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Prif Weithredwr GIG Cymru
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Director General Health and Social Services/
NHS Wales Chief Executive
Health and Social Services Group

Llywodraeth Cymru
Welsh Government

Local Health Board - Chief Executives
Medical Directors
Nursing Directors
Directors of Therapy
Directors of Planning
Chief Operating Officers

Local Authority - Directors of Social Services

28th February 2018

Dear colleagues,

SAFER Patient Flow Guidance

We are writing to announce the publication of the *SAFER Patient Flow Guidance* document. This is the first in a series of quick guides that will act as key enablers for an overarching good practice guide on *Improving Patient Flow*, to be published shortly.

The *Improving Patient Flow* guide identifies ten areas of focus to support flow across the unscheduled care patient pathway and SAFER fits into one of these ten areas, relating to transfers of care.

SAFER consists of five elements of best practice, summarised as:

S – Senior review of all patients before midday, informed by a multi-disciplinary assessment.
A – All patients, and their families involved in the setting of an Expected Discharge Date.
F – Flow of patients at the earliest opportunity from assessment units to inpatient wards.
E – Early discharge, with at least a third of patients discharged from inpatient wards by midday on their day of discharge.
R – Review involving multi-disciplinary team, patients and their families for those with extended lengths of stay.

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This work is informed by the NHS Wales Delivery Unit reviews of discharge practices undertaken in recent years. These reviews highlighted significant opportunities to improve practices when it comes to enabling people to return home (or as close to home as possible) from a hospital bed, through: improved inpatient discharge processes; delivering more care closer to home; and implementing a 'Home First'/Discharge to Recover and Assess models.

We know there is an appetite for such guidance amongst practitioners and that elements of SAFER are already being used, to some extent, in a small number of sites in Wales. SAFER's non-prescriptive approach allows local teams to work together to adapt and deliver the five elements in a way that is tailored to local circumstances. The intention is for this document, and the overarching good practice guide, to build on ongoing local work and pockets of existing good practice and provide a launch pad to develop a shared sense of purpose, with everyone pulling together to make these principles common practice across the piece.

Successful implementation is contingent on the principles being followed consistently each day, every day to ensure there is a positive, cumulative effect on improving patient flow. Strong clinical leadership is also essential. Where these principles have been implemented effectively, by well-led teams and communicated clearly to staff enabling them to fully understand all elements, health and care systems have seen real benefits to both patient outcomes and staff satisfaction.

The recent *Parliamentary Review of Health and Social Care in Wales* reiterates the need for a whole system approach and integration across health and social services. We also know a range of agencies including health, social services, housing, wider statutory and third sector organisations all play increasingly important parts in people's lives. The outcomes set out in SAFER cannot be delivered by practitioners working in isolation. The best outcomes are delivered when these organisations work in partnership and offer an integrated approach in the wider context of what health and social care can do together.

As part of the National Programme for Unscheduled Care's whole system focus on flow, the Delivery Unit has been commissioned to undertake a review of complex discharge management in Wales. This review aims to identify and support opportunities to improve the timeliness, quality of transfer and the experience of patients with complex discharge needs, based on an evidence base and shared learning.

Part of this work will also include observation of the implementation of the SAFER Patient Flow Guidance, in order to identify existing good practice and any practical challenges that may be needed to support this. The Delivery Unit team will contact Chief Operating Officers and Directors of Social Services directly in the next few weeks. A copy of the DU proposal in relation to this work is attached for information.

We would ask that you disseminate the *SAFER Patient Flow Guidance* document across relevant teams and consider how this good practice can be fully embedded and integrated across all parts of the system. A copy of the document can be found at the link: http://howis.wales.nhs.uk/sitesplus/407/page/36206

Yours sincerely

Dr Andrew Goodall
Chief Executive, NHS Wales

Albert Heaney
Director of Social Services & Integration

Professor Jean White CBE
Chief Nursing Officer

Dr Frank Atherton
Chief Medical Officer