Meeting Date	**28 June 2022**	**Agenda Item**	**6.3**
Report Title	**Clinically Optimised Patients – update on actions to reduce COPs at SBUHB**		
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Presented by	Kate Hannam, Interim Service Group Director, Morriston		
Freedom of Information	Open		
Purpose of the Report	This report provides an update to the committee on the actions being taken to address the number of clinically optimised patients (COPs) in SBUHB		
Key Issues	The number of patients who are clinically optimised in the Health board has remained relatively static, despite a number of actions being taken to address the situation. Length of stay in this cohort is also extending as a result of the inability to transfer patients into settings requiring social care support which is further exacerbated by the impact of covid restrictions. The following actions are being taken to mitigate the increase of COPs within the Health Board: • Admission avoidance and frailty programme (page 3) • Early supported discharge (page 4) • Process review (page 4) • Ongoing procurement of transitional care home bed capacity (page 4)		
Specific Action Required ***(please choose one only)***	**Information**	**Discussion**	**Assurance**	**Approval**
	☐	☐	☐	☐
Recommendations	Members are asked to: • **NOTE** the report and the ongoing actions to address the COPs within SBUHB.			

Clinically Optimised Patients – update on actions to reduce COPs at SBUHB

1. INTRODUCTION

The report below provides a brief overview of the current position with regards to clinically optimised patients and the actions being taken to address this position.

2. Background

The clinically optimised position in the Health Board remains a key challenge with high numbers of patients occupying acute beds waiting to move to more appropriate settings to continue their care pathway or waiting for community support/placement.

There is operational focus on this patient group in all hospital sites with weekly review meetings with Local Authority (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**

3. Actions to address the COPs

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 patients across the health board, 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.

- **Ongoing procurement of transitional care home bed capacity** – the Health Board continues to commission beds within the community to meet the gap in residential/home care market.

4.0 Recommendation

Members are asked to:

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

Governance and Assurance		
Link to Enabling Objectives *(please choose)*	**Supporting better health and wellbeing by actively promoting and empowering people to live well in resilient communities**	
	Partnerships for Improving Health and Wellbeing	☒
	Co-Production and Health Literacy	☐
	Digitally Enabled Health and Wellbeing	☐
	Deliver better care through excellent health and care services achieving the outcomes that matter most to people	
	Best Value Outcomes and High Quality Care	☒
	Partnerships for Care	☒
	Excellent Staff	☐
	Digitally Enabled Care	☐
	Outstanding Research, Innovation, Education and Learning	☐
Health and Care Standards		
(please choose)	Staying Healthy	☒
	Safe Care	☒
	Effective Care	☒
	Dignified Care	☒
	Timely Care	☒
	Individual Care	☒
	Staff and Resources	☒

Quality, Safety and Patient Experience
Extended hospital stays due to lack of capacity in out of hospital pathways have cumulative detrimental effect on patients, particularly those who are old and frail. The Health Board is looking to both avoid patients needing hospital admission and being supported via virtual wards and frailty programme and to expedite discharge once patients become clinically optimised via early supported discharge, more effective processes and additional out of hospital capacity.
Financial Implications
None specific to this paper. The required investment for Virtual wards and Transitional Care Home beds has been addressed and approved through separate business cases that have gone through the Health Boards governance processes.
Legal Implications (including equality and diversity assessment)
No implications to note
Staffing Implications
None specific to this paper. Recruitment related to expansion of frailty services and virtual wards is taken forward by the appropriate work streams
Long Term Implications (including the impact of the Well-being of Future Generations (Wales) Act 2015)
Briefly identify how the paper will have an impact of the “The Well-being of Future Generations (Wales) Act 2015, 5 ways of working.

- **Long Term** – Earlier interventions such as virtual wards and enhanced frailty services will deliver longer term benefits with less patients requiring care packages or requiring less intense packages of care
- **Prevention** – Early interventions will have preventative benefits both for patients (improved health and functionality) and for healthcare providers (reduced resource requirements in the future)
- **Integration –** The interventions are based on multidisciplinary approach and integrated care pathways
- **Collaboration –** Close partnership working with Local Authorities and other care providers
- **Involvement –** Patient and family involvement are firmly at the centre of these pathways

Report History	V1
Appendices	None