Meeting Date	**24 January 2023**	**Agenda Item**	**5.1**
Report Title	**Urgent and Emergency Care Improvement**		
Report Author	Kate Hannam, Interim Service Group Director Jonathon Baglow, Business Intelligence		
Report Sponsor	Inese Robotham, Chief Operating Officer Kate Hannam, Interim Service Group Director		
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	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 a U&E care improvement programme. 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 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. 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. The ED nursing workforce continues to have high sickness level at around 6% and is reliant on temporary workforce solutions. 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.		

<table>
<tr><td></td><td colspan="4">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 3 2022/23 have been included.

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.</td></tr>
<tr><td rowspan="2">Specific Action Required
(please choose one only)</td><td>Information</td><td>Discussion</td><td>Assurance</td><td>Approval</td></tr>
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<tr><td>Recommendations</td><td colspan="4">Members are asked to:

• NOTE the U&E care performance position and the ongoing actions taken to support its recovery and Improvement.</td></tr>
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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;

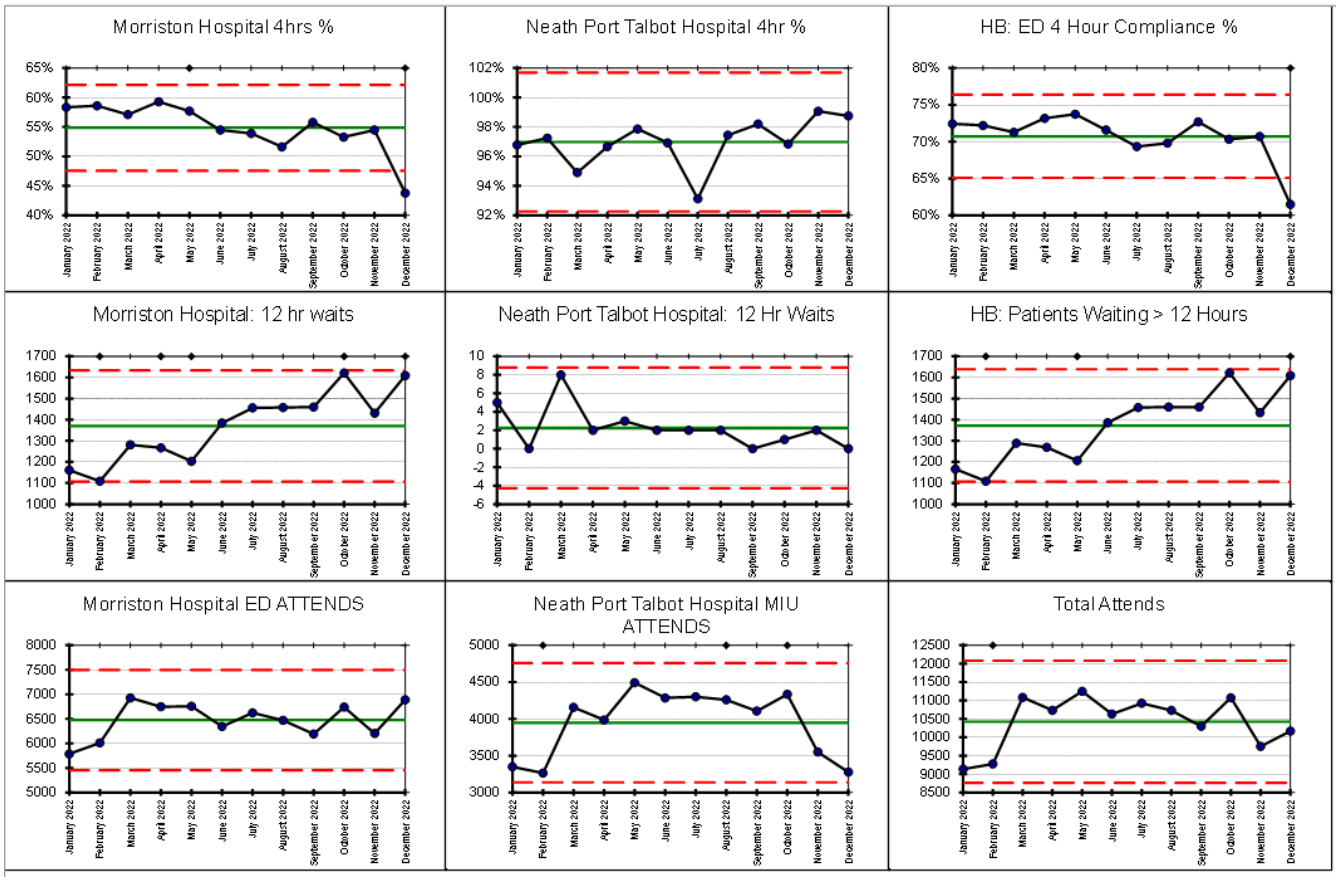
In order to improve and ensure focused delivery on the U&E care performance, there has been further review of the Morriston U&E care improvement plan, incorporating ambulance handover improvement plans, in addition to implementation of the AMSR programme which commenced in a transitional phase on 5th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

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 below show the performance against the ED access standards and ambulance handovers for 2022/23 (12 month rolling position). The graphs show the

performance at Morriston, NPT and combined. December data requires further validation and is expected to improve by 10%.



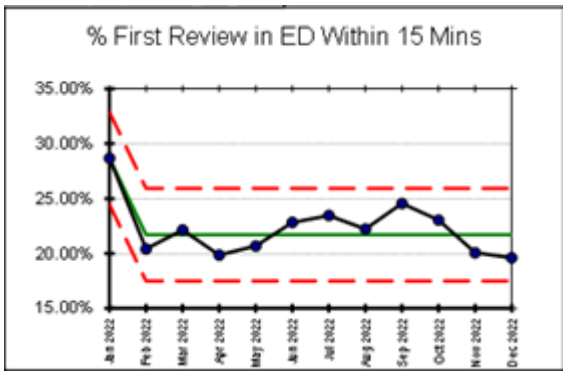
Four Hour Target

Performance against the 4hr target has remained stable throughout October and November at circa 70% (circa 54.5% for Morriston).

December data has been included but is currently under-going revalidation of this position which is expected to improve this position by 10%. The 4-hour standard largely relates to capacity in ED, both in terms of space and workforce which is constrained due to the ability for patients to be transferred from the ED to downstream wards resulting in over-crowding.

The 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. The department has developed a rapid improvement action plan and a general improvement plan in response to an unannounced visit by HIW between 5-7th September 2022. The action plan focuses on improvements to delays in time sensitive conditions and other flow/governance issues which were reflected in the full report published on 8th December 2022 (the graph below shows the

improvement in review time since the visit). Both action plans have been accepted by HIW and are monitored via weekly escalation meetings.



The department continues to have covid pathways in place which restricts also the 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 January. 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 safe care within the Emergency Department.

12-hour Target

On average, 21% of patients wait in excess of 12 hours within the ED before either being discharged or admitted into the hospital. The 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.

3.1 Ambulance attendance and handover delays >1 hour – Target ZERO

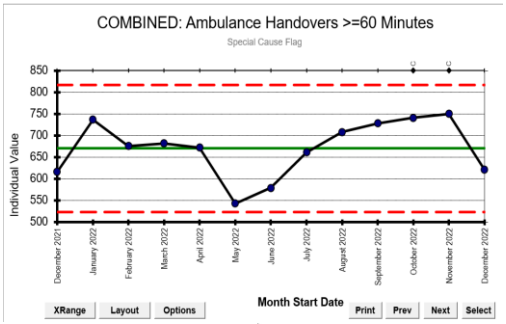
Ambulance attendance to ED is markedly reduced compared to pre-covid levels. This can be explained by a number of factors including:

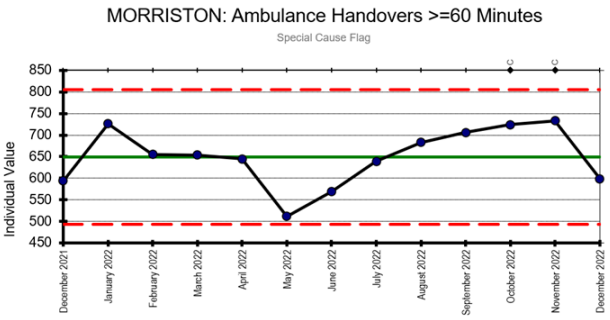
- WAST Clinical Safety Plan-this is the escalation framework for WAST. Their actions will vary dependant on the level of escalation reported however at moderate to high levels of escalation, ambulance response is 'rationed' and persons in lower acuity categories will not receive an ambulance response.
- Advanced practice paramedic screening of the waiting demand with redirection of appropriate patients to alternative pathways thus avoiding ED – the Advanced

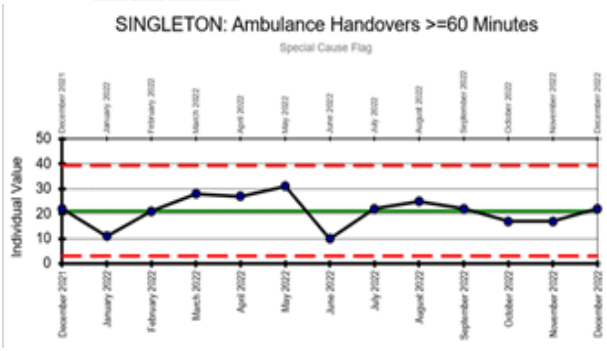
paramedics have recently moved in the acute hub and work alongside the acute GP's in Same Day Emergency Care which will allow improved opportunity for non-conveyance and redirection.

- 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 performance remained challenging throughout October and November 2022 (in the number of ambulances waiting for handover), with December reflecting a similar (reduced) level to that of December 202. The number of hours lost to delayed handover continued to average at over 200 minutes per vehicle throughout quarter 3 despite a number of ongoing initiatives at the front door including 'fit to sit', redirection to OPAS (older person assessment service), and discharge direct from an ambulance, along with the opening of AMU (which initially had an instant, positive impact on ambulance handover delays). This is further indicated in the following SPC charts and data table:

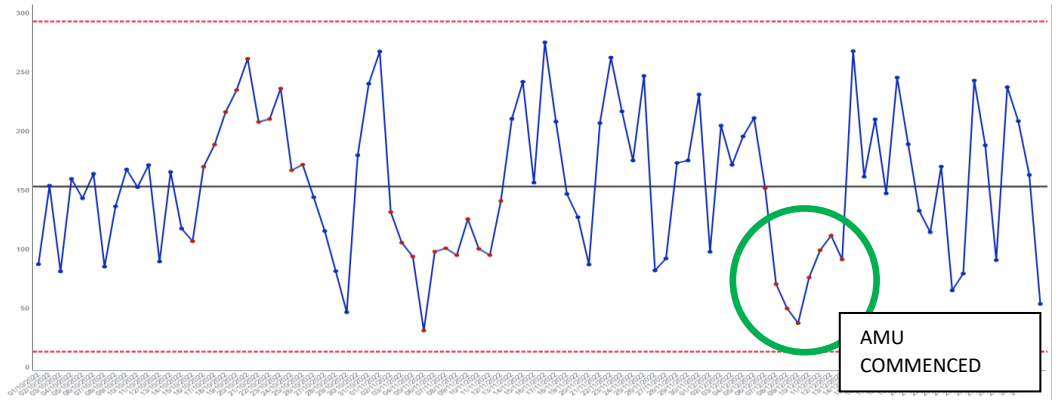




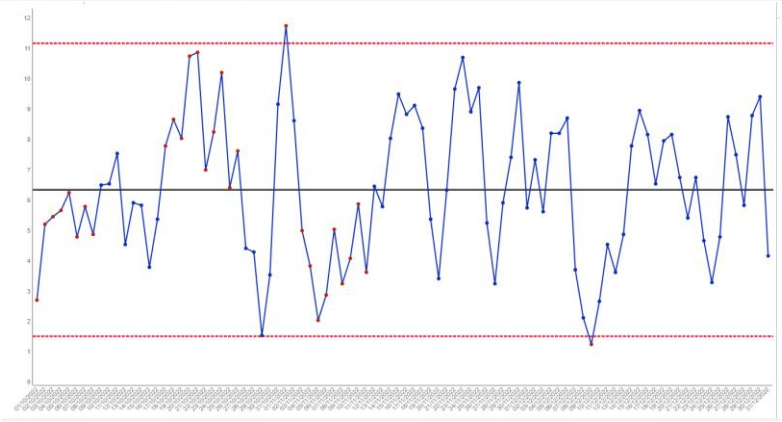


MonthYear	Average Ambulance Notify to Handover (Minutes)
Dec 2021	120
Jan 2022	152
Feb 2022	149
Mar 2022	143
Apr 2022	157
May 2022	85
Jun 2022	139
Jul 2022	137
Aug 2022	172
Sep 2022	204
Oct 2022	212
Nov 2022	204
Dec 2022	220
Total	**160**

1st October 2022 to 31st December 2022
Number of Emergency Ambulance Hours Lost Waiting for Handover



Mean Number of Ambulances Waiting for Handover: Average hourly number of ambulances waiting at hospital (time between arrival and handover). Source: WAST.



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 and resus capacity– frequently throughout December for example there was no capacity within resus due to overcrowding with additional patients placed in these areas due to flow challenges
- Availability of REACT capacity to support timely offload and review of patients
- 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
- Within December, the impact of Industrial Action on flow also impacted on the ambulance and ED performance as well as increased presentation of covid and flu requiring IP&C (infection prevention and control) capacity to be available.

The introduction of 2-hourly huddles in ED have re-focused attention on prioritising ambulance offloads and maintaining safety within the department as well as the focused drive from the Ambulance Liaison nurse working directly with the site teams and the ODU to manage demand.

3.2 Wider system measures

In order to understand performance in ED, there is a requirement to explore wider system performance issues which are impacting on the inability to flow patients out from the department in an effective way. A number of internal metrics can be viewed to understand the issues with the mismatch of capacity to meet the demand, resulting in delays and overcrowding in ED.

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

3.2.1 Occupied Beds

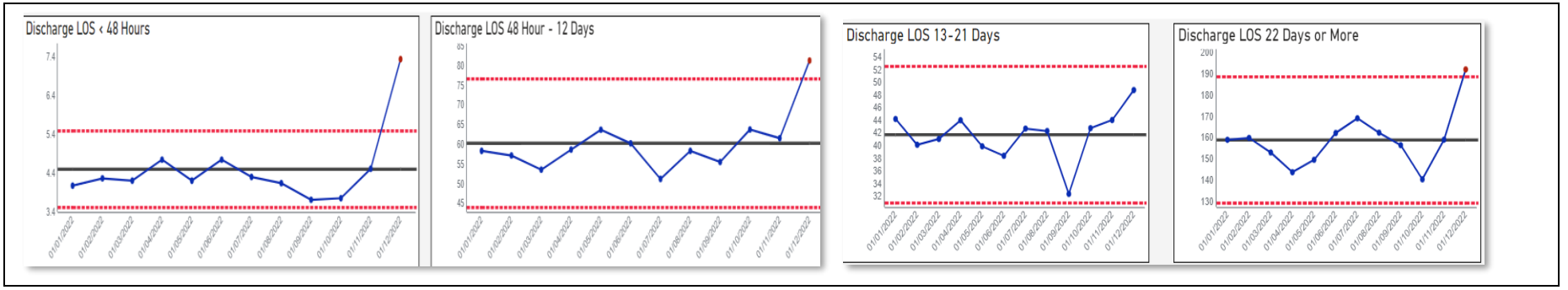
The table below highlights the key metrics being monitored with regards to occupied beds at Morriston – this shows that since October there have been a higher number of patients occupying beds with an increase noted especially within medicine and the number of outliers/surge beds being used. The number of patients waiting in ED for a bed remains significant and impacts on the ability of ED to undertake its function in an effective way as previously described, but also does impact on the quality of care for these patients and the impact on staff.

Key Priorities	Jan 2022	Feb 2022	Mar 2022	Apr 2022	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Total
Average Patients in General Beds Midnight	536	529	534	537	542	552	553	544	555	553	553	597	**549**
Average Patients in Medical Beds Midnight	274	268	255	257	267	275	274	274	273	284	283	350	**278**
Average Patients in Surge Beds Midnight										3	1		**0**
Average Number of Outliers	79	67	56	54	53	53	55	50	52	66	59	73	**60**
Average Number of Patients in ED waiting for bed at 9am	34	34	38	37	31	37	39	39	39	40	37	42	**37**
Total ED New Attendances	5787	6011	6928	6747	6758	6346	6624	6471	6192	6741	6203	6892	**77700**

3.2.2 Length of stay (LOS)

The length of stay of patients impacts significantly on the capacity available to meet demand.

The graphs below provide an overview of the average number of patients discharged by time bands for emergency medical patients at Morriston to highlight the challenges faced currently with regards to having sufficient capacity across the bed bases to support effective flow of patients from the ED/AMU into beds. This does not reflect the patients who are managed and discharged within ED who otherwise would have been admitted.



These graphs highlight the impact of the improvement work to support patients at the early stages of admissions within SDEC (same day emergency care), the assessment unit and SAFER systems and processes, with a step improvement with the number of patients discharged <48hrs and between 48hrs-12 days. However, the challenges of delays associated with the patients who are clinically optimised is reflected in the length of stays >13 days where it can be seen the number discharged within these timeframes has grown significantly.

The table below reinforces the LOS (length of stay) challenges with patients who have become clinically optimised (COP) and provides a comparison of the ALOS for medical patients who are COP and non COP by site.

	NON ELECTIVE GENERAL MEDICINE NON COP - ANNUAL: ALL SITES				
	Morriston Hospital	Singleton Hospital	Neath Port Talbot Hospital	Gorseinon Hospital	HB WIDE (M&S Only)
2015/16	8.6	8.3			8.5
2016/17	8.2	8.2			8.2
2017/18	7.5	7.3			7.4
2018/19	8.3	6.7			7.5
2019/20	9.0	7.6			8.5
2020/21	6.3	5.0			5.8
2021/22	5.9	4.9			5.5
2022/23	7.1	4.2			5.6

	NON ELECTIVE GENERAL MEDICINE COP ONLY - ANNUAL: ALL SITES				
	Morriston Hospital	Singleton Hospital	Neath Port Talbot Hospital	Gorseinon Hospital	HB WIDE (M&S Only)
2019/20	26.5	no data			26.1
2020/21	19.4	20.8			20.1
2021/22	30.9	29.7			30.4
2022/23	37.0	43.9			38.9

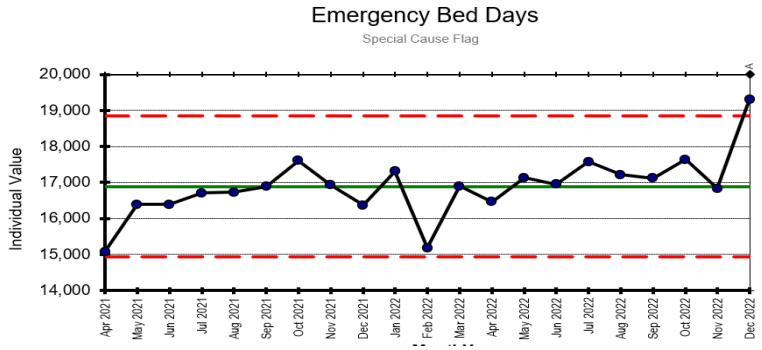
	NON ELECTIVE (M&S) GENERAL MEDICINE ALL PATIENTS - ANNUAL: ALL SITES				
	Morriston Hospital	Singleton Hospital	Neath Port Talbot Hospital	Gorseinon Hospital	HB WIDE (M&S Only)
2015/16	8.6	8.3	37.1	33.8	8.5
2016/17	8.2	8.2	46.8	38.3	8.2
2017/18	7.5	7.3	41.5	28.6	7.4
2018/19	8.3	6.7	41.8	29.1	7.5
2019/20	9.8	7.6	40.8	34.1	8.8
2020/21	8.1	8.5	35.2	30.3	8.3
2021/22	8.7	8.4	42.8	42.8	8.6
2022/23	11.3	8.5	58.4	53.4	9.7

Applied filters:
Measure is Average Length of Spell
Main Specialty is Endocrinology, Gastroenterology, General Medicine, Nephrology, Neurology, Thoracic Medicine, or Medicine For The Elderly
Patient Class is IP
Site is Morriston Hospital, Singleton Hospital, Neath Port Talbot Hospital, or Gorseinon Hospital
Admission Type is EMERGENCY

The table highlights the increase in LOS at Morriston for the emergency medical patients – both pre-COP and post COP and a significant increase is also noted at NPT and Gorseinon – both hospitals being essential to support patient transfers from Singleton and Morriston to enable effective flow. Singleton has seen a decrease in length of stay for medicine, in addition to a reduction in emergency admissions due to a number of admission avoidance initiatives which have been put in place to support re-direction from hospital. Length of stay reduction remains a key factor in successfully delivering the AMSR programme and these are being monitored via the Urgent and Emergency Care Board, chaired by the Chief Operating Officer.

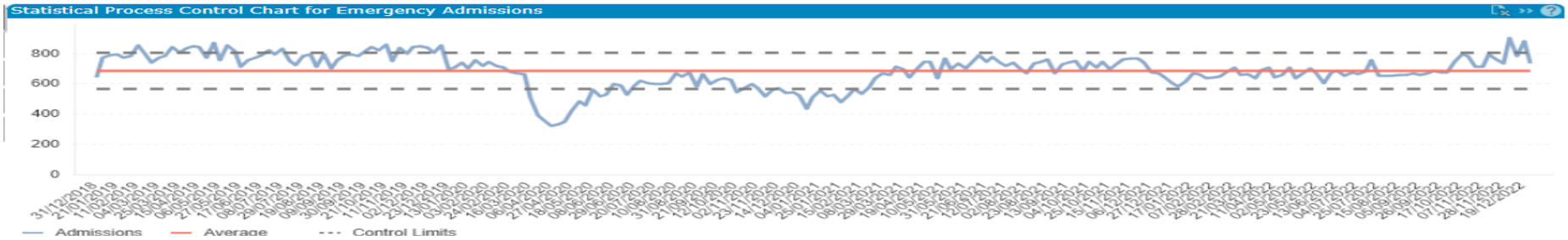
3.2.3 Emergency bed day utilisation (Morriston Hospital Only):

Emergency bed day utilisation is a good barometer of pressure in the system. The graph below demonstrates that December 2022 experienced a higher level of Total Emergency Bed days than at any time previously (including before the date range applied in the chart) and this correlates with the growing number of patients waiting in ED for admission to a bed (which rose from 37 in November to 42 at the 80th percentile during December 2022). 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 and remains a critical issue.

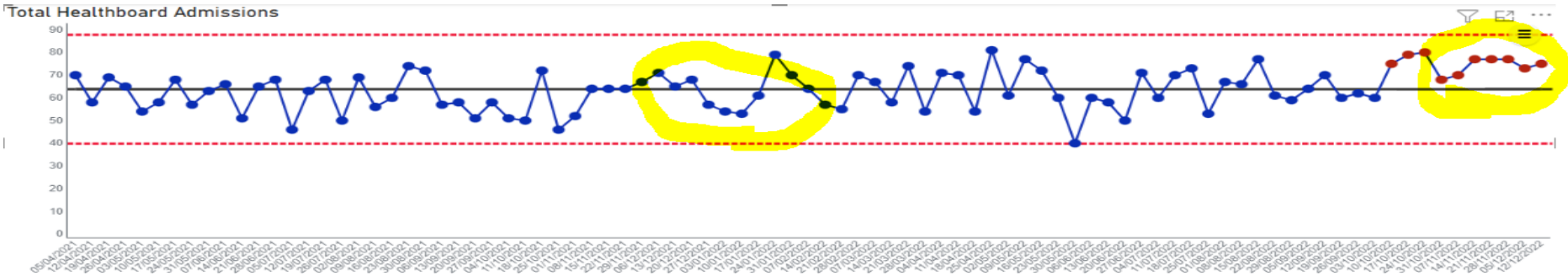


3.2.4 Admission activity:

At an aggregate level, Emergency Admissions to Morriston Hospital during quarter 3 **increased** as evidenced in the chart below, at times at a level higher than at any point post pandemic (and as high as any point previously). Unfortunately, the level of patients in ED awaiting admission also rose during December as stated above (from 37 in November to 42 at the 80th percentile), despite a maturing working partnership between the Clinical site team, ED and virtual wards which has resulted in an increase in admission avoidance for this patient cohort.



In addition to the ED, across the Health Board there are other admission methods into the acute beds – for example direct admissions via consultant connect, AGPU (acute GP unit), SDMU, major trauma and transfers from other HB). Admissions via these sources are also increasing (see graph below) which puts additional pressure on the site teams with regards to bed management and also impacts on the flow from ED as patients from these cohorts will be also requiring bed allocation.



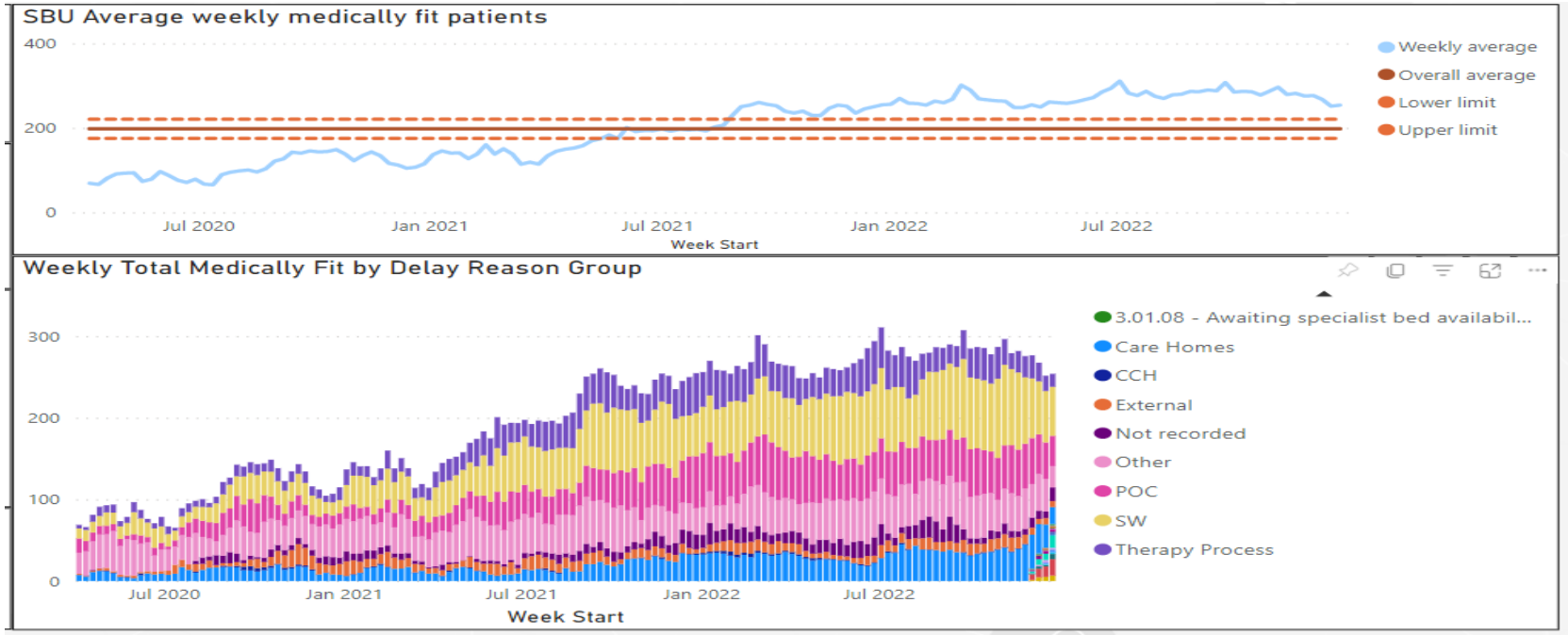
3.2.5 Clinically optimised position

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 LA and community partners to expedite the pathways of these patients however progress is slow with capacity being the constraint.

There has also been the reintroduction by Welsh Government (November 2022) of monthly census submissions regarding the delays associated with COPs which require validation by the LA as to the reasons for the delay. This data will provide an opportunity to review capacity deficits in the pathways management of this cohort of patients and to inform future models of care and additional commissioning requirements.

The introduction of the weekly review of Red and Amber priority patients during quarter 3 has also enabled early escalation to Primary Care partners and Executive leads, and the most recent data is indicating a reduction in aggregate levels of clinically optimised patients, although the length of stay associated with these patients is increasing as was seen in 3.2.2.



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. Examples of such developments to target this include:

- Virtual wards - these are rolled out across SBUHB now. 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.

- 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

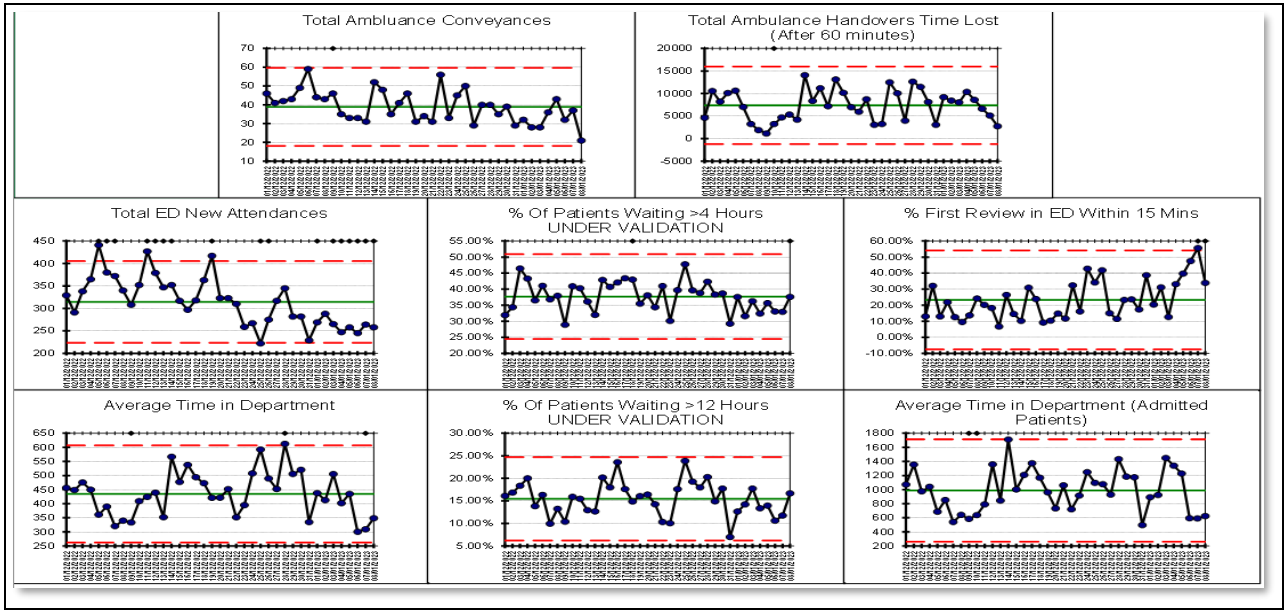
geriatric assessment at point of contact with the front door and with support from community teams and more latterly virtual wards are very practised in admission avoidance for this patient group. In addition, WAST (Welsh Ambulance Service NHS Trust) now have direct admission pathways into OPAS thus 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. There is a requirement to introduce a 'pull' mechanism within the service in order that more patients attending ED are redirected for ambulatory management.

3.3 EARLY JANUARY 2023 OVERSIGHT POSITION

Despite the pressure and challenges faced throughout the system, particularly in December 2023, the following SPC charts demonstrate a number of positive indications emerging during early January 2023: -

i. *Total ambulance conveyances have reduced*
ii. *Total ED attendances have reduced*
iii. *Ambulance handover delays (Over 60 minutes) is highly variable day-to-day*
iv. *4hr performance and 12hr performance is currently undergoing validation*
v. *A higher proportion of patients are being assessed within 15 minutes of arrival*
vi. *Average time in the ED department is highly variable day to day*
vii. *The time a patient spends in ED awaiting admission o average fluctuated between 5 hours (low) to 17 hours (high) during the period*



3.4 Improvement Overview

There has been a number of improvement activities targeting UEC at Morriston and across the wider HB. The table below provides an update with regards to these. A re-fresh of the programme is currently underway at Morriston following the appointment of a programme lead to support in the development of these and a further update will be provided following quarter 4.

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-	Initial audit suggested 23% of conveyances could have been managed at an alternative setting if capacity had been	Clinical lead SDEC	In place

Issue	Actions to address issue	Output/Aim	By whom	By when
	conveyance where clinically appropriate	available – baseline required of capacity gaps		
	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
	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 Mon-Fri 8am-8pm Extend to weekends planned April ‘22
	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.	Clinical Lead SDEC	In place

Issue	Actions to address issue	Output/Aim	By whom	By when
		Potential for 10-12 alternative conveyances – auditing 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
	-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	To reduce occupancy and improve flow through the day through senior decision makers, effective board rounds, effective	All service groups	Start of Nov

Issue	Actions to address issue	Output/Aim	By whom	By when
	Morriston with particular initial focus on medicine	discharge management processes		
	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 and piloted during MADE	Business case presented to WG for funding
	Focus on the Real Time and Demand Capacity information to ensure early discharge and prompt escalation.	Support early flow through the day to reduce ED overcrowding	Matrons	In place
	Weekend discharge team	Increase the discharges at weekends for medicine patients	CD Medicine	Discharge registrar in place
	-Extraordinary Silver Command in place for Community service focussed on flow into	Support timely discharge of clinically optimised patients and	HON Primary, Therapies &	In place

Issue	Actions to address issue	Output/Aim	By whom	By when
	community services and use of Care Homes as temporary capacity solution.	ensure maximisation of all capacity	Community Services	
	Implementation of discharge lounge	Support increased flow through Morriston	ASGD Hospital Ops	In place
	Opening of the AMU	Increase capacity at Morriston to support the centralisation of the medical take and increase the number of patients treated within <48hrs	ASGD Morriston	Transitional approach – 5th Dec to 1st Feb
Additional Capacity	Additional surge/escalation beds in use system wide as follows: +2 Gorseinon +21 Singleton +10 NPTH + 10 Morriston -5 ED surge trolleys and OPAS 5 trolleys	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
	Transitional beds – review of the use of the transitional beds	Increase flow through the transitional beds with new criteria	SGD – Primary and Community	Jan '23

3.5 AMSR Update

Further work has also been progressed with regards to the AMSR programme. The Acute Medical Unit opened on the 5th December 2022 with a transitional approach agreed to the centralisation of the medical take. Initial indicators saw a very positive impact in terms of patient flow and quality of care for patients. Challenges with patient flow out of the hospitals as described earlier in the document has meant however, that the Unit has not been as efficient as it could be with significant patients waiting for medical beds impacting on the ability/capacity to assess patients in a timely way. The Unit however has provided essential capacity during very challenged times and systems and processes associated with the Unit continue to evolve to improve further its effectiveness with the capacity it has available to it.

The discharge lounge was successfully opened and has met the SAFER target of 33% of discharges through by midday – the team continue to work with the wards to further improve that position and overall utilisation.

5.0 Recommendation

The committee are requested to note this paper and the update provided with regards to the ED performance associated with the UEC programme.