Urgent and Emergency Care (UEC) & Harm

Challenges and Current State of UEC Pathway (see slides 20 - 28)

- Average Length of Stay (LoS) before patients become medically optimised are too high particularly in relation to our > 75s inpatient population
- Long Length of Stay contributes to deconditioning (harm) and increased demand for care in the community – which is finite
- Waits for care contribute further to the LoS and a Bed Occupancy rate which is intolerable for 'system flow' from Emergency Dept.
- Long waits for bed availability for patients in ED and no 'offload space'
- Ambulance Handover Delays
- Unmet Emergency Demand in the Community

Urgent and Emergency Care – Impact

- Resultant Risk and Impact

Harm in the Community for Patients waiting from Ambulance Conveyance

Harm in the Community for people formally assessed as requiring social care to meet critical Activities of Daily Living and which cannot be provided

Harm at our 'Front Doors' for patients being cared for in environments that are not conducive to patient safety / optimal clinical outcomes

Harm to patients from clinical risk associated with sub optimal staffing levels (medical, nursing and therapeutic)

Harm to frail patients whose LOS has contributed to deconditioning and a new or increased need for care on discharge

Sustained and extreme pressure across the NHS urgent and emergency care system has negatively impacted patient flow through all hospital sites

Whilst such pressure was evident prior to the COVID19 pandemic it has been most acute as we have emerged from the pandemic in late 2021 and into 2022 and continues today with limited improvement.

This pressure has led to a number of risks and does impact on quality and safety across the system.

Resultant Risk & Impact on Workforce, Quality & Patient Experience

Poor Patient Experience and Potential Harm to patients who are unable to access timely scheduled surgical intervention

Consequent Impact on our workforce in terms of staff retention, resilience and absence

Red Release Performance

Ymddiriedolaeth GIG Gwasanaethau Ambiwlans Cymru
Welsh Ambulance Services NHS Trust

Immediate Vehicle Release Requests

Summary From 25/07/2022 To 31/07/2022

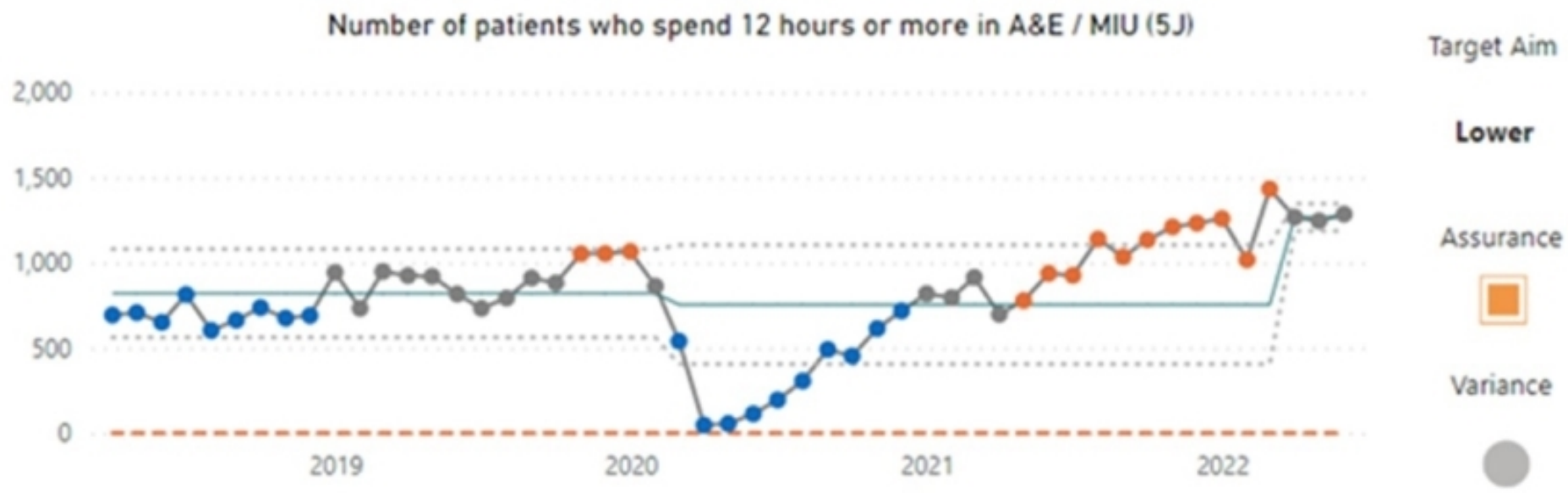
Priority	Hospital Health Board	Hospital Name	Accepted	Not Accepted	Total
RED	Hywel Dda	Bronglais Gen Hosp Aberystwyth	2	0	2
		Glangwili Hosp Carmarthen	2	0	2
		Prince Philip Hosp Llanelli	3	1	4
		Withybush Hosp Haverfordwest	1	0	1
		Total	**8**	**1**	**9**
AMBER1	Hywel Dda	Glangwili Hosp Carmarthen	5	10	15
		Prince Philip Hosp Llanelli	2	7	9
		Withybush Hosp Haverfordwest	3	0	3
		Total	**10**	**17**	**27**

	Accepted	Not Accepted	Total
Grand Total	18	18	36

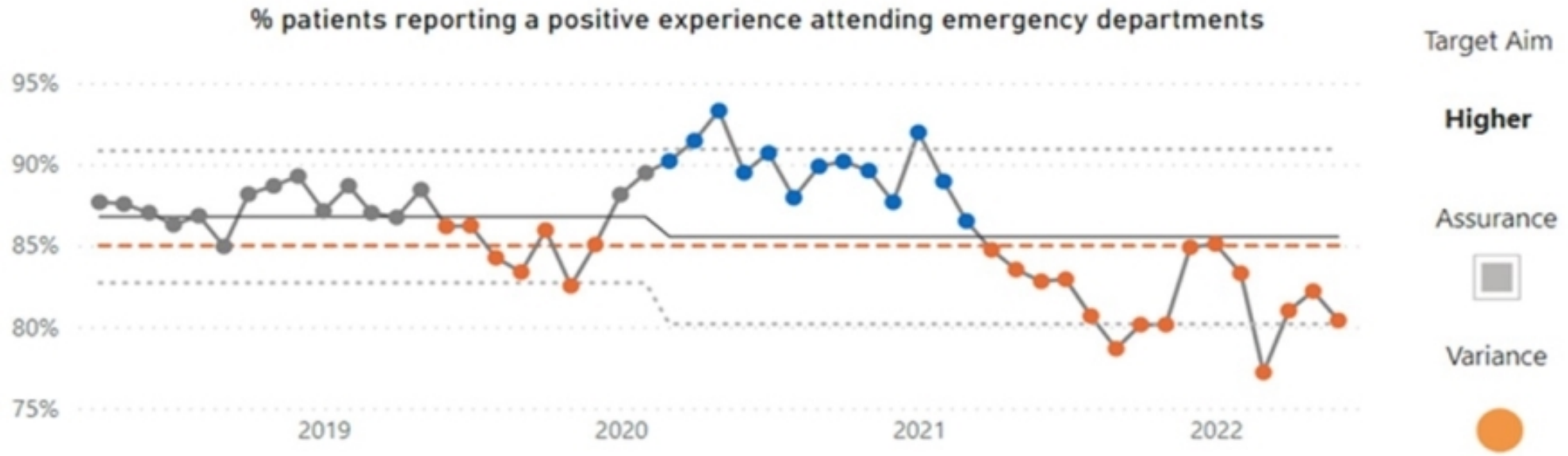
Annexe B – WAST investigation into community Harm – Analysis

- Should be reported within 72 hours to Health Board, for review and potential joint investigation
- Report received from Delivery Unit, March 22 identifying All Annex B's reported
- Review by HB identified out of 28 reported 21 were notified to HB
- Delays between receipt of reporting by incident and received into HB were between 11 – 100 days. Average 43 days to receive Annexe B
- Difficult to identify true harm currently within community – working with WAST to improve joint investigations

Number Patients spending > 12 hours in ED



Patient Experience



Emergency Department Complaints

Row Labels	Accident & Emergency	Minor Injuries Unit	Grand Total
Managed through PTR	191	20	211
2021-22	191	20	211
Unscheduled Care - BGH	28	2	30
Unscheduled Care - GGH	83		83
Unscheduled Care - PPH		18	18
Unscheduled Care - WGH	80		80
Grand Total	191	20	211

Q1 2022-23	Count of Primary Location
Managed through PTR	50
HDUHB / Bronglais General Hospital / Emergency & Urgent Care Centre	5
HDUHB / Glangwili General Hospital / Accident & Emergency Department	27
HDUHB / Withybush General Hospital / Accident & Emergency Department	18
Grand Total	50

Quarter One comparison would indicate that complaints this year are similar to previous years to date.
Key themes that have been identified include communication, long waits in department, poor discharge planning

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

What Patients told us

Waited 12 hours in A&E. very busy, nothing to drink, vending machine out of stock for water. Not enough staff, to deal with the volume of the public. I was discharged, and asked to come back for an MRI scan on Monday morning at 8:30. Waited four hours, seen by Dr, to be told there was no chance of having an MRI as it was booked up fully. Waste of time turning up.

Discharge without transport, no follow up, no idea whats going on

My father recently admitted with a broken hip.. treated really well in hospital.. he was discharged yesterday a fortnight after the op.. with no care plan in place and no exercises in place for him to progress .. it has been assumed that we as a family are capable of caring 24/7 ... no home visit to ensure safe return .. very disappointing

Excellent treatment my mother went to ward after a bleed on the brain recovered remarked after one day on the ward however although medically fit doctor told mum she could go home without informing us knew by accident as family member dropping off clothes x although the doctor said she could stay in another day as I complained of no discharge planning living alone , obviously wanted to be go home there and then , as a nurse I am aware of the severity of demands of the service , this was very poor

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How are we mitigating harm

- Established an Operational Delivery Group led by WAST with senior leadership representation
- Agree actions that reduce conveyance and conversion rates and enable learning across organisations.
- Key actions include:
- Implement ‘Consult to Convey’ approach – Advanced Paramedic Practitioner (APP) integrated with community Intermediate Care service (GP led).
- Implement Paramedic access to social care information to support decision making re conveyance
- Paramedic direct referral to Same Day Emergency Care (SDEC)
- Triangulation of WAST and Health Board incident information re handover delays and ‘red releases’ for joint learning and development of action plan
- Working with Relationship managers within ED – Listening spaces, pro-active recruitment campaingns

Patient Experience – What Matters

Ray Evans - YouTube

Use of
PROMS
and
PREMS

Transformation Urgent & Emergency Care Programme

- Frailty Matters!
- Best Practice Standards for UEC (Conversion, Conveyance and Complexity)
- Frailty Standards – Leading at All Wales Level with Dep Chief Medical Officer, Chief Nursing Officer, Chief Allied Health Professions Adviser
- Focus across 6 UEC Policy Goals and its components – Urgent Primary Care & Establishment of a Clinical Streaming Hub, Same Day Emergency Care, Home First and Discharge to Recover then Assess
- Programme Governance Structure, Triumvirate Leadership reporting at Exec and Board level

Urgent Primary Care & Intermediate Care Standards

Conveyance

100% of all > 75 year olds screened for frailty on our community caseloads	Rapid access to care & support for individuals presenting with sudden physical and mental decline to provide care at home for at least one week but up to 6 weeks where appropriate (Integrated with other pillars of intermediate care i.e. reablement, bed based care and home based therapy
100% of frail / complex patients on our caseloads have 'stay well' plans in place and whose cases are care coordinated	100% of patients with positive frailty screening receive CGA by senior diagnostician and MDT (particularly those with Clinical Frailty Score >5)
Crisis response & assessment for physical and mental health sudden decline available for all patients presenting within a 1 - 2 hour time frame	Frailty Assessment Unit (or similar) available to support complex care decision making with Consultants and implementation of 'care and treatment' at home.
Response and assessment for reablement / therapy led care within 72 hour time frame	
Urgent Primary Care response within 8 hour period	Access to appropriate diagnostics to provide care and treatment at home (e.g SDEC, Point of Care Testing)

Emergency Care Standards

Conversion

WAST Response – define Red standard (8 mins), 15 mins turnaround at front door, 0 delays by 2023
Same Day Emergency Care (SDEC)– 30% of the Acute Medical Take streamed through SDEC with 90% of these being discharged within 12 hours ('to their own bed')
Emergency Department Response - No patient will wait > 4 hours before transferring to onward care unless clinically necessary, all patients should complete their clinical ED care within 12 hour period
60 mins from arrival to handover to clinician by 2025

Complexity (Frailty) Standards inc. Complex Discharge

Standards for Complex Patients Presenting to Acute and Community Hospitals		% of acute medical take who are managed in SDEC (aim 30%)
100% of all > 75 year olds screened for frailty at the 'front door' of acute hospitals	100% of patients with positive frailty screening receive CGA by clinician and MDT	% of patients in SDEC who are not admitted (aim 90%)
Patient transferred to agreed D2RA pathway within 48 hours of becoming medically optimised	100% of all > 75 year olds screened for frailty at the 'front door' of acute hospitals	% of people managed in SDEC who continued to have their care managed outside hospital (aim 100% of those not admitted)
Maximum of 5% patients readmitted to acute hospital within 28 days of transfer to D2RA destination	Frailty Assessment Unit (or similar) available to support 'turnaround' of frail patients within 72 hours	% of these who remained well and at home for 30, 60 and 90 days following SDEC intervention

Development of dashboard to measure- System risks and potential harms - measures

Topic	Measure
Workforce	Staff sickness
	Agency use
	Nurse staffing
	Staff experience
Quality and patient safety	Incidents causing harm
	Complaints
	Infection control incidents
	Healthcare acquired pressure damage
	Medication errors
	Patient falls
	Patient experience
	Hospital acquired thrombosis
	Sepsis
	Acute kidney injury
Planned Care	Patients waiting >52 weeks for a new outpatient
	Patients waiting >104 weeks for treatment
	Tbc
	Tbc
Urgent and emergency care	Number of ready to leave patients
	Average length of stay for UEC patients aged 75+
	Ambulance handovers >4 hours
	Patients waiting >12 hours in an ED
	Readmissions within 28 days
	Red release not agreed
Women and children	Tbc
Mental health	CAMHS referrals to assessment within 28 days
	CAMHS assessment to treatment within 28 days
	Children & young people waiting >26 weeks for neuro assessment

Next Steps

- Finalise and Implement Unscheduled Emergency Care (UEC) Quality and Safety Outcome Measures Dashboard
- Analysis of Outcomes
- UEC Operational Delivery Groups to oversee implementation of actions to improve outcomes based on the analysis
- Update report to be scheduled for QSEC December '22

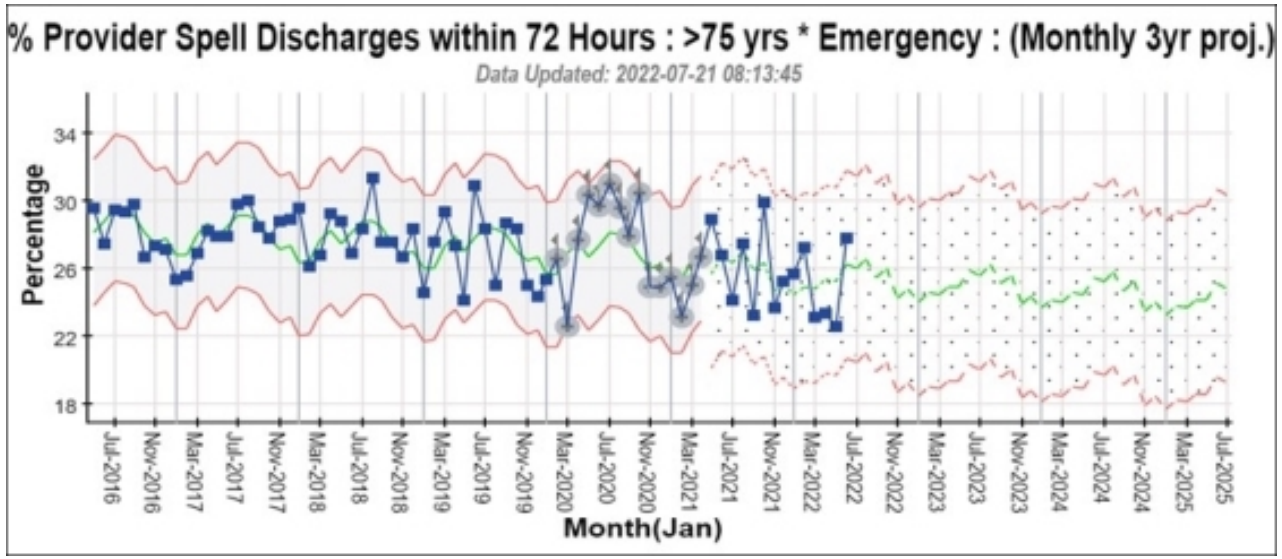
Recommendation

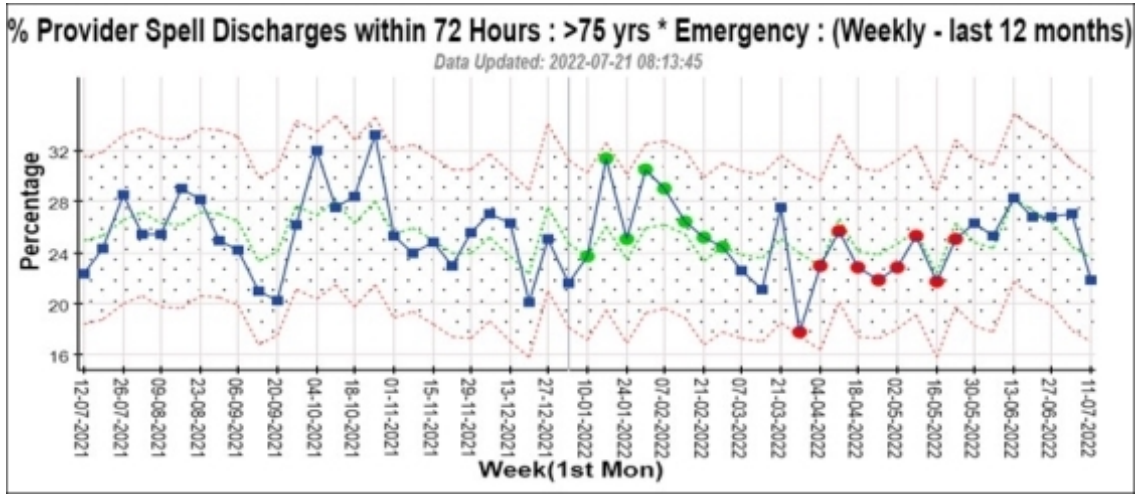
For QSEC to note the update provided and receive assurance from the actions being taken internally and with WAST to mitigate the risks.

Any Questions?

Complexity – HDuHB

% patients discharged in 72 hours
Monthly 3 year projection

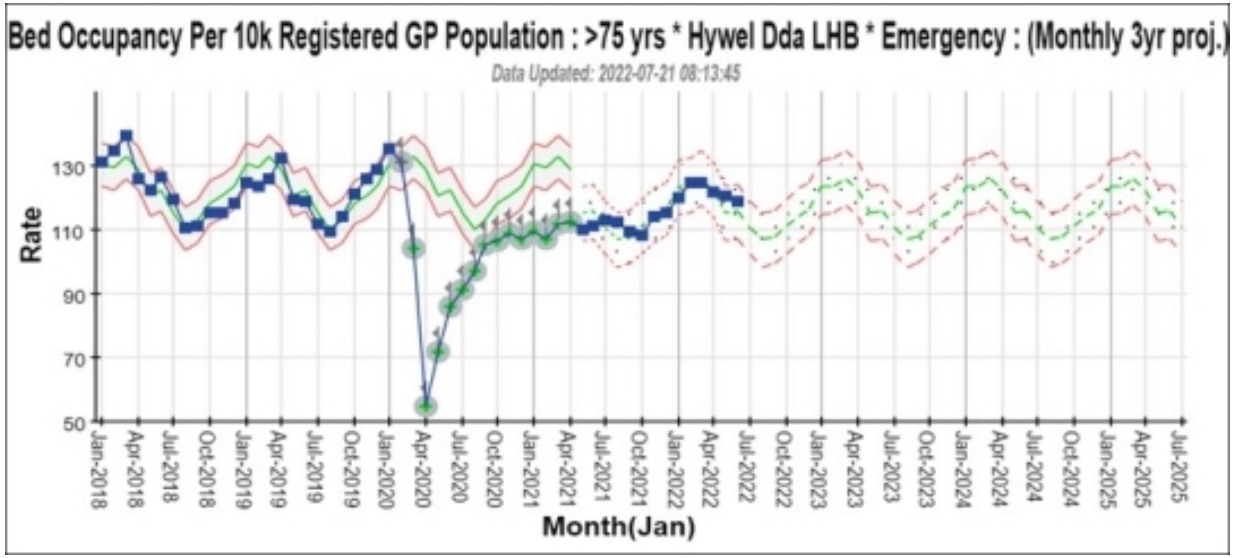


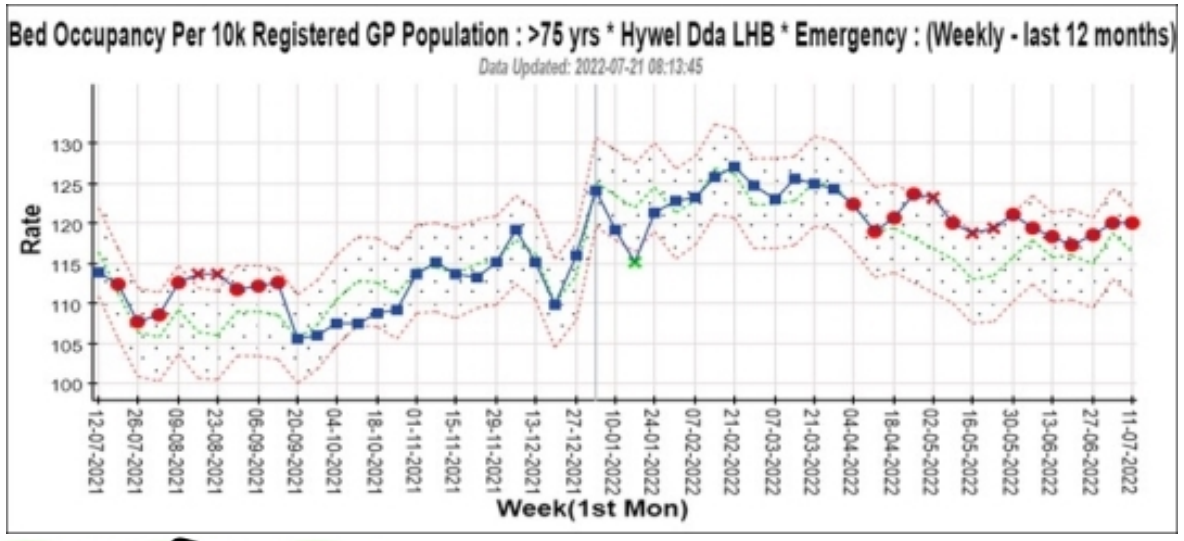


% patients discharged in 72 hours
Weekly – last 12 months

Bed Occupancy Impact – HDuHB

Occupied beds
Monthly 3 year projection
per 10k population

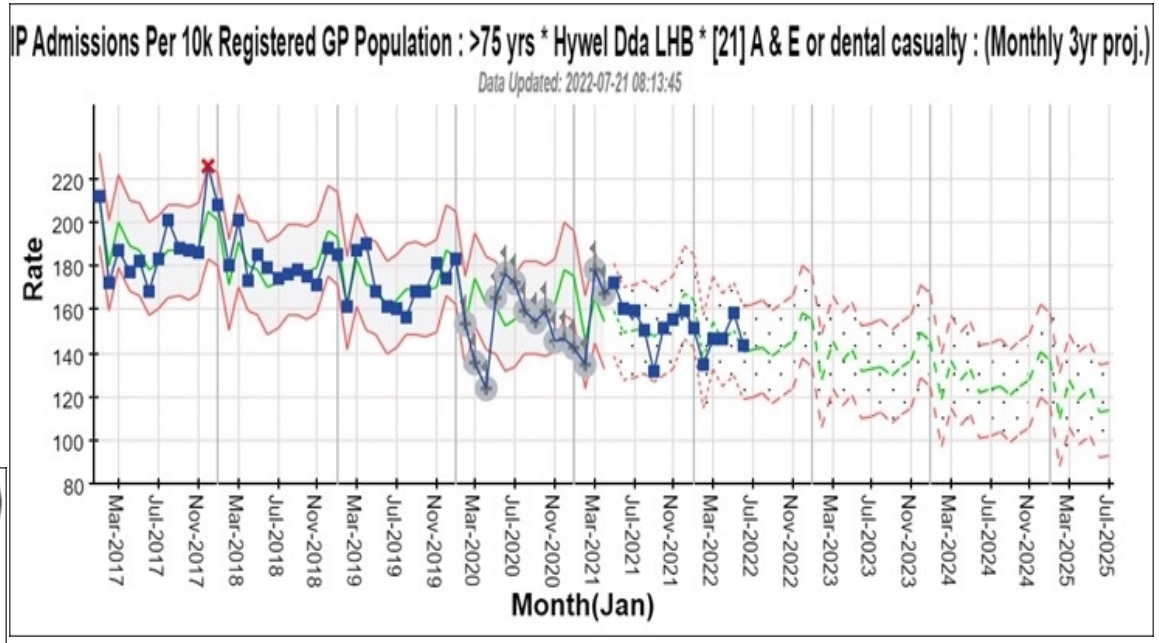


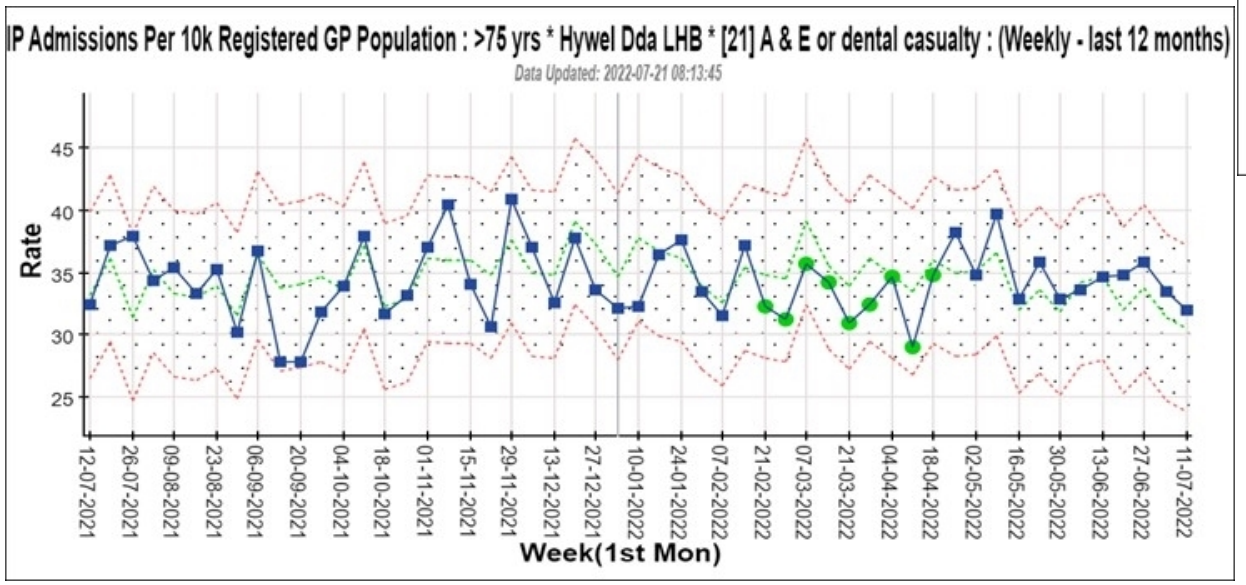


Occupied beds
Weekly – last 12 months
per 10k population

Conversion (Admissions) - Improving Picture

Emergency Admissions
Monthly 3 year projection
per 10k population





Emergency Admissions
Weekly – last 12 months per 10k
population

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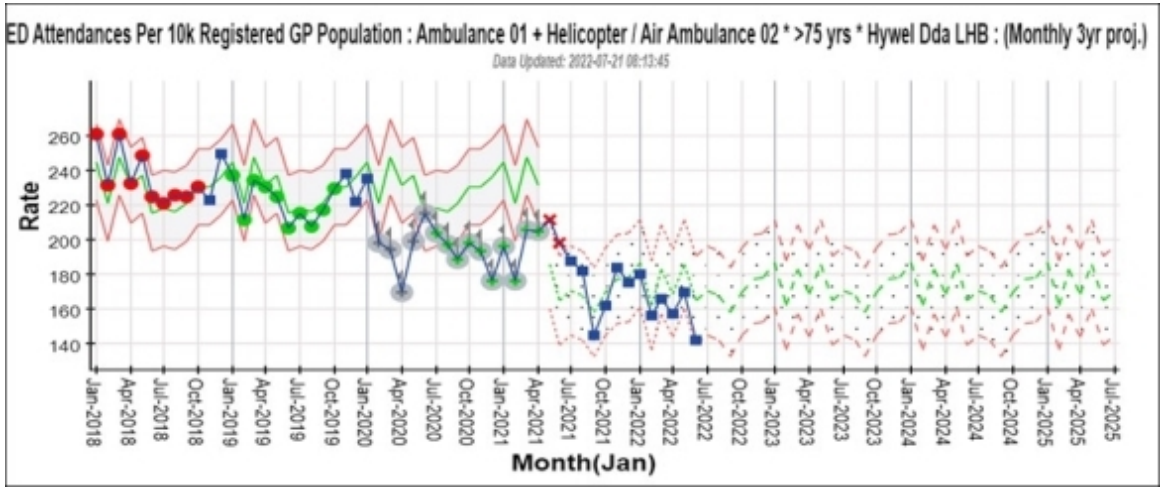
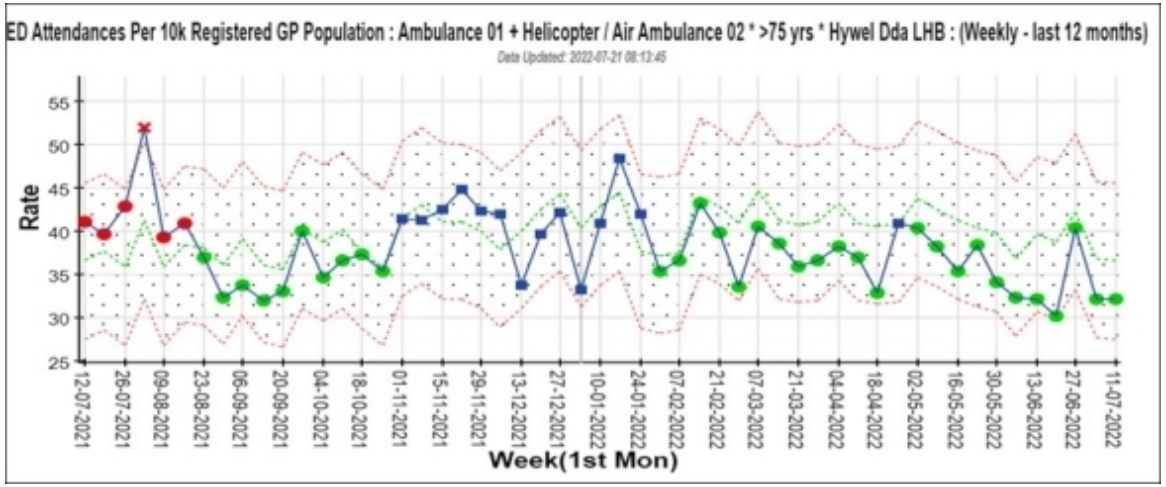
Conveyance – HDuHB Improving Picture

Emergency Department (ED)
Ambulance attenders
Monthly 3 year projection
per 10k population

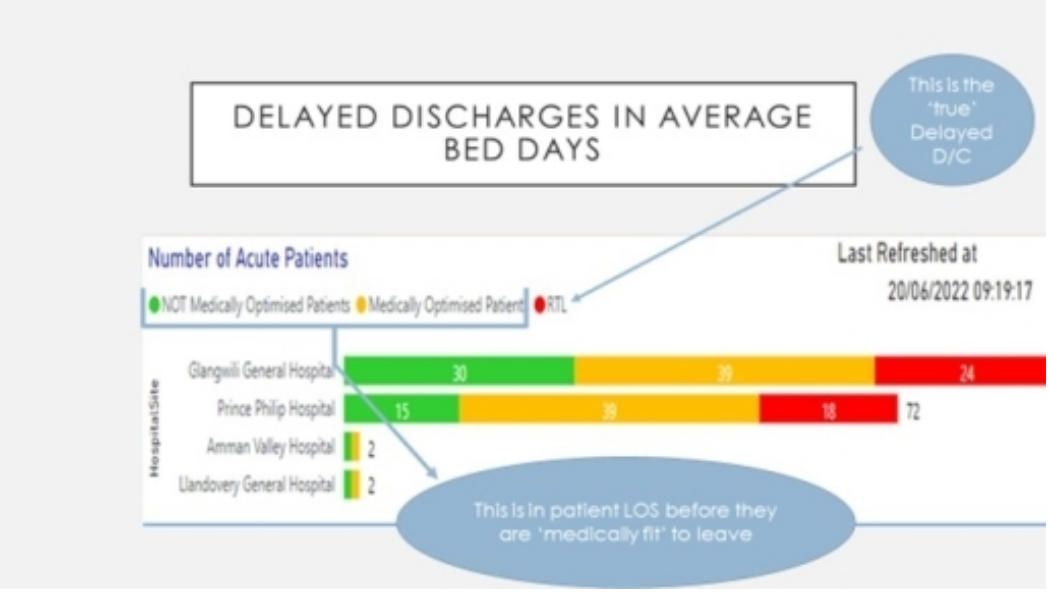




ED Ambulance attenders
Weekly – last 12 months per 10k population

Complexity Management & Harm

- Medically Fit (or Optimised) in isolation is not an indicator of harm
- It would be reasonable for an inpatient to be Medically Optimised if they had a length of stay (LOS) of < 13 days and discharge pending on day 14 i.e the standard should be < 10 day LOS with < 72 hours to source care and support to support discharge



- A better measure of 'harm' would therefore be a LOS of > 13 days
- Readmission as a balance measure of 'harm'

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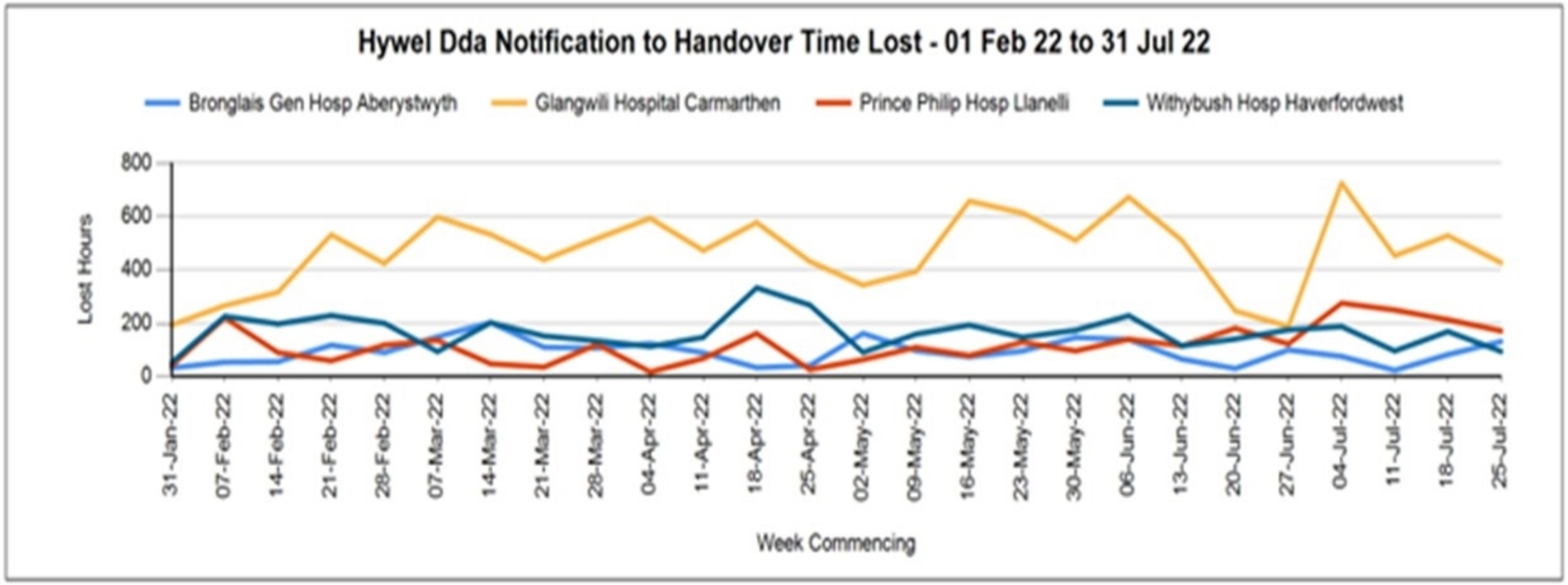
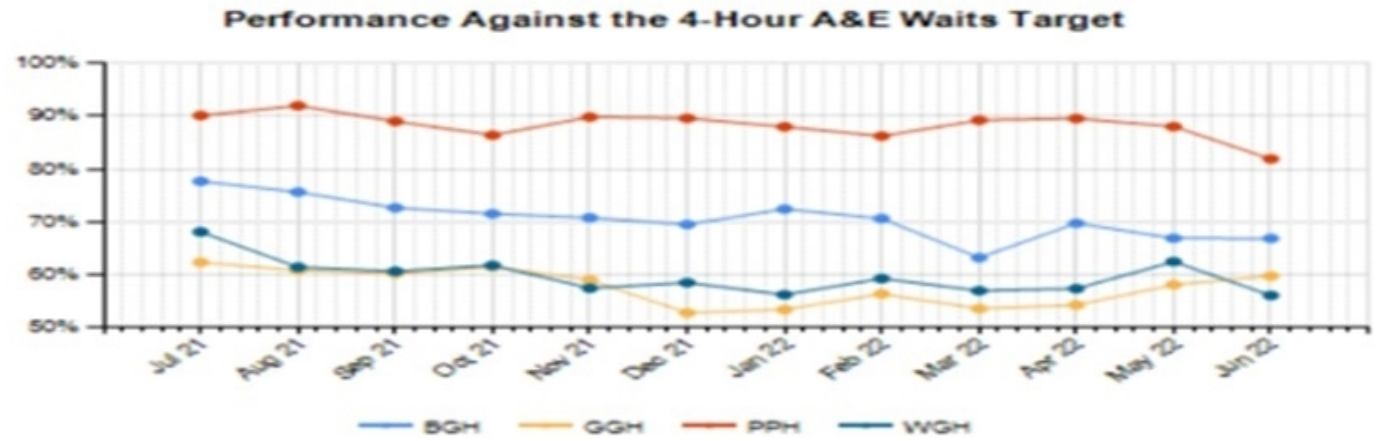
Handover Delays / Lost Hours



Meeting the desired Target

Performance against the 4 hour A&E waits target (IRIS)



	Trend	Jul 21	Aug 21	Sep 21	Oct 21	Nov 21	Dec 21	Jan 22	Feb 22	Mar 22	Apr 22	May 22	Jun 22
BGH		77.7%	75.7%	72.7%	71.6%	70.8%	69.5%	72.5%	70.7%	63.3%	69.8%	66.9%	66.9%
GGH		62.4%	60.9%	60.3%	61.6%	59.1%	52.9%	53.5%	56.4%	53.7%	54.3%	58.2%	59.8%
PPH		90.1%	92.0%	89.0%	86.4%	89.9%	89.6%	88.0%	86.2%	89.2%	89.6%	88.0%	81.9%
WGH		68.1%	61.5%	60.7%	61.8%	57.5%	58.6%	56.3%	59.3%	57.0%	57.4%	62.5%	56.2%

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Impact on Workforce Quality Assurance

ESR data

	Staff Group	BGH (including CDU)	GGH	WGH
PADR (as at 26/07/2022)	RN	67.74%	43.24%	5.13%
	HCSW	72%	54.17%	6.25%
	Admin	67.74%	28.24%	75%
Mandatory Training (as at 26/07/2022)	RN	79.69%	65.42%	79.06%
	HCSW	77.22%	65.74%	67.11%
	Admin	87.04%	66.67%	54.17%
Sickness (June 2022)	RN	6.44%	11.64%	15.03%
	HCSW	4.26%	13.09%	4.47%
	A&C	2.49%	9.83%	4.17%