The Manchester Model

Dr Mark Holland
Consultant Physician in Acute Medicine

versus

Miss Clare Mason
Consultant General & Colorectal Surgeon
Conflicts of Interest

None
Mash-Up – High End Healthy Dialogue
Vincent Connolly

NHS patient flow strategy
This Talk

• AEC 2016
• Bigger Picture
• Wider Context
• Synthesis
• Manchester
  – Devolution
  – Healthier Together
AEC 2016

- SAMBA 2016
  - Society for Acute Medicine Benchmarking Audit
  - 4140 patients
Age distribution of 4140 patients
Route of admission

AEC 11%

![Chart showing Route of admission with AEC at 11%]

No. of patients: ED 2871, AMU 630, AEC 453, OPD 1, Other 154.

% of patients: AEC 11%.
AEC 2016

- For patients admitted via ED
  - PTWR in ED 14.3%
  - PTWR in AMU 85.7%
AEC 2016

• 103 hospitals submitted unit data
  – 79 had an AEC unit
  – 34 (43%) integrated within AMU

• 605 patients were cared for in AEC
  – 453 patients were directly admitted to AEC from the community
  – 152 were admitted from ED or AMU
AEC 2016

• Of the 605 (15%) patients:
  – 344 (57%) were female
  – 537 (89%) patients were discharged home
  – Mean NEWS 2
  – 13 (2%) patients had a NEWS of 5 or more
  – 58 (9.5%) patients were frail (CFS 5 or more)

• Where outcome data was recorded for AEC patients (n=572)
  – 96% went home
AEC 2016

• But for SAMBA 2016
  – Things were complicated
  – Pathways are now complex
### Attainment of Clinical Quality Indicators 1, 2 and 3 for patients with complete data sets and incomplete data sets by route of admission

<table>
<thead>
<tr>
<th></th>
<th>ED</th>
<th>AMU</th>
<th>AEC</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patients with complete data sets with complete and validated times</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Quality Indicator 1</td>
<td>68%</td>
<td>70%</td>
<td>73%</td>
<td>69%</td>
</tr>
<tr>
<td>Clinical Quality Indicator 2</td>
<td>60%</td>
<td>90%</td>
<td>94%</td>
<td>69%</td>
</tr>
<tr>
<td>Clinical Quality Indicator 3</td>
<td>80%</td>
<td>79%</td>
<td>98%</td>
<td><strong>81%</strong></td>
</tr>
<tr>
<td>Composite Clinical Quality Indicators 1, 2 + 3</td>
<td>36%</td>
<td>53%</td>
<td>73%</td>
<td>41%</td>
</tr>
<tr>
<td><strong>All Patients including those with incomplete data points</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Quality Indicator 1</td>
<td>60%</td>
<td>62%</td>
<td>58%</td>
<td>59%</td>
</tr>
<tr>
<td>Clinical Quality Indicator 2</td>
<td>57%</td>
<td>86%</td>
<td>86%</td>
<td>65%</td>
</tr>
<tr>
<td>Clinical Quality Indicator 3</td>
<td>71%</td>
<td>67%</td>
<td>55%</td>
<td><strong>68%</strong></td>
</tr>
<tr>
<td>Composite Clinical Quality Indicators 1, 2 + 3</td>
<td>28%</td>
<td>39%</td>
<td>33%</td>
<td>30%</td>
</tr>
</tbody>
</table>
Manchester

• Devolution

• Hospital Mergers
  – Single service

• Healthier Together
Healthier Together

• Improving outcomes for general surgical patients

• Knock-on effects
  – Ambulances
  – Emergency Departments
  – Radiology
  – Intensive Care Medicine
  – Medicine
    • GI Bleed
    • Sepsis
    • AKI
Healthier Together

1. Royal Bolton Hospital
2. CMFT – Manchester Royal Infirmary
3. CMFT – Trafford
4. Salford Royal Hospital
5. Tameside General Hospital
6. Pennine – Bury – Fairfield General Hospital
7. Pennine – North Manchester General
8. Pennine – Royal Oldham Hospital
9. Pennine – Rochdale Infirmary
10. Stepping Hill Hospital – Stockport
11. UHSM – Wythenshawe Hospital
12. Royal Albert Edward Infirmary – Wigan
Healthier Together  Sectors

North West
• Salford Royal Hospital
• Bolton
• Wigan

South West
• CMFT
• UHSM
• North Manchester General
• Trafford

North East
• Oldham
• Bury
• Rochdale

South East
• Stockport
• Tameside
Manchester

• Widespread changes
  – In challenging times
• Laudable aims and objectives
  – Integrating social care
• Ambulatory care will play a vital role
  – Surgery
Every Day is Like Sunday - Morrissey
Emergency Surgery

Ambulatory care at SRFT
Surgical Triage Unit

- Unit for triage of emergency patients referred by ED/GP
- Opened 2\textsuperscript{nd} January 2016
- Joint unit: General Surgery, Urology, Gynaecology
Pre – Surgical triage unit (STU)

• What we didn’t have
• What we needed
• Why
Commissioning guide:
Emergency general surgery (acute abdominal pain)
Pre – Surgical triage unit (STU)

• What we didn’t have
• What we needed
• Why
STU model

- 8 assessment beds, 6 assessment chairs, 2 clinic rooms
- Maximum 24hr LOS
- Dedicated specialty ‘hot clinic’ slots
- Nurse led hot clinics
- Bookable diagnostic slots
- Bookable daycase surgery slots
- Booking managed via online ‘sharepoint’
STU ‘ethos’

- Higher quality/efficient patient centred care
- **Assess to admit** NOT admit to assess
- Early involvement of senior decision makers
- Unnecessary admissions avoidance
- Better (different) use of hospital resources
- Rapid (improved) inter-specialty reviews
STU admissions criteria

- GP referrals direct to STU
- ED criteria based upon patient safety & nursing acuity
- Criteria ‘relaxed’ following appraisal of service and experience

Examples of ED patient referrals not appropriate for direct transfer to STU:

- Patients with NEWs $\geq 5$ and/or in majors or resus requiring interventions e.g. IV fluid resuscitation for haemodynamic instability/ > 2L nasal specs oxygen.
- Patients who are identified as requiring more than level 1 care.
- Patients who have dementia or cognitive impairment such that the STU environment would not be appropriate.
Population of Salford ≈ 250,000
January – September 2016
January – September 2016
Hot clinics

Reduce unnecessary admissions
Facilitate earlier discharge for inpatients
Daycase abscess pathway

Avoid unnecessary admissions/overnight stays
Not available at the weekend
Length of stay

Average LOS in Days

Includes patients discharged from STU
STU opens

<table>
<thead>
<tr>
<th>LOS</th>
<th>Pre-STU Jan - Sept</th>
<th>Post-STU Jan - Sept</th>
<th>% increase / decrease</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 3372</td>
<td>N = 4017</td>
<td>+19%</td>
<td></td>
</tr>
<tr>
<td>&lt; 12 hours</td>
<td>26%</td>
<td>43%</td>
<td>+17%</td>
</tr>
<tr>
<td>&lt; 24 hours</td>
<td>12%</td>
<td>10%</td>
<td>-2%</td>
</tr>
<tr>
<td>&gt; 24 hours</td>
<td>62%</td>
<td>47%</td>
<td>-15%</td>
</tr>
</tbody>
</table>
Inpatient bed use

Total Emergency Admissions That Went on to Another ward

<table>
<thead>
<tr>
<th></th>
<th>Pre-STU Jan - Sept</th>
<th>Post-STU Jan - Sept</th>
</tr>
</thead>
<tbody>
<tr>
<td>3372</td>
<td></td>
<td>1440 (36%)</td>
</tr>
</tbody>
</table>
Total Emergency Admissions - Admission Ward

- Direct to STU
- Other

Year: 2015-2016

Months: 1-9

Admissions:
- 2015:
  - January: 350
  - February: 300
  - March: 320
  - April: 380
  - May: 400
  - June: 370
  - July: 420
  - August: 450
  - September: 390

- 2016:
  - January: 250
  - February: 200
  - March: 220
  - April: 280
  - May: 300
  - June: 340
  - July: 390
  - August: 430
  - September: 370
Bed days savings

Total Beds Saver Per Month

- Jan-16
- Feb-16
- Mar-16
- Apr-16
- May-16

Legend:
- GENERAL SURGERY
- GYNAECOLOGY
- UROLOGY
The money
Jan – March 2015/16 vs. 2016/17

• Activity has increased 17%
• Associated income has increased by 13%
• Average cost per patient has decreased
• £2036 vs. £1974
<table>
<thead>
<tr>
<th></th>
<th>Now</th>
<th>Future</th>
<th>Benefits</th>
</tr>
</thead>
</table>
| **Hot clinics**       | Registrar lead                           | Consultant lead                          | • Improved utilisation  
                        |                                          |                                          | • Reduce repeat attendances             |
| **STU**               | Registrar lead                           | Consultant lead                          | • Improved senior decision making  
                        |                                          |                                          | • Further reduce unnecessary admissions |
| **CEPOD list**        | Unselected emergency patients            | Divert CEPOD ‘18hrs – 4 days’ to separately run ‘hot’ elective lists | • Improve management of biliary disease  
                        |                                          |                                          | • Increase capacity for emergency / urgent cases |
| **Diagnostics & supporting services** | 2 USS slots/day  
4 MRCP slots/week | Increase USS slots  
Increased MRCP slots  
Bookable CT slots  
Bookable pre-op slots | • Enhance patient pathway  
• Optimise use of hot clinics  
• Facilitate ‘hot’ elective lists |
Emergency Surgery

Ambulatory care at SRFT

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