Transforming Urgent & Emergency Care; Frailty Matters

SDODC 26 June 2023

Transforming Urgent and Emergency Care: Frailty Matters

Planning Objective 22 / 23; *To develop and implement a four year 6 UEC Goals Programme Plan for the Health Board that will implement an integrated 24/7 urgent and emergency care model. The Programme will oversee the development of a strategy and implementation of best practice for our frail population to ensure optimal outcomes for this vulnerable group are achieved.*

- **Scenario Modelling**
- Assume the current trajectory in admissions reduces to match Ceredigion
  - Admission rate accounts for most of Ceredigion's lower occupancy rate
- Assume average length of stay is reduced more slowly towards proposed standards delivering 13 days average in five years
- This will enable Hywel Dda to compensate for demographic growth and deliver reduced bed requirement

Key Metrics at year five	At Year Five
Occupancy rate	82 (100 achieved mid 2023)
Occupied Beds	377 (-135)

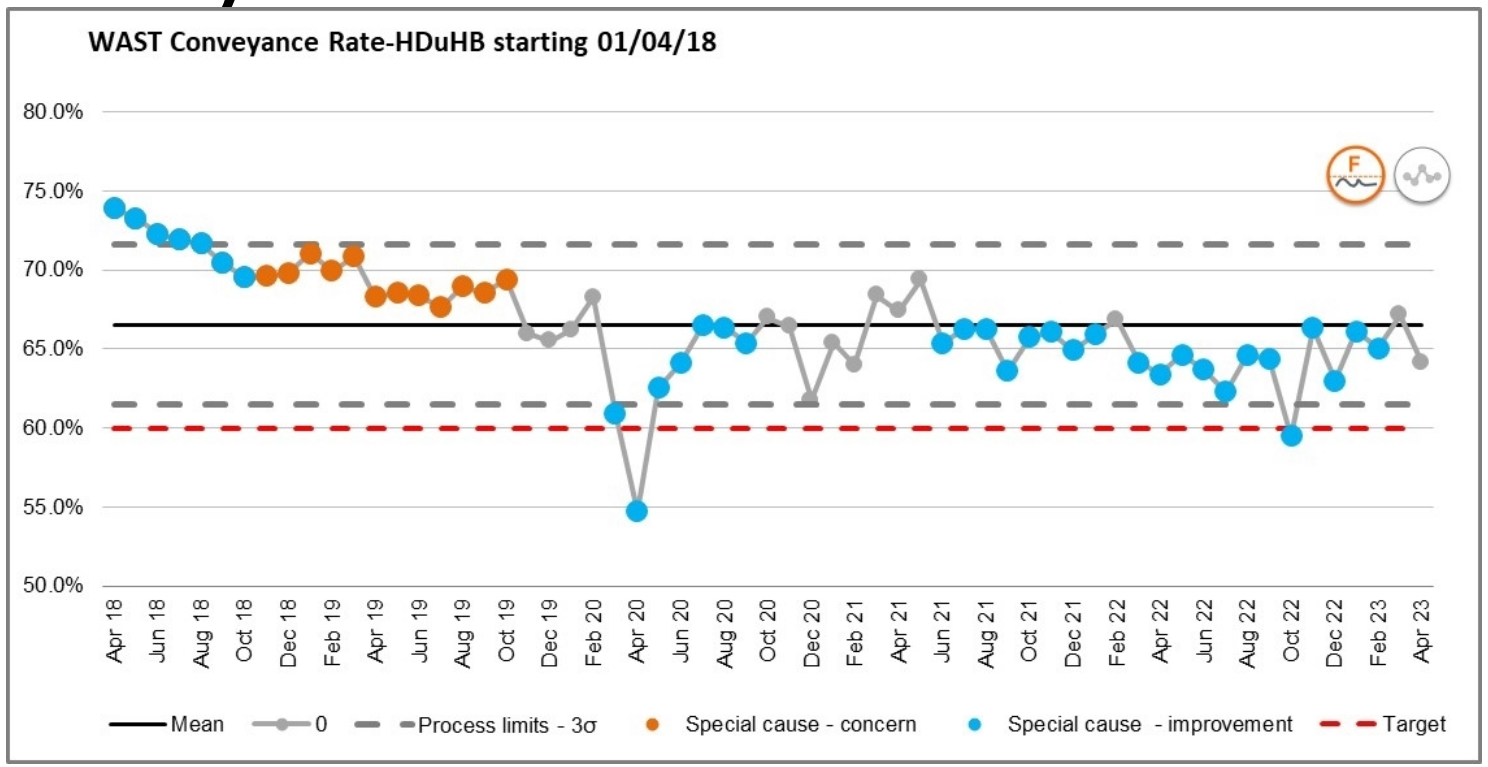
Intervention Logic – Reducing Occupied Beds for 75+ and High Risk

Strategy (the 3Cs) & Programme Outcome Indicators	Enablers	Outcome Impact	Measures
Reduce Conveyancing	Risk Stratification of Complex Proactive Monitoring Anticipatory Care Planning Clinical Streaming Hub Home First Health & Care System for Older People (including same day urgent care(SDUC)	Increased Care Closer to Home provision Reduced Conveyance (All Wales Target 60%) and Self Presentation Increased direct access to scheduled Same Day Emergency Care (SDEC) Reduced ED waits > 12 hours Improved ambulance handover	Ambulance presentations % patients admitted following conveyance to ED (should be 100% if 'true emergency) Self Presentation (as balance measure) Conveyance Rates by County ED attendances by County
Reduced Conversion rate	Front Door Turnaround Front Door Streaming to 72 hour assessment units (including frailty) SDEC	Reduced admission rate Reduced ED waits > 12 hours Improved ambulance handover Improved 4 hour delays	Admission rate. Length of stay (LOS) 0 – 1 Days LOS <72 hours ED length of stay distribution by admitted and non-admitted SDEC Measures Assessment Unit LOS
Managing complexity	Implementation of SAFER including D2RA Frontier Optimal Flow Tool Effective and Responsive Home First / Health and Care System for Older People	Reduction in Average LOS < 13 days for **All** patients	Average LOS distribution 48% of admissions discharged in under 3 days 50% between 3 and 10 days Reduced count patients bed days > 21 Increased discharges > 21 days Reduce proportion of patients LOS > 50 days Reduced bed occupancy rates
System impact	Increased Care Closer to Home Streaming patients to Right Care, Right Place, Right Time	Optimal flow for emergency and planned care pathways. Increased Healthy Days at Home PROMS & PREMS Older People	Reduction occupied beds (n = 135) by 2027

Tracking the Programme Outcome Indicators

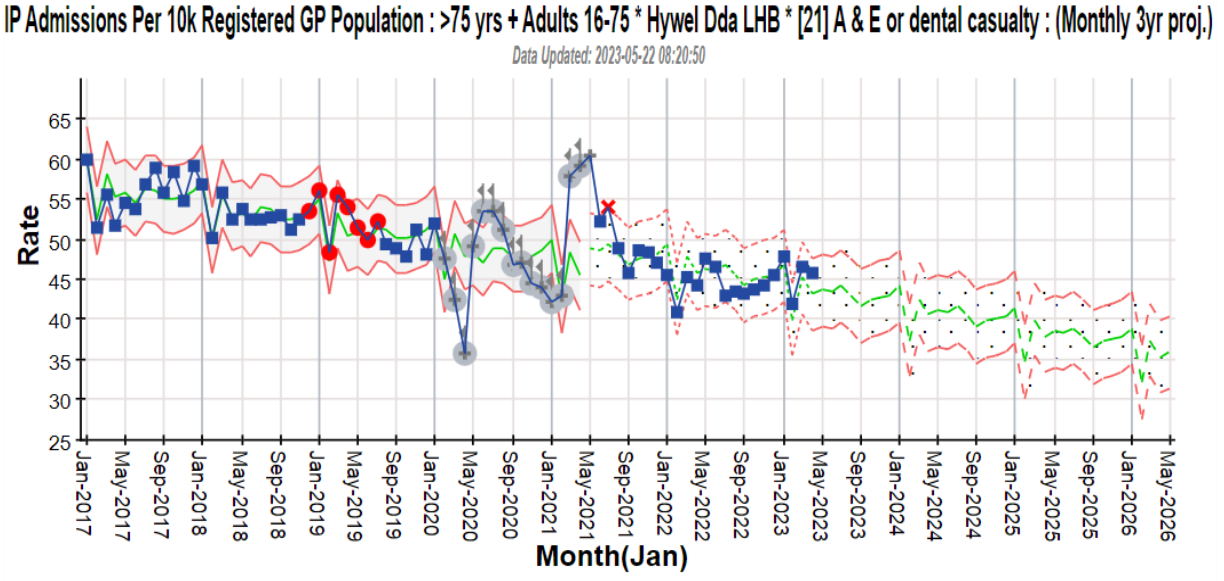
The 3Cs: Current State

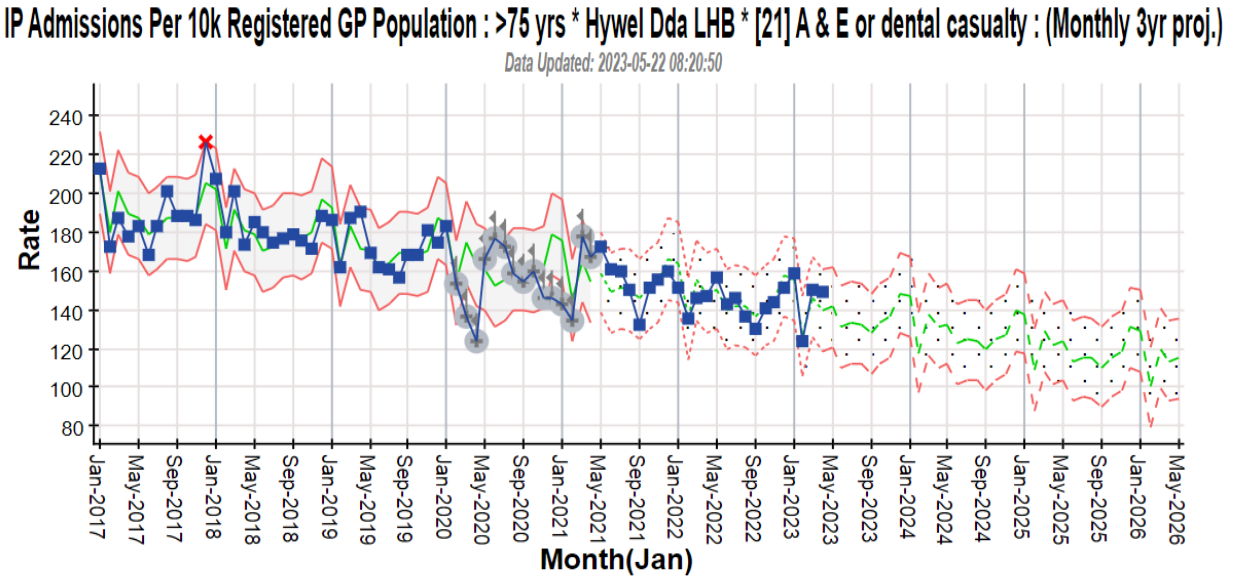
TUEC Programme Outcome Indicators (Conveyance Rates)



What does look like for conveyance? By 2027 100% of patients conveyed to ED require admission ???

TUEC Programme Outcome Indicators (Conversion Rates) per 10k Population





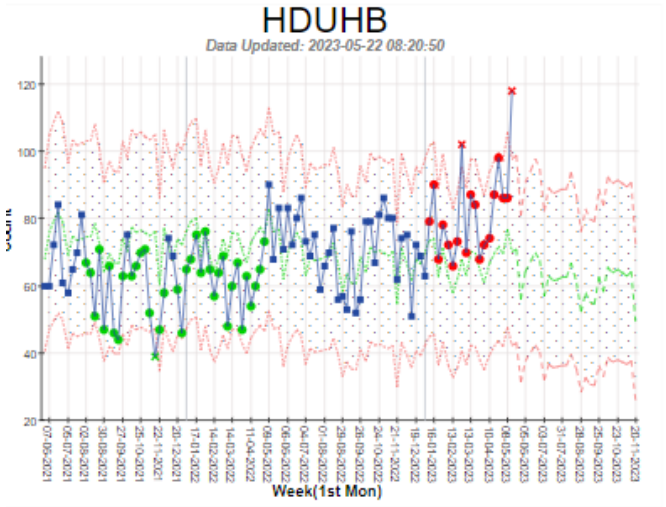
Analysis:
Conversion rates for all population are reducing and the forecasted trend is a continuation.

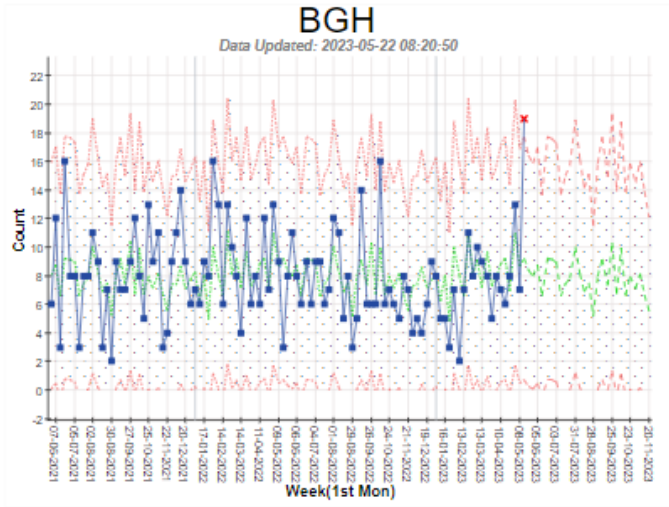
The admission rate for the >75s as a 10k population demonstrates that they are **three times more likely to be admitted.**

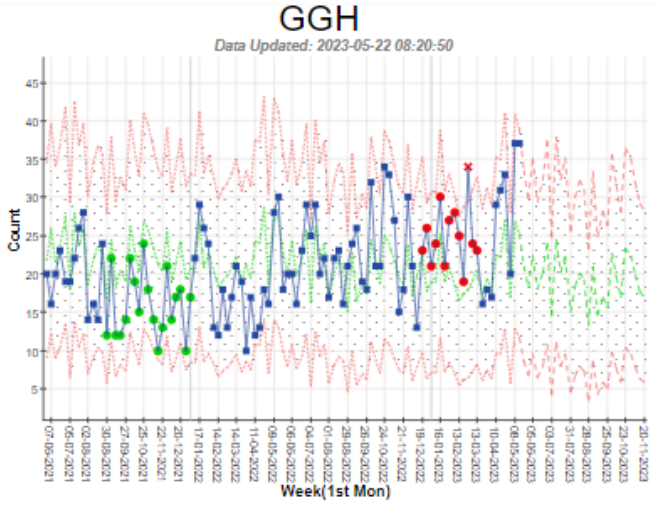
Weekly data (refreshed 22.05.2023)

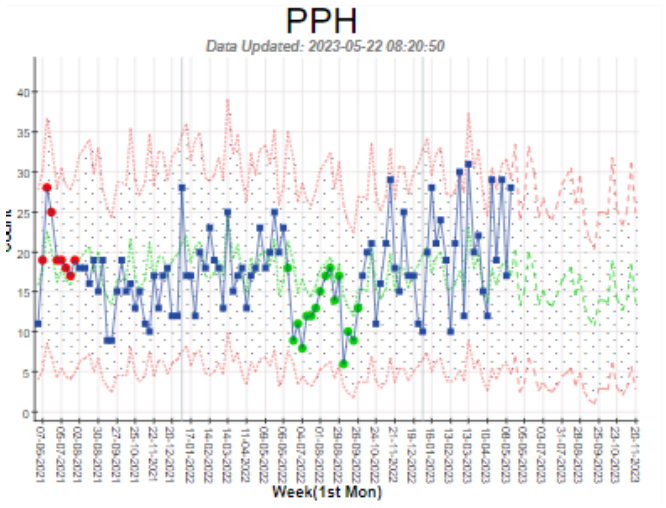
TUEC

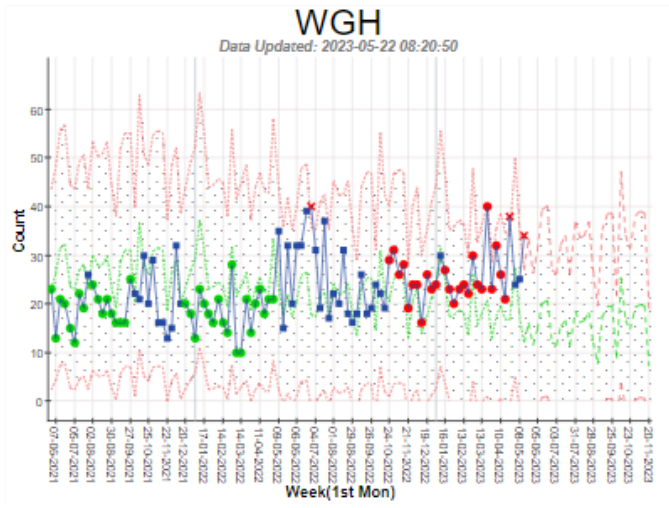
Patients aged 75 and over and a LOS of 0 or 1 days (Conversion avoidance)









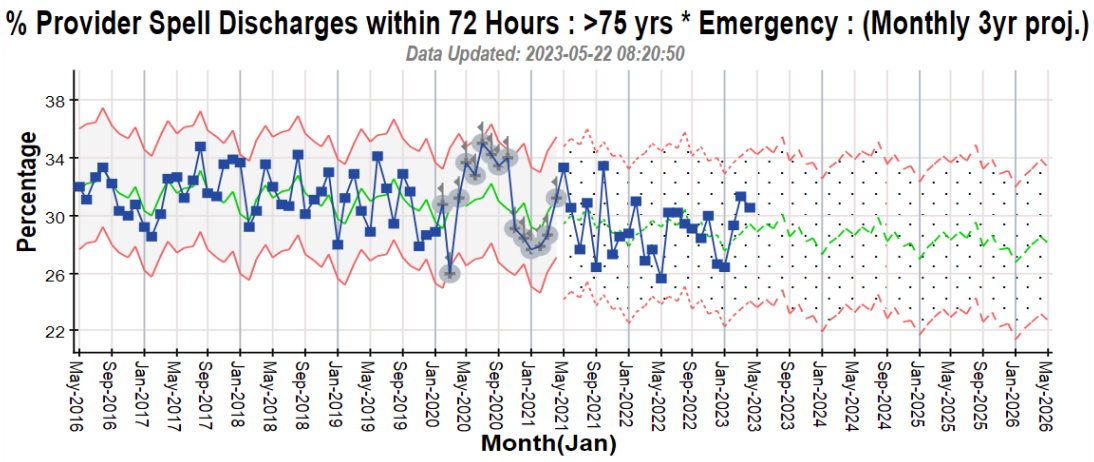


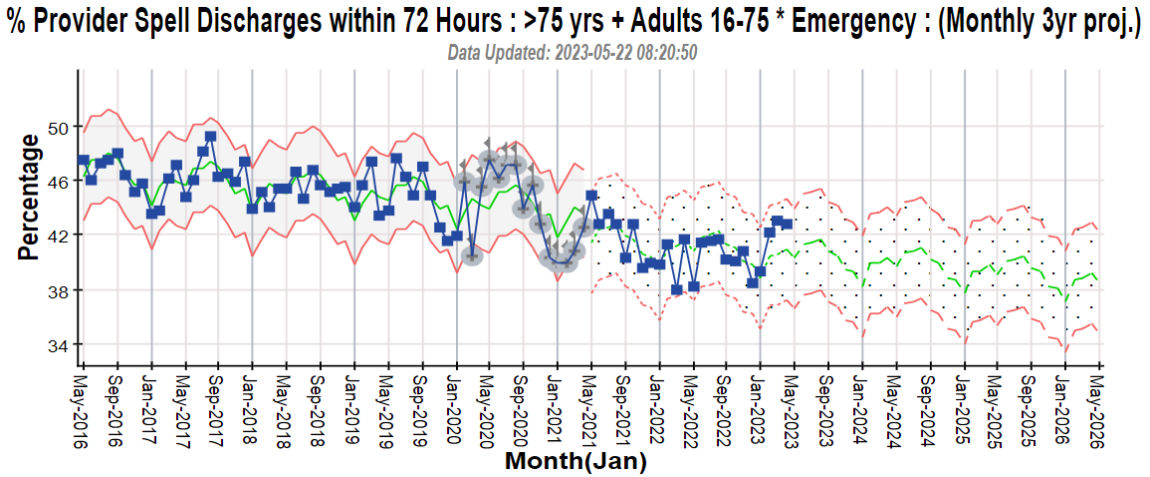
Data includes SDEC

Overall Health Board 'turnaround within 12 hours' and is **improving against forecasted downward trend** (special cause variation (SCV) wrongly presented as red)

Data source: Lightfoot

TUEC Performance Indicators (Complexity)





Analysis:

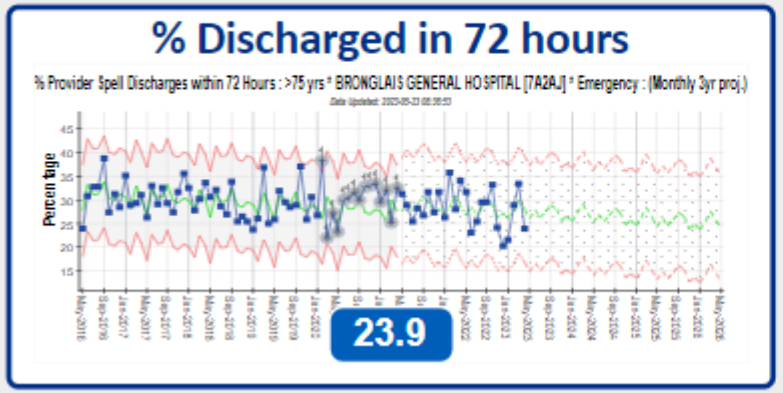
We established at the outset that a focus on increasing % discharges of >75s within a 72 hour period would reduce number of patients whose stay in hospital > 21 days.

Current data demonstrates that % discharges within 72 hours has been broadly following **deteriorating trend** however improvement seen in All Adults since January 2023. Some early indication of improvement for > 75s in last couple months.

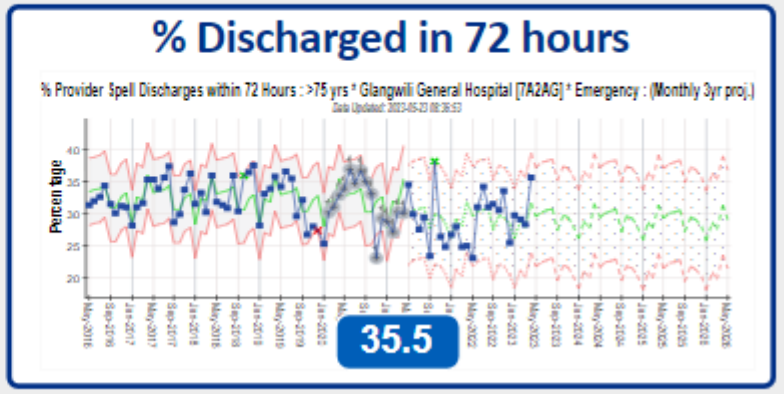
Count of beds occupied > 21 days continues to grow as does the number of bed days associated with these patients. Charts on next slide demonstrates that the > 75 population continues to be the majority.

Discharges within 72 hours at Site level (increase in % anticipated)

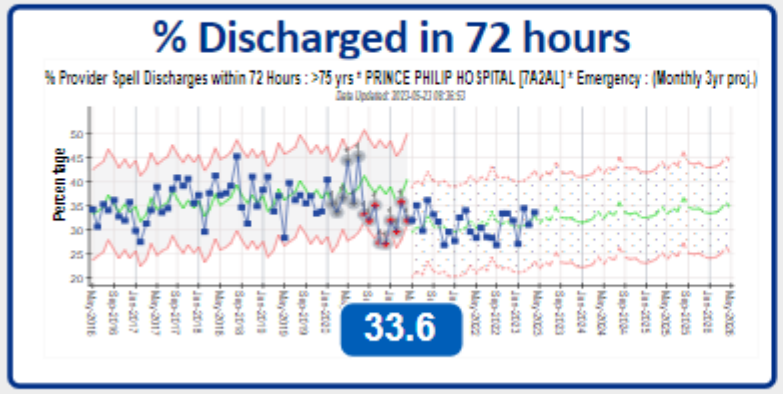
Bronglais



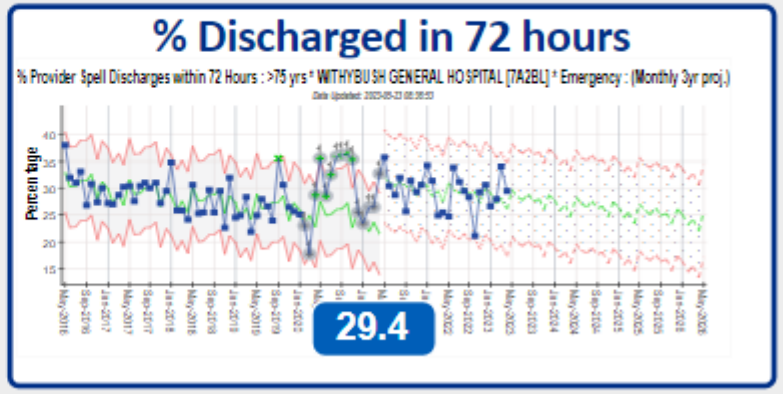
Glangwilli



Prince Philip



Withybush



Analysis

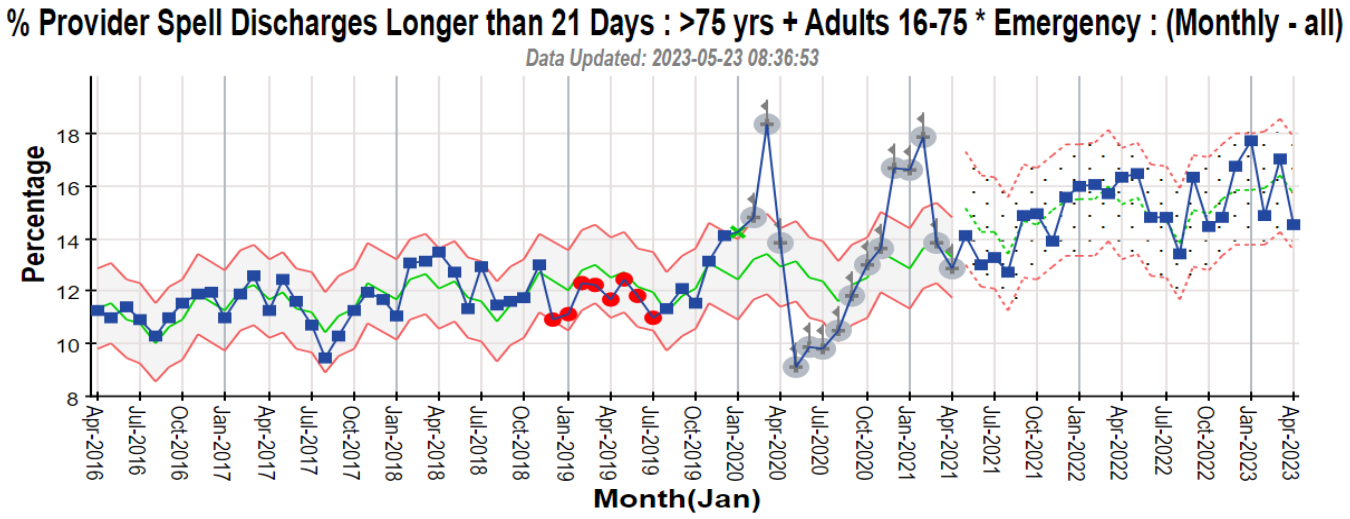
BGH demonstrating regular variation

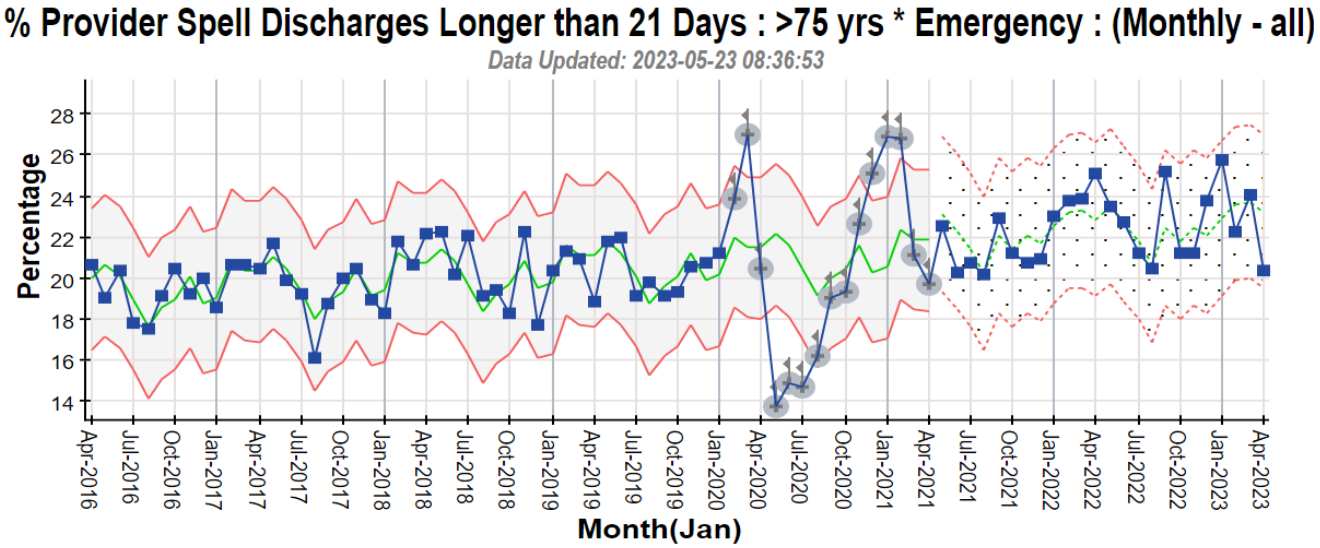
GGH have seen dramatic rise in last month following a plateau

PPH following the average which is an upward trend

WGH above average but following downward trend

% Discharges > 21 days





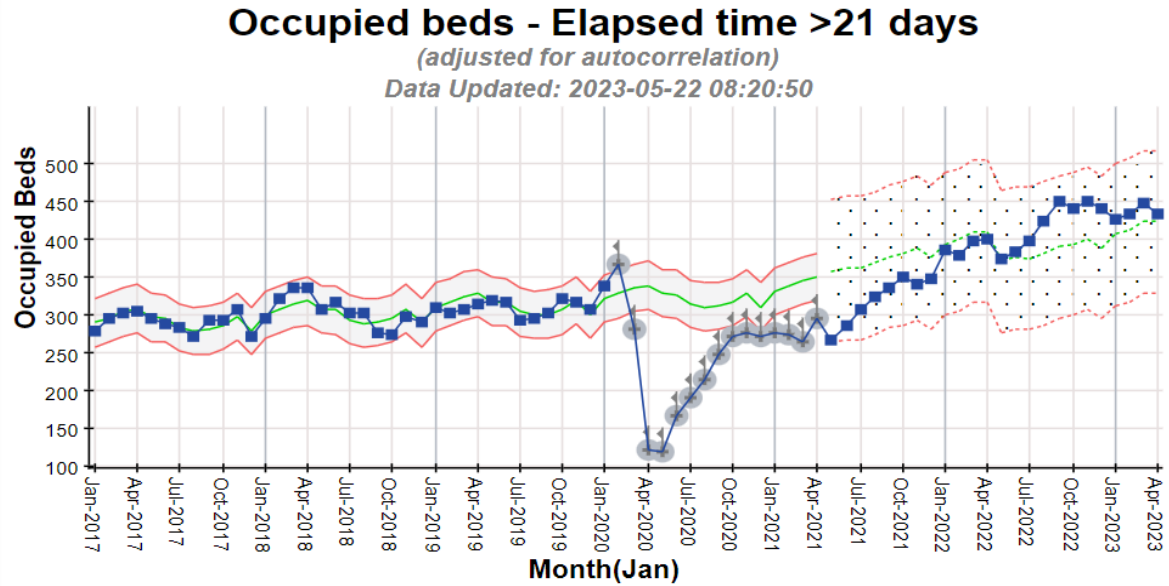
Analysis

Increasing trend for both populations but > 75s flatter

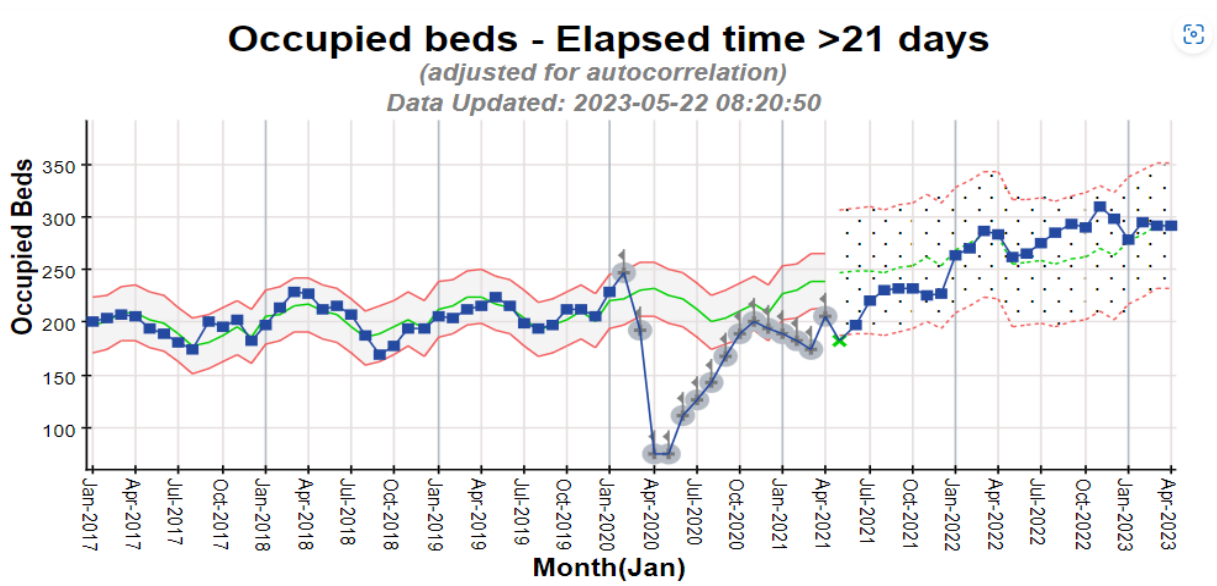
- 75s at site – Carmarthenshire flat, Pembrokeshire slightly increasing, Ceredigion slightly increasing
- All Adults at site – all increasing

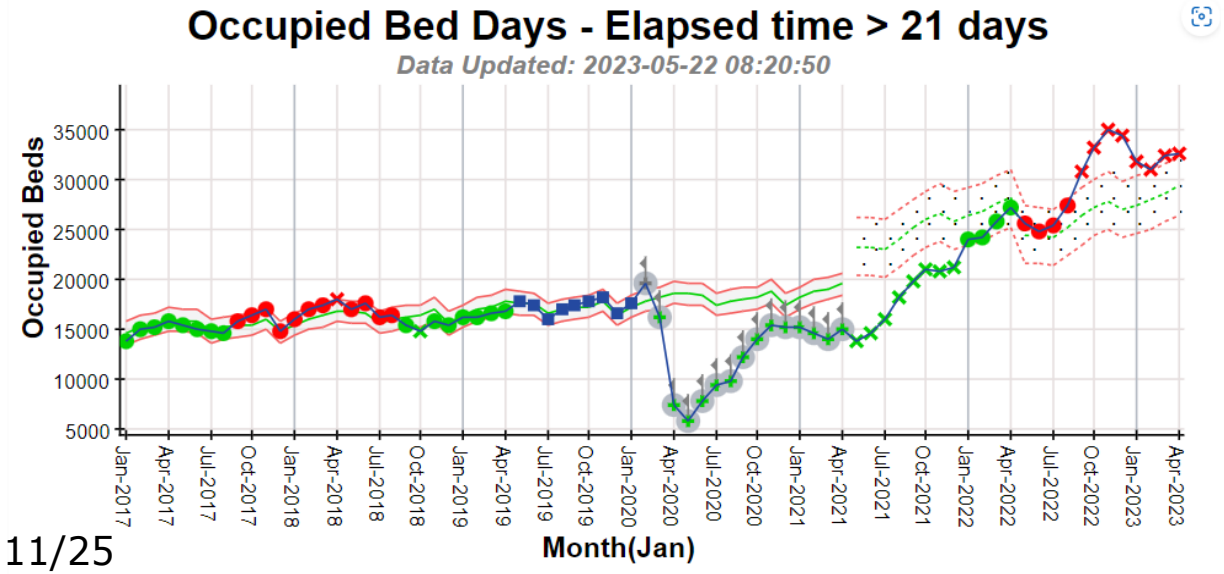
TUEC Programme Outcome Indicators (Complexity Management)

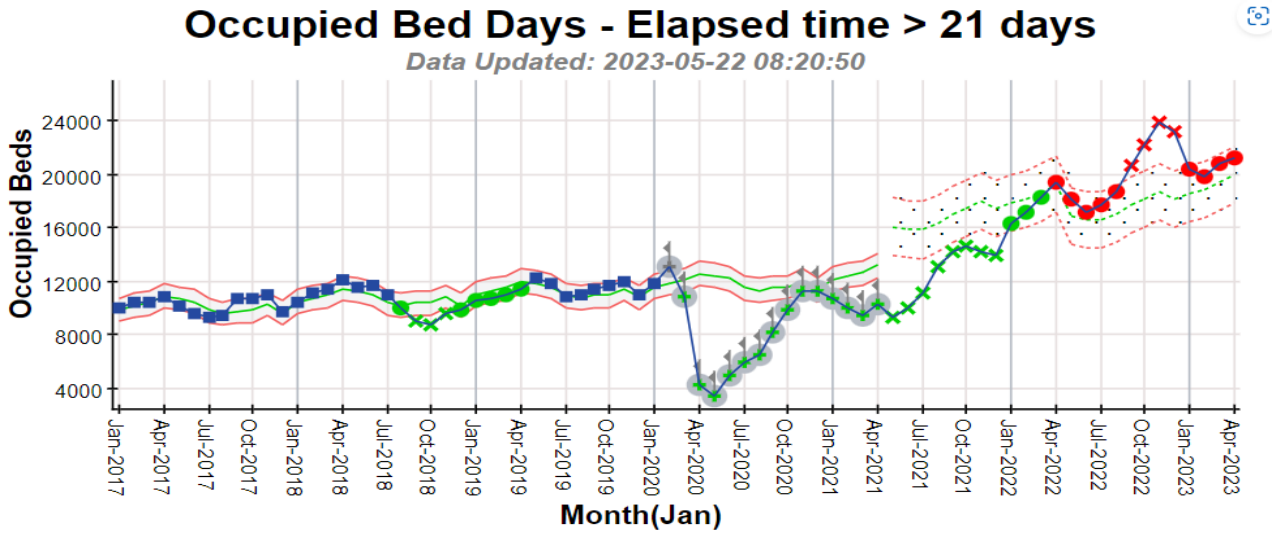
All Adults



>75s

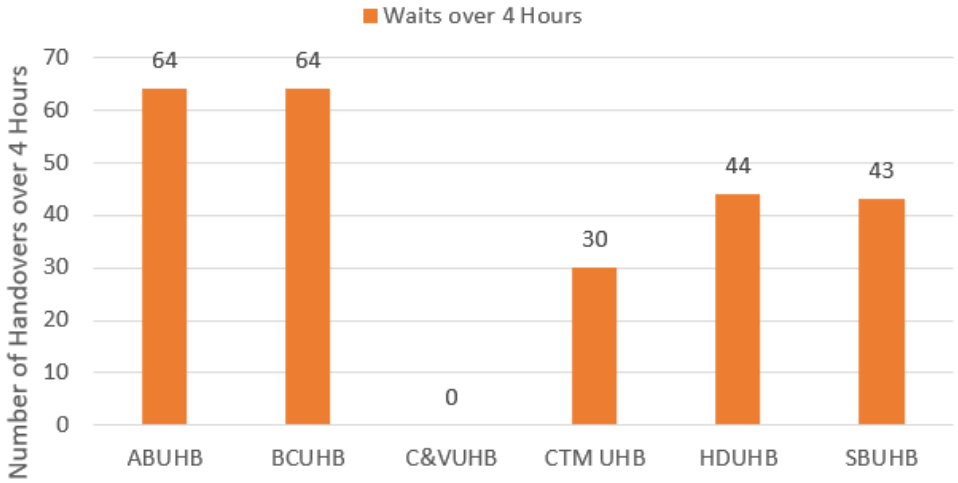




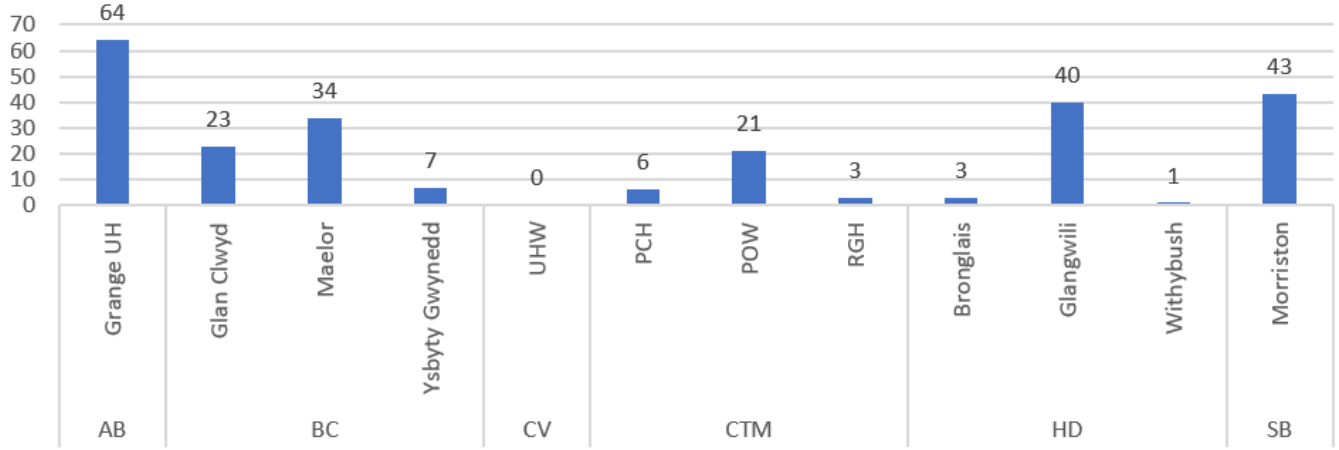


UEC – ambulance delays >4 hours (TUEC Impact at Front Door) June 12th 2023

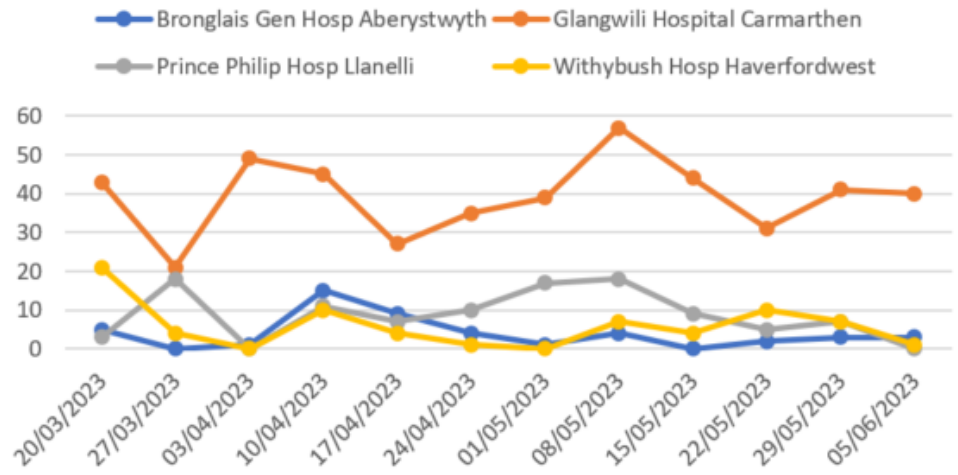
Ambulance delays > 4 hours by Health Board - \



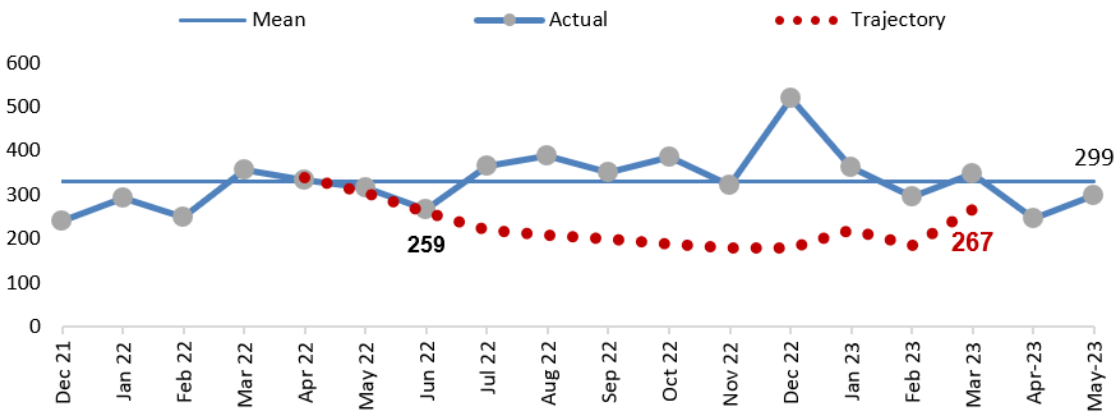
Ambulance delays > 4 hours by hospital - w/b 05



Ambulance delays > 4 hours trend by hospital

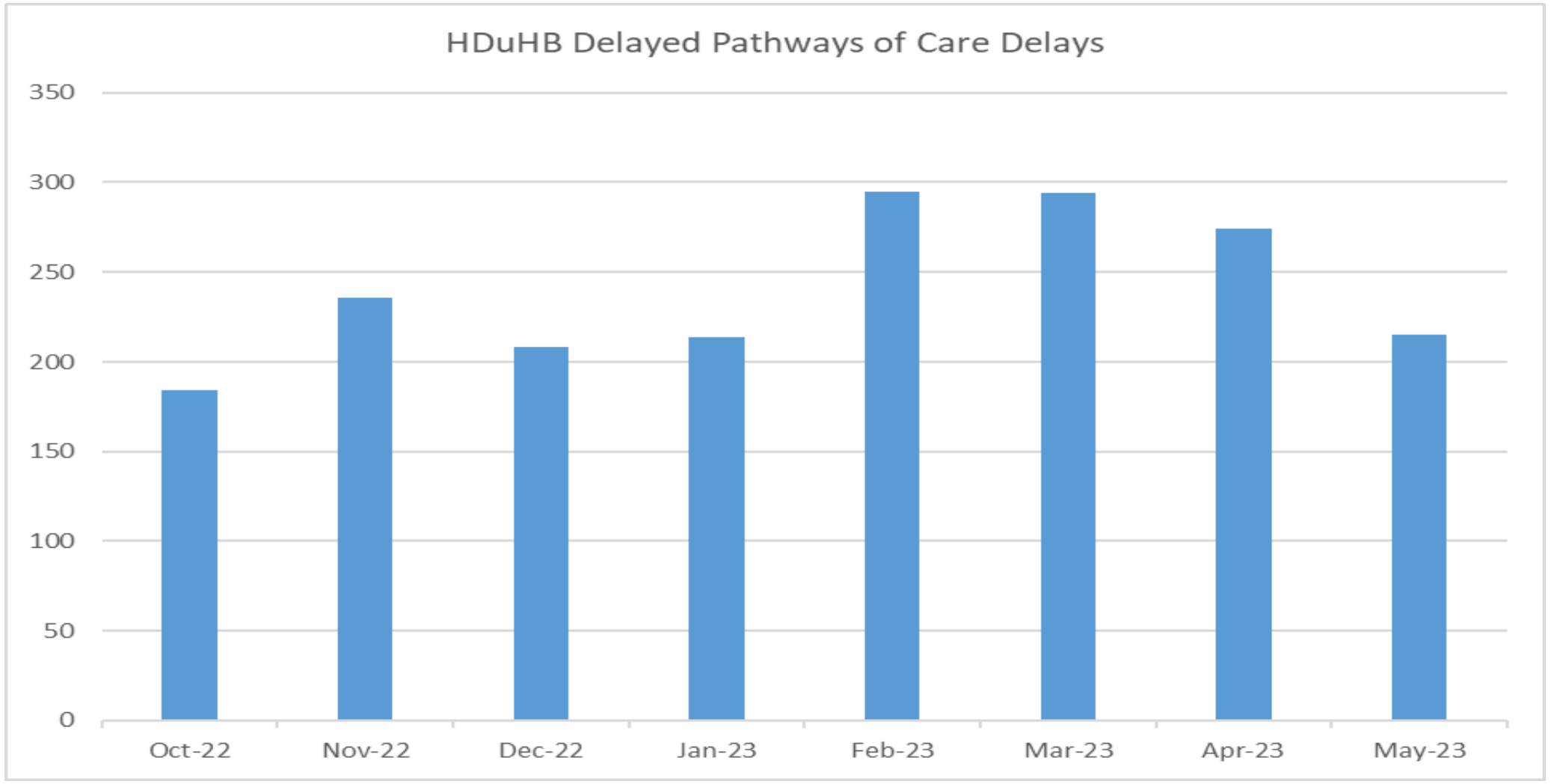


Ambulance handovers > 4 hours – monthly trajectory



Data Source: EASC and WAST handover notification

UEC – Pathways of Care Delays May 2023 (TUEC Impact at Back Door)



TUEC Deliverable 2023 / 2024

Focus on Key Areas for Improvement to Reduce 'Front Door' Pressures

Community Homefirst (Regional)

Proactive Care & Risk Stratification

HDdUHB Long term Goals:
Implementation of our defined HomeFirst approach across a 7 day period. Includes identification / development of a digital system for risk stratification and TEC based monitoring and management of vulnerable groups

Areas of focus/ projects 23 / 24 :

- Risk Stratification: Includes local and links to strategic /AI Digital Risk Stratification
- Proactive Monitoring (TEC Solutions)
- Co-ordination care, planning and support for high risk groups
- Stay Well Planning
- Prehab & Health Optimisation

Links through to the Regional Tech and Digital Board Proactive Therapy / Planned Care work

Bwrdd Partneriaeth Rhanbarthol Gorllewin Cymru
West Wales Regional Partnership Board

Reducing Conveyance & Self-Presentation

HDdUHB Long term Goals:
Development and implementation of Digitalised Coordination Hub:

Defining, scoping and implementation of clinically safe alternatives to hospital.

Defining, scoping and implementation of rapid response services in a physical or mental health crisis. Includes HomeFirst approach implementation across 7 day period.

Areas of focus/ projects 23 / 24

- Urgent Dental Pathways via 111
- SDUC Community Model Scale Up & Roll Out
- MH SPOA, Rapid 24/7 Triage & Assessment
- Alternative Pathways to Admission
- Virtual Ward
- Care Home Immedicare Pilot
- APP Navigator Model scale up and roll out
- Urgent Care Service (within 1- 8hours of contacting) based on presenting need
- 111 Press 2 for Mental Health Scale Up
- Clinical Streaming Hub

Managing Complexity

HDdUHB Long term Goals:
Development and implementation of Digitalised Coordination Hub:

Defining, scoping and implementation of rapid response services in a physical or mental health crisis.

Developing a health and care system for older people (while sitting in PG 6 this spans all goals).

Areas of focus/ projects 23 / 24

- Home First Hub/SPoA
- Crisis response within 2 hours
- Implement D2RA Pathways within 48 hours
- Management of high impact users
- Reporting of D2RA Pathway Delays (DPoC)
- Right Sizing Community Services

Managing Complexity and Conversion Reduction - Acute

HDdUHB Long term Goals:
Defining, scoping and implementation of clinically safe alternatives to hospital.

Defining, scoping and implementation of rapid response services in a physical or mental health crisis.

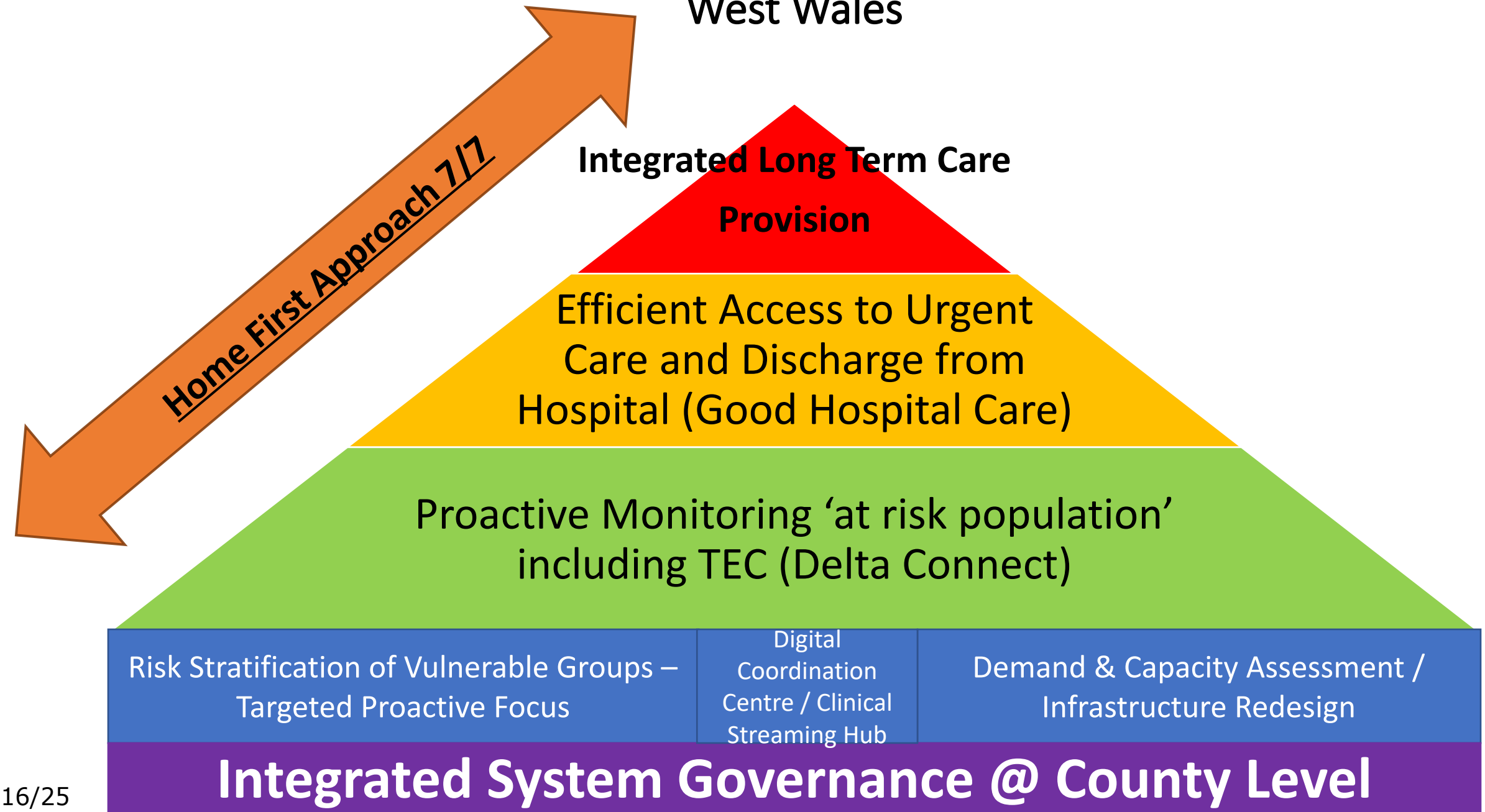
Implementation of SAFER

Areas of focus/ projects

- Early identification of complex patients
- Frailty Screening at Front Door
- Implementation of SAFER Principles
- Implementation of Deconditioning Patients
- SDEC Model Scale Up& Roll Out
- Implementation of Clinical Criteria of Discharge
- Improving Standards in Emergency Departments
- Implementation of Digital solutions to support care planning and discharge e.g. Frontier

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

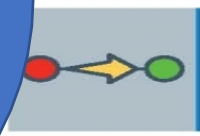
Building Blocks for UEC and Integrated Health & Care System for Older People in West Wales



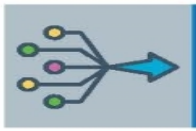
Service Infrastructure – community nursing, therapy, Delta, social care, 3rd Sector, Specialty Doctors, 1' Care Contractors

'Home' is usual place of residence and any long term care that may be in place

homefirst

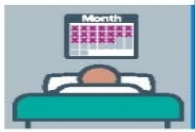


Discharge to Recover & Assess (Red to Green)



Proactive Case Management & TEC (virtual ward)

Single Point of Contact (SPOC) & Clinical Streaming to 'Right Place'



Short Term Reablement Beds

Rapid Response to Crisis (1-2 hours) & Urgent 'Wrap Around' Care

Integrated Reablement & Intermediate Care (48 hours)

<u>NOT A SERVICE –</u>
It's an approach that focuses on prevention / asset based / proportionate commissioning & best practice for frail

TUEC Deliverable 2023 / 2024: To increase flow at 'front door' by reducing bed surge by 80 across all sites

The table below sets out the bed efficiencies associated with the 6 policy goals and the respective benefits realisation of each scheme/programme (aggregated by site)

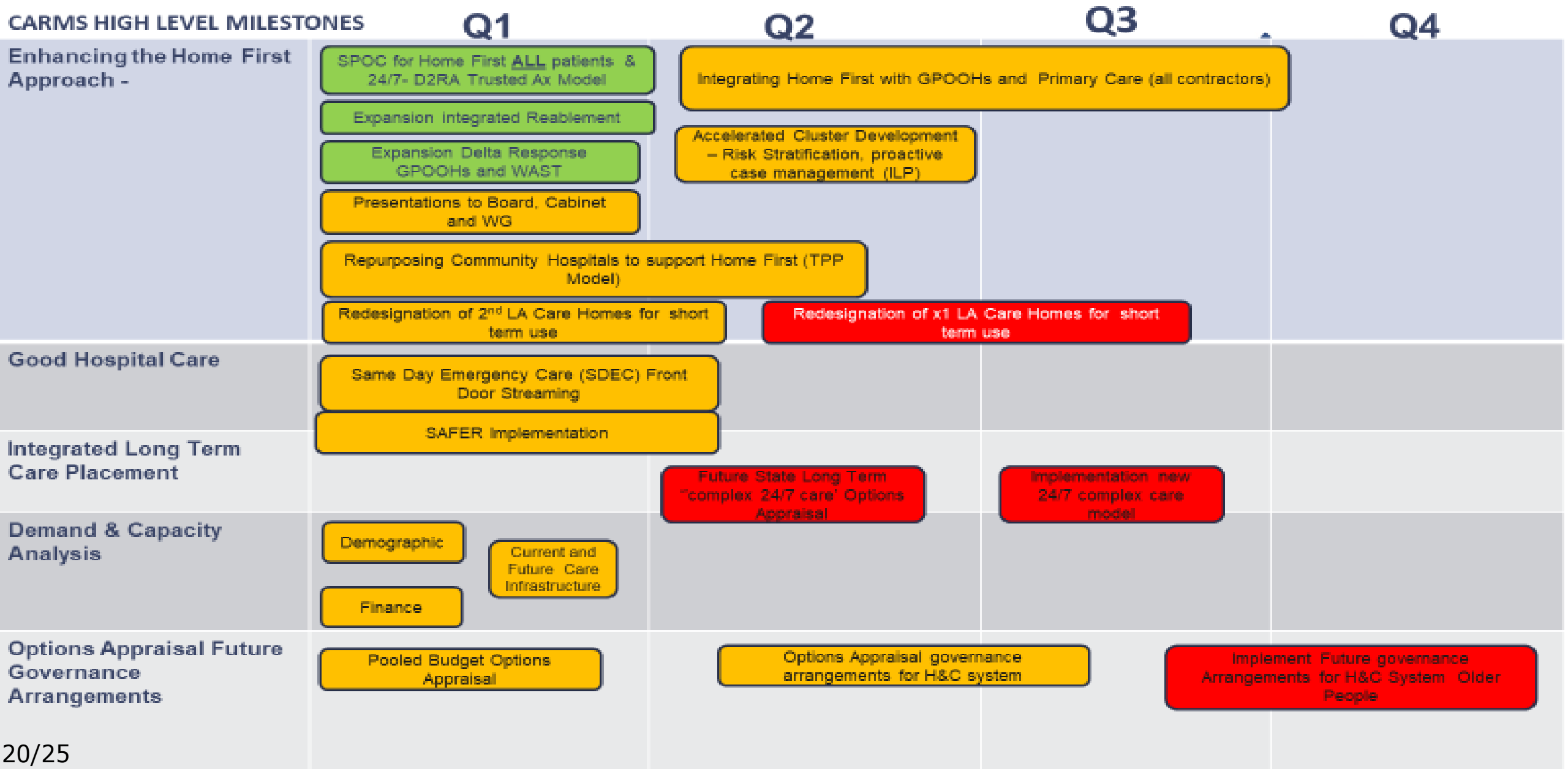
- Each of the three counties have developed their operational plans to respond to the unprecedented demand, with quality and performance improvement at the heart of the plans. Equally, a clear focus has been on reducing the current level of financial expenditure within the current run rate and in as far as is reasonably possible, the expenditure has been suitably mitigated and reduced.
- As part of the operational planning approach in 2023/24, the reduction and improvement across each site relating to the bed 80 bed efficiency encompasses all of the applicable (Transforming Urgent and Emergency Care) TUEC deliverables
- To facilitate and deliver an 80 bed efficiency, the operational plans have identified a number of surge beds across each site. Further, the operational plans have appropriately attributed the beds to both the Policy Goals and 3 C's (Conveyance, Conversion and Complexity) within the TUEC programme
- To note, the bed efficiencies are based on local system responses, these responses are based on but not limited to; adopting best practice within the acute hospitals to enable flow. All aspects of discharge, including assessments, home first, nurse liaison and community services. Moreover, to improve and deliver seamless discharge in 2023/24, we are working closely with our Local Authority partners to develop robust system plans. This includes increasing domiciliary care capacity, which commenced in 2022/23 under the auspices of Building Community Capacity. However, this will now novate under TUEC and will form part of Home First/Further, Faster, Together
- Bed efficiencies are also aligned to reducing bed occupancy in Y Lolfa in Glangwili (Dedicated Discharge Ward). It is important to note that while Y Lolfa as an inpatient environment will be decommissioned to comply with fire and safety improvement, the model of patient care being delivered in Y Lolfa will be re-provided in another designated area, which may be within a community hospital
- All of the efficiencies are triangulated between finance, planning and workforce to provide an overall net financial reduction. Consequently, £1.6m of the £3.0m savings affiliated to the TUEC have been identified below:

County/Site	Bed Efficiency Expectation	Plan to deliver full Bed Efficiency from:	Total Financial Reduction in 2023/24 (cumulative)	Full Year Effect
Ceredigion – Bronglais General Hospital	13	November 2023	£484,263	£590,000
Pembrokeshire – Withybush General Hospital	23	December 2023	£268,000	£492,000
Carmarthenshire- Glangwili General Hospital	27	November 2023	£736,239	£1,261,000
Carmarthenshire –Prince Philip Hospital	17	November 2023	£122,740	£245,000
All Counties and Sites	80	November / December 2023	£1,611,242	£2,588,000

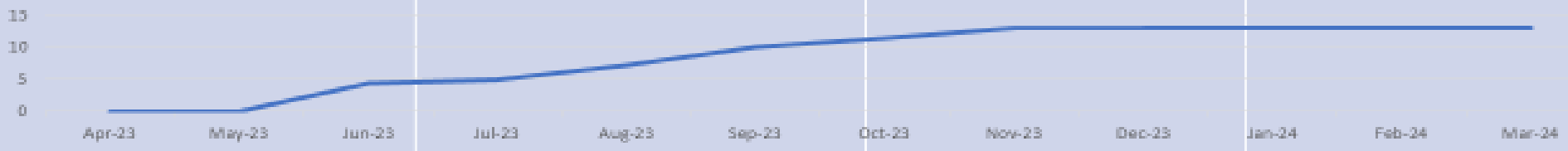
Projected 80 beds efficiency (TUEC Deliverable 23 / 24)

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24
Expected Impact at the Front Door - Conversion (i.e. surge bed reduction, agency etc.) - Bed Reduction												
BGH	0	0	2	2	2	3	3	3	3	3	3	3
GGH	0	0	2	3	4	5	7	9	9	9	9	9
WGH	4	4	5	3	4	5	6	8	8	8	8	8
PPH	0	4	5	6	7	8	9	10	10	10	10	10
	4	8	14	14	17	21	25	30	30	30	30	30
Expected Impact at the Backdoor - Complexity Management (i.e. surge bed reduction, agency etc.) - Bed Reduction												
BGH	1	1	4	5	6	8	9	10	10	10	10	10
GGH	0	5	10	15	18	18	18	18	18	18	18	18
WGH	1	1	3	3	7	7	11	11	15	15	15	15
PPH	0	2	3	4	5	6	7	7	7	7	7	7
	2	9	20	27	36	39	45	46	50	50	50	50
Total Bed Reduction	**6**	**17**	**34**	**41**	**53**	**60**	**70**	**76**	**80**	**80**	**80**	**80**
Proposed Financial Impact (£k)												
BGH	£0	£0	£317	£317	£317	£317	£317	£484	£484	£484	£484	£484
GGH	£0	£0	£0	£30	£90	£150	£211	£316	£421	£526	£631	£736
WGH	£1	£2	£4	£6	£14	£25	£63	£104	£145	£186	£227	£268
PPH	£0	£0	£0	£0	£0	£0	£12	£32	£53	£82	£102	£123
Cumulative Total	**£1**	**£2**	**£321**	**£353**	**£421**	**£492**	**£602**	**£936**	**£1,103**	**£1,278**	**£1,445**	**£1,611**

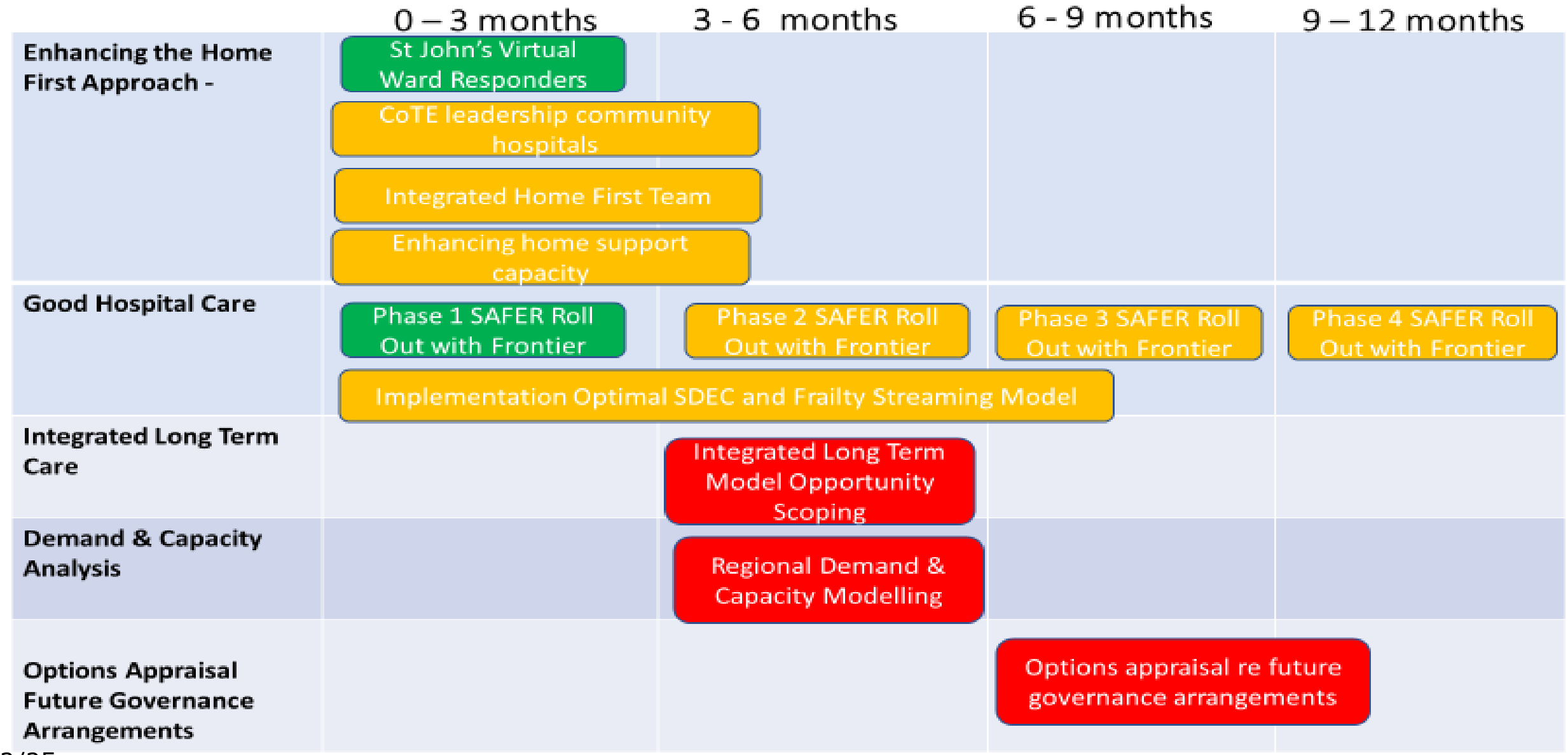
Carmarthenshire Operational plan 23 / 24



Ceredigion Operational plan and Quarterly Milestones

CEREDIGION	0 – 3 months	3 - 6 months	6 - 9 months	9 – 12 months
Enhancing the Home First Approach -	Reinstatement Powys Discharge Liaison Nurse Development of a Return to Community or Admission Avoidance by Utilizing Bedded Facilities Review of the discharge process to enable a streamlined approach from hospitals to community provision Clinical Health Psychology conversations to manage expectations Reconfiguration of Ceredigion Community Services			
Good Hospital Care	Phase 1 SAFER Roll Out with Frontier Implement National Optimal Hospital Flow and Real Time Demand Capacity Further utilisation for Palliative and End of Life Patients at Tregaron Hospital	Phase 2 SAFER Roll Out with Frontier	Phase 3 SAFER Roll Out with Frontier	Phase 4 SAFER Roll Out with Frontier
Regional Schemes		Regional Demand & Capacity Modelling Integrated Long Term Model Opportunity Scoping	Options appraisal re future governance arrangements	
Anticipated output: reduction in demand for surge beds				

Pembrokeshire Operational plan and Quarterly Milestones



Risks to Delivery of Plan & Mitigations

Risks	RAG	Mitigation & Control
Culture Change re clinical management of frailty and perception of risk		Developing 'team' of clinical champions under direction of Deputy Medical Directors, TUEC Clinical Leads
RAAC		Alternative Bedded Facilities in community
'Passing Baton' of responsibility for discharge planning to ward management (implementation of SAFER) to reduce long lengths of stay associated with complex discharge		Phased roll out of improvement programme supported by QI team EDoN endorsement / priority
Nurse stabilisation analysis		Undertaken & for simultaneous discussion to discount duplication
Care availability to manage increasing complexity on discharge exceeds available capacity and recruitment schemes have not been successful		Joint plans being progressed and implemented by Pembrokeshire and Carmarthenshire respectively which aims to 'reset' the infrastructure to ensure fit for purpose – increased step up bedded facilities in community (includes 'alternative bed units') and explore options for dual registered homes able to manage very complex individuals with fluctuating and challenging needs. This is the 'Further, Faster' work
Increased demand for complex care following care home resident conveyance and consequent admission		We continue to see increasing numbers of care home residents being conveyed – these severely frail individuals decondition and are predisposed to delirium and increased morbidity and mortality in hospital. All conveyances should be avoided unless by exception (eg # or symptoms that cannot be controlled in community)
Managing demand through alternative pathway provision – Chest Pain, Falls, Catheter, End of Life and Home First		Phase 2 APP navigator will begin reviewing patients with NO crew on site Focused 'test of change' with WAST to increase uptake of catheter / falls pathways

Y gofal iawn, yn y lle iawn, y tro cyntaf
Chwe Nod ar gyfer Gofal Brys a Gofal mewn Argyfwng

Right care, right place, first time
Six Goals for Urgent and Emergency Care

Bwrdd Iechyd Prifysgol Hywel Dda University Health Board

Welsh Government

HB Exec

IEG

Transformation & PMO Support

Regional HomeFirst & Acute Streams
Nominated Workstream Leads – accountable for **Workstream Oversight of Delivery**

Integrated Home First
Community, Primary & Social care

PDG (WG / NHS Exec, PMO, Clinical Leads, Chairs of 'Delivery Pillars, Enabler Reps (workforce, therapy, meds mgt, digital, workforce etc)

Managing Complexity & Conversion Reduction
Secondary Care

Operational/ Project Leads
Nominated Project Leads – accountable for **project delivery**

Operational planning

Performance

Operational Risk Log

Benefit

Finance Business Partners

Performance Monitoring

Operational Planners

Recommendation

- For the Committee to receive assurance from the Urgent and Emergency Care Update.