Ward 25 PW0 Discharges

Theme | Capacity and Flow

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SaTH Improvement Hub

The Shrewsbury and Telford Hospital NHS Trust

REASON WHY?

Ward 25 opened on 22nd December 2025 with an initial 18 bed footprint followed by an additional 18 beds opening 29th December 2025. The ward forms part of the General Internal Medicine pathway and was designed to support de-escalation of the emergency department by delivering a high-functioning rapid turnout unit.

SMART AIM

S SPECIFIC | M MEASUREABLE | A ACHIEVABLE | R RELEVANT | T TIME-BOUND

Sustain the following for a period of 90 days from ward opening 22nd December 2025 –
LOS: 72 hours post acute intervention
Pre 12:00 discharges: 35%
Pre 17:00 discharges: 80%
PW0 discharges: 75%

PLAN

Two Quality Management System (QMS) workshops were held - one with consultants and nursing leaders, and one with the wider nursing team. Across both sessions, the focus was to establish a clear and shared understanding of:

- Ward culture and what "success" looks like for a rapid turnover unit.
- Shared aims for Ward 25 and how teams will work collectively towards them.
- Standard work and an agreed rhythm of the day, including behaviours, expectations, and escalation routes.
- Criteria for operating as a rapid turnover ward, including patient selection and clinical pathways.

These sessions resulted in co-produced standards, a defined daily cadence, and a collective understanding of how Ward 25 should function to optimise patient flow.

DO

Ward 25 has now been open for 7 weeks. Early signs show promising progress as well as challenges.

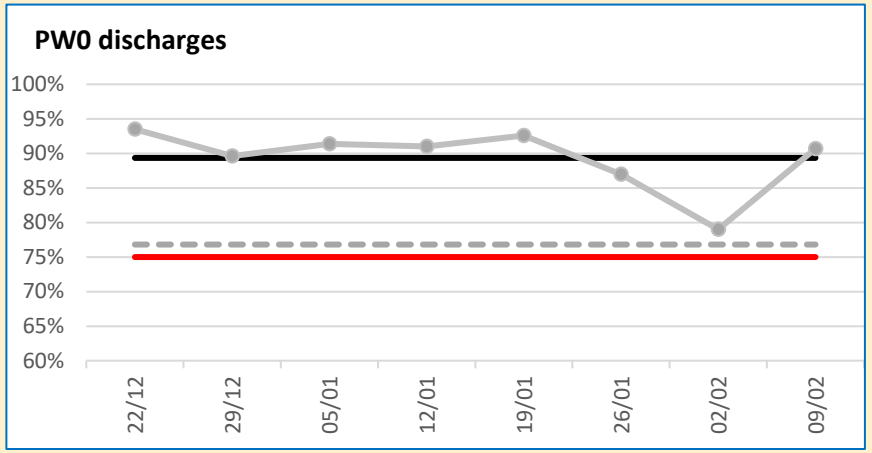
To keep within the agreed metric, ward 25 has a criteria which excludes patients requiring a rehabilitation or new care home placement on discharge, as well as larger care packages.

The ward also has no therapy provision which has supported and empowered nursing staff to mobilise patients on admission. Therapy referrals are being made only when required and necessary, these are then bleeped through to the ward cover therapist. Therapy referrals are challenged on admission to the ward from AMU, and a high number are being removed. Medics are challenged by nurse in charge (NIC/WM) as to why they need therapy and this supporting educated decisions.

Discharge on admission is being discussed by the medical team, patients and their families are being involved in what discharge looks like.

Referrals for smaller, localised POC (care packages) are being referred into the CTH (care transfer hub) at early stages of the patient journey – resulting in the TOC (transfer of care) being completed prior to the patients being declared medically optimised for discharge.

STUDY



There was a 2-week decline in the data due to the switch from a pull to push model resulting in patients outside of the criteria being admitted/transferred to the ward. There was an increase in patients needing larger social care packages and an increase in those outside of local areas. There was also 2 end of life patients WC: 26th who required social placements on discharge. The data has since recovered due to refinement of the SOP, and extending the criteria to localised, smaller packages of care plus patients who have therapy agreed exit plans before admission to ward 25.

ACT

Criteria and SOP has been re-distributed with wider stakeholders and laminated and printed for ward staff.

NIC are being empowered to follow SOP and criteria when accepting handovers.

Therapy referrals are continuing to be challenged and removed when required.

Nursing staff are being empowered to mobilise patients from admission to avoid deconditioning leading to prolonged hospital stays and pathway discharges.

ACKNOWLEDGEMENTS & REFERENCES | Suresh, Sana, Mona, Richel, Siji, Chinelo, Jey, Johnson, Michael, Elizabeth, Stacy, Michelle, CSS