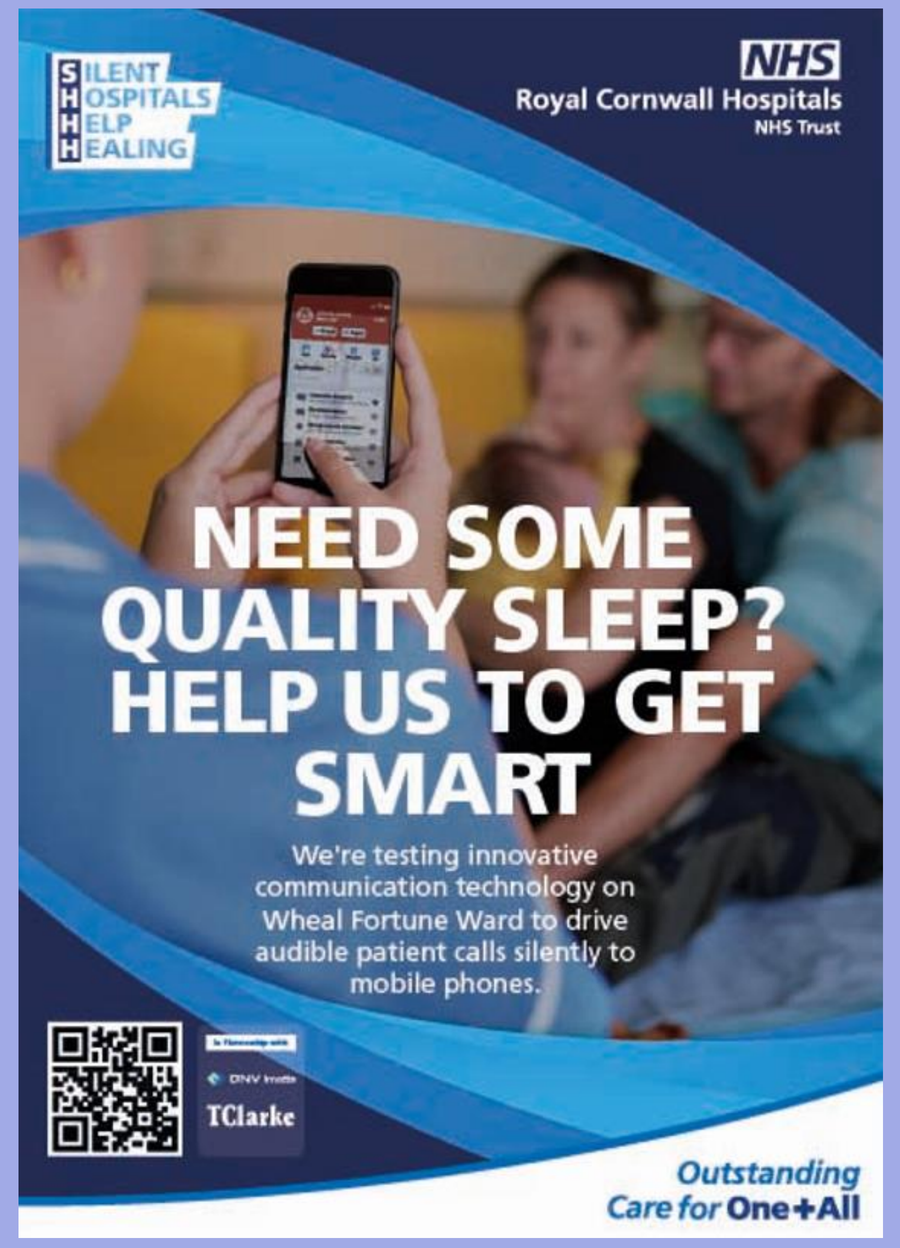
Manual, cumbersome routines and planned orders lack oversight and require excessive manual work

Saves 15 to 17 hours
per shift each day
on coordination and
manual routines

4: Alarm management & communication

Royal Cornwall Hospital, UK, Wheal Fortune post-natal ward

Excessive noise in hospitals disrupts patient sleep, increases staff stress, and can affect the length of stays



- **0.5 a day reduction in Average Length of Stay (ALOS)** per patient confirmed.
- **£75k per annum** Indicative non-cash releasing benefit of **£75k per annum** (just on one 25-bed ward).
- **50% reduction in sound energy** Recorded 3 Decibel (dB) reduction on the ward; a benefit of **50% reduction in sound energy.**
- **12% increase in patient sleep quality** Mothers and babies more relaxed and recovering quicker; patient surveys show a **12% increase in patient sleep quality.**
- **Improved working environment** for staff; reduced noise levels, less interruptions, more considerate, and lower volume behaviours.
- **Recordable call bell response data;** allows task analysis, performance information and supports greater staff accountability.

Royal Cornwall Hospital NHS Trust

“This distributed control and communication platform has ***huge potential to change the way NHS staff work*** *- from desk based to mobile working, and with more time to care at the bedside.*

Even small changes to improve the quality of the environment in which care is delivered could achieve a ***happier, heathier, and more productive ward****.*

I am excited to explore where DNV Imatis Fundamentum may take us next beyond our initial trial of the technology.”

NHS
Royal Cornwall Hospitals
NHS Trust

Roberta Fuller BA(Hons) Exec MBA MSc
Associate Director Major Capital Projects
Programme Director, Women and Children’s Hospital Programme

Summary

Home News US Election Sport Business Innovation Culture Arts Travel Earth Video Live

NHS must improve productivity, says Streeting

19 hours ago

Share Save

Nick Triggle
Health correspondent • @nicktriggle

The NHS owes it to taxpayers to improve productivity in return for the extra money it is getting, the health secretary says.

The Western Norway Regional Health Authority

15-20% increased productivity

Subscribe to our newsletter

Thank you.

CONVENZIS

Case Study

Netcompany

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Slido

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

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Case Study

Julian Brailsford
Principal - Platforms
Netcompany

Andy Williams
Interim Chief Digital Officer
Harrogate & District NHS Foundation Trust

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Keynote Presentation

Andy McCann

Lead Data Scientist ML Nursing & Urgent Care - NHS ML

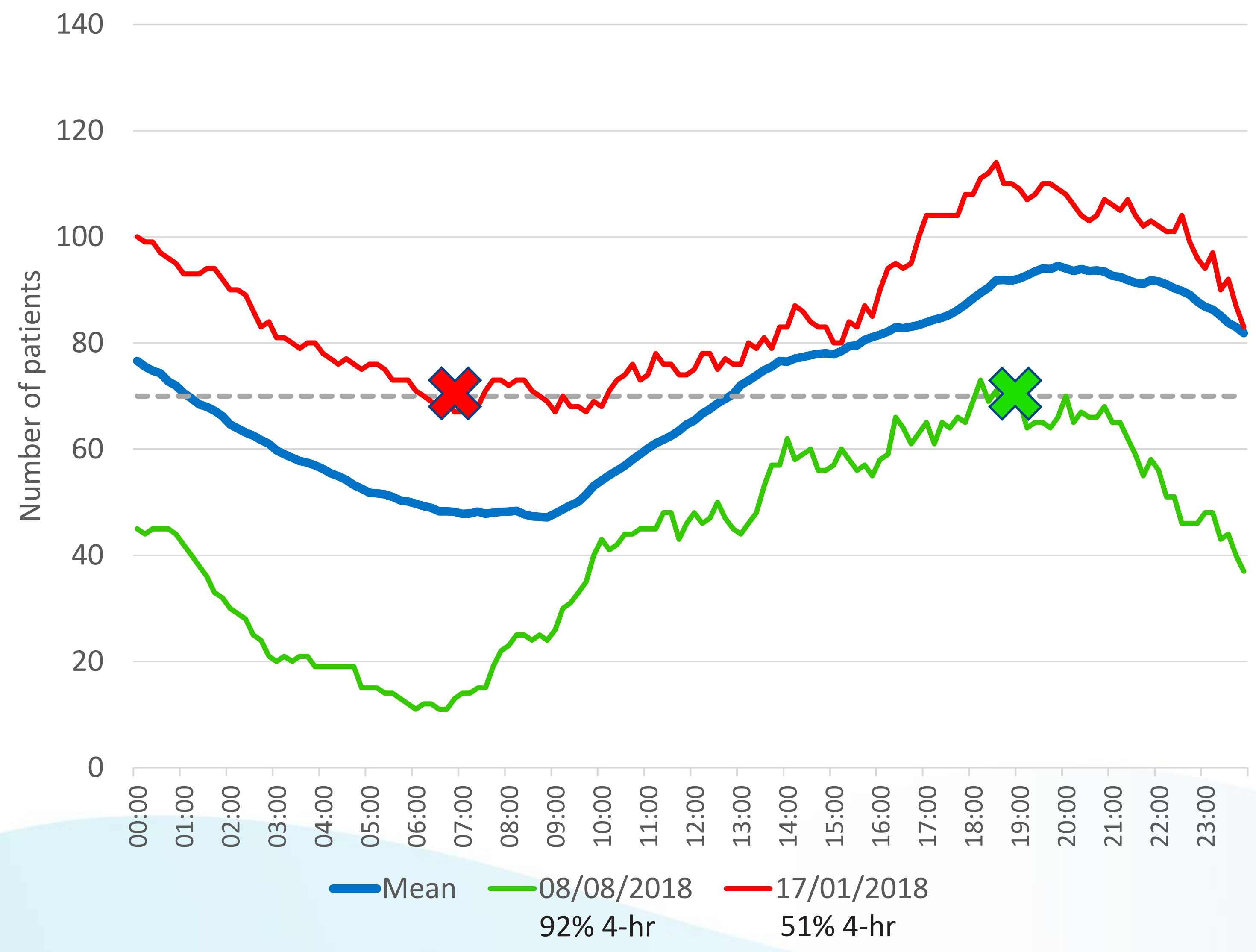
Data Analytics to Understand Patient Flow

The National NHS Patient Flow Summit, Convenzis

6th November 2024

andrew.mccann1@nhs.net
Lead Data Scientist
ML Nursing & Urgent Care Team

Emergency Department (ED) Stock and Flow



The 'flow' of attendances into an Emergency Department (ED) minus the 'flow' of departures out leads to a change in the 'stock' of patients in the department at a point in time.

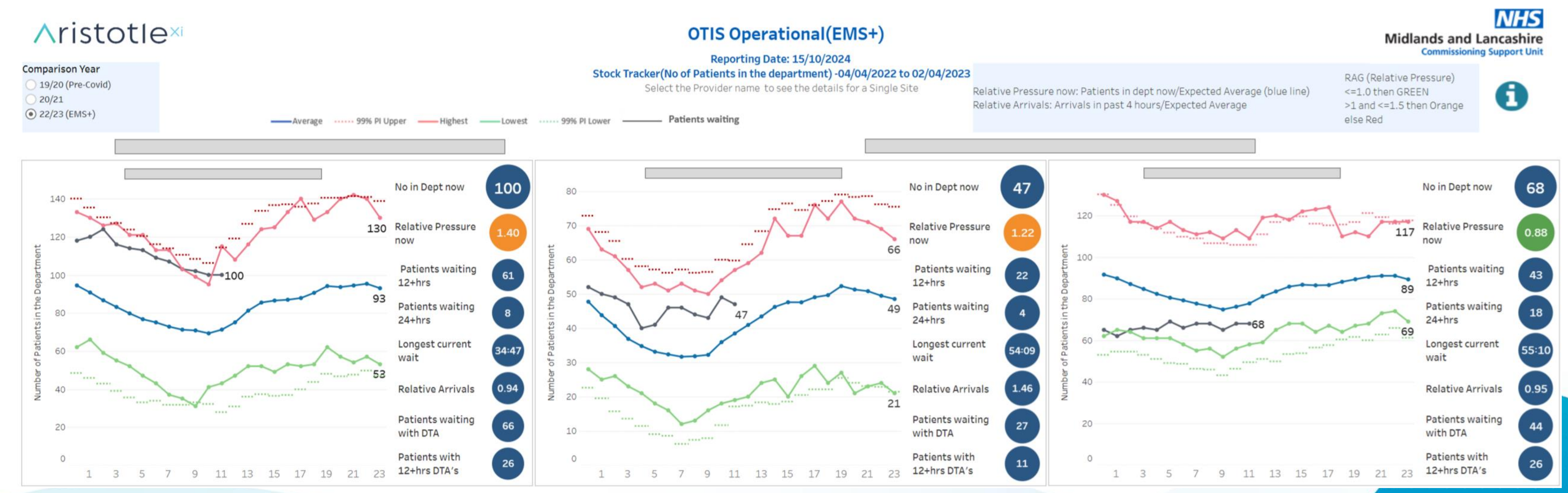
This hospital can cope with 70 patients in ED department at 7pm …

… but 70 patients at 7am means there will almost certainly be problems

Source: ML from SUS AE data, a single A&E Department, selected Wednesdays

Live ED Stock Charts

Live stock charts can show all acute sites within a system. These provide a real-time view of the number of patients in each department, allowing early warning of building pressures, assessment of relative pressure in different sites across a system and so inform decisions around mutual aid, ambulance diverts and so on.



 Source: ML Aristotle OTiS EMS+ Dashboard

EDs have seen Increased Congestion …

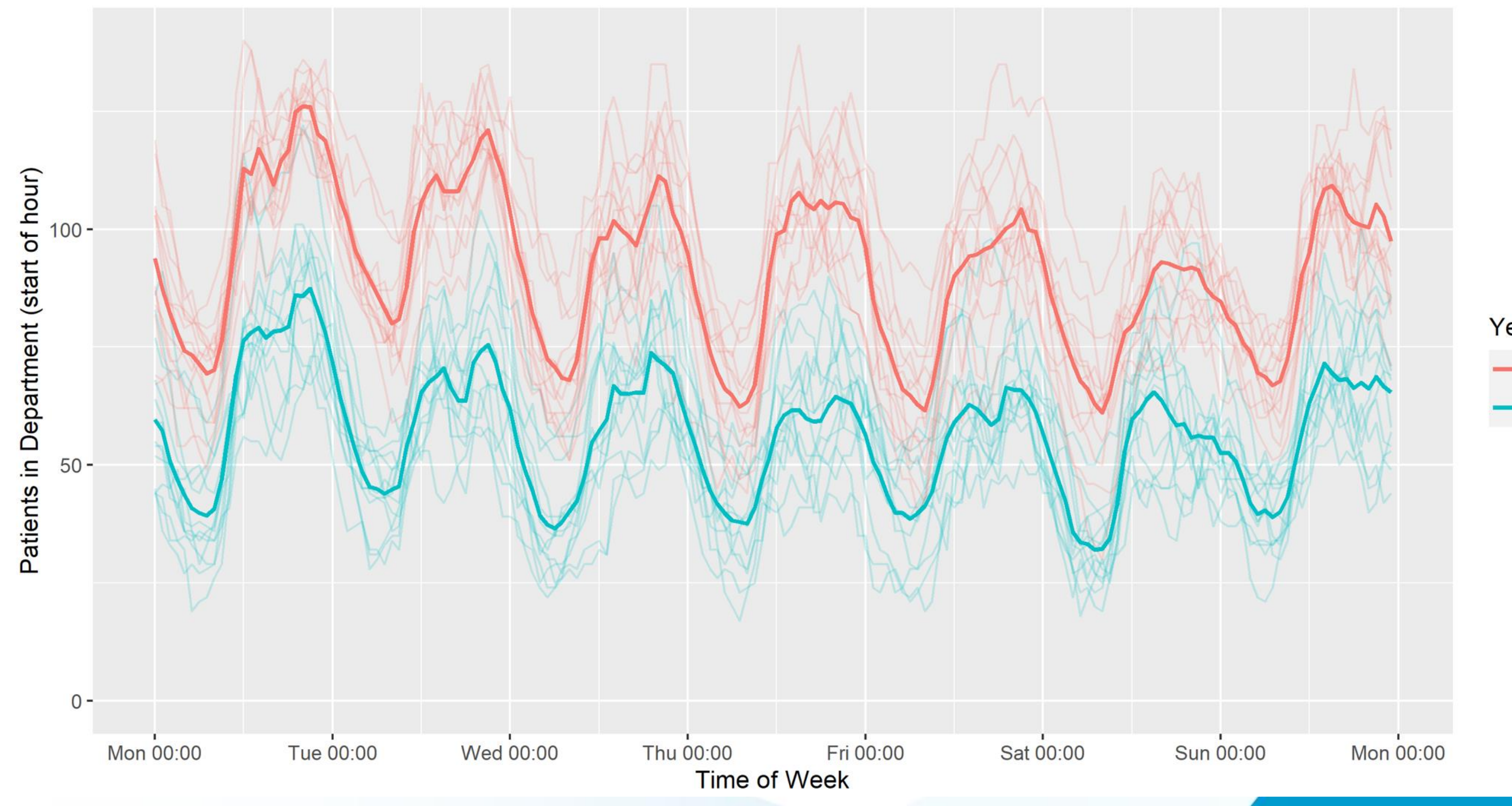
By late 2021, EDs were recognised to be experiencing unprecedented pressure.

Measured by the number of patients in the department at a point in time, this example ED was on average

61%

more congested in late 2021 than it had been in late 2019.

Almost every week in late 2021 was ‘busier’ in terms of patients in the department than the busiest week in late 2019 and staff naturally felt pressured, often blaming demand and footfall.



Source: MLCSU from NCDR ECDS. Mon 13 Sep 2021-Sun 12 Dec 2021 vs Mon 16 Sep 2019-Sun 15 Dec 2019.

… far more than increased footfall

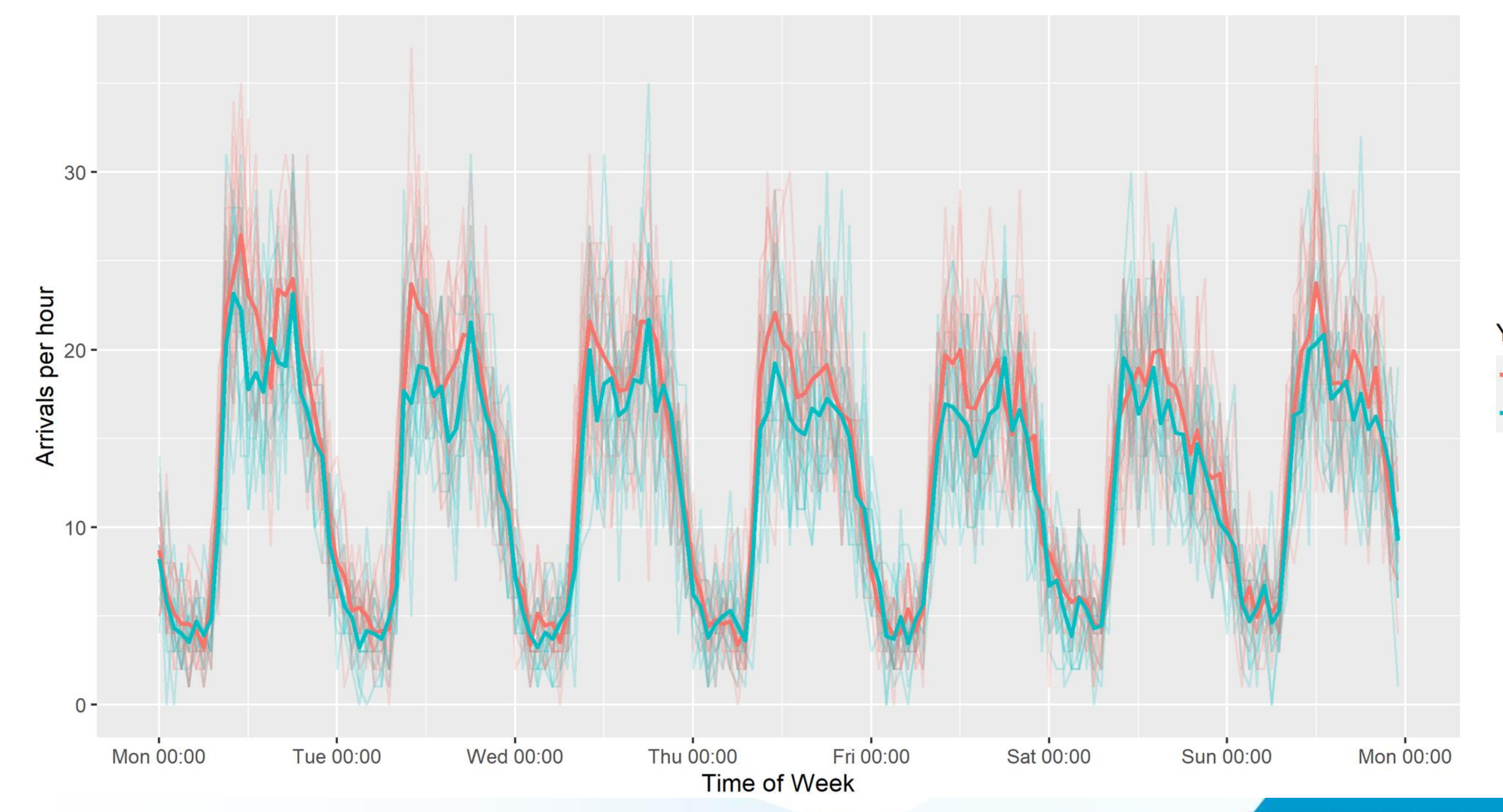
However, footfall has increased by far less than congestion. In this same ED, average attendances were less than

10%

higher in late 2021 than in late 2019.

EDs are more congested and ‘busier’, not mainly due to increased attendances but as a result of longer wait times and consequently backlog build up.

Waits have increased the most for patients ultimately admitted, suggesting that the root cause is reduced flow due to bed availability.



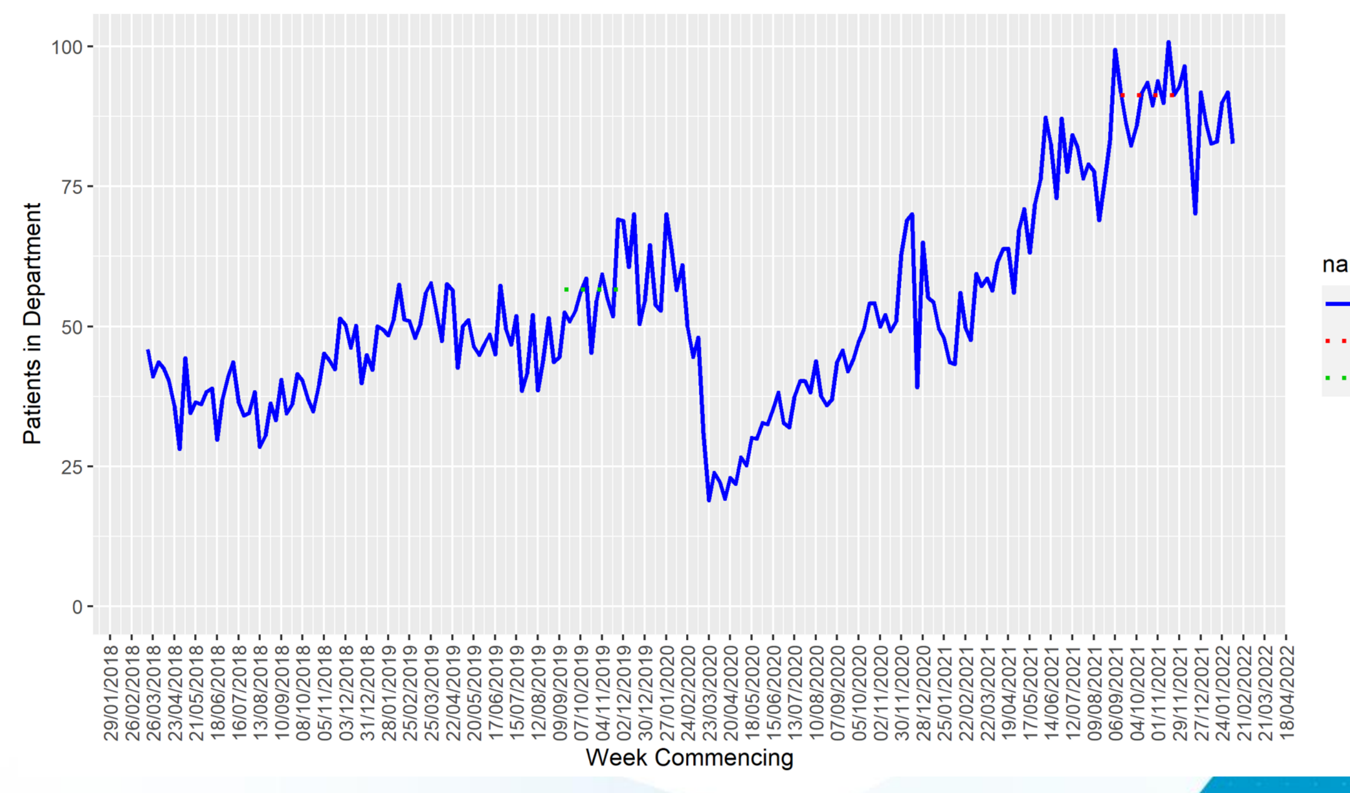
Source: MLCSU from NCDR ECDS. Mon 13 Sep 2021-Sun 12 Dec 2021 vs Mon 16 Sep 2019-Sun 15 Dec 2019.

Creeping Normalisation

Between April 2020 and October 2021, the average number of patients in this example department grew (on average) by less than one per week, but the cumulative effect of this over eighteen months is a department that is more than four times as congested.

If the capacity of a system, whether to treat within ED or to discharge patients from beds or at any other stage in the process, is insufficient to deal with the flow of arrivals, then even a small deficit can lead to gradually increasing queues.

Perhaps partly because it happens gradually, congested departments, waits of over 12 hours and corridor care become normalised.



ED Patient Flow during Covid

When we started this project, in early 2022, the conventional wisdom was that the Covid effects on urgent and emergency flow had, like the effects on the rest of the health system, been exclusively negative.

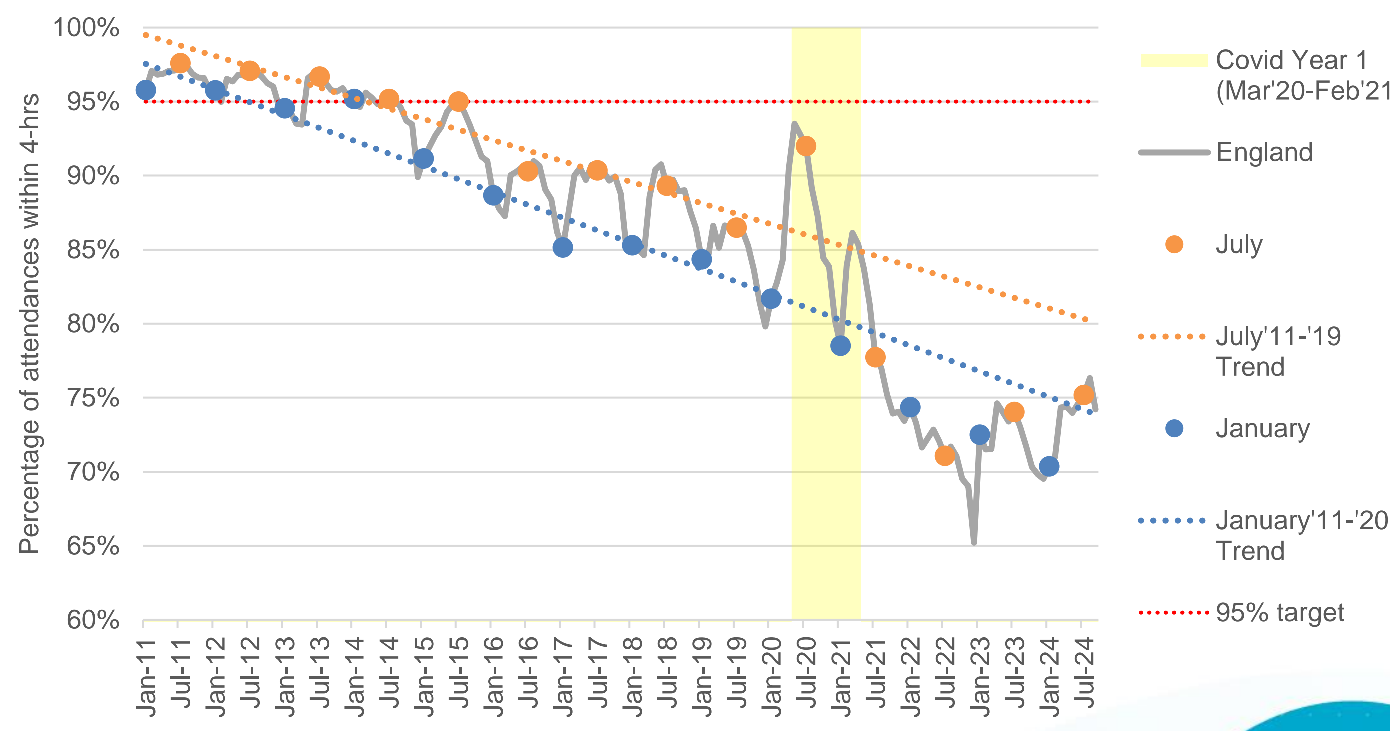
However, counter-intuitively, the first year of Covid actually saw the best 4-hour performance in five years.

For the whole decade prior to Covid, A&E performance had been on a clear downward trend (with a pronounced seasonal pattern).

As Covid hit in March 2020, 4-hour performance rapidly improved, as attendances and, critically, bed occupancy fell dramatically.

Winter 2020/21 saw similar performance (though for different reasons) than the long-term trajectory and Spring 2021 again saw an improvement. It was only after April 2021 that performance fell below the levels of the long-term trend.

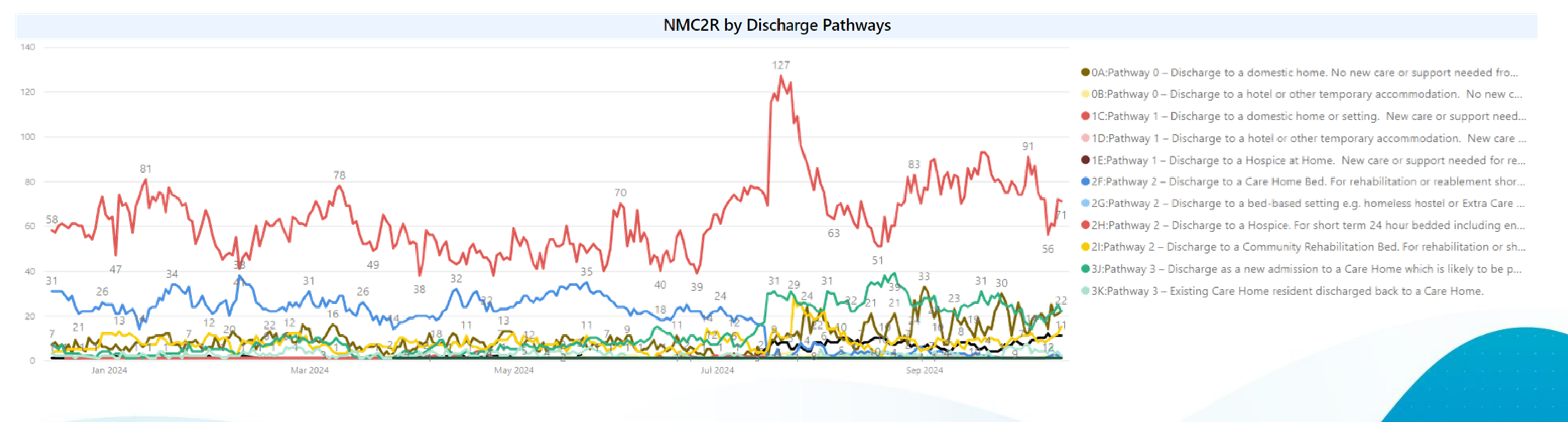
Since early 2023 there has been a stabilisation in performance, but remaining below the pre-Covid trend.



Source: MLCSU from public data at: https://www.england.nhs.uk/statistics/statistical-work-areas/ae-waiting-times-and-activity/
Note: England, NHS and independent sector organisations, excludes CRS Field Testing Sites May 2019-May 2023

NMC2R Faster Data Flows

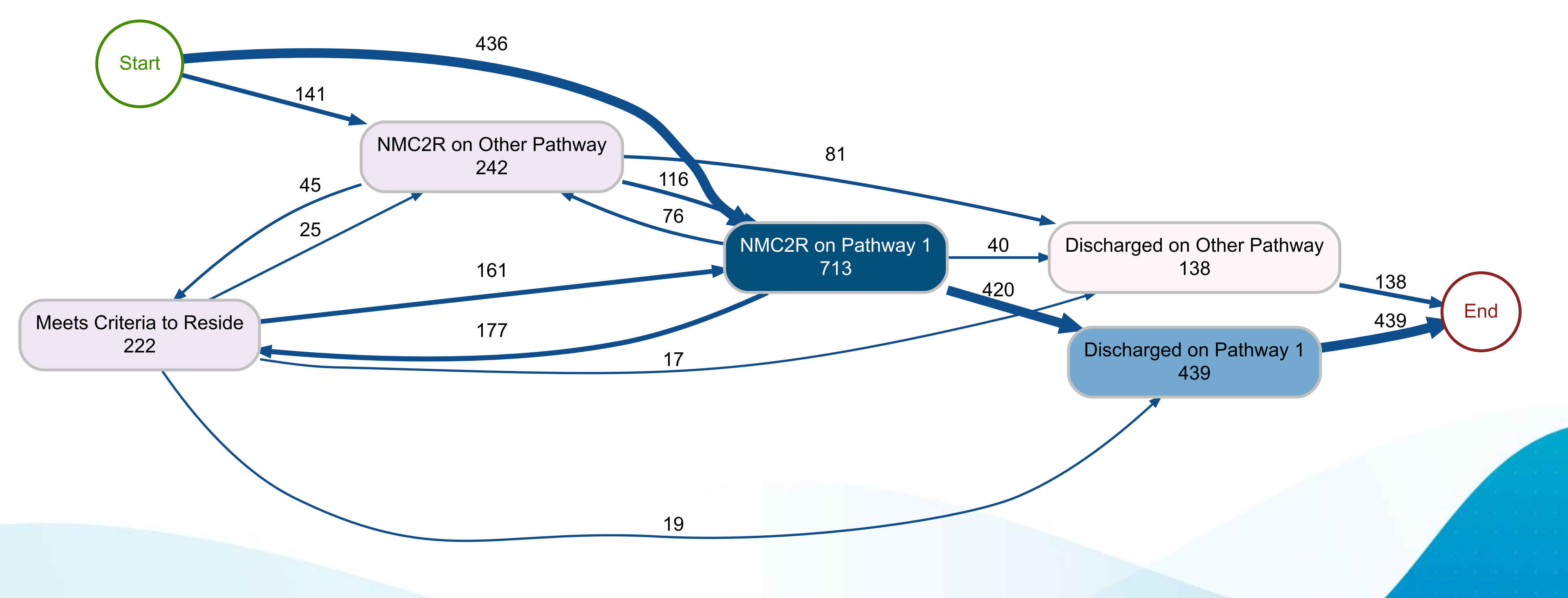
Faster Data Flows (FDF) is a relatively new national data feed which (among other things) allows timely monitoring of Not Meeting Criteria to Reside (NMC2R) numbers and discharge pathways across systems.



 Source: ML Aristotle FDF Report (in development)

NMC2R FDF Process Mining

Because Faster Data Flows is a daily submission, Process Mining the data to follow patient journeys can reveal insights such as where NMC2R patients move between planned pathways and where (likely due to deconditioning) they temporarily Meet the Criteria to Reside again.



Source: ML from Faster Data Flows data, simplified focus on Pathway 1

Winter Pressures-Patients in Beds, not Admissions

Just looking at the number of admissions for respiratory conditions fails to capture the impact of winter pressures. Considering instead the number of patients in a bed each day reveals far more clearly the regular impact (disrupted by Covid).

Non-Elective Patients in Beds, Respiratory Conditions, Covid/Non-Covid

800
700
600
500
400
300
200
100
0

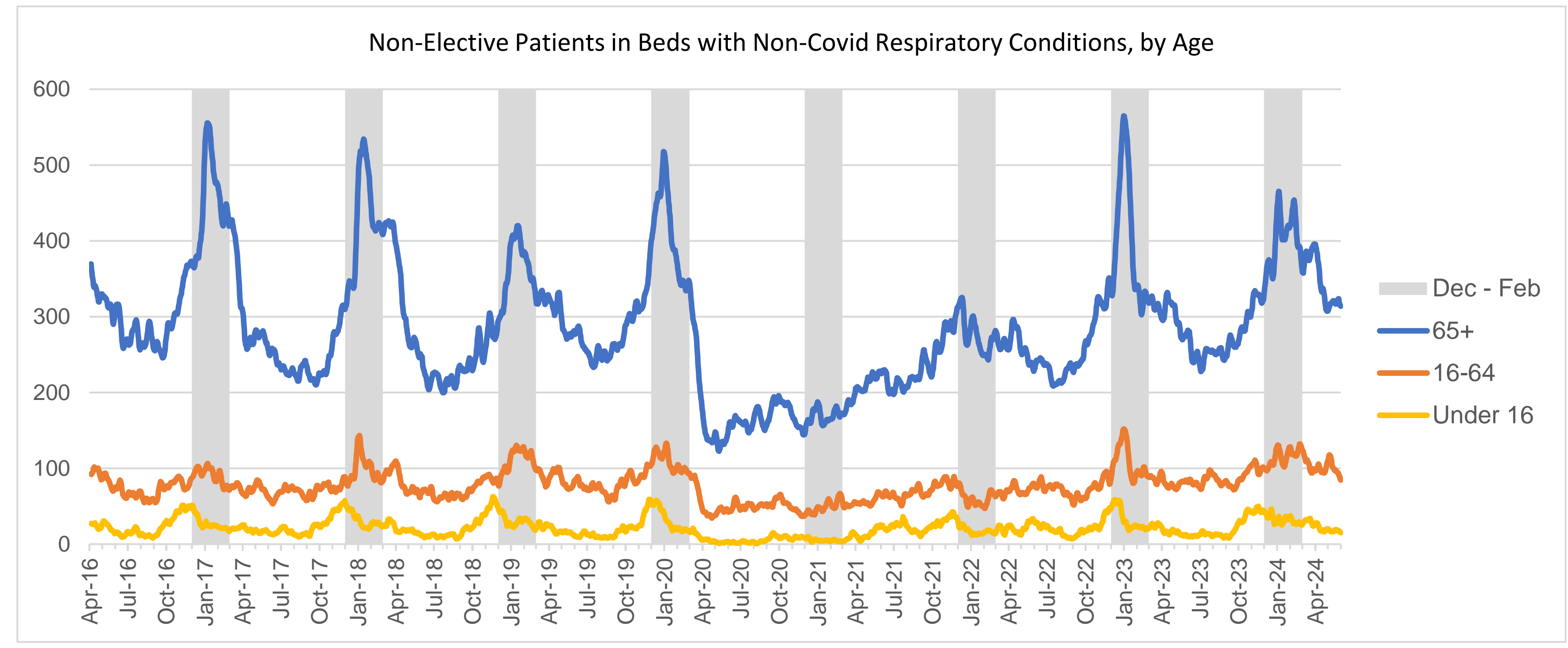
Apr-16 Jul-16 Oct-16 Jan-17 Apr-17 Jul-17 Oct-17 Jan-18 Apr-18 Jul-18 Oct-18 Jan-19 Apr-19 Jul-19 Oct-19 Jan-20 Apr-20 Jul-20 Oct-20 Jan-21 Apr-21 Jul-21 Oct-21 Jan-22 Apr-22 Jul-22 Oct-22 Jan-23 Apr-23 Jul-23 Oct-23 Jan-24 Apr-24 Jul-24 Oct-24 Jan-25

Dec - Feb
Primary Non-Covid Respiratory Patients in Beds (7 day average)
Primary COVID Patients in Beds (7 day average)
Non-Covid Respiratory projection (avg 2016/17-2019/20 & 2022/23-2023/24)
Covid Projection (Covid SitRep to date then same as 2023/24)

Source: ML from SUS Inpatient data. Covid patients those with Primary Diagnosis ICD10 code starting ‘U’
Non-Covid Respiratory Conditions those with Primary Diagnosis ICD10 code starting ‘J’

Winter Pressures-Older Patients

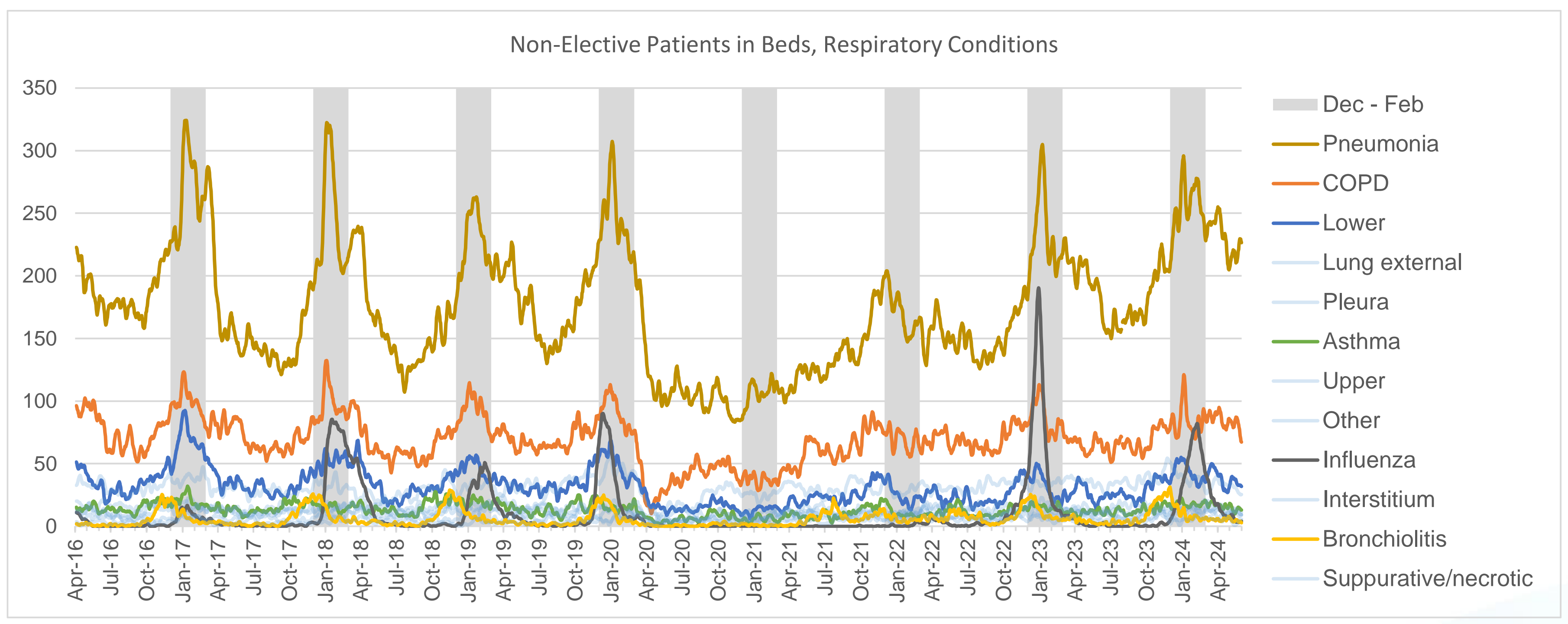
Because older patients have, on average, a longer length of stay they dominate the beds in use and so the winter increase in respiratory beds (blue line, chart below), even though there are a similar number of admissions for patients aged 16-64.



Source: ML from SUS Inpatient data. Those with Primary Diagnosis ICD10 code starting ‘J’ (Diseases of the respiratory system).

Winter Pressures-Pneumonia

While there is often a particular focus on ‘flu over winter, it is in fact patients with a primary diagnosis of pneumonia who dominate the beds in use from respiratory conditions (brown line, chart below).



Anything which can be done to avoid admissions of older people with pneumonia or reduce their subsequent length of stay will have the greatest effect on winter acute bed demand.

Source: ML from SUS Inpatient data. Those with Primary Diagnosis ICD10 code starting ‘J’ (Diseases of the respiratory system).

Summary

- Tracking the number of patients in an Emergency Department over time gives a better reflection than attendances of pressures. It can provide an early warning of emerging pressures, help with mutual aid across a system and reveal the 'creeping normalisation' of long waits and corridor care
- The first year of Covid showed the effect of improved flow through ED, with the best 4-hour performance in five years
- Faster Data Flows (FDF) allows timely monitoring of Not Meeting Criteria to Reside (NMC2R) numbers and discharge pathways across systems
- Process Mining can reveal insights such as where NMC2R patients move between planned pathways and where (likely due to deconditioning) they temporarily Meet the Criteria to Reside again
- Winter pressures are dominated by long stays in beds for older patients with pneumonia. Anything which can be done to avoid these admissions or reduce subsequent length of stay will have the greatest effect on winter acute bed demand

andrew.mccann1@nhs.net
Lead Data Scientist
ML Nursing & Urgent Care Team

Get to know us or get in touch

X: @NHSmidslancs
Facebook: @Midlandsandlancs
LinkedIn: MLCSU
midlandsandlancashirecsu.nhs.uk

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Case Study

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Lunch & Networking

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Chair Afternoon Address

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

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Case Study

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Case Study

Fiona Longhurst
Director of Knowledge
Royal Voluntary Service

NHS CARE
Volunteer Responders
Accelerating discharge and enhancing patient care
Service provided by:
ROYAL VOLUNTARY SERVICE
GoodSAM Instant.Help
FIRE EXIT
Store Room
First aid
Barnsley Hospital NHS Foundation Trust
Safeguarding Team Structure
Gillick Competence and Fraser Guidelines

Introduction to the programme

NHS and Care Volunteer Responders (NHSCVR) is a large-scale, **NHS-approved** volunteering programme supporting the NHS and healthcare teams across England.

Digitally delivered enabling fast, real-time volunteer deployment

Adds capacity to healthcare teams & services to improve delivery

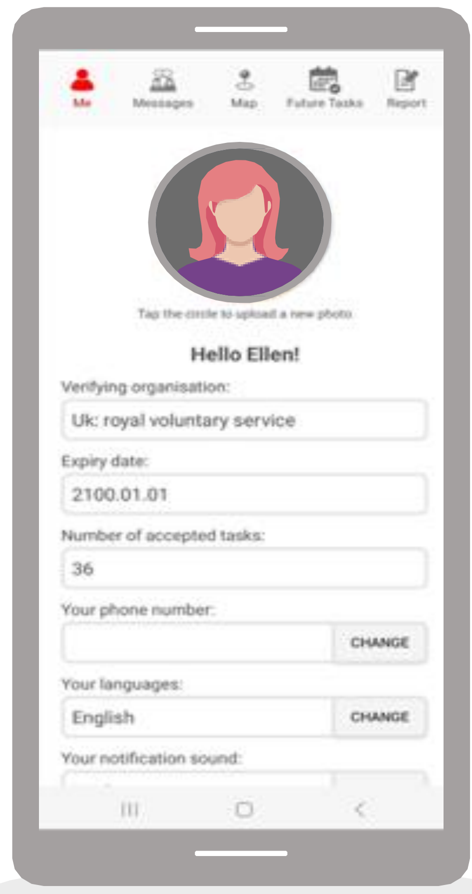
Compliments existing volunteering programmes

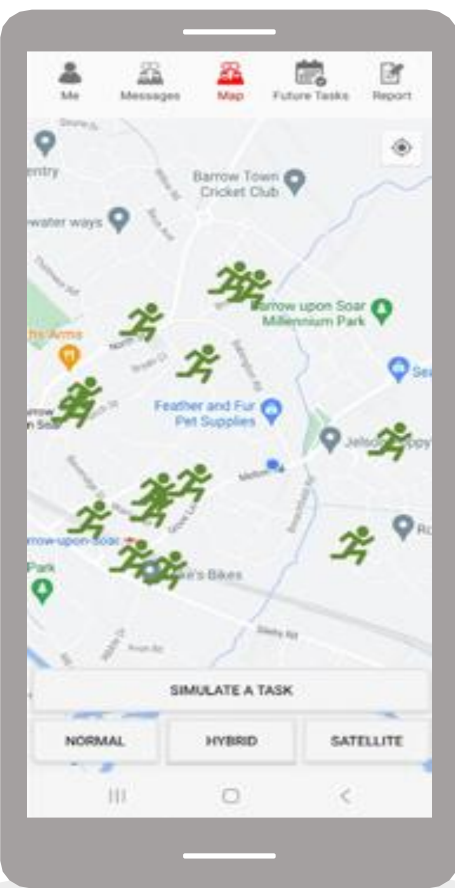
An inclusive programme with a diverse pool of volunteers

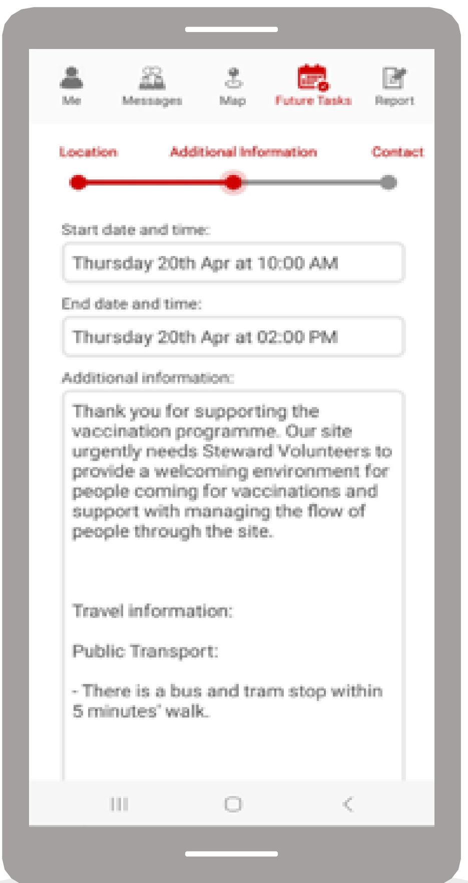
Evolving programme developed using insights from local systems

Service provided by:

The GoodSAM app







Service provided by:

Over 43,000 volunteers

available to support

Service provided by:

Driving support services

Pick Up and Deliver volunteers

- Drop off medication/TTOs and equipment to patients' homes following discharge.
- Collect and return equipment to the NHS to recycle and reduce waste/cost.

Service Impact

- ✓ **Quicker patient discharge**

8% improvement in ‘discharge by 17:00’

*Patients, on average, **discharged 3 hours earlier** in the day*

- ✓ **Alleviate staff workload**

- ✓ **Resource optimisation**

According to NHSE data ‘If just two out of every five walking aids were returned, the average hospital could ***save up to £46k per year***

https://www.england.nhs.uk/greenernhs/publication/delivering-a-net-zero-national-health-service/
https://www.england.nhs.uk/ahp/greener-ahp-hub/specific-areas-for-consideration/walking-aid-reuse/

Service provided by: ROYAL VOLUNTARY SERVICE

Testimonial – Barnsley Hospital

We have found the Pick Up and Deliver service to be incredibly helpful and necessary. We have already recommended it to other colleagues and department heads in the hospital.

The service is available seven days a week and is highly responsive, which is fantastic. There is no lengthy referral form required, which makes it easy to use.

Jaqueline Howarth, Operational Manager of Right Care Barnsley

Hospitals and Pick Up and Deliver

- Pick Up and Deliver being utilised by early adopters
- Hospital teams in Rotherham, Barnsley, Crewe, Wolverhampton, Mansfield, Gloucester and St Georges, West Suffolk, Leicester (amongst others) currently using the service
- Sites launching soon include West Sussex, Chesterfield, Lincolnshire
- Conversations ongoing with more than 10 trusts

Package of support for your patients

- **Telephone Support**

Calls to people in need of a friendly voice and a listening ear.

- **Community Response**

Assistance with essential shopping and prescription delivery.

- **Community Response – Connect**

Supporting individuals in enjoying social activities within the community.

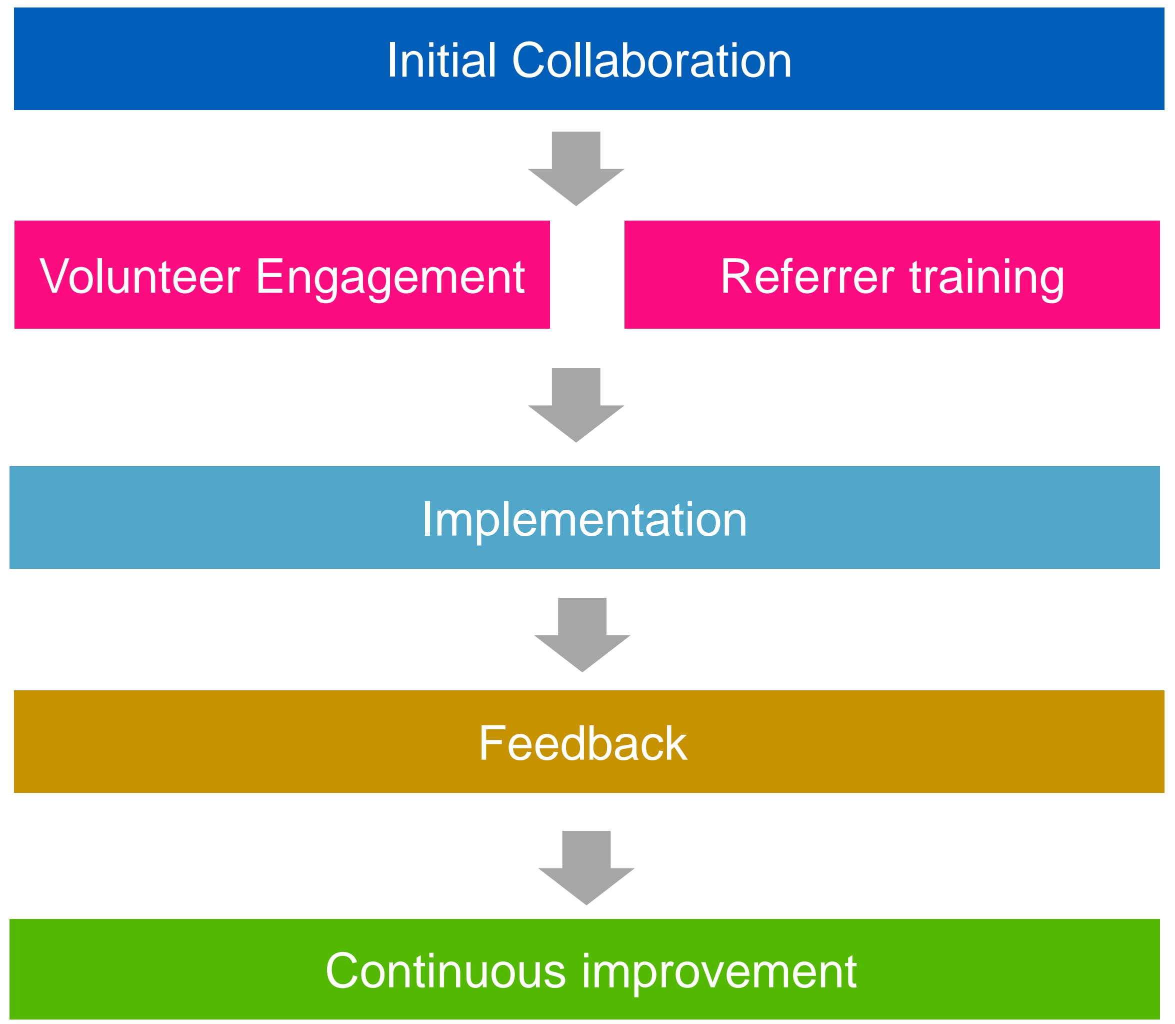
✓ **Social and emotional support** for people who may otherwise feel isolated

✓ **Easing the burden on healthcare providers** by helping patients maintain a sense of connection and well-being

✓ **Reduced unnecessary GP visits** by addressing non-clinical needs

Service provided by:

Collaborative approach

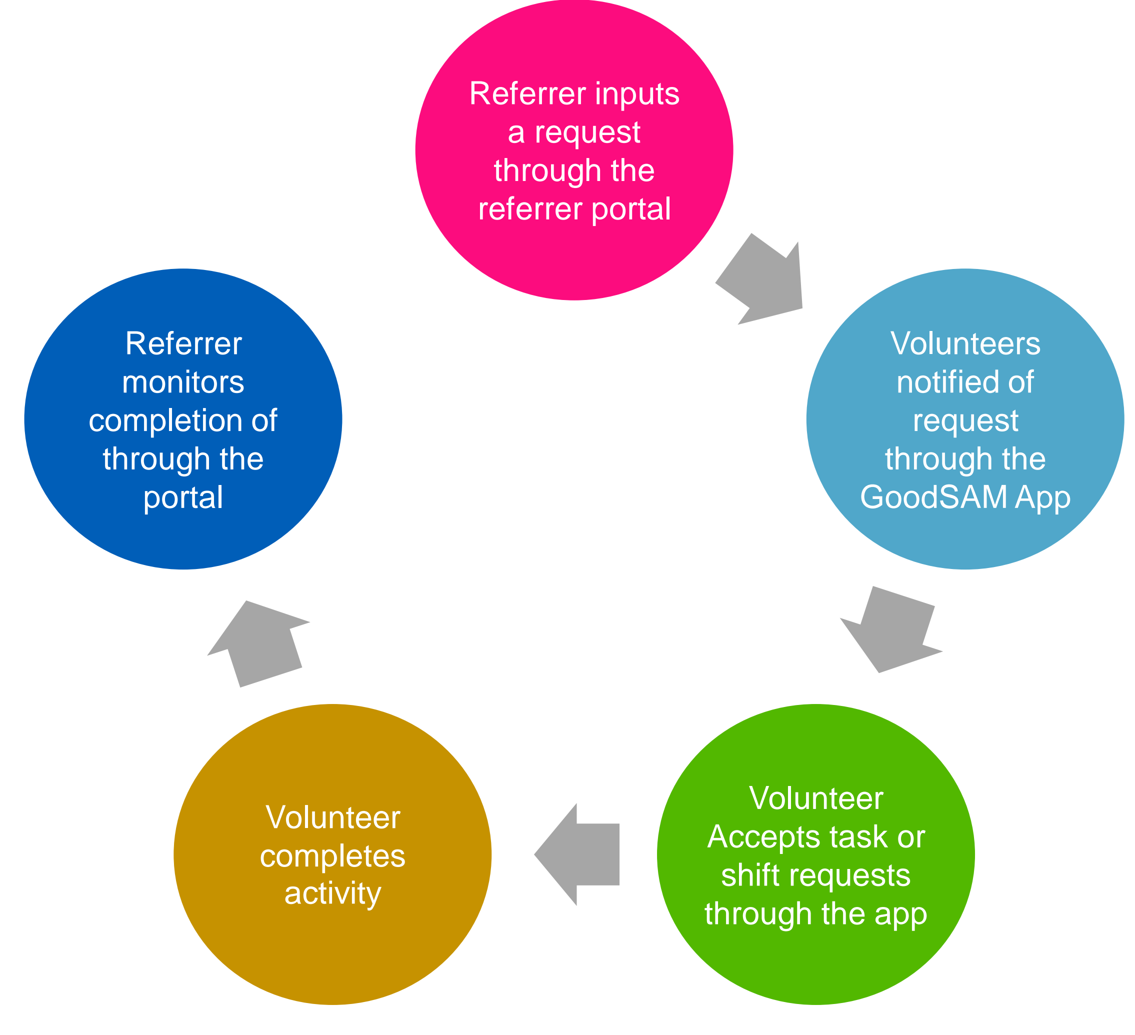


Service provided by:

Streamlined processes

NHS CARE Volunteer Responders

- Straightforward and hassle-free
- Specifically produced asset pack *(NHS approval Letter, SOP & DPIA documents)*
- Training hub on the website



76% *referrers agree that the* ***referral process is easy.***

Volunteer checks

Fully approved NHS volunteer service. Appropriate background checks are carried out for **all volunteers**

	Checks	Check In and Chat	Companionship Calls	Community Response	Driving Support	Driving Support Plus	Site Support
Green	• ID Check • Driver status completed • Enhanced DBS with Adult Barred			✓		✓	
Blue	• ID Check • Driver status completed • Enhanced DBS		✓				
Red	• ID Check • Driver status completed • Self-declaration of unspent convictions for Stewards only	✓			✓		✓

This approach is in line with Home Office guidance around eligibility for DBS checks.

Service provided by:

Volunteer support

- ✓ Volunteers recruited and supported centrally
- ✓ Appropriate background checks are carried out for **all volunteers** in-line with home office guidance
- ✓ Expenses paid for by the programme
- ✓ Problem Solving and Safeguarding Teams available 7 days a week

Impact on clients

42%

People receiving Telephone Support **visit their GP less often** thanks to Volunteer Responders

36%

Attend A&E less often due to the assistance from Volunteer Responders

89%

of VR clients find this **service important**, with **63%** calling it **very important**.

72%

of VR clients are **highly satisfied** with the service, underscoring its **significant impact**.

62%

Report **higher satisfaction with the NHS** compared to just 49% in the general population (ONS, May 2024).

57%

are only receiving NHSCVR support

"After having a stroke, I felt so vulnerable and disabled. Your service and the wonderful volunteers gave me back a bit of independence. 'Little steps forward' is what I have been told, I can do this with your NHSCVR volunteer support."

(Male, 45-54)

Service provided by:

Key Takeaways

- NHS-approved and free
- Easy to use with real-time support and training
- A growing, national pool of volunteers available immediately
- A trusted volunteer programme - all 42 ICS' are using in some capacity

Almost ***2 out of 3*** *front line staff said that NHSCVR had a* ***positive impact on their workload.***

Service provided by:

Next Steps

Talk to us at our table in the exhibition area

Contact your RRM

Visit the website

Search online for

‘Volunteer Responders’

Service provided by:

Questions?

Service provided by:

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Slido

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

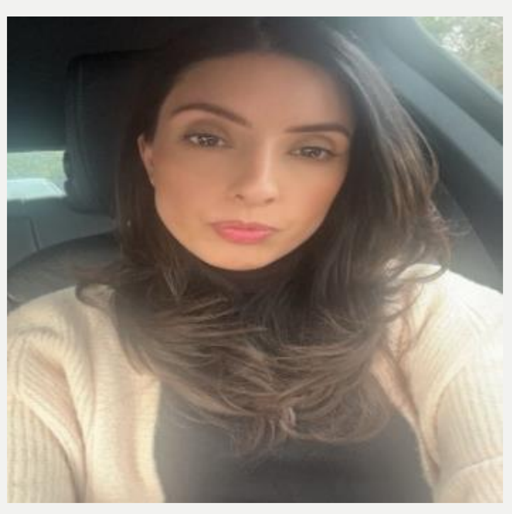
THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

CONVENZIS

Keynote Presentation

Dr Sulaxni Nainani
Deputy Chief Medical Officer
NHS Leicester, Leicestershire & Rutland ICB



Kerryjit Kaur
Head of Integration and Transformation
NHS Leicester, - Leicestershire & Rutland ICB

Optimising UEC pathways to enhance operational efficiency, alleviate A&E wait times and improve patient experience

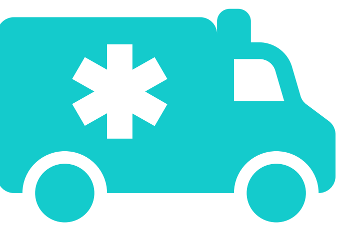
Dr Sulaxni Nainani-Deputy Chief Medical Officer, Leicester, Leicestershire and Rutland ICB
Kerry Kaur- Head of Integration and Transformation, Community Care, Leicester, Leicestershire and Rutland ICB

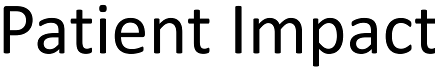
A proud partner in the:

Our need for change

- Patients were not being seen in the right place, at the right time or receiving the right care
- Significant Ambulance delays, as a result of losing hours on a daily basis outside our hospital which resulted in patients waiting hours for an ambulance response
- Increased pressures in our hospital, delaying clinical assessments and treatment, resulting in poor patient experience
- A struggling workforce, who were exhausted, feeling like they were not delivering the best care to their patients
- We recognised we needed a system approach to resolve our challenges and the only way to do this was through “collaboration”.

Optimising UEC pathways through





Collaboration

LLR UEC Pathways

- Primary Care interventions
- Home Visiting service
- Falls Response – Across LLR
- SDEC'S
- Urgent Care Centres
- Social care – Urgent Community Response (ICRS/CRS/MiCare)
- Community health services- UCR (Nursing, Therapy)
- Pre-Transfer Clinical Decision and Assessment (PTCDA)
- Virtual wards
- Crisis mental health services
- End Of Life- Loros, Integrated Community Specialist palliative Care, Diana, Rainbows

EMAS pathway utilisation- 1/06/23-30/06/24

	Total PW	SUCCESS PW	Success %	FAILED PW	Failed %
Derbyshire	17498	15217	87.0%	2281	13.0%
Leicestershire	28820	25164	87.3%	3656	12.7%
Lincolnshire	18646	15764	84.5%	2882	15.5%
Northamptonshire	19417	16929	87.2%	2488	12.8%
Nottinghamshire	19613	17132	87.4%	2481	12.6%

Pre Transfer Clinical Decision Assessment (PTCDA) Service

The following demonstrates impact on system flow since April 2024

Year	Month	Number of patients served in this period	Quarterly total	Annual total
2023	April	216	605	2658
	May	224		
	June	236		
	July	201	615	
	August	178		
	September	234		
	October	208	702	
	November	260		
	December	263		
2024	January	228	736	
	February	245		
	March	223		
2024	April	274	719	1333
	May	222		
	June	241		
	July	216	614 (to 23/09/24)	
	August	237		
	September (to 23/09)	161 (to 23/09/24)		

Metric	April	May	June	July	August	September	Year to date
ED attendances avoided	184	149	162	145	159	108	907
Acute admissions avoided	136	110	119	107	117	80	669
In-patient bed days avoided	1245	1009	1095	982	1077	732	6141
Estimated bed days avoided per day	42	34	37	33	36	24	34
In-patient cost avoidance @ £137/bed-day	£170,627	£138,245	£150,077	£134,509	£147,586	£100,259	£841,305

Virtual Wards

Patient Admissions per year

23/24 = 2,681
24/25 (6 months) = 1,865

Patients avoiding admissions per year

23/24 = 1,093
24/25 (6 months) = 743

Patients reduced LOS per year

23/24 = 1,588
24/25 (6 months) = 1,122

Total BDR per year

23/24 = 11,221
24/25 (6 months) = 9,004

% of total patients avoiding admissions per year

Step Up - 23/24 = 41%
Step Up - 24/25 = 40%

% of total patients with a reduced LOS per year

Step down - 23/24 = 59%
Step down - 24/25 = 60%

Overall Patient Feedback

97.41%

Further achievements that have enhanced operational efficiency, alleviated A&E wait times and improved patient experience

- April 24- Aug 24: UCR has supported 3,925 patients. NHSE target is 80% of these referrals need to be supported within 2 hours. Our achievement is 92%
- April 24-Aug 24: The falls response service has supported 1,613 patients. 85% of these patients have remained safely at home
- Reduction in Care Home Emergency Admissions – 19/20 (baseline) 8,389 compared to 23/24 4,698. Continue to see improvements
- April 24-Aug 24: An additional 1,653 patients supported through the Integrated Community Specialist Palliative Care Service

How Patients feel

It was reassuring to have support in this difficult situation, as we have at times, felt as though we are on our own with all of this

Everyone has done as much as they can to help me gain my independence back

They worked together as a team to support me and improved my life

I didn't want to go to hospital, I was scared this might happen. I was listened to, and everything was sorted so I could stay at home

Angels in disguise

They are so kind, I am treated with absolute respect and dignity

BALANCING THE RISK

A proud partner in the:

Leicester, Leicestershire and Rutland
Health and Wellbeing Partnership

It’s Not New..

‘We are doing this already’ – we adjust our clinical risk already in our day-to-day practice but possibly don’t have any formal approach or mandate.

Discussion with our clinical colleagues done nearly everyday-seeking clinical expertise to support decision making

Discussion with family/carers on benefits vs risks of admission, investigations, surgery, discharge etc

Adjusting risk appetite

Viewing the risks together illustrates where our patients are most at risk

Identifies areas where we might increase our risk appetite during time of system pressure

Should be dynamic to support our operational teams to understand where the clinical body would recommend making adjustments (nudge effect)

Should only be undertaken if the action reduces our highest risks (note – already used in IP&C)

Culture change & big decisions

Multiple small increases in individual risk appetite

Small number of actions, with a need to increase risk appetite +++

Considerations

ITS NOT NEW AND MORE ABOUT SHARED DECISION MAKING WITH CLINICAL COLLEAGUES, PATIENTS, FAMILIES AND CARERS

CLINICAL TEAMS SIGHTED ON PRESSURE AND ENCOURAGED TO PUT FORWARD OPTIONS

NOT MAKING UNSAFE DECISIONS OR EVER DOING ANYTHING WHICH FEELS AGAINST YOUR PROFESSIONAL JUDGEMENT OR OUT OF YOUR SCOPE OF COMPETENCE

REQUESTS TO ADJUST RISK APPETITE ARE SHARED ACROSS THE SYSTEM, NOT JUST IN 1 PART

ACTION REQUESTED SHOULD BE PROPORTIONATE TO THE RISKS

STAFF NEED TO BE BACKED BY THE ORGANISATION AND THE SYSTEM CLINICAL LEADERS

ACKNOWLEDGEMENT THAT THERE MAY BE DETRIMENTAL IMPACTS ON OTHER AREAS, I.E. INCREASE IN ADMISSIONS, INCREASE IN LOWER LEVEL INCIDENTS, STAFF SICKNESS. THESE NEED TO BE TAKEN INTO CONSIDERATION

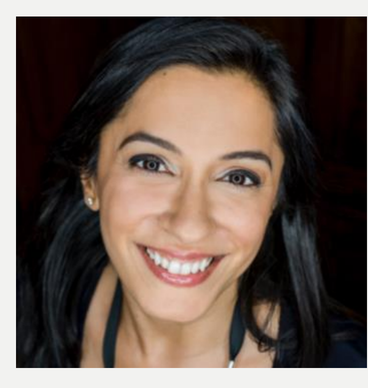
PATIENT, SERVICE USER AND CARER COMMUNICATIONS

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

Panel Discussion

Andrew Stradling
Chief Medical Officer
NHS LPP, HCSA



Dr Sulaxni Nainani
Deputy Chief Medical Officer - NHS Leicester, Leicestershire & Rutland ICB

Dr. Simon Moralee
Head of Health Management Group, Senior Lecturer in Healthcare Management, Alliance Manchester Business School - The University of Manchester

CONVENZIS

Drinks and Networking

THE NATIONAL NHS PATIENT FLOW CONFERENCE

Improving NHS Pathways

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

3rd July 2025
15Hatfields Conference Centre,
London SE1 8DJ