3.1.3 Unscheduled Care

As a result of our actions over the last two years, our numbers of medical admissions have stabilised and our rates of readmissions have steadily decreased over the last 18 months. Additionally our improvements in admission avoidance and hospital flow have changed our planning by highlighting two issues: the Emergency Department internal flow at Morriston needs to be improved and the discharge difficulties at the back door of our hospitals are a major constraint to any further reductions in length of stay. The increasing number of DToC patients over the summer of 2018 is a challenge that we continue to address. In 2017/18 we remodelled our inpatient capacity, but we did not complete the full suite of changes planned due to the demonstrable pressures in our unscheduled care system.

To tackle the Emergency Department (ED) issue, we are exploring the options to commission a targeted 10-week improvement programme in ED at Morriston in Quarter four of 2018/19 on which we can build our improvement programme in 2019/20.

With regard to the backdoor, we have drafted our Frailty Model in conjunction with partners (see our Older People's Section 3.1.10). In light of the growing number of patients in our hospitals who are medically fit for discharge we therefore commissioned a Right Care Right Place Bed Utilisation Survey with Local Authority partners to ensure we have a shared, jointly owned understanding of the constraints and blockages in the system and an optimum model of intermediate care to make a major step change in admission.

The Right Care Right Place review also identified that we have more opportunities within our own gift to improve flow through the National Unscheduled Care Programme; reducing variation in implementing the SAFER flow bundle and service improvement actions around Estimated Date of Discharge, board rounds and clinical leadership. The NHS Wales Delivery Unit audit of complex discharge has also identified similar opportunities and, although we have achieved a great deal in rolling out these approaches over the last two years, we plan to implement a programme management approach to discharge improvements as a priority for 2019/20. This approach will be overseen by our Unscheduled Care Service Improvement Board to ensure delivery in 2019/20 and in particular ahead of winter 2019/20.

The Clinical Services Plan confirmed that we will improve our unscheduled care system with the aim of centralising the Acute Take for Swansea at Morriston Hospital. Whilst we do not yet have a detailed critical path for the centralisation of the Acute Take, our plan is based on some of the major underpinning step changes we know we will need to make. This includes the agreement of our Acute Care model as a first step. In 2019/20, improving the efficiency of our unscheduled care system by reducing our length of stay and reducing bed occupancy at Morriston will be an essential step towards improving performance and releasing capacity on the site to centralise the service. This will also improve quality by reducing the likelihood of transmitting infections and the deconditioning effects on older people of a prolonged hospital stay.

The Clinical Services Plan also includes a Single Point of Access (SPoA) for patients and professionals to gain access to advice to avoid admission and to keep well at home and to improve communication. The provision of the SPoA is closely linked to the expansion in Acute Clinical Teams and reablement services which will be included in the Hospital2Home Transformation Bid and this is included in our plan for 2019/20.

Living Well

Working towards our Strategic Aim of supporting better health and wellbeing by activating, promoting and empowering people to live well in resilient communities through our population health, primary prevention and digital wellbeing plans is essential to achieve a sustainable unscheduled care system. Our plans to improve population health through implementing the Primary Care Model for Wales by rolling out the Primary Care Cluster Model, developing the Cwmtawe Neighbourhood Approach, the Swansea Wellness Centre and digital wellbeing are described in Section 2.1, 2.2 and 2.3.

The prevention actions regarding flu and smoking cessation described in Section 2.2 are particularly important in the Health Board's area due to the high incidence of respiratory disease as evidenced in our rapid health needs review. Our plans to improve respiratory health are included in our

Respiratory Disease Delivery Plan included in Appendix 2. We have also been at the forefront in pushing the boundaries of the current restricting General Dental Service's contract which disincentiveses holistic oral health care through a range of new approaches which are included in our Oral Health Delivery Plan included in Appendix 2. This includes all of our continuing actions to improve oral health for children and adults in 2019/20.

Reduction in Unnecessary Hospital Attendance

Our plans for 2019/20 are based on our achievements over the last two years and the national approach to address the five national priorities which are:

- Falls
- Breathing difficulties
- Chest pain
- Health care professional calls
- Mental health.

We have tested innovation and improvement through our Winter Plan 2018/19, a summary of which is included in Appendix 9, and made very good progress to implement the Emergency Ambulance Five-Step Pathway. Our plans for 2019/20 build on this learning with our ambulance and Local Authority partners. Our work through EASC is described in more detail and documented in the EASC and NUSC templates included in Appendix 9. Our joint work to reduce frequent attendances to A&E through a multi-agency approach is now mainstreamed as part of our normal business.

A significant range of joint improvement initiatives are planned with the Welsh Ambulance Service Trust (WAST) to deliver sustained improvements in the quality of care and timeliness of 999 responses whilst also supporting improvements across the Health Board's wider Unscheduled Care system. We will also be working with WAST colleagues to implement the recommendations of the WAST Amber review.

A core focus of the joint initiatives are to deliver prudent conveyances system with a demonstrable reduction in the number of patients conveyed to hospital by ambulance, where clinically safe and appropriate by enhancing access to alternative pathways of care, improving management of frequent service users and particularly improving services for managing falls. We will also increase the number of patients referred to a primary or community care setting for their ongoing care needs and avoiding an unnecessary admission to hospital. To achieve this we will:

- Work with the ambulance service to identify opportunities to enhance and develop alternative care pathways including jointly reviewing activity to improve the compliance with established care pathways and, where required, develop new care pathways to meet the needs of our patients and avoid unnecessary admissions into hospital.
- Continue the multi-disciplinary team approach to manage frequent service users including the regular review of activity data.
- Work closely with WAST clinical leads to pro-actively manage and reduce demand from patients who have fallen. This includes Health Board funding for the Joint Falls Response Vehicle and continuing to support the roll out of the 'IStumble' and 'I Fell Down' falls assessment toolkits across all Residential and Nursing Homes.
- Fully embed the additional 6 Advanced Paramedic Practitioner (APP) rotational roles providing specialist care within both a Primary Care setting (supporting the GP workload) and providing a WAST response to clinically appropriate 'Amber' and 'Green' 999 patients..
- Through the expansion of Hospital2Home we plan to embed the successful pilot, which is not currently funded, for the Acute Clinical Teams to take directly from the ambulance 'stack' to care for patients at home instead of redirect patients to services away from hospital, as described in the Primary Care plan.

We recognise that delays during hospital handover can deplete the availability of ambulance resources to respond to incoming 999 calls in the community. On top of the actions listed above to reduce the number of 999 patients taken to hospital, during peak periods of activity we will ensure that in line with the recommendations of the WAST internal audit report on hospital handover that robust operational management arrangements are in place to manage patient flow at the front door to enable the safe and timely handover of ambulance patients.

We will continue to engage and collaborate with the ambulance service to support service transformation / service change proposals through our existing joint planning mechanisms. This will include future changes to our Stroke models and the transition period of the Bridgend Locality boundary changes. In addition to our work with ambulance partners the Health Board will be continuing to drive towards treating 25% of A&E attenders through ambulatory care pathways.

We have also taken up the offer of the Care and Repair Wales (CRW) to support at Morriston and Neath Port Talbot hospital through a targeted Assessment Service during Quarter 4 2018/19 to pilot this approach. The objective of the three month pilot is to link health and housing services by enabling CRW case workers to join ward rounds to identify needs of older people before they are discharged. We know that over 80% of patients using the service in Princess of Wales have fallen before and that it provides significant support for secondary prevention of falls.

Timely Access to Emergency and Urgent Care

The work we have done to improve flow over the last 18 months has highlighted that internal flow issues within the Emergency Department at Morriston need to be better understood. Following the Bridgend transfer, around 70% of our A&E performance will be driven by performance through the Morriston department. Last year our Plan described the workforce issues within the department which requires investment of around £1.5m. This is not affordable within the Health Board's financial plan in 2019/20 but will need to be addressed as recruitment opportunities present in future years.

The priority for 2019/20 is a shared understanding with senior staff about the cultural, clinical leadership, workforce and system issues that are influencing the performance within the department. The Health Board has commissioned improvement programmes for vascular, fractured neck of femur and Acute Medical Assessment Unit pathways and these will have a positive impact on emergency department flow in 2019/20. The Health Board is exploring use of the same diagnostic and change approach in the Emergency Department to develop a holistic improvement plan for 2019/20.

Additionally, we have trialled new direct-to-specialty pathways for general medicine, cardiology, respiratory and neurology, including hot clinics, in 2018/19. We will be gaining the full-year benefit of in 2019/20 and these approaches are built into our performance improvement plans as well as providing evidence-based, quality services for patients with chronic conditions.

We will also be concluding our work to change the workforce model and put in place sustainable primary care Out of Hours services for the new Health Board within the year as described in the Primary Care Plan.

Reduced patient risk through reduction in avoidable delays and prolonged hospital stay

We reduced our length of stay in combined medicine by 17% over the eighteen months between April 2017 and September 2018 but benchmarking shows that we still have major opportunities to further reduce length of stay, improve quality and reduce bed occupancy across our system. We will be aiming to achieve the Capita efficiency length of stay benchmarks which underpin our Clinical Services Plan over the next three years. These validated the work we had already done to underpin our Annual Plan 2018/19 and we will continue to build momentum in service change to achieve reductions, using the organisational learning from the last two years.

Transformation Opportunities

Hospital 2 Home

In partnership with Swansea City Council and Neath Port Talbot County Borough Council we will take forward a new project to strengthen the Western Bay optimum model to become a Hospital 2 Home service. This is an outcome of the Right Place Right Care review findings which highlighted there is a great deal of opportunity to make changes, both within Health Board services, and in partnership with the Local Authorities to improve flow through the whole system, to use our joint capacity effectively and to improve outcomes for older people

The development of an agile Hospital2Home service that has the ability to assess, care and reable patients at home is based on recent social care research undertaken by Professor John Bolton of Oxford Brookes University. This service will maximise the independence of older people and ensure care packages are right sized before being put in place. It will be built around a trusted assessor model where assessment does not take place in a hospital bed and strengths-based assessments taking place when the patient is not in crisis. It is felt that this service could help to maximise the use of the existing social care capacity to best effect and ensure there is flow across the system.

Demand and capacity modelling supported by the work undertaken in the Right Care Right Place review will ensure a clear evidence base to underpin partnership working that delivers the right care in the right place for Older People. A revised Transformation Bid for the Hospital2Home service was submitted to Welsh Government in quarter 2 2019/20 but Phase 1 of the service will be implemented in for winter 19/20 using ICF monies.

Our plan includes a mixture of service improvement actions which are within our gift as a Health Board, and the development of new services including a major step change in integrated community service provision through an integrated Hospital2Home service which will which will build on our existing partnership arrangements and Western Bay Optimum Model of Intermediate Care.

Our service improvement plan is based on the recommendations of the NHS Wales Delivery Unit review of complex discharges and the Right Care Right Place bed utilisation survey, both of reported in the latter half of 2018/19. Both of these reports show that we can improve quality and use prudent healthcare approaches to reduce variation in our internal processes. Our action plan, which will be driven through the Unscheduled Care Service Improvement Board includes targeted, detailed actions to further improve:

- SAFER board rounds
- Senior review before midday
- MDT clinical management plans for each patient
- Use of Estimated Date of Discharge methodology
- Standardised identification of patients who are Medically Fit for Discharge;
- Assessment processes for Continuing Health Care
- The number of, and bed days used by, stranded patients
- Use of the Red2Green methodology to improve patient care.

We will also be improving our Psychiatric Liaison Service to improve services for patients with mental health problems in our general hospitals to improve the quality of care and support discharge arrangements. Additionally, we will also be revising our escalation policy for 2019/20 to build on the 'safety huddle' approach to managing patient flow which has been supported by the NHS Wales Delivery Unit in 2018/19. This will recognise the required changes in the patient flow process, improve the management across our unscheduled care system, improve quality by clarifying the additional capacity protocol to risk-assess the use of 'pre-empt' beds and also prepare for the Bridgend boundary transfer.

As well as this focus on service improvement within our hospital systems we have also undertaken continuous planning work during 2018/19 which underpin this three year unscheduled care plan. Based on the previous Capita demand/capacity analysis in 2016 a linked series of plans to reduce length of stay and bed occupancy at Morriston hospital by rebalancing the underlying medical bed deficit of 40 beds has been developed. Several components of this have been tested with Winter Plan monies in 2018/19 including the hot clinics, expansion of the frailty at the front door service (OPAS), and a trial of the pathway co-ordinators. Not all of these schemes are affordable within the Health Board's financial plan for 2019/20 but we will be continuing to explore innovative investment approaches through Invest to Save or Value-based Healthcare or other sources to develop sustainable solutions going forward.

We have also taken the opportunity to revisit our dialogue with partners about the back door flow, as the rising numbers of DToCs and constraints in social care provision have become increasingly apparent as our internal processes have improved over the last year.

To do this we undertook the Right Care Right Place bed utilisation survey in October 2018 in partnership with our Local Authority colleagues. This helped to promote cultural change as it included a multi-disciplinary, multi-agency team of 71 staff undertaking point prevalence survey and using the results to undertake multi-agency, collaborative planning. The main findings of the report are include in the Plan on a Page which is in Appendix 8. As well as the service improvement actions around ward flow which have already been described this identified major out-of-hospital opportunities to:

- Increase admission avoidance, particularly with regard to patients admitted for IVs by increasing the capacity and responsiveness of the Acute Clinical teams as well creatively using the ACTs as the Single Point of Access and to work with WAST partners to take from the ambulance stack
- Put in place a default Hospital2Home 'discharge to recover and assess' service which will be the only gateway to assessment for patients' ongoing needs, by assessing at home and after /during reablement
- Make a step change towards a default position of reablement at home instead of in hospital by increasing capacity in reablement at home services, thereby moving towards our Clinical Services Plan aim of moving Care Closer to Home.

Local Authority colleagues strongly advised that there were limited opportunities to increase capacity social care due to the workforce and financial environment. However, based on the work of Professor John Bolton's work at Oxford Brookes University on out of hospital care, there is collaborative support for a Hospital2Home service to right-size demand for social care and maximise the prudent use of the existing resources. A Transformation Bid for the Hospital2Home service was submitted to Welsh Government in quarter 4 2018/19 with the aim of putting the service in place for the winter 2019. The new service will link closely with our chronic conditions management services including the existing Early Supported Discharge for COPD and it will also support the further development of Early Supported Discharge for Stroke which is described in the Stroke Care Plan. We will also be implementing our Liver Disease Plan which is included in Appendix 2.

Major Trauma
The plans for Major Trauma are included in Appendix 10.

The summary plan and enablers below are our original plan as described in the Executive Summary. Our revised plan which addresses the further challenges we have faced in 2019/20 is included in section 3.1.3a.

Summary Plan and Enablers– Unscheduled Care

Actions		Milestones 2019/20	Measures	Lead
Improve **Flu Vaccination** rates for at risk groups to meet WG targets.	(see Section 2.2)			
Implement the **Neighbourhood Model** (Cwm Tawe).	(see Section 2.1)			
Roll-out **Primary Care Cluster Model.**	(see Section 3.1.2)			
Reduce **Unnecessary Hospital Attendance** through admission reduction for the Big 5 in partnership with WAST (see Appendix 9), continuing multi agency approach to manage frequent attenders, and Care and Repair Wales pilot scheme rollout. Including falls response vehicle to reduce un-necessary conveyance to hospital.	Q1	Reduction in frequent A&E attenders (2018 baseline)	NDF_76 NDF_77 NDF_78	COO
	Q1	Evaluation of Care and Repair pilot scheme		
	Q4	Reduction in medical admissions (March 18 baseline) Reduction in the conveyance of non-injury falls patients from 18/19 baseline.		
	Q4	25% patients seen in ambulatory care pathways		
Ensure **Timely Access to Urgent or Emergency Care** through implementing assessment recommendations for vascular, Fractured neck of femur, Acute Medical Assessment Unit (AMAU) and ED pathways, maximising use of Medicine Neurology and Respiratory Hot Clinics and flexible beds.	Q1	Implement recommendations Fractured neck of femur, AMAU, vascular improvement programmes	NDF_77 NDF_78	COO
	Q2-4	Monitor effectiveness of improvement programmes		
	Q2-4	Monitor effectiveness of Hot Clinics		
	Q4	Implement recommendations ED pathways		

Reduce patient risk through reduction in **avoidable delays and prolonged hospital stay** through Implementing the NHS Wales Delivery Unit complex discharge audit recommendations and Right Care Right Place review recommendations.	Q1	Implement key priorities from audit recommendations Reduce variation in SAFER flow bundle Discharge process improvements	LM_18 HW_DP10	COO
	Q1	Implement revised Escalation and patient flow policies.		
	Q3	Monitor impact and improvement		
	Q4	Improve Psychiatric Liaison service (funding required)		
Rebalance medical bed capacity at Morriston through maximising the use of Early Supported Discharge for COPD patients at Morriston and Singleton, and the use of community hospital frailty beds, pathway coordinators (funding dependent), Green to Go ward relocation (funding dependents) and implementing OPAS pus (funding dependent).	Q1	Maximise early supported discharge for COPD and use of community hospital frailty beds	LM_18 LM_19 LM_20 HW_DP9	COO
	Q2	Implement Pathway Coordinators (funding dependent)		
	Q2	Implement OPAS plus (funding dependent)		
	Q3	Implement Green to Go (funding dependent)		
Draft Transformation Fund Bid for **Hospital2Home** service including new discharge to assess and recover model, expansion in reablement at home, expansion in acute clinical teams & Single Point of Access.	Q1	Final bid and service model signed off by RPB	LM_18 LM_19 LM_20 NDF_31 HW_DP10	DoS
	Q2	Recruitment and communications plan		
	Q3	Prepare implementation		
	Q4	Implementation		
Centralise the Acute Medical Take at Morriston and align with continued planning for the HASU (subject to any engagement/consultation requirements).	Q1	Commence planning and Critical path	NDF_76 NDF_77 NDF_78 NDF_66 HW_DP8	DT/ DoS
	Q2	Plan for wraparound ward agreed		
	Q3	Plan for 2nd MRI scanner agreed		
	Q4	Planning for HASU and Acute Medical Take aligned		

Workforce	Finance
• Centralisation of the Acute Medical intake at Morriston Hospital will require the Health Board to redesign the workforce to support this service change. • Develop new workforce models to support unscheduled care including; integrating therapy and mental health staff into ED, to support the turn around and management of patients at the front door. • An integrated service and workforce model, for Hospital 24/7 care at Morriston Hospital which will release time of qualified staff to manage the sickest patients in the hospital.	• Revised Transformation Fund Bid for Hospital2Home Service submitted Qu2 2019/20, no feedback received. Phase 1 proceeding with ICF monies. • ED Department workforce plan included as a risk in Financial Plan

• Development of a sustainable Minor Injuries Unit working closely with Morriston and Singleton DU to enable an integrated workforce model across the Health Board. • Utilisation of Pharmacists to reduce prescription turnaround times by increasing ward based dispensing, and ensuring early involvement in discharge planning with other health care professionals. • Workforce plan for Phase 1 of Hospital2Home in place.	• Roll out of schemes tested through Winter Plan will be tested through Invest to Save and Value-based Healthcare approaches
Capital	**Digital**
• 2019/20 Enhance the Acute GP Unit and Medical Day Case Unit at Singleton to increase ambulatory care pathways • 2020/21 SDMU/Wraparound Ward and second MRI scanner at Morriston • Prepare for the centralisation of the Acute Take at Morriston and Major Trauma Unit included in regional plans	See Section 3.3
Bridgend Transfer Implications	
Transfer issues are being addressed with WAST and the performance trajectories have been calculated on the basis of the new Health Board footprint.	

3.1.3a Unscheduled Care Plan September 2019 – March 2020

During the first half of 2019/20 the Health Board has experienced unprecedented challenges in our unscheduled care system and our performance has not achieved the planned trajectory levels that we submitted to the Board for approval in January 2019.

With regard to demand there has been an unexpected rise in front door (Emergency Department and Minor Injuries Units) attendances from May onwards, with an increase of around 6% from 2018 experienced across the summer months. The good work that has been done in the Health Board area (as described in our main plan) to implement the 111 service and falls conveyance vehicle has continued enabling a 10% reduction in Healthcare Professional (HCP) and amber calls month on month over the summer than was the case in 2018. The falls service results in at least 65% conveyances to hospital being avoided for the target patient group although there remains significant numbers of people being admitted due to falls when not managed through the falls service. Overall, conveyances by ambulance have reduced by 8-10% month on month compared with the same period last year. However the main growth in demand at the front door has come from Red calls which are 20% higher than the same period last year. This accords with the clinical view which is that patient acuity has been significantly higher than previously experienced over the summer period, alongside an increase in the number of acutely unwell patients who are self-presenting at our Emergency Department.

Due to much of the work that is described in our main plan, the number of emergency admissions has not increased over the period from last year to this year, showing that our work over the last three years to improve our front door assessment and admission avoidance capabilities has been successful. This also includes managing demand for older people, as the number of 75 year olds admitted to hospital is still significant (around 12,000 pa) but has remained stable over the period, despite the increase in the ageing population.

In terms of segmenting this demand, the main underlying clinical conditions are still respiratory conditions and falls. The number of frail older people being admitted to hospitals remains high – as would be expected given the demographics. However, the challenges with capacity to the community (in both health and social care) can lead to a prolonged hospital stay for some patients with the associated risk of deconditioning. We have further work to do to reduce the number of bed days used by patients with these conditions.

The Health Board has experienced a range of capacity challenges which have contributed to the difficulties in our system over the summer period. At the front door, the Minor Injuries Unit at Singleton has been temporarily closed due to staffing difficulties. A review of our 'front door' workforce (undertaken by Kendall Bluck) has also identified that there are significant workforce shortfalls in Morriston Hospital's Emergency department, particularly with regard to Consultant staffing, which has impacted on senior decision-making capacity - these are being addressed. There also remains challenges in capacity across the system which contributes to the compounds the issues of demand and flow across the system.

With regard to the flow of patients into our hospital sites, our main plan identified that, based on the Capita review and the Clinical Services Plan underpinning efficiency assumptions, we have an imbalance in medical bed capacity at Morriston Hospital of an average of 40 beds (14,600 beddays pa). Additionally we are continuing to experience significant challenges in discharging patients to the most appropriate place. Our original plan identified that there had been a steep rise in Delayed Transfers of Care in the summer of 2018 and this has remained a serious cause for concern in 2019 as numbers have continued to rise. The Health Board agreed a target of 50 DToCs per month with partners but actual numbers have been over 80 per month from May through to August. In addition to the challenges the Health Board continues to work through, the collapse of a number of homecare providers in the Swansea and Neath Port Talbot areas has contributed to this position in an already fragile domiciliary care market.

Additionally, due to the ward fire in Singleton hospital and other environmental issues, there has been a net loss of 30 beds on the site since March. As a mitigating action the Health Board has kept our winter 'surge' capacity open on all 4 hospital sites (including Gorseinon). Despite our best

efforts, the ring-fenced orthopaedics ward at Morriston Hospital has had to be used to care for medical patients since March. This has had a consequent impact on our planned care performance which is discussed in that chapter.

In summary, many of the drivers addressed in our main plan continue to be issues for the Health Board. Our actions to improve the internal ED processes and workforce remain a priority, as do the need to tackle respiratory and falls admissions to better manage our demand, alongside the implementation of the Hospital2Home service to address the challenges in discharging patients to the most appropriate place.

However, as a result of the unexpected rise in demand due to acuity, and the additional capacity issues experienced, the Health Board is off-track on delivering the planned national front door measures that were agreed by the Board in January. This is impacting adversely on our patients' experience of our service and is putting huge pressure on our staff. Improving the position is an urgent focus over the next six months and a mitigating action plan is in place that is monitored weekly by the Chief Operating Officer and team, with the support of the internal Delivery Support Team. We will be maximising all opportunities afforded by the Health Board and Regional Partnership Board Winter Plan monies to improve our performance.

Based on this action plan, revised trajectories have been agreed (see Appendix 3 based on the mitigating actions that the Health Board has in place. Some of the actions were identified in our main plan (for example the Hospital2Home and respiratory services) for implementation in the second half of the year but this also includes further new actions which have been agreed in-year.

Summary Plan – Unscheduled Care September 2019 – March 2020

Actions	Milestones 2019/20 Q3, Q4		Measures	Lead
Improve **Flu Vaccination** rates for at risk groups to meet WG targets.	(see Section 2.2)			
Implement the **Neighbourhood Model** (Cwm Tawe).	(see Section 2.1)			
Roll-out **Primary Care Cluster Model.**	(see Section 3.1.2)			
‘Keep Me at Home’: **Reducing Unnecessary Hospital Attendance**		Full time frequent attenders nurse and administrative support has now funded by WG on a non-recurrent basis until 31st March 2020.	NDF_76 NDF_77 NDF_78	COO
	Q3	Continue falls level 1 service for full year 2019/20.		COO
	Q3	Exploring potential to develop falls level 2 service over the winter months.		COO
	Q3	Support with ambulance handover delays/ managing relationships/ supporting ambulance release at high escalation including: Explore tailored HALO support for the winter months with WAST Assistant Head of Operations (i.e. afternoons/ evenings as opposed to 24/7 cover) and Develop proposal as part of HB winter plan – costings circa £91k		COO
	Q3	Proposal developed for A Healthier Wales funding via EASC - Seek additional support for 5 day service through RPB and/ or HB winter monies.		COO
	Q3/Q4	ACT to take from the stack when daily capacity allows.		COO
	Q3/Q4	Implement WAST handover plan		COO
Ensure Timely Access to Urgent or Emergency Care	Q3	Advertise to recruit 4 WTE ED consultants immediately supported with recruitment package – as first stage of Kendall Bluck recommendations.	NDF_77 NDF_78	COO
	Q3	Confirm acute medical care workforce model for Swansea Bay.		MD
	Q3	Develop proposal for GP Triage in ED.		COO
	Q3	Implement medical ambulatory care service and Increase trolley capacity across AMAU and SSSU		COO
	Q4	Older People’s CRG to implement single frailty at the front door model		COO

	Q3	Implement improved pathways for AMAU, vascular and #NOF Medical and respiratory hot clinics in place		COO
	Q3	Following extension of the Psychiatric Liaison Service, implement third sector support to front door for low level mental health interventions to prevent crisis.		COO
'Good Hospital Care' :Reduce patient risk through **reduction in avoidable delays and prolonged hospital stay** and rebalance medical bed capacity at Morriston	Q3	Increase the number of patients who receive end of life care by the palliative care team from current baseline, confirming the status of plan/ resource implications of increasing capacity in community services.	LM_18 HW_DP10 LM_18 LM_19 LM_20 HW_DP9	COO
	Q3	Relaunch SAFER flow campaign. Medical engagement in SAFER patient flow practice.		MD/DON
	Q4	COPD Pathway developments – consider implementation of phase 2 ESD business case, which will reduce patients presenting to ED & reduce length of stay.		COO
	Q4	Increase system capacity through Use of NPT Ward and consideration of capacity available in old MAU space and maintaining surge capacity and reopening singleton wards 11 and 12		COO
	Q3	Develop nurse or criteria led discharge protocol and rollout new choice and escalation policies.		COO
	Q4	Increased system capacity through Pharmacist working in ED to provide clinical input and accelerate patient flow		COO
'Hospital2Home'	Q3	Develop additional Swansea Bay ESD service capacity, in advance of, and leading into, the hospital to home transformation capacity plan.	LM_18 LM_19 LM_20 NDF_31 HW_DP10	COO
	Q3	Reduce discharge challenges through new discharge to recover and assess model including Trusted Assessor and increasing community reablement capacity		COO
	Q3	Identify options to strengthen LA accountability/ escalation support and implement changes to NPT LA social care model to be implemented by the end of Sept/ early October.		DCEO
	Q4	Implement stroke ESD model		COO
System Enabling Actions	Q3	Develop options for better collecting of clinical information – including temporary enhanced clerical resource to implement.		ADI

	Q3	Roll out SIGNAL system to Morriston on a phased basis by the end of Q3. Already in place and successful in Singleton.		ADI
	Q4	Roll out SIGNAL system to NPT and Gorseinon hospitals.		ADI
	Q3	Seek HR support with review of ward receptionist JD's.		COO
	Q3/Q4	Targeting of DST support, LEAN resource, first through agreeing where service improvement resource is best targeted to support system improvement.		DOT
	Q3	Re-clarify (or change) expectations of what being at level 4 triggers means/ actions expected		DON
	Q3	Implement agreed HB protocol for the management of medically fit for discharge meetings.		COO