Delivering optimal outcomes and experience for people in hospital

Operational guidance bringing together key approaches to support professionals to improve patient flow and deliver timely pathways of care.

This guidance is a product of the national Six Goals for Urgent and Emergency Care Programme

Foreword

We all want to deliver the best outcomes and experiences for people in hospital, reducing inefficiencies within the system and ensuring people receive the care and treatment they need, when they need it. This guidance has been developed to bring together key approaches to embed hospital flow best practice and support continuous improvement.

Right care, in the right place, first time.

In February 2022, the Welsh Government published its strategic vision for urgent and emergency care, through six policy goals (Figure 1). Our aim is to prevent unnecessary escalation of care where possible, by providing proactive support, and to enable access to the right care, in the right place, first time for people who have a need for urgent or emergency care.

Figure 1: Six Goals for Urgent and Emergency Care

The six goals approach aligns with the commitments of A Healthier Wales (2018), the Workforce Strategy for Health and Social Care (2020), the Programme for Government (2021) and the National Clinical Framework (2021). We want to ensure through a joined up, whole system approach people have access to the right health and social care services to help them stay well, to get better when they are ill, or to live as independently as possible with any long-term conditions.

The six goals policy handbook sets out expectations for health, social care, independent and third sector partners for the integrated delivery of six goals for urgent and emergency care to help achieve the best possible clinical outcomes, value and experience for patients and staff involved in the delivery of care. This care may be provided by health or social care services in the community, within primary care or within secondary care including acute hospital sites.

The whole system must work together to enable successful delivery of each goal. This guidance has been designed as a product of goal five and six to support professionals within all disciplines and of all levels to deliver timely progress in continuity of care and improve patient flow.

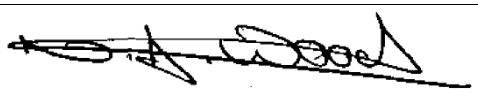
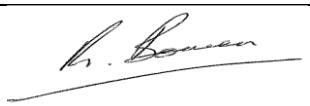
Admission to a community or acute hospital bed should occur only when the treatment they require can only be provided in that setting. Many people who are older and living with frailty or co-morbidities leave hospital less mobile and less independent than when they were admitted.[1] Many also lose confidence and the ability to care for themselves very quickly when they are away from their familiar surroundings. This is why good multi-professional discharge practice is the foundation to the delivery of optimal hospital based care and must begin from the point a decision is made that admission is necessary.

When people move between care settings, the risk of miscommunication and unintended changes to medicines remain significant problems.[2] Improving the transfer of information about people's needs, including information about their medicines, across all care settings helps to reduce incidents of avoidable harm, improving outcomes and patient safety, and contributing to a reduction in avoidable medicines related admissions and readmissions to hospital.

Timely pathways of care are everyone's responsibility.

We know that a large volume of people who are within the health and social care system are in the last 1000 days of their lives, and we need to make this time as valuable as we can, minimising time away from home and family. When hospitalisation is required, treating individuals' acute symptoms promptly and enabling them to be supported to safely return to their own home is vital. This can be achieved through joined up working between professionals and confident clinical decision making.

This guidance provides the tools you need to reduce hospital delays and inefficiencies during a person's care and treatment. It integrates the approaches taken within D2RA, SAFER and Red2Green to support delivery of transformational care and safeguard against deconditioning, ensuring better outcomes and experiences for people in hospital.

	
Nick Wood Chair of Six Goals for Urgent and Emergency Programme	Richard Bowen Six Goals for Urgent and Emergency Programme Director

[1] 4 Ways Hospitals Can Harm You (forbes.com)
Delayed transfer of patients causing widespread failings across NHS and social care (senedd.wales) NHS England » New NHS plan to help patients avoid long hospital stays

[2] Royal Pharmaceutical Society. 2012. Keeping patients safe when they transfer between care providers. Available here.

Contents

Introduction

This guidance brings together the tools required to support improved patient experience and clinical outcomes, through delivery of highest quality of treatment and timely transfer home or to a more appropriate setting, for adults admitted to acute or community hospital sites.

It is intended to enable an improvement in delivery of care to people who possess a clinical need for a hospital stay, and support their transfer home, or as close to home as possible, as soon as practicable.

The guidance is based around **four 'what matters to me' questions** which all professionals must be able to answer for every person within their care:

1. What do you think is wrong with me?
2. What is going to happen today?
3. What needs to happen to get me home and what can I do to speed things up?
4. When can I go home?

Patients, their families and carers must be central to all decision making and their views should always inform the answers to these questions. These four questions are designed to ensure people receiving care are clear on how their needs are being met by health and social care services.

Purpose of this guidance

This guidance should be used for all adults who have been admitted to a hospital bed at either an acute or community hospital site.

As part of the six goals programme, the NHS Delivery Unit has been commissioned to develop an **Optimal Hospital Care and Home First Programme**. This guidance is an early marker of this work. It has been developed through a series of expert groups comprising of operational and clinical staff, to integrate previous approaches and ensure the system delivers the most effective care and treatment to the population.

It has become clear that even though guidance requiring the use of SAFER, Red2 Green and D2RA guidance has been in place since 2018, many patients are bypassing

D2RA and some of the fundamental elements of SAFER and Red2Green principles are not consistently being met. This means patients are experiencing longer length of stays and are deconditioning as a result.

To ensure these principles remain relevant, they have been refined and collated into this document, ensuring they reflect the changes needed to the way we work. **This document therefore supersedes all previous SAFER, Red2Green and D2RA guidance.**

The guidance identifies the tools and processes which should be activated as soon as there has been a decision to admit, irrespective of where the person is currently located be that within an emergency department (ED), assessment area or a ward-based environment. This will ensure that each person achieves timely care and can be efficiently discharged as soon as it is safe to do so.

It is not expected for teams to re develop processes but to concentrate on those not yet embedded in your care. It's the implementation of all the tools that will have the greatest impact. For areas where these tools are not yet embedded, it is suggested teams begin with D2RA and move through embedding each tool.

Target audience for this guidance

It is intended that this guidance will support every health and social care professional at every level especially those who deliver and support inpatient care, to deliver timely continuity of care and to improve patient flow to discharge.

The six goals programme is founded on a whole system approach, with this in mind, this guidance has been endorsed by Welsh Government senior clinicians, who are also keen to support the implementation phase of this work. This in itself indicates the wide-ranging scope of professionals who are involved in supporting a person's care, assessment and treatment and must play a part in understanding and answering the **four questions**.

Key Principles

From the decision to admit

The processes that support timely person-centred care and treatment should not be delayed due to the location of a person and any delay in transferring them to the appropriate inpatient ward bed.

The principles of SAFER and D2RA must be custom and practice wherever there are patients who are deemed to require an inpatient hospital admission.

S A F E R

Is the **Right Patient,** in the **Right Place,** having the **Right Care**, **first time?**

SEEN

SEEN BEFORE MIDDAY

Key Staff Questions:

- Clear actions and accountability with a timeframe?
- Patient waiting for a diagnostic/ treatment? Can this happen today, if not, why not?
- Is the patient clinically optimised for discharge or transfer?
- A senior support structure in place for escalation.

AIM

WHAT MATTERS TO ME?

Key Patient Questions:

1. What do you think is wrong with me? (Diagnosis)
2. What is going to happen to me today? (Tests, interventions etc.)
3. What is needed to get me home, and is there anything I can do to help? (Clinical criteria for discharge and Recovery Plan)
4. When can I go home? (EDD) Patient, family/ carers involved in care planning.

FLOW

RIGHT BED FIRST TIME

Prepare for early morning transfer to wards

- Front door, can admission be avoided?
- All patients on correct D2RA pathway?
- Identification of patients requiring supported discharges.
- Review discharges daily
- Are tomorrow's discharges planned?
- Patients discharged at earliest opportunity – Each day a green day.

EARLY DISCHARGE

HOME FOR LUNCH/ASAP

Ward battle rhythm set?

- Prioritise patients being discharged today.
- Pharmacy to be on board round to review medications?
- Link with Family, Friends, Carers to arrange transport.
- Key/ keycode available?
- Book patient transport service if no alternative.
- Identify, clear actions and accountability with a timeframe to avoid delays

RECOVERY

WHAT MATTERS TO ME?

- Discussion with patient on recovery goals and expectations and plan updated regularly?

Can they go home?

- Stakeholder communication: Think GPs, DNs,3rd sector, Community Services, Social Workers.
- Right support for recovery? Think : AHP, social worker, carer, volunteer support.

GIG CYMRU NHS WALES

Click on the link to Goal 5 where you will find the main documents

SAFER ENABLERS • Get up, Get Dressed, Keep Moving • Board Rounds • Huddles • Red2Green • Discharge Lounge • Community Liaison • Integrated Hubs (Single Point of Access)

DISCHARGE

Pathway 0

NO ADDITIONAL SUPPORT REQUIRED FOR DISCHARGE

- Fully independent – no further support required
- Multidisciplinary Team assessment within hospital 'front door' units to avoid full admission.
- Patient returns to usual place of residency (including Care Home)
- Restart Package of Care (POC) with no changes
- Has pre-existing community services in place

GIG CYMRU NHS WALES

Click on the link to Goal 5 where you will find the main documents

TO

Pathway 1

SUPPORTED HOME FIRST

- Patient returns to usual place of residency with short term support.
- Preventative services delivered in collaboration with third and voluntary sector organisations. e.g Meal provision, shopping, housing
- New POC or increase of existing package.
- Short term reablement to maximise independence.
- Assessment and some additional care and support (including therapy, nursing, Pharmacy, domiciliary care & new equipment). e.g Community Resource Teams
- Safe between calls/ overnight.

RECOVER

Pathway 2

SHORT TERM SUPPORTED FACILITY

- Patient is transferred to a non-acute bed and receives rehab/reablement and assessment until able to return safely home.
- Unsafe to be at home overnight/between care calls.
- Currently needing some care (eg: ADL) support/ intervention 24/7
- Includes specialist rehab. (e.g Stroke, Neuro, T&O)

ASSESS

Pathway 3

COMPLEX SUPPORT

- Patient is transferred to a new long term bed, assessment bed or usual residence and receives the complex support and/or assessment for their needs.
- Complex/significant health and/or social needs in usual residency.
- Significant change requiring new placement.
- Longer term placement
- Life changing health care needs
- Complex end of life or mental health needs.

Discharge planning must begin at the point of admission.

Within 24 hours of a decision to admit:

The outcomes of the following conversations and decisions should be documented into the patients notes and relevant information added to the ward board.

- A thorough "what matters to me" conversation, which includes the **four questions** needs to be undertaken with the patient and their family and/or carers.
- All patients should have an estimated date of discharge (EDD) that has been discussed and agreed with the patient and their family and carers.
- All patients should be allocated to a D2RA pathway.
- A plan should be in place to prevent deconditioning and prioritise availability of take-home medicines at discharge.

Ward based care

Every day a person is in a hospital bed should **add value to their care**.

The Red2Green approach aims to reduce a patient's length of stay by highlighting 'non-value' adding days and reducing avoidable delays where a patient is kept waiting for things to happen to progress their care. Each ward-based environment across all hospitals in Wales should be utilising this approach.
Any delays in treatment, investigation or discharge that means patients are having days in hospital that are not adding value need to have clear escalation processes and actions implemented to ensure that each day adds value.

It is suggested that an agreed process is put in place that allows for wards to collate delays with clear escalation (including timeframes) so that health boards have a clear understanding of bottle necks within the system.

Additional resources on Red2Green are available.[3]

All staff should support patients by answering the **four questions** daily to ensure patients are informed about their care and that everyone is clear around the plans for each patient, each day. Lack of clarity to the answers to any one of these four questions will result in more RED days spent in a hospital bed. Staff should not expect patients to ask the questions, but should proactively provide the answers as clear information.

[3] Red2Green resources: rig-red-green-bed-days.pdf (england.nhs.uk) and Red and Green days - YouTube

RED TO GREEN

Click on the link to **Goal 5** where you will find the main documents

A DAY OF NO VALUE

KEY QUESTIONS

1. Can the patient care or interventions received today be delivered at HOME or in a non-acute setting?
   YES – It's a RED DAY
2. If I saw the patient in an outpatient setting, would their current 'physiological status' require an emergency admission? **NO – It's a RED DAY**

- Inadequate MDT presence at the Board Round to allow firm decisions to be made.
- The care or interventions the patient is receiving today could be delivered in a non-acute setting.
- Tests and investigations have occurred but the results have not been reviewed by the Medical team and acted upon.
- A planned investigation, clinical assessment, discharge assessment or therapy intervention for today does not occur.
- Acute - The medical care plan lacks a Senior Medic approved expected date of discharge.
- Acute - The patient is a new admission and has not yet had a medical review/there is no initial diagnosis/treatment plan.
- If a patient is due for discharge today and the discharge prescription medications are not ready (Pathways of Care Delay).
- Transport delaying discharge or causing plans to fail today.

A DAY OF VALUE

- Patient progresses towards discharge
- Everything planned and requested is done
- Patient needs this bed for Acute care

- Everything that was planned for today gets done
- The patient requires acute hospital care
- The patient requires community hospital care
- The results from tests and investigation have been reviewed by the Medical team and acted upon
- The patient is receiving active interventions to get them to be discharged by tomorrow, and the discharge prescription medications are ready by the evening before the expected date of discharge.

Preventing deconditioning

There is growing recognition that lack of physical activity during hospital stays can have significant negative consequences for patients, especially in older people. Patients lose physical and cognitive abilities within hours if actions aren't taken to prevent deconditioning.

Deconditioning causes harm to patients and can prolong their hospital stay and prevent them getting back to their home and family. It also can have long term consequences.

10 days in hospital (acute or community) leads to the equivalent of 10 years ageing in the muscles of people over 80 years old.[4]

48% of people over 85 years old die within one year of hospital admission[5]*.*

It is the professional responsibility of all staff to implement steps to prevent deconditioning from the moment a patient arrives at a hospital. This includes any time they are held on an ambulance, in an emergency department or assessment unit on a trolley or on a hospital ward.

Professionals should ensure patients, carers and families are made aware of the risk of deconditioning and they should be given information and advice on what they can do to avoid deconditioning whilst in hospital.

Deconditioning should be an ongoing assessment by all staff who interact with the patient and focus on:

- **Functional ability** – *has the person's mobility decreased?*
- **Cognitive ability** – *has there been a decline in the person's orientation to time and place?*
- **Continence** – *has there been any change to the person's continence needs?*

Following assessment, action must be taken by appropriate team members to minimise identified risks. This might include embedding actions in the care plan to:

- maximise mobility and encourage self-care, including eating away from bedside and toileting independently;
- explain and communicate the specific dangers and risks to the person, for example the potential impact on future independence and return home;
- ask family to provide clothing; and

[4] Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

[5] Clark et al 2014

- provide active rehabilitation where indicated.

Time to move: get up, get dressed, keep moving

End PJ paralysis was a global movement that started in 2018 and focused on encouraging patients to get up, get dressed and keep active. Encouraging patients to get dressed and out of bed reduces deconditioning, maintains muscle strength, improves mood, improves appetite, improves sleep, reduced the risk of constipation and also falls. Put simply, you are at your best when you are up and dressed[6].

[6] Health in Wales | End PJ Paralysis

PREVENT DECONDITIONING

"Get Up, Get Dressed and Keep Moving"

PREVENT & IDENTIFY DECONDITIONING

- Is the patient at high risk of deconditioning?
- What is the patient's level of mobility/ bladder and bowel control/ cognitive function?
- Has there been a change in the patient's mobility/ bladder and bowel control/ cognitive function?
- Has there been a conversation with the patient and family/ carers on what they can do to prevent deconditioning and why it is important?

GIG CYMRU NHS WALES

Click on the link to **Goal 5** where you will find the main documents

PROMOTE FUNCTIONAL ACTIVITY

- Patients should be enabled and encouraged to get out of bed, sit out in a chair and mobilise everyday if clinically able to do so
- Patients should be encouraged to wash and dress themselves when possible or with as minimal assistance as required
- The clinical environments should promote functional activity and mobility (chairs at the bedside, corridors kept clear of clutter)
- Enable and encourage patients to mobilise to the toilet and/or bathroom to use the facilities
- If patients require their glasses or a walking aid to mobilise, ensure they are within easy reach
- Encourage patients to sit out for lunch

CONTINENCE MANAGEMENT

- Patients should be encouraged and supported to use toilet facilities if clinically able to do so
- The use of bedpans and commodes at the bedside should be actively discouraged to ensure patient dignity and encourage mobility
- The use of incontinence products such as pads should be discouraged for patients with bowel/ bladder control – including at night-time
- Promote and support good nutrition and hydration
- Record bowel movements and prevent, identify and manage constipation as early as possible

COGNITIVE FUNCTION

- Focus on delirium prevention
- Ensure mechanisms are in place to orientate patients to time, date and day
- Promote establishing a day and night routine in the clinical environment
- Promote activities that will provide cognitive stimulation and social interaction in clinical areas
- With the patient's permission, promote involving family, friends and carers in their care to prevent deconditioning and delirium – review visiting times to facilitate this
- Promote and support good nutrition and hydration- monitor and record intake
- Patients with an acute change in cognitive function should be screened for delirium
- Patients that are delirium positive should have a medical review and a holistic management plan in place, including a medication review and appropriate pharmacological management of delirium

DECONDITIONING STARTS WITHIN HOURS – PREVENTION IS EVERYONE'S BUSINESS

Deconditioning is a complex process of physiological change following a period of inactivity, bedrest or sedentary lifestyle. It results in functional losses in areas such as mental status, degree of continence and ability to accomplish activities of daily living. (Gillis et al 2005)

Pathways of care and all Wales discharge policy

The all-Wales discharge policy is being updated (2022) and should be used to support the transfer of patients once they are clinically optimised and can move to a more suitable place of care. Their next stage of care should be identified by the D2RA pathway that they are on.

There are two new pieces of guidance that will be available which will support this framework and become part of the updated discharge policy:

- Trusted Assessor role guidance.
- Reluctant discharge guidance.

Smart Operational Management

There is a responsibility for the operational teams within hospitals to support optimal patient flow and ensure the principles of right bed, first time are adhered too. An additional working group has been tasked with creating guidance on what good looks like for operational management in both acute and community hospitals. This will form part of the final framework due for publication by Summer 2023.Right bed, first time.

"*A stay of four to eight hours in the ED increases inpatient length of stay by 1.3 days, while a stay of more than 12 hours increases length of stay (LOS) by 2.35 days and there is a 43% increase in mortality at 10 days after admission through an overcrowded ED"7.*

Ensuring patients are transferred to the most appropriate ward reduces the LOS of that patient and supports the principles of ensuring every day within hospital adds value.

Operational teams and ward colleagues should work together by taking actions from the board rounds to unlock constraints and feed back to the teams to ensure all patients have "green" days.

Decision making around bed allocation needs to take into account all patients who require transfer to a different bed. This includes ED and assessment unit patients awaiting admission, patients awaiting transfer out of critical care, repatriations from other health boards, tertiary referrals waiting to come in and direct admissions from an out-patient department or specialty clinic.

Pressures in the system should not determine any decision about bed allocation. The focus of clinical and operational teams should be on patient need and clinical priority.

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[7] Richardson, 2006

Standards and measures

All standards and measures around optimal patient flow need to be meaningful and be able to drive improvement. They should provide accountability and allow recognition of good practice.

A process is underway to standardise definitions across NHS Wales which are used within the suggested standards and measures. Finalised definitions will feature within the more detailed framework expected to be released during the summer of 2023.

Some measures will be mandated and will need to be reported monthly through all-Wales monitoring and assurance processes. Other measures will be obtained through on-site audits (details being developed).

Once there is an agreement on what the standards and measures will be, they will need to be approved through the NHS Wales data standards governance process.

Current mandated measures

- Number of patients with a LOS >21 days. Monthly reporting of the number of patients with an inpatient stay of greater than 21 days.
- Pathway of care delays – currently in pilot phase and being standardised through the NHS Wales governance process for data standards. Measures to be released in 2023.
- D2RA – being standardised through the NHS Wales governance process for data standards. Measures to be released in 2023.

Suggested standards and measures

The following standards and measures are recommended by the national expert group for use by health boards and partners to inform local learning about how successful teams are in delivering timely pathways of care and improved patient flow.

It is intended that the standards and measures will drive the following outcomes:

i. better quality care to patients – right bed, first time;
ii. decongestion in emergency departments;
iii. promptly offloading ambulances releasing them back into the community for those emergency patients who need them; and
iv. reduction in avoidable mortality, falls and harm
v. Prevent deconditioning whilst in hospital and therefore reduce the need for long term social care at home and in the community

Suggested standards

- Every ward must undertake an early morning board round each morning, followed by an afternoon huddle. These need to be action focused.
- Actions need to be put in place to ensure that day adds value to the patient's inpatient stay and is GREEN.
- Actions must be recorded at the morning board round including who is responsible, timescale for feedback and outcome and achievement of action reviewed at the afternoon huddle.
- All patients must have an expected date of discharge (EDD) that has been agreed with the patient and family and is a realistic date based on the patient's current condition and requirements for discharge. This should link to the 4question conversation and D2RA pathway recorded in the patients notes on admission.
- Rehabilitation or other treatment from health professionals to reduce deconditioning and maximise optimisation must be provided as required.
- Once patients are clinically optimised, this must be documented, and the patient discharged or transferred as soon as possible. If a patient's discharge or transfer be delayed by more than 48 hours, this needs to be escalated and recorded as a pathway of care delay
- Every patient must be allocated to a D2RA pathway that reflects the ongoing requirements for the patient and will guide discharge planning.
- Patients aged 65 and over must have a clinical frailty score (CFS) on arrival into urgent care and those that are frail must have rapid access to comprehensive geriatric assessment (CGA) and rehabilitation

Suggested measures

- Number of patients discharged in time to be home for lunch (pre midday). Aim for 33%.
- % of patients during each week that are discharged on a weekend.
- % of discharge prescriptions written and pharmacy notified on the day prior to discharge.
- % of patients with a nominated community pharmacy documented.
- % of transport journeys that are booked day before discharge.
- Number of ward moves a patient undertakes.
- Number of ward moves overnight (after 8pm).
- % of repatriations transferred in within 24 hours.
- % of patients transferred out of critical care within four hours.
- Number of patients with a >7 day LOS.
- Number of patients with a >21 day LOS.
- Number of falls.

- % of patients dressed and out of bed by midday.
- % of patients who have a frailty assessment.
- % of patients who have received rehabilitation as required

The development of digital and informatics solutions will allow for the creation of a dashboard where measures can be seen and utilised to encourage good practice.

The development of these standards and measures will include details of what good looks like and what we should be aspiring to for our patients

Next Steps and Implementation plan

It is recognised that health boards are at different levels of maturity in respect to the implementation and embedding of the principles laid out within this guidance.

Over the next six months, the NHS Delivery Unit will work with health and social care colleagues to determine the priorities within each regionor implementation and the scale at which SAFER, Red2Green and D2RA can be embedded. This will be carried out with both virtual and on-site visits and training.

For real change to occur, implementation needs to go at a pace that works for each individual health boards, recognising that there will be variation. Implementation plans will be developed with a focus on cultural change and support to staff, this will ensure we can make permanent improvements for our patients.

Health and social care across Wales is under immense pressure, this guidance aims to standardise and simplify ward processes and discharge, whilst giving support to staff to make the changes required. Longer term, to help with the delivery of this work, support has also been sought from the behavioural science unit at Public Health Wales to ensure as staff are fully supported when incorporating this guidance. Learning will be incorporated into future versions of this guidance to drive continual improvement.

A team of clinical and operational colleagues from the NHS Delivery Unit are working with the clinical and operational Goal 5 leads from each health board and region to ensure bespoke implementation plans are developed, to take into account the specific needs of each ward, hospital, community and social care services. If you would like to speak to the team, please contact Rachel Taylor, Assistant Director NHS Delivery Unit, rachel.taylor8@wales.nhs.uk

Summary

If you had 1,000 days to live, how many of these would you choose to spend in hospital?

This guidance has been developed to support the management of hospital patient flow and effective discharge to:

- Ensure that discharge plans reflect **what matters to me** conversations.
- Ensure that patients get the **right care, in the right place, first time**.
- Reinforce that **Red2Green** directly relates to the Last 1000 Days concept – **patients' time is the most important currency in healthcare**.
- Ensure a culture of not tolerating avoidable delays for patients – every day in hospital is a day away from home and should be a 'green day' for patients helping them return home.
- Mitigate against the fact that the longer older, frail people spend in hospital the greater risk of clinical deconditioning through effective timely provision of rehabilitation and activity during admission.
- Drive proactive acute hospital flow and discharge by **embracing the SAFER, Red2Green and D2RA minimum standards** as 'business as usual' throughout hospital processes.
- Working smartly for the benefit of our patients by being clear on the roles and responsibilities of staff and professional groups relating to flow and discharge.
- Drive good clinical practice improving clinical outcomes and therefore improving patient flow using the standards as a toolkit.
- Achieve the following outcomes:
    - Better quality care to patients, right bed first time;
    - Reduction in avoidable mortality, falls and harm.
    - Decongestion in EDs;
    - Promptly offloading ambulances releasing them back into the community for those emergency patients who need them;
- Ensure that **patients experience less clinical deconditioning** and deterioration so they can be more likely to regain their independence quicker.
- Drive the D2RA approach to ensure **more patients can be assessed in their own environments**.

Thank you and next steps

The NHS Wales Delivery Unit Transformation Team has led on the development of this guidance which has been co-produced by NHS managers and clinicians.

Thank you to all the members of the workshop and expert group in delivering this to enable optimal outcomes and experience for people in hospital.

This guidance has been shared across health and social care in Wales and engagement sessions have been held with clinical and operational teams to ensure principles are well understood and effectively put into practice.

If you have any comments on this guidance document, or would like to be involved in the expert group supporting optimal hospital patient flow, please contact **Rachel Taylor** (Assistant Director of Transformation Goal 5 and SDEC, NHS Wales Delivery Unit) on: SBU.DUTransformation@wales.nhs.uk

Appendix 1

A Healthier Wales (2018) –

A healthier Wales: long term plan for health and social care | GOV.WALES

A Healthier Wales is a long-term plan that encourages health and social care organisations to find new ways of working together, to ensure that people stay healthy and independent for as long as possible.

A Healthier Wales: Our Workforce Strategy for Health and Social Care (2020) –

A healthier Wales (nhs.wales)

This strategy sets out the vision, ambition and approaches that are needed to put wellbeing at the heart of plans for the workforce. It aims to create a compassionate culture, address a number of long-standing challenges, prepare the workforce for future challenges and achieve maximum value from investment in the workforce, for the people we serve and for the health and social care system in Wales

Programme for Government (2021) –

Programme for government: update | GOV.WALES

The programme for government sets out the ambitious commitments they will deliver over the next 5 years. These will tackle the challenges that we face and improve the lives of people across Wales.

National Clinical Framework (2021) –

National clinical framework: a learning health and care system | GOV.WALES

The National Clinical Framework is guidance on how to plan and provide local and national clinical services.