Meeting Date	**28 June 2022**	**Agenda Item**	**4.2**
Report Title	Urgent and Emergency Care Recovery Plan 2022-23		
Report Author	Alison Gallagher, Interim Associate Service Group Director-Emergency Care and Hospital Operations, Morriston		
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 Morriston's 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 is fragile with a high vacancy factor, a sickness level at 6 - 7 % and reliance on temporary workforce solutions. This unstable workforce results in increased pressure being placed 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 1 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>
<tr><td>☒</td><td>☐</td><td>☒</td><td>☐</td></tr>
<tr><td>Recommendations</td><td colspan="4">Members are asked to:
NOTE this report and the ongoing progress towards establishing a framework for improvement within the U&E care service at the Morriston;
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.</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

In 2021/22 there were 82,593 ED attendances at Morriston, of these patients 12,461 patients (15.1%) waited in excess of 12 hours to be discharged or transferred from the department. As at Month 12, 2021/22 - 60% of patients were seen, treated and discharged within 4 hours. At the end of May 2022 (12 month rolling position), the number of patients treated within 4 hours was 59% and those over 12 hrs was 16.7 % which is a worsening position compared to previous months, and reflects 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;
- 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 fracture 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 NBT 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 finalisation and executive sign off of the Acute Medical Services Redesign (AMSR) business case which seeks to address issues affecting flow for the acute medical services and thus ED.

In addition, the acute medical services redesign has offered up an opportunity to review the divisional structures and associated capacity and capability. Requests for additional support have been made to ensure there is sufficient resource to support the implementation and sustainability of the programme with additional support from the PMO. The Health Board have also invested in membership of the NHSe Same Day Emergency Care collaborative to understand the opportunity and to support development of an integrated SDEC hub.

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 tables and SPC Charts below show the performance against the ED access standards and ambulance handovers for 2022/23 (12 month rolling position for both the health board position and Morriston). In both indicators, the position remains variable and there are no step changes in performance. An improvement in ambulance handover position is noted.

Number of A&E attendances

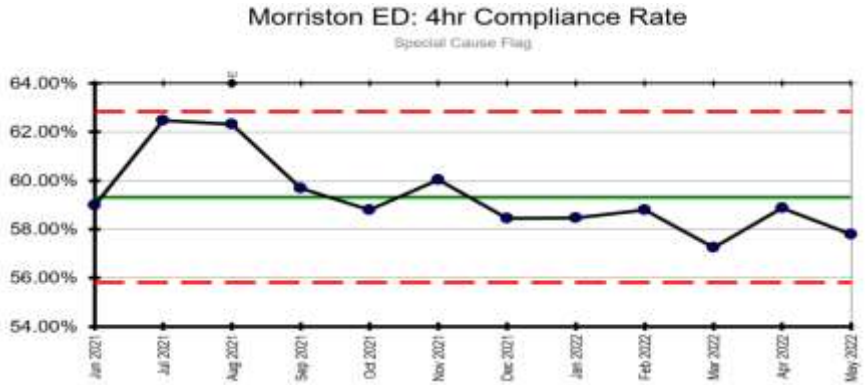
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22 (1st-15th)
Morriston	7,580	7,332	7,290	7,273	7,251	6,648	6,156	5,787	6,011	6,928	6,747	6,758	3,275
NPTH	4,008	4,120	3,788	3,884	3,486	3,490	2,926	3,350	3,264	4,156	3,986	4,492	2,198
Total	**11,588**	**11,452**	**11,078**	**11,157**	**10,737**	**10,138**	**9,082**	**9,137**	**9,275**	**11,084**	**10,733**	**11,250**	**5,473**

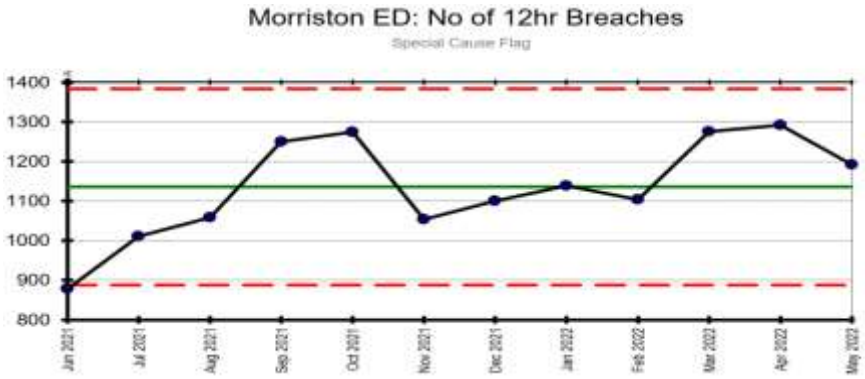
% patients seen within 4 hours in ED

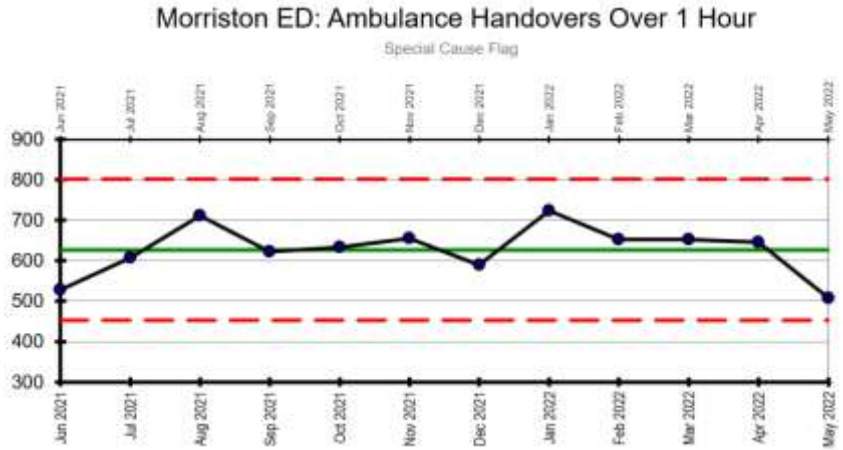
	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22 (1st-15th)
Morriston	59.0%	61.5%	62.3%	59.7%	58.8%	60.0%	58.5%	58.5%	58.8%	57.2%	58.9%	57.8%	55.3%
NPTH	97.7%	97.8%	99.4%	98.3%	99.4%	99.0%	94.9%	96.8%	97.2%	95.0%	96.7%	97.9%	97.3%
Total	**72.4%**	**74.7%**	**75.0%**	**73.1%**	**72.0%**	**73.5%**	**70.2%**	**72.6%**	**72.3%**	**71.4%**	**72.9%**	**73.8%**	**72.2%**

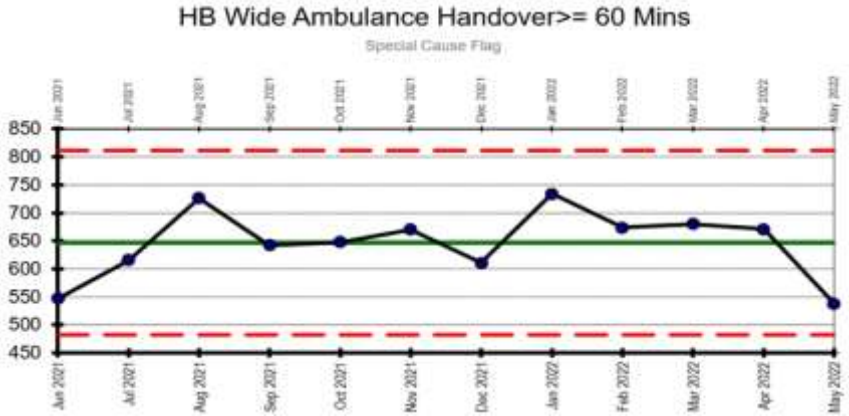
Number of patients waiting over 12 hours in ED

	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	Jun-22 (1st-15th)
Morriston	879	1,013	1,059	1,250	1,275	1,054	1,100	1,139	1,104	1,276	1,292	1,192	712
NPTH	1	1	1	0	1	1	1	3	1	6	2	3	1
Total	**880**	**1,014**	**1,060**	**1,250**	**1,276**	**1,055**	**1,101**	**1,142**	**1,105**	**1,282**	**1,294**	**1,195**	**713**









In reviewing the main breach reasons against the 4-hour standard, this largely relates to capacity in ED, both in terms of space and workforce, which is constrained and impacts directly on the ability for patients to be transferred from the ED to wards resulting in over-crowding.

The poor performance in the 4-hour standard 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.

An external review of the ED workforce undertaken by Kendall Bluck in 2018/19, demonstrated a significant gap in skill mix and workforce numbers in the medical workforce and a skill mix gap in nursing with little or no investment in advanced nursing practice roles. Small progress has been made from within the current funding envelope largely due to vacancies to increase the nursing skill mix and to secure advanced nursing roles, and retention of staff remains a key challenge. A review of the workforce plan for the ED has been requested from the Division to understand further opportunities to match capacity of workforce to demand across the ED footprint.

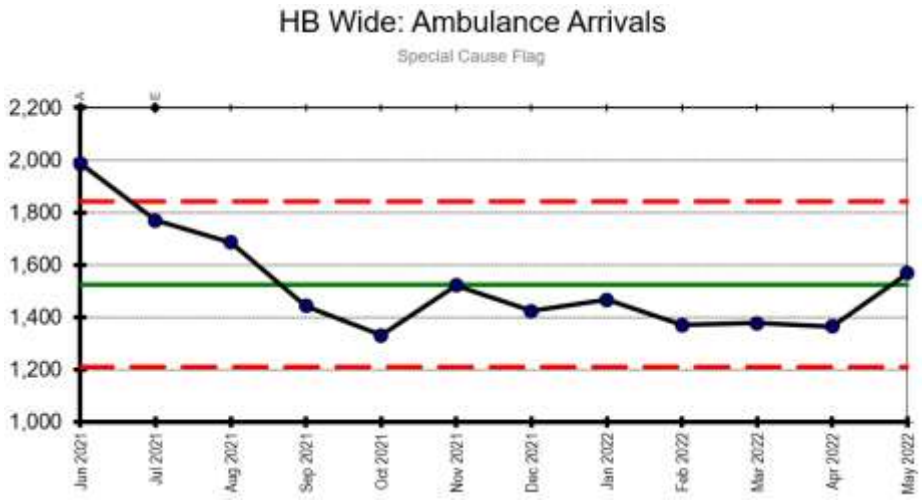
Non delivery of the 12 hour urgent and emergency care target relates predominantly to the system flow challenges and unavailability of in-patient beds. Patients waiting in ED for admission to an acute specialty bed will have been referred through a number of routes. There are those patients that have attended ED and are referred on to a specialty for assessment, however there are also patients that have been referred by GP's or other health care professionals who default to ED due to lack of

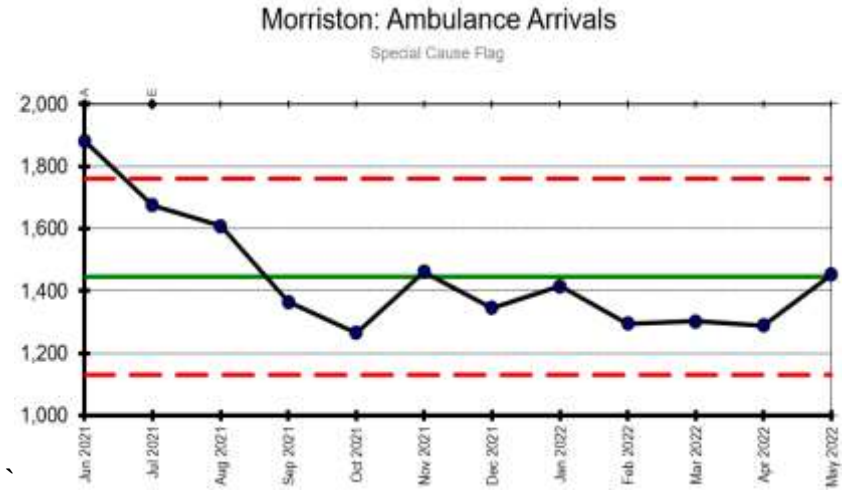
capacity in the specialty, there are also urgent clinical transfers that are admitted from other hospitals usually requiring specialist tertiary services who also default to ED due to lack of capacity. The 12-hour standard is almost directly linked to system flow and the challenges experienced within SBUHB are common across NHS Wales.

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

The number of ambulance attendances to ED has markedly reduced since June 2021. 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 - 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
- GP review of the waiting ambulance demand with redirection into alternative community pathways, self-care or SDEC





In order to further reduce ambulance attendance at ED, WAST are working with the Health Board to integrate the advanced practice paramedics into the SDEC hub where they will work in parallel with the GP's and will have more redirection opportunities into direct access pathways or non-conveyance with GP oversight.

Ambulance handover performance, despite the significant pressures in ED, shows a sustained reduction in both the number of ambulances waiting for handover and the hours lost to delayed handover. As a result of initiatives at the front door including 'fit to sit', redirection to OPAS, and discharge direct from an ambulance, a positive outcome is being realised; more recent *Ambulance Hours Lost* and *Average Ambulances Waiting for Handover* is showing a steady improvement – date range 31st Dec 2021 to 5th June 2022:

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 the inability to admit patients into the hospital

The introduction of 2-hourly huddles in ED have also re-focused attention on prioritising the ambulance offloads and performance monitoring and management of this is undertaken daily as part of the site team performance huddles.

3.2 Wider system measures:

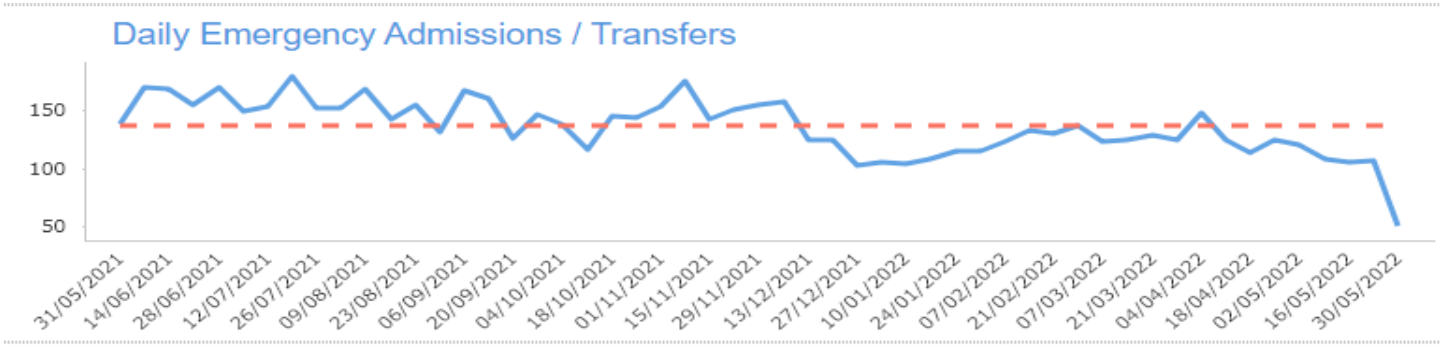
In order to understand performance in ED, there is a requirement to explore wider system performance, the performance outputs in ED are directly impacted by performance in other parts of the health and social care system.

There are also internal measures that help to explain the ED crowding including and improvement activities are directed to improving the position in these areas.

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

3.2.1 Admission activity:

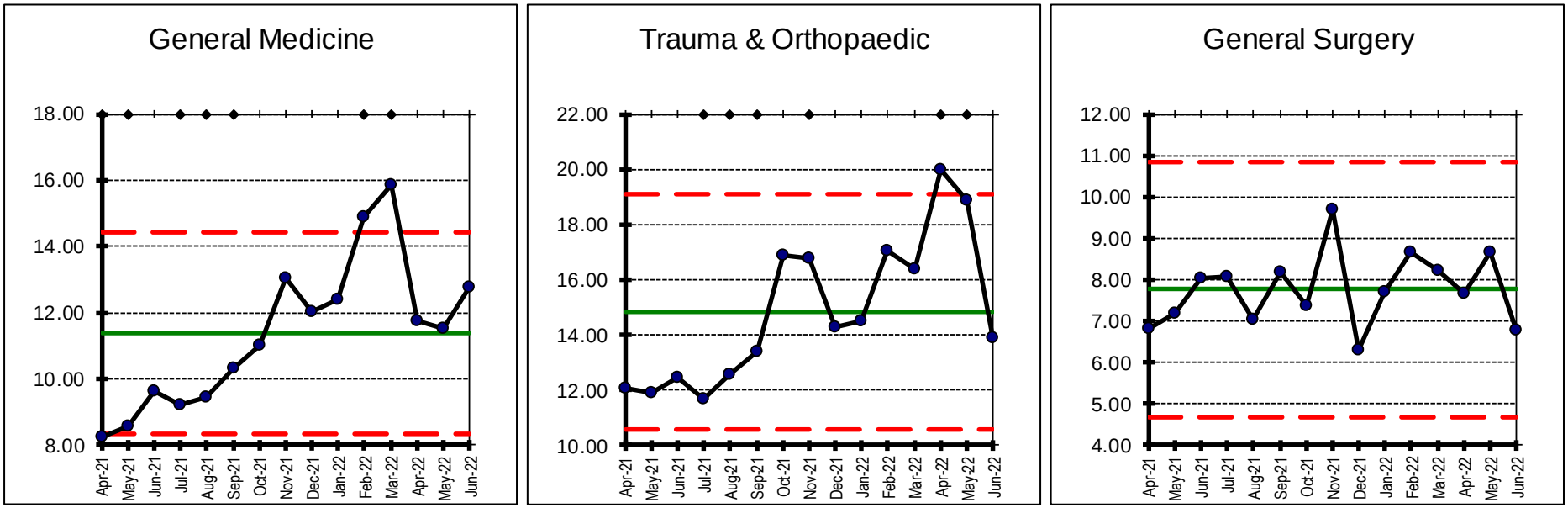
There is a reduction in admissions to the Morriston site as indicated on the graph below. Reasons for the improvement in this position are a combination of the cumulative impact on the admission avoidance schemes which are in place across Morriston and the community settings as outlined in 3.3, and can also be explained through the significant increase in patients who are 'boarding' in ED and discharged from that setting without being admitted onto the system– this position has more than doubled since 2021 and represent at least 15 patients a day who would otherwise have been admitted onto the site



3.2.2 Length of stay

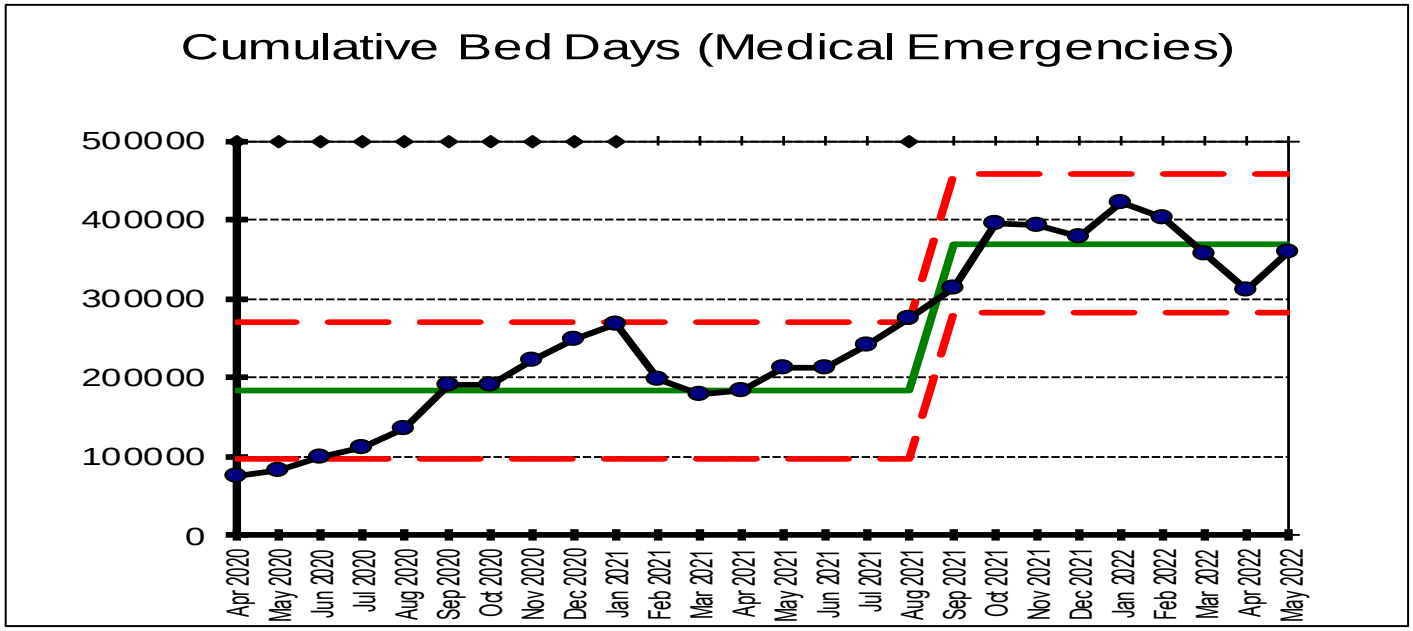
System flow is sensitive to changes in length of stay. The three graphs below represent length of stay for emergency admissions in the three biggest bed holding specialties in Morriston. It is recognised that there are LOS reduction opportunities in all specialties and the Divisional teams are working to agreed action plans to achieve this. However, the two specialties with the highest number

of clinically optimised patients with prolonged waits for discharge or transfer (general medicine and T&O), have an increasing length of stay as can be seen by the rolling 12-month overview.



3.2.3 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 the admitted patients to general medicine and thus correlates with the growing number of patients waiting in ED for admission to a medical bed. 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.



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3.2.4 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.

Weekly COP Snapshot					
Year / Month	**GORSEINON**	**Morriston**	**NPT**	**Singleton**	
2021					
Jan	14	61	34	44	
Feb	9	59	50	44	
Mar	5	55	41	46	
Apr	7	52	59	37	
May	7	68	71	36	
Jun	9	69	79	49	
Jul	9	73	72	56	
Aug	12	79	70	55	
Sep	13	103	82	69	
Oct	16	103	85	56	
Nov	12	89	79	58	
Dec	18	95	77	51	
2022					
Jan	16	104	70	62	
Feb	17	105	72	64	
Mar	22	113	82	56	
Apr	21	95	78	58	
May	19	100	81	58	
Jun	15	111	77	56	
Grand Total (Average)	**13**	**84**	**70**	**53**	**Total (Average) 220**

With regards to actions being taken to improve the clinically optimised position, there are a number of work streams which are targeting reducing the total number of clinically optimised across the healthboard, but also reducing more importantly the length of stay for those patients once they have been deemed clinically optimised. These work streams include:

- **Admission avoidance and frailty programme** – aimed at reducing the number of patients presenting to the hospital who otherwise would be at risk of admission once presented.

  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 currently 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 development of these services offers the opportunity for patient optimisation in the community, admission avoidance and supported discharge from hospital thus reducing length of stay. 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. 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. The introduction of a nurse navigator will commence by end June 22 as a 3-month pilot.

  Early review of the measures relating to the implementation of virtual wards demonstrates a 10% reduction in admission of the >65 yrs. patient group, vs a 3% reduction in the clusters that don't currently have virtual wards. It should be noted though that this reduction will be a culmination of ALL admission avoidance schemes rather than

virtual wards in isolation and work is underway to understand the contribution of the various schemes in place which are targeting this group.

- **Early Supported discharge** – the reintroduction of early supported teams to support patients early in their recovery pathway to be managed within the community setting is being explored across all sites currently.

- **Process review** – a review of the current system and processes in managing patients who require further support on discharge is underway. Morriston has expanded its discharge co-ordinator resource which is supporting early identification of patients on admission with the multi-disciplinary team, along with co-ordinating discharge functions to reduce the risk of delays through capacity by the ward and multi-disciplinary teams to undertake these tasks. The implementation of a dashboard to track the reasons for delays and understand better the capacity gaps across the system has also been introduced at Morriston. This allows for early escalation for patients who are delayed and a better understanding of the capacity constraints across all pathways for our patients – insufficient capacity currently is reported against those patients requiring specialist rehab and community support in a bedded facility; home first services and pathway 4 services.

- **Purchase of additional capacity** – the Health board continues to commission beds within the community to meet the gap in residential/home care market.

3.3 Improvement Overview

Table 1 summarises the actions which have been the focus in Q1 for improvement of U&E care at Morriston. Further work to assess the impact and improvement using IHI methodology is in development with the BI team.

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	Clinical lead SDEC	Commenced WC 31st Jan 22 – initial output positive in redirecting to alternative provision

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 July 22

Issue	Actions to address issue	Output/Aim	By whom	By when
		Potential for 10-12 alternative conveyances		
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
	Introduction of HALO ambulances x 3 to improve ambulance handover performance and to release EMS crews to community response	Reduced handover delays	WAST	In place however model non consistent and resource not available to provide sustainable solution
	Internal ambulance handover escalation and red 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	March ‘22

Issue	Actions to address issue	Output/Aim	By whom	By when
	-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 to incorporate RTDC methodology– support from Improvement Cymru	To reduce occupancy and improve flow through the day through senior decision makers, effective board rounds, effective discharge management processes	All service groups	In place Morriston
	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 IP&C impacting of lack of flow
	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	Associate Service Group Director ECHO	In place
	Focus on the 'Golden patients', discharge by 09:30 hrs to Discharge Lounge or home.	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	In place
	-Extraordinary Silver Command in place for Community service	Support timely discharge of clinically optimised patients and	HON Primary, Therapies &	In place

Issue	Actions to address issue	Output/Aim	By whom	By when
	focussed on flow into community services and use of Care Homes as temporary capacity solution.	ensure maximisation of all capacity	Community Services	
	Operational processes	Ensure robust and timely operational processes are in place with escalation to support and mitigate against risks – breaking the cycle events held as required	ASGD ECHO	In place
Additional Capacity	Additional surge/escalation beds in use system wide as follows: +2 Gorseinon +21 Singleton +10 NPTH + 22 Morriston with 5 ED surge trolleys +/- OPAS 5 trolleys	The surge benefit has been offset by the high number of clinically optimised patients occupying acute beds.	Service Group Directors	Complete
	Introduction of HALO ambulances x 3 to improve ambulance handover performance and to release EMS crews to community response	Reduced handover delays	WAST	In place however model non consistent and resource not available to provide sustainable solution
	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

Issue	Actions to address issue	Output/Aim	By whom	By when
	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	2 wards in place Plan to extend – Sept '22

3.4 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 312 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 as previously discussed 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.

Business cases have now been approved and the organisational change policy was launched on Monday 13th June 22.

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 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:

- **Goals 1,2, 3 – Co-ordination, signposting and alternatives to admission**
    - Collaboration with WAST with joint reviews of the WAST stack including Contact First to sign post to alternative pathways/management – APP joining the existing review team to start end of July '22
    - Frailty expansion to support additional 'hot clinics' at Singleton and extension of OPAS services from Morriston into care homes and 'pre-hospital home visiting initiative' – start July '22
    - Direct conveyance into SDEC from WAST in line with All Wales Paramedic Pathway Policy – Start July '22
    - Virtual Wards – implemented in 4 clusters, roll out to remaining 4
- **Goal 4 – Rapid response**
    - Direct access pathways from WAST to Mental health assessment facilities
    - Extended access to psychiatric liaison for attendance at font door services
    - Integration of long-term condition based teams to admission avoidance agenda to offer 'rapid response' at referral
- **Goal 5 - Acute Medical Services Redesign (AMSR) – Dec '22:**
    - Centralisation of the emergency medical take to Morriston Hospital (currently two separate takes at Morriston & Singleton Hospitals)
    - Expansion of SDEC services – SDEC Recovery collaborative with NHS Elect (June – Nov '22)
    - Establishment of an AMU short stay unit – 50% medical take to be managed in <48hrs
    - Robust site management and discharge arrangements – Improvement Cymru RTDC
- **Goal 6 – Home First**
    - Demand and capacity review for 'out of hospital services' to prevent extended lengths of stay in hospital settings
    - Review D2RA model in collaboration with social care to ensure sustainable delivery model across all pathways

- Extension of SBUHB purchase of 'care home beds' to support D2RA gaps

Enabling Priorities

- Capital and revenue investment to advance the 6 goals priorities
- Support in technology to underpin system wide operating models
- Recruitment to 6 Goals Triumvirate Team
- Alignment of governance to the 6 goals priorities

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 report and the ongoing progress towards establishing a framework for improvement within the U&E care service at the Morriston;
- **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.

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

Timely access to emergency care remains one of the highest Health Board risks related to quality and safety of patient care. The paper outlines remedial actions in place and in train to improve patient flow and access to care and to mitigate the levels of risk across the whole urgent care pathway.

Financial Implications

None specific to this paper.
The investment required for the implementation of the Acute Medical Services redesign is subject to a separate Business Case.

Legal Implications (including equality and diversity assessment)

No implications to note

Staffing Implications

None specific to this paper. There OCP that relates to the Acute Medical Services has implications of various degree for circa 1700 staff, this is picked up via the Health Boards OCP process. Equally the AMSR business case included additional posts; HR will be assisting with the required recruitment processes.

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** – A complete redesign of acute medical model is to be implemented with associated stepped benefits to the care of patients on urgent care pathways
- **Prevention** – Early interventions and admission avoidance has the dual benefit of patients spending less time in or not being admitted to hospital settings and reduction of bed occupancy and improved flow through the hospital.

○ **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 centre of these pathways	
Report History	V1
Appendices	None

Paper