NHS Providers

PEER LEARNING EVENT

OPTIMISING PATIENT FLOW USING CONTINUOUS IMPROVEMENT

IMPROVEMENT

February 2025

Housekeeping

- Please note, this event is being recorded
- Please keep your camera on wherever possible
- If you lose connection, please re-join using the link in your joining instructions or email improvement@nhsproviders.org
- Please ensure your microphone is muted during presentations to minimise background noise
- We will come to questions after each speaker
- Please feel free to use the chat box for any questions or comments.
- If you would like to ask a question audibly, please use the raise hand function during the Q&A section and we will bring you in
- You will receive a link to an evaluation form after today's event. Please take the time to complete it, we really do appreciate your feedback.

Agenda

Welcome and introductions
Facilitated by the chair, Dimple Keen, Head of Development and Engagement, NHS Providers

Presentation One
- Michael Anderson - Associate Director of Improvement and Transformation, Royal Berkshire NHS Foundation Trust

Presentation Two
- Paul Brookes-Baker - Head of Continuous Improvement, University Hospitals of Leicester NHS Trust

Presentation Three
- Tara Bain - Service Manager, Leeds Teaching Hospitals NHS Trust
- Alyson Beckett - Head of Nursing, Leeds Teaching Hospitals NHS Trust

Interactive Q&A

Summary and close

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Michael Anderson - Associate Director of Improvement and Transformation, Royal Berkshire NHS Foundation Trust

IMPROVEMENT

NHS
Royal Berkshire
NHS Foundation Trust

Royal Berkshire Improving Together Approach

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Our journey

Royal Berkshire NHS Foundation Trust

Organisational Values and Behaviours

March 2022: Strategy Deployment

- Identification of strategic metrics and breakthrough priorities

July 2022: Management System

- Management System thinking introduced linking teams work to the Trusts objectives
- Training and coaching started

November 2022: Wave 1

- 4 frontline, 2 directorate and 4 corporate teams are trained in the methodology

March 2023: Wave 2

- 5 frontline and 5 directorate teams are trained and IT take over the running of QI projects across the Trust

June – December 2023: Accelerated Roll Out (Waves 3 - 5)

- 25 frontline, 12 directorate and 2 corporate teams are trained in the IT methodology
- Trust strategic programs are identified to become a delivery vehicle for the organisational strategy

December 2023: Strategic Filter

- All Trust transformation projects are aligned to the objectives through a transparent and standardised filter

2024: Wave 6 - 9

- 9 frontline and 5 corporate teams are trained and coached.

2024:Rapid Process Improvement Workshops

- 5-day process focused improvement workshops teaching staff practical Lean tools to impact their work

Three Elements of Improving Together

Royal Berkshire NHS Foundation Trust

Cultural values and behaviours

Our people are supported and enabled to do their job and enjoy coming to work

Improvement Management System

Everyone knows what they are working on and how it links to the bigger picture

Everyday Improvement by Everyone

Improvement is part of everyone's job on a daily basis

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Management System Driving Flow

Royal Berkshire NHS Foundation Trust

Our Vision: Working together to deliver outstanding care for our community

- Achieve long-term sustainability
- Cultivate Innovation & Improvement
- Deliver in partnership
- Invest in our people and live out our values
- Highest quality of care for all

- Average Length of Stay (LOS) for Non-Elective Patients
- Identify Efficiency Savings Against Full Year Plan
- Total Volume of First Outpatient (OP) Activity

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Management System Driving Flow

Royal Berkshire NHS Foundation Trust

Breakthrough Priority (BTP) = Improve Flow: Average Length of Stay (LoS)

Networked Care Group Driver Metric

Strategic Alignment	Metric	Current Performance	Target
BTP Improve Flow: Average Length of Stay (LoS)	Length of Stay for non-elective admissions	8.3 days	7.3 days

Specialist Medicine Directorate Driver Metric

Strategic Alignment	Metric	Current Performance	Target
BTP Improve Flow: Average Length of Stay (LoS)	Reducing length of stay on Elderly Care wards	All 5 wards: 13.7	Reduce by 0.5 days

Woodley Ward Drive Metric

Strategic Alignment	Metric	Current Performance	Target
BTP Improve Flow: Average Length of Stay (LoS)	Accuracy of Targeted Date of Discharge by week (TDD)	25% w/c 6th May	50% per week (Oct 2024)

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Executive Huddles

Royal Berkshire NHS Foundation Trust

Pre-Work:

Time	Pre-Work	Person
Minimum 1 day before	Update Driver Lanes	SRO for BTP
Minimum 1 day before	Go and See Feedback Forms	CEO Team

Huddle:

Time	Activity	Documentation	Person
8 min (1 minute each)	Feedback from Go and See	Go and See feedback form and tracker	CEO Team
10 min	Update on BTP Progress	Driver Lanes	SRO for BTP
10 min	Identify and Assign Go and Sees	Go and See Visual Management	SRO for BTP
2 min	AoB and agree next week chair	N/A	CEO Team
Total: 30 min			

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Rapid Process Improvement Workshops (RPIWs)

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- A focussed event looking at a specific process
- Inch wide mile deep
- Designed to identify, test and implement improvements within **one week**

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RPIW A3

Royal Berkshire NHS Foundation Trust

RPIW Title: Pharmacy TTO Turnaround

1. What is the opportunity?

Problem:
Delays in patient TTO delivery to ward.

Impact:
Delays to patient discharge/disruption to patient flow

Link to Trust Strategy:
Patient flow (Breakthrough priority)

In scope:
TTO booked in to receipt on ward.

Out of scope:
Out of hours 19:00-09:00
Weekend processes
Non-TTO dispensing

Dependencies:
Spread of demand and capacity

Sponsor:
Dom Hardy

Workshop Leads:
Kate Rowley
Jade Glover

Process Owners:
Aatif Farooqi
Jose Antunes

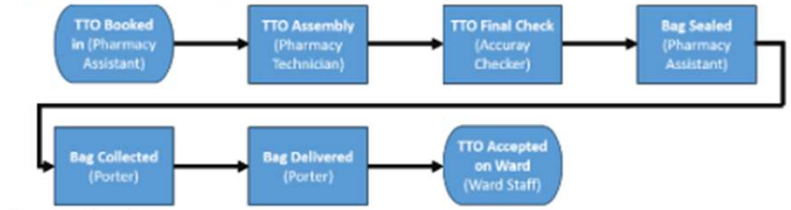
Team Leaders:
Ashima Singh
Narinder Anjarlekar

Team Members:
Amrit Pinglia
Ajitha Narayanan
Charlotte Auden

Volunteers: Ken/Tim

2. Where are we now?

High level process map:



Current Baseline:
Pharmacy: TTO booked in – TTO ready for collection, Target <90mins, met 65% Aug
Portering: TTO collected - TTO delivered, NO KPI currently

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Current State:

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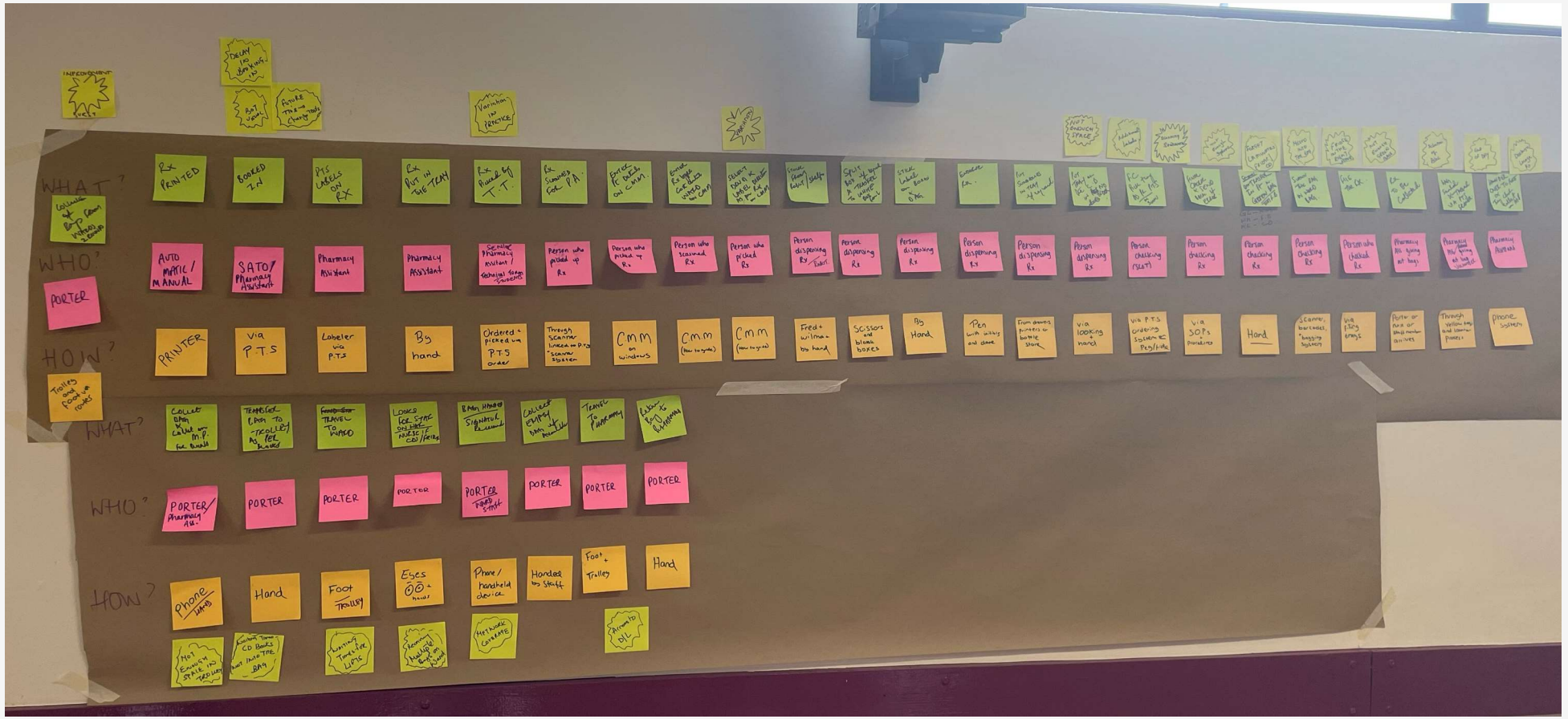

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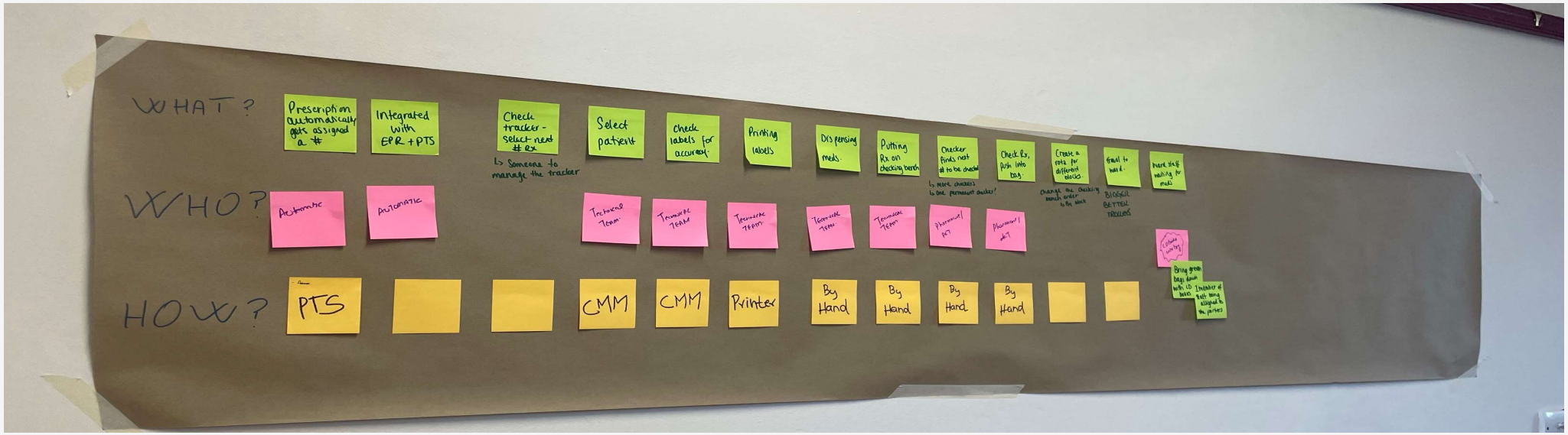
Future State – Integrated and automated!

Royal Berkshire NHS Foundation Trust



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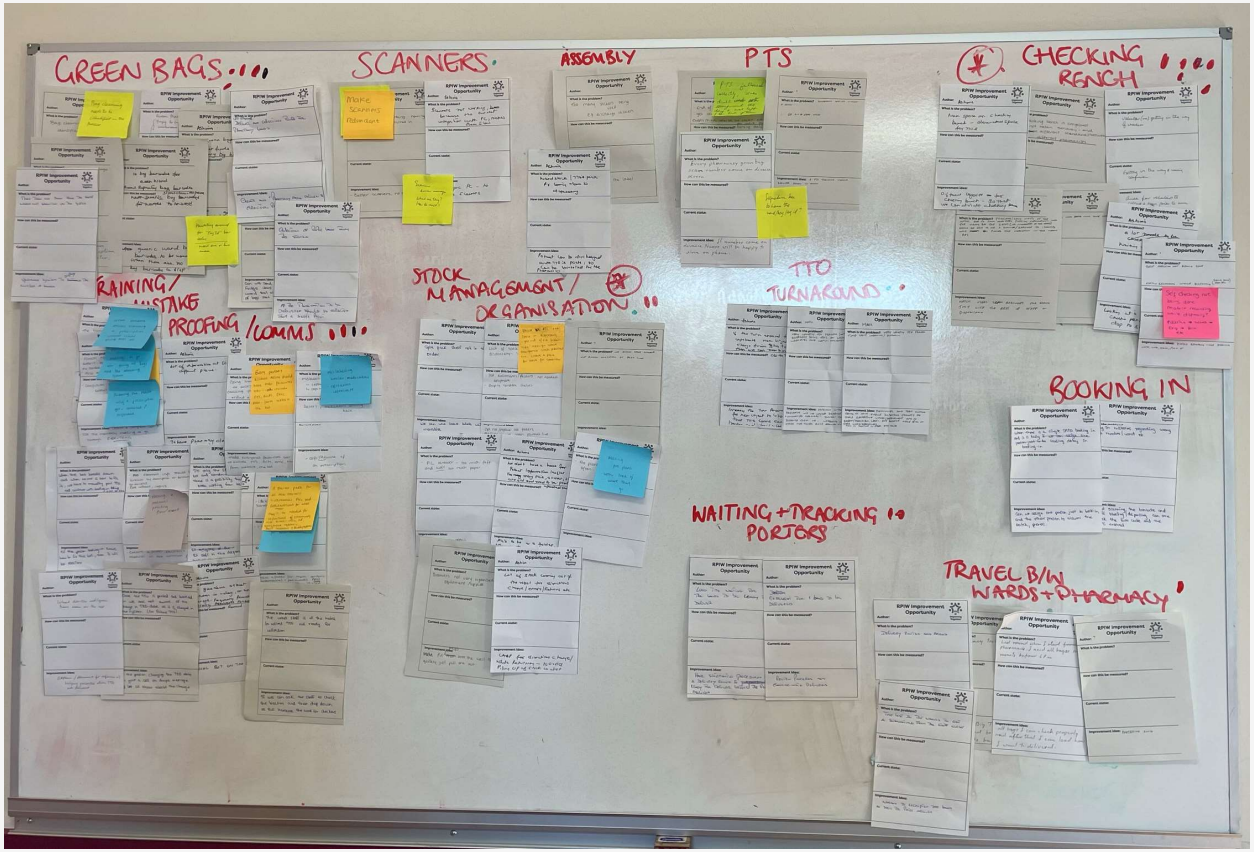
Idea Forms generated

Royal Berkshire NHS Foundation Trust



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After Event Metrics:

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Metric	Baseline	Target	Current from testing	30	60	90
TTO booked in to receipt on ward	02:32	20% reduction (02:00)	02:19			
TTO booked in - Complete	65%	90% compliant to 90 mins target	50%			
Waiting for checking	00:38	20 mins	00:18			
Completed to Delivered	01:07	TBC	To be tracked			
Data driven delivery allocation	None	In place	*In place*			
Handover	16 mins	10 min	*11 mins*			
Total number of delivery hrs (porter)	13hrs	14hrs	*14hrs*			
Allocated Green bag collection points on wards	0	32 wards	*27 wards*			
Invalid Drug Returns	81%	0%	*33%*			
Hatch Collections	25/day	20% reduction (20/day)	*16 /day*			

Working Together to Improve Patient Care

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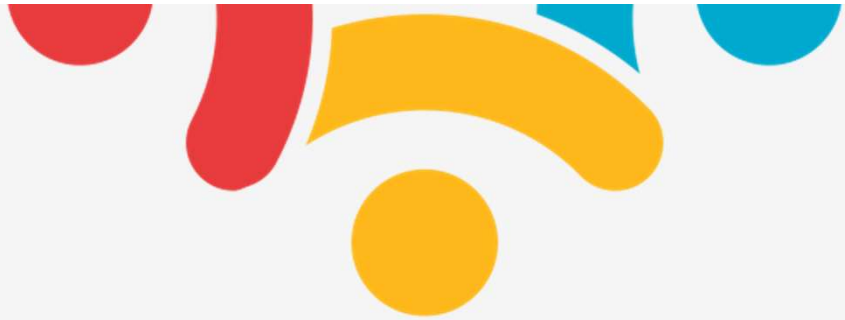

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Questions?

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Paul Brookes-Baker - Head of Continuous Improvement, University Hospitals of Leicester NHS Trust

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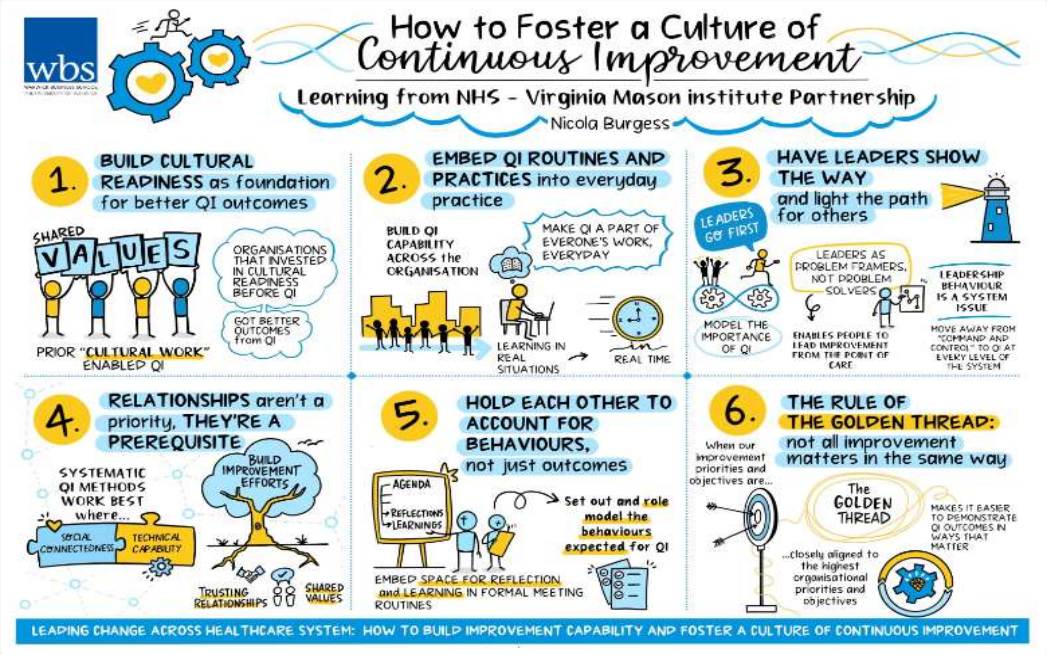
University Hospitals of Leicester
NHS Trust

Continuous Improvement Culture Development

Paul Brookes-Baker
Head of Continuous Improvement

UHL Continuous Improvement Journey:



NHS IMPACT

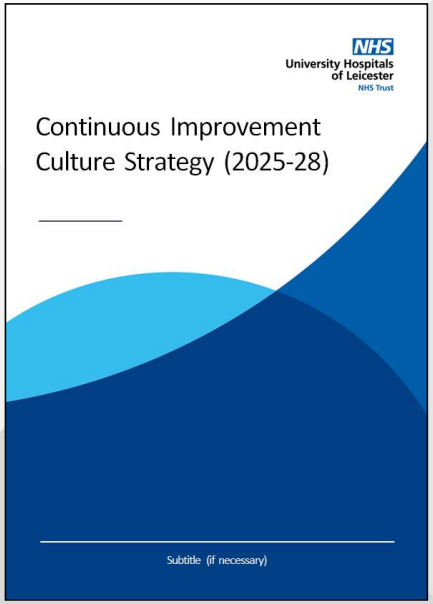
UHL's CI Development Strategy is informed by this work, along with LEAN thinking way both within and without the healthcare sector.

UHL Continuous Improvement Journey:

Self-Assessment Category	Starting	Developing	Progressing	Spreading	Improving & Sustaining
Board and executives setting the shared purpose and vision:					
Improvement work aligned to organisational priorities					
Co-design and collaborate - celebrate and share successes					
Lived experience driving this work (patients, staff, communities)					
Pay attention to the culture of improvement					
What matters to staff, people using services and carers:					
Enabling staff through a coaching style of leadership					
Enabling staff to make improvements					
Leadership and management development strategy					
Board, executive and senior leadership and management values and behaviours					
Senior leadership and management acting in partnership					
Board development to empower collective improvement leadership					
'Go and see' visits					
Improvement capacity and capability building strategy					
Clear improvement methodology training and support					
Improvements measured with data and feedback					
Co-production					
Staff attend huddles					
Aligned goals					
Planning and understanding status					
Responding to local, system, and national priorities					
Integrating improvement into everything we do					

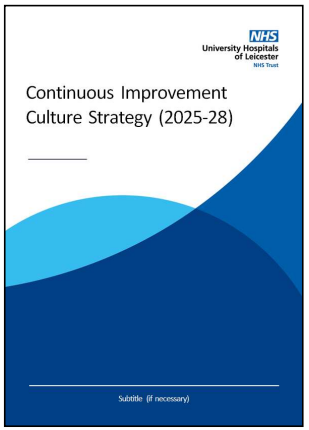
Our NHS Impact QI maturity Self-Assessment shows were at an early stage of our journey

Continuous Improvement approach is recognised as a key enabler to achieve our goals. Our strategy outlines our plan for the next 3 years



Next 3 years

Culture change will not happen without active endorsement and engagement from the Executive and Leadership teams.



Continuous Improvement Culture development

	Year 1	Year 2	Year 3
Patient First Approach	Add Health Equality prompts to AQIP	Embed QI methodology into ProEquity framework	
	Add Patient Experience links to AQIP	Develop Patient Co-deisng & production approach & embed into Improvement Projects	
	Train PSIRF lead in Reoccurrence Prevention	Partner patient safety team themes with QI approach	
	"Go & See" of safety incident actions	Review 10% of patient pathways: assess level of patient centric approach & improvement actions	
Bullding a Shared Vision and Purpose	Establish "MyQI"	Agree standard across UHN & LLR	
	Align QI team project to Trust priorities	Build presence at National Level	
	Establish AQIP Quartly showcase & UHL award	Build framework for process management approach	
Building Improvement Capability	Train 4% of UHL staff in "MyQI"	Train 6% of UHL staff in "MyQI"	Train 8% of UHL staff in "MyQI"
	Build Masterclass portfolio		
	Roll-out "5S" in 10% of specialities	Roll-out "5S" in 30% of specialities	Roll-out "5S" in 50% of specialties
Developing Leadership Behaviours for Improvement	Train Exectutive team in QMS	Establish Leadersip process walks	
	Develop QI for Leaders programme		QI for Leaders mandatory for B7 & above
	Train 30% of triumvirate in QI for Leaders	Train 60% of triumvirate in QI for Leaders	Train 100% of triumvirate in QI for Leaders
Investing in Culture and People	Develop Process Huddleboard Standard +10%	Process huddle boards in 30% of Specialities	Process Huddle boards in 50% of Specialities
	Launch "QI Network" framework	Build QI support dosing model	
	Launch AQIP Audit Lead annual planners	Focus FY Doctors on P1 & P2 Improvements	
Embedding a Quality Management System	Standardise strategic goals cascade process	Establish Standard activity report	
	Redevelop Appraisal system	Develop progression framework for management cohorts	
	Link Individual Objectives to Priorities	Strengthen & rationalise strategic governance process	

What's the difference? Continuous Improvement & "QI"

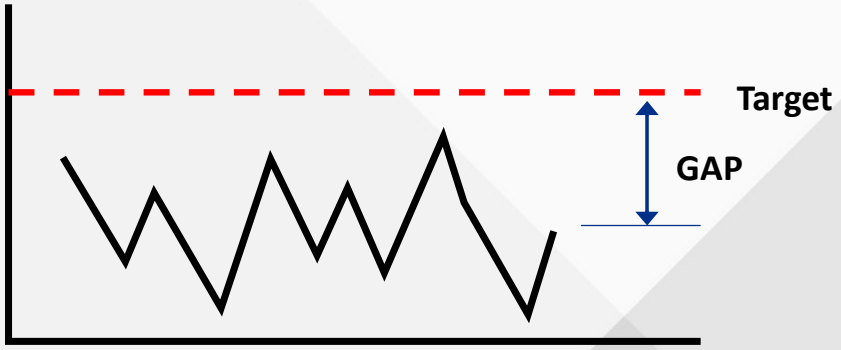
Continuous Improvement Culture

Is how our daily routines, standards, systems and processes within our organisation at all levels help to foster behaviours and thinking way that result in safety, cost and efficiency improvements in our daily roles – it is not a "bolt on".

This ultimately creates a better place to work for our staff and achieves better care and outcomes for our patients.

Quality Improvement (QI) methodology

We can use a methodology approach in situations where we don't know what's causing a gap to target / objective or Standard,

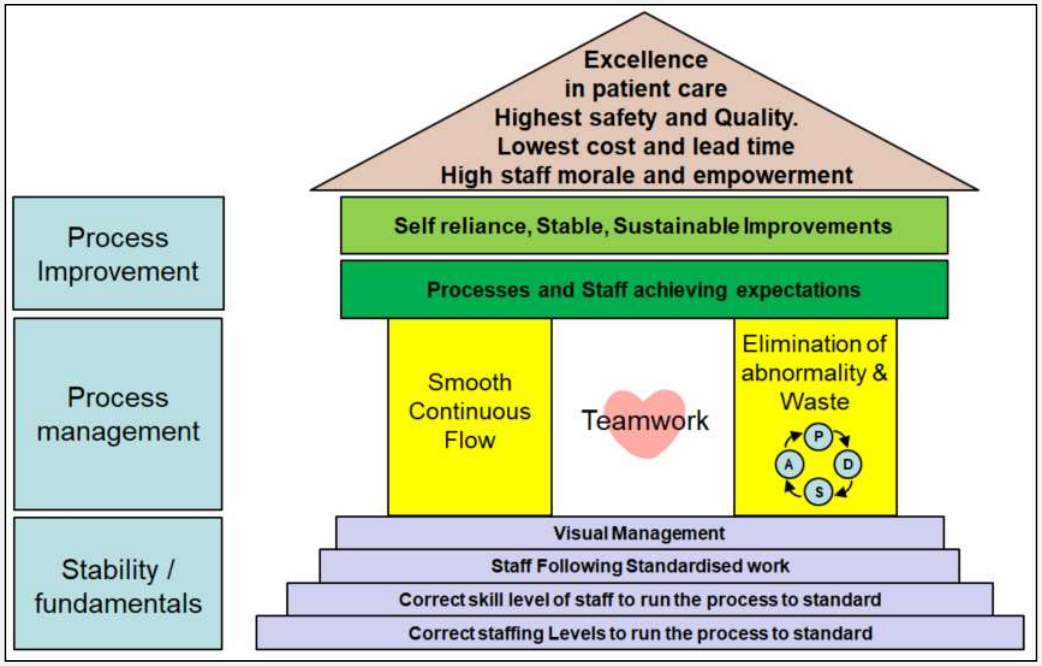


or where there could be many causes of the gap and it's difficult to prioritise or understand each contribution so we can then take the appropriate action.

Continuous Improvement Culture

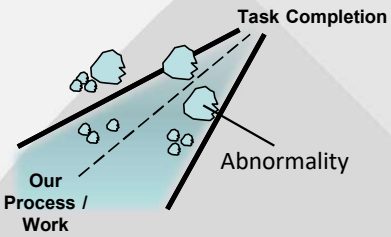
Everything is a Process

By developing our staff to see things as a process, it starts to become clearer what peoples roles are to improve it and what any process needs to run smoothly and efficiently.



Process Waste

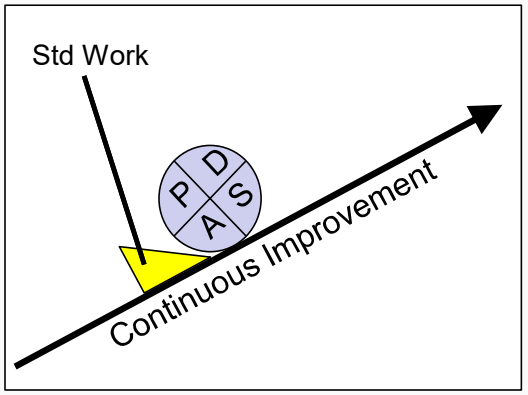
Frustrations / Abnormalities



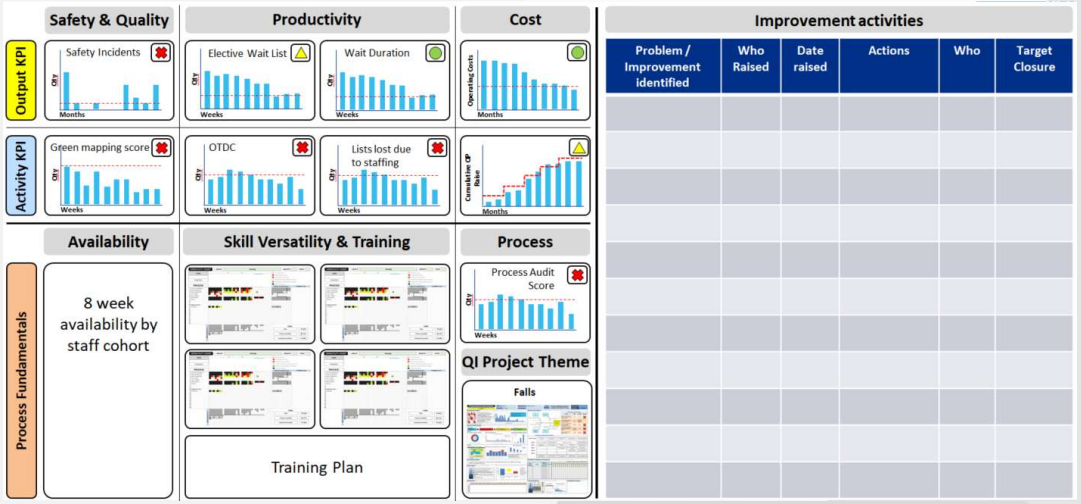
Daily Improvement Routines

Practical Steps to take to build Improvement behaviours:

- Effective appraisal system linked to progression framework.
- Process waste Identification and elimination.
- Improvement projects aligned to Trust priorities.
- 5S
- Process Huddle-boards
- Leadership Process Walks & **KATA** questions
- Go & See Safety incident improvement actions.
- Recurrence Prevention approach
- Building a network of improvement practitioners



Process Huddle-board



"Shop Floor" Process management routines are vital to embedding CI Culture

Quality Improvement (QI) methodology

UHL

MyQI:

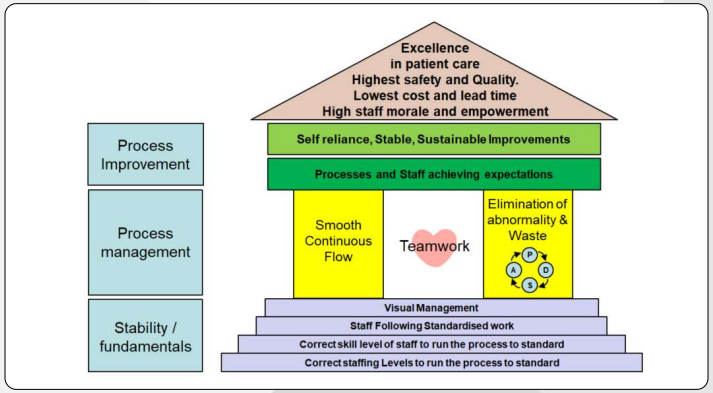
Structured QI Capability Development

Scalable Framework based on Cohort / Project

L4 & L5 6 Sigma Training Data analytics Strategy Development Institute for Apprenticeships & Technical Education **5**	**Target Cohort:** For those who have Quality Improvement as a core element of their role. **Target outcome:** Capability for managing Medium sized Improvement projects & data led root cause analysis
QI for Leaders Developing Continuous Improvement Culture **4**	**Target Cohort:** For those who manage a team / Specialty / process. **Target outcome:** Reduction or abnormality & creating the environment for sustained Quality Improvement
QI – Advanced Based on 8 Step Lean improvement approach & "A3" document **3**	**Target Cohort:** Data heavy analysts & those who manage larger improvement projects. e.g. Transformation Leads, Clinical Audit Leads, BIs, Improvement Leads **Target outcome:** Increases UHL capability to train others and develop QI culture.
QI Fundamentals Based on Model for Improvement & "6C" Document **2**	**Target Cohort:** Those who need to improve their process in addition to delivering standard role in busy working environment. e.g. nursing staff **Target outcome:** Provides a simple on-boarding method for majority of UHL staff to incorporate local improvements in daily job
eLearning Introduction to QI concepts and approach helm health education learning management **1**	**Target Cohort:** Everyone **Target outcome:** Basic awareness of QI and a platform to start further capability development

Master Classes

Clinical Audit / AQIP Intro	PDSA
Standardised Work	Process Huddle boards
Re-Occurrence Prevention	Process Waste
Demand and Capacity	5S
A3 Reports	Basic Data Analysis

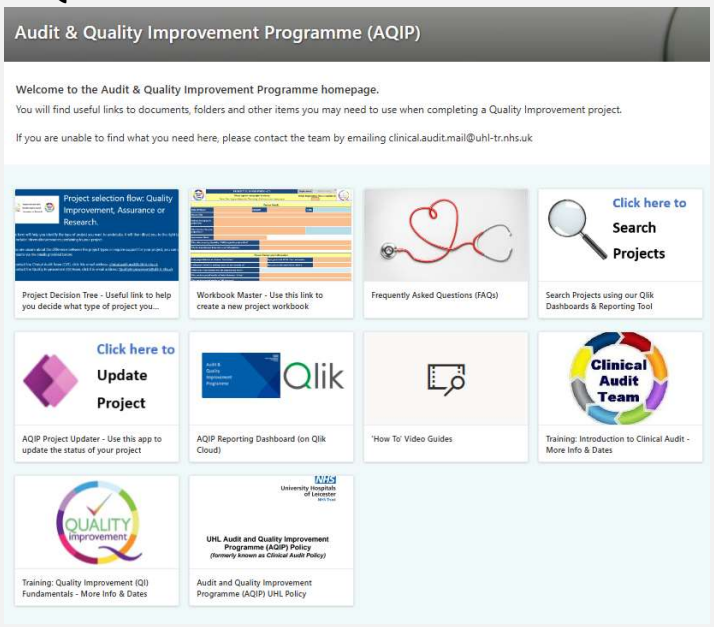


Delivery Method	Training	Application by doing	Experience Success
Development	Knowledge	Understanding / Skill / Will	Belief
Capability	Common Language	Thinking Way / Adaptable Achiever	Coach Others

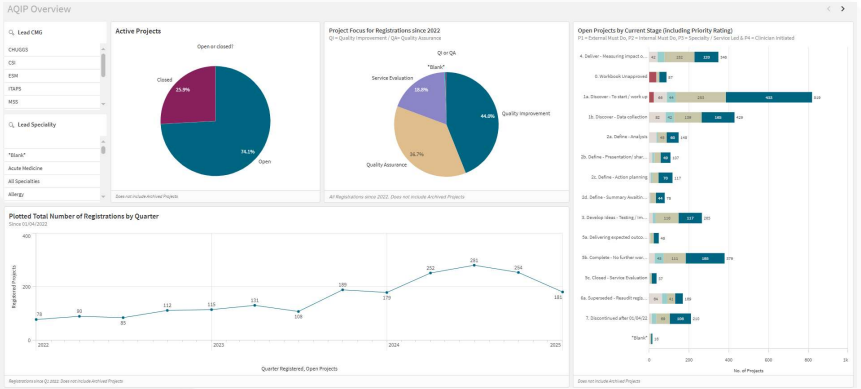
Developing a problem solving "Thinking Way" is more important than any specific tool

Linking Clinical Audit & QI

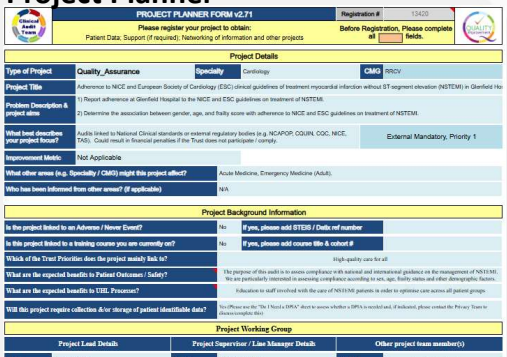
AQIP Intranet Site:



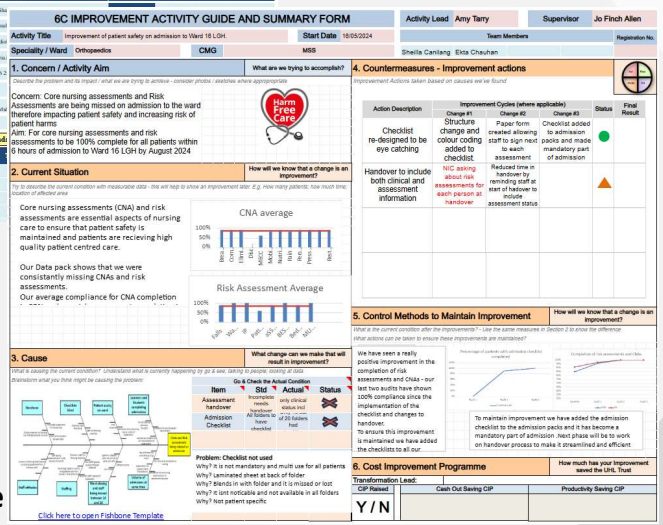
AQIP Trust Dashboard



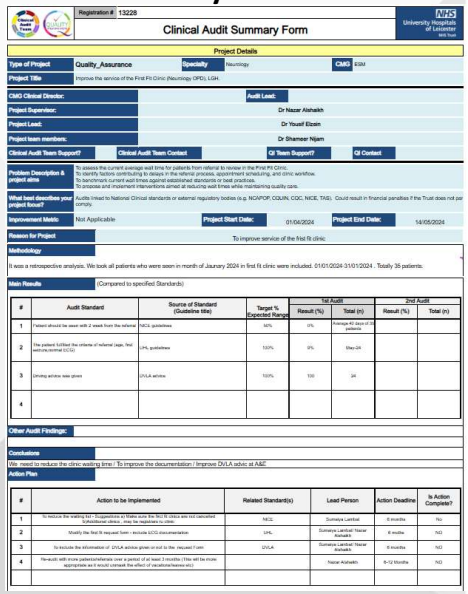
Project Planner



QI 6C Template



Audit Summary

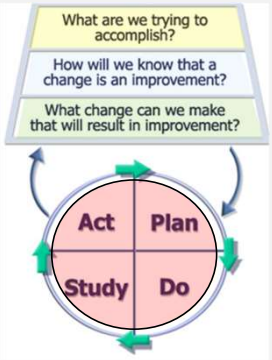


By linking QI with Clinical Audit, we build on our existing Audit network across the Trust and progress from auditing to auditing + Improvement with QI methodology.

Building QI Capability Across the Trust

NHS University Hospitals of Leicester NHS Trust

Our methodology helps to make sure we focus on the right things which will make a difference and we sustain our improvement. We do this by following a Golden Thread on our "6C" template.



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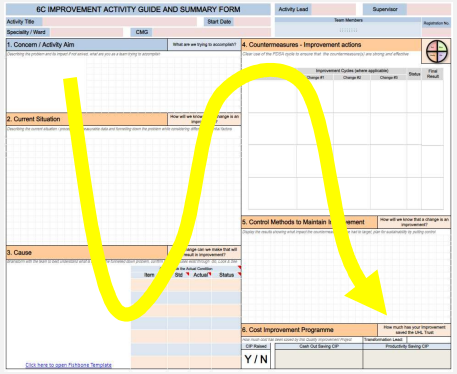
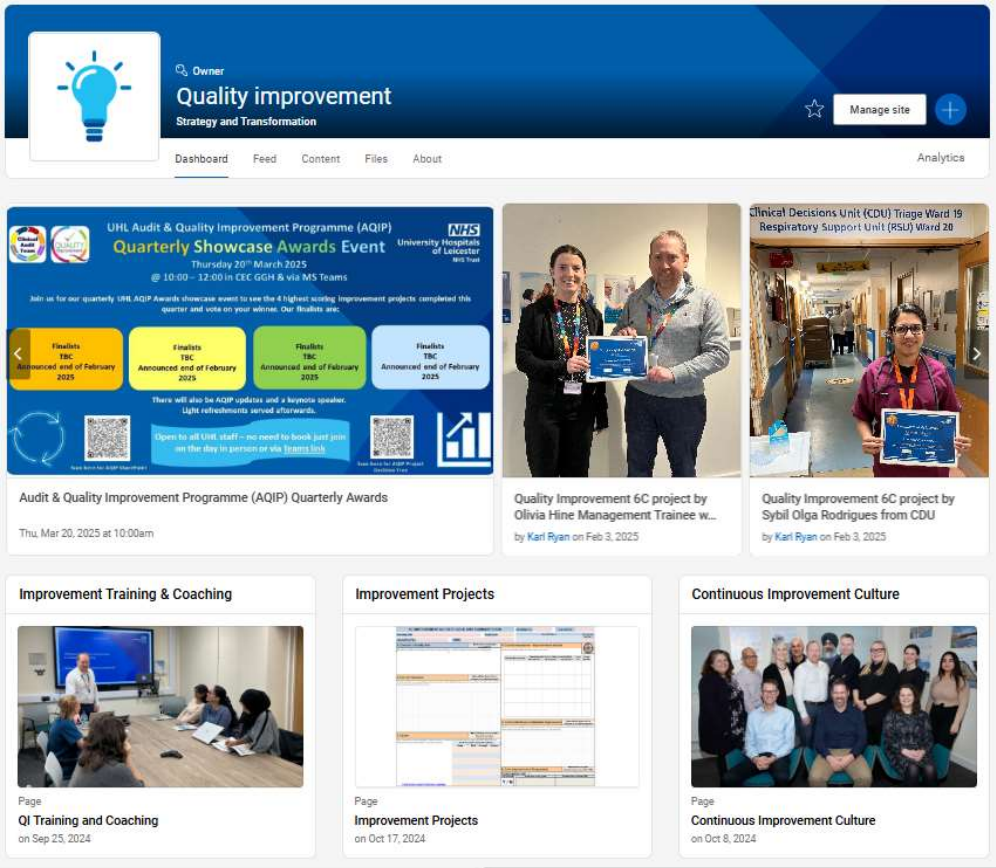




Building QI Capability Across the Trust

- Delegates in training or coaching = 174
- Total completed training = 491 delegates (2.7%)
- Total completed training with project = 277 (1.5%)
- CIP captured as part of delegate's projects

Leicester Excellence Accreditation Framework

NHS PSIRF-Ready

Journey to Pathway to Excellence – American Nurses Credentialing Center – We're on a Journey to EXCELLENCE

Royal College of Nursing

UHL Together – Many people, one team

helm – health education learning management

NHS Leicester, Leicestershire and Rutland

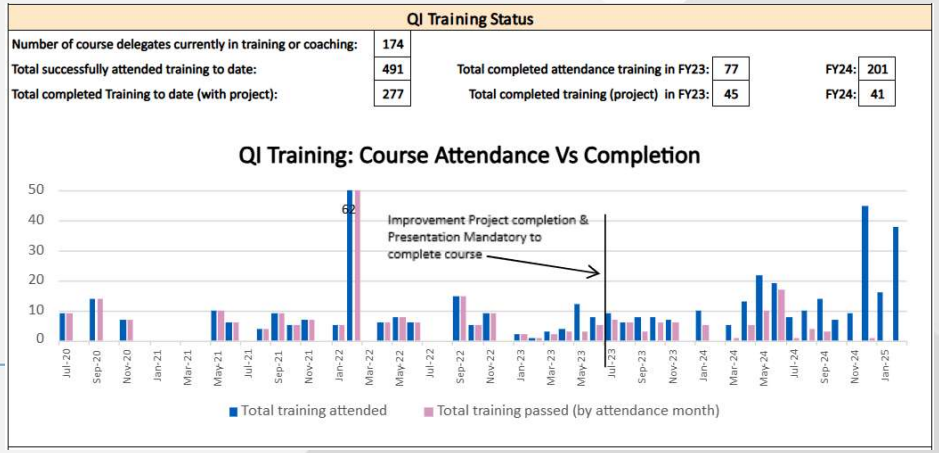
Clinical Audit Team

- FY1
- FY2
- SFP

- IEH
- MSc

- Induction
- Staff Capability Development
- Leadership Development

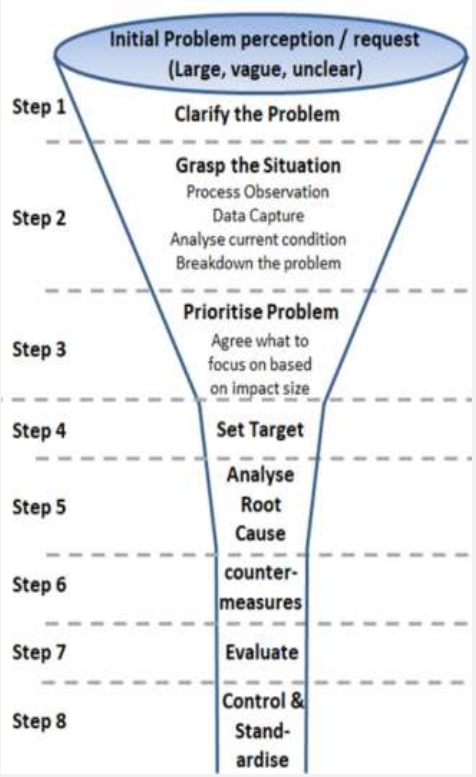
Embedding QI Capability training within existing core Trust initiatives / staff development programmes

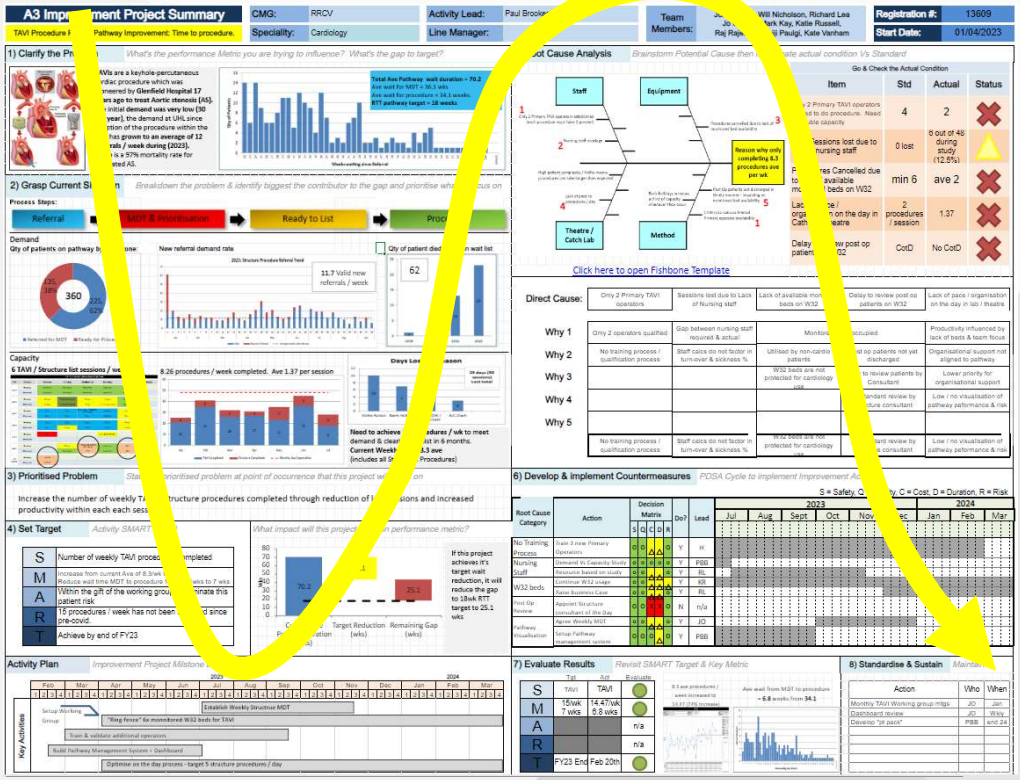


Breakthrough Projects:

- MDT approach
- Data led & problem visualisation
- Process mapping current and future states
- Demand & Capacity analysis
- Actions that link to causes
- Process Standardised
- Sustained Improvement
- Further improvement areas identified.

Project Examples
Cardiology Admission Avoidance
TAVI Structural procedure pathway improvement
Renal Pathway Improvement
ESM Frailty SDEC
Respiratory process efficiency Improvement
Rheumatology Efficiency Improvement
Cardioversion Pathway Improvement
Perfusion Process risk reduction
Stroke 4hr target compliance improvement
Stroke discharge Improvement
Cath Lab productivity & efficiency improvement
Interventional Radiology operational management

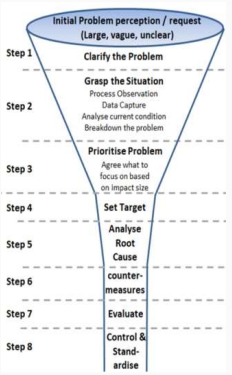




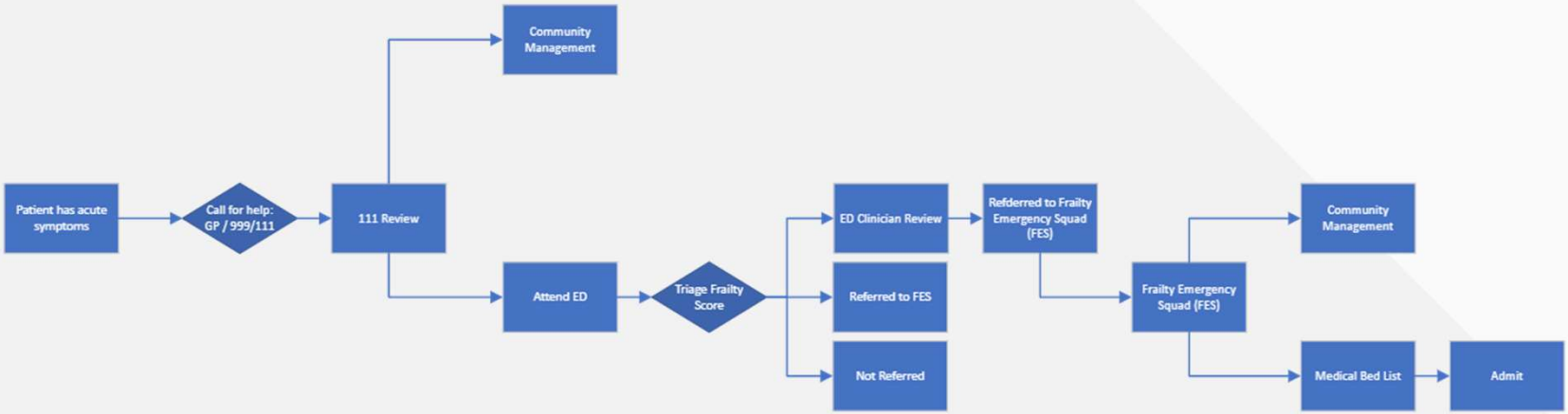
Thinking Way "golden thread" guided by A3

Breakthrough Project

Establishing Frailty SDEC



Original Process:

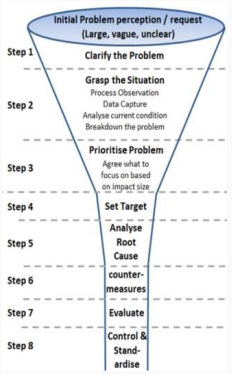


Key Problems affecting frailty patients through process:

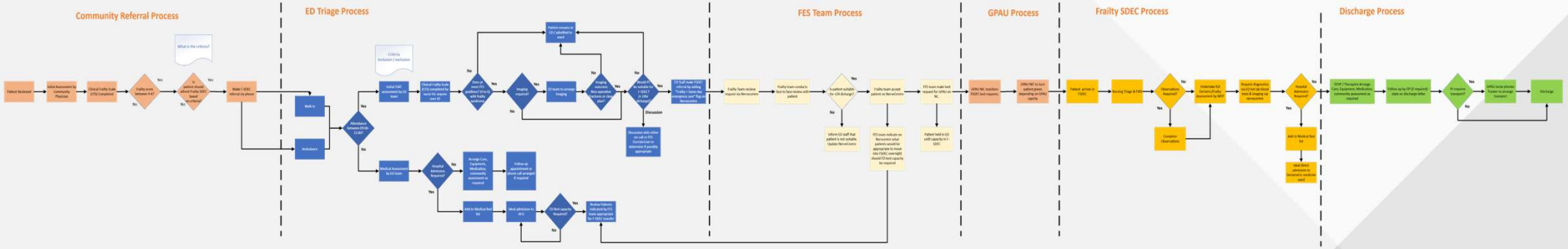
- Attending ED when not required (not receiving the appropriate care required)
- LoS in ED affecting patient flow
- Patient admitted when not required to help with ED flow
- Existing Frailty Emergency Squad (FES) not able to see all appropriate patients

Breakthrough Project

Establishing Frailty SDEC



Future State Process Development:



Key change points:

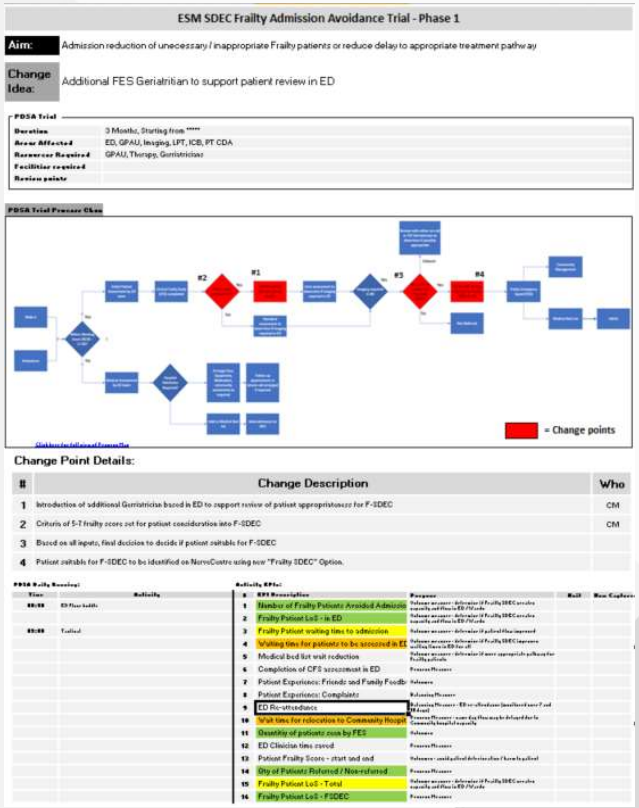
- Establishment of a 12 bed Frailty SDEC
- Definition of patient criteria for transfer to Frailty SDEC
- FES team initially act as gatekeepers
- Direct GP referrals into F-SDEC (Phase 2)
- Direct EMAS referrals into F-SDEC (Phase 3)

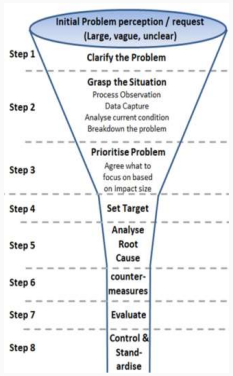
Breakthrough Project

Establishing Frailty SDEC

Key activity steps:

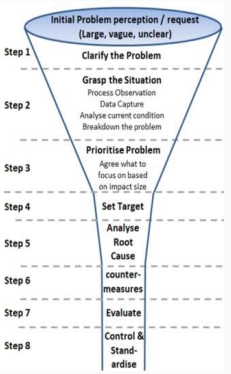
- Detailed process study through “Genchi Genbutsu”
- Demand & capacity staffing model
- Forming of MDT & working group to gain input from affected staff cohorts
- Modification of EPR system for patient tracking
- Development of SOP
- Development of process dashboard
- Strong communications
- Daily review meeting in F-SDEC for rapid cycle improvement

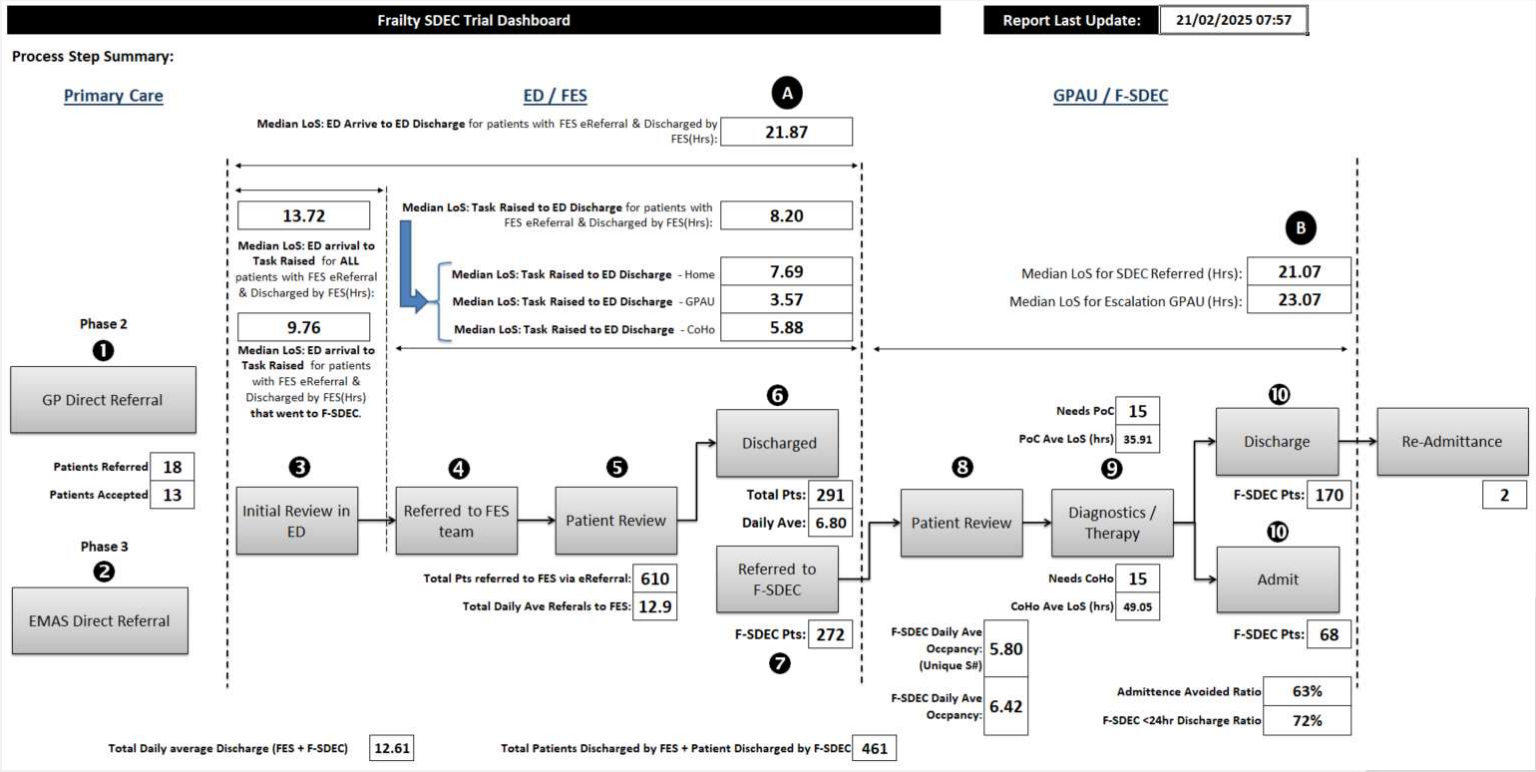




Breakthrough Project

Establishing Frailty SDEC



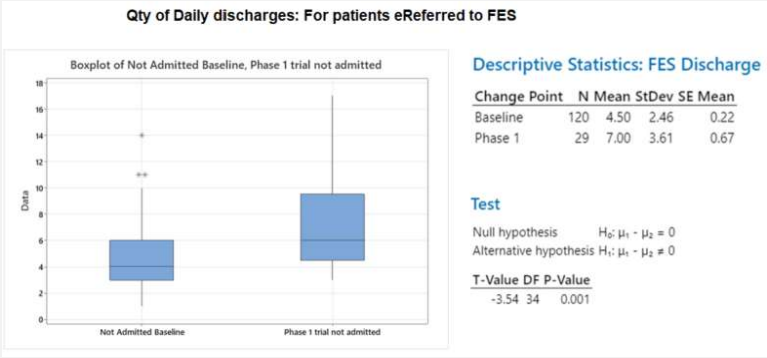


Process performance visualisation for continued improvement

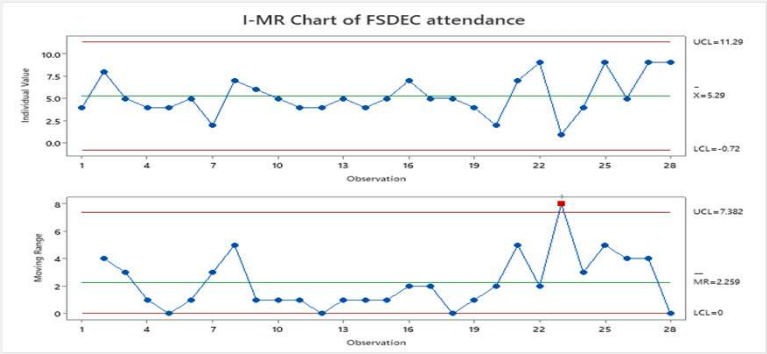
Breakthrough Project

Establishing Frailty SDEC – Results so far (Phase 1)

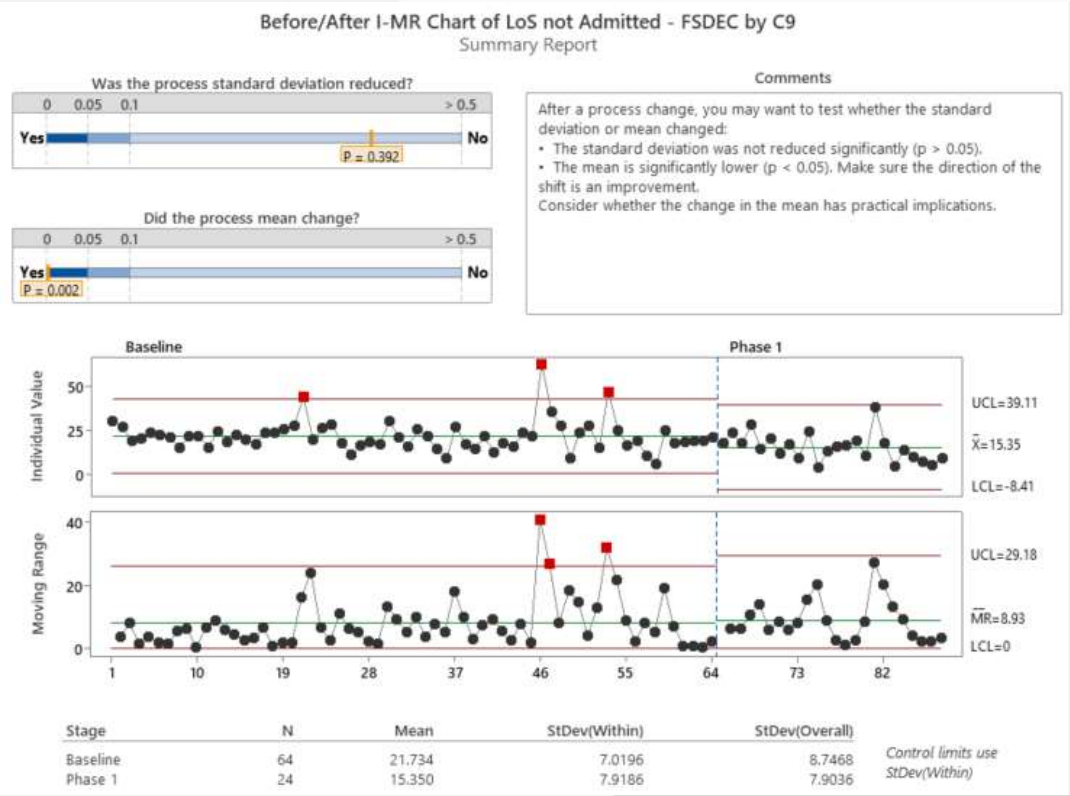
ED FES Discharges increased in addition to F-SDEC



F-SDEC attendance trend



F-Patient LoS in ED reducing



Thank you for listening

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Q&A

NHS Providers

Tara Bain - Service Manager, Leeds Teaching Hospitals NHS Trust

Alyson Beckett - Head of Nursing, Leeds Teaching Hospitals NHS Trust

IMPROVEMENT

Urgent Care

NHS
The Leeds Teaching Hospitals
NHS Trust

Primary Care Access Line

Tara Bain – Service Manager, Urgent Care
Leeds Teaching Hospitals Trust

PCAL - What We Do

Primary Care Access Line or PCAL team Created in 2003

- 10 calls per day (3,650 calls a year)
- 3 clinical Access Pathways
- 1 Band 6 Registered Nurse

- 400 calls per day (Mon- Fri) (85,000 calls a year)
- Over 50 Clinical Access Pathways
- Team consisting of clinical and non-clinical roles
- Open 365 Days a year

Who is referring?

Out of Hours GPs

Nursing Homes

Urgent Treatment Centres

Specialist Nurses

A&E Minor Illness Stream - SJUH/ LGI

Practice Nurses

Local Care Direct

GPs

Specialist Physiotherapists

Advanced Practitioners

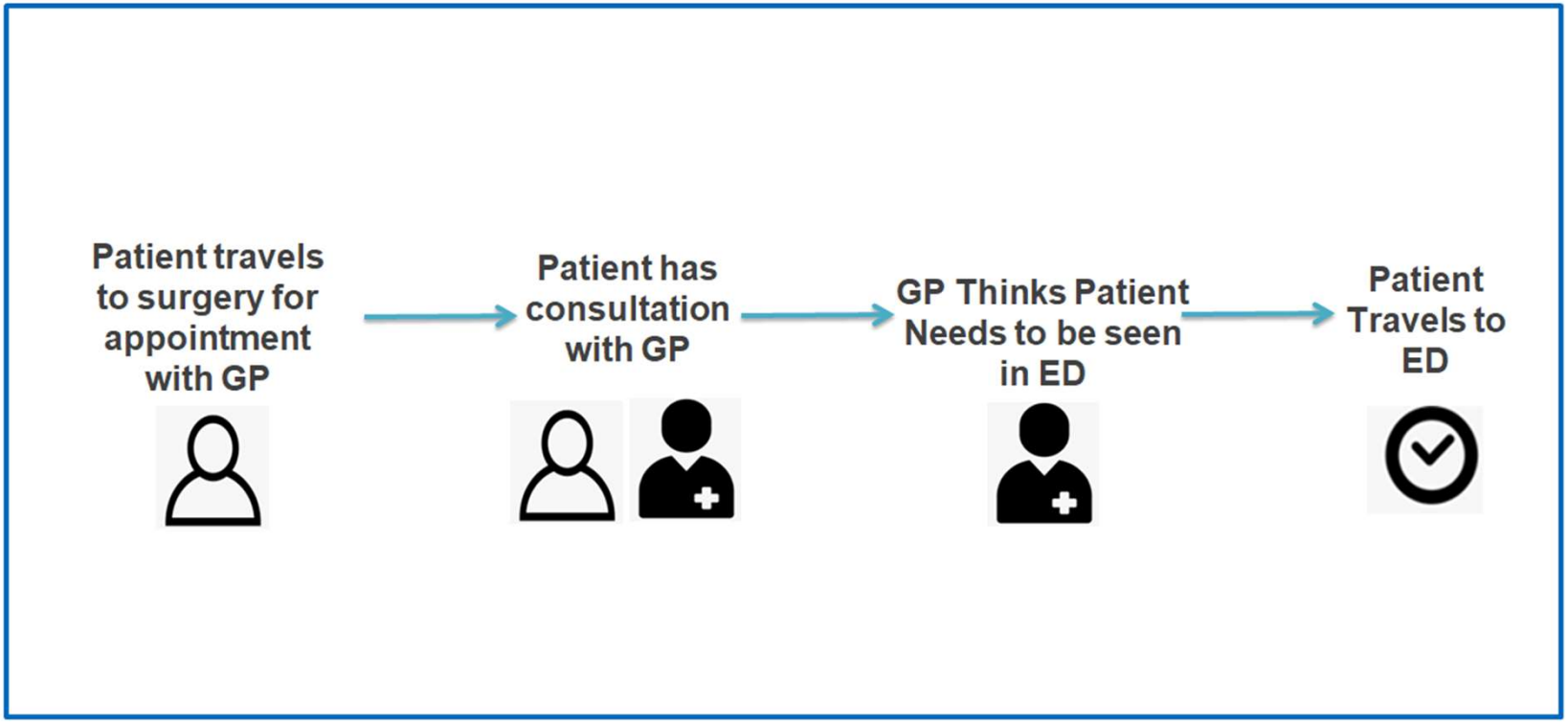
Paramedics

Optometrists

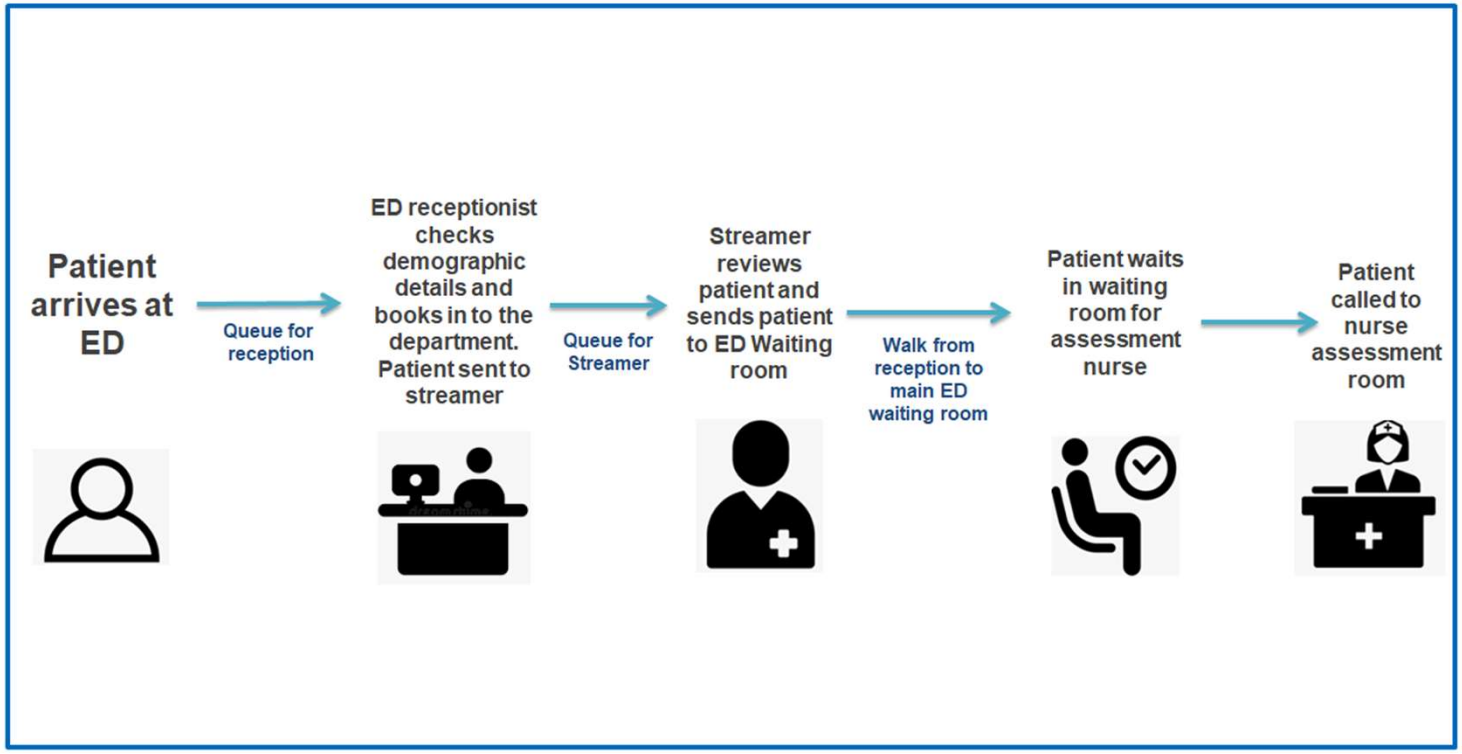
Community Midwifes

111 Clinicians

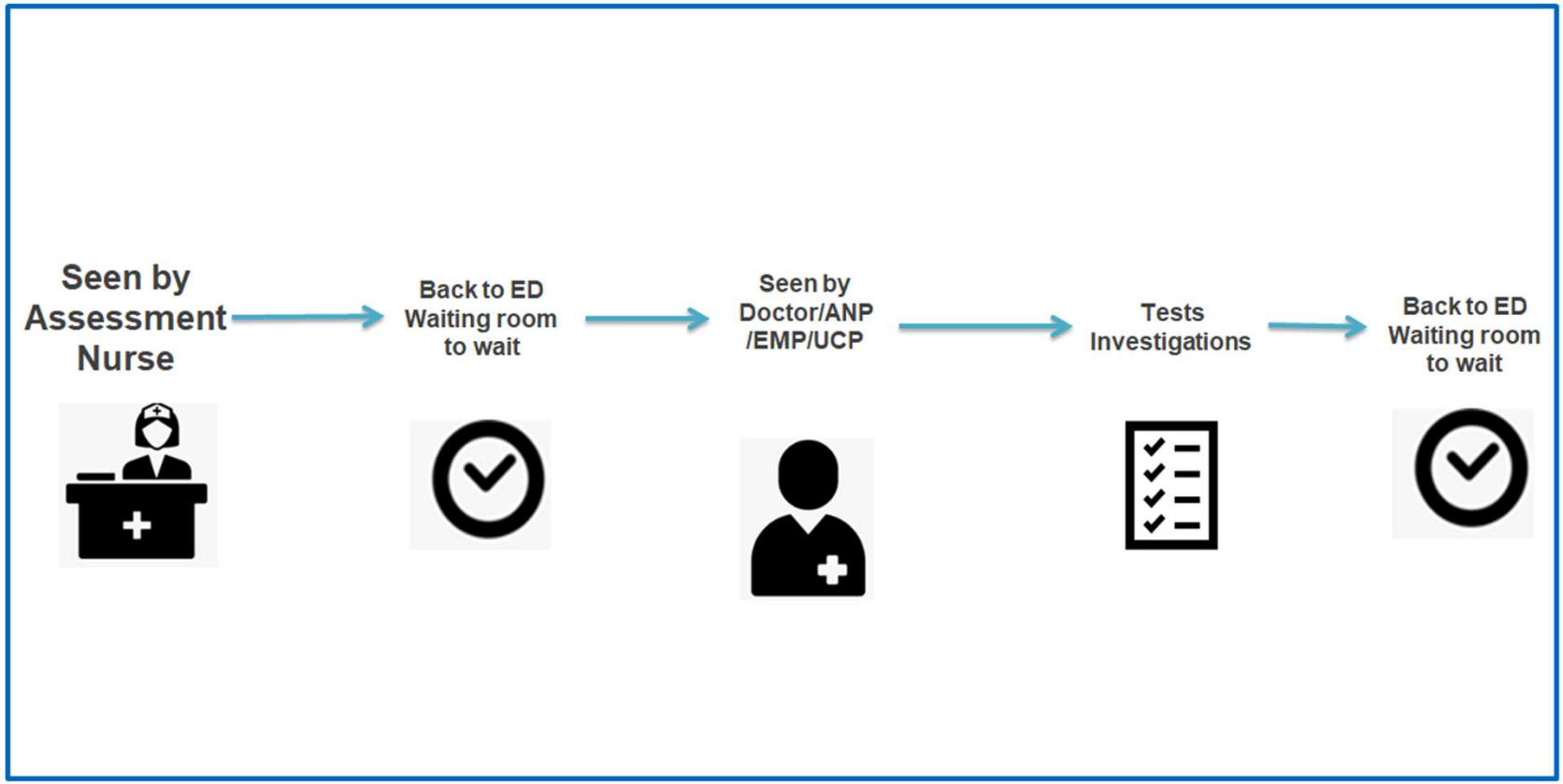
Patient Journey before PCAL (Part 1)



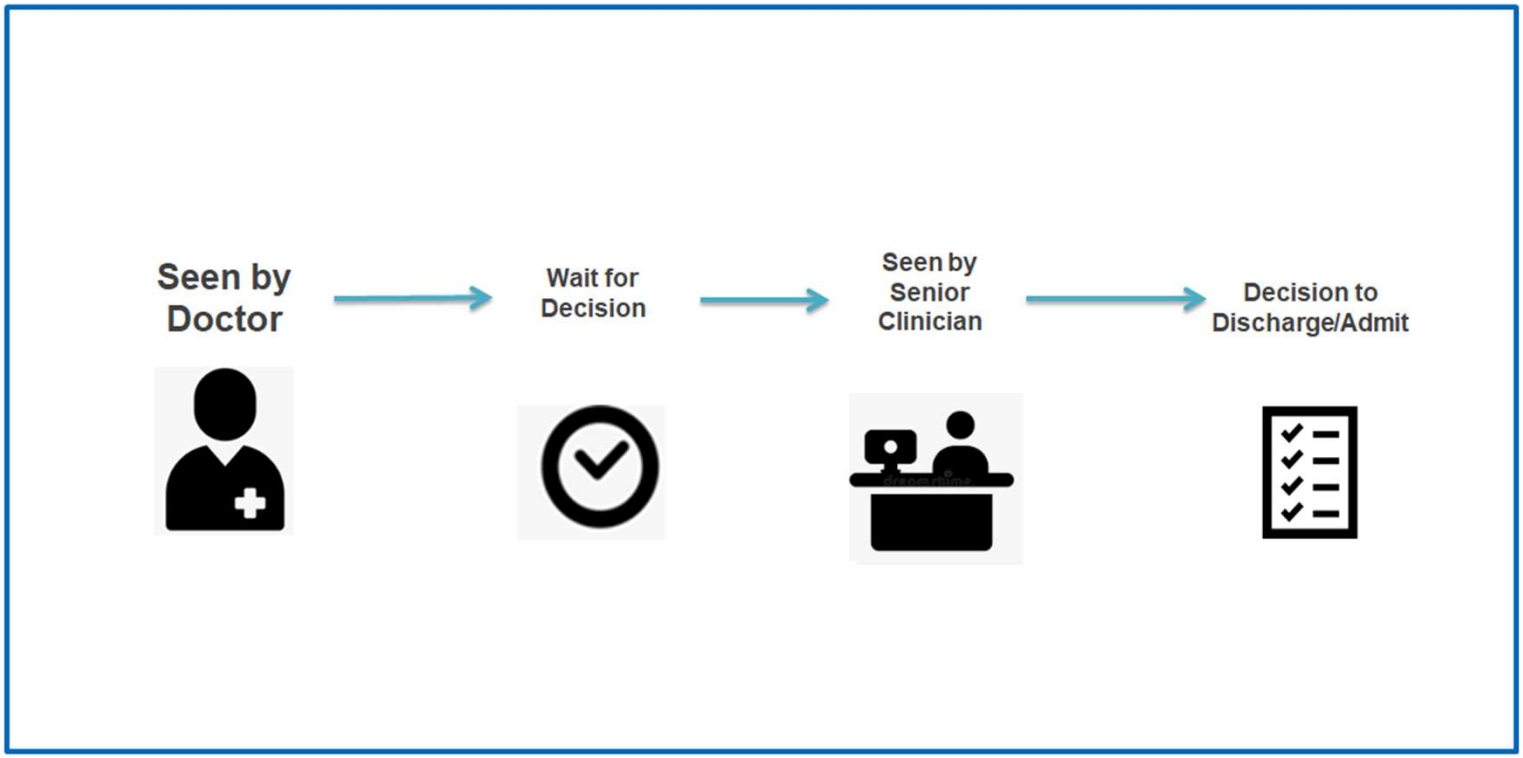
Patient Journey before PCAL (Part 2)



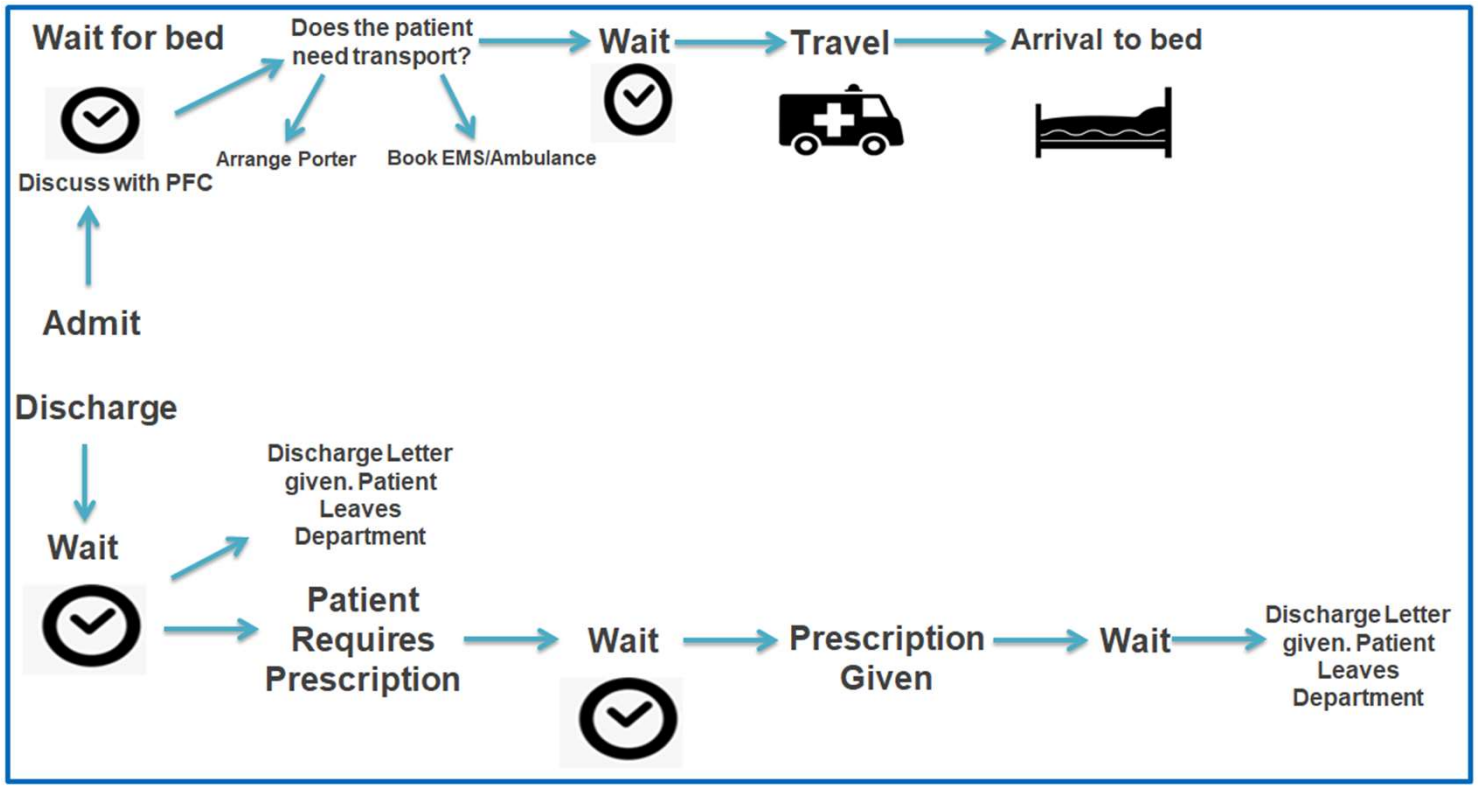
Patient Journey before PCAL (Part 3)



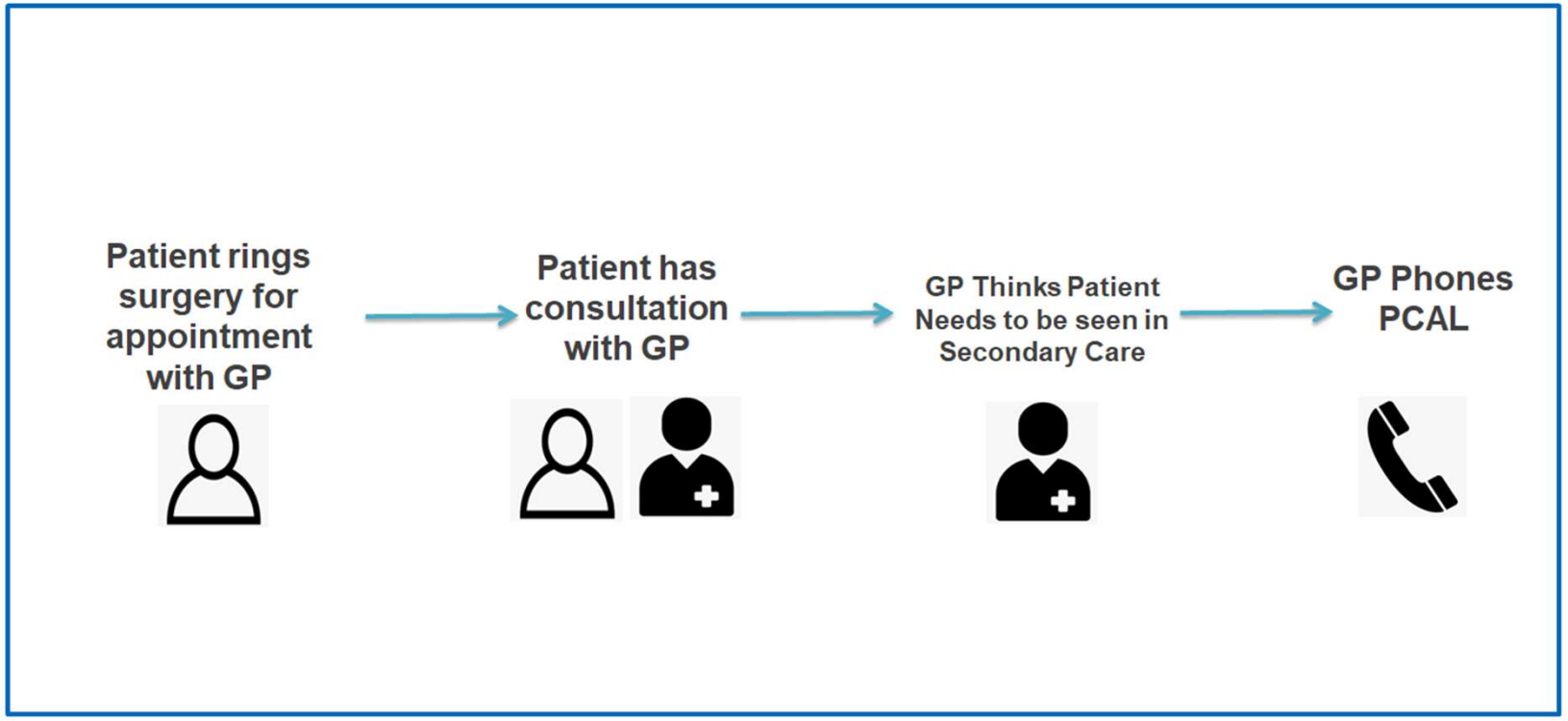
Patient Journey before PCAL (Part 4)



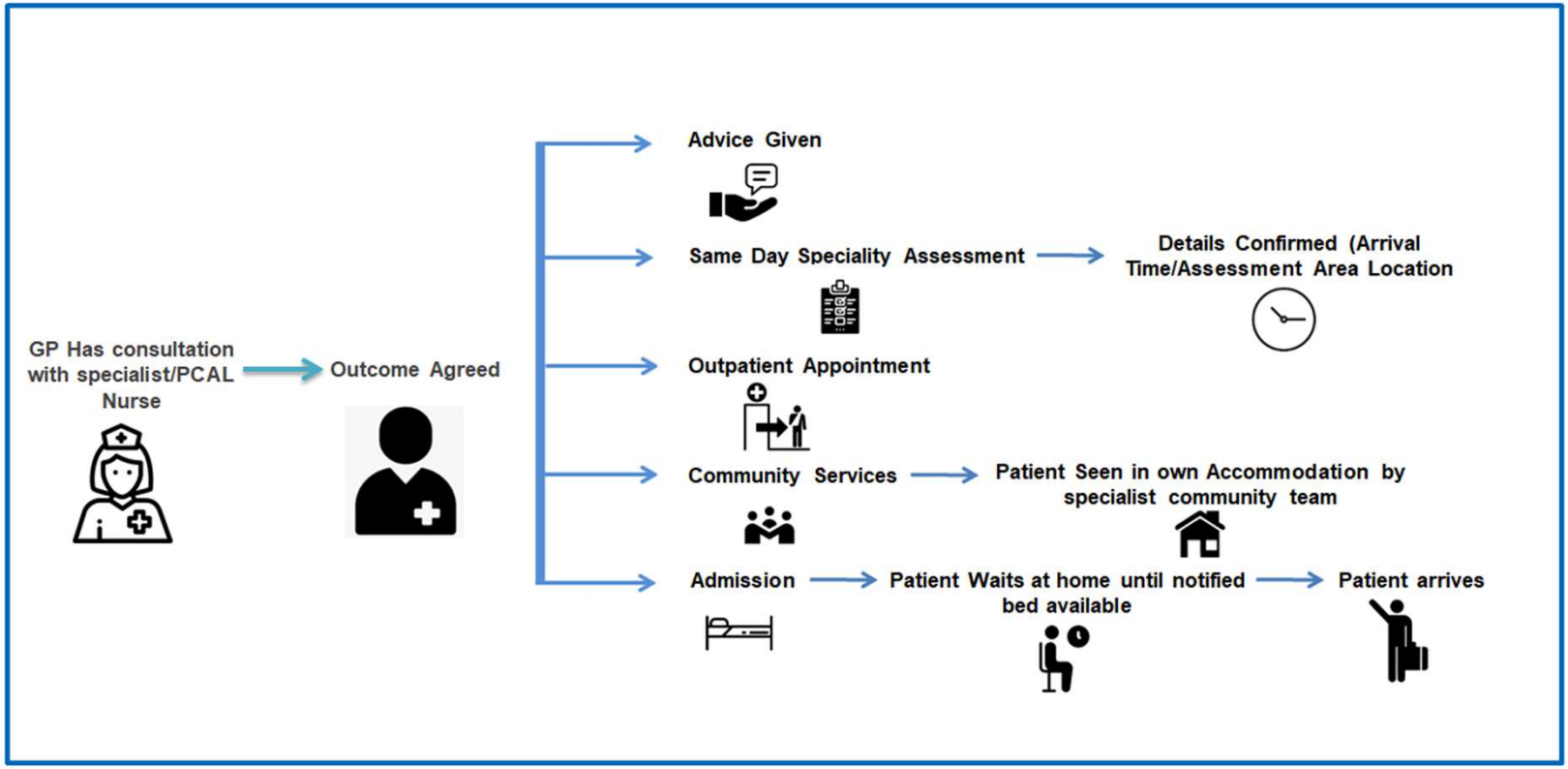
Patient Journey before PCAL (Part 5)



Patient Journey with PCAL (Part 1)



Patient Journey with PCAL (Part 2)



PCAL – Then vs. Now

Year	Referrals	Average Time to Answer (Mins)
2018/19	45,401	00:03:33
2019/20	45,534	00:03:00
2021/22	52,361	00:01:25
2022/23	81,916	00:01:35
2023/24	84,697	00:01:33
Jan-25	7,279	00:01:11

Urgent Care

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PCAL Call Outcomes

Month	Hospital Avoidance		ED Avoidance						Unplanned Care	
	Referred back to Primary Care		Assessment Area/ SDEC		Clinic Appointment		Ward Admission		ED Attendance	
	Outcomes	*Percentage*	*Outcomes*	*Percentage*	*Outcomes*	*Percentage*	*Outcomes*	*Percentage*	*Outcomes*	*Percentage*
18/19	2712	7%	1864	57%	323	10%	41	1%	747	23%
19/20	3457	8%	22811	56%	5049	12%	725	2%	8820	22%
20/21	7152	22%	13936	42%	4633	14%	849	3%	6404	19%
21/22	10668	15%	30446	44%	12261	18%	2648	4%	10457	15%
22/23	9721	13%	37085	49%	14790	20%	2287	3%	8224	11%
23/24	8167	10%	41232	53%	14289	18%	1887	2%	7286	9%
Jan - 25	715	11%	3645	55%	1121	17%	136	2%	582	9%

Continuous Improvement

- Clinical Access Pathway's
  - Engaging with Specialities
- Stakeholder Engagement
  - YAS's
  - GP's
- Internal Processes
  - Admin Vs Nursing

KPIs – 25/26

Additional KPIs to measure:

- Volume of calls increased by 10% for 25/26
- Reducing the time to answer calls.
- Reduce patient's outcome to ED by an additional 1%

Think Hospital?
Think PCAL!

Any Questions?

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Making Every Day Count

A whole-trust Leeds Improvement project

Making Every Day Count

Aims:

- To use the Leeds Improvement Method (LIM) to empower staff to improve ward efficiency and reduce patient Length of Stay (LoS).

- July 2024- RPIW including 3 wards from different clinical service units
- October 2024- Whole trust Improvement project
- Weekly exec report outs

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Why was this undertaken?

- Reduce harms to patients from avoidable delays
- Standard Work/Role clarity=Effective Teams
- Reduction and Collective Strategy to reduce delays
- Specific work to ensure timely completion of eDans

L Leeds Improvement Method
I M
CONTINUOUS LEARNING

Measuring Impact

KPI / Outcome Measures:

- Quality - Discharge before 12:00 midday
- Quality - Total daily discharge numbers
- Delivery - Ward LoS (Time)
- Quality - Completion of EDDs (%)
- Quality - Golden patient / discharge before 10am
- Service - Patients able to correctly answer the 4 key questions (%)
- Quality - eDANs completed the day before discharge

Process or balance measures

- Quality - % patients who had a value-added day
- Quality - % days when a 'daily debrief' huddle to cross-check tasks was completed
- Morale - % staff who feel the action cards have added clarity to their role / responsibilities
- Delivery - Duration of the MDT

Expectations

1. To socialise the bundle with clinical colleagues

2. To understand each clinical teams starting point

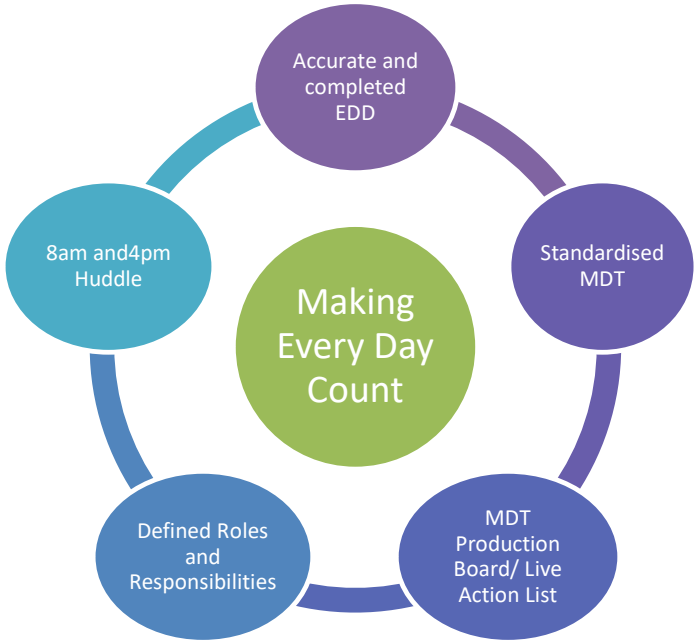
3. Support clinical teams to build on whatever currently exists to ensure more days can be value-added for patients in our care

4. Support clinical colleagues to understand their opportunities, test interventions, and measure results based on the bundle provided

5. Be curious and explore how we can remove barriers to improvement

Making Every Day Count Bundle

- Action cards outlining roles and responsibilities
- Standard work for what makes a good MDT
- Standard ward processes for huddles and MDT
- All patients to have an accurate EDD on PPM
- MDT Production Board / live action list
- Empowering patients to understand their own journey



Action Card

Making Every Day Count
Leader on Point

Aim of the role:	Accountable to:
• To provide leadership and coordinate the actions at CSU level to ensure we are making every day count for our patients. • Be accountable for the actions required to ensure every day counts for our patients	CSU Tri Team/Ops Centre

Daily Standard Work		Completed / notes
Leader on Point	**Daily** • Obtain overview from each Matron/Nurse in charge, the number of early discharges and total planned discharges for the day for the CSU • Discuss with Patient flow the number of patients awaiting a bed into the CSU and any signicant bed pressures across the trust • Attend Silver command or Patient flow meetings as required • Discuss with Matrons/Nurse in Charge the outcome of the review and gain assurance that all EDDs have been discussed and documented • Discuss with resident doctor any concerns or escalations required • Visit each clinical area once each day (minimum) and review Production board **(Check, Challenge, Chase)** • Be the point of escalation for any internal escalations within the CSU • Be the point of contact for the CSM/Ops team for any escalations not solvable at ward level	

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Patient Involvement

Making Every Day Count

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Making Every Day Count

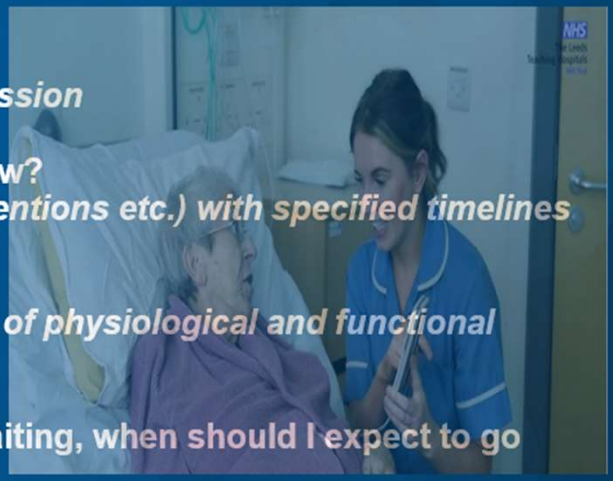
EVERY PATIENT (RELATIVE/CARER) SHOULD KNOW THE ANSWER TO FOUR KEY QUESTIONS:

1. Do I know what is wrong with me?
This requires a competent senior assessment and discussion

2. What is going to happen now, later today and tomorrow?
The 'inputs' needed (diagnostic tests, therapeutic interventions etc.) with specified timelines

3. What do I need to achieve to get home?
The 'clinical criteria for discharge' (CCD), a combination of physiological and functional parameters.

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



Leeds Improvement Method
CONTINUOUS LEARNING

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What's Working Well

- Good knowledge and awareness of MEDC on all wards
- High staff engagement and motivation
- Rollout across all wards
- Action cards continue to be developing – therapies, ward clerk, radiology, discharge and flow
- Discharge Lounge utilisation
- Collaboration with therapies
- Identification of Golden Patients for discharge before 10am
- Good feedback on 4pm huddle

L Leeds Improvement Method
I M
CONTINUOUS LEARNING

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Target Progress Report:

Metric	Week 3	Week 4	Week 5	Week 6	% Change
Standard Lis JP1	25/10/2024	11/11/2024	18/11/2024	JP0 /11/2024	Calculation.
Number of areas where intervention bundle deployed	JP2 100%	100%			
Patients able to answer the 4 key questions	0%	100%			
eDANs completed the day before discharge	38.89%	TBC			
Patients who had a value-added day	TBC	TBC			
Days when a 'daily debrief' huddle was completed	100%	100%			
Staff who feel the action cards have added clarity	50%	50%			
MDT starts prior to 12 midday	30%	30%			
Duration of the MDT	60 – 80 mins	60 mins			
Options / Additional					
[Local metrics can be added here]					

L I M
Leeds Improvement Method
CONTINUOUS LEARNING

Slide 63

JP0 The % change calculation is:
Baseline value / (Baseline - change value) x 100 = % change.
PARVIN, Jimmy (LEEDS TEACHING H, 2024-10-28T17:16:11.477

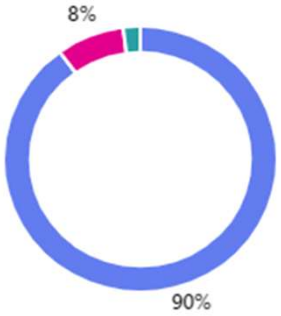
JP1 Please report a combined value for the areas in you service where the intervention bundle has been applied.
PARVIN, Jimmy (LEEDS TEACHING H, 2024-10-28T17:17:34.417

JP2 Please report the % of areas in your CSU where the appropriate elements of the intervention bundle have been applied.
The calculation should be:
number of areas in progress / total number of areas = xx%
PARVIN, Jimmy (LEEDS TEACHING H, 2024-10-28T17:24:39.957

Local example of intervention

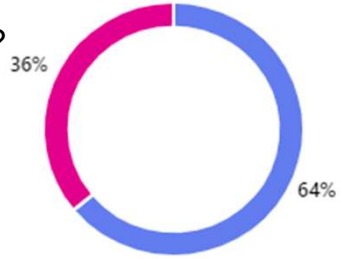
Do I know what is wrong with me?

Yes	45
No	4
Unsure	1



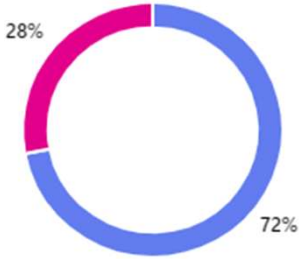
Do I know what is going to happen now with my care?

Yes	32
No	18



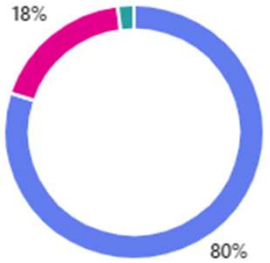
Do I know what is going to happen tomorrow with my care?

Yes	36
No	14

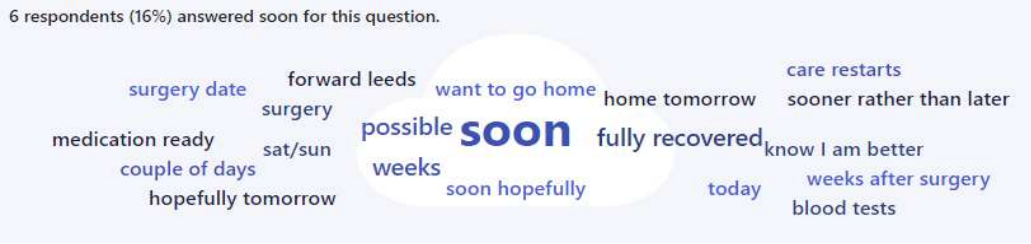


Do I know what needs to be achieved to get home?

Yes	40
No	9
Unsure	1



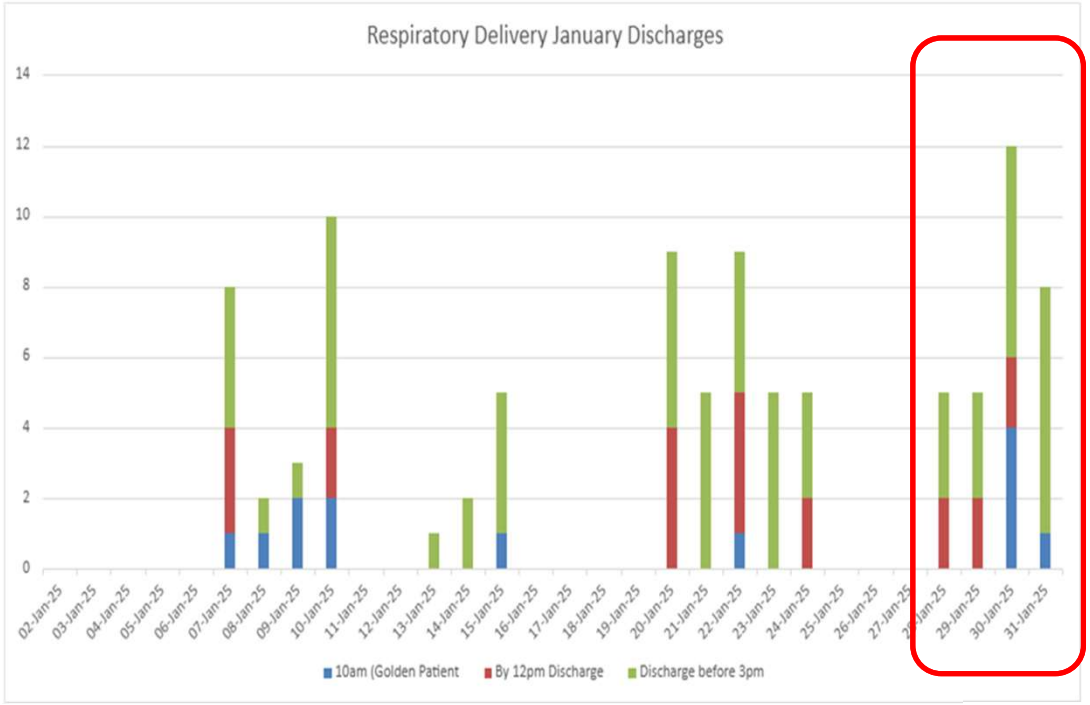
If recovery is ideal and there is no unnecessary waiting, do I know when I am expecting to go home?



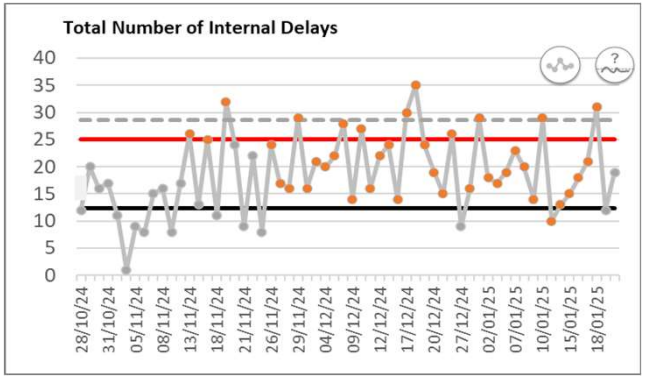
Local example of intervention

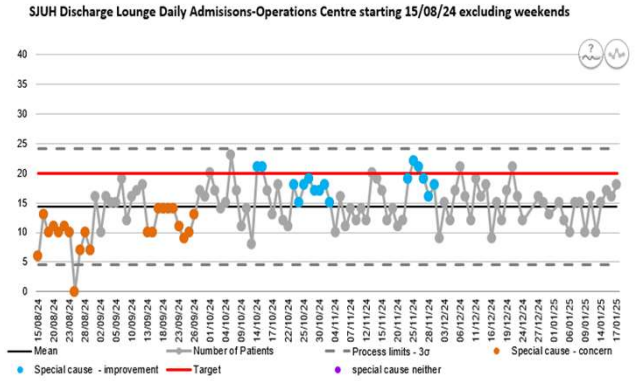
	Ward Discharge by 12 noon	September 2024	January 2025
	L18	8.25%	20.6%
	L19	7.38%	24.7%
	L16	5.75%	20%

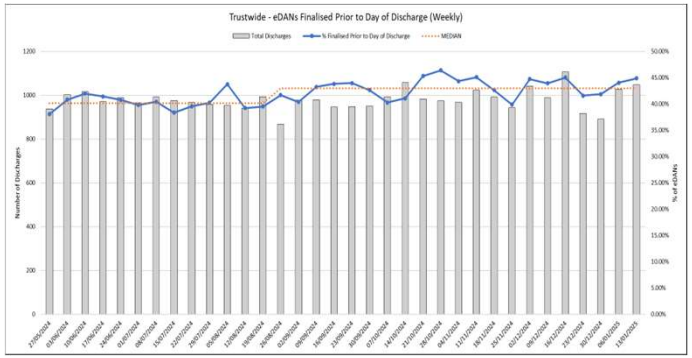
CSU / Business unit	Sep	Oct	Nov	Dec	Jan
Cardio-Respiratory	3.8	3.7	3.8	4.0	4.0
172 - Cardiac Surgery (CARS)	11.4	15.6	13.9	17.2	17.0
320 - Cardiology (CARD)	2.5	2.2	2.2	2.7	2.4
340 - Respiratory Medicine (THOR)	7.4	7.1	8.0	7.2	7.5
343 - Adult Cystic Fibrosis (CF)	3.7	4.8	5.7	3.6	7.0
	3.8	3.7	3.8	4.0	4.0



Measuring Impact

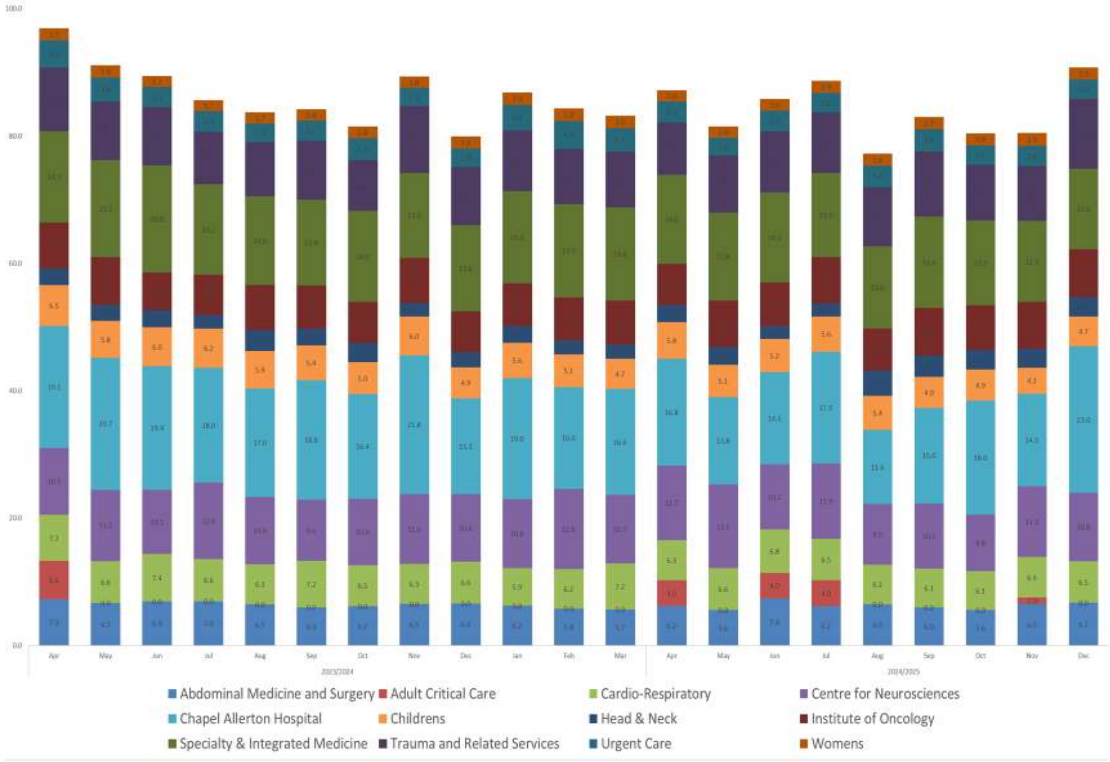






Week commencing	Total discharges	Total Discharges before Midday	% discharges before midday
04-Nov	1366	206	15%
11-Nov	1364	199	15%
18-Nov	1377	227	16%
25-Nov	1361	185	14%
02-Dec	1393	218	16%
09-Dec	1397	235	17%
16-Dec	1482	200	13%
23-Dec	1114	179	16%
Grand Total	10854	1649	15%

Total LOS by CSU



CSU / Business unit	2023/2024 Dec	2024/2025 Dec	Variance
Specialty & Integrated Medicine	13.6	12.6	-0.9
Childrens	4.9	4.7	-0.2
Cardio-Respiratory	6.6	6.5	-0.1
Womens	1.9	1.9	0.0
Abdominal Medicine and Surgery	6.6	6.7	0.1
Urgent Care	2.9	3.0	0.1
Centre for Neurosciences	10.6	10.8	0.2
Head & Neck	2.3	3.0	0.7
Institute of Oncology	6.4	7.5	1.1
Trauma and Related Services	9.1	11.0	1.9
Chapel Allerton Hospital	15.1	23.0	7.9

Length of Stay – target 0.9 day reduction

Target Process Measures

- Intervention bundle had been rolled out to 97% of wards
- 83% of MDTs occurring before 12MD
- 88% of patients asked were able to respond to the 4 key question
- Number of golden patients being identified for transfer to the discharge lounge before 10am
- 14% increase in eDANs being processed on a weekend
- 16% increase in eDANs released by Pharmacy before 4pm
- 8% increase in eDANs being released by 2pm on the day of discharge
- 43.9% of eDANs being completed before midday.

Upcoming events

- **Improvement peer learning event | Building capacity and capability**
  Monday 24th March 3.00pm – 4.00pm

- **Webinar | Waiting lists - Is prehabilitation the magic bullet?**
- Monday 10th March 12.00pm

Tell us what you think

Scan the QR to complete our evaluation form, or the link is in the chat

THANK YOU FOR ATTENDING