Community Flow Principles

NHS England

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

Improves Health and Wellbeing: When people feel in control, they make decisions that help them optimise their overall well-being.

Improves Quality of Care: Active participation reduces unwarranted variation in the provision of care, treatment and support, including time spent away from home.

Improves Patient Outcomes: When there is a focus on what matters to people based on available options, they feel less anxious and make fewer complaints.

We have a ‘duty to promote involvement of each patient…in their care or treatment’ - The Health and Care Act 2022

See references; slide 8 – Resources (ii)

Applicable to all our teams – not just those providing direct care

Admin and support staff

I am usually the first point of contact for patients and visitors. I ensure everyone feels welcome, supported and safe.

Ward teams

I include patients in all care planning, listening with empathy to understand their needs. I speak compassionately and act as an advocate. I involve adult social care colleagues early in the patients journey

AHPs

I ensure rehabilitation plans are patient led, well documented and include clear functional criteria for discharge and expected dates of discharge. I work closely with my colleagues in adult social care

Operational management

I co-design pathways that support patients' involvement, and reduce the burden of multiple tasks for staff, releasing time to care

Executive leadership

I take care of our staff; our staff take care of our patients. I am visible, and a champion of patient involvement.

Integrated Care Board

I encourage staff to participate in system-wide learning from concerns, complaints and incidents to improve patient safety

Key initiatives can help deliver the principle

The Initiative	The Impact	The resource	Where it Works
Personalised care	Personalised care is based on 'what matters' to people and their individual strengths and needs.	NHS England » Personalised care	Intermediate Care Programme Futures Page
The 4 Key Patient Questions	Involving patients routinely, helps discharge planning and transition of care	Video - How the *4 patient questions help patient flow	North Tees and Hartlepool NHS Foundation Trust
15 Steps Quality Improvement Programme	Unannounced visits to wards to talk to patients, carers and staff ensures good experience of care for staff and patients	People Caring for People	Northumbria Healthcare NHS Foundation Trust
Post-discharge check in calls	Supports a smoother transition home for those who don't need a package of care, reducing patient and staff time following up on ad hoc queries. Provides rapid escalation where problems do occur.	Hospital Discharge and Community Support Guidance (publishing.service.gov.uk)	24hrs post discharge phone calls
Safely home: discharge from hospital	Aids hospital flow, home support (with volunteers), community recovery and assessment of long-term care needs.	Planning Discharge Together from the start	The Newcastle Upon Tyne Hospitals NHS Foundation Trust
Modern Ward Rounds	Ensures active involvement of patients in ward rounds, with family and carers as required, or requested	Modern ward rounds guidance - Case Studies	Nottingham University Hospitals NHS Trust

Other initiatives

Where best next campaign	Enabling patients to continue their recovery at home or care settings that is most suited.
Video - The Last 1000 Days	Respect patients' time and dignity, by involving and letting them know what will happen today
Community Rehab; best practice standards	Best practice standards from the Community Rehabilitation Alliance providing recommendations developed to guide the development, delivery and monitoring of high-quality patient-centred rehabilitation.

Related initiatives in other areas

#EndPJparalysis	Valuing patients' time - protect cognitive function, social interaction and dignity by reducing immobility

Getting it right makes a big difference to everyone

Mrs NH is a 93 year old living with dementia, she experiences memory loss and problems with communication. She was admitted to hospital after waking up limping after falling at night. After a short spell in hospital there are no major injuries, but she isn't as mobile as she was.

Scenario 1

35 days Length Of Stay

Admission (day 1-2)

- Goals set
- Rehab plan developed
- Care plans initiated

Rehabilitation (Days 2-21)

- Wheelchair provided for meal-times
- Rehabilitation aim to independently mobilise 10m with rollator frame in 6weeks

MDT meeting (Day 22)

- Not making as much progress as initially expected.
- Plan for discharge likely to need long term placement.

Conversation with Family (Day 23)

- Disagree with MDT plan
- Mother came in walking by herself
- Agree for more rehab with an aim to returning home.

Discharge planning (Day 29)

- Aim: Discharge home with QDS care and hoist
- Wheelchair ordered

Discharge (day 35)

- Mrs NH discharged with bridging care provided by trust.
- Care needs will be assessed at home by Local authority

Scenario 2

15 days Length Of Stay

Admission (Day 1-2)

- Conversation with Mrs NH and family together to identify goals and care needs.
- Short term goals planned
- Agreed an anticipated stay of 2 weeks

Rehabilitation (Days 2-14)

- Rehabilitation aim to be able to transfer to commode (already at home)
- To be able to walk to the toilet (5m) with supervision (home set up)
- Joint sessions with family (who she lives with)

MDT meeting (Day 12)

- Team would like longer for rehab; however, Mrs NH and family want ongoing support at home in the short term
- Care transfer Hub contacted, and support set up.

Discharge home visit (Day 14)

- Mrs NH and OT visit her home together.
- Mrs NH able to stay at home with reablement and family support.
- Family have phone number of transfer of care hub if need an increase in support.

Intermediate care at home (day 15)

- Mrs NH has two weeks reablement support at home
- Mrs NH continues to have support from family and assistive tech overnight in her home.

✓ Length of stay reduction and more positive experience for Mrs NH, her family and the clinical staff

A few references to support this principle

Academic evidence and reports

- Developing Best Practice Guidance for Discharge Planning Using the RAND/UCLA Appropriateness Method – Frontiers in Psychiatric, Tyler N et al (2021)
- Improving Hospital Flow 'Ensiab Project' – British Medical Journal Open Quality, Alotaibi Y et al(2021)
- NHS England: Valuing Patients' Time
- NHS England » Improving hospital discharge resources

Resources

- SCIE: Co-production
- NIHR: Patient Involvement
- NICE: Putting you at the heart of our work
- The King's Fund: From listening to action
- NHS England » Involving people in their care
- PMC: Engaging patients to improve quality
- NICE: Patients should be involved
- PMC: Involving patients, carers and families
- Involving People
- Home First Act Now - elearning for healthcare (e-lfh.org.uk)
- What matters to you?
- Rehab on track: community rehabilitation best practice standards | The Chartered Society of Physiotherapy (csp.org.uk)

Useful websites

- Digitally enabling patient flow - How North Bristol NHS Trust tackled the winter crisis - Healthcare - PwC UK blogs
- A Thousand days video
- Hospital Discharge Service Action Cards
- Reducing long stays: Where best next campaign
- North Tees and Hartlepool NHSFT
- Northumbria Healthcare NHS Foundation Trust (People caring for People)
- Dementia UK

Patient partner organisations

- Healthwatch England
- Care Quality Commission
- Age UK
- National Voices | Person centred care
- The Patients Association (patients-association.org.uk)
- National Association of Patient Participation
- Personalised Care Institute

Stakeholders

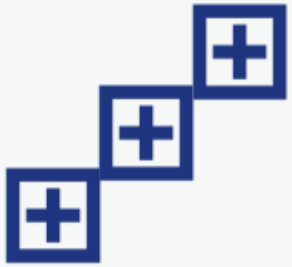
- HOPE - Heads of Patient Experience Network
- Co-production National EoC Team
- Beneficial Changes Network
- Emergency Care Improvement Support Team ECIST
- Equality and Health Inequalities Network

Co-productions as default

- 3 Key Principles for Improving Experience of Care – National Quality Board
- Shared Commitment to Quality – National Quality Board
- NHS England » Co-production resource toolkiton Model - NHSEI
- NHS Co-production Model - NHSEI
- How to listen to and learn from people and communities - The Kings Fund

Principle 2

We ensure every step adds value



Value can mean a lot of different things to different people

We are all responsible for the equitable, sustainable and transparent use of resources to achieve better outcomes and experiences for every person - positively impacting flow requires waste in all forms to be driven out.

The NHS continues to see an increase in the demand for the highest quality service with the best possible outcome in the most time and cost-efficient way possible – although outcomes can be difficult to measure and interpret.

Ultimately, we should ask – what does value look and feel like to our patients? What is important to them and how do we promote this at every step?

1. Defining Value-based Healthcare in the NHS (cebm.net) (Centre for Evidence-Based Medicine Report 2019/04)

There is value in every interaction and transaction we make with patients and families, and between staff

Patients

I am at the centre of the recovery process, and I am well informed about my medical treatment and care. I am a partner in planning my goals and participate in activities to aid my recovery.

Executive leadership

I ensure that our teams have visible, involved leadership and there are suitably qualified staff and technology for them to do their job. I listen to teams when they identify waste and unblock problems they identify.

AHPs

I value every patient and seek to understand their priorities, needs and abilities to offer high standard of care. I work collaboratively with social care to ensure my patient is able to get home with the support they need .

Operational management

I feel supported to facilitate and co-ordinate patient flow, 24 hours a day, 7 days a week. I work collaboratively with my local authority colleagues to facilitate timely discharge.

Ward Teams

I support an ethos of recovery over 24 hours. I make confident decisions in medication management, and I work collaboratively with my local authority and acute colleagues to discharge and admit people 7 days a week

Integrated Care Board

I understand the variation across the different bedded units in our ICB footprint and take action to ensure each unit has a focus on recovery.

Some key initiatives help ensure every step is both valuable and adds value

Home First Approach

Early Discharge Planning

Board/ward rounds

Acute Discharge planning

Admission to community beds

Recovery focused support

Goal Planning/ Functional Criteria for Discharge

Ongoing Intermediate Care support at home

Involving Patients and Families at every stage

Criteria Led Discharge

Post discharge care coordination

Key initiatives can help deliver the principle

The Initiative	The Impact	The resource	Where it works
Robust multi-disciplinary care planning	Ensures care is progressed every day, and through every interaction the patient is closer to going home. Provides a clear rationale for every test and procedure, all of which are critical to the patient's recovery	Releasing Time to Care – Multi-disciplinary Team Working	Effectiveness of multidisciplinary team case management: difference-in-differences analysis
Early discharge planning including effective use of expected date of discharge	Set at the first senior review. An accurate and achievable Expected Date of Discharge (EDD) is a reference point for discharge planning, resource allocation, care coordination and patient communication.	Discharge timeliness and its impact on hospital crowding and emergency department flow performance	Interventions to Promote Early Discharge and Avoid Inappropriate Hospital (Re)Admission: A Systematic Review
Modern ward rounds	Keeps care moving by bringing together the MDT to monitor the patient's progress, clarify diagnoses and relevant problems, and ensuring the clinical team to work with the patient to coordinate, document and communicate any changes to the plan.	Modern ward rounds | RCP London	Case Studies and Good Practice for Multidisciplinary Inpatient Review
Post-discharge check in calls	Supports a smoother transition home for those who don't need a package of care, reducing patient and staff time following up on ad hoc queries. Provides rapid escalation where problems do occur.	Hospital Discharge and Community Support Guidance (publishing.service.gov.uk)	24hrs post discharge phone calls
Active Hospitals	Active Hospitals aims to change the physical activity culture within hospitals to encourage patients to move more.	Active Hospitals - Moving Medicine	Leeds Thesis Template (movingmedicine.ac.uk)
Exercise prescription in Frailty & Sarcopenia	Routinely using frailty and sarcopenia assessment methods during initial patient assessment provides an opportunity to identify sarcopenia in an at risk patient population and guide exercise prescription.	Resistance exercise as a treatment for sarcopenia: prescription and delivery - PMC (nih.gov)	

Other initiatives

The Where Best Next Campaign	A National campaign to help patients avoid long hospital stays.
Red and Green Bed Days	Visual management system to identify wasted time in patients' journey.
Community Rehab; best practice standards	Best practice standards from the Community Rehabilitation Alliance providing recommendations developed to guide the development, delivery and monitoring of high-quality patient-centred rehabilitation.

Related initiatives in other areas

- **Admission avoidance schemes such as Virtual wards**
- **Patient-centred communication**
- **A system level transfer of care hub**
- **Discharge to assess/Home first**

Getting it right makes a big difference to everyone

Scenario 1

38 days Length Of Stay

Day 1

- Patient transferred from Acute hospital on Friday
- Patient managed in bed until, therapy assessment takes place

Day 4

- Therapy assessment
- Patient able to sit out in chair for meal times.
- Referral to OT for Wheelchair

Day 5 – 7

- Wheelchair measured up to use while on unit.
- Ongoing rehabilitation

Day 12

- MDT meeting
- Wheelchair provided to patient
- Therapy goals identified.

Day 12-28

- Ongoing rehabilitation
- Discharge planning begins

Day 29

- Complex social situation identified
- Discharge delay as unable to mobilize services to support.

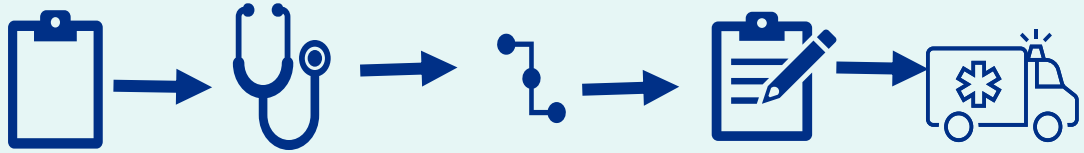
Day 38

Patient discharged

Elderly Patient admitted to community beds after an infection.
The same patient experiences very different care in these two scenarios – one where this principle is not achieved, and the other where it is

Scenario 2 – Principle applied

14 days Length Of Stay



Day 1

- Patient seen by MDT who work collaboratively with the patient to identify care and support needs.
- Chair with pressure relief supplied
- Rehabilitation goals (functional criteria) identified
- Expected discharge date agreed

Day 2

- Patient measured and supplied with wheelchair for use in unit
- Discussion with patient and family about discharge and home arrangements
- Complex social situation identified.

Day 2-12

- Patient measured and supplied with wheelchair for use in unit
- Discussion with patient and family about discharge and home arrangements
- Complex social situation identified.

Day 13

Intermediate care teams ready to assess and provide support at home.
Initial time of visit agreed with family

Day 14

Patient meets Functional Criteria for Discharge and discharged by a nurse.

- Better outcomes for the patient
- Less risk of harm and deconditioning
- Bed days saved

A few references to support this principle

Academic evidence and reports

- Defining Value-based Healthcare in the NHS (cebm.net)
- ECIST expected date of discharge and clinical criteria for discharge – YouTube
- Alice Coffey et al – Interventions to Promote Early Discharge and Avoid Inappropriate Hospital (Re) Admission: A Systematic Review https://doi.org/10.3390%2Fijerph16142457 Published July 2019
- M.T Fox et al – Effectiveness of Early Discharge Planning in acutely ill or injured hospitalized older adults: a systematic review and meta-analysis https://rdcu.be/dejhS Published July 2013
- S. Williams et al – Early Supported Discharge for Older Adults admitted to hospital with medical complaints: a protocol for a systematic review https://bmjopen.bmj.com/content/11/10/e049297 Published October 2021
- Discharge Challenge (14 pilot sites, 12 social care sites, 10 best practice initiatives) Discharge Challenge - FutureNHS Collaboration Platform
- Discharge to Assess (inc virtual wards) Improving hospital discharge in England: the case for continued focus and support - The Health Foundation
- Discharge to Assess, criteria to reside, NHS/LAs: Hospital discharge and community support guidance - GOV.UK (www.gov.uk)
- Discharge planning, checklist and booklets care transitions from hospital to home: Strategy 4: Care Transitions From Hospital to Home: IDEAL Discharge Planning | Agency for Healthcare Research and Quality (ahrq.gov) Published 2017
- Improving the patient discharge process: implementing actions derived from a soft systems methodology study - PMC (nih.gov) Published 2018
- Managing sarcopenia: PowerPoint Presentation (csp.org.uk)

Resources

- Rapid Improvement Guide – Earlier Discharge Times
- Hospital discharge and community support guidance - GOV.UK (www.gov.uk)
- Guides available for Community and Acute MaDEs: ECIST:
- Virtual Wards - Dr Tara Sood: ECIST
- People Stories - leaving hospitals (Healthwatch Report)
- Healthwatch Report - our position on safe hospital discharge
- Active Hospitals - Moving Medicine
- Rehab on track: community rehabilitation best practice standards | The Chartered Society of Physiotherapy (csp.org.uk)

Stakeholders

- National UEC programme
- Emergency Care Improvement Support Team ECIST
- Ambulance Services
- ICBs/CCGs
- NHS Trusts
- Partner Organisations such as DHSC, Local Authority and Voluntary sectors
- Industry bodies such as the Royal Colleges (RCEM, RCGP, RCN, RCP, RCS)
- Patient Bodies such as HealthWatch
- The public such as Patient, Carers, families and Community

Useful websites links and case studies

- Where best next - Kettering General Hospital NHS Foundation Trust
- Where best Next - South Warwickshire NHS Foundation Trust
- Length of Stay - United Lincolnshire Hospitals NHS Trust
- Home First Approach - Other Case Studies
- A Thousand days video
- Hospital Discharge Service Action Cards
- Reducing long stays: Where best next campaign
- Northumbria Healthcare NHS Foundation Trust (People caring for People)
- Rapid improvement guide to expected date of discharge and clinical criteria for discharge - Supporting information - NHS Transformation Directorate (england.nhs.uk)
- B0682-fnal-report-of-the-non-emergency-patient-transport-review.pdf (england.nhs.uk)
- Ten best practice initiatives - 100 day discharge challenge - NHS Transformation Directorate (england.nhs.uk)
- Patient experiences of integrated care within the United Kingdom: A systematic review
- Case study: Salford Royal NHS Foundation Trust | The King's Fund (kingsfund.org.uk)
- The journety to Person Centered Care - core-info-care-support-planning-1.pdf (england.nhs.uk)
- Optimising discharge medication to improve patient flow
- The Ipswich Hospital – Discharge case study

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

If we get patients to the right team at the right time, delays are minimised and there is less likelihood of inappropriate admission to community beds.

The right team includes being able to access the right level of support through the transfer of care hub, the right community unit but also the right team for onward referral, in the community.

The right time starts at the decision about admission – is it necessary and the best option for someone to be in a hospital bed to get the care that they need, what are the alternatives?

Getting patients to the right team at the right time is a whole team effort

Integrated Care Board

I have oversight of flow out into the community and work closely with my local authority colleagues to avoid excessive use of and prolonged stays in community beds

AHPs

I have the time and skills needed to support change and to help patients meet their goals. I work with our colleagues across all organizations, to ensure that any delays are minimized.

Care Transfer Hubs

I engage with a range of healthcare and social care staff to put in place the plan for discharge. I communicate proactively with internal and external colleagues to avoid delays.

Ward team

I listen to our patients, their families/carers and advocate for their needs. I ensure staff are aware of their responsibilities and empower all members of the Multi Disciplinary Team to challenge decisions and involve adult social care early in the journey.

Operational manager

I take a key role in ensuring our key targets for in-patient flow, including our own internal standards, are met by taking escalations from clinical teams and unblocking obstacles. I escalate as appropriate to resolve issues.

Executive leadership

I have oversight of the whole trust and work to ensure all departments work as one organisation. I resolve issues between organisations and foster a culture where teams can agree on ‘the way we do things round here’.

Key initiatives can help deliver the principle

The Initiative	The Impact	The resource	Where it works
D2A and Home First	Everyone should have the opportunity to recover and rehabilitate at home (wherever possible) before their long - erm health and care needs and options are assessed and agreed.	NHS England » Implementation of a discharge to assess model	NHS England » Swindon's discharge to assess model
Modern Ward Rounds	We achieve the best possible outcomes for patients, their families and their carers giving them a chance for clarity, reassurance and advice from those charged with their care.	Modern ward rounds | RCP London	East Lancashire Hospitals NHS Trust
AHP workforce planning	Job planning is recognised as an important means of linking best use of resources with quality outcomes. However, the way in which trusts deploy their AHPs varies significantly. This makes it challenging to match AHP resources to trusts' overall activity plans	ahps-job-planning-best-practice-guide-2019.pdf (england.nhs.uk)	
Understanding flow **(Capacity and Demand tools and techniques)**	Reducing variation in capacity and ensuring that capacity meets variation in demand supports flow optimisation. This ensures enough capacity or 'slack' in the system to adjust for hourly, daily and seasonal changes in demand.	Measuring for improvement, Chris Green ECIST Demand and Capacity planning - Alice Lundsten, ECIST	Demand and capacity planning case study – University Hospitals Birmingham

Other initiatives

Criteria Led Discharge	Accelerated discharge enabling a range of registered practitioners to lead a patient's discharge.
Community Rehab; best practice standards	Best practice standards from the Community Rehabilitation Alliance providing recommendations developed to guide the development, delivery and monitoring of high-quality patient-centred rehabilitation.

Related initiatives in other areas (interdependencies)

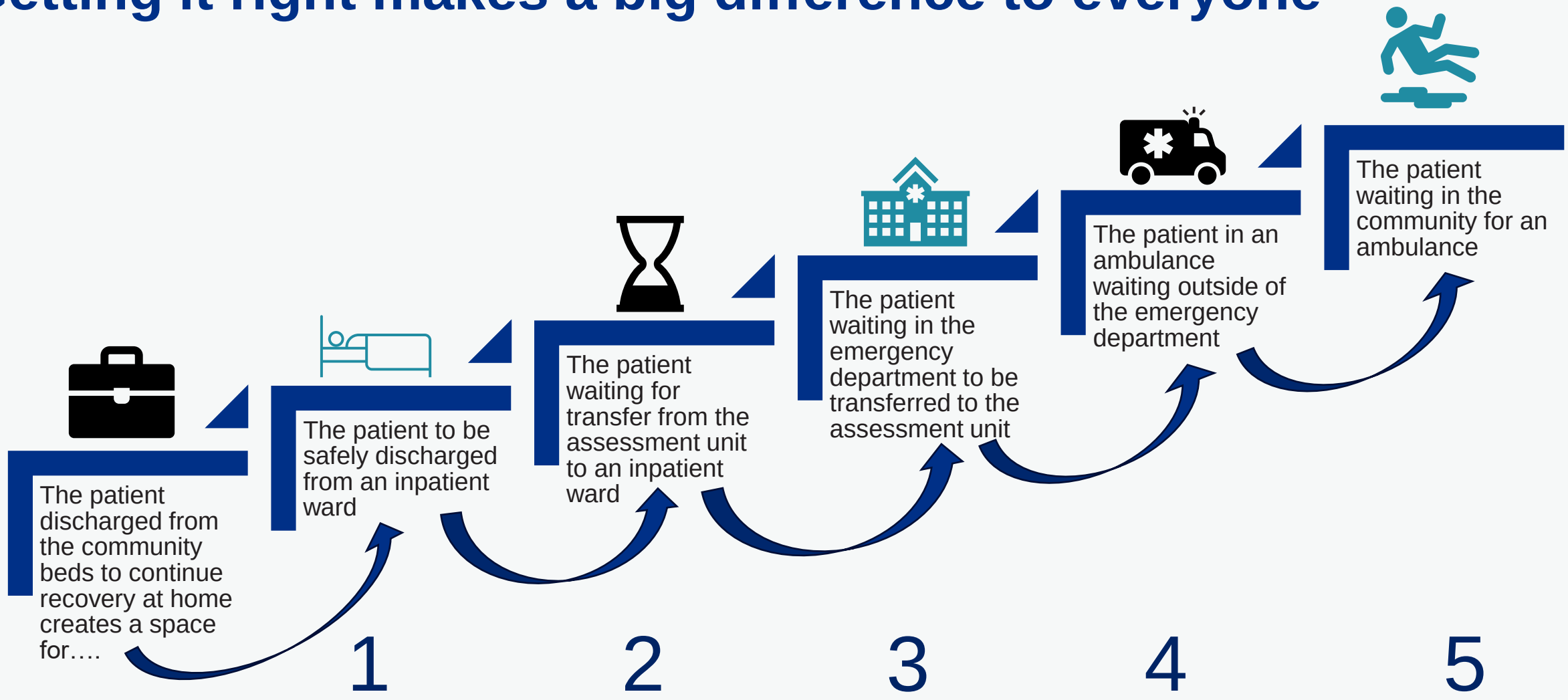
Admission avoidance schemes such as Virtual wards

Patient-centred communication

A system level transfer of care hub

Discharge to assess/Home first

Getting it right makes a big difference to everyone



A few references to support this principle

Academic evidence and reports	Resources	Useful website links and case studies
• Understanding delays in hospital discharge | Nuffield Trust • Getting the fundamentals right: how to better prepare for discharge pressures next winter | Nuffield Trust • Managing transfers of care – A High Impact Change Model | Local Government Association • Modern ward rounds | RCP London • B0682-fnal-report-of-the-non-emergency-patient-transport-review.pdf (england.nhs.uk)	• Home First D2A Practical Guide • Criteria To Admit Flow Chart • Criteria Led Discharge • Earlier discharge times • Multi Agency Discharge Event • Weekend discharges • Optimising discharge medication to improve patient flow • Internal Professional Standards • Escalation roles cards - examples • Early Clinical Conversation - Case study • Quick Guide: Discharge to Assess (www.nhs.uk) • Criteria led discharge guidance • A managers guide to Criteria Led Discharge • Improvement guidance for writing a Criteria Led discharge policy • Example patient leaflet for Criteria Led Discharge • Example policy for Criteria Led Discharge • Rehab on track: community rehabilitation best practice standards | The Chartered Society of Physiotherapy (csp.org.uk) • NHS and Care Volunteer Responders | Supporting Health & Social Care (nhscarevolunteerresponders.org) • NHS England » Allied health professionals job planning: a best practice guide	• Emergency Care Improvement Support Team ECIST • Getting It Right First Time - FutureNHS Collaboration Platform • RCP (rcplondon.ac.uk) • SDEC Experience of Care Collaboration Platform • Intermediate Care Programme - FutureNHS Collaboration Platform • Age UK • Care Quality Commission

Principle 4

We use data and evidence to make decisions and improve service delivery

Using data and evidence is vital to the delivery of high quality, safe patient care. It can be used to

Better manage system and hospital flow, effectively manage pressure and support timely discharge

Understand variation between demand for healthcare and resources development to inform service planning

Evaluate the impact of interventions and provide evidence to inform clinical decision making

Using data and evidence is a vital part of everyone's role

Executive leadership

I can use data to forward plan and ensure I have the right capacity day-by-day, hour-by-hour, to treat our patients in the right place at the right time

Integrated Care Board

High-quality, real-time flow data helps me understand where pressure is across the system and direct resources more effectively to manage it. I advocate sharing appropriate data between health and social care to benefit patients

Operational Manager

Real-time data enables me to be responsive to increased demand. I can use it for service planning and to understand fluctuations in the assumptions underpinning our demand and capacity plans.

Admin/Support staff

(including porters, Patient transport, pharmacy, diagnostics)

Accurate information enables me to understand the work I have to do and quickly respond to requests when they come in.

Clinical/AHPs/HCAs

Effective IT systems and equipment help me to plan care and share information seamlessly between teams and across organisations.

Using a robust evidence base allows me to make better decisions and deliver high quality patient care

I can use data to understand the impact of quality improvement initiatives on our services.

Key initiatives can help deliver the principle

The Initiative	The Impact	The resource	Where It works
Moving from paper processes to digital solutions **(EPR/Electronic Whiteboards)**	Having effective IT systems and equipment saves time by enabling clinicians to better plan care, book diagnostics, order TTOs and share information seamlessly between teams and across organisations.	National Information Board – Guidance for Developing Local Digital Roadmaps	Gateshead Health NHS Foundation Trust – Electronic Whiteboards Pilot
Understanding flow **(Capacity and Demand tools and techniques)**	Reducing variation in capacity and ensuring that capacity meets variation in demand supports flow optimisation. This ensures enough capacity or 'slack' in the system to adjust for hourly, daily and seasonal changes in demand.	Measuring for improvement, Chris Green ECIST Demand and Capacity planning - Alice Lundsten, ECIST	Demand and capacity planning case study – University Hospitals Birmingham
Using data to benchmark performance	Provides a structured approach to using data for quality measurement and improvement. Can be used by individuals for peer-to-peer challenge as well as for organisations and systems	NHS Bechmarking Network The Model Hospital – YouTube video	Example of benchmarking report – Cambridgeshire Community Services NHS Trust
System level demand and capacity modelling **(Systems Thinking approaches)**	Analysing and modelling complex interactions between organisations and processes at a strategic level, such as an integrated care system (ICS) supports long-term planning for workforce and other resources and supports evidence-based decision making for healthcare system transformation.	NHS England » System level demand and capacity planning	Academic Paper – system dynamics mapping of acute patient flows
The Community daily discharge situation report (SitRep)	This helps to drive the effective implementation of wider Hospital Discharge guidance and post-discharge care and is flowing into the national capacity and demand tool to support system planning and commissioning. It will lead to better care for patients and service users by increasing understanding of discharge practices, the use of pathways, and demand and capacity availability.	Coronavirus » COVID-19 EPRR Community Daily Discharge SitRep: Technical specification (england.nhs.uk)	
Exercise prescription in Frailty & Sarcopenia	Routinely using frailty and sarcopenia assessment methods during initial patient assessment provides an opportunity to identify sarcopenia in an at-risk patient population and guide exercise prescription.	Resistance exercise as a treatment for sarcopenia: prescription and delivery - PMC (nih.gov)	

Using data and evidence well makes a big difference to everyone

Reactive community bed flow management

- ✗ Lack of visibility of estimated discharge/ transfer dates
- ✗ No flagging/visibility of changes to care plans
- ✗ Late referrals to community flow partners
- ✗ No access to shared EPR
- ✗ Poor understanding of demand and capacity in local health and care system
- ✗ No sighting/ownership of community flow data by clinical and operational leads
- ✗ Insufficient use of evidence and benchmarking to improve quality of care and outcomes
- ✗ Community beds flow not discussed at designated clinical, operational and executive meetings
- ✗ No executive accountability for improving community beds flow

Pro-active community bed flow management

- ✓ Patients planned for transfer/admission to community beds are flagged and estimated transfer date visible to relevant leads
- ✓ Patients with social care needs flagged/referred to relevant teams as soon as need identified
- ✓ Occupancy and estimated admissions/discharges in community beds visible live across system
- ✓ Regular monitoring and reporting of demand and capacity in local health and care system
- ✓ All community beds are reported into Community Discharge Sit Rep, benchmarked position discussed at clinical, operational, executive and board level and clear plans to address unwarranted variation put in place
- ✓ Community beds are included in regular LoS benchmarking by bed/patient category, reasons for variation understood and plans put in place to align to recommended optimal practice
- ✓ All factors and evidence affecting local community bed flow are systematically reviewed and insights used to inform improvement plans

A few references to support this principle

Academic evidence and reports	Resources and case studies	Multimedia links
Board Rounds • Patient Journey Champions: A project to facilitate delivery of effective board rounds for inpatients, aiding flow through the hospital | RCP Journals • Quality Improvement: Supporting a hospital in difficulty: (rcpjournals.org) **Real-time data to manage flow** • Can good bed management solve the overcrowding in accident and emergency departments? | Emergency Medicine Journal (bmj.com) **Capacity and demand** • QSIR demand and capacity - a comprehensive guide NHS England » System level demand and capacity planning	• Rehab on track: community rehabilitation best practice standards | The Chartered Society of Physiotherapy (csp.org.uk) • Coronavirus » COVID-19 EPRR Community Daily Discharge SitRep: Technical specification (england.nhs.uk) • Developing a capacity and demand model for out-of-hospital care (local.gov.uk) • Commissioning out of hospital care services to reduce… | IPC Brookes Rehab on track: community rehabilitation best practice standards | The Chartered Society of Physiotherapy (csp.org.uk)	**YouTube videos** • Measuring for improvement, Chris Green ECIST • Demand and Capacity planning - Alice Lundsten, ECIST • Demand and capacity planning case study – Medway Foundation Trust • Demand and capacity planning case study – University Hospitals Birmingham • Electronic patient records – Bolton Hospital **Other** • GIRFT frailty webinar - Adrian Hopper • Improvement science 1 – think like a farmer, Nick Holding ECIST • Improvement science 2 – the journey not the destination, Nick Holding ECIST

Principle 5

We work together to create a culture of trust and support

Value can mean a lot of different things to different people

"Culture is the way we do things around here…by conforming to the values and norms that we see others enacting."

**Professor Michael West Head of Thought Leadership, The King's Fund*

When staff feel valued, able to speak up and psychologically safe this can have a positive impact on teamwork, staff wellbeing, efficiency and lead to higher standards of patient care.

There is a clear link between attitude, behaviour, culture, workforce and patient safety.

**Being fair 2 – improving organisational culture in the NHS*

Everyone has a role in creating and maintaining the culture

Integrated Care Board lead

I set policies and practices that are inclusive, encourage communication, transparency, and trust between our organisations and the staff in them, leading to better collaboration, problem-solving and higher productivity.

Executive leadership

I take care of our staff; our staff takes care of our patients. I ensure that our teams have visible, involved and approachable leadership and put in place systems and processes that safeguard patients and staff. I am compassionate, listen to and learn from my teams.

Admin/Support staff

(including porters, Patient transport, pharmacy, diagnostics)

I am often the first point of contact for patients and visitors and a brand ambassador for my organisation. I ensure our visitors feel welcome, supported and safe. I am valued by the organisation for the role I play.

Clinical teams

I am enabled to make the right clinical decisions for our patients. I can raise concerns and expect them to be properly investigated. I am open to challenge from colleagues and always seeking to improve safety and quality. I embrace the wider professional team that supports my patients.

Operational managers

I work with my clinical colleagues to enact decisions to ensure effective daily functioning of the hospital, paying attention to the impact on safety, as well as staff/patient experience. I share values with my colleagues and take accountability for service delivery with them.

All staff

I am enabled to do my job to the best of my ability because I am free to be myself, show compassion, speak up and continuously improve in an environment free from bullying, where there is learning, quality and effective organisational leadership.

Key initiatives can help deliver the principle

The Initiative	The Impact	The resource	Where it works
(2023) Being fair 2 – improving organisational culture in the NHS	aims to promote the value of a person-centred workplace that is compassionate, safe and fair. sets out the benefits to an organisation of adopting a more reflective approach to learning from incidents and supporting staff.	Being fair 2 - improving organisational culture in the NHS - NHS Resolution	Mersey Care NHS Trust Barts Health NHS Trust
Why is culture important?	support providers to give patients safe, high quality, compassionate care within local health systems that are financially sustainable help boards to assure their governance on the culture and capability domain of the well-led framework.	Culture and leadership programme - Phase 1: discover - why is culture important? (england.nhs.uk)	Pilot sites: Central Manchester University Hospital NHS Foundation Trust · East London NHS Foundation Trust · Northumbria Healthcare NHS Foundation Trust
Improvement Leaders' Guide Building and nurturing an improvement culture	introduce you to the concept of organisational culture by taking you through three statements that will help to define what culture is and how cultures develop within the NHS. the Guides will give you the basic tools and techniques to: Involving patients and carers; Process mapping, analysis and redesign; Measurement for improvement; Matching capacity and demand	ILG-3.3-Building-and-Nurturing-an-Improvement-Culture.pdf (england.nhs.uk)	Case studies Acute Hospital in the South of England Integrated NHS Trust, South of England
NHS England Culture and Leadership programme	a modular programme which provides opportunities for organisations to understand their own culture using evidence-based tools, develop tailored leadership strategies for developing compassionate, inclusive and collective leadership and deliver culture change.	NHS England » The Culture and Leadership programme	North Middlesex University Hospital Lincolnshire Partnership NHs Trust Isle of Wight NHS Trust
Safety culture: learning from best practice (2022)	we share the insights from these discussions and some ideas of good practice that may be helpful relating to the language, tools, and interventions that these organisations have used to help improve their patient safety culture.	B1760-safety-culture-learning-from-best-practice.pdf (england.nhs.uk)	Case studies: Norfolk Community Health and Care NHS Trust Central and North West London NHS Foundation Trust

Other initiatives	Related initiatives in other areas (interdependencies)
ICB Chief People Officer Peer Network	Learning from the highest performing trusts (report by Chris Morrow Frost (NHSE) and Tim Gillatt (ECIST) - 2023

A patient journey

Cultural environment detrimental to patient care and recovery

Whenever a patient on a ward had a fall, any of the nursing staff involved in the care of that patient can be called to attend a panel to account for the movement/ mobilisation/care decisions of the patient that resulted in the fall.

This leads to a culture where there is a substantial fear of the consequences; fear of being blamed and fear for future employment; it becomes 'safer for staff' in terms of the organisational culture to mobilise patients less thereby reducing the likelihood of being called to the panel but had the adverse effect of preventing staff from sharing and learning as well as resulting in the deconditioning and slower recovery of patients.

Cultural environment supporting good patient care and recovery

Having a kinder culture, more focused on providing peer and senior support for nursing staff generated through an MDT approach, enables teams determine the most beneficial approach to the care of their patients.

This can lead to positive changes to the culture, and subsequent improvements in the delivery of patient care such as the introduction of falls prevention training for staff rolled out using a cascaded training approach and the adoption of the Avoiding Falls Level of Observation Assessment Tool.

A few references to support this principle

Academic evidence and reports

NHS England UEC Recovery Plan
NHS 'Culture of Care' Barometer

- The Health Foundation: Strengthening NHS management and leadership - Priorities for reform
- NHS England: Just culture case profiles
- NHS England: Patient Safety Incident Response Framework
- NHS England Improving Patient Safety Culture: A practical guide
- Gov.UK: Culture change in the NHS
- NHS managers and leaders: Supporting new standards for board members
- Better Conversations: https://youtu.be/nCP4joBUVhc

NHS resources

- NHS England: Staff Networks
- Future NHS: Culture Community
- Future NHS: SDEC Collaboration Platform
- Nottingham and Nottinghamshir It's ok to ask.
- NHS England: Inspiration: sharing the "whys" and the "hows" of compassionate and inclusive leadership
  The Beneficial Changes Network
  Emergency Care Improvement Support Team (ECIST)
- NHS Leadership Academy: Download the Do OD app and Culture change tool
- NHS England: Speaking Up support scheme
  Supporting culture change: Stories and training
- Healthwatch England
- NHS Leadership Academy
- NHS Employers
- NHS Professionals
- Rehab on track: community rehabilitation best practice standards | The Chartered Society of Physiotherapy (csp.org.uk)
- Digital Social Care Pathfinders Programme 2019-21 - NHS Digital

Useful website links

Forbes: Eight Tips To Create A Company Culture Of Support And Collaboration
Changing culture one habit at a time
Harvard Business Review: The 3 Elements of Trust
Affina Organisation Development AOD Culture Assessment Tool
Michael West: developing cultures of high quality care

Partner organisations

Department of Health and Social Care
Civility Saves Lives

- Institute for Healthcare Improvement – IHI: What If We Flipped the Patient Discharge Process?
  The Kings Fund Improving NHS culture
  Nuffield Trust
- Care Quality Commission
  National Voices: 'blueprint for culture change'
- Managing transfers of care – A High Impact Change Model: Changes 1-9 | Local Government Association

We need to know we are making a difference

Key Ambitions: Create system capacity and improve flow across the urgent and emergency care pathway

Support the UEC Recover Plan and; *Improve to 76% ED performance against the 4-hour target by 03/24*

Improve ambulance response time for Category 2 to 30minutes average, over 23/24

Data we can collect to help us to understand if the changes we make are making a difference

Qualitative	Quantitative
Well-documented MDT care plans with the 4 key patient questions visible and relevant to everyone involved in the care process (process)	Number and proportion of plans for discharge completed within 24 hours of admission (process)
Evidence of care and treatment reviews (process)	Number of ward and board rounds per week (minimum average set)
Care quality and flow audits (process)	Number and proportion of patients with Clinical Criteria for Discharge (process)
Staff surveys, staff feedback and pulse checks (outcome)	Number and proportion of changes in expected discharge date during a patient's stay (process)
Temperature check of staff's confidence in engaging with families and carers, having difficult conversations with empathy(process)	Number and proportion of patients leaving before midday, 17:00h and 20:00h and proportion of weekend discharges (process)
Feedback from patients, families and carers (outcome)	Proportion of patients returning to their usual place of residence (UPR) (process)
Staff and patient stories sought, shared and acted upon on a regular basis (outcome)	Number and proportion of unplanned readmissions to hospital (balancing)
Complaints and concerns (including feedback from Grievance and Freedom to Speak up) (outcome)	Staff data including sickness absence, retention, performance review and personal development plan completion rates (process)
Exit interview feedback (outcome)	Proportion of beds reported into community discharge sitrep (process)
Nationally recognised feedback mechanisms, including friends and family test (process)	Proportion of beds benchmarked for overall length of stay (process)
Recruitment and selection approach and questions (process)	% Community beds usage by commissioned category/speciality (process)
	Patient flow indicators in UEC recovery plan: Emergency Department – 4 hrs; Cat. 2 ambulance response; 12 hrs Emergency Department; Bed occupancy (process)
	Staffing Ratios (process)
	Proportion of people accessing pathway 1 support on discharge (community sit rep)
	Numbers of people delayed associated with pathway 2 from acute providers (acute sit rep)

Thank You

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