Meeting Date	**25 October 2022**	**Agenda Item**	**5.1**
Report Title	**Urgent and Emergency Care Improvement**		
Report Author	Shirley Hoskins, Directorate Manager - Emergency Care and Hospital Operations, Morriston Kate Hannam, Interim Service Group Director		
Report Sponsor	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 Morristons' 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 an 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. 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 2 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.			
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☒	☐	☒	☐
Recommendations	Members are asked to:			

	• **NOTE** the U&E care performance position and the ongoing actions taken to support its recovery and Improvement.

Urgent and Emergency Care recovery plan 2022-23

1. INTRODUCTION

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

2. BACKGROUND

At the end of September 2022, the number of patients treated within 4 hours across the health board was 73% which is an improved position compared to August 2022. The number of patients treated within 4 hours at Morriston was however 56%, which whilst an improvement over the past 3 months, is reflective of the significant challenge to delivering timely safe urgent and emergency care to patients and also in admitting patients from ED into the specialty bed pool.

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:

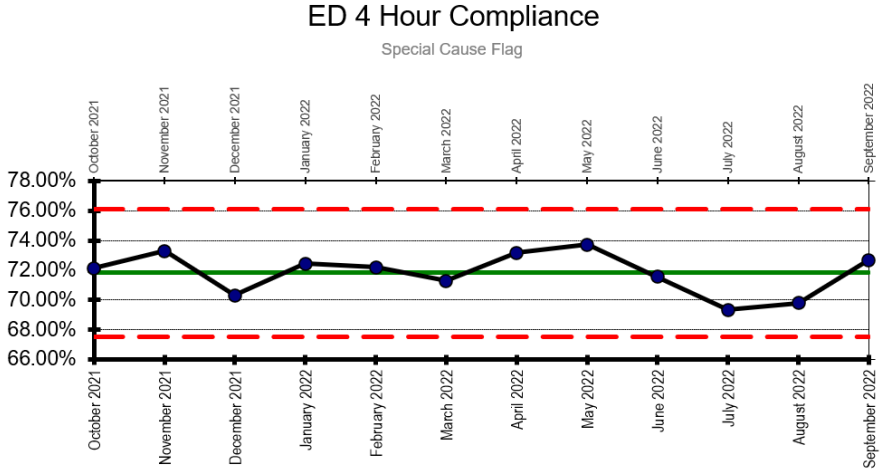
- Delay in patients being offloaded from ambulances into the ED;
- Delays in patients accessing ward beds and requiring 'boarding' within the ED, including resuscitation;
- Delay in step down from ITU onto general wards;
- Delay in patients gaining access to the 'right ward first time' as reflected in 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;

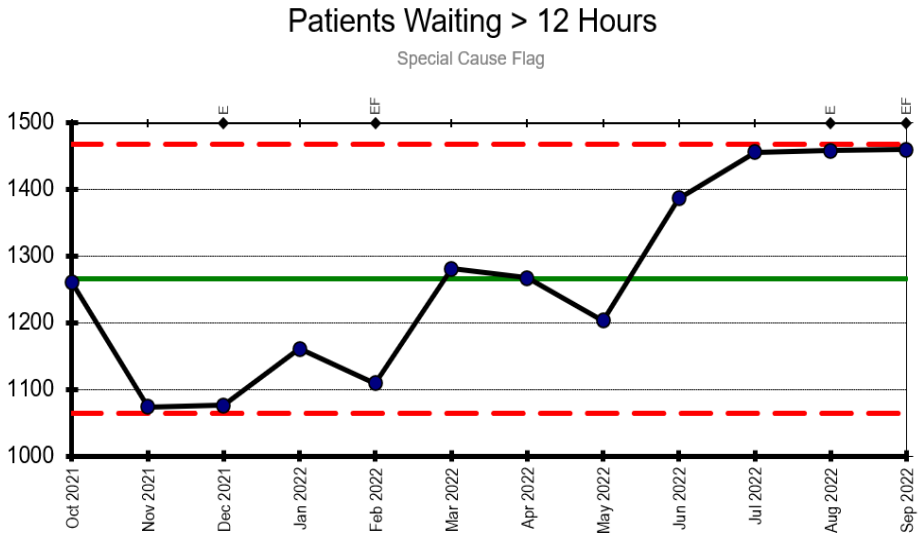
In order to improve and ensure focused delivery on the U&E care performance, there has been further review of the Morriston U&E care improvement plan, incorporating ambulance handover improvement plans, in addition to implementation of the AMSR programme with the target delivery of 5th December 2022.

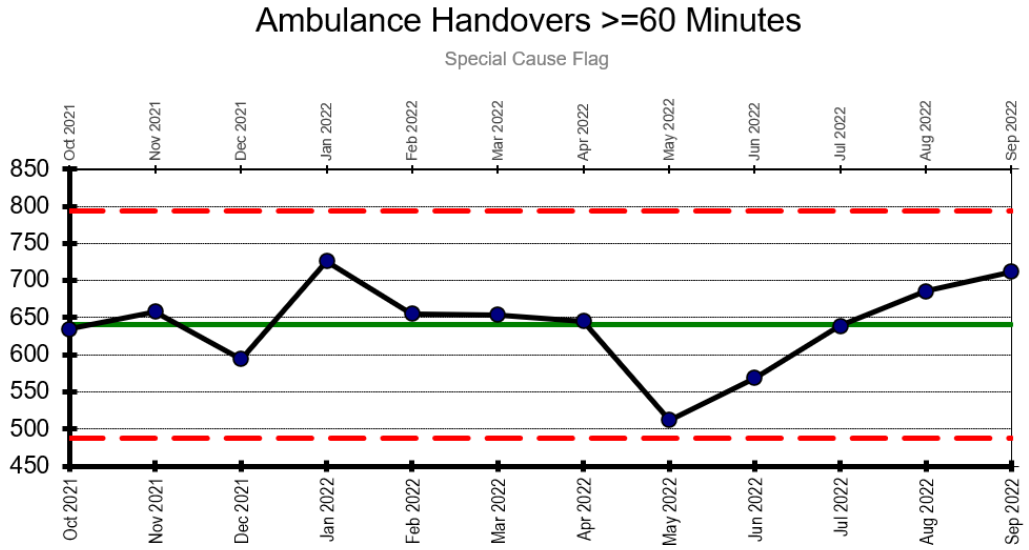
Wider health board schemes targeting admission avoidance and earlier discharge are also in place to support the wider system flow agenda.

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). 4hr performance improved during Sept 2022 to 73% (55.88% for Morriston). 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 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 following a recent unannounced visit by HIW which focuses on improvements to delays in time sensitive conditions. The action plan has been accepted by HIW and we are currently awaiting the full review to focus on additional factors they found during their review.

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 mid –November, when a workforce paper will be finalised for both nursing and medical staff which will recommend appropriate nursing levels for the department and also the Children's Emergency Unit to support a sustainable and resilient workforce to deliver care within the Emergency Department.

The 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

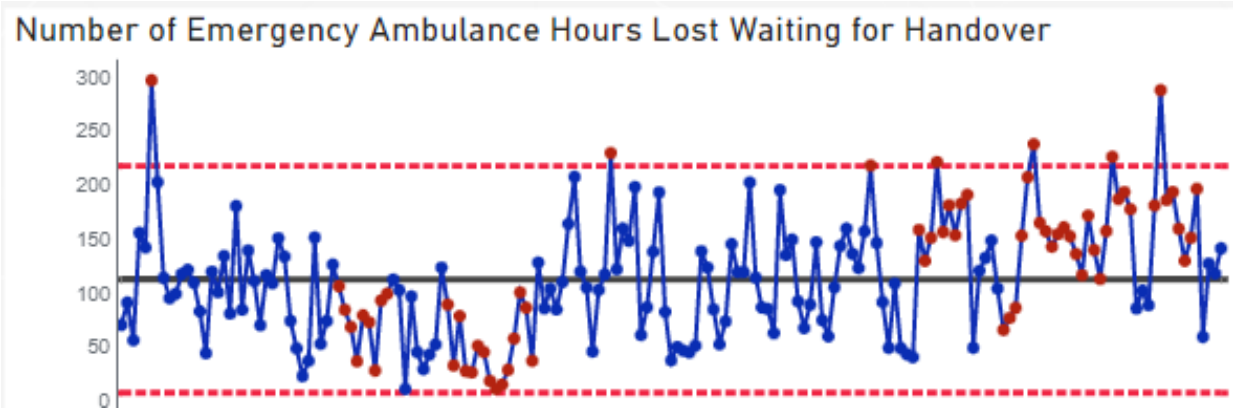
Ambulance attendance to ED is markedly reduced compared to pre-covid levels. This can be explained by a number of factors including:

- 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.

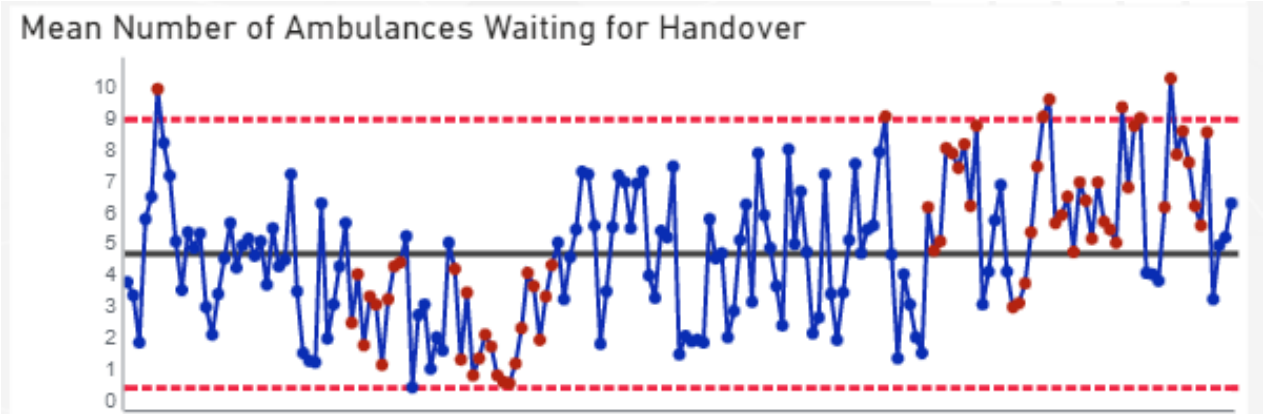
Ambulance handover performance has remained challenging throughout September 2022, in both the number of ambulances waiting for handover and the hours lost to delayed handover, despite a number of ongoing initiatives at the front door including ‘fit to sit’, redirection to OPAS, and discharge direct from an ambulance, as indicated in the following 2 SPC charts:

Number of Emergency Ambulance Hours Lost Waiting for Handover: Total time from emergency ambulance notifying of arrival at hospital, to transfer to ED in minutes. Source: WAST.

1st April to 30th Sept 2022



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
- Overcrowding in the ED caused by poor system flow site wide resulting in the inability to admit patients into the hospital
- The withdrawal by WAST of the 3 HALO vehicles which supported crews to be released by supporting patients on dedicated vehicles whilst waiting to be offloaded into the ED – when a patient went into to the HALO vehicle they were taken off of the clock

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

Welsh Ambulance Service Trust (WAST) implemented their immediate release policy in July 2022 which has also put additional pressure into the teams through the addition of 'amber 1' (serious) calls extends this to cover both life threatening (red) and serious (amber 1) calls. A robust escalation pathway which includes Bronze (Clinical Site Matron), Silver (Director of the Day chairing the safety huddle calls), Gold (Exec of the Day) and CEO in the event of 3 failures to release is in place to support this policy. Risks to patient safety for those in the ED are considered as part of the 'amber 1' release and since the introduction of this policy, there has been minimal ability to support the 'amber 1 release' but all requests for 'red' release have been supported.

3.2 Wider system measures:

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

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

3.2.1 Length of stay (LOS)

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

SUMMARY TABLE – GENERAL MEDICINE (NON COP / COP / COMBINED)

	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	17.0	10.7	9.4
2016/17	8.2	8.2	25.9	19.3	9.2
2017/18	7.5	7.3	14.1	26.6	8.3
2018/19	8.2	6.7	23.6	26.2	8.4
2019/20	8.9	7.6	19.2	37.7	9.1
2020/21	6.3	5.0	29.7	19.1	6.0
2021/22	6.1	5.0	22.3	7.1	5.9
2022/23	7.7	6.9	40.0	31.5	6.3

	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	27.1	no data	63.5	no data	27.2
2020/21	19.4	20.8	39.2	38.5	20.5
2021/22	30.5	29.1	46.9	49.1	30.0
2022/23	37.3	43.5	66.0	64.5	36.7

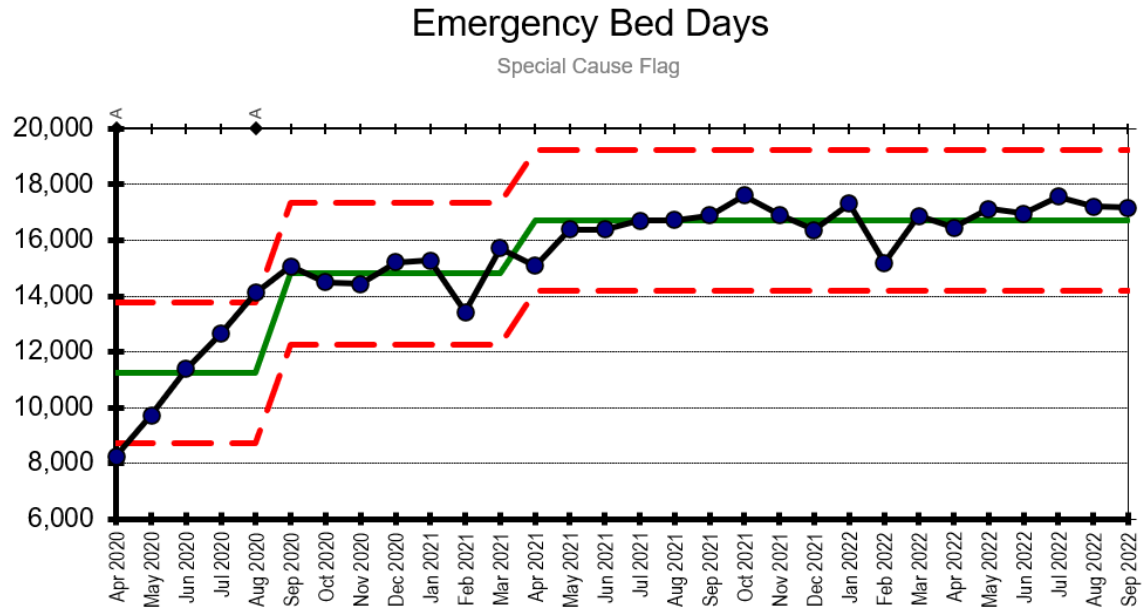
	NON ELECTIVE GENERAL MEDICINE ALL PATIENTS - ANNUAL: ALL SITES				
	Morriston Hospital	Singleton Hospital	Neath Port Talbot Hospital	Gorseinon Hospital	HB WIDE (M&S Only)
2015/16	8.6	8.3	37.1	33.8	9.4
2016/17	8.2	8.2	46.8	38.3	9.2
2017/18	7.5	7.3	41.5	28.6	8.3
2018/19	8.2	6.7	41.8	29.1	8.4
2019/20	9.8	7.6	40.8	34.1	9.5
2020/21	8.1	8.5	35.2	30.3	8.7
2021/22	8.7	8.4	42.8	39.6	9.0
2022/23	11.5	7.8	56.5	55.8	10.0

Applied filters:
Measure is Average Length of Spell

The table highlights the increase in LOS at Morriston for the emergency medical patients. An 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.

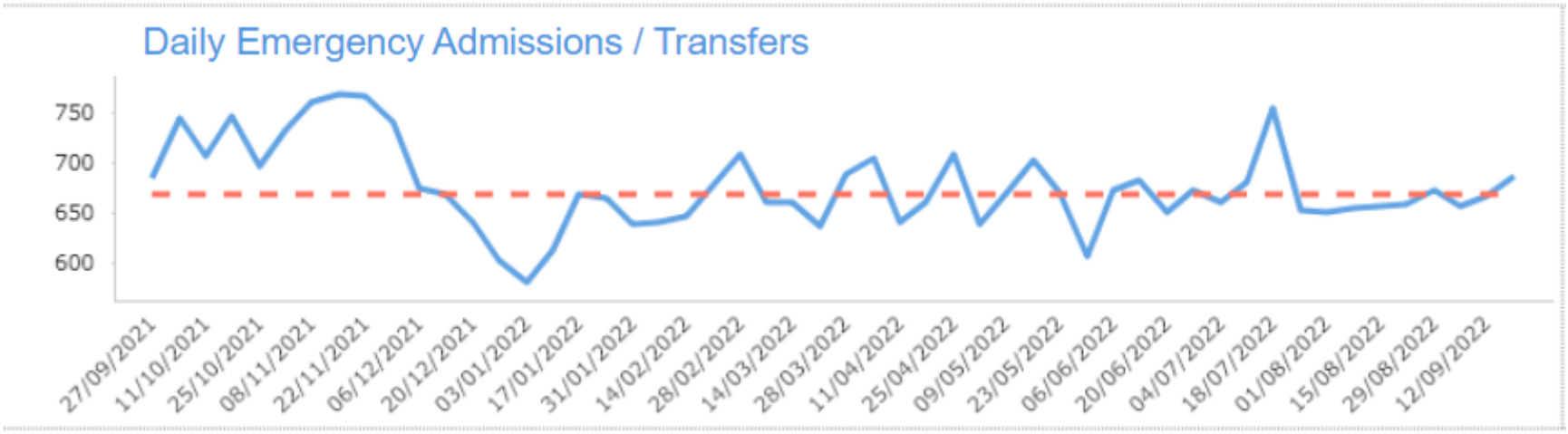
1.2.1 Emergency bed day utilisation:

Emergency bed day utilisation is a good barometer of pressure in the system. The graph below demonstrates a step change in the number of bed days used by admitted emergency patients and this correlates with the growing number of patients waiting in ED for admission to a bed (currently 38 at the 80th percentile). 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.



1.2.2 Admission activity:

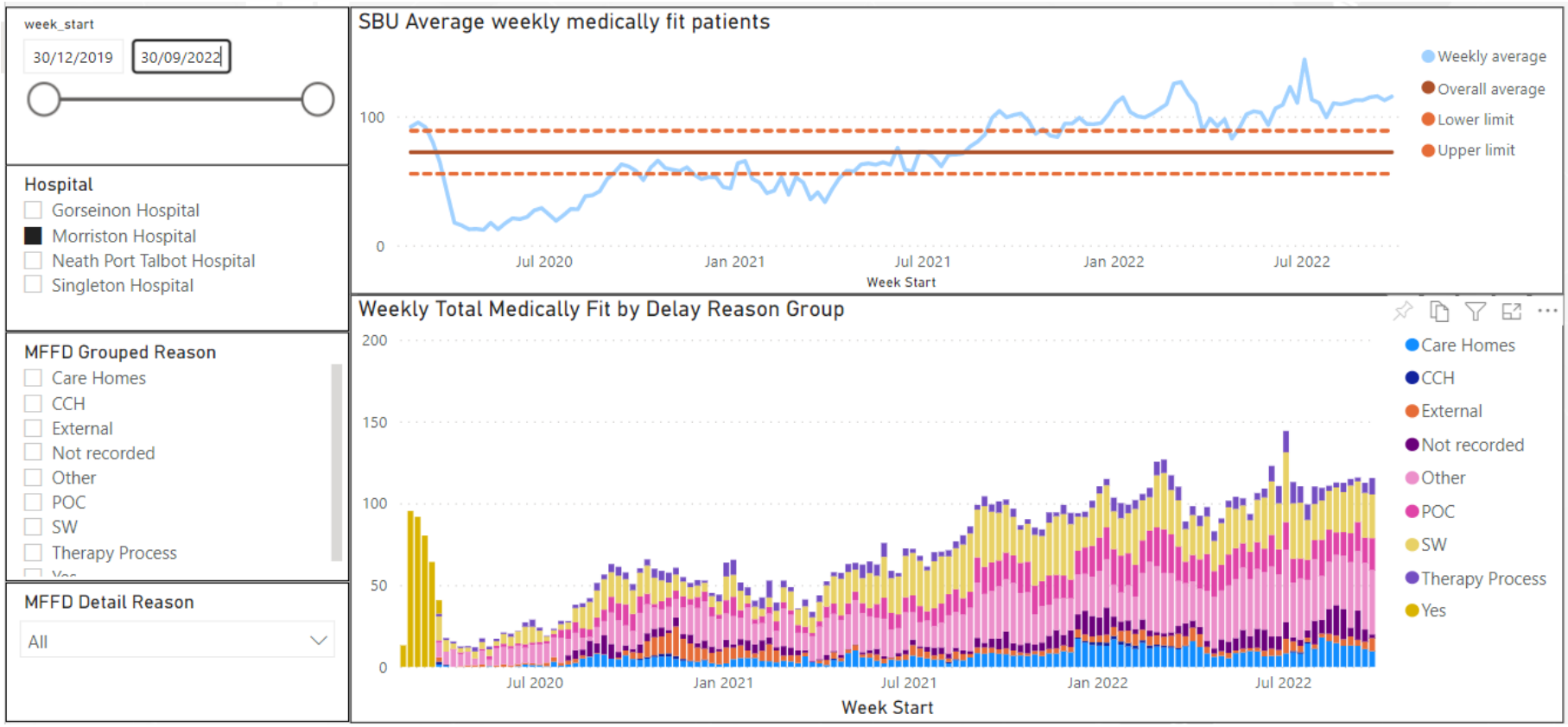
There has been a reduction in admissions to the Morriston site as indicated on the graph below. However, the previously mentioned INCREASE in the number of patients in ED awaiting admission, which has increased year on year since 2018, reflects the challenges accessing necessary inpatient capacity who will not therefore be admitted onto the system. This contributes to the reduction in emergency admissions, as well some success of admission avoidance schemes.



1.2.3 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.

Introduction of the weekly review of Red and Amber priority patients enables early escalation to Primary Care partners and Executive leads.



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

Virtual wards are in their infancy in SBUHB however, the working partnership between the Clinical site team, ED and virtual wards has resulted in an increase in admission avoidance.

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. Early review of the measures relating to the implementation of virtual wards demonstrates a 10% reduction in admission of the >65yrs patient group, vs a 3% reduction in the clusters that don't currently have virtual wards. Admission avoidance pathways have been developed with the OPAS team in Morriston and an ED in-reach pilot demonstrates an opportunity to pull patients from ED directly into virtual wards.

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

The Same Day Emergency Care service is also focussed on admission avoidance managing people with ambulatory sensitive conditions on a same day basis without the need for admission. 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 Improvement Overview

Table 1 summarises the actions which have been the focus in Q2 for improvement of U&E care at Morriston.

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

Issue	Actions to address issue	Output/Aim	By whom	By when
Admission Avoidance schemes	Pre-hospital - Scheduled WAST stack review for 12 hours per day-GP triage of patients waiting for ambulance response with a view to non-	Initial audit suggested 23% of conveyances could have been managed at an alternative setting if capacity had been available – baseline required of capacity gaps	Clinical lead SDEC	In place

Issue	Actions to address issue	Output/Aim	By whom	By when
	conveyance where clinically appropriate			
	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	Start of Phase 2 pilot - November 2022
	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	Mid November 2022
	-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

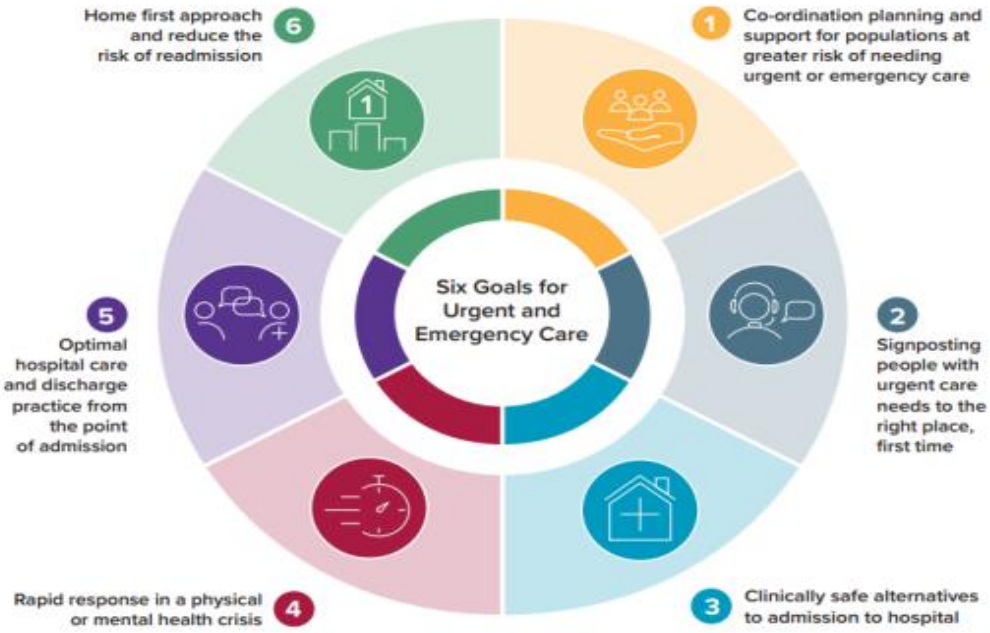
Issue	Actions to address issue	Output/Aim	By whom	By when
	community services and use of Care Homes as temporary capacity solution.	ensure maximisation of all capacity	Community Services	
Additional Capacity	Additional surge/escalation beds in use system wide as follows: +2 Gorseinon +21 Singleton +10 NPTH + 18 Morriston to include 8 TAU, 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

3.5 AMSR Update

Further work has also been progressed with regards to the AMSR programme. This significant programme of work which aims to centralise acute medicine onto the Morriston site and support the development of NPT as a centre of excellence for rehabilitation, is an ambitious programme which seeks to address the constraints of the current system and improve as a result patient flow and therefore outcomes for patients.

Opportunities to improve flow and ensure patients are treated in the right place, by the right clinician with no delays have been embraced to support the business case, which details an ambitious length of stay improvement plan to reduce the current amount of beds occupied by medicine across Singleton and Morriston from an average of 494 beds to a recurrent position of 347 beds. This reduction is aimed to be delivered through a combination of reducing delays for medically optimised patients through the virtual wards and home first schemes; through process improvements; through centralising expertise and maximising the use of same day emergency care and short stay and through initially retaining temporary capacity of 90 beds at Singleton to support the phasing of improvements. A shift to 7 day working models also underpins the ambition.

4.0 Six Goals for Urgent and Emergency Care Programme



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

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

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

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

- **Urgent Primary Care (Goals 1/2 / 3)**
    - Establishment of virtual wards and use of risk stratification tools to support people at high risk of admission being managed within the community setting
    - sustainable delivery of a 24/7 urgent care service which can provide clinical or professional advice remotely and face to face in the right place, first time. Integration of Urgent Primary Care Centres/services, GP and multi-professional practitioners (in and out of hours), and other community services such as community pharmacy, dental and optometry which provides consistency of service appropriate to the local needs.
    - Scheduling arrival slots into a range of local services including minor injuries units (where appropriate), emergency departments or same day emergency care hospital services to be further explored where this has added benefit to patient outcomes.
    - Same Day Emergency Care (SDEC) – a co-ordinated service model which supports people to access appropriate and safe care as close to home as possible and avoids the need for admission to an acute hospital through the provision of alternative pathways and ambulatory care – core component of the AMSR programme

    - Extension of OPAS service to support care homes and patients escalated for risk of deterioration
- **Rapid response in a physical or mental health crisis (Goal 4)**
    - Review of rapid response services
    - Establishment of single point of access
- **Home First and Reduce risk of readmission (Goal 6)**
    - Review of Home First provision and Reablement support
    - Establishment of 'bridging' and personal care support to enable earlier discharge from hospital
    - Engagement with virtual wards and third sector in supporting patients at risk of readmission including access to 'hot' clinics with secondary care expertise

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

5.0 Recommendation

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