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Performance and Improvement

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Six Goals for Urgent and Emergency Care

Optimal Hospital Patient Flow Framework

Delivering optimal outcomes and experience for people in hospital

Operational guidance bringing together key approaches to support professionals in improving patient flow and delivering timely pathways of care

Updated: October 2025

This guidance is a product of the Six Goals for Urgent and Emergency Care National 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.

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.

Figure 1: Six Goals for Urgent and Emergency Care

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

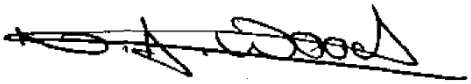
they were admitted.[1] Many also lose confidence and the ability to care for themselves very quickly when they are away from their familiar surroundings. This is why good multi-professional discharge practice is the foundation to the delivery of optimal hospital based care and must begin from the point 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 Care Programme

Richard Bowen
Six Goals for Urgent and Emergency Care 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.

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A Moment for Reflection

Before we move into the operational guidance, this poem offers a reminder of the human impact behind our systems and processes. It reflects the values at the heart of our work, compassion, dignity and the shared responsibility we hold in supporting people through their care journey.

Why am I different today from then,
I laughed, I ran, I built a den,
I'm older okay, but I can still walk the hallway!
94 days in this hospital bed, I could have been at home instead! Let me go home! Oh, let me go home! I miss everything about it, even my garden gnome!

I hear best interest this, unsafe that! When all I want is to be home with my cat.
Safe in hospital? Tell me then, why am I becoming MORE brittle!
Hospital acquired infection? Huff, this place is why I need protection!
I've been sick, I've been ill, I swallowed the pill
If I make no trouble, sit quite don't burst the bubble, then can I go? Or is the answer still no?
IM STUCK, out of luck, sometimes I just want to scream...I'm so stuck
The way is shut, and I'm stuck in a rut.

But, another test, another assessment, oh this builds such resentment!
Have you asked me? The man of 83? Does my age make difference? Or does the system need deliverance? I've lived this way for 20 years, so should I be deprived, because of YOUR fears?

My life, my wishes? At this rate, I'd rather be sleeping with the fishes!
You're taking my power, telling me when I should eat or when I should shower!
I may get confused, but does that mean I lose my right to choose? If it's my life, my choice? Why do I have such a small voice?

Save me from harm, help me, take my arm! Do something, take action. Do something, build traction. Don't apologies, just optimise!
Bring back my Zen because I'm not different from then.

Adam Cook-Young
Clinical Practitioner, CTMUHB.

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.

Due to growing pressures across our hospital system, the occurrence of 'corridor care'—where patients receive treatment in unsuitable locations—has become increasingly visible. This includes care delivered in front-door areas such as Emergency Departments and acute units, as well as within ward corridors. During periods of escalation, this practice becomes more widespread, contributing to poorer patient outcomes, including deconditioning and extended hospital stays. It is therefore critical to ensure effective patient flow throughout the hospital to eliminate corridor care and enhance overall patient outcomes

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.

The Six Goals Programme, 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, R2G and D2RA has been in place since 2018, it is evident that these principles are not yet fully embedded into routine ward practice. As a result, patients are experiencing prolonged hospital stays and are at increased risk of deconditioning.

To ensure these principles remain relevant, they were refined and collated into version one of this document in 2022, ensuring they reflected the changes needed to the way we work. **This document superseded all previous SAFER, R2G and D2RA guidance.**

The guidance identifies the principles 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.

Teams are not expected to re develop processes but rather to concentrate on embedding those elements of the guidance that are not yet part of routine care. The greatest impact will be achieved through the consistent implementation of all the Optimal Hospital Patient Flow Framework (OHFF) principles outlined. For areas where these principles are not yet embedded, it is recommended that teams begin with D2RA and progressively work towards integrating each component.

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. In line with this, the guidance has been endorsed by senior clinicians within Welsh Government, who are also committed to supporting its implementation.

This endorsement reflects the broad spectrum of professionals who are involved in delivering care, assessment and treatment and highlights the importance of understanding and answering the **four key 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, R2G and D2RA must be embedded as standard practice wherever patients require inpatient admission. These principles support a proactive approach to hospital flow and discharge, integrating the OHFF principles into routine operations. They promote collaborative working, emphasising that hospital flow everyone's responsibility, and encourage a 'Home First' approach to avoid unnecessary or prolonged care or assessments within hospital settings.

SAFER approach to board rounds.

The SAFER approach supports timely, person-centred care by promoting planning and discharge. The aim is to ensure patients move through the hospital system efficiently, receiving the right care in the right place, at the right time, first time.

S - SEEN

- Ensure that all patients are seen before midday, ideally before 10am.
- Ensure there are clear staff actions and accountability with a timeframe.

A- AIM

Ensure that discharge plans reflect the four 'What matters to me 'questions:

- What do you think is wrong with me?
- What is going to happen to me today?
- What is needed to get me home and is there anything I can do to help?
- When can I go home?

F - FLOW

- Ensure that patients get the right care, in the right place, first time.
- Admission avoidance where safe to do so.

E - EARLY DISCHARGE

Discharge planning from the point of admission and daily review of discharges.

- Prioritisation of patients being discharged today to ensure they are home for lunch/asap.

R - RECOVERY

- Open discussion with the patient on their recovery goals and what matter to me questions.
- Prioritise the flow of patients.
- Plan ahead.
- Every hour counts, every bed counts

Discharge planning must begin at the point of admission.

Think 'Home First' - keep the individual at the centre of all discharge planning and prioritise discharge to home.

D2RA – Allocated within 1 day of an admission:

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

- 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 with the patient and their family and carers.
- All patients should be allocated to a D2RA pathway. This pathway should be reviewed daily and updated as required to enable timely discharge planning.
- A plan should be in place to prevent deconditioning and prioritise availability of take-home medicines at discharge.
- During a patient's hospital stay a proportionate assessment of their current needs should be undertaken to support the person to move to the next stage in their care journey – always aim for home in line with D2RA

Red to Green (R2G) - Ward based care

Every day a person is in a hospital bed should **add value to their care and actively progress them towards discharge**.

The R2G approach aims to reduce a patient's length of stay by identifying 'non-value' adding days and reducing avoidable delays, such as waiting for investigations, treatments or discharge arrangements.

This approach should be consistently applied across all ward environments in hospitals throughout Wales.

Escalation of Delays

Delays that result in patients remaining in a hospital bed without adding value must be pro-actively managed. Where possible, teams should work to resolve the underlying issues causing the delay.

For delays that cannot be resolved, it is recommended that each ward works to:

- Identify and record delay/s in their digital inpatient system
- Attempt resolutions at local level
- Escalate unresolved delays through a clear escalation pathway.

All staff should support patients by answering the **four 'What matters to me' questions** each day. This ensures the patients are well-informed about their care and that staff have a shared understanding of the plan for each patient, every day.

Failure to provide clear answers to any of these questions can result in unnecessary delays, leading to more Red Days spent in hospital beds without value.

Staff should not wait for patients to ask these questions. Instead, they must take the initiative to offer clear, timely information that support person-centred care and promotes safe, effective discharge planning.

Additional resource on Red2Green are available.[3]

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

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.

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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 residence (including Care Home)
- Restart Package of Care (POC) with no changes
- Has pre-existing community services in place

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.

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RED TO GREEN

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

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)

Deconditioning start within hours – prevention is everyone's business

Deconditioning can affect anyone, irrespective of their age. When a person stops moving their body begins to lose its ability to function effectively. This can impact:

- ✓ Functional mobility
- ✓ Cognitive function
- ✓ Bladder and bowel control

For frail older patients, the onset can be more rapid, more severe and in some cases irreversible. Early mobilisation, proactive care planning and a multidisciplinary approach are essential to prevent avoidable harm and promote recovery. [4]

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]

A muscle at complete rest loses 5% muscle strength every day.[5]

Deconditioning Early Warning Indicator (DEWI)

The development of a Clinical Assessment Tool to Identify and Monitor Hospital Acquired Deconditioning (HAD)

Funded by the Six Goals Programme and the Value Transformation Team, and led by CEDAR, a systematic literature review was conducted which identified gaps in available tools to identify HAD. The review highlighted significant gaps in current assessment methods. To address this, a comprehensive stakeholder engagement process was conducted, including:

- A nationwide survey
- Focus groups with clinical and operational staff
- Interview with service users, family members and carers with lived experience of HAD

[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. Link to BGS - Deconditioning Syndrome
[5] (PDF) The Effect of Bed Rest on Older People

Based on these insights, a short Clinical Assessment Tool (CAT) was developed through an iterative test and change process. The tool went through two rounds of testing in two Welsh health boards, followed by staff feedback to inform updates.

The CAT will be implemented across all hospitals in Wales and made available nationally. It comprises of 11 domains designed to enhance the detection of HAD in hospital inpatients, with the aim of improving patient outcomes through timely intervention and prevention and can be found in **Appendix 2.**

PJ Paralysis

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 falls. Put simply, you are at your best when you are up and dressed[6].

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

Staff should ensure patients, carers and families are made aware of the risk of deconditioning and are provided with clear advice on how they can help maintain function and independence during the hospital stay.

Ongoing Risk Assessment

Deconditioning risk should be assessed continuously by all staff interacting with the patient, with a focus on the following domains:

- Cognition / Delirium (such as the 4AT score)
- Continence
- Hydration
- Nutrition – Appetite
- Nutrition – Ability to eat
- Mobility
- Pain on mobilisations / movement
- Daily activities (refer to 'Typical Day'
- Sleep
- Feeling bothered by emotions
- Social engagement

Further information on the DEWI tool can be found in **Appendix 2**

[6] #EndPJparalysis - End PJ Paralysis

Taking Action

Following assessment, timely action must be taken to minimise identified risks. This may include embedding the following into the patients care plan:

- Promote mobility and encourage self-care, including eating away from bedside and toileting independently.
- Clearly explain the risks and potential impact of deconditioning on future independence and discharge planning.
- Involve family members by requesting personal clothing and items that support normal routines.
- Provide active rehabilitation where clinically indicated.
- Encourage cognitive stimulation through meaningful interaction and activities

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?

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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)

All Wales Hospital Discharge Guidance

The all-Wales hospital discharge guidance Jan 2025[7], sets out guidance on hospital discharge standards for health, social care, third and independent sector partners in Wales. These standards support safe, timely and efficient discharge of patients either to their own home or on to the next stages of care. The principles and processes that help support safe, timely and effective discharge are set out in the D2RA pathways. D2RA pathways must be used to support the discharge of patients once they are clinically optimised, using a Home First approach.

A proportionate assessment of the patients' current needs should be undertaken to support discharge in all but the most complex of patients, where a comprehensive assessment may be required. Always aim for home first, using the discharge to assess principle in line with D2RA. This is - once home, and following a period of recovery, a more comprehensive assessment can be undertaken for any ongoing care needs.

Further pieces of guidance that are available to support this guidance are:

- Trusted Assessor guidance.[8]
- The Management of Reluctant Discharge / Transfer of Care to a More Appropriate Care Setting Guidance

Criteria Led Discharge (CLD) arrangements

Additionally, to support Hospital discharge and flow all Health Boards should develop efficient discharge processes, including Criteria led Discharge arrangements.

Criteria-Led Discharge (CLD) is a structured process that enables designated nursing or allied health professionals to discharge patients once pre-defined, consultant-approved clinical criteria have been met. These criteria are agreed and documented early in the patient's admission and typically include clinical parameters, functional status, required investigations, medication plans, and arrangements for follow-up or community support. When all criteria are satisfied, the patient can be discharged without the need to wait for a routine medical review.

The purpose of CLD is to support safe, timely, and consistent discharge. By ensuring that discharge criteria are established in advance and understood by the multidisciplinary team, delays related to clinician availability are reduced. This promotes

[7] Hospital discharge guidance: January 2025
[8] performanceandimprovement.nhs.wales/functions/six-goals-uec/goal-6/goal-6-resources/trusted-assessor-role-guidance-pdf/
performanceandimprovement.nhs.wales/functions/six-goals-uec/goal-6/goal-6-resources/the-management-of-reluctant-discharge-transfer-of-care-to-a-more-appropriate-care-setting-guidance-pdf/

smoother patient flow, optimises bed utilisation, and helps avoid unnecessary length of stay.

Key benefits of CLD include improved patient experience through earlier and more predictable discharge, enhanced ward efficiency by enabling discharges throughout the day, and reduced bottlenecks associated with traditional discharge processes. CLD also supports professional development by enabling nurses and allied health professionals to undertake extended responsibilities within a clearly defined and clinically safe framework.

Smart Operational Management

Operational teams within hospitals play a critical role in supporting optimal patient flow and ensuring the principle of 'right bed, first time'

An expert operational management learning group has emphasised the importance of whole-system education and training for operational managers working in highly complex roles across equally complex healthcare environments. These leaders must be equipped with the most current and relevant improvement methodologies and flow science to effectively support them in their roles.

Ensuring patients are transferred to the most appropriate ward, at the right time reduces the length of stay and supports the principles of ensuring every day in hospital should add value to the patient.

Operational teams and ward colleagues should work collaboratively, using **board rounds** to:

- Identify and act on constraints to patient flow
- Take ownership of actions
- Provide timely feedback to teams
- Ensure all patients experience 'green' days (days that add value)

Bed Allocation Decision-Making

Bed allocation decisions must consider the full range of patients requiring transfer, including:

- Emergency department and assessment unit patient awaiting admission
- Patient ready to step down from critical care
- Repatriations from other health boards

- Tertiary referrals awaiting admission
- Direct admissions from outpatient departments or speciality clinics

System pressures should not dictate bed allocation decisions. Instead, decisions must be based on clinical priority and patient need, ensuring safe, timely, and per-centred care.

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.

Some measures are already mandated and will need to be reported monthly through all-Wales monitoring and assurance processes. Other measures will be obtained through National delivery groups.

Once agreed, the standards and measures 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 – Patient delays and total days delayed.
- D2RA Measures:
  -Total people allocated to a D2RA pathway and no pathway allocated within 1 day of admission.
  -Total people clinically optimised and allocated a D2RA pathway and no pathway allocated.
  -Total people discharged to each D2RA pathway 0,1,2,3, and no pathway allocated.
  -Median length of stay for each pathway and no pathway allocated.

Suggested standards and measures

The following standards and measures are recommended for use by health boards and partners to inform local learning about how successful teams are in delivering timely discharge pathways 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. Promptly offloading ambulances (maximum of 45 mins, aim for less than 15 minutes releasing them back into the community for those emergency patients who need them; and
iii. Reduction in avoidable mortality, and harm
iv. 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 board rounds must include all members of the multi-disciplinary team and 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 accountable, 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 4-question conversation and D2RA pathway recorded in the patients notes
- Rehabilitation or other treatment from health professionals to reduce deconditioning and maximise optimisation must be provided as required.
- Once patients are clinically optimised for discharge or clinically stable for transfer, this must be documented, and the patient discharged or transferred as soon as possible. If a patient's discharge or transfer is 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

- Total number of patient daily discharges
- Total number of patients discharged in time to be home for lunch (pre midday). Aim for 33%
- Total number of patients with a green day status
- Total number of patients with a red day status
- Total number of patients with a red day status and a red constraint code
- If red status, and a constraint code/s, the total number of patients against each of the 58 assigned red constraint codes.
- Total number of patients with a red day status and no red constraint code
- Total number of patients with a <3-day length of stay
- Total number of patients with a >7-day length of stay
- Total number of patients with a >21-day length of stay.
- Total pathway of care delays and days delayed. Aim to reduce total patient delays and days delayed.
- Number of occasions a patient changes the status of clinically optimised i.e. the number of times a patient is clinically optimised, then not clinically optimised in one hospital stay.
- Percentage of patient a Clinical Frailty Score (CFS >6).
- Number of ward moves a patient undertakes
- Number of wards moves overnight (after 8pm)
- % of repatriations transferred within 24 hours
- % of patients transferred out of critical care within 4 hours

Digital records are part of a patient's care. 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.

The Six Goals team will continue to work with Health Boards and Trusts to implement this framework into everyday practice.

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. Further information to support implementation of the framework can be found in **Appendix 3.**

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.

Summary

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 **R2G** directly relates to the Last1000days 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.

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

- Drive proactive acute hospital flow and discharge by **embracing the SAFER, R2G 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, and harm.
    - Decongestion in EDs;
    - Promptly offloading ambulances (maximum of 45mins) releasing them back into the community for those emergency patients who need them;
    - Reduce hospital discharge delays, both the total number of delays and the days delayed.
- Ensure that **patients experience less hospital acquired 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**.

Appendix 1

Supporting Information

Six Goals UEC - NHS Wales Performance and Improvement -

The Six Goals, co-designed by clinical and professional leads, span the urgent and emergency care pathway and reflect the priorities in the Programme for Government 2021–2026 to provide effective, high quality and sustainable healthcare as close to home as possible, and to improve service access and integration.

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.

Appendix 2

Deconditioning Early Warning Indicator (DEWI)

DEWI Deconditioning Early Warning Indicator

Hospital-Acquired Deconditioning Tool
Clinical reporting tool based on discussions with patients &/ family members/ caregivers

[place patient sticker here]

Consistently refer to 'On Arrival' (on admission to hospital) and the best assessment since arrival		Usual Level	On Arrival	Assessment frequency (insert intervals below)						Sheet No.
				_ days	_ days	_ days	_ days	_ days	_ days	
Assess 'Usual level' as 2 weeks prior to admission	**Date**									
	Initials									
Cognition/ Delirium (such as the 4AT score)	Full function (4AT 0)									0
	A little 'muddled'/disoriented (4AT 1-3)									1
	Visibly confused/fluctuating confusion (4AT 4-7)									3
	Very confused/very drowsy/very agitated (4AT 8-12)									5
Continence	Toileting independently									0
	Needs assistance to toilet/at bedside									1
	Single incontinent									3
	Double incontinent									5
Hydration	Drinking well without support									0
	Needs prompting to maintain hydration									1
	Requires support or assistance									3
	Unable to maintain sufficient intake without significant input from staff/caregiver									5
Nutrition - Appetite	Appetite is normal									0
	Less appetite than normal									1
	Poor appetite									3
	Little or no appetite									5
Nutrition - Ability to eat	Food being consumed as normal									0
	Encouragement/assistance required to eat									1
	Trouble eating or swallowing									3
	Not eating at all									5
Mobility	Walking confidently/requires aid to do so									0
	Cannot walk for more than a few metres									1
	Needs assistance to stand									3
	Uses wheelchair at all times/bedbound									5
Pain on mobilisation/ movement	No pain, even when mobilising/moving									0
	No pain at rest but some pain on mobilising/moving									1
	Moderate pain that is affecting mobility/movement									3
	In extreme pain at rest									5
Daily activities (refer to 'Typical Day')	Able to manage independently									0
	Might need some help									1
	Will need more help/assistance in place									3
	Fully dependent on help/assistance									5
Sleep	Undisturbed sleep									0
	Some sleep disturbed									1
	Most/all sleep disturbed									3
	Not sleeping at all									5
Feeling bothered by emotions	Not at all									0
	Slightly									1
	Quite a bit									3
	Extremely									5
Social engagement	Happy to engage									0
	Needs some prompting to engage									1
	Will only engage with trusted individuals									3
	Will not engage									5

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* Escalate to MDT if there have been changes in 1 or more levels across 2 or more domains

Deconditioning Early Warning Indicator (DEWI) tool to assess changes in patient condition

– Clinical reporting tool based on discussions with patients &/ family members/ caregivers

Language used : _____ Communication requirements: _____

Sensory, sleep, or mobility aids required: _____

Patient sticker here, or Health Board: _____

Patient Name: _____

Date of birth: _____/_____/_____

NHS number: _____

Typical Day	Washing	Dressing	Cooking	Walking	Using Stairs	Shopping
Independent						
Assisted						
Dependent						

Any additional information: _____

_____

_____

Information on the domains of Hospital-Acquired Deconditioning

Cognition/ Delirium	Patient's cognition level (the 4AT tool final score may be used here), ability to pay attention to the conversation
Continence	Patient's continence status and any aid required
Hydration	Patient's hydration levels and any aid required
Nutrition – Appetite & Ability to eat	Patient's appetite, ability to eat, and any aid required
Mobility	Patient's abilities to mobilise and any aid required
Pain on mobilisation/movement	Patient's pain when they are mobilising/moving, focus on any pain management needs
Daily activities	Using above 'Typical Day' activities as prompts, patient's ability to complete these tasks
Sleep	Patient's sleeping habits and any aid required
Feeling bothered by emotions	How much has the patient been bothered by emotional problems i.e. feeling anxious, depressed, irritable or sad?
Social engagement	Patient's desire to engage socially, or their engagement during assessments

Action when there has been a deterioration of one or more levels in two domains or more:

- Refer to relevant domain-specific assessments whenever changes are identified,
- **AND** ask patient &/ family members if they have noticed changes wherever possible,
- **AND** escalate to the MDT, e.g. on the board round, and make plans to address: either continue to monitor, or treat the patient

Implementing & Scoring

- On admission, fill out the **On Arrival** level & ask about the patient's **Usual Level** (**2 weeks** prior to admission to hospital), involve family members and/or caregiver input if possible
- Mark the score with a dot in each box and link to previous score with a line to indicate deterioration/improvement/no change compared to last assessment
- Maintain focus on individual domain changes over time, and note if there are multiple changes across the tool in a single assessment – refer to action box
- After the first week of stay, review the frequency of assessments needed for the patient (2-3 times a week is suggested, but allow no longer than 1 week between assessments) – assessments **must** be made when the patient is clinically optimised, and again on discharge

Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng
Six Goals for Urgent and Emergency Care
GIG CYMRU NHS WALES Perfformiad a Gwella Performance and Improvement
GIG CYMRU NHS WALES Trawsnewid Gwerth Value Transformation
Canolfan ar gyfer Gwerthuso, Asesu Dyfeisiau ac Ymchwil Gofal Iechyd CEDAR Centre for Healthcare Evaluation, Device Assessment and Research

Appendix 3

Optimal Hospital Flow Framework Implementation Checklist:

Governance & Leadership	
Ensure organisational alignment to the standards and principles in the Optimal Hospital Flow Framework and embed a whole-system “Home First” culture	
Develop local implementation plans to embed framework as business-as-usual.	
Ensure senior clinical endorsement and cross-system engagement.	
Train operational leaders in flow science and improvement methodologies.	
Consider all patient cohorts awaiting transfer (ED, critical care, repatriations, etc.).	
Base bed allocation on clinical priority, not system pressure.	
Implement digital dashboards to support performance oversight.	
Embed SAFER as Routine Ward Practice	
Ensure all patients are seen before midday with clear staff actions and accountability.	
Conduct a full “What matters to me” conversation on admission with a daily review.	
Allocate a D2RA pathway within 1 day and review daily	
Prioritise early discharge and discuss recovery goals clearly with patients - *Agree and record an Estimated Date of Discharge (EDD) with patient/family.*	
Implement Red2Green Daily	
Use board rounds to identify constraints, take ownership, and ensure green days.	
Ensure each inpatient day adds value towards discharge.	
Identify, record, and resolve delays; escalate unresolved delays promptly.	
Ensure staff proactively answer the four “What matters to me” questions daily.	

Preventing Deconditioning	
Embed proactive deconditioning prevention across all inpatient areas.	
Provide clear advice to patients and families on activity, dressing, and mobility.	
Continuously assess using key domains such as cognition, mobility, continence, and nutrition.	
Implementation of the NHS Wales Deconditioning Early Warning Indicator (DEWI) tool and take timely action to mitigate risks.	
Deliver Safe, Timely Discharge Using D2RA	
Ensure consistent application of All-Wales Hospital Discharge Guidance.	
Use proportionate assessments for most patients, reserving CGA for complex needs.	
Ensure consistent application Trusted Assessor guidance (where applicable)	
Monitor mandated measures including LOS >21 days, pathway delays, and D2RA performance.	
Track local measures such as EDD compliance, delivery of rehabilitation, and delays >48 hours	
Implement Criteria-Led Discharge (CLD)	
Develop CLD processes and document consultant-approved criteria early in admission.	
Enable nurses/AHPs to discharge once criteria met without routine medical review.	

Thank you

The Six Goals national team led the development of the original published guidance which was co-produced in collaboration with NHS managers and clinicians listed below. In September 2025, the guidance was updated to reflect best practice and ensure alignment with current system priorities.

Thank you to all the members of the original workshops and expert group who helped to develop this framework.

This updated guidance has been re-shared across health and social care in Wales.

If you have any comments on this updated guidance document, please contact email : **ABB.SixGoalsUEC@wales.nhs.uk**