Meeting Date	**27 June 2023**	**Agenda Item**	**6.3**
Report Title	**Clinically Optimised Patients – update on actions to reduce COPs at SBUHB**		
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Presented by	Deb Lewis, Chief Operating Officer		
Freedom of Information	Open		
Purpose of the Report	This report provides the quarterly update to the committee on the actions being taken to address the number of clinically optimised patients (COPs) in SBUHB		
Key Issues	The committee received reports on 28/06/2022 and 27/09/22 detailing the actions to address the significant number of clinically optimised patients within the Health Board Additional actions have been implemented to support discharge and to reduce ambulance conveyancing to hospital for patients who traditionally have a longer length of stay, for example a pilot supporting 5 care homes including a falls and chest pain pathway. This could be expanded if proven to be successful The national framework for Discharge to Recover then Assess (D2RA) has been simplified from 5 to 4 pathways and this has been implemented across Swansea Bay Despite the above initiatives, the number of patients who are clinically optimised in the Health board has remained relatively static.		

Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☐	☐

Recommendations	Members are asked to: • **NOTE** the report and the additional actions to address the COPs within SBUHB.

1. INTRODUCTION

The committee received a report on 28/06/22 and 27/09/22 outlining the main actions being taken to reduce the number of clinically optimised patients within the Health Board. This report provides an update on the current position with regards to clinically optimised patients and the additional actions being taken to address this position.

2. Background

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.

There is operational focus on this patient group in all hospital sites with weekly review meetings with primary and community care, Local Authority (LA) and community partners to expedite the pathways of these patients.

In May 2023 the national framework known as Discharge to Recover then Assess (D2RA) was updated and was launched across Swansea Bay on 9th May. The framework has been simplified from pathways 0-4 into pathways 0-3 providing clear and common language across Wales as part of a renewed focus on best outcomes for patients.

As part of this the corresponding Home First pathways were implemented within Signal and a full review of COPs to allocate a new pathway was undertaken across all sites.

The table below shows the average number of COPs for Jan-May 2023 and the average per site when compared to years 2021 and 2022. Despite the range of interventions the number of COP continues to raise on average.

COP snapshot					
Month	Site				
	Gorseinon	Morriston	NPT	Singleton	Average total
Jan	11	97	86	69	263
Feb	15	66	89	82	252
Mar	13	87	79	83	262
Apr	11	102	74	86	273
May	22	105	76	76	279
Average per site '23*	**14**	**91**	**80**	**79**	**265**
Average per site '22*	**19**	**83**	**76**	**59**	**238**
Average per site '21*	**8**	**59**	**51**	**33**	**151**

*months of Jan-May

3. Additional actions to address the COPs

In addition to the initiatives and actions described and implemented in the previous papers the Health Board continues to develop new services to support the movement of patients into more appropriate accommodation.

We continue to take the actions to improve the clinically optimised position targeting reducing the total number of clinically optimised patients across the health board. Below are schemes that also focus on admission avoidance and overall reduction of length of stay of all patients across the Health Board.

- **Implementation of SAFER across all ward areas**
  Rolled out to 20 wards at Morriston with a plan to have all areas covered along with Singleton (first ward started), NPT and community hospitals. Initial feedback is positive from staff with a 43% improvement of using the SAFER principles (Meridian report), an increase in virtual assessments on “closed” wards by social workers and an increase of referrals to Pathway 1 – virtual ward and fracture early supportive discharge
- **Care home rapid response and optimisation pilot**
  This pilot will provide rapid response to care home WAST calls and follow up care with a focus on medication reviews, ACP and optimisation of care. The pilot will include 1) identification of care homes with highest 999 call out/ admission rates across SBUHB 2), additional workforce to deliver rapid response for urgent remote/ face to face assessment of medically deteriorating/ injured care home residents to maximise care at point of crisis and support admission avoidance where possible, 3) liaison with established ACT (Acute Clinical Team) and OPAS (Older person Assessment Service), 4) follow up within Virtual Wards to optimise care (including ACP and medication reviews). This pilot also encompasses a trial for chest pain and falls pathways for high risk patient cohorts – initial focus on frail/ elderly population
- **Same Day Emergency Care single point of access**
  The HB has a number of clinical teams focused on supporting patient treatments on the same day and discharging, or returning the patient to a “hot clinic” for further assessment and treatment. In April work began to integrate these teams providing a single point of access for all SDEC services. Since then patient numbers have increased by 10 patients per day with on average 2-4 patients direct from ED. Future plans for SDEC include the expansion with Consultant medical cover to 12hrs Mon-Fri and a Saturday-Sunday service and the development of new pathways including chest pain and head injury for patients meeting certain criteria.
- **Directory of Services (DoS)**
  WAST are the custodians across was of the DoS, a directory which contains all the available services available that can be used as clinically safe alternatives rather than conveyancing to hospital. As services are continually developing a national piece of work to update the directory across all HBs has commenced with the view of being finalised over the next 3 months
- **Intergrated discharge – single point of access**

Work is currently underway to provide a single point of access for complex discharges, further update can be provided in the next quarterly briefing

- **Data collection and presentation**
  A new Unscheduled and Emergency Care dashboard has been developed in collaboration with service operations to provide daily and weekly information. Along with the AMSR dashboard this provides a comprehensive view of the UEC system. Currently the RPB is going through a process to identify what data is contractually required to be provided for Home First services and what further information would services require. This will need to feed into updated All Wales metrics of which all HBs across Wales will be required to submit.

The impact of previous schemes and the above schemes will be monitored via service performance reviews and the Management Board.

4.0 Recommendation

Members are asked to:

- **NOTE** the report and the additional actions to address the COPs within SBUHB.

Governance and Assurance		
Link to Enabling Objectives ***(please choose)***	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒
Quality, Safety and Patient Experience		
Extended hospital stays due to lack of capacity in out of hospital pathways have cumulative detrimental effect on patients, particularly those who are old and frail. The Health Board is looking to avoid patients needing hospital admission via admission avoidance initiatives and early supported discharge.		

Financial Implications
None specific to this paper.
Legal Implications (including equality and diversity assessment)
No implications to note.
Staffing Implications
None specific to this paper. Recruitment related to expansion home visiting service and virtual ward in-reach is taken forward by the appropriate work streams
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
Briefly identify how the paper will have an impact of the "The Well-being of Future Generations (Wales) Act 2015, 5 ways of working. ○ **Long Term** – Earlier interventions such as virtual wards and enhanced frailty services will deliver longer term benefits with less patients requiring care packages or requiring less intense packages of care ○ **Prevention** – Early interventions will have preventative benefits both for patients (improved health and functionality) and for healthcare providers (reduced resource requirements in the future) ○ **Integration –** The interventions are based on multidisciplinary approach and integrated care pathways ○ **Collaboration –** Close partnership working with Local Authorities and other care providers ○ **Involvement –** Patient and family involvement are firmly at the center of these pathways

Report History	This is an update on previous reports to the Committee on 28/06/22 and 27/09/22
Appendices	