



Meeting Date	25 April 2023	Agenda Item	4.1
Report Title	Urgent and Emergency Care Improvement		
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Report Sponsor	Deb Lewis, Chief Operating Officer		
Presented by	Kate Hannam, Interim Service Group Director		
Freedom of Information	Open		
Purpose of the Report	To provide a summary of Morriston Urgent and Emergency Care (U&E) improvement programme to improve the delivery of timely, safe patient care and the U&E care standards.		
Key Issues	<p>U&E care performance has been escalated into enhanced performance monitoring with the Chief Operating Officer holding oversight and assurance against the development and monitoring of an U&E care improvement programme.</p> <p>The delivery of the 4-hour standard remains a significant challenge and the risk of patients coming to harm due to delays in both assessment and treatment remains a key focus for the Emergency Department (ED) clinical management team. In addition, the overcrowding of the ED linked to poor flow and delayed admission of patients into the in-patient bed pool results in poor patient experience, reduced ED capacity to assess new attendees to the department and frequently prevents protection of resuscitation capacity to treat very sick patients who require immediate clinical intervention.</p> <p>There are key system performance indicators that explain the challenges associated with delivering timely and safe patient care and thus the required levels of performance and these are discussed in the paper.</p> <p>The ED nursing workforce sickness levels have started to reduce as have the number of vacancies on the unit. Gaps do remain however following the covid pathways across medical and nursing areas. The continued high demand places pressure on the substantive workforce and staff report failure to deliver the desired standards of care to patients which has a negative impact on staff morale.</p>		

	<p>A U&E improvement plan has been developed to address the systemic issues affecting patient flow for Morriston and an overview of the areas of focus in quarter 4 2022/23 have been included.</p> <p>Welsh Government require all Urgent and Emergency Care Boards and reporting to align to the Six Goals for Urgent and Emergency Care and the health board have rapidly moved to adopt this approach.</p>			
Specific Action Required <i>(please choose one only)</i>	Information	Discussion	Assurance	Approval
	☒	☐	☒	☐
Recommendations	<p>Members are asked to:</p> <ul style="list-style-type: none"> • NOTE the U&E care performance position and the ongoing actions taken to support its recovery and Improvement. 			

Urgent and Emergency Care recovery plan 2022-23

1. INTRODUCTION

The report below describes urgent and emergency care activity and performance to date including progress against the U&E care standards. Wider system indicators are also used to demonstrate the flow constraints that exist resulting in poor access to timely urgent and emergency care and poor patient experience. The report provides an update on the strategic programme to improve delivery of acute medical services to patients and on local improvement actions.

2. BACKGROUND

Patient flow at Morriston continues to be significantly compromised due to the high occupancy level in which the hospital is operating. This is further exacerbated by the system flow challenges which impacts on patients transferring in a timely way into services outside of Morriston which increases delays in clinically optimised patients and increases the number of patients being treated outside of their core bed base. The impact of the lack of flow also has unintended consequences in other parts of the urgent and emergency care system including:

- Delay in patients being offloaded from ambulances into the ED;
- Delays in patients accessing ward beds and requiring 'boarding' within the ED, including resuscitation;
- Delay in step down from ITU onto general wards;
- Delay in patients gaining access to the 'right ward first time' as reflected in stroke and # NoF performance;
- Delay in transferring major trauma and regional specialty patients into the specialist services at SBUHB;
- Delays in patients transferring to the next stage of their recovery – complex and general rehabilitation at NPT and Singleton;
- Inability to increase elective capacity on the Morriston site to treat 'Morriston Only Patients' and the impact this has from a patient safety, quality and experience perspective;

In order to improve and ensure focused delivery on the U&E care performance, there has been further review of the Morriston U&E care improvement plan, incorporating ambulance handover improvement plans, in addition to implementation of the AMSR programme which commenced in a transitional phase on 5th December 2022, and is now fully implemented.

Wider health board schemes targeting admission avoidance and earlier discharge are also in place to support the wider system flow agenda.

3. PERFORMANCE –Tier 1 urgent & emergency care standards

The SPC Charts and tables below demonstrate performance against the ED Access Standards and Ambulance handovers for 2022/23 (12 month rolling position). Overall, 4hr performance has **improved** during 2023 (to March 31st) when compared to 2022, underpinned by a

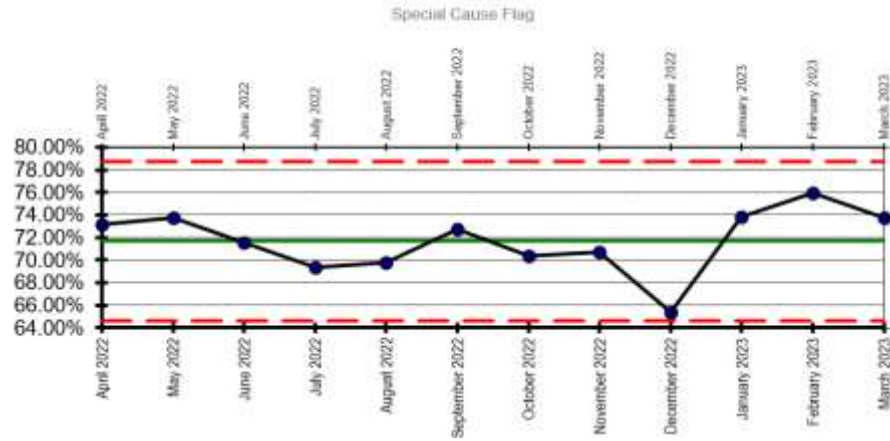
noticeable improvement within the Morriston site. Similarly, the number of patients waiting for 12 hours or more also **reduced** when compared to the 2022 baseline level.

Despite the recent improvement, the ongoing challenging situation and generally poor performance in the 4-hour standard at Morriston translates operationally to poor patient experience and risk as patients can wait several hours for assessment by a clinician during which period their condition may be more serious than as assessed at triage, or may have deteriorated. Health Inspectorate Wales action plans continue to be monitored via weekly escalation meetings.

The department continues to have covid pathways in place which restricts patient flow through the department and is driving significant additional costs into the department. A review of the continued necessity for these pathways is underway and will conclude end March, when a workforce paper will be finalised for both nursing and medical staff which will recommend appropriate nursing levels for the department and also the Children's Emergency Unit to support a sustainable and resilient workforce to deliver care within the Emergency Department.

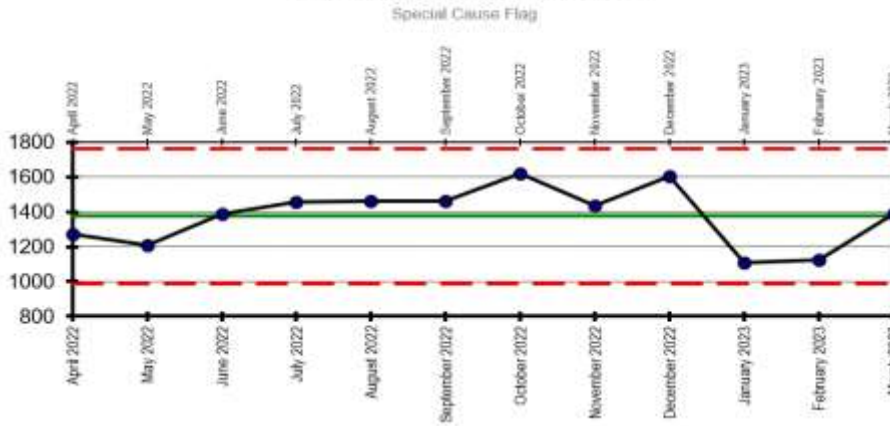
The overall non delivery of the 12-hour urgent and emergency care target relates predominantly to the system flow challenges and unavailability of in-patient beds. Patients waiting in ED for admission to an acute specialty bed will have been referred through a number of routes. There are those patients who will have presented as 'walk-in' to the department in addition to the ambulance arrivals. Due to the tertiary services on site, there are also urgent clinical transfers that are admitted from other hospitals who also default to ED due to lack of capacity. The 12-hour standard is directly linked to system flow and the challenges experienced within SBUHB are common across NHS Wales.

Health Board: 4 Hour Compliance



Month Start Date	ED 4 Hour Compliance	Morrison ED 4hr %	NPTH LAC 4 Hour Compliance2
April 2022	73.17%	59.29%	96.66%
May 2022	73.73%	57.69%	97.86%
June 2022	71.55%	54.46%	96.92%
July 2022	69.33%	53.89%	93.12%
August 2022	69.81%	51.61%	97.44%
September 2022	72.70%	55.78%	98.20%
October 2022	70.33%	53.29%	96.84%
November 2022	70.70%	54.47%	99.07%
December 2022	65.34%	49.44%	98.75%
January 2023	73.86%	58.15%	98.71%
February 2023	75.97%	62.34%	98.89%
March 2023	73.74%	59.33%	98.76%

Patients Waiting >12 Hours

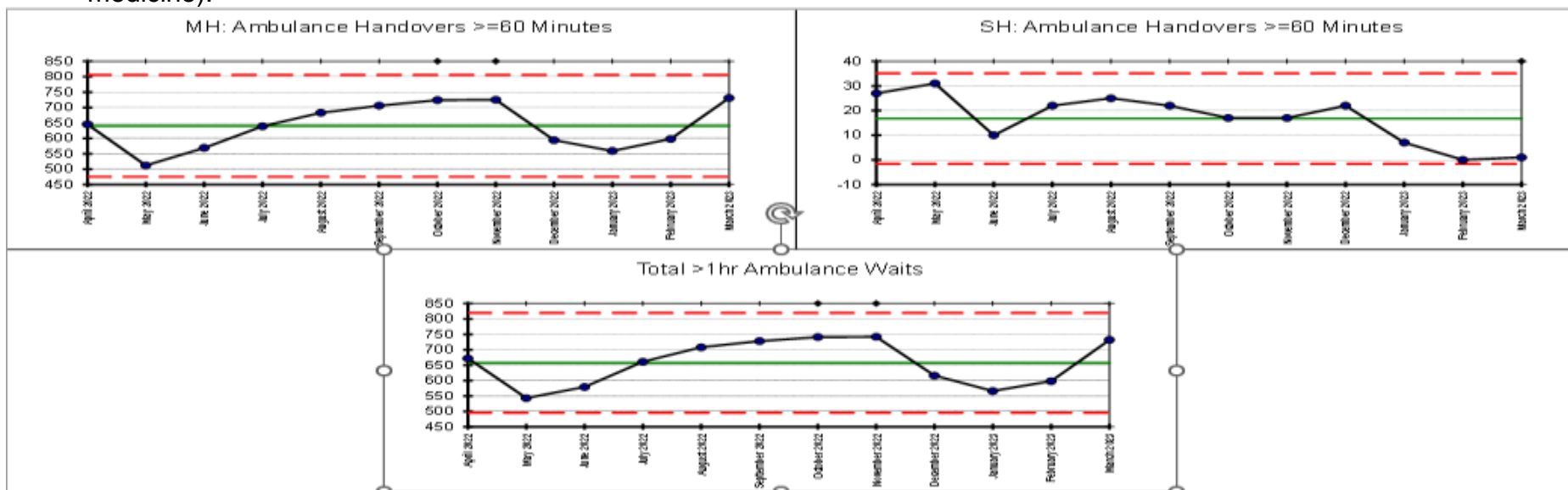


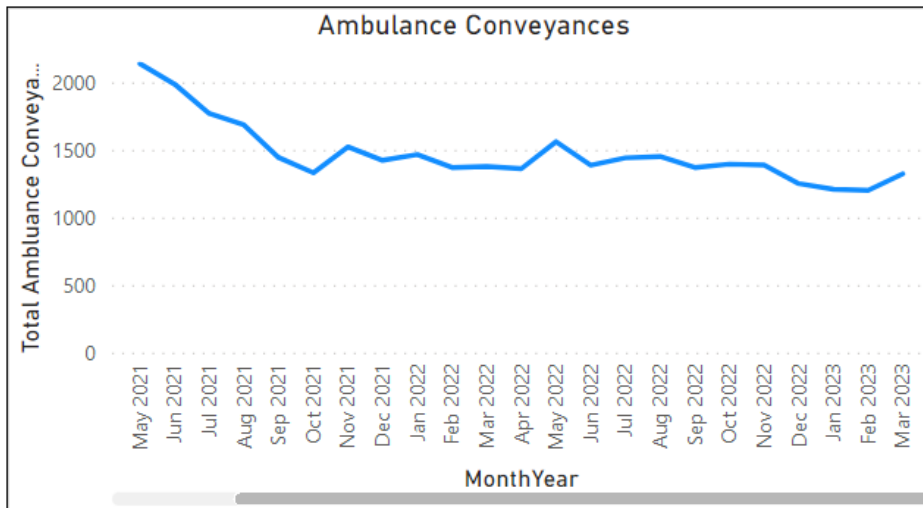
Month Start Date	Patients Waiting >12 Hours	MH: Patients Waiting > 12 Hours	NPTH: Patients Waiting > 12 Hours
April 2022	1269	1267	2
May 2022	1206	1203	3
June 2022	1389	1387	2
July 2022	1458	1456	2
August 2022	1460	1458	2
September 2022	1460	1460	0
October 2022	1622	1621	1
November 2022	1433	1431	2
December 2022	1604	1604	0
January 2023	1110	1109	1
February 2023	1123	1122	1
March 2023	1386	1385	1

3.1 Ambulance attendance and handover delays >1 hour

Ambulance attendances to ED remain at a reduced level compared to pre-covid levels, but remains entirely stable on a month – by – month basis. This can be explained by a number of factors including:

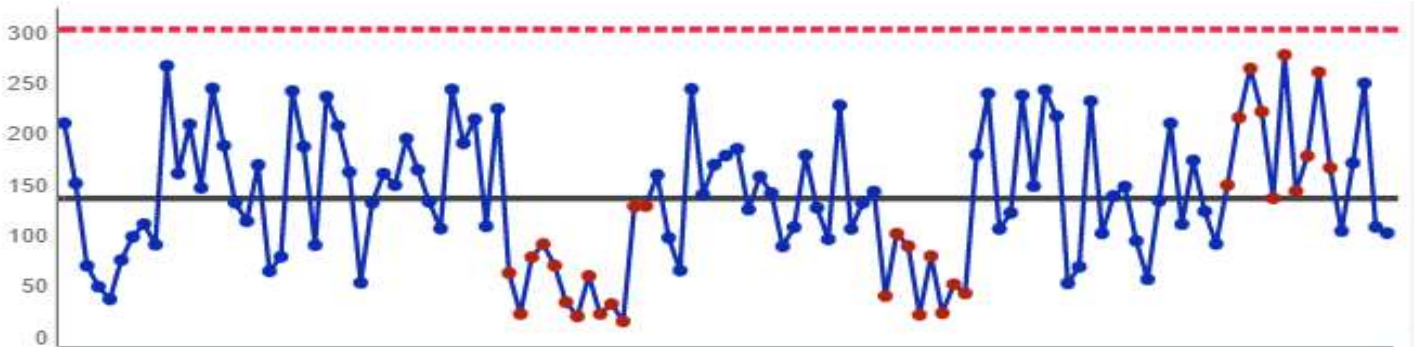
- Welsh Ambulance Service Trust (WAST) Clinical Safety Plan-this is the escalation framework for WAST. Their actions will vary dependant on the level of escalation reported however at moderate to high levels of escalation, ambulance response is 'rationed' and persons in lower acuity categories will not receive an ambulance response.
- Advanced practice paramedic screening of the waiting demand with redirection of appropriate patients to alternative pathways thus avoiding ED – the Advanced paramedics have recently moved in the acute hub and work alongside the acute GP's in Same Day Emergency Care which will allow improved opportunity for non-conveyance and redirection.
- GP review of the waiting ambulance demand with redirection into alternative community pathways, self-care or SDEC.
- Introduction of training to Nursing homes around the management of patients that have fallen ensures appropriate conveyance if required.
- Ambulance handover delays deteriorated during March 23 (both in terms of the number of delays, and the average time for handover) . The number of hours lost to delayed handover continued to be highly variable, averaging around 174 minutes per vehicle, with periods of low handover delays (circa 20 minutes) to period of high handover delays (circa 250 minutes) within the data. This is despite a number of ongoing initiatives at the front door including 'fit to sit', redirection to OPAS, and discharge direct from an ambulance, along with the opening of AMU (note, all ambulance data reflects ALL specialties and not just medicine):



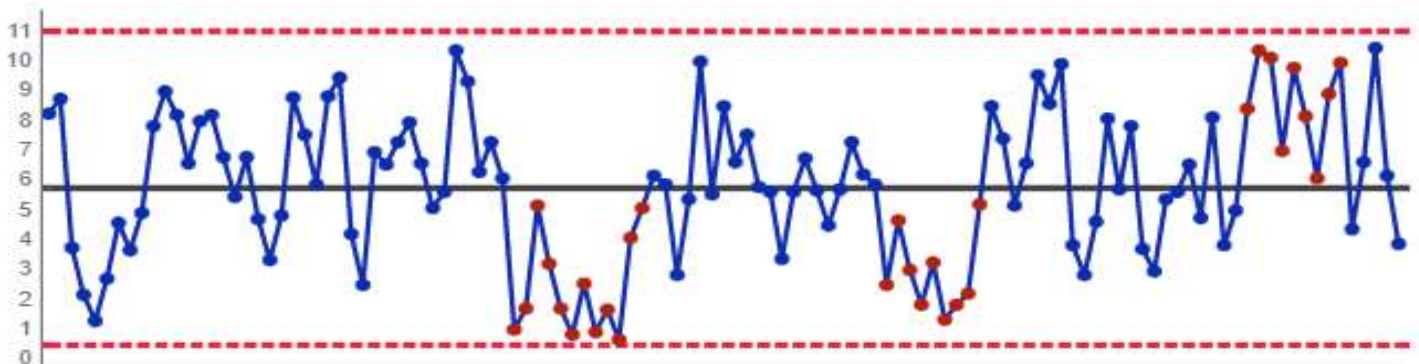


MonthYear	Average Ambulance Notify to Handover (Minutes)
Apr 2022	157
May 2022	85
Jun 2022	139
Jul 2022	137
Aug 2022	172
Sep 2022	204
Oct 2022	212
Nov 2022	204
Dec 2022	219
Jan 2023	184
Feb 2023	175
Mar 2023	226
Total	174

1st October 2022 to 31st March 2023
 Number of Emergency Ambulance Hours Lost Waiting For Handover



1st October 2022 to 31st March 2023
 Mean Number of Ambulances Waiting for Handover



The reasons for the delays in 'offloading' are multi-factorial and include:

- Surges in demand from the ambulances or self-presenting patients;
- Availability of 'red' capacity to manage respiratory pathways
- Overcrowding in the ED caused by poor system flow site wide resulting in the inability to admit patients into the hospital
- The withdrawal by WAST of the 3 HALO vehicles which supported crews to be released by supporting patients on dedicated vehicles whilst waiting to be offloaded into the ED – when a patient went into to the HALO vehicle they were taken off of the clock

The introduction of 2-hourly huddles in ED have re-focused attention on prioritising ambulance offloads and maintaining safety within the department.

3.2 WAST Immediate Release Policy (IRP)

The 'All Wales Immediate Release Protocol' was approved on 14 July 2022 by the NHS Wales Chief Executive Group, and issued and adopted on 25 July 2022 following agreement at Emergency Ambulance Services Committee (EASC). The protocol details that *'Chairs and Chief Executives across Wales agreed that to manage in real-time the serious risk of harm to patients categorised as immediately life threatened (Red) or Serious (Amber 1) in the community without an available emergency ambulance resource assigned that all immediate release directions made by the Trust will be accepted by the receiving emergency department without unnecessary delay enabling a response to be made to the patient awaiting a response in the community'*. The protocol also states: 'declining an immediate release direction for Red and Amber 1 patients must not occur.'

A robust escalation pathway which includes Bronze (Clinical Site Matron), Silver (Director of the Day chairing the safety huddle calls), Gold (Exec of the Day) and CEO in the event of 3 failures to release is in place to support this policy. Risks to patient safety for those in the ED are considered as part of the 'amber 1' release. When a request is received for an IRD, a clinical risk assessment is made by the Consultant and Nurse in charge of the ED, if the patient safety risk in the department is deemed too great then this is escalated to the senior management team where an immediate review of any additional pre-empt and surge capacity is undertaken. If these avenues have already been exhausted then regrettably a request will be declined. Since the introduction of this policy, there has been minimal ability to support the 'amber 1 release' but all requests for 'red' release have been supported.

A joint monthly meeting is in place between WAST and the health board which follows an All Wales agenda and reviews incidents including the IRP conformity – challenges to the ‘red’ release in particular are discussed and all have been refuted and learning from inability to release ‘amber’ requests is also included.

An Internal Audit report of the IRP dated January 2023 has recently been shared with the Health board which details performance against the IRP for the period of 1 July 2022 to 5th September 2022 and looks also at internal escalation and reporting within WAST of the position. The table below shows the performance against both red and amber release by Health board. Swansea bay has a combined performance of 23% of requests to release ambulances across both pathways being accepted which is the lowest of the Health boards, although this relates predominantly to amber release.

Red Priority Incidents					
Hospital Name	Accepted	Not Accepted	Total	Percentage accepted	Percentage not accepted
Bronglais General Hospital - Aberystwyth	7	1	8	88%	13%
Glan Clwyd Hospital - Bodelwyddan	92	2	94	98%	2%
Glangwili General Hospital - Carmarthen	18	2	20	90%	10%
Grange University Hospital - Cwmbran	56	16	72	78%	22%
Maelor General Hospital - Wrexham	59	2	61	97%	3%
Morriston Hospital - Swansea	68	17	85	80%	20%
Prince Charles Hospital - Merthyr Tydfil	21	2	23	91%	9%
Prince Philip Hospital - Llanelli	8	2	10	80%	20%
Princess of Wales Hospital - Bridgend	12	22	34	35%	65%
Royal Glamorgan Hospital - Pontyduon	27	3	30	90%	10%
Royal Gwent Hospital - Newport	0	1	1	0%	100%
Singleton Hospital - Swansea	1	0	1	100%	0%
University Hospital of Wales - Cardiff	56	7	63	89%	11%
Withybush Hospital - Haverfordwest	22	0	22	100%	0%
Ysbyty Gwynedd Hospital - Bangor	58	5	63	92%	8%
Total	505	82	587	86%	14%

Health Board Quarter 1 2022/23	Number accepted	Number declined	Total	Percentage Accepted	Percentage Declined
Aneurin Bevan University Health Board	138	42	180	77%	23%
Betsi Cadwaladr University Health Board	829	644	1473	56%	44%
Cardiff & Vale University Health Board	135	15	150	90%	10%
Cwm Taf Morgannwg University Health Board	133	117	250	53%	47%
Hywel Dda University Health Board	156	123	279	56%	44%
Swansea Bay University Health Board	117	401	518	23%	77%
Not defined	20	13	33	61%	39%
Total	1,528	1,355	2,883	53%	47%

Amber 1 Priority Incidents					
Hospital Name	Accepted	Not Accepted	Total	Percentage accepted	Percentage not accepted
Bronglais General Hospital - Aberystwyth	6	6	12	50%	50%
Glan Clwyd Hospital - Bodelwyddan	126	163	289	44%	56%
Glangwili General Hospital - Carmarthen	14	51	65	22%	78%
Grange University Hospital - Cwmbran	24	24	48	50%	50%
Maelor General Hospital - Wrexham	119	131	250	48%	52%
Morrison Hospital - Swansea	14	267	281	5%	95%
Prince Charles Hospital - Merthyr Tydfil	17	2	19	89%	11%
Prince Philip Hospital - Llanelli	12	9	21	57%	43%
Princess of Wales Hospital - Bridgend	8	44	52	15%	85%
Royal Glamorgan Hospital - Pontyduon	7	2	9	78%	22%
University Hospital of Wales - Cardiff	27	2	29	93%	7%
Withybush Hospital - Haverfordwest	20	2	22	91%	9%
Ysbyty Gwynedd Hospital - Bangor	107	109	216	50%	50%
Total	501	812	1313	38%	62%

The red performance is not recognised by Morriston and there is concern that updates to the WAST system have not been made following investigations into query 'red requests' being declined. The most common issue with regards to 'red' release related to decisions made by WAST to support the crew to go on break/swap crews even though the ambulance had been released, or the system not being updated by WAST in a timely way. During this quarter, there was frequent requests to release multiple crews at the same time for 'amber' release which was not feasible, and also requests to release more ambulances than were on site – data quality issues during this period were recognised as an issue as the process was embedded and this has also been reflected in the internal audit report.

It is acknowledged though that the ability to release 'amber' calls is often not possible due to the acuity of patients within the department and overcrowding. A number of improvement actions have been undertaken and are detailed later in the paper. The implementation of AMSR is also expected to improve this position with patients being directed to AMU and SDEC rather than the ED and improved flow across the system and measurement against the IRP will be formally introduced into the weekly dashboard and daily site huddles. The layout of the ED also does not allow for patients to be placed in corridors within the ED which is the practice in some of the other Health boards to achieve the IRP and 'boarding' on wards is frequently undertaken already to support the heightened escalation. Other opportunities to learn how this is being achieved has been undertaken by the COO late in 2022 when all Health boards submitted and presented the joint ambulance recovery plan. Further opportunities to learn from others though will be followed through direct with the Health board ED leads and included within the recovery plan.

3.3 Wider system measures:

In order to understand performance in ED and ambulance performance, there is a requirement to explore wider system performance, the performance outputs in ED are directly impacted by performance in other parts of the health and social care system. There are internal measures that help to explain the ED crowding including:

- Length of stay
- Emergency bed day utilisation
- Admission activity
- Clinically optimised position

3.3.1 Average Length of stay (LOS) & Length of Stay of Admitted Patients

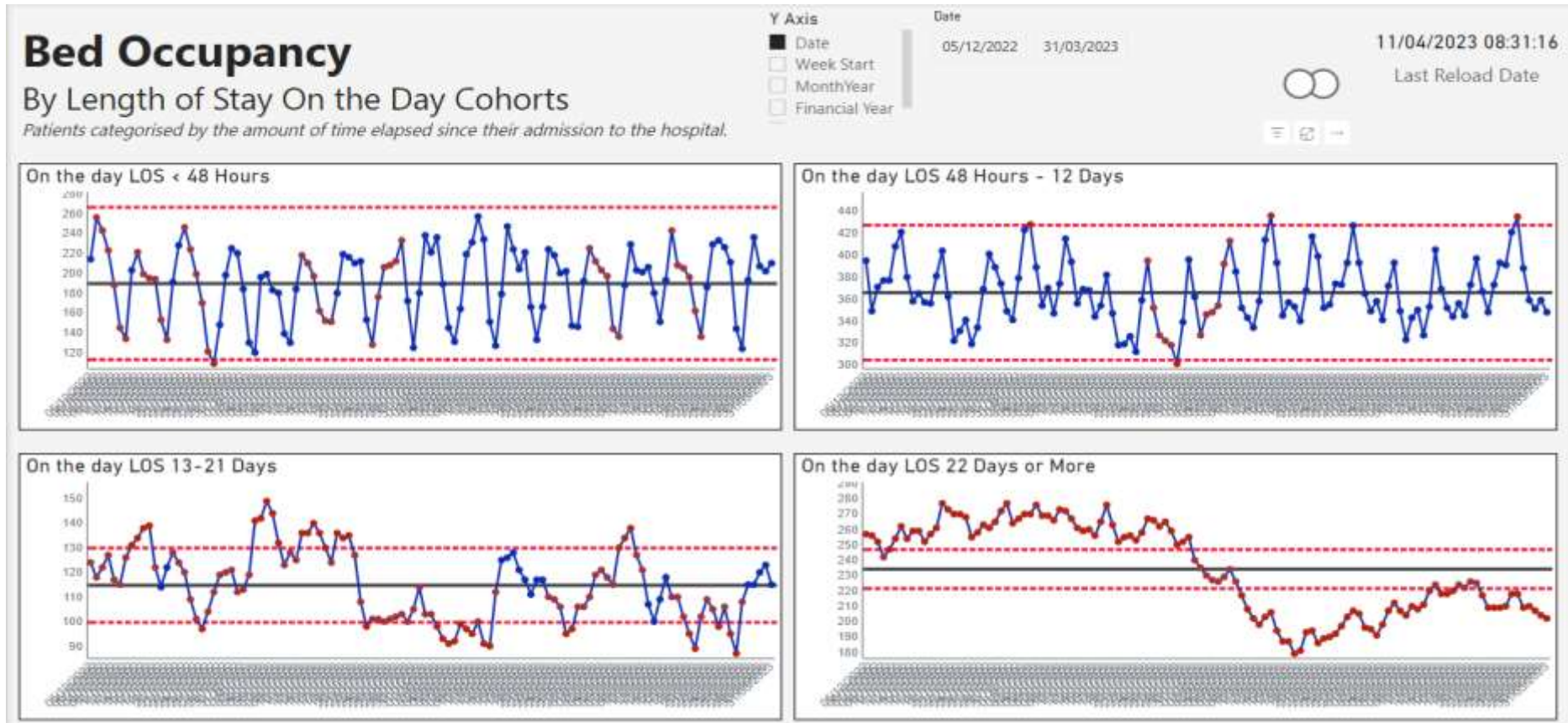
The summary table provides an overview of the LOS for general medicine to highlight the challenges faced currently with regards to having sufficient capacity within the medicine bed base across the Health Board to support effective flow of patients from the ED.

ALL EMERGENCY GENERAL MEDICINE <u>NON COP</u> - ANNUAL: ALL SITES					
	Morrison Hospital	Singleton Hospital	Neath Port Talbot Hospital	Gorseinon Hospital	HB WIDE (ACUTE ONLY)
2015/16	8.6	8.3	37.1	33.8	8.5
2016/17	8.2	8.2	46.8	38.3	8.2
2017/18	7.5	7.3	41.5	28.6	7.4
2018/19	8.3	6.7	41.8	29.1	7.5
2019/20	9.0	7.6	40.7	34.1	8.4
2020/21	6.3	5.0	27.8	22.2	5.8
2021/22	5.8	4.9	30.0	21.6	5.5
2022/23	7.9	4.4	29.5	28.6	5.7
ALL EMERGENCY GENERAL MEDICINE <u>COP ONLY</u> - ANNUAL: ALL SITES					
	Morrison Hospital	Singleton Hospital	Neath Port Talbot Hospital	Gorseinon Hospital	HB WIDE (ACUTE ONLY)
2019/20	26.1	-	63.5	-	26.1
2020/21	19.4	20.8	39.2	38.5	20.1
2021/22	30.9	29.6	47.0	49.1	30.4
2022/23	34.2	49.6	66.8	65.5	45.2
ALL EMERGENCY GENERAL MEDICINE <u>ALL PATIENTS</u> - ANNUAL: ALL SITES					
	Morrison Hospital	Singleton Hospital	Neath Port Talbot Hospital	Gorseinon Hospital	HB WIDE (ACUTE ONLY)
2015/16	8.6	8.3	37.1	33.8	8.5
2016/17	8.2	8.2	46.8	38.3	8.2
2017/18	7.5	7.3	41.5	28.6	7.4
2018/19	8.3	6.7	41.8	29.1	7.5
2019/20	9.8	7.6	40.8	34.1	8.8
2020/21	8.1	8.5	35.2	30.3	8.2
2021/22	8.7	8.4	42.8	39.6	8.6
2022/23	10.2	8.8	58.5	54.6	9.7

The table above continues to highlight the increase in LOS at Morrison for the emergency medical patients (this is mainly attributable to patients who are clinically optimised but remain in a hospital bed). An increase is also noted at NPT and Gorseinon – both hospitals being essential to support patient transfers from Singleton and Morrison to assist in enabling effective flow.

Length of stay reduction remains a key factor in successfully delivering the AMSR programme and these are being monitored via the Bed Decommissioning Group chaired by the CEO and the 6 Goals Board, chaired by the Chief Operating Officer.

The Length of Stay of **ALL** admitted patients (whilst in a hospital bed in Morriston or SIngeton ONLY) indicates a positive reduction in the number of long stay patients (22days or more), a result of the increased focus on board and ward round governance that underpins the SAFER programme of work being rolled out and in the transfer of COP patients to Sinleton as part of the overall AMSR programme.



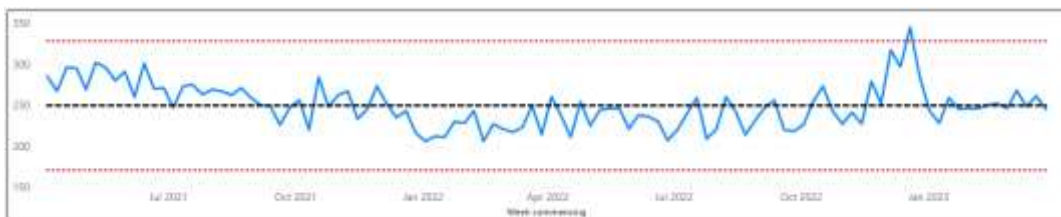
3.2.2 Emergency bed day utilisation (Morrison Hospital Only):

Emergency bed day utilisation is a good barometer of pressure in the system. The graph below demonstrates that since December 22, a higher level of Total Emergency Beddays has occurred than at any time previously (including long before the date range applied in the chart), even accounting for the AMSR switch. The bed day utilisation will include the period of active clinical management and for clinically optimised patients will include the 'non-added value' bed days used, the latter of which remains a critical issue.



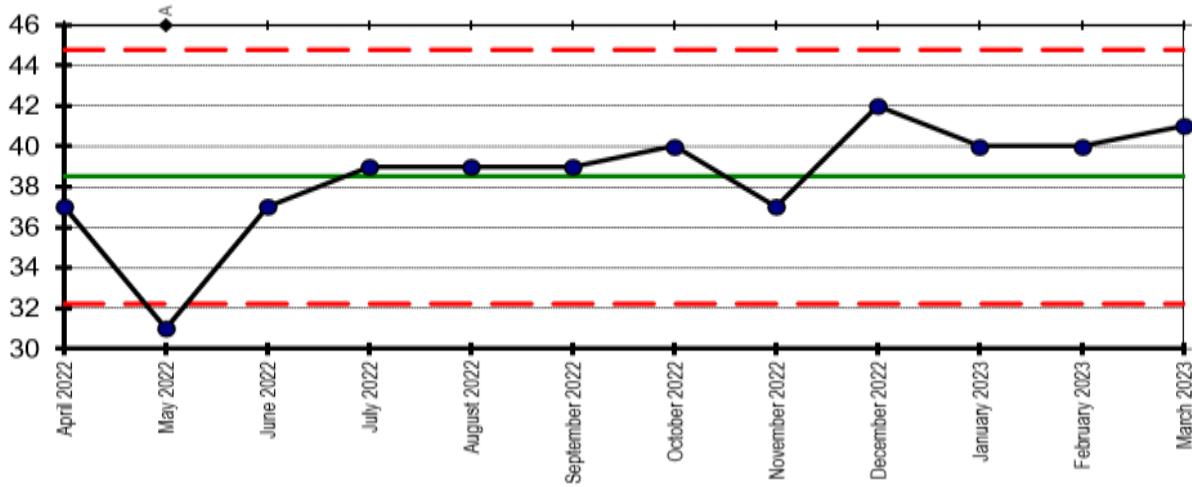
3.3.2 Admission activity (Acute Medical Emergencies, Morrison & Singleton):

At an aggregate level, acute Emergency Medical Admissions (excluding ZERO DAY admission) clearly peaked in December 22, driven by an increase in Influenza and Covid presentations, reaching a level higher than at any point since April 2021 (and as high as any point previously). The level reduced back to within the usual expected levels during 2023 (to 31st March 2023).



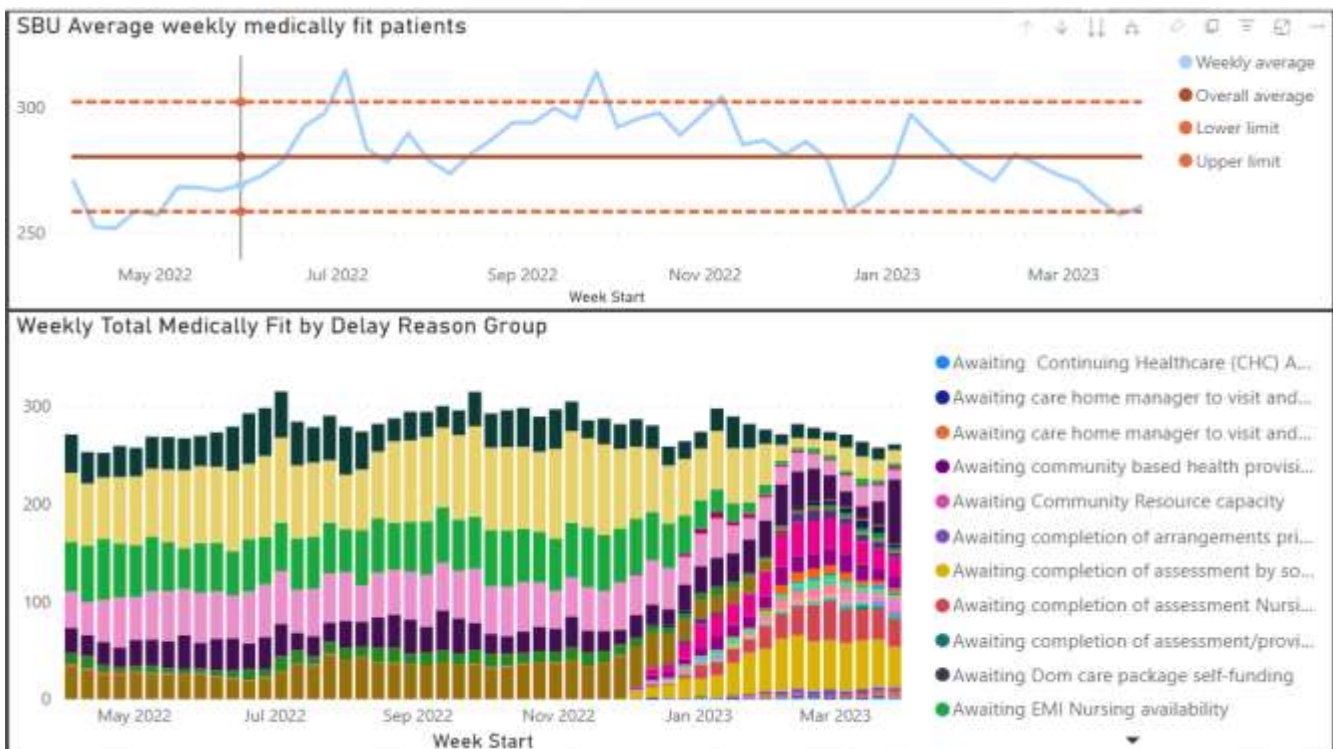
The level of patients in ED awaiting admission has remained relatively constant throughout the last 12 months 2023 (this includes ALL specialties as it is not possible to disaggregate General Medicine from the ED system currently):

Average number of patients in ED waiting for a bed at 9am
(ALL SPECS)



3.2.4 Clinically optimised position

Whilst, the clinically optimised position in the Health Board remains a key challenge with high numbers of patients occupying acute beds waiting to move to more appropriate settings to continue their care pathway, or waiting for community support/placement, a small reduction (-32 pts per weekly average) has occurred during 2023, as evidenced in the chart below. There is operational focus on this patient group in all hospital sites with weekly review meetings with LA and community partners to expedite the pathways of these patients.



There is a 'step up, step down programme of work being led by Primary Care, Community and Therapies services to right size community services and thus prevent the prolonged patient delays in hospital beds. There is also national and local focus on delivery of the Discharge to Recover and Assess pathways to improve system flow. However, *prevention* of clinically optimised patients is demonstrating the greatest opportunity with services and teams aimed at avoiding admission of frail older persons who following an acute hospital stay often join the clinically optimised queue. The key question for the frail older person patient group is 'does the need to treat their acute presentation outweigh the well evidenced risk of the negative impacts of hospitalisation in this patient population?'

Virtual wards are in their infancy in SBUHB with regards to 'step down' activity, however, the working partnership between the Clinical site team, ED and virtual wards has resulted in an increase in admission avoidance and more recently, an increase in patients discharged from the wards with support from the virtual ward teams.

Currently, the majority of referrals are from primary care and community however there is joint working with the hospital sites to promote a 'push/pull' mechanism into virtual wards to balance the referral numbers between primary and secondary care. Admission avoidance pathways have been developed with the OPAS team in Morriston and an ED in-reach pilot demonstrates an opportunity to pull patients from ED directly into virtual wards.

The OPAS service co-located with the Emergency Department has been expanded based on the success of the service in terms of admission avoidance for frail older persons. The multi-disciplinary team undertake comprehensive geriatric assessment at point of contact with the front door and with support from community teams and more latterly virtual wards are very practised in admission avoidance for this patient group. In addition, WAST now have direct admission pathways into OPAS thus avoiding ED.

The Same Day Emergency Care service is also focussed on admission avoidance managing people with ambulatory sensitive conditions on a same day basis without the need for admission. The Health Board participated in the NHS Benchmarking of SDEC services (England and Wales) at the end of 2022, and participated in the National feedback review where considerable discussion took place about the actions and next steps required to further develop SDEC services.

3.2.5 Acute Medical Unit

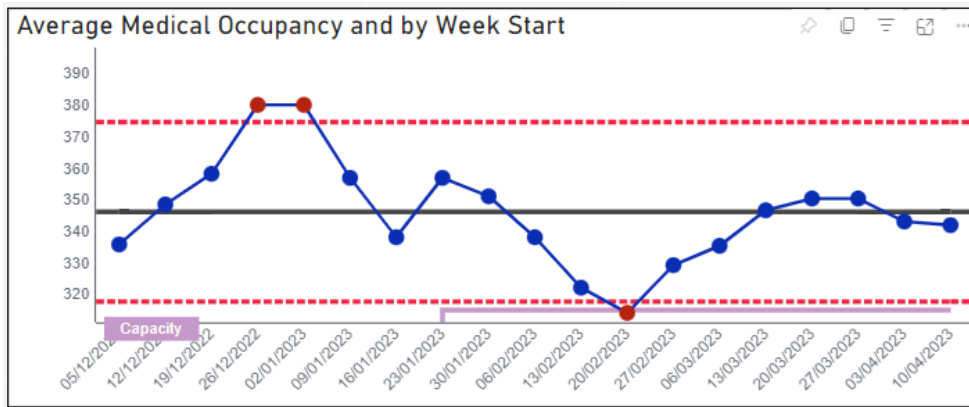
A summary of the key performance metrics relating to the Acute Medical Unit is provided in the following table (some analysis is based upon a separate, detailed AMU report), but key highlights include:

- Activity through AMU continues to progressively increase as the model matures following the full centralisation of the medical take at the end of January 2023;
- Flow to downstream wards for patients requiring >48hrs care is increasingly impaired as the full impact of the centralisation is realised onto the Morriston site -

this impacts negatively upon the AMU ability to function in line with its' design (ie a <48hour short stay unit);

- Bed occupancy within AMU has been stabilised at a maximum of 55 patients throughout 2023 (to 31st March), in line with the current SOP – the funded capacity for the unit is 45;
- Medical Bed occupancy fell throughout January and February as additional capacity in the care homes came on-line post xmas;
- Singleton continues to support the medicine transition with 99 beds currently opened for COP patients – the plan to decrease this commitments is overseen by Rob Royce and Anjula Meta through a Bed Decommissioning group established by the CEO.
- The reduced level of Medical outliers are even lower than those reported in the table as these include patients under the care of Cardiology on Ward C and in Dyfed (Surge capacity);
- Further work is in place to increase the use of the discharge lounge.

	Dec 2022	Jan 2023	Feb 2023	Mar 2023	Total
Avg Patients Waiting in ED	43	40	40	41	41
Emergency Medical Admissions	1002	1085	1209	1406	4702
Emergency Medical Discharges	921	1093	1207	1365	4586
Admissions / Transfers to AMU	579	653	745	846	2823
Discharges from AMU	271	360	398	498	1527
Transfers from AMU to downstream wards	263	279	352	349	1243
Avg Bed Occupancy AMU	49	53	54	57	53
% of Patients Admitted to AMU With LOS < 48 Hours	53 %	50 %	54 %	56 %	54 %
% of Patients Admitted to AMU Assessment With LOS < 48 Hours	54 %	53 %	57 %	57 %	56 %
Transfers to Singleton	25	41	88	65	219
Transfers to NPT	33	47	38	58	176
Transfers to Gorseinon	9	23	12	20	64
Avg Core Medical Occupancy	294	301	301	307	301
Avg Medical Outliers	61	58	29	36	46
Discharges Using Discharge Lounge	92	131	106	120	449
Discharges Using Discharge Lounge Transferred Before 12pm	38	49	46	54	187
Avg COP Patients	107	117	94	92	103
Avg Medical COP Patients	72	81	59	62	69
Ambulance Handover Delays > 1 Hour	508	559	598	731	2396
Ambulance Handover Delays > 4 Hours	294	258	292	416	1260



Additionally, the percentage of all medical patients with a length of stay of less than 48hrs when admitted to any ward has increased to 42% (this will exclude those patients waiting in ED for admission). This increases to 53% for those patients admitted via AMU. Enhancement to the reporting capabilities continue to be refined. The average LOS of patients in AMU as a whole has been at or below 2 days since January 2023. For assessment , it is circa 24 hours, and for the short stay element it is circa 3 days.

3.3 Improvement Overview

Table 1 summarises the actions which have continued to be the focus in Q4 for improvement of U&E care at Morriston.

Table 1: Overview of Improvement actions for U&E care at Morriston

Issue	Actions to address issue	Output/Aim	By whom	By when
Admission Avoidance schemes	Pre-hospital - Scheduled WAST stack review for 12 hours per day-GP triage of patients waiting for ambulance response with a view to non-conveyance where clinically appropriate	Initial audit suggested 23% of conveyances could have been managed at an alternative setting if capacity had been available – baseline required of capacity gaps	Clinical lead SDEC	In place
	Pre-hospital - Consultant Connect – paramedics and GPs are able to access primary care and care of the elderly advice - also extended to other specialties	Support the management of the patients in the community rather than admitting	SDEC and Care of the elderly	In place
	Pre-hospital – Contact First	Triages the 111/WAST ED outcome calls to provide potential directing from ED – 34% are discharged from the reviews to date	SDEC team	In place – 24/7
	Pre-hospital – WAST paramedic referral from scene	Support patients to be managed in alternative setting/direct admission from ED	SDEC team	In place
	Expansion of the Older Persons Assessment Service (OPAS) aimed at admission avoidance of the frail older person.	80% admission avoidance of the frail older person patient group assessed via the OPAS team. Time extended to 7am-7pm 5/7 – plan to extend to weekends	Clinical Lead Older Persons Services	In place – 7am-7pm 5/7

Issue	Actions to address issue	Output/Aim	By whom	By when
	Primary care – access to primary care services in ED and as part of SDEC	Offer alternative pathway for primary care presentations	SDEC team	In place 7 days 8am-8pm
	Direct admission pathways for WAST to alternatives to ED	Expand direct admission pathways – in place for OPAS – Plan to extend to SDEC based on the national direct paramedic referral pathway. Potential for 10-12 alternative conveyances – auditing in place	Clinical Lead SDEC	In place
Front door flow and ED overcrowding	Dedicated Ambulance Co-ordinator roles, 2 wte in post – current cover available 10:00 – 22:00 hrs 6 days per week	Dedicated Ambulance Co-ordinator roles, 2 wte in post – current cover available 10:00 – 22:00 hrs 6 days per week	ED Team	In place
	Internal ambulance handover escalation and immediate release framework in place	Aimed at reducing handover delays and ensuring red release ability at all times	Associate Service Group Director ECHO	In place
	Workforce – match capacity to demand	Flex workforce to meet peak demands to improve responsiveness time	ED Clinical Leads	In place – subject to further expansion and skill mix review
	Introduction of a dedicated acute medical team in ED to provide support to patients with prolonged waits for in-patient medical beds and to ensure senior decision maker support available for those patients that can be discharged from ED.	Improved patient safety. Reduced length of stay for medical pts.	Associate Service Director Medicine.	In place
	Primary care triage at front door	Redirection of patients to SDEC – estimate 6-10 patients	SDEC	In place

Issue	Actions to address issue	Output/Aim	By whom	By when
	-Use of the 'Fit to Sit' operating procedure with all patients assessed against this criteria to promote handover.	To support offloading and better use of capacity in the department	ED Clinical lead	In place
Internal flow activities to support reduced occupancy and improve flow throughout the day	Refocus of SAFER bundle with the appointment of an internal improvement team for Morriston with particular initial focus on medicine	To reduce occupancy and improve flow through the day through senior decision makers, effective board rounds, effective discharge management processes	All service groups	In place – all medicine wards have had their initial focused week of improvement and now supporting surgery
	Refocus acute assessment and short stay units to expedite discharges	Surgical SDEC in place; frailty assessment and short stay units in place; medical	ASGD	In place Constrained by lack of flow from the assessment units
	Weekly review of the clinically optimised patient group with LA partners and alignment of the patients waiting to the D2RA pathways. Includes expansion of an integrated discharge service to proactively support discharge management on the wards	To expedite outflow and reduce the number of clinically optimised patients occupying acute beds	Deputy Head of Nursing ECHO PLUS Exec led reviews of amber and red patients	In place
	Establishment of an Integrated Discharge Hub including Single Point of Access to support the management of complex discharges – trial phase 1 for a SPA at Morriston	Reduction in delays associated with COPs	Task and Finish group established	Phase 2 pilot – no update available
	Focus on the Real Time and Demand Capacity information	Support early flow through the day to reduce ED overcrowding	Matrons	Replaced by the roll out of SAFER

Issue	Actions to address issue	Output/Aim	By whom	By when
	to ensure early discharge and prompt escalation.			
	-Extraordinary Silver Command in place for Community service focussed on flow into community services and use of Care Homes as temporary capacity solution.	Support timely discharge of clinically optimised patients and ensure maximisation of all capacity	HON Primary, Therapies & Community Services	In place
Additional Capacity	Additional surge/escalation beds in use system wide as follows: +2 Gorseinon +21 Singleton +10 NPTH + 10 5 ED surge trolleys 4 trolleys OPAS 5 15 beds TAWA ward	The surge benefit has been offset by the high number of clinically optimised patients occupying acute beds.	Service Group Directors	Complete
	Additional capacity to support D2RA capacity	Additional capacity at care homes to be purchased to offset challenges in social care market and to support	COO	Ongoing
	Expansion of virtual wards	Support step-up and step-down of patients requiring on-going health support to be managed at home	MD Primary care	Expansion to all virtual wards in place – gaps in recruitment preventing full benefit

4.0 Six Goals for Urgent and Emergency Care Programme



The Welsh Government's policy vision is that all users of urgent and emergency care services will receive the right care, in the right place, first time. The Six Goals for Urgent and Emergency Care Policy handbook 2021 - 2026, published in February 2022, set out clear ambitions of a programme of work that will, when delivered collectively support achievement of the policy vision and secure optimal patient and staff experience, clinical outcomes and value.

In supporting delivery of the policy, there are requirements to ensure at a national, regional and local level the component parts of the programme are working towards the desired outcomes for the people of Wales.

All health boards have received clear instructions with regards to the expected governance of the programme and appointment of a 'triumvirate' team who will support the delivery of the programme. The Programme Manager for the 6 Goals Programme has been appointed and started on 10th October 2022 and sits within the Morryston service group. The current U&E care Board will be restructured to reflect the delivery of the programme of improvement and actions into the 6 domains and future reports will be written in this way, reflecting that U&E care improvement is across all health and social care structures.

In addition to the areas of improvement already discussed (largely Goal 2 and 5), a high level overview of activities currently underway against these domains include

- **Urgent Primary Care (Goals 1/2 / 3)**
 - Establishment of virtual wards and use of risk stratification tools to support people at high risk of admission being managed within the community setting
 - sustainable delivery of a 24/7 urgent care service which can provide clinical or professional advice remotely and face to face in the right place, first time. Integration of Urgent Primary Care Centres/services, GP and multi-professional practitioners (in and out of hours), and other community services such as community pharmacy, dental and optometry which provides consistency of service appropriate to the local needs.
 - Scheduling arrival slots into a range of local services including minor injuries units (where appropriate), emergency departments or same day emergency care hospital services to be further explored where this has added benefit to patient outcomes.
 - Same Day Emergency Care (SDEC) – a co-ordinated service model which supports people to access appropriate and safe care as close to home as possible and avoids the need for admission to an acute hospital through the provision of alternative pathways and ambulatory care – core component of the AMSR programme
 - Extension of OPAS service to support care homes and patients escalated for risk of deterioration
- **Rapid response in a physical or mental health crisis (Goal 4)**
 - Review of rapid response services
 - Establishment of single point of access
- **Home First and Reduce risk of readmission (Goal 6)**
 - Review of Home First provision and Reablement support
 - Establishment of 'bridging' and personal care support to enable earlier discharge from hospital
 - Engagement with virtual wards and third sector in supporting patients at risk of readmission including access to 'hot' clinics with secondary care expertise

Further work is required to ensure targeted delivery against the ambitions outlined in the plans and a supportive infrastructure is embedded which assures delivery and improvements for patients accessing U&E care services.

The Urgent and Emergency Care Board is being transformed to the '6 Goals Board' to provide oversight to the delivery of the programme across the Healthboard – the Board will be establishing the trajectories for improvement across the programme including the Tier 1 standards.

5.0 Recommendation

The committee are requested to note this paper and the ongoing progress towards establishing a framework for improvement within the U&E care service at the Morriston and also note the changes in future structure and governance of the programme of work to reflect the requirements of the Welsh Governments ambition for 'right care, right place, first time' to be delivered through the 6 goals programme for U&E care.