Instructions:
1. Review the Outcomes and strengthen where possible

2. Where possible provide measures

3. Consider if sub-tasks need to be added under methods
4. review/add timelines to the methods/tasks using the
5. Indicate the timing of capital, finance or workforce

Key			
Methods	Planning Task	Implementation/ Delivery Task	Consultation Task (Staff or Public)
Finance	Investment		Financial Benefits
Workforce	Planning/ Engagement	Recruitment/Staff Change	
Capital	Investment	Capital Work	
Funding	Base	COVID	Recovery	Other

ANNUAL PLAN 2021/2022 DELIVERY TIMELINES: URGENT AND EMERGENCY CARE

GOALS (What are we	METHOD (How	Sub Action	TIMELINE												OUTCOME (What
			Quarter 1			Quarter 2			Quarter 3			Quarter 4			
			Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	
	Relocate the AGPU from Singleton to Morriston to provide a single service with single point of access for ED referral into the servce and develop into a 7 day service	Develop T&F Group to oversee service transfer													Diversion of 6 pts a day from Morriston ED.
		Agree Operational Policy to include referral path from ED													
		Organisational change staff consultation													
		Operationalise service at Morriston working 8-8, 5 days per week (Phase 1)													

	Consider implementation of 7 day working based on service need (Phase 2)														
Development of an AEC service model at Morriston - within the overarching Medical Short Stay Unit (MeSSU)	Identify Clinical Lead														
	Identify required capacity, workforce and fit for purpose location (may require capital / estates input)														Full model: Streamlined discharge profile across 7 days. Total est. bed day reduction equates to admission avoidance of 8-10 pts per day.
	Commence recruitment of workforce														
	Implement Phase 1 (limited hours -weekdays) of AEC model pending ACP recruitment														
	Consolidate Phase 2 workforce plan and operational model to provide 7 day AEC														
	Implement Phase 2 (extended hours/weekends) of AEC model pending ACP recruitment														

Improve quality of care and outcomes for acutely unwell patients through rapid access to medical assessment, investigation, diagnostics, treatment and if appropriate	Acute physician led AMAU at Morriston integrated with community teams and care pathways based on single ambulatory model	Identify Clinical Lead													
		Agree and clarify components of clinical model (expect to discuss at Core Group meeting TBC date in April/ May 2021)													
		Agree Operational policy, workforce, location and community inreach/pull model, realigning the Keep me at Home workstream to the acute front door services													
		Commence recruitment of workforce linked to the AEC recruitment programme													
		Relocate Ward D and staff team to Enfys AMAU					Informal	Informal							
		Launch new Integrated AMAU at Morriston													

admission to hospital; An Acute Medicine model implemented on the Morriston site based on single ambulatory assessment and admission An Ambulatory Assessment Unit integrated with acute care community teams and clusters, to reduce admission rate, improve patient experience and reduce LOS. Improved GP access to manage deteriorating patients through access to specialty hot clinics	Centralised acute medical admissions with single specialties for older people, gastroenterology respiratory	Identify Clinical & Management Lead per specialty													Aligned to, and within the AEC and MeSSU bed day reduction outcomes above (i.e. 6 pts AGPU and 8-10 pts AEC/AMAU) As the work matures, specific sub-speciailty bedday reduction outcomes will be formulated, but are expected to equate to at least 1 day LOS per patient
		Agree and clarify components of clinical model to include respiratory, gastroenterology, COTE, Haematology & Oncology													
		Undertake modelling and sign off bed pools and ward designations Singleton and Morriston to include surgical specialties, COTE, acute medical specialties, haematology and oncology													
		Agree workforce models for both sites to cover in patients, front door services, on call and other DCC commitments by specialty													

and cardiology on Morriston site	Describe pathways and flows between Singleton/Morriston site linked to action above													
	Undertake medical/nursing staff recruitment linked to the AEC recruitment to cover integrated medical model													
	Undertake formal staff consultation as per Organisational change policy in respect of hospital base/service changes - also to include CHC engagement regarding major service change.													
	Activate revised service model and pathways													

Development of 7-day working of therapy and clinical support services (also including Local Authority TBC)	Re-establish workforce workstream to explore the feasibility of seven day working and identify workforce affected													Essential,and aligned to the AEC and MeSSU outcomes above (i.e. 6 pts AGPU and 8-10 pts AEC/AMAU)
	Restart workforce consideration s process													
	Start Organisation al Change Process to consultant and agree seven day working with staff													
	Once OCP process complete, implement workforce changes													
Standardised hot clinics linked to Consultant Connect around medical and elderly care five days per week	To be integrated as part of the revised job planning process linked to the wider medical model													Further admission avoidance opportunity 10 pts per week (2 per day) coupled with 1 earlier discharge per day - bed equivalent of 3 beds per day saved.
	Phased implementati on of hot clinics through Consultant Connect - 2 specialties													

		Full roll out of hot clinics linked to development of specialty based services													
Implement an integrated Medicine for Older People pathway across SBU to - Support Older people to live well in the community - Improve management of complex co-morbidities, frailty, falls, and dementia	Establish Cluster based Virtual Wards	**Step down: Community Geriatrician**													
		Active recruitment into posts to support the community COTE service													
		Step up: Enhance regional ACT service to reduce number of avoidable admissions,													

- Provide rapid support close to home at times of crisis - Deliver good acute hospital care when needed (including surgery), - offer high quality rehabilitation and re-ablement after acute illness or injury including good discharge planning and support, - Offer choice, control and support towards end of life - Reduce negative impact of avoidable hospital admissions and long lengths of stay on older people's physical and mental wellbeing		**RisK Stratification** GP practices/clusters to be offered participation to complete e-frailty index risk stratification to identify high risk severely frail population and complete framework with defined indicators. Indicatorswill include falls risk assessment/ prevention, advanced care planning (if indicated), Chronic disease optimisation, review of admissions to improve future care													9,000 bed days saved per year (Lightfoot analysis) Strength and balance programme to prevent falls can reduce risk of falls by 54% impacting on reduced ED attendance and serious injury with associated morbidity and mortality
		Deliver an evidence based strength and balance programme to prevent falls at a cluster level													

	Develop cluster chronic conditions team to offer proactive input to high risk patients with one or more chronic condition with aim to optimise treatment, enhance self management and avoid future hospital admissions.													
	Commence virtual ward Community Geriatric service in 4 Clusters- Develop/enhance virtual ward service in 3-4 clusters to include clinical and managerial workforce requirements													
Establsih Emergency Frailty Unit (EFU) based	Identify Clinical and Mangerial lead													Between 16th April and 31st Augst 2018

on Older Peoples Assessment Service (OPAS) Model in ED Deliver extended service extended hours 8am - 8pm 7 days per week	Develop clinical/operational model and workforce model to deliver 7 day 12 hour EFU service integrated with older peoples pathway.													OPAS assessed 437 patients (23 patients per week). 333 (76%) of patinets were discharge home after OPAS Intervention (17 per week). Extended hours to increase ED dicharges by 17 per week. (Further data awaited from Lightfoot - available w/c 19th April).
	Engagement with Hospital 2 Home wokstreams to ensure re-ablement pathways exist to support EFU model													
	Consultation with existing workforce to move to extended hours/seven day working													
	Commence recruitment of identified posts to support 7 day EFU model and wider single frailty model													
	Implement extended 7 day EFU model													
Establish Acute Frailty Unit (AFU) based in the	Identify Clinical and Mangerial lead													25 % (~60 per week) of patients aged >75 admitted

Medical Assesment Unit at Morriston Hospital Based on iCOP model. Deliver extended service extended hours 8am - 8pm 7 days per week	Develop clinical/operational model and workforce model to deliver 7 day 12 hour AFU moel integrated with older peoples pathway													to Acute Medical Unit to recieve CGA. Increased % of patients dicharged from the assessment unit without need for extended inpateint stay. (iCOP assessed 1,697 frail patients in Singelton Assessment Unit since 09/18. 40% were dicharged from assessment unit. 40% has LOS less than 3 days). Reduced LOS for those subsequently admitted. Improved access to community services including virtual wards and ACT. Improved recognistion of frailty. Better adherence against National Standards of care for frail older people (falls delirium
	Engagement with Hospital 2 Home wokstreams to ensure re-ablement pathways exist to support AFU model													
	Consultation with existing workforce to move to extended hours/seven day working													
	Commence recruitment of identified posts to support 7 day ICOP model and wider single frailty model													
	Implement extended 7 day AFU model													
Re-configure bed based rehabilitation services	Identify Clinical and Managerial Lead													Improve % of patients benefiting from

	across NPTH/Singleton/Gorseinon hospitals	Define Swansea Bay bed based rehabilitation model with appropriate capacity, workforce and support services.													alternative bed based re-abelemnt e.g. Bon-y-maen House, Ty waunarlwydd
		Identify inter dependicies with local authority intermeidate care and mental health services and develop clinical/operation and workforce models to improve access and useability of intermediate care facilities.													
		Model and agree bed pools and ward designation for bed based rehabiliation on Singleton/NPT site including nurse and therapy led rehabilitation units.													

		Commence staff consultation in line with organisational change policy to support relocation of wards potentially													
		Deliver revised footprint for rehabilitation services across NPTH/Singleton/Gorseinon Hospital footprints													
	Enhance ortho-geriatric care to deliver optimal care for older patients diagnosed with a # neck of femur. Establish a surgical liaison service delivering peri-operative medical care for older people undergoing surgery	Implement Business Case Proposal for Fragility Fracture service. Extending service from managing older people with #NOF (550-630 pateints per year) to all older people with a frgility fracture (~900 patient per year)													Improve ortho-geriatic performance based on KPIs defined by National Hip Fracture Data base: Ortho-geritric review within 48h of admission (currently 87%), prompt surgey within 24h admission (currently 55%cf. NHFD overall 68%), NICE Compliant surgery (70% cf. NHFD overall 71%), Prompt mobilisation (currently 74% cf
		Apoint additional 2 Consultants in Ortho-geraitics													

		Indetify Clinical and Managerial Lead for Surgical Liason Service													NHFD overall 74%), Non delirious post op (74% cf. NHFD overall 58%), Return to original residence (76% cf NHFD overall 71%). Improve % patient with # NOF discharged on facilitated discharge pathway. Reduced 30 day mortality post #NOF. Improve % perioperative assessment by care of
		Develop Clinical l model and workforce model to deliver enhanced perioperative care for older people undergoing surgery													
		Implement Surgical Liason Service													
Increased Hospital to Home capacity and expanded intermediate care model	Increased Hospital at Home capacity and expanded intermediate care model (dependent on: Outcome of the independent review - Agreement of LA partners - Additional Funding availability).	RPB agreement on the directon for H2H following ICP Review													To be agreed follwing agreement from the RPB post review of IPC plan
		Confirmation of the non recurrent shortfall in current provision within the H2H service													

		Develop action plan to deliver recommendations from the IPC review and the increased capacity requirements and following agreement from RPB													
		Recruitment into posts agreed													
		Dependent on RPB agreement, phased delivery of enhanced H2H													
	Investment to SUSTAIN current service changes in Heart Failure services; 1. Improving Diagnostic Pathway 2. Delivery of routine heart failure care in primary care 3. Enhancing Community HF Specialist Nursing Team 4. Value	Embed rapid access HF diagnostic clinic & integrated working with community nursing team													95% of patients receive an urgent / routine specialist assessment within 2 / 6 weeks (Baseline = 10%) 30% reduction in acute admissions before specialist review (Baseline = 282 / 5816 bed days)

	based healthcare approach (measuring patient reported outcomes)	Embed immediate transfer of care to community nursing team at diagnosis													100% of patients seen within 1 week after diagnosis for education and start of treatment (Baseline = 3-6 months)
		Embed responsive community HF nursing team management of patients at high risk of admission													100% of patients seen within 2 weeks of discharge from hospital (Baseline = 3-6 months) Contributes to 39% reduction in hospital re-admission

Alleviating unintended variation and inequalities in the provision of whole system Heart Failure pathway.		Embed integrated approach with patients “stepped up” and “stepped down” to specialist services													100% of urgent patients referred into Community Nursing Team are seen within 2 weeks (Step Up) 100% of patients are discharged to primary care when patient is stable (Step Down) NB: Some patients will never be stable - however, there is some capacity in the team to accommodate this and supportive care service is developing.
		Delivery of Heart Failure reviews and routine care for stable patients in primary care and community settings													90% of Heart Failure patients offered a 6 monthly HF review.

	Investment to ENHANCE HF Service with Value Based HealthCare approach (Measuring Patient Reported Outcomes)	Providing specialist involvement during acute admissions (Morriston only)													Halve the average length of stay (LoS) for patients admitted with Heart Failure (primary diagnosis). SBuHB Baseline Average = 17 days,
		Providing Supportive/Palliative Care service													
Improve the outcomes for COPD patients and	Investmentment in COPD ESD (Early Supported Discharge) Team, that covers front door working, ED, AGPU, Primary Care and admission avoidance working with WAST and GPs for Singleton, Morriston and NPT.	Review current COPD and ESD models in Swansea and NPT and develop sustainable model to provide and equitable service.													Reduce NOP GP referrals by at least 20% Admission Avoidance = 437 admissions per year Reduction in bed days = 1424 bed days per years Reduce re-admission rates to 6-8%, national average 43% ALOS 2.5 days TBC % medication reviews, £ medication wastage, reduction in GP apporintments & home visits
		Agree workforce model for Swansea & NPT, to cover expansion of services across sites, Primary Care and front door working and options for 7 day working.													
		Activate recruitment into additional posts													

patients and reduce the impact of COPD patients on the front door through a whole system pathway approach.		Implement & embed COPD ESD community service.													
		Implement Primary Care Practice Pilot													
		Evaluation of Primary Care Pilot, proof of concept and if successful gradual roll out to further practices.													Reduction of NOP GP referrals by 20%
	Development of integrated working, collaboration and co-production between COPD ESD Team, PCC and WAST to provide seamless care and support patients in a community setting.	Develop a robust community respiratory pathway, to provide an alternative to admission by allowing WAST referral to the COPD ESD team. Collaborative working with WAST to explore additional options e.g. APP as part of the COPD ESD team.													TBC admission avoidance, reduction ED admissions
	Roll-out of	Continue to maximise take-up of DES/ NES and training													**Improved** diagnosis rate **20% reduction** in

Implement pathway for Type 2 patients living with Diabetes	the Diabetes Enhanced Service	Review re-referrals and identify additional support required for Clusters														follow up Outpatient appointments and emergency admissions **35% reduction** in Hospital DNAs Waiting times - **for all measures - zero weeks 30% improvement** to Target value for all National Diabetes Audit -Care Processes
	Development of Diabetes Community Model Business Case - Investment required	Review model agreed, and update - this includes the clinical model and the financial assumptions.														
		Secure investment through Health Board Governance (this would have been IBG)														
Improved access to multi-professional support for patients with diabetes	Provide dedicated Psychological Support for adults and young people	Agree a temporary pathway for patients to LPMHS														**10% reduction in DKA admission rate**s (pilot undertaken in Wrexham saw a 45% reduction in DKA admissions over 5 years. **Compliance** with 2017/ 18 Welsh Government Transition Standards Treatment for psychological conditions, including depression, has been shown to lead to
		Secure investment for dedicated support through Health Board Governance														
	Dedicated dietetic support for young adult clinics	Secure investment for dedicated support through Health Board Governance														

	Type 2 X-pert education	Secure investment through Health Board Governance this would have been IBG)														Increased patient self-management and activation Support for those patients starting on insulin thereapy Increase % offered NICE compliant structured education. Reduction in planned care/ out patient attendances, reduction in insulin costs

Diabetes Structured Education/ Improved Self Management	Type 1 DAFNE education - centrally co-ordinated															Increased patient self-management and activation **Offer structured education programme within 6-12 months of diagnosis** Equitable access to the required structured education programmes for people with Type 1 Diabetes for those who are newly diagnosed or who are being considered for pump therapy. **Increase capacity to 64 patients per annum with estimated cost savings of £81 per attendee**
Diabetes - Commuication and information sharing	Improved access to patient records	Scoping exercise with digital services to understand scale of challenges														Providing care with an integrated approach - reducing the risk to patients
TO BE DELIVERED BY STROKE DELIVERY BOARD																

Deliver improved outcomes for stroke patients; A Hyper Acute Stroke Service compliant with national standards	Investment to create Hyper Acute Stroke Unit	Define Swansea Bay acute stroke model with appropriate capacity, workforce and support services modelled in with scope of model to be agreed with Hywel Dda													Significantly improved Stroke Quality Improvement Measure performance - top performing HB in Wales and upper quartile UK. Reduction in suspect stroke patients. 100 •% stroke patients seen within 72hrs & deliver national standards
		Plan/agree estates works in the Morriston unit and some capital investment to support a purposed acute stroke unit													
		Start programme of works to develop appropriate clinical environment to deliver hyper acute stroke services within one unit													

		Commence recruitment of essential workforce to enable HASU to be implemented (may consider a phased approach to full operating model)													
		Staff engagement in line with organisation change policy													
		Engagement with CHC's, Hywel Dda, stroke organisations, public													
		Implement hyper acute stroke unit													