Orchestrating NHS Discharge with UiPath Maestro Case

09:00 – medically ready to go home

A patient story we'll come back to at the end

09:00

Medically ready to leave

Ready

Medication ready to take home

Booked

Transport arriving at 14:00

Outstanding

No community support confirmed for when they get home

Who owns fixing that, and does anyone know it's a problem?

UiPath

01

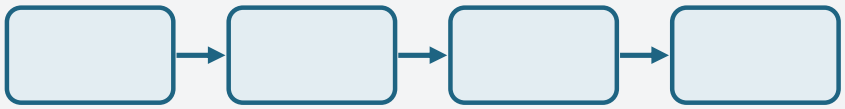
Case management at UiPath

What it is, and where it fits

Processes vs Cases

PROCESS

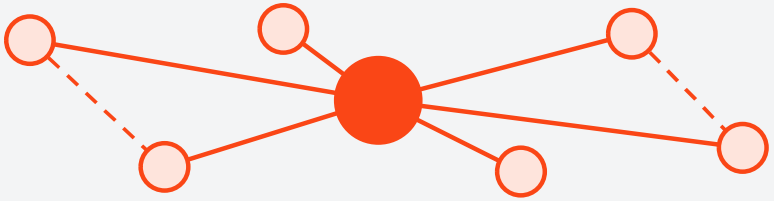
Runs in a straight line



- Same steps, same order, every time
- Predictable inputs and outcomes
- e.g. invoice processing, payroll updates

CASE

Branches, waits and changes



- Work arrives out of order and in parallel
- New information changes the plan
- e.g. hospital discharge, safeguarding referrals, benefit claims

Where Maestro Case Management fits

UiPath

Where people work

Action Apps, email, Teams and portals

Maestro Case · orchestration and case management

Coordinates decisions, work, people and escalation across the whole case

Agents · Robots · API workflows

Do the reading, reasoning, chasing and system updates

Systems of record

EPRs, PAS, casework, CRM, finance, HR systems

Maestro sits above the systems you already run.

Systems of record stay the system of record. People keep working where they work today.

The building blocks of Maestro Case

UiPath

Stages

The phases a case moves through.

Under the hood

Entry and exit conditions open and close each stage.

Tasks

Units of work, done by a person, agent, robot or API.

Under the hood

Run in parallel, once or repeatedly.

Rules

Decide what happens next from what the case knows.

Under the hood

Conditions on case variables, e.g. transport confirmed.

SLAs

Every stage has a clock, and the right person hears before it runs out.

Under the hood

Notify at 75% of the SLA; escalate on breach.

Exceptions

Real life interrupting the plan.

Under the hood

Interrupting stages fire at any point, then hand back.

Four kinds of worker in one case

UiPath

People

Action Apps

Judgement, authority and conversations

e.g. Clinician records discharge intent; coordinator confirms what carers can provide.

AI agents

Agentic automation

Reading and reasoning over unstructured information

e.g. Interprets a signed therapy assessment; evaluates whether the plan is ready.

Robots

RPA

Legacy systems with no API

e.g. Checks community capacity; falls back to legacy transport booking.

API workflows

Integrations

Modern systems, fast and reliable

e.g. Syncs discharge intent to the EPR; books transport.

02

Why now?

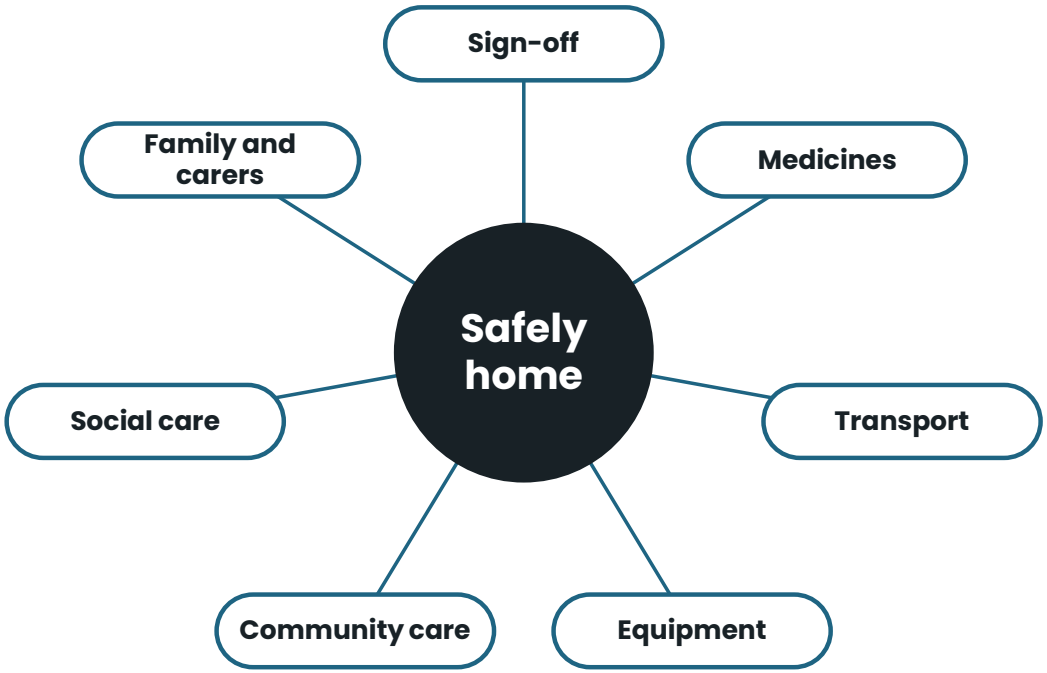
From seeing the work to moving it

UiPath

Visibility tells us where we are. Orchestration determines what happens next.

Data can show the condition of a service. Improving it depends on what the system can do in response.

Ready to go home, still in a bed



~13,000 people a day in England are medically fit to leave hospital, but still in a bed

1 in 7 hospital beds are occupied by someone medically fit to go home

6.75m bed days lost in 2025/26 to discharge delays of a week or more

Sources: Age UK (2026); HSJ analysis of NHS England data (Aug 2026)

Discharge happens when a chain of clinical, operational, social, and personal actions comes together, each with its own owner, system, and timeline.

6 in 10 delays are process, not capacity

Reason for delay	Share of delayed patients	How a UiPath Maestro Case helps
Community and social care capacity	34%	Outside the case: needs more care capacity. The case makes the wait visible from day one, so referrals start sooner.
Interface processes	28%	One shared case for the trust, council, and providers, with referrals and updates sent automatically, not chased by phone and email.
Hospital processes	19%	Sign-off, medicines, transport, and equipment run in parallel as owned tasks, tracked against the discharge ready date.
Care transfer hub processes	13%	Pathway decision and referral information gathered and routed as one case milestone, so nothing waits in an inbox.
Patient and family wellbeing	6%	Partly human and legal. The case keeps families and assessments in the loop, with every concern logged and owned.

Process and coordination delays: around 60% of the total

Source: The King's Fund analysis of NHS England discharge delay data

Discharge today: an illustrative view

UiPath

1	2	3	4	5	6
Clinician decides the patient can go	Ward contacts therapy, pharmacy and transport one by one	Each team works in its own system	Coordinator chases by phone and email	A blocker surfaces late, e.g. no community support available	Discharge slips to tomorrow
Intent lives in notes, not a plan	**Serial, not parallel**	**No shared view of the case**	**People are the glue**	**No owner, no alert**	**A bed lost for a day**

Work runs in series, in separate systems, held together by phone calls and memory.

UiPath

03

The To-Be Maestro Case solution

One live case per admission

The To-Be case at a glance

UiPath

1

Discharge Intent Established

Clinician records intent; one case per admission

2

Prepare for Discharge

All known work starts in parallel

3

Pathway Coordination

Agent reads therapy findings; clinician authorises

4

Dependency Convergence

Books transport and secures handover

5

Ready to Transition

A deterministic go / no-go gate

6

Transfer and Handover

Patient, medicines and documents move together

7

Transition Assurance

Evidences the outcome and flags gaps

EXCEPTION STAGES · CAN INTERRUPT AT ANY POINT

Clinical Deterioration and Pathway Change

A clinical decision reshapes the case; an agent summarises what changes.

Capacity Unavailable

A service can't meet the date; an agent sets out recovery options.

Technical Failure Recovery

The transport API fails; a legacy robot secures the booking.

Safeguarding Review

A concern holds discharge until the safeguarding lead decides.

Works with the estate you already have



Clinical teams keep working in the systems they use today. The same approach applies to any public service whose casework spans several systems.

What to watch for in the demo

Scenario: Margaret Lewis, admitted due to a fall, expected home on the 11th September.

1. **Five tasks start at once**
   Therapy, medicines, community support, carer circumstances and transport run in parallel.

2. **An agent assesses the operational impact**
   When the pathway changes, an agent works out what it means operationally and presents its findings to a person for review and approval. It holds no decision-making authority.

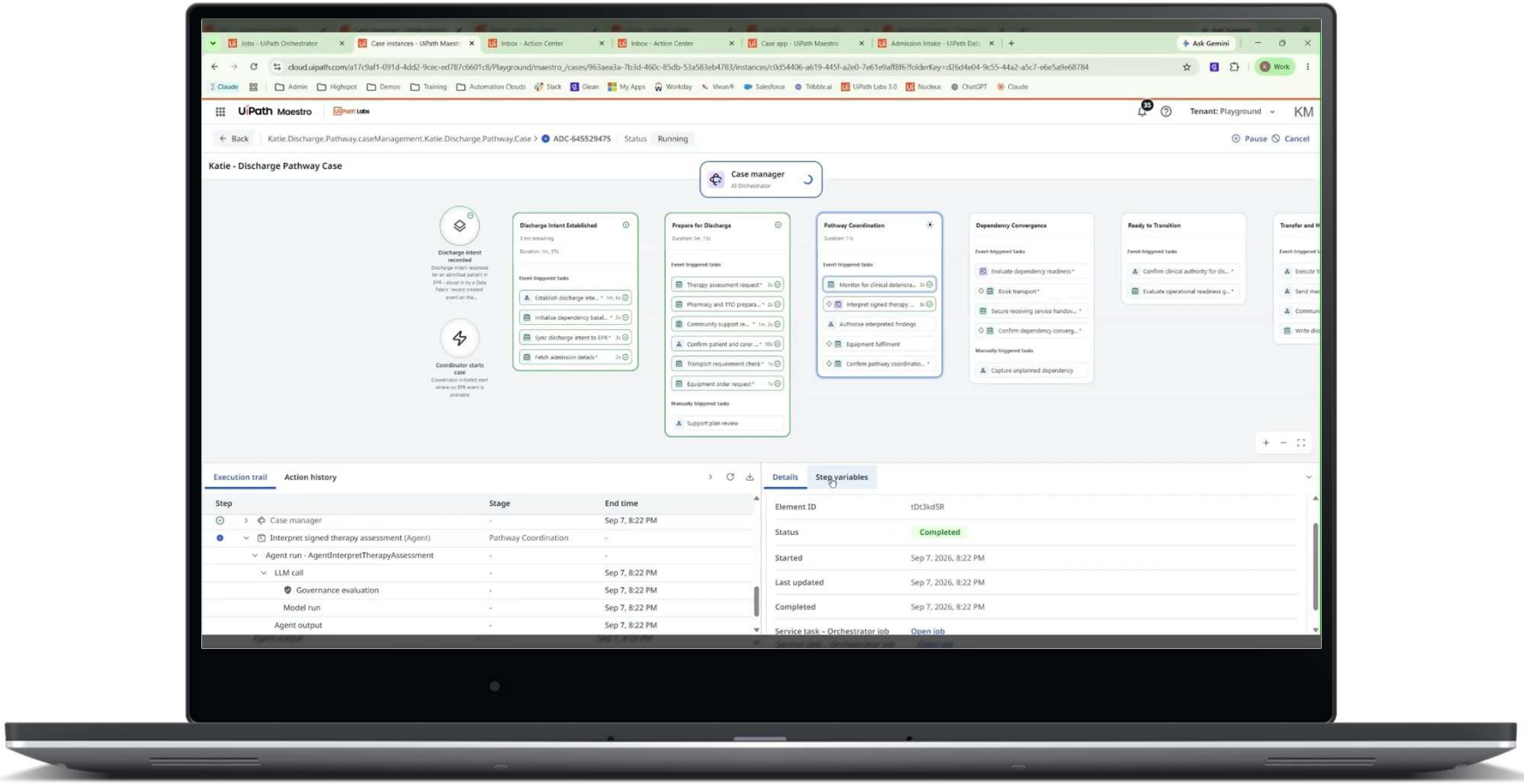
3. **The carer conversation runs late**
   The care transfer coordinator doesn't confirm the family's circumstances in time, so the SLA is breached and the case escalates.

4. **The transport API fails**
   But the same process is retried via a legacy robot, which secures the booking.

5. **The readiness gate turns green**
   The transfer only begins once every dependency is confirmed.

Integrations are simulated for this demo. In a live deployment they connect to the Trust's own systems.

Demo: the discharge case, end to end



UiPath

04

So, what?

Outcomes and the benefits

Back to the 09:00 patient

The question	Today	With the case
Who owns the gap?	Whoever notices	A named role, with a task and an SLA
Does the care provider know it's today?	Only if someone calls	Yes. They're contacted on day one and confirm as a tracked task
What if there's no capacity?	Found out late	Flagged early, and an agent sets out recovery options for the team to choose from
Who is alerted?	Nobody, until it's too late	The owner at 75% of the SLA, then leadership on breach
What happens to the bed?	Discharge slips a day	Freed on the planned day, or flagged early so patient flow can replan

The same pattern across public services

Wherever work crosses teams, systems and organisations, and doesn't run in a straight line

Social care referrals

Assessments, providers and families working to one plan

Benefits and grants

Evidence, eligibility checks and payments across departments

Planning and licensing

Consultations, site visits and statutory deadlines

Safeguarding

Multi-agency concerns that must never stall

Recruitment and right to work

Checks, approvals and onboarding across HR and legal

Complaints and FOI

Statutory clocks, many contributors, one response

Questions?

Thank you

Governing AI across the UiPath Platform

UiPath

Masked in flight

Personal and patient identifiers are masked before any prompt reaches an LLM.

Zero data retention

Third-party model providers keep none of the prompts or responses sent to them.

Policy-controlled access

Admins decide which teams can use agents, models, and AI features, by tenant or group.

Central guardrails

Prompt injection, jailbreak, and PII checks are set once and apply to every LLM call.

Human oversight enforced

Policy can stop any agent being published without a human approval step.

Every call audited

Prompts, outputs, and agent actions are logged for review in one audit trail.

Every case is audited and can be monitored, paused, retried or escalated in real time.

What faster discharge could mean

An illustrative model using public data, not validated benefits

FOR PATIENTS

~1 day sooner

Home almost a day earlier on average, as the wait after being medically fit falls from 1.9 to 1.0 days.

FOR ONE HOSPITAL

32 beds

Freed every day at a trust like Milton Keynes, the equivalent of about one bed back on every ward.

FOR THE NHS IN ENGLAND

~5,900 beds

Freed every day, nearly half of the beds currently held by people well enough to go home.

Every day saved is a day at home for one patient, and a bed for someone who's waiting.

Modelled estimates, not validated benefits. Beds freed are average daily figures, assuming the delay after being medically fit falls from 1.9 to 1.0 days and freed beds run at 85% occupancy. Baseline: NHS England discharge data, September 2025.