Transforming Together

NHS Greater Glasgow and Clyde

Hackathon 2

Engagement Record

Hackathon 2 was held: **17th June 2025**

East Dunbartonshire Health & Social Care Partnership

EAST RENFREWSHIRE HEALTH AND SOCIAL CARE PARTNERSHIP

Glasgow City HSCP Health and Social Care Partnership

INVERCLYDE HSCP Health and Social Care Partnership

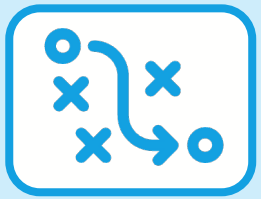
Renfrewshire Health & Social Care Partnership

West Dunbartonshire Health & Social Care Partnership

Contents

Hackathon 2 - Write-up and results

Appendix:



“Hackathon”
A collaborative, output focussed workshop

1. Schedule

Hackathon 25

Transforming Together

Hackathon 1

Mar 2025

Established overarching strategic vision with early exploration of four clinical themes

Hackathon 2

17th Jun 2025

Focussed on design and development of new care pathways

Hackathon 3

24th Sep 2025

Focus on HSCPs, Primary Care, Community Services

2. Clinical areas

Clinical areas explored in Hackathon 1

- Frailty
- Respiratory
- Cardiology
- OPAT

Clinical areas explored in Hackathon 2

- Frailty
- Respiratory
- Cardiology
- OPAT
- Mental Health
- Paediatrics & Neonatology
- Surgical Specialties
- Emergency Medicine & RAaC

3. Context setting

190
Attendees
Including support staff

x8
Specialist clinical areas covered

4/5
High Average Attendee Score

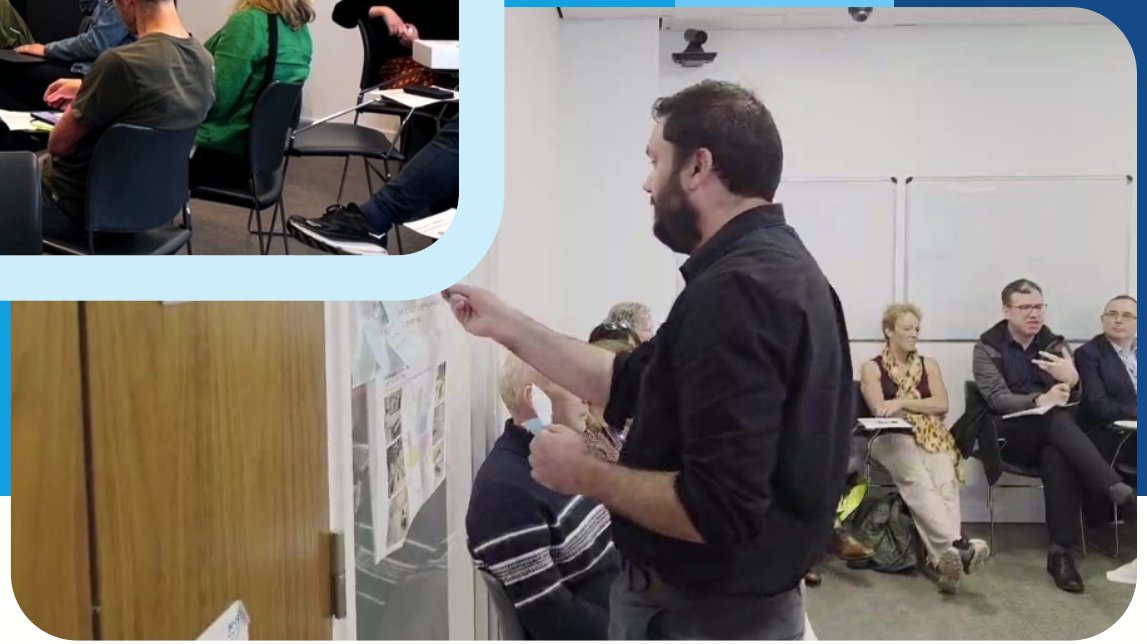
x22
Resulting Pathways

Pre & Post Surveys

doccla
Representation & Demos


3
Shift the Balance of Care
Taking a whole system approach, we will shift the balance of care between acute services & our communities
4
Improve Population Health
Working with people to prevent illness and more proactively meet people's needs we will support proactive prevention.


Part 3: Feedback, close & next steps
12:20
12:50



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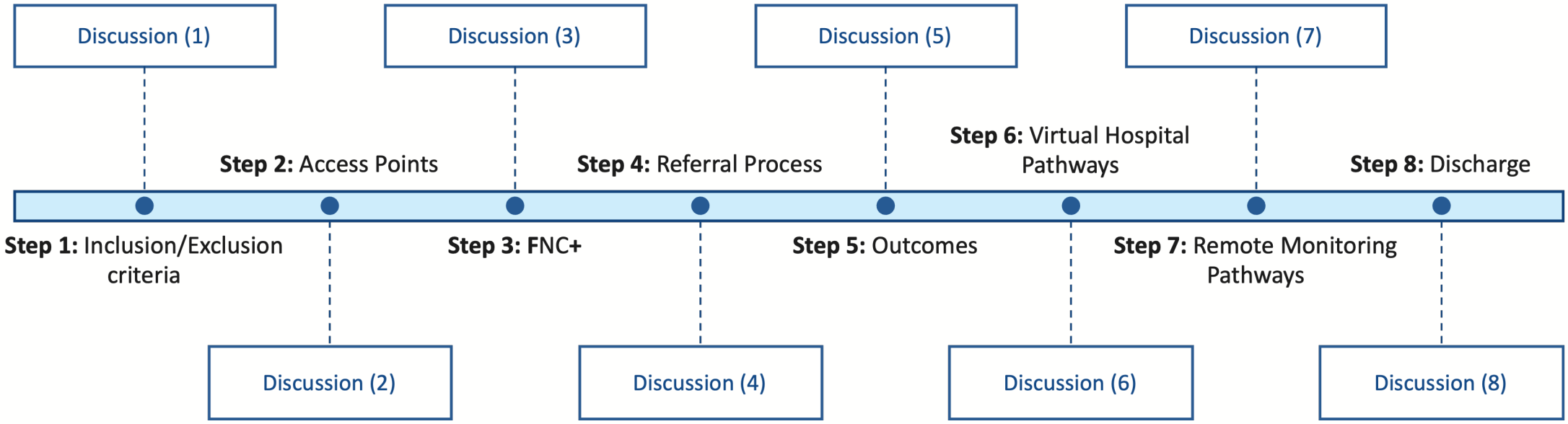
4. Pathway design & development

4. Pathway design & development

Hackathon 2 Output = Pathway development

Below are consistent considerations used at Hackathon 2 to help guide Pathway development:



22 Pathways emerged from Hackathon 2, each being at different stages of development, and working through to governance approval.

Resulting Pathways

Pathway outputs as a result of Hackathon 2

Clinical area	Pathways
Frailty	• Proactive; frailty monitoring • Frailty Assessment/>75 years ED attendance, refer to FNC+ • Care Home
Respiratory	COPD and other chronic respiratory conditions (e.g. Bronchiectasis, Asthma, Interstitial Lung Disease) with lower acuity exacerbations and acute respiratory infections or other acute presentations on case-case basis
Cardiology	• Atrial fibrillation • Heart Failure
OPAT	• Cellulitis • Pyelonephritis • Low risk febrile neutropenia • Selected drug toxicity monitoring
General Surgery	• Remote Monitoring exploration with Doccla
Mental Health	• Clozapine initiation/re-titration • Support patients awaiting NDD assessment and potential expansion to CAMHS
Paediatrics	• Acute respiratory conditions • Cardiac Remote Home Monitoring • Jaundice

5. Hackathon 2 Break-out results

- Executive Summary of results
- Summary of results by clinical break-out cohort (x8)

5. Executive Summary of results

Cross-cutting themes

1

Redirection Requires Trust and Visibility

Redirection as part of the new pathway development has wide support, but should be underpinned by senior decision-making, clear clinical criteria, and visible data on outcomes to build confidence and ensure safety.

2

FNC+ as a Central, Coordinated Engine

Flow Navigation Centre Plus is consistently envisioned as the operational and clinical hub for triage, coordination, escalation, and virtual care — but its success depends on integrated staffing, governance, and 24/7 capability.

3

Digital Tools Enable — But Don't Replace Care

Remote monitoring, virtual consultations, and platforms like Doccla are enabling care at home, but their effectiveness hinges on system interoperability, patient suitability, and thoughtful human oversight.

4

Standardise Pathways, Localise Flexibility

There is a universal call to reduce variation across sites and services by standardising referral pathways, diagnostics, and monitoring — while retaining enough flexibility to reflect local context and needs.

5

Realistic Medicine and Shared Decisions Matter

Across all clinical areas, participants highlighted the need for early conversations, advance care planning, and realistic expectations — with families and carers actively involved in decision-making.

6

Workforce Design is Make-or-Break

New models rely heavily on the right mix of staff: senior clinicians, rotational roles, specialist input, and protected time for virtual care — all of which require sustained investment, not redistribution alone.

5. Clinical areas covered at Hackathon 2

By Clinical break-out cohort:

- 5.1 Frailty
- 5.2 Respiratory
- 5.3 Cardiology
- 5.4 OPAT
- 5.5 Mental Health
- 5.6 Paediatrics & Neonatology
- 5.7 Surgical Specialties
- 5.8 Emergency Medicine & RAaC

5.1 Frailty

View full summary

Pathway development engagement: Key topics

#	Theme	Description	Weighting *(mentions / emphasis)*
1	**Role of FNC+**	FNC+ positioned as central coordinator for triage, referral, and virtual assessment; supports 24/7 coverage and care navigation	High
2	**Suitability of Virtual Models**	Strong support for virtual hospital and monitoring pathways for patients with low-to-moderate frailty, especially care home residents	High
3	**Inclusion/Exclusion Clarity**	Falls, heart failure, decline, infections and delirium seen as suitable; stroke, fractures, GI bleeds excluded	High
4	**Referral & Admission Pathways**	Call for pathway consolidation and stronger coordination, including use of ACPs and family engagement	High
5	**Workforce & Resourcing**	Highlighted need for rotational roles, protected time, geriatrician access, and job planning aligned with virtual service delivery	Medium
6	**Community Integration**	Cross-HSCP consistency, shared language, better community interfaces, and more coherent out-of-hours coverage were seen as key	Medium
7	**Consultant Connect & Digital Tools**	Improved use and functionality of Consultant Connect, proactive care platforms, and tools like Doccla supported, especially in care homes	Medium
8	**Realistic Medicine & Family Role**	Importance of shared decision-making, consent, and family reassurance via monitoring noted throughout	Medium

5.1 Frailty

View full summary

Pathway development engagement: Key observations

- **FNC+ as Core Coordinator:** The service should act as a single point of triage and coordination, with virtual consultations, MDT involvement, and the ability to own the care plan 24/7.
- **Care Homes Are an Ideal Fit:** Patients in care homes benefit from remote monitoring and pathway integration — especially in areas with variable local provision.
- **Structured Pathways Needed:** Current admission routes are fragmented; the group called for referral clarity, escalation criteria, and links to step-up/step-down services like H@H.
- **Digital & Remote Tools Enable Confidence:** Doccla, virtual consultations, and proactive frailty tracking tools were seen as important enablers for family reassurance and early detection.
- **Resourcing Gaps Persist:** Rotational clinical roles, consultant availability, and proper planning (e.g. National geriatrician on-call rotas) are needed to make these models sustainable.

QUOTE OF NOTE

"Patients identified as failing at home by carers, GP's etc. could be referred via FNC+ for discussion at MDT, to help prevent further deterioration and hospital admissions."

Recorded during discussion about the role of FNC+ for Frailty.

5.2 Respiratory

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Pathway development engagement: Key topics

#	Theme	Description	Weighting *(mentions / emphasis)*
1	**Access & Referral Pathways**	Broad step-down referral routes, co-ordinated through and with FNC+ and subsequently step-up of diagnosed/characterised patients known to respiratory services (e.g. ANPs, AHPs, DNs, SAS, self-referral); concern about delays tied to consultant sign-off	High
2	**Inclusion & Exclusion Criteria**	Emphasis on flexible, case-by-case criteria for chronic respiratory patients; digital access and home support key	High
3	**Education & Awareness**	Need for consistent, ongoing education for staff, patients, and carers across geographies	High
4	**Service Standardisation Across HSCPs**	Wide variation in services/staffing; interest in centralised teams and shared models of care	High
5	**Information Sharing**	Essential for safe patient management across acute, community, pharmacy, and social care systems	High
6	**Use of Doccla for Default Pathway**	Strong support for VW/H@H/FNC+ as standard care route rather than fallback to hospital admission	Medium
7	**Escalation Protocols**	Escalation processes need clear parameters and individualised response plans	Medium
8	**Decision-Making Autonomy**	Calls for distributed decision rights to speed up care and reduce delays	Medium
9	**Community Services**	Community-based support noted but inconsistent across regions; some pilot models in place	Medium
10	**Imaging Access at Home**	Identified as a technical/logistical barrier in virtual-first care	Medium

5.2 Respiratory

View full summary

Pathway development engagement: Key observations

- **Referral Delays Are a Barrier:** The current model, which relies heavily on GP or consultant sign-off, is viewed as a bottleneck. Expanding referral authority could reduce delays.
- **Education Is Foundational:** Ongoing awareness for both professionals and patients is critical for effective use of virtual services. Variation across regions must be addressed.
- **Avoiding Two-Tiered Care:** Given that certain VW/H@H/FNC+ patients may not require Doccla monitoring, ensuring equity of care is vital, to avoid the risk of hospital-admitted patients otherwise receiving higher-quality care.
- **Case-by-Case Inclusion:** Flexibility is vital, especially regarding patients with disabilities or digital access challenges. Carer involvement is seen as key.
- **Standardisation Opportunity:** The transformation programme is seen as a chance to unify services, staffing models, and specialist resource access across HSCPs.

QUOTE OF NOTE

“Decision-making should not be reliant on GPs or Consultants — ‘decision paralysis’ is a current issue.”

Access routes to the service should be as wide as possible, given that many hours are wasted waiting on a consultant to make a decision, thus elongating the patient’s journey.

5.3 Cardiology (AF & HF)

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Pathway development engagement: Key topics

#	Topic	Description	Weighting *(mentions / emphasis)*
1	**Access to Testing**	Echo, NTProBNP, CT Angio, Troponin, point-of-care testing	High (Recurring, detailed)
2	**Hot Clinics**	Demand for more; need dedicated space, time, admin, referrals	High
3	**Virtual Hospital Pathway**	Strong support for use; integration needed; not optional add-on	High
4	**Communication & Coordination**	Consultant Connect issues, email concerns, need for Sky-gateway	High
5	**System Integration**	Need for unified data platform and visibility across sectors	High
6	**Workforce Capacity**	Advanced Nurse Practitioners' and experienced consultants are critical	Medium
7	**Remote Monitoring**	Patches, remote ECG, 24-hour pharmacy, integration with care	Medium
8	**Care Home Integration**	Empowering care homes to avoid ED conveyance	Medium
9	**Training Needs**	Pathway-wide training, registrar involvement	Medium
10	**Cultural Shift**	Public expectations, clear patient info, care continuity	Medium

5.3 Cardiology (AF & HF)

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Pathway development engagement: Key observations

- **Testing Bottlenecks:** Access to diagnostic testing is a consistent barrier, often delaying discharge or forcing unnecessary admissions.
- **Virtual Care Potential:** A well-supported virtual hospital model can prevent avoidable ED visits, streamline transitions, and optimize resources — if treated as a replacement, not an addition.
- **Administrative Infrastructure:** Strengthening the functionality and use of tools like Consultant Connect can improve communication and ensure consistent access to specialist advice when it's needed most.
- **Hot Clinics:** Call to expand availability, improve referral pathways, and ensure patients and staff are clear on expectations and processes.
- **Coordination Challenges:** Communication gaps across primary, community, and acute sectors are a risk to patient safety and pathway success.
- **Workforce Impact:** ANPs play a vital role, especially in managing frail/elderly patients; consultant time must be managed carefully within new responsibilities.
- **Data Fragmentation:** No unified access to test results; strong desire for an integrated "single source of truth" system.

QUOTE OF NOTE

"The Virtual Hospital should be a full alternative to physical pathways, not an add-on."

This quote captures the ethos behind multiple comments — participants value the virtual care approach, but only if it is treated as core and properly resourced.

5.4 OPAT

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Pathway development engagement: Key topics

#	Theme	Description	Weighting *(mentions / emphasis)*
1	**Communication & Documentation**	Need for consistent communication with patients, stakeholders, and between services. Discharge summaries should match hospital standard.	High
2	**Governance & Responsibility**	Discussions around Virtual Ward clinical governance and escalation, with patients under the care of an ID Physician with access to an ID Consultant 24/7.	High
3	**Referral Pathways**	Questions around who can refer to OPAT, e.g., non-medical staff, SAS. Integration with FNC+ suggested. Avoid siloed services.	High
4	**Service Expansion & Integration**	Opportunity to link OPAT with H@H, particularly for frail patients needing multiple daily doses. Avoid overuse of virtual platforms like DOCCLA.	High
5	**Geographic Equity**	Current service inconsistency across locations; access to services and diagnostics varies by site.	High
6	**Data & Improvement**	Use of TrakCare and development of a dashboard to measure outcomes and support continuous improvement.	Medium
7	**Role of Diagnostics & Prescribing**	Highlighted need for improved access to blood tests, consistency in prescribing responsibility, and involvement of pharmacy.	Medium
8	**Use of Doccla**	Potential to support new patient groups with remote monitoring (e.g., low-risk neutropenic sepsis); caution advised on overuse.	Medium
9	**Education for Referrers**	Importance of education across all referring groups including primary care and registrars.	Medium
10	**Operational Coverage**	Need for 7-day OPAT services across all locations to ensure equity and efficiency.	Medium

5.4 OPAT

View full summary

Pathway development engagement: Key observations

- **Clear Roles Needed for Safe Expansion:** As OPAT treats more acute patients, the need for clear lines of responsibility grows. Questions remain around whether the ID consultant team can absorb this within current capacity.
- **Referral Flexibility and Integration:** Pathways must be inclusive of ANPs, SAS, and other non-traditional referrers. A unified referral model through FNC+ could streamline access.
- **Avoiding Silos:** While OPAT has clear strengths, its success depends on integration with other services like H@H and infection specialists, to avoid fragmentation.
- **Monitoring New Populations:** Incorporating remote monitoring (e.g. Doccla) could expand OPAT access to new patient groups, but caution is needed to maintain safety and resource focus.
- **Phlebotomy Access Is a Bottleneck:** Community capacity for blood draws is inconsistent and must be improved to support broader OPAT reach.
- **Consultant Connect:** Need to consider how FNC+ is positioning alongside Consultant Connect. This likely applies to other pathways/specialist areas also.

QUOTE OF NOTE

"Ideas around hospital admission need to be challenged – there is a perception that being in hospital is safer, which is not always the case."

This quote was captured when the OPAT break-out group was discussing communication.

5.5 Mental Health

View full summary

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Pathway development engagement: Key topics

#	Theme	Description	Weighting *(mentions / emphasis)*
1	**Access & Service Integration**	Explored linking mental health services to FNC+; current underuse of Consultant Connect noted	High
2	**Clozapine Pathway Innovation**	Proposal to initiate/re-titrate clozapine virtually; aims to reduce inpatient admissions and delays	High
3	**Digital Monitoring Tools**	Remote monitoring for NDD and CMHT patients via digital stratification tools; also supports staff with adjustments	High
4	**Use of Virtual Hospitals**	Early-stage discussion on applying virtual models to mental health, including eating disorders and inpatient detoxification	Medium
5	**Workforce Roles in FNC+**	Interest in embedding MH practitioners (medical, ANP, pharmacist) into FNC+ hub to enhance responsiveness	Medium
6	**System Communication**	Need for reliable information flow across inpatient and community settings, especially around non-GP prescribed meds	Medium
7	**Bed Pressures & Interfaces**	Acknowledged longstanding challenges with occupancy and interface issues despite home-based care growth	Medium

5.5 Mental Health

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Pathway development engagement: Key observations

- **Clozapine Reforms Could Be Transformative:** The group supported a move toward virtual clozapine initiation and re-titration. Noted potential to widen access and reduce unnecessary admissions caused by poor data sharing (e.g. ECS not reflecting clozapine use).
- **Digital Expansion Already Underway:** The NDD digital platform is being scaled up following a pilot, with the goal to enhance patient engagement and streamline titration, especially in CMHTs.
- **Untapped Potential in Consultant Connect:** Despite its success in other specialties, mental health uptake has been limited. There's support for embedding MH roles directly within FNC+ to improve utility.
- **Cross-Service Collaboration is Essential:** Integration of physical and mental health care remains a challenge, but tools like Doccla could play a future role — though they are currently at exploratory stages.
- **Strained Capacity Persists:** Despite years of community-based care reform, occupancy remains >100%, pointing to persistent bottlenecks in the system.

QUOTE OF NOTE

“There is potential to widen access to clozapine if initiation didn’t require a hospital admission.”

This quote was recorded when the Mental Health break-out group was discussing proposals to use the Virtual Hospital for clozapine initiation/re-titration.

5.6 Paediatrics & Neonatology

View full summary

Pathway development engagement: Key topics

#	Theme	Description	Weighting *(mentions / emphasis)*
1	**Early Pathway Prioritisation**	In addition to respiratory, paediatric cardiac and neonatal jaundice were identified as initial paediatric pathways due to strong clinical foundations	High
2	**Existing Remote Models**	Participants recognised the success of current virtual paediatric care services, calling for a unified "Paediatric Remote Care Programme"	High
3	**FNC+ Integration**	Strong focus on designing pathways that embed FNC+ as a central support tool, with senior clinical engagement	High
4	**Resourcing Requirements**	Effective implementation depends on programme management, clinical leadership, eHealth, and workforce capacity	High
5	**Branding & Identity**	Continued emphasis on clearly defining and visually positioning Hospital at Home for paediatrics and neonatology	Medium
6	**Tertiary Engagement**	Targeted messaging and leadership buy-in needed from key specialties to support integration	Medium
7	**Data-Driven Testing**	Piloting with clear metrics and adjusting based on real-world evidence remains a key strategy	Medium

5.6 Paediatrics & Neonatology

View full summary

Pathway development engagement: Key observations

- **Three initial Pathways Identified:** General paediatric respiratory, cardiac, and neonatal jaundice conditions are viewed as optimal starting points for remote care rollout, thanks to existing planning and engagement.
- **Learn from Success, Scale What Works:** Existing services using virtual models for paediatric care are proving effective — participants proposed integrating them under a single, cohesive programme structure.
- **Embed FNC+ in Clinical Pathway Design:** Designing new paediatric pathways must go hand-in-hand with FNC+ functionality and staffing, requiring close input from clinical leaders.
- **Resource Planning is Critical:** Beyond clinical readiness, success will depend on up-front investment in programme infrastructure, comms, eHealth, and evaluation capacity.
- **A Distinct Identity Matters:** Paediatric H@H (Virtual Hospital) must be clearly positioned to differentiate it from other services — this includes naming, visuals, and messaging that resonate emotionally with families and staff.

QUOTE OF NOTE

"What makes this model distinct? Is it about joyful, family-centred care, digital enablement, or seamless transitions?"

This quote was captured when discussion took place around establishing the virtual hospital identity and defining the vision.

5.7 Surgical Specialties

View full summary

Pathway development engagement: Key topics

#	Theme	Description	Weighting *(mentions / emphasis)*
1	**Hot Clinics & Centralised Access**	One-stop hot sites, algorithm-based triage, and GP access to booking systems	High
2	**Imaging & Diagnostics**	Urgent need for equitable, front-door imaging access and universal phlebotomy pathways	High
3	**Standardisation Across GGC**	Consistent pathways and service models across sites and specialties to reduce variation	High
4	**Role of FNC+**	Positioned as a hub for triage, decision-making, ED streaming, and early surgical input	High
5	**Virtual Hospital Integration**	Need to support discharge, community escalation, and pharmacy coordination	High
6	**Workforce Capacity & Role Design**	Calls for MDTs, senior decision-makers, rotating staff, and digital prescribing roles	Medium
7	**Real Estate & Infrastructure**	Revamp physical spaces for better flow, triage, and access to theatres	Medium
8	**Coordination Across Interfaces**	Integration across diagnostics, hot clinics, and sector-based services	Medium
9	**Virtual Pathway Clarity**	Lack of visibility and ownership of virtual models seen as a potential challenge	Medium

5.7 Surgical Specialties

View full summary

Pathway development engagement: Key observations

- **Hot Clinics Are a Priority:** A streamlined, one-stop approach to urgent surgical care — supported by decision-making algorithms — was seen as a key opportunity to improve efficiency and access.
- **FNC+ as a Central Engine:** There's strong appetite to position FNC+ as the control centre for triage, imaging coordination, and virtual care redirection — with decision-makers embedded centrally.
- **Investment in Imaging Is Essential:** Without rapid, equitable access to imaging (particularly ultrasound and CT), surgical flow and discharge timelines remain constrained.
- **Virtual and Physical Must Work Together:** Virtual Hospital concepts are welcome but require pharmacy support, better community links, and clearly defined roles for escalation and discharge planning.
- **Standardisation = Equity:** A pan-GGC approach is needed to address service variation, for example in OOH gallbladder/jaundice management and minor procedures.

QUOTE OF NOTE

"Patients should not progress upstairs until imaging is complete."

This reflects the group's emphasis on resolving front-door bottlenecks to improve surgical flow and avoid unnecessary admissions.

5.8 Emergency Medicine & RAaC

View full summary

Pathway development engagement: Key topics

On Missingness

A lack of easily accessible community or specialty support was identified as a barrier to managing care outside the ED. Several structural and social issues contribute to patients becoming invisible to the system:

- **Barriers**: High DNA rates, missed follow-ups, inadequate housing pathways, poor public education on service use and lack of mental health contacts in the Community impacting ED.
- **Enablers**: ED Navigator roles and outreach models (e.g. Hunter Street, PHOENIX) show impact in reaching vulnerable groups.
- **Actions Needed**: Reinstate outreach for homeless patients, integrate care with HSCPs, embed community-based redirection, and ensure visible support services in ED environments.

On Flow Navigation Centre Plus (FNC+)

The FNC+ was positioned as a key mechanism for both risk-managed redirection and workforce transformation:

- **Workforce Dependencies**: Success depends on senior decision-makers, a multispecialty staff mix, and continuous coverage. Training in FNC+ and the Virtual Hospital is recognised as important.
- **Model Features**: Includes automated bookings, outcome tracking, telemedicine expansion, and Prof-to-Prof support (e.g. into care homes).
- **Barriers**: Risk-averse cultures, fragmented NHS24 integration, lack of feedback loops, and unequal interest across sites.
- **Opportunities**: Trust-building in redirection pathways, visible results through patient-level data, and aligning governance through KPIs.
- **Ownership**: FNC+ needs centralised leadership and must be integrated with system-wide escalation oversight.

5.8 Emergency Medicine & RAaC

View full summary

Pathway development engagement: Key topics

On the Rapid Assessment and Care Unit (RAaC)

RAaC was envisioned as a frontline response unit with specific structural and operational needs:

- **Model Vision**: Shared decision-making between clinicians & nurses, with hot diagnostics and no overnight bedding. Advanced frailty and respiratory practice embedded.
- **Data Focus**: KPIs include TTFA, radiology timing, diagnostic volumes, and safety indicators. Clear tracking of patient movement and discharge is essential.
- **Workforce**: Senior nurses, advanced practitioners, and consultants working in partnership to reduce duplication and standardise care.
- **Infrastructure Gaps**: Real estate, diagnostics, IT connectivity, and inconsistency in pathway development were seen as critical challenges.
- **Additional Considerations**: Frequent attenders and upstream investment.

On Escalation

The group strongly advocated for escalation to be a **shared, proactive process** — not solely ED's burden:

- **Proactive Management**: Virtual care should be used to decompress beds earlier; escalate based on real-time capacity tracking and morning ward round outputs.
- **Shared Responsibility**: Placing unstable patients in overcrowded EDs was challenged; escalation must span the system.
- **Avoidable Demand**: ED should not be the post-discharge safety net for all specialities. Visibility of specialty capacity and real-time coordination were seen as essential.
- **Social Barriers**: Housing delays and legal status (AWI/POA) continue to block discharges. Learning from other successful models was suggested.
- **Focus Areas**: Frailty, palliative care, and major incident planning all require integrated escalation-ready capacity and cross-site coordination.
- **Requirements**: Clear escalation protocols, leadership roles, centralised oversight, and real-time system visibility.

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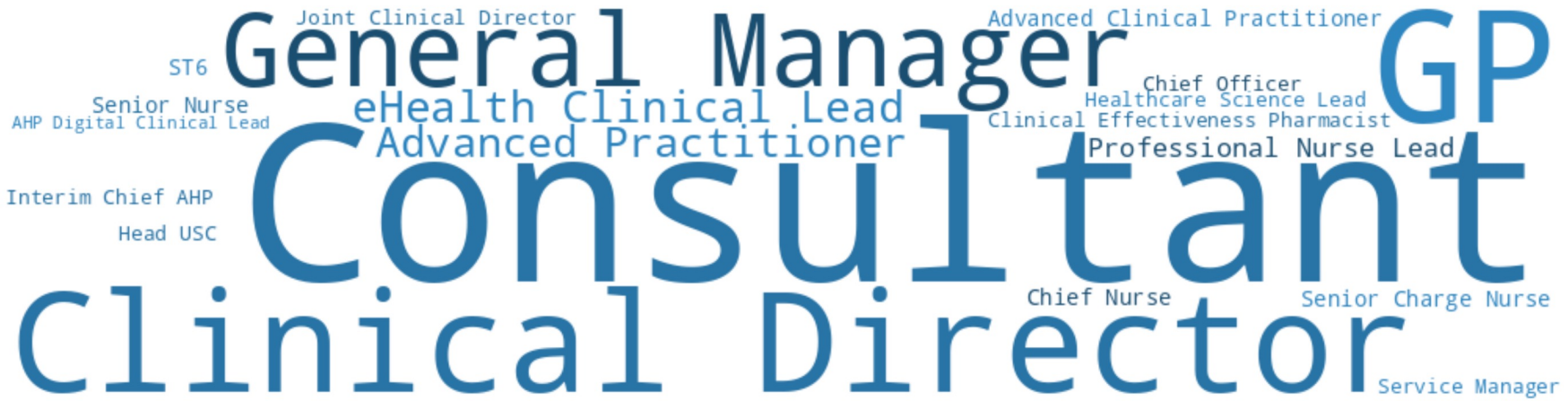
Appendix

Pre-attendance survey

36 Individuals completed the survey BEFORE attending the event

- Average completion time: **19 mins**
- Respondent role types:



Questions:

How would easier/earlier access to expert advice, re-direction, remote monitoring and/or diagnostics help with:

1. ONBOARDING?
2. MONITORING & ESCALATION?
3. DISCHARGE?
4. What improvements do you hope to see in patient care and/or service delivery as a result of your participation at Hackathon 2?

Pre-attendance survey

Questions covered BEFORE attending the event (1/4)

Q How would easier/earlier access to expert advice, re-direction, remote monitoring and/or diagnostics help with **ONBOARDING?**

Top 5 POSITIVE Themes

1. Quick access to expert advice helps avoid unnecessary admissions.
2. Remote monitoring supports safe care at home for chronic/frail patients.
3. Clear redirection pathways improve patient flow and reduce pressure on ED.
4. Faster diagnostic access in the community aids quicker decisions.
5. Virtual collaboration (e.g. MDTs) enhances coordinated, efficient care.

Top 5 CHALLENGE Themes

1. Risk of increasing GP workload if not carefully managed.
2. Confusing language and unclear processes create barriers.
3. Remote monitoring not always suitable for acute or complex cases.
4. Lack of ownership/support can undermine redirection efforts.
5. Need for better community skills, not just more referrals.

Pre-attendance survey

Questions covered BEFORE attending the event (2/4)

Q

How would easier/earlier access to expert advice, re-direction, remote monitoring and/or diagnostics help with **MONITORING & ESCALATION?**

Top 5 POSITIVE Themes

1. Remote monitoring supports early intervention, reducing admissions and enhancing patient engagement.
2. Access to diagnostics and imaging speeds up clinical decisions and prevents delays.
3. Hospital-at-home models enable care in the community, especially for complex and older patients.
4. Timely specialist advice helps ensure patients are treated in the right place at the right time.
5. Improved flow and capacity management through faster discharge and reduced bed pressure.

Top 5 CHALLENGE Themes

1. Increased GP workload and limited capacity could undermine implementation.
2. Concerns about access to full clinical records for external providers (e.g. Doccla).
3. Need for clear escalation pathways to avoid delays in urgent cases.
4. Remote monitoring not always suitable for complex or high-risk situations.
5. Governance and accountability for decisions made outside traditional hospital settings.

Pre-attendance survey

Questions covered BEFORE attending the event (3/4)

Q

How would easier/earlier access to expert advice, re-direction, remote monitoring and/or diagnostics help with **DISCHARGE?**

Top 5 POSITIVE Themes

1. Remote monitoring supports earlier, safer discharge and continuity of care at home.
2. Faster access to diagnostics and follow-up enables quicker discharge decisions.
3. Reduced hospital bed days through step-down care and specialty-specific review pathways.
4. Improved patient and family reassurance supports confidence in home-based care.
5. More efficient discharge planning when technology and services are coordinated effectively.

Top 5 CHALLENGE Themes

1. Increased pressure on GPs due to unclear discharge roles and added responsibilities.
2. Risk of failed or poorly coordinated discharges without clear communication and responsibility.
3. Duplication of effort and records, especially between hospital, DOCCLA, and community teams.
4. Lack of infrastructure and capacity in the community to support rapid discharge models.
5. Need for shared, real-time information systems to ensure safety and accountability.

Pre-attendance survey

Questions covered BEFORE attending the event (4/4)

Q

What improvements do you hope to see in patient care and/or service delivery as a result of your participation at Hackathon 2?

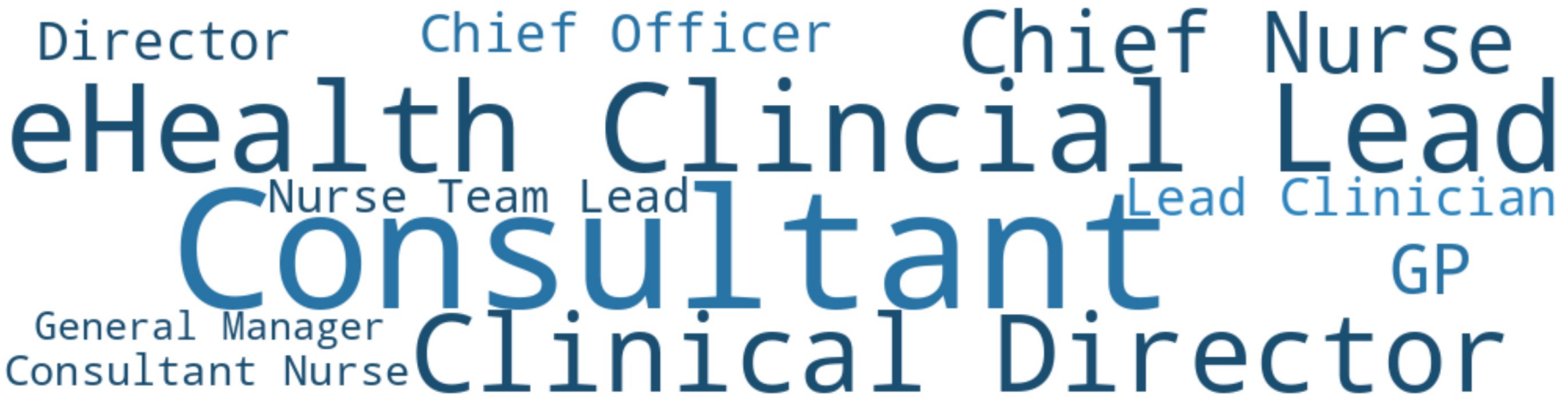
Top 5 Themes

1. **Joined-Up, Patient-Centred Pathways Across Care Settings:** A strong emphasis on *end-to-end integration* between primary, secondary, and community services. This includes better digital records, shared care plans, and seamless handoffs that centre on the patient's journey.
2. **Admission Avoidance & Early Supported Discharge:** Clear appetite for models like Hospital at Home, SDEC, and ambulatory care to *avoid unnecessary admissions* and *enable faster discharge* with safety nets in place.
3. **Access to Diagnostics & Specialist Input in the Community:** Consistently cited as a way to *reduce delays*, improve confidence in decision-making, and allow patients to stay out of hospital when safe to do so.
4. **Workforce, Workload & Resource Pressures in Primary Care:** Many participants note the *risk of overburdening GPs*, calling for proper resourcing, clarity on responsibilities, and recognition of the pressures in community settings.
5. **Collaboration, Culture Change & Equity Across Sites:** Respondents want *better interprofessional collaboration*, shared ownership of care, and *consistent service access* regardless of location, time of week, or patient demographics.

Post-attendance follow-up survey

22 Individuals completed the survey AFTER attending the event

- Average completion time: **12 mins 32 Secs**
- Respondent role types:



Questions:

1. What worked well?
2. What could we improve?
3. Rank the event (1= Low 5= High)
4. What opportunities or challenges would you suggest need further exploration in Hackathon 3?
5. Anything you didn't have a chance to share on the day?

Post-attendance follow-up survey

Questions covered AFTER attending the event (1/4)

Q What worked well?

“The SME breakout session I attended (Frailty) was excellent — there was lots of energy in the room and a real sense of it being a working session towards a shared aim.”

“Inspirational speakers in the morning, with lots of variety and enthusiasm to kick off the day.”

“Highlights included the pre-meeting pack setting agenda and background; organisation; enthusiasm and presence of C-suite team; and a clear enthusiasm of those that had chance to see the Doccla pathways in action.”

“Great enthusiastic introductions. Met a lot of well-meaning and nice colleagues. Smaller break-out room allowed some good communications.”

4/5

High Average Attendee Score

Post-attendance follow-up survey

Questions covered AFTER attending the event (2/4)

Q What could we improve?

“Felt the discussion time in groups was too short to get through everything.”
A recurring theme across follow-up responses was the desire for more time to explore ideas meaningfully.

“More opportunity to identify key next steps, some agreed pathways to address, mechanisms to take ideas forward.”
Some participants wanted clearer next steps, and follow-up actions from the group sessions.

“Needed more background info on Doccla, that arrived for a few brief minutes…”
There was some frustration about insufficient time to explore the Doccla solution.

“I scored 4/5 only because there was not enough time for feed back at the end”

Post-attendance follow-up survey

Questions covered AFTER attending the event (3/4)

Q What opportunities or challenges would you suggest need further exploration in Hackathon 3?

1. **Clarify how virtual care will be delivered in the community**, including governance, prescriptions, monitoring, and emergency scenarios.
2. **Involve clinical staff more deeply** in shaping pathway details, especially around implementation and daily operations.
3. **Strengthen integration with HSCPs and primary care**, particularly around delayed discharges, equitable service delivery, and real-world resourcing.
4. **Expand discussions on digital infrastructure**, including record systems, inter-professional access, and use of ecosystem mapping tools.
5. **Ensure a whole-system approach**, linking acute, community, third sector, and HSCP stakeholders with shared responsibility and communication.
6. **Map realistic patient journeys** across services to identify consistent, strategic ways to operationalise new models.
7. **Promote equity across localities**, resolving variability in access (e.g. surgical ambulatory care, radiology) and standardising models across sites.
8. **Facilitate ongoing cross-professional collaboration**, including staff from across sectors and roles, supported by leadership and OD.
9. **Prioritise workforce planning and role clarity**, ensuring staff allocation for virtual models is recognised, resourced, and embedded in job plans.
10. **Don’t lose sight of recovery and discharge pathways**, balancing high-tech care with compassionate support and effective step-down processes.

Post-attendance follow-up survey

Questions covered AFTER attending the event (4/4)

Q Is there anything you didn't have a chance to share on the day, or thought of after the event - concerns, further ideas, considerations etc? Please share any overall comments.

1. **Clarification of Virtual Hospital Offer:** There's a strong need to clearly define what services will (and won't) be available to virtual hospital patients — including diagnostics, medication changes, IV therapy, and clinical responsibilities.
2. **Cross-System Collaboration and Governance:** Respondents stressed the need to break down silos between HSCPs, specialties, and directorates — and for senior leadership to actively demonstrate support and commitment to this.
3. **Concerns Around Pre-Selected Solutions (e.g. Doccla):** Some felt that committing to a digital solution before defining the clinical problems may have limited the scope for innovation and more fundamental service redesign.
4. **Primary and Secondary Care Integration:** Calls for improved coordination between sectors, especially around chronic disease prevention, outpatient backlogs, and shared infrastructure like phlebotomy hubs.
5. **Equity, Inclusion, and Community Representation:** Several comments noted the need for equity in resource allocation, greater inclusion of staff from all professions and grades, and representation from underserved or marginalised communities.
6. **Time, Resources, and Capacity for Change:** Transformation efforts must be properly resourced — including protected time, investment in staff, and clarity on how services will be supported during transition.
7. **Digital and Public Health Foundations:** Respondents emphasised the importance of IT infrastructure for joined-up care, patient access (e.g. apps), and supporting patient education and engagement in their own health.
8. **Honest Conversations About Risk and Sustainability:** A recurring suggestion was the need to openly discuss system risks and sustainability — including realistic conversations about current pressures in GP, social care, and outpatient services.