Same Day Emergency Care

Regional Workshop

19 June 2019, Newcastle

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network


EVALUATION
Excellent
Good
Average
Poor

Useful Links

The SDEC programme website is:

https://improvement.nhs.uk/resources/same-day-emergency-care/

The SDEC programme email address is nhsi.sdec@nhs.net

The Ambulatory Emergency Care Network website is: www.ambulatoryemergencycare.org.uk

The AEC Network email address is aec@nhselect.org.uk

If you want to tweet about this event or anything relating to same day emergency care please use **#NHSSDEC** to spread the conversation a little wider

Agenda

10:00 Welcome and Overview

Strategic Vision

What is SDEC?

Coffee Break

SDEC Dataset

Market Place

Lunch

AEC in Emergency Care – Introducing the RCEM toolkit

Market Place

Showcase sites

Developing a Dashboard for AEC

16:00 Next Steps and Close

Slido - Event Evaluation

Access our event evaluation in 3 easy steps

1. Go to any web browser from any device

2. Go to slido.com

3. Type in the event code **#SDEC170619**

Same Day Emergency Care

Dr Cliff Mann

National Clinical Advisor

Co-Chair SDEC Programme Board

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NHS England, NHS Improvement and the Ambulatory Emergency Care Network

Same Day Emergency Care

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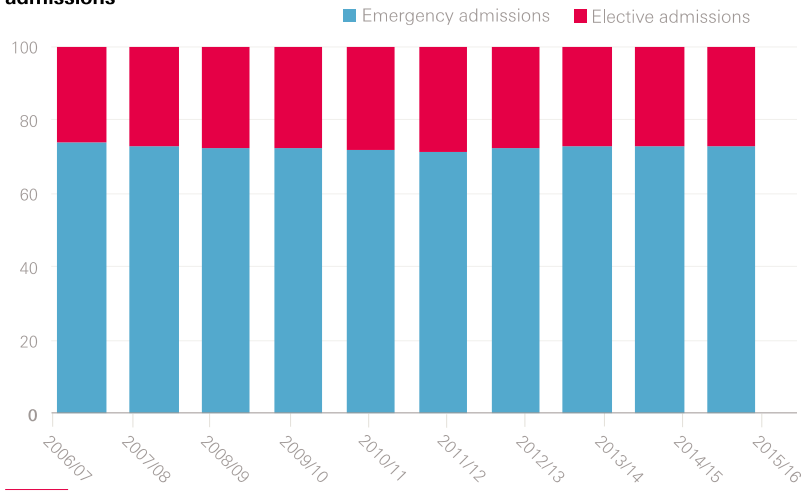
National Clinical Advisor

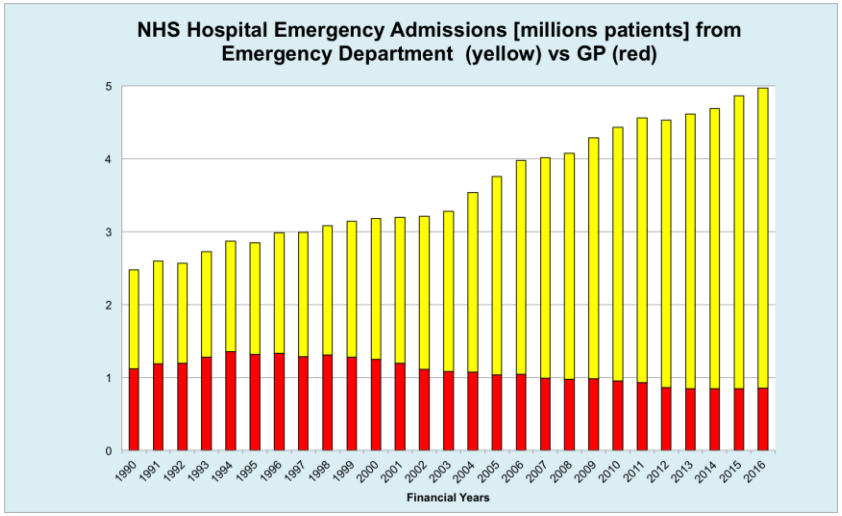
Co-Chair SDEC Programme Board

Thanks for attending

Not here to lecture
Not here to patronize
Not here to claim this is a transformational imperative
We are here because
This works
Most trusts already do some of this
If we did more – more patients would benefit
It would be cost efficient

Figure 5:† Proportion of total bed days for emergency admissions and elective admissions





* CQC figures for 2016/17 (http://www.cqc.org.uk/sites/default/files/state-care-independent-acute-hospitals.pdf).

† Health Foundation analysis of Hospital Episode Statistics data. Where patients were transferred from one hospital to another, we included the length of the subsequent hospital stay.

SDEC patients = 22% of all acute admissions

(16% ED, 6% direct)

Moving from 'a fifth to a third'
= 13 % absolute increase

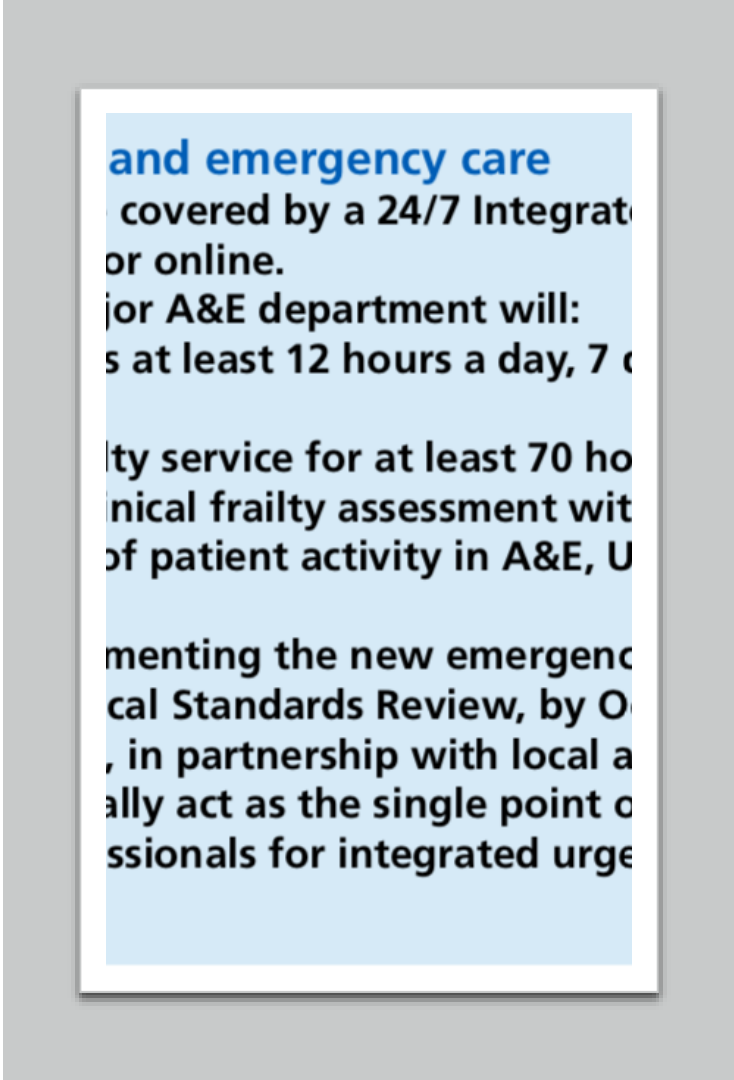
= 782,600 fewer MN stays

= 4% reduction in bed occupancy

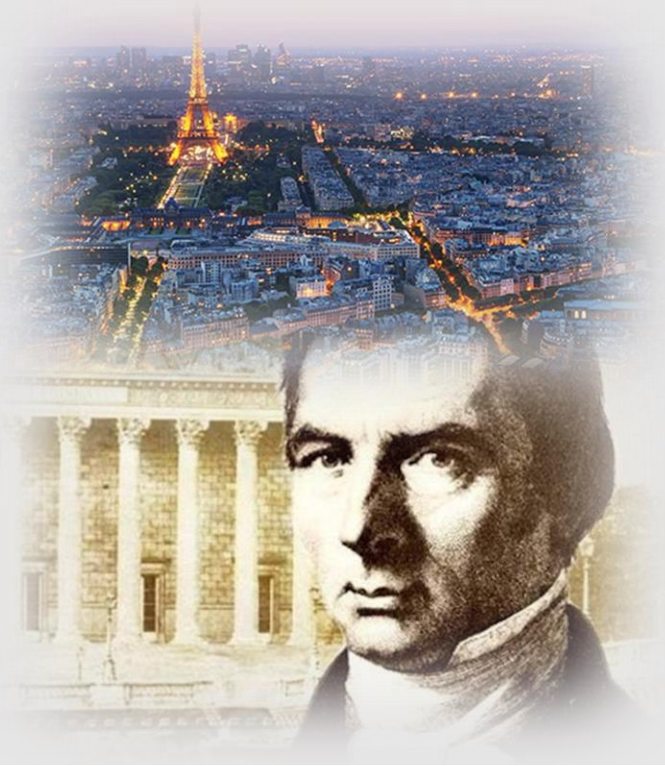
£1.1 billion

This Year

- Regional Launch Workshops
- CQUINS
- AECN led accelerator programmes



Paris will be fed



NATIONAL

REGIONAL

LOCAL

SIGNAL

COUNT

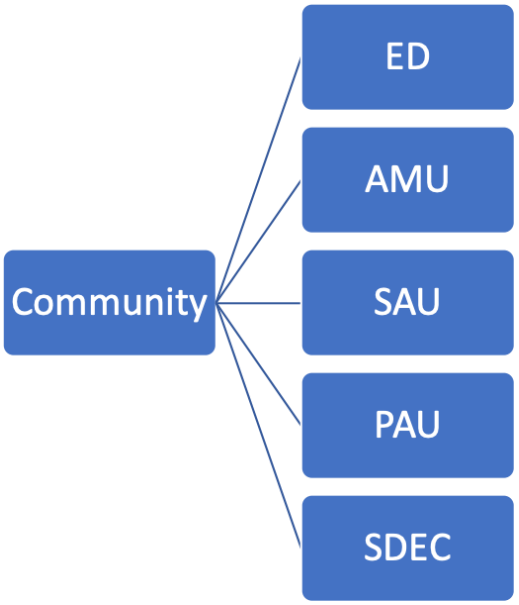
PAY

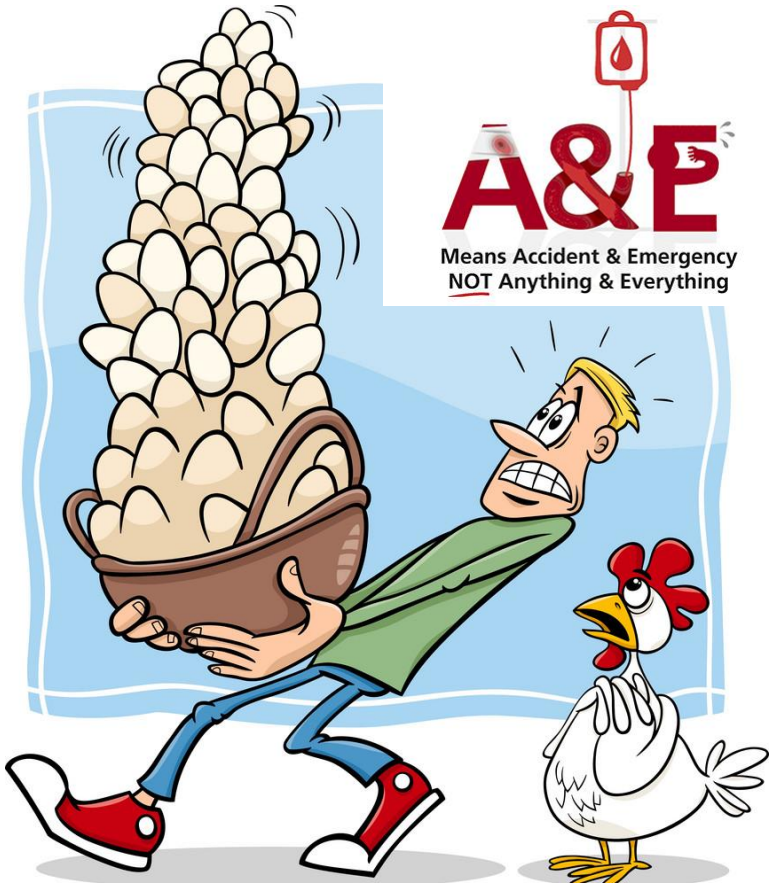
SDEC

≠ ZLoS

≠ A Place/ Site Code/ Ward

= Diagnosis +/- Ix +/- Rx recorded via SDECDS


Community
ED
AMU
SAU
PAU
SDEC


A&E
Means Accident & Emergency
NOT Anything & Everything

ECDS_Description	AEC Description	Scenario	SNOME	ICD1
Complication of gastrostomy (PEG tube)	Attention to gastrostomy	PEG related complications	309773000	Y833
Upper gastrointestinal hemorrhage	Gastrointestinal haemorrhage, unspecified	Upper gastro-intestinal haemorrhage	37372002	K920
Lower gastrointestinal hemorrhage	Gastrointestinal haemorrhage, unspecified	Lower gastro-intestinal haemorrhage	87763006	K921
Crohns disease	Inflammatory Bowel Disease	Inflammatory Bowel Disease	34000006	K509
Ulcerative colitis	Inflammatory Bowel Disease	Inflammatory Bowel Disease	64766004	K519
Oesophageal stricture			63305008	K222
Migraine	Migraine, unspecified	Acute headache	37796009	G439
Cluster headache	Cluster headache syndrome	Acute headache	193031009	G440
Stroke			230690007	I64
Transient ischaemic attack	Transient cerebral ischaemic attack, unspecified	Transient ischaemic attack	266257000	G459
Epilepsy : generalised	Epilepsy, unspecified	Seizure in known epileptic	352818000	G403
Status epilepticus	we have different types of epilepsy but not by these nam	s	230456007	G419
Epilepsy : absence	we have different types of epilepsy but not by these nam	s	79631006	G403
Epilepsy : focal	we have different types of epilepsy but not by these nam	s	29753000	G400
Asthma	Asthma, unspecified	Asthma	195967001	J459
Chronic obstructive pulmonary disease	Chronic obstructive pulmonary disease, unspecified	Chronic obstructive pulmonary disease (COPD)	13645005	J449
Pulmonary embolism	Pulmonary embolism with mention of acute cor pulmonal	Pulmonary embolism	59282003	I269
Spontaneous pneumothorax	Spontaneous tension pneumothorax; Other spontaneous	Pneumothorax	80423007	J931
Pleural effusion	Pleural effusion, not elsewhere classified	Pleural effusions	60046008	J90
Anaemia	Anaemia, unspecified	Anaemia	271737000	D649

Agreement with NHS Digital to record as ECDS type 5

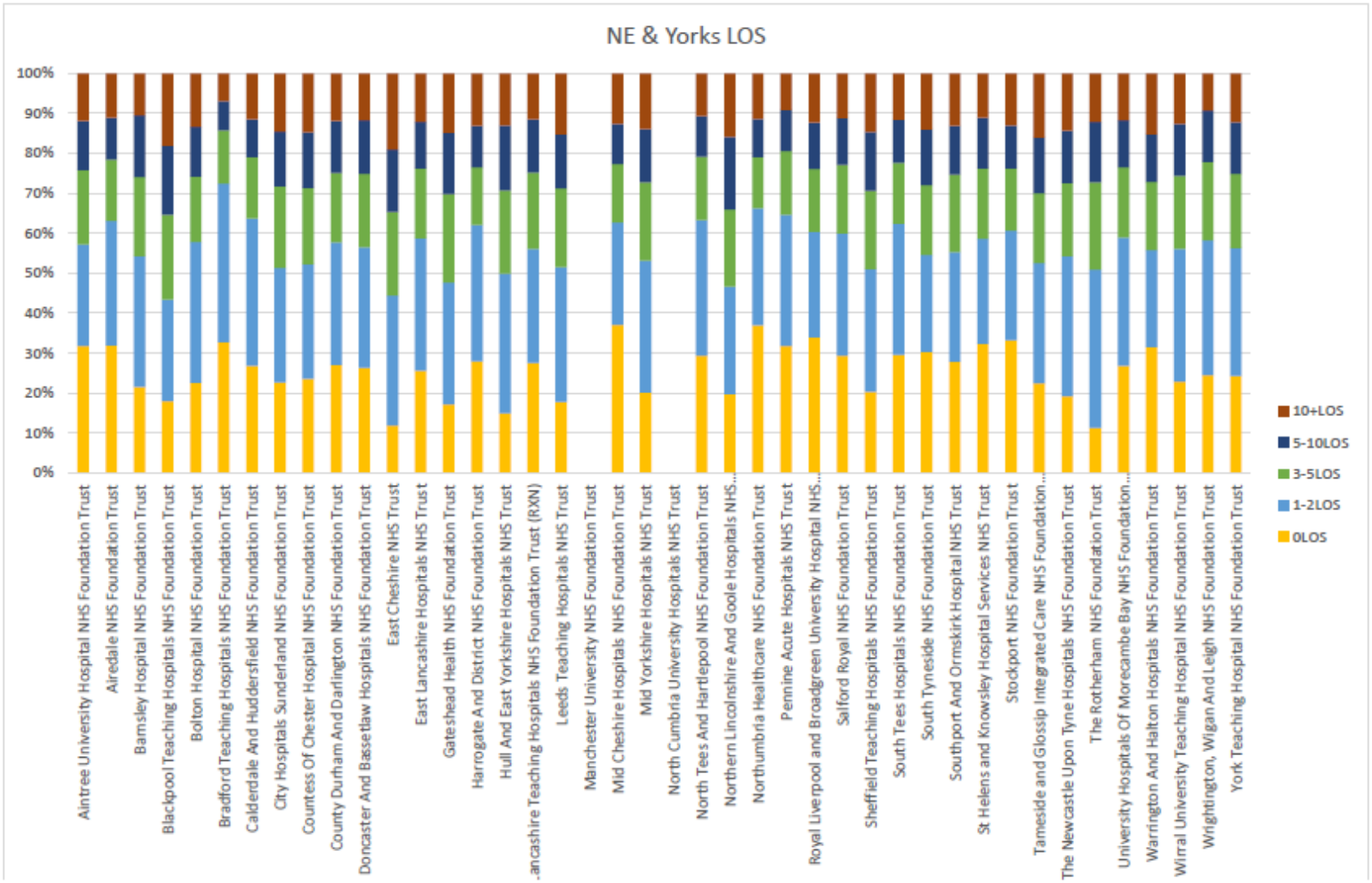
10 pilot sites currently testing the proposed SDECDS

The Royal Free

Northwick Park
Wexham Park

Warrington and Halton
Epsom & Helier

Leeds Teaching Hospital
Northampton
Norfolk & Norwich
City Hospitals Sunderland
Western Sussex Hospitals

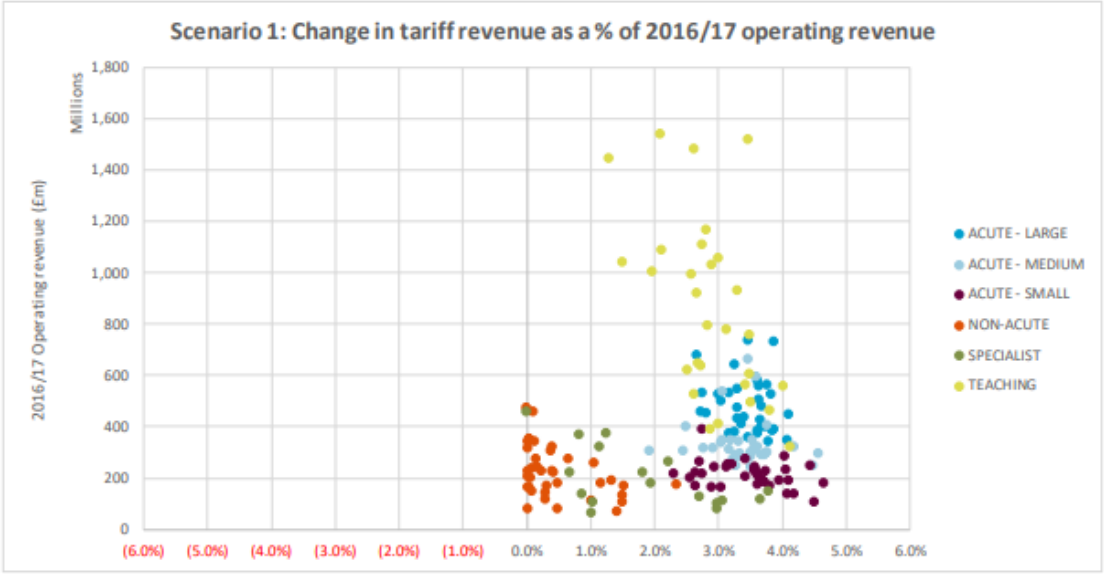

NE & Yorks LOS
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
10+LOS
5-10LOS
3-5LOS
1-2LOS
0LOS
Aintree University Hospital NHS Foundation Trust
Airedale NHS Foundation Trust
Barnsley Hospital NHS Foundation Trust
Blackpool Teaching Hospitals NHS Foundation Trust
Bolton Hospital NHS Foundation Trust
Bradford Teaching Hospitals NHS Foundation Trust
Calderdale And Huddersfield NHS Foundation Trust
City Hospitals Sunderland NHS Foundation Trust
Countess Of Chester Hospital NHS Foundation Trust
County Durham And Darlington NHS Foundation Trust
Doncaster And Bassetlaw Hospitals NHS Foundation Trust
East Cheshire NHS Trust
East Lancashire Hospitals NHS Trust
Gateshead Health NHS Foundation Trust
Harrogate And District NHS Foundation Trust
Hull And East Yorkshire Hospitals NHS Trust
Lancashire Teaching Hospitals NHS Foundation Trust (RXN)
Leeds Teaching Hospitals NHS Trust
Manchester University NHS Foundation Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Yorkshire Hospitals NHS Trust
North Cumbria University Hospitals NHS Trust
North Tees And Hartlepool NHS Foundation Trust
Northern Lincolnshire And Goole Hospitals NHS...
Northumbria Healthcare NHS Foundation Trust
Pennine Acute Hospitals NHS Trust
Royal Liverpool and Broadgreen University Hospital NHS...
Salford Royal NHS Foundation Trust
Sheffield Teaching Hospitals NHS Foundation Trust
South Tees Hospitals NHS Foundation Trust
South Tyneside NHS Foundation Trust
Southport And Ormskirk Hospital NHS Trust
St Helens and Knowsley Hospital Services NHS Trust
Stockport NHS Foundation Trust
Tameside and Glossip Integrated Care NHS Foundation...
The Newcastle Upon Tyne Hospitals NHS Foundation Trust
The Rotherham NHS Foundation Trust
University Hospitals Of Morecambe Bay NHS Foundation...
Warrington And Halton Hospitals NHS Foundation Trust
Wirral University Teaching Hospital NHS Foundation Trust
Wrightington, Wigan And Leigh NHS Foundation Trust
York Teaching Hospital NHS Foundation Trust

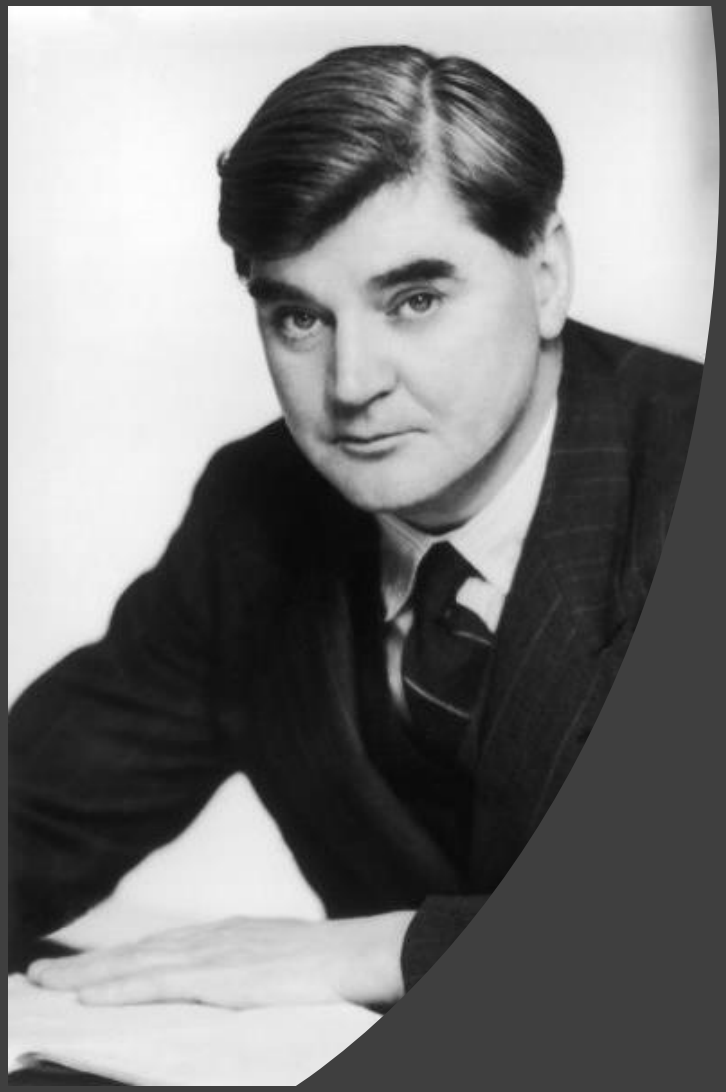

20
20
Bank of
£5

For most SDEC conditions
Tariff < Cost
if LoS > 1.5 days

- Pneumonia
- CQUIN
- Atrial Fibrillation
- Pulmonary Embolus

Figure 1: Impact of 2019/20 NTPS proposals on NHS provider tariff revenue (ie what a provider would receive in 2019/20 using proposed new prices, compared to 2018/19), based on 2016/17 activity (scenario 1)[26]





“After the first year of the NHS, one of the chief causes of our troubles is the increasing demand made on our hospitals by the aged sick"

The Royal College of Emergency Medicine

sam
THE SOCIETY FOR ACUTE MEDICINE

BGS

Last 1000 Days

65% of acute bed days are occupied by people over 65

65%

65+

75% of delayed discharge bed days are occupied by people over 75

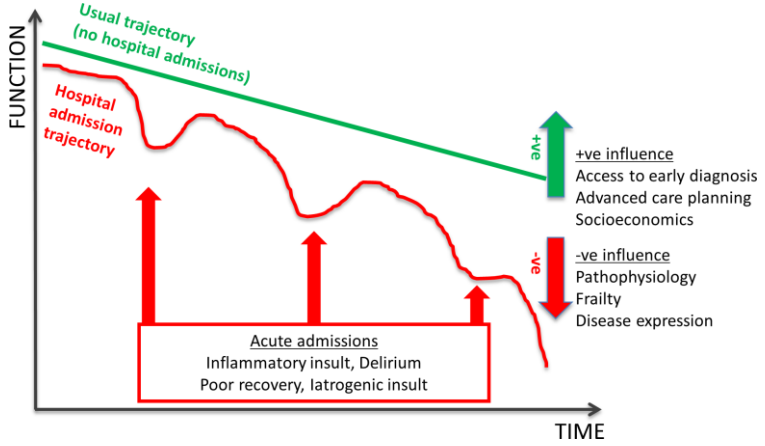
75%

75+

100% projected increase in people over 85 between 2010 and 2030

100%

85+



Better for

Patients who can be managed without admissions	Patients who require admission	Hospitals	The NHS

Strategic Vision

Mark England

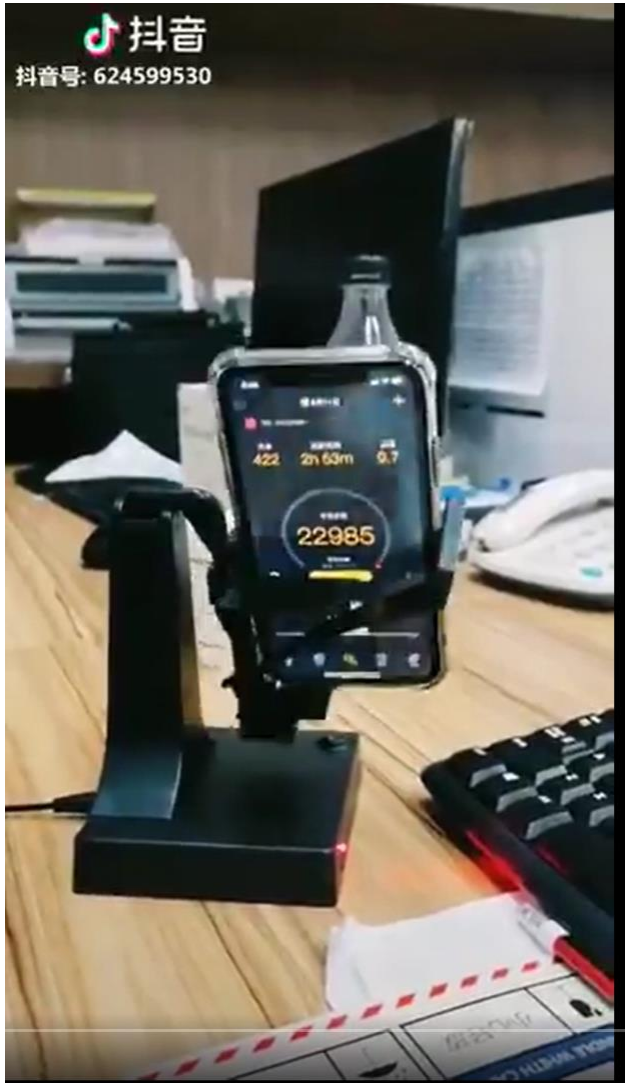
Deputy National Director of Emergency and Elective Care

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

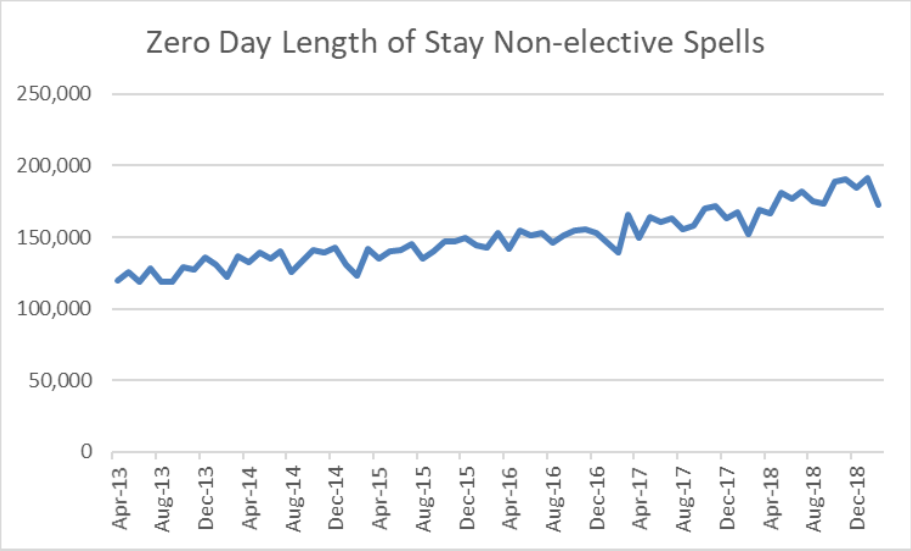
SDEC Workshop

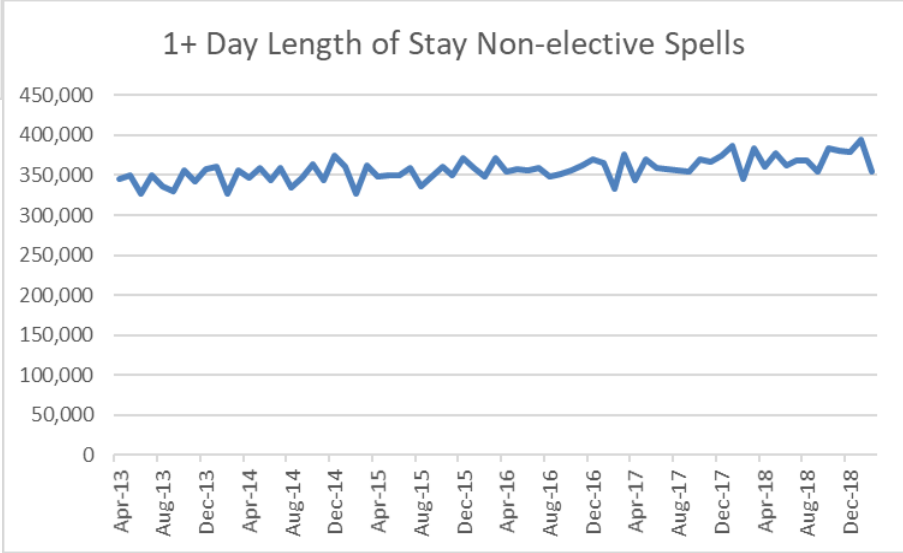
June 2019

NHS England and NHS Improvement

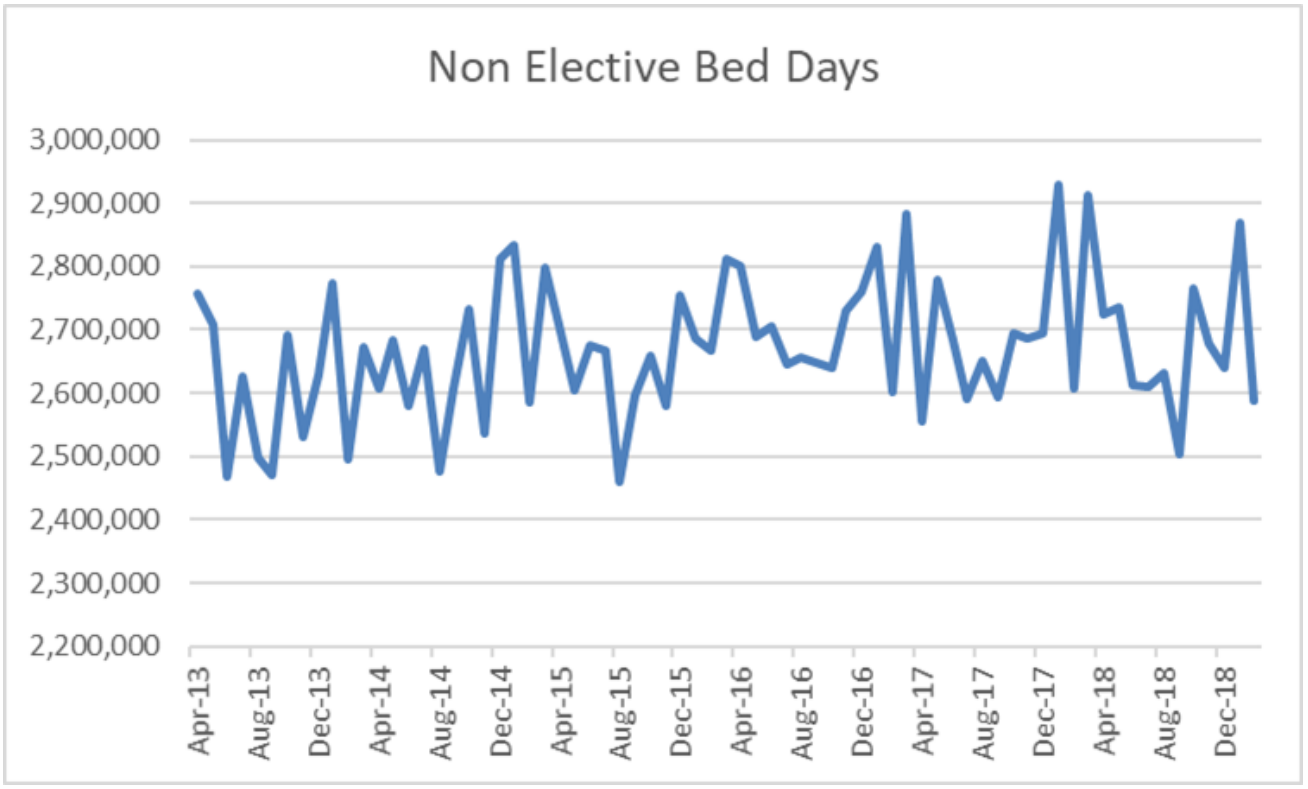

抖音
抖音号: 624599530
422
2h 53m
9.7
22985

Non-elective spells at M11





Bed Days at M11



The National Context SDEC (1)

We are responsible for reforming hospitals emergency care delivering a step-change in Same Day Emergency Care this year

1. By September 2019 every Type 1 ED Provider will operate a comprehensive model of Same Day Emergency Care (SDEC) - 12/7
2. By December 2019 every Type 1 ED Provider will establish an Acute Frailty Service (AFS).
3. During 2020 all Type 1 ED Providers will embed the Same Day Emergency Care Data Set (SDECDS) into all SDEC services. Providing a platform to record activity, develop counting, coding enabling development of a national tariff.

National SDEC CQUINs published for 2019/20

- pulmonary embolus
- community acquired pneumonia
- atrial fibrillation with tachycardia

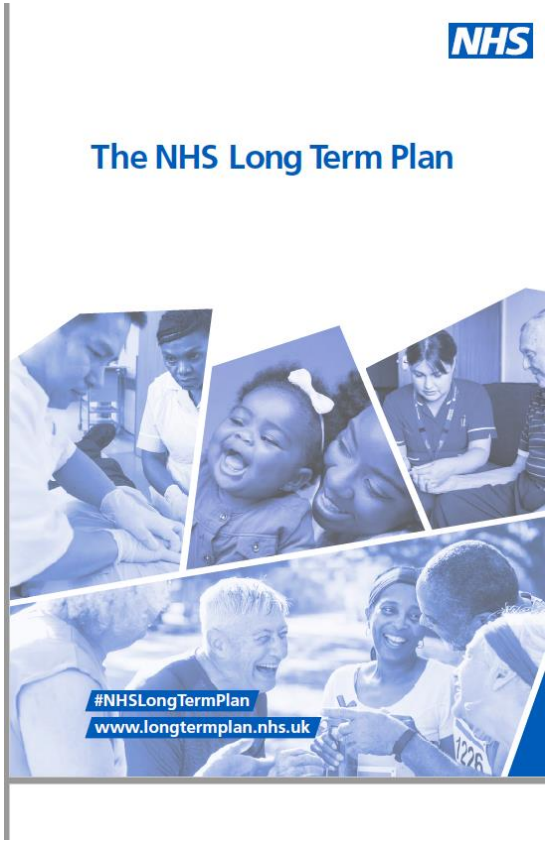
NHS Operational Planning and Contracting Guidance 2019/20

The National Context SDEC (2)

We are responsible for reforming hospitals emergency care delivering a step-change in Same Day Emergency Care over the three years

"For those that do need hospital care, emergency 'admissions' are increasingly being treated through 'same day emergency care' without need for an overnight stay. This model will be rolled out across all acute hospitals, increasing the proportion of acute admissions typically discharged on day of attendance from a fifth to a third [by 2023]. "

"we commit to increase investment in primary medical and community health services as a share of the total national NHS revenue spend across the five years from 2019/20 to 2023/24. This means spending on these services will be at least £4.5 billion higher in five year's time." [What opportunities for SDEC?]

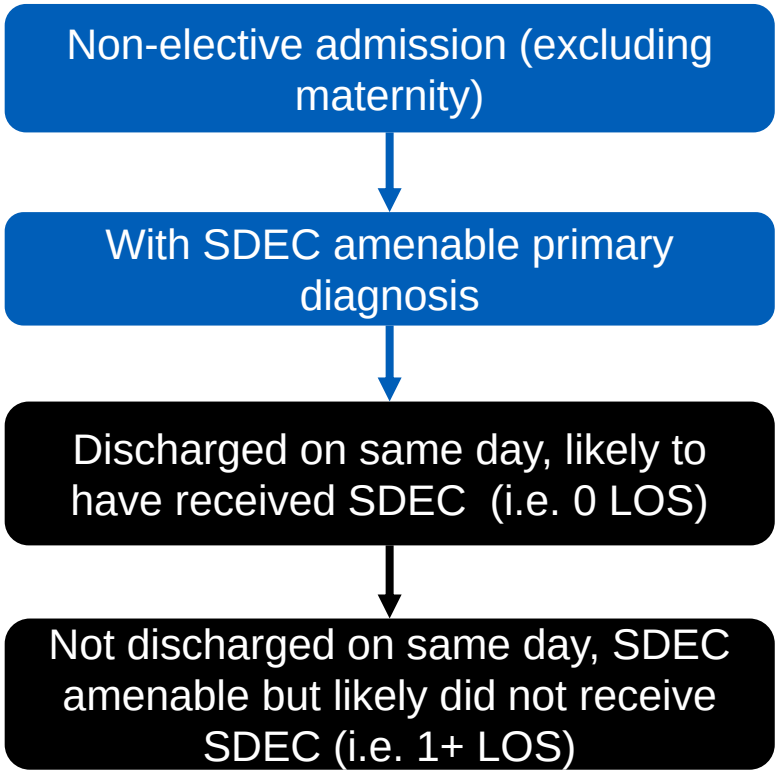


SDEC – Patient Level Information Cost System (PLICS) Analysis

April 2019

NHS England and NHS Improvement

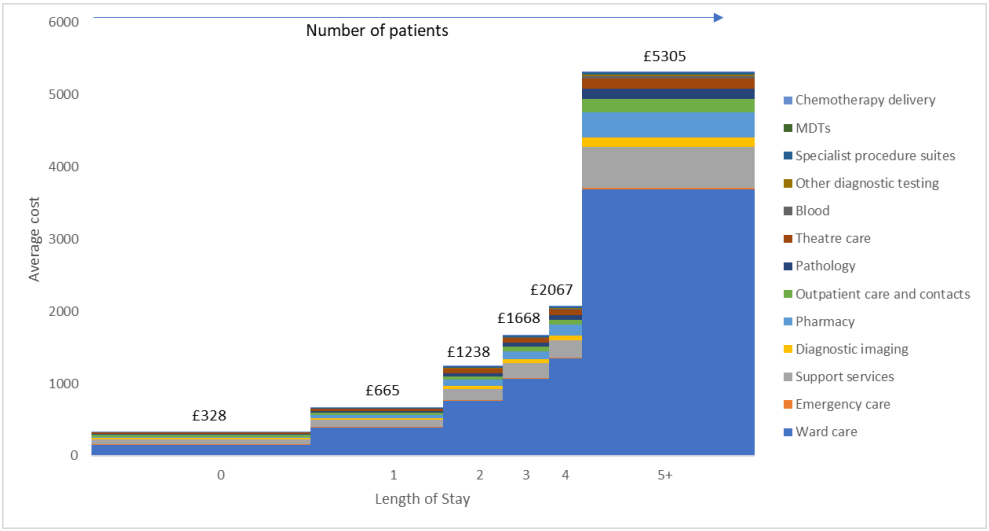
The approach used to identify SDEC amenable patients

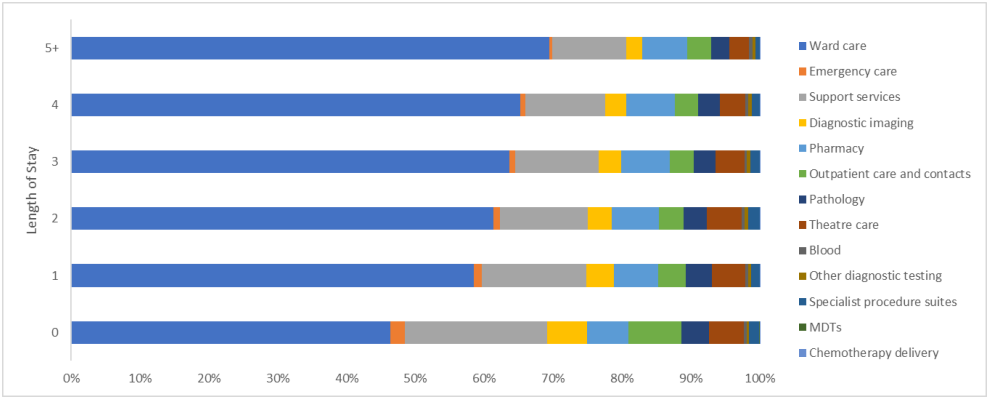


- We identify SDEC and potential SDEC spells in 2017/18 PLICS data. This covers 69 acute trusts.
- This approach was applied as a way to analyse historic data and thus applies contemporaneous information on diagnoses amenable to SDEC treatment from the Directory of Ambulatory Emergency Care for Adults (version 6).
- Thus, while similar, the identification method does not reflect developments by the SDEC Data Group to reach a definition for future coding of SDEC.
- This includes all non elective routes to SDEC treatment.

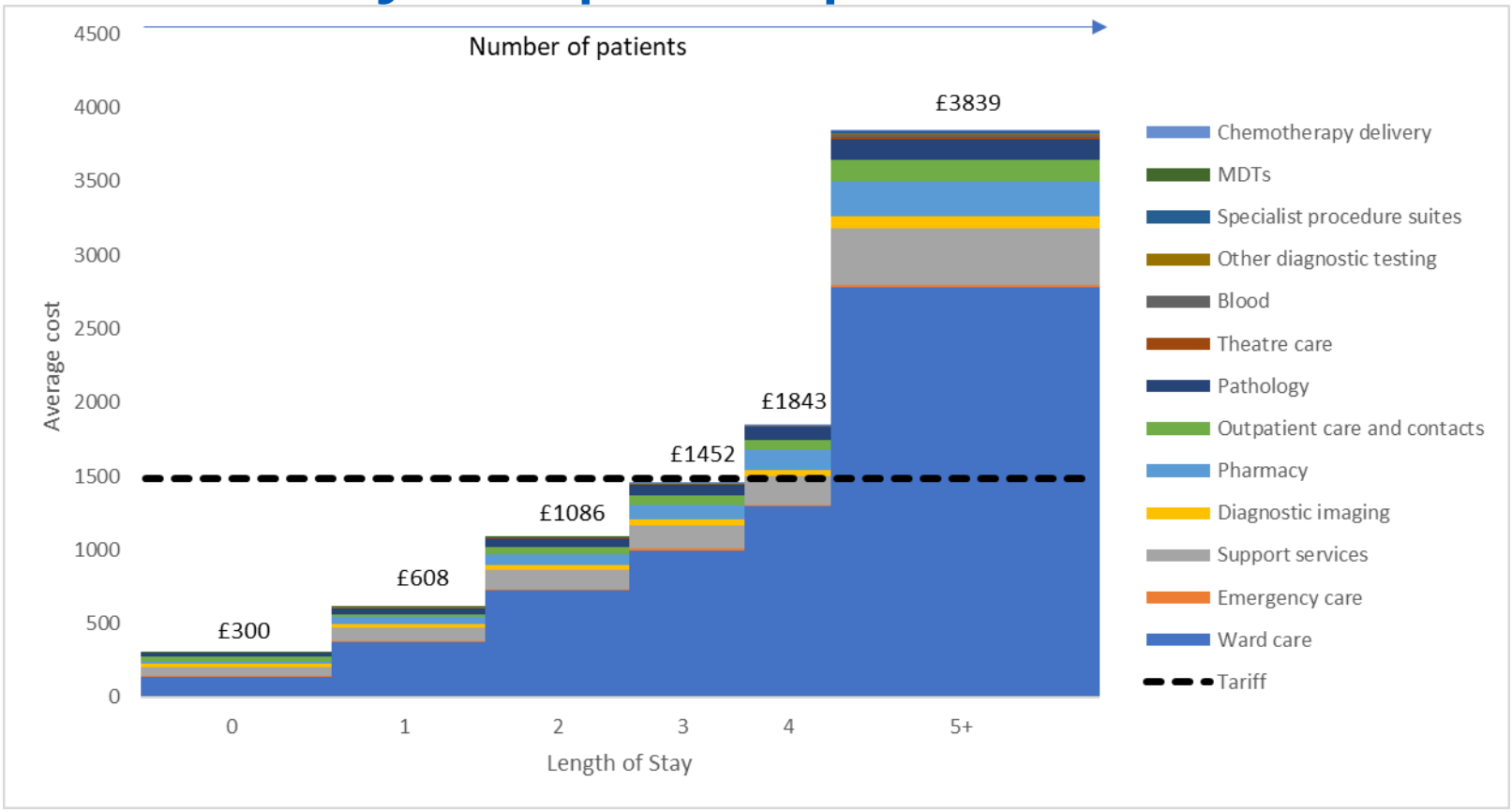
There are large differences in cost per patient as length of stay increases

- Cost per patient increases as length of stay increases (top).
- Support services make up a larger proportion of costs as LoS decreases and ward care makes up a larger proportion of costs as LoS increases (bottom).
- Costs are MFF-adjusted.
- This top right analysis is reproduced for the top three largest conditions by their largest HRG on the slides which follow.
- Tariffs on the following slides are calculated using the first episode HRG, and do not adjust for the marginal rate, nor do they incorporate locally agreed arrangements. In 17/18 (the time of the data) the marginal rate reduced tariff by 30% for activity above the threshold.
- Further, the tariff is applied to all emergency admissions without excluding 30-day readmissions.



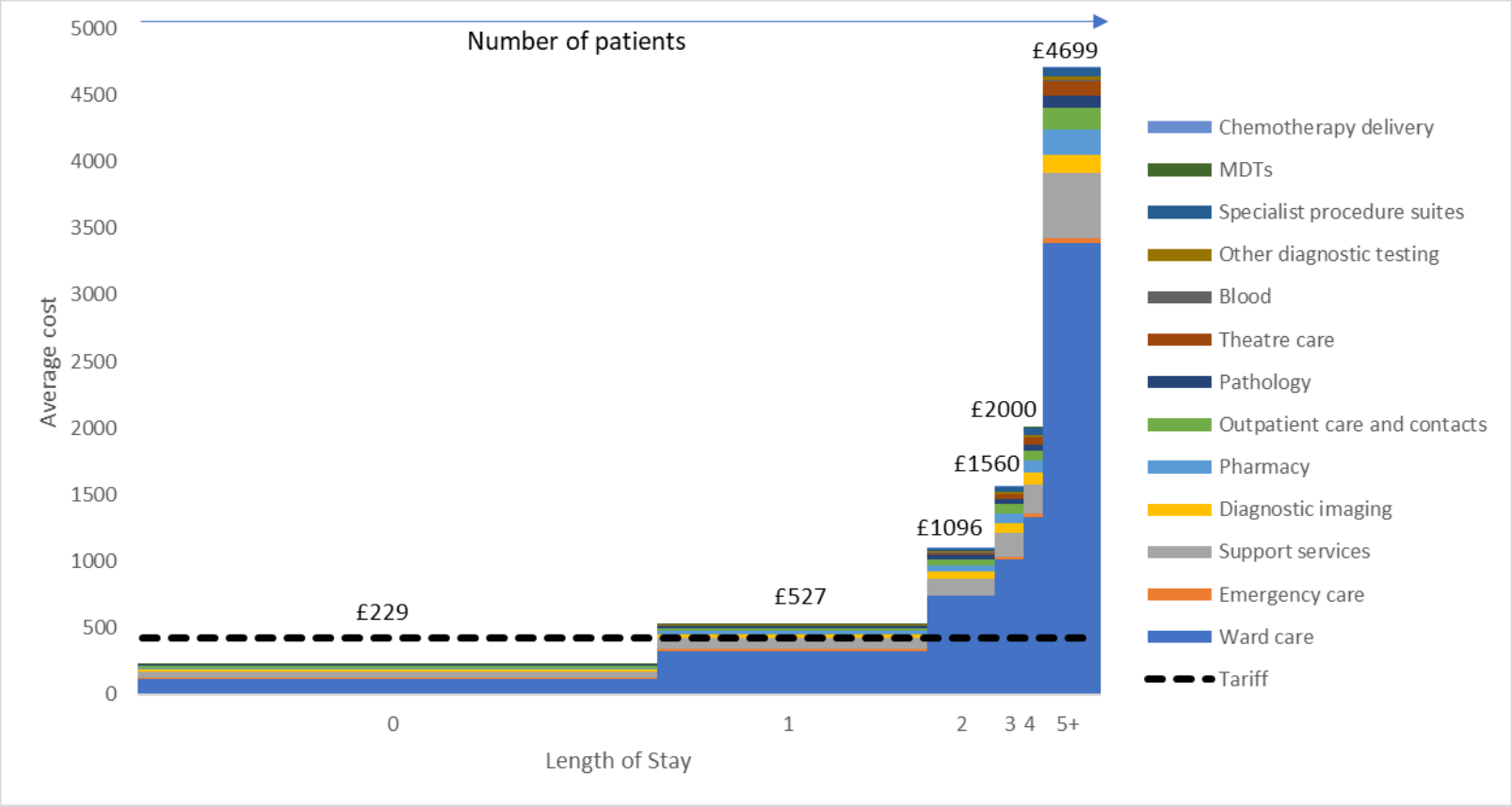


Community-acquired pneumonia



HRG: Lobar, Atypical or Viral Pneumonia, without Interventions, with CC Score 0-3 (DZ11V)

Falls including syncope or collapse



HRG: Syncope or Collapse, with CC Score 0-3 (EB08E)

Cost reductions from additional SDEC amenable patients treated same day

The average trust* in the PLICS dataset had 99 NEL admissions per day in FY2017/18, of which 35 were SDEC amenable. Of these 35 SDEC amenable admissions, seven had a 0 day LOS and an average cost of admission half of that of the eleven who had a 1 day LOS. Shifting more admissions to same day would thus reduced total costs for the trust.

Table 1: Estimated cost reductions per trust* based on 5 scenarios of treating increased volumes of 1+ day LOS SDEC amenable admissions same day

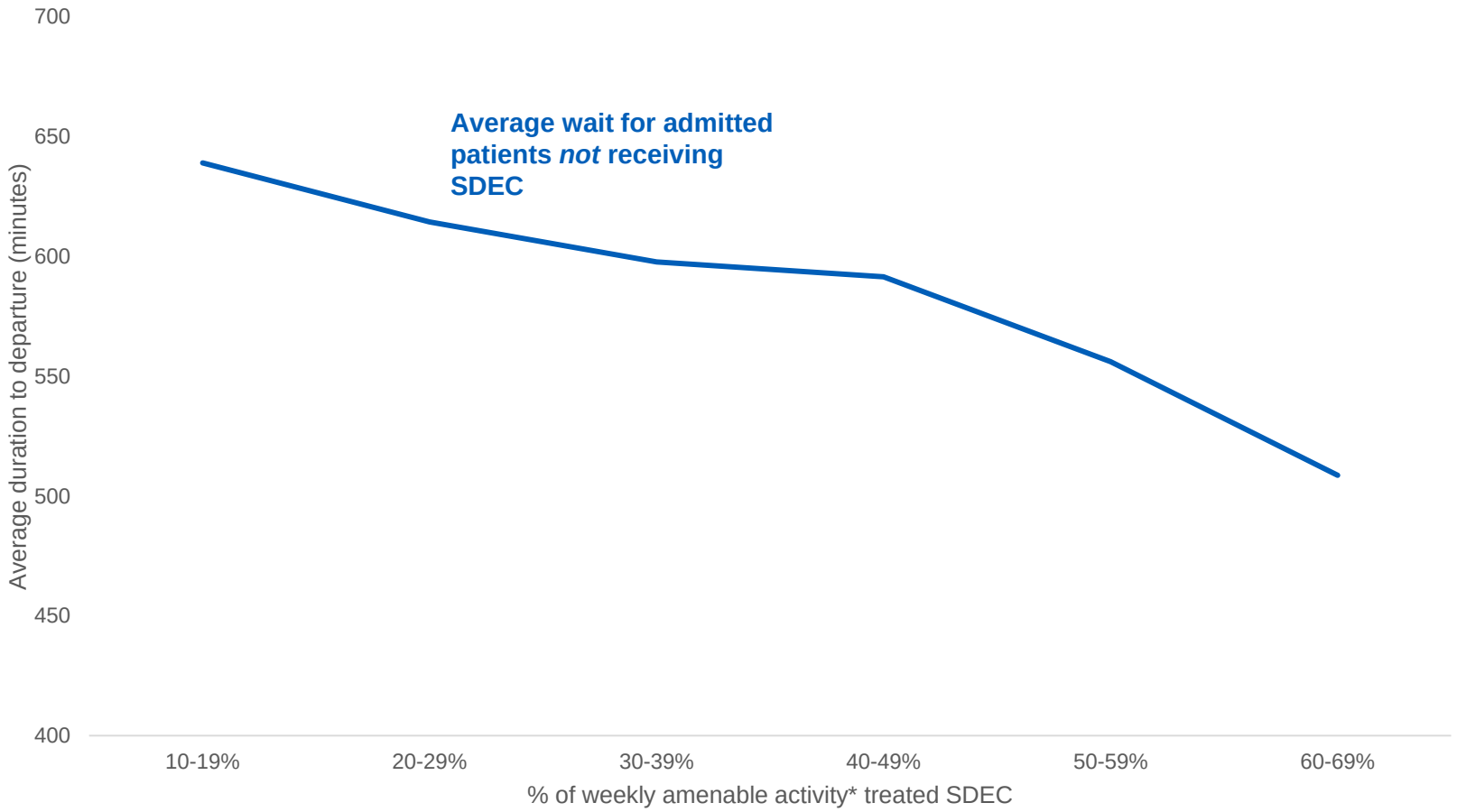
5 Scenarios:	No. of 1+ LOS admissions shifted to 0 LOS		Estimated cost reductions	
	Per year	Per day	Per admission	Per year
A: Increase to AEC Network minimum estimate per condition ^	2,440	7	£715	£1.7m
B: Increase to AEC Network mid point estimate per condition ^	4,154	11	£939	£3.9m
C: Increase to AEC Network maximum estimate per condition ^	6,178	17	£1,333	£8.2m
D: Shift all 1 day LOS admissions to 0 day LOS	3,562	10	£363	£1.3m
E: Shift all SDEC amenable admissions to 0 day LOS	11,924	33	£2,596	£31m

* The average trust is based on the 69 trusts in the PLICS dataset with substantial NEL activity in FY2017/18.

^ The method applied to these scenarios was to shift the lowest LOS patients to 0 day LOS necessary to meet the AEC Network threshold.

Knock-on effect of SDEC for patients admitted from Type 1 A&E

This graph illustrates how increasing SDEC activity affects average time spent in A&E for admitted non-SDEC patients.



*Patients with an amenable condition, arriving during core AEC unit operating hours

What is SDEC?

Deborah Thompson
Director, NHS Elect

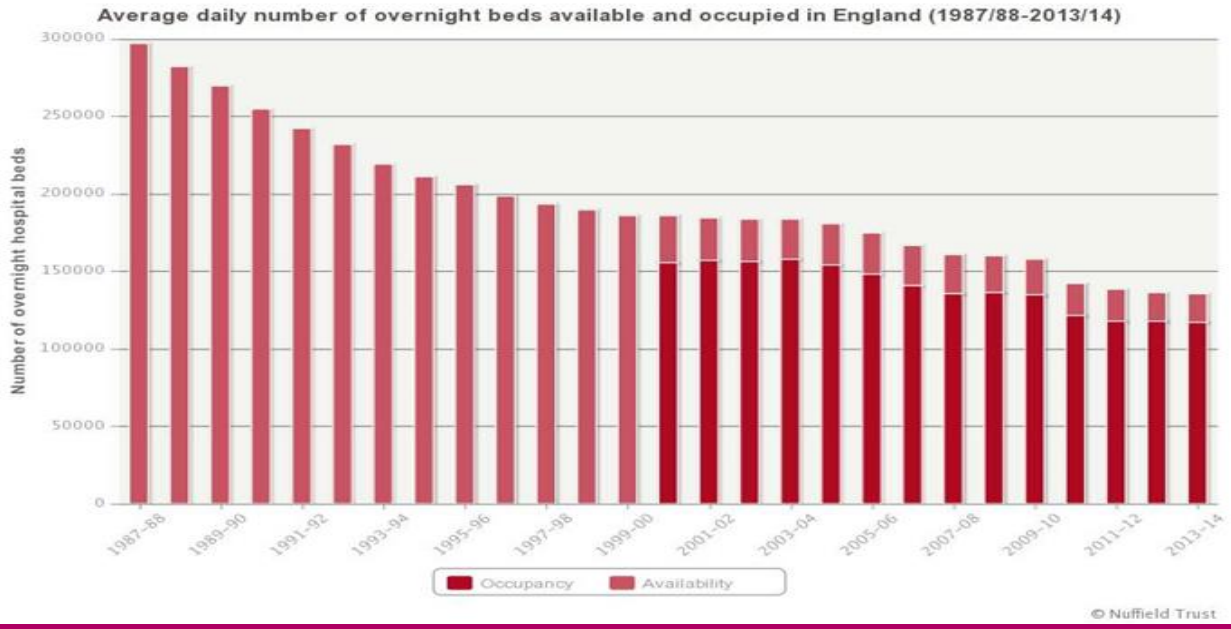
Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

NHS

Ambulatory Emergency Care Network

Dr Vincent Connolly
Clinical Lead AEC Network

Deborah Thompson
Director
AEC Network



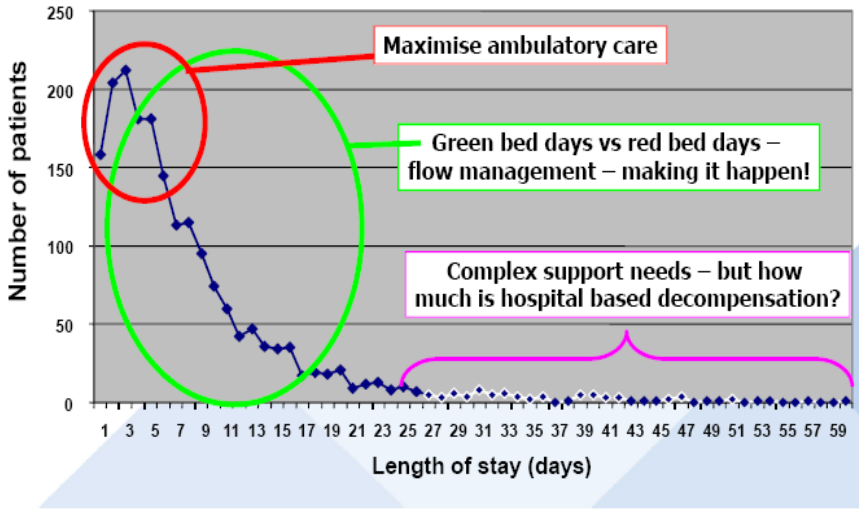
Supporting the NHS to redesign emergency care to provide same day emergency care (SDEC) and reduce reliance on hospital beds

The ‘broom cupboard’ beginning …….

Same Day Emergency Care is a way of managing a significant proportion of emergency patients on the same day without admission to a hospital bed

Managing Length of Stay

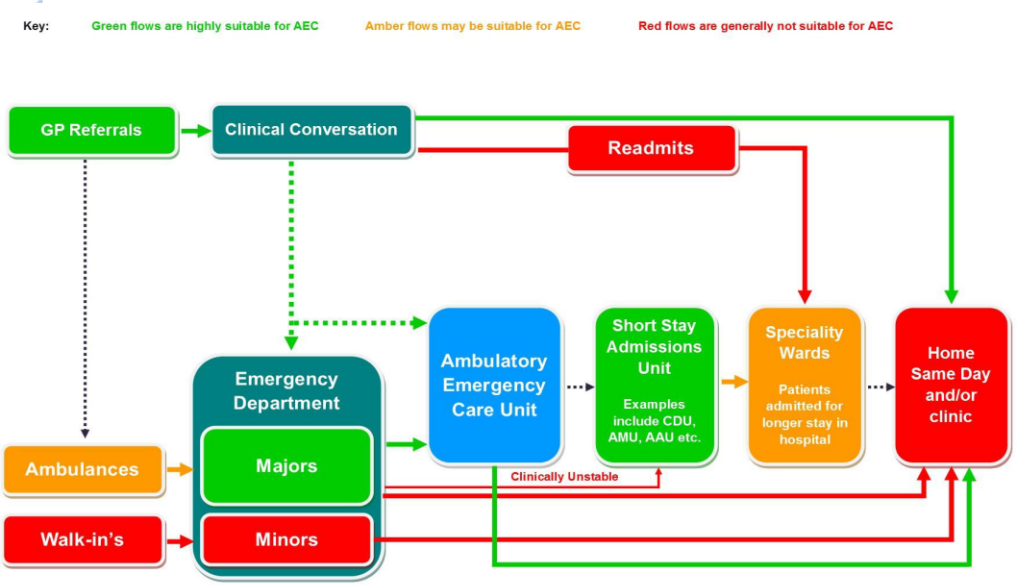
NHS Institute for Innovation and Improvement



'Converting at least 20-30% of emergency admissions to AEC'

Royal College of Physicians 2012

Its about redesigning the system to stream clinically appropriate 'admitted patient flow' to SDEC for rapid assessment, treatment and 'same day discharge'

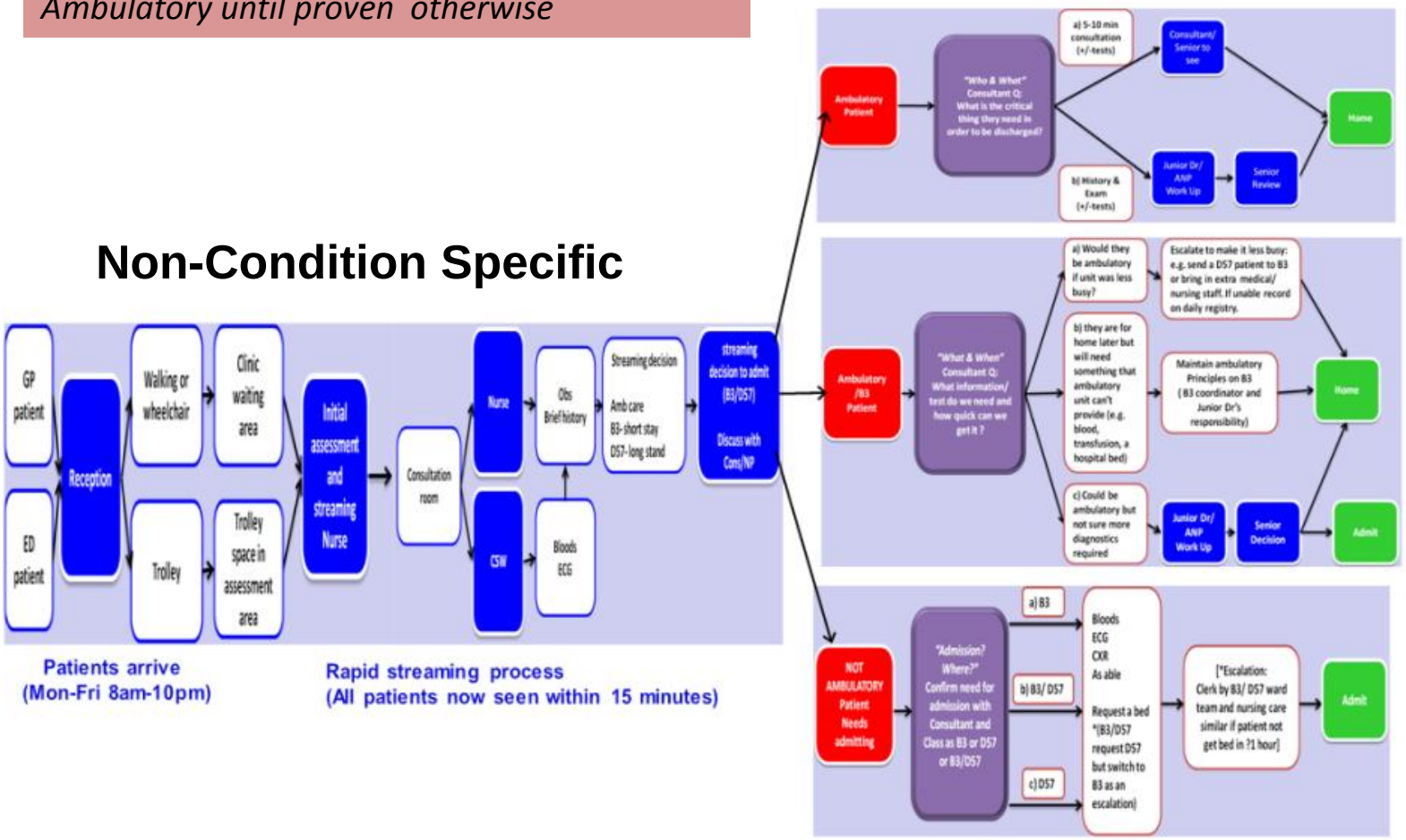


Models of AEC - the 4Ps

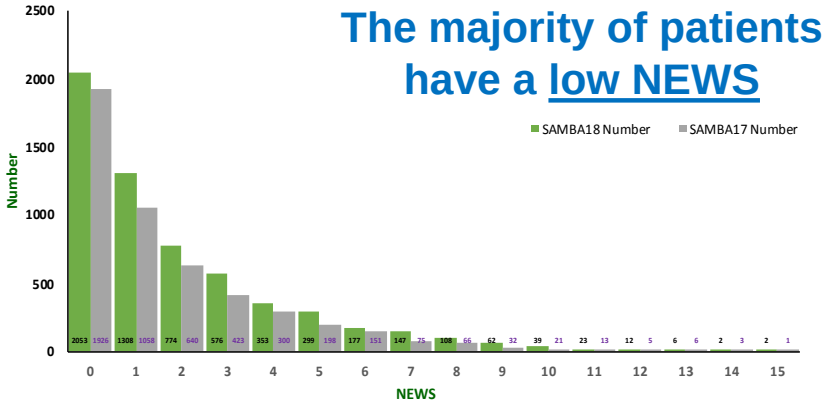
- **P**assive
  - – - receive referrals
- **P**athway driven
  - – - restricted to particular agreed pathways
- **P**ull
  - – - senior clinician takes calls for emergency referrals
- **P**rocess driven
  - – - all patients considered for AEC

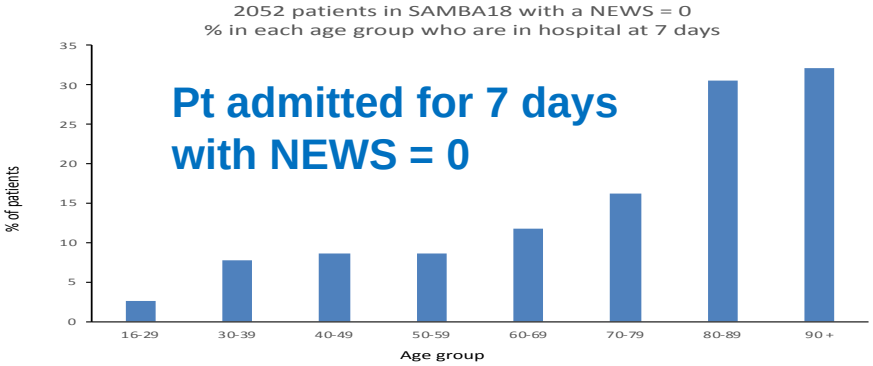
Process for GP Assessment and Same Day Emergency Care

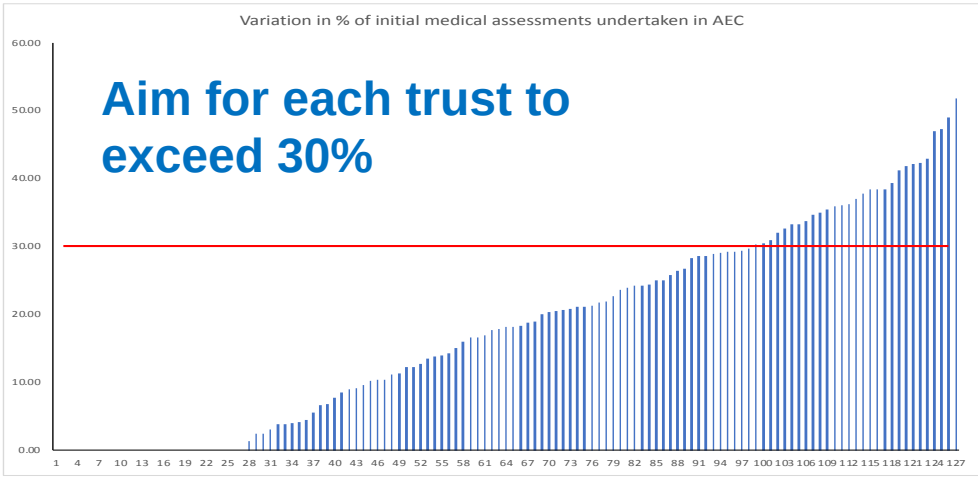
Overarching principle; *Treat all patients as Ambulatory until proven otherwise*



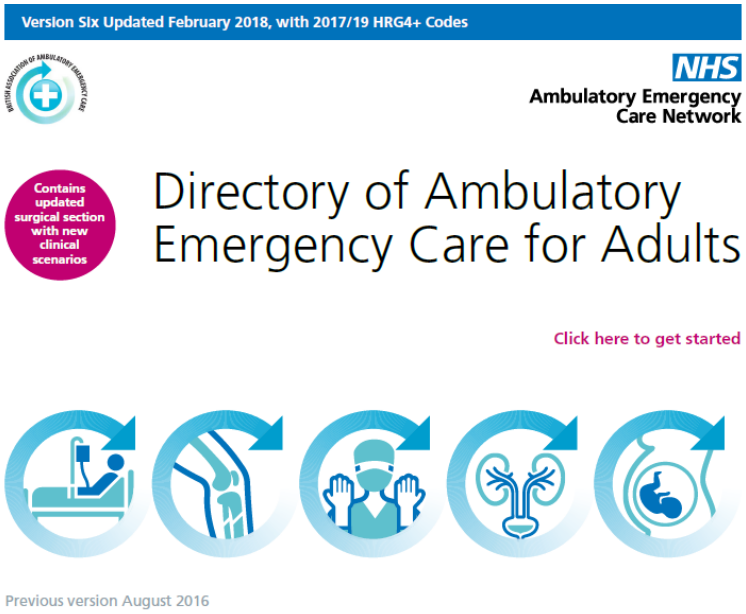
The opportunity for AEC

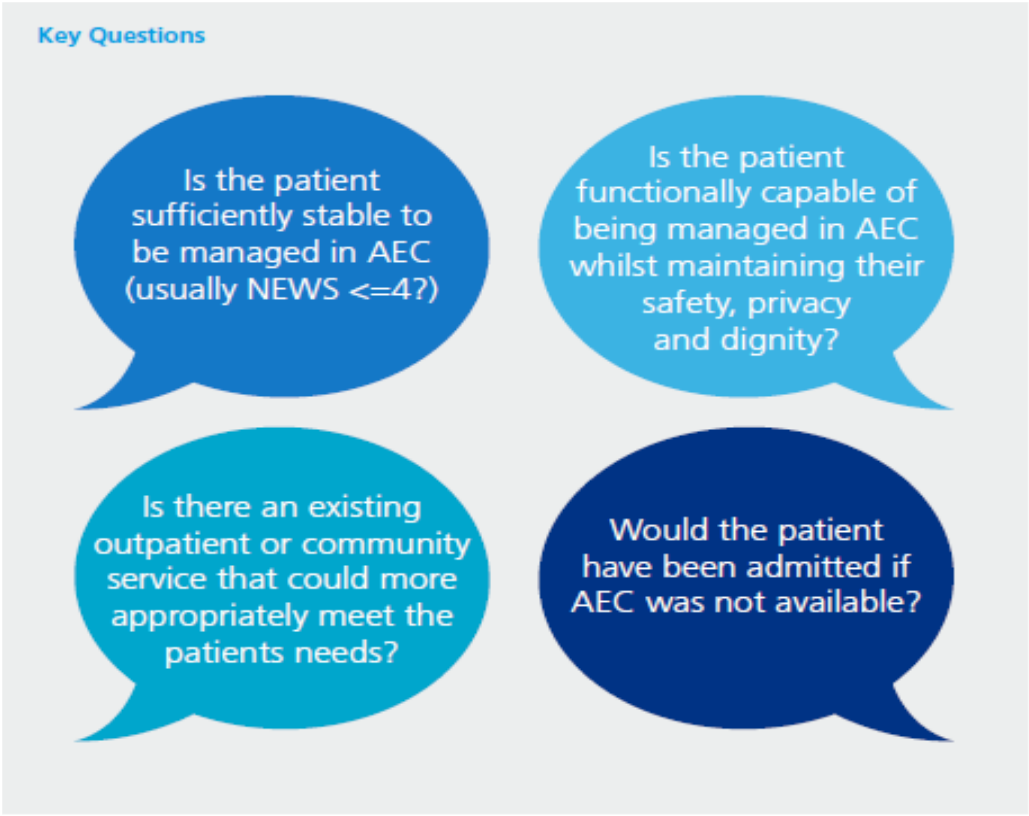






The Bible

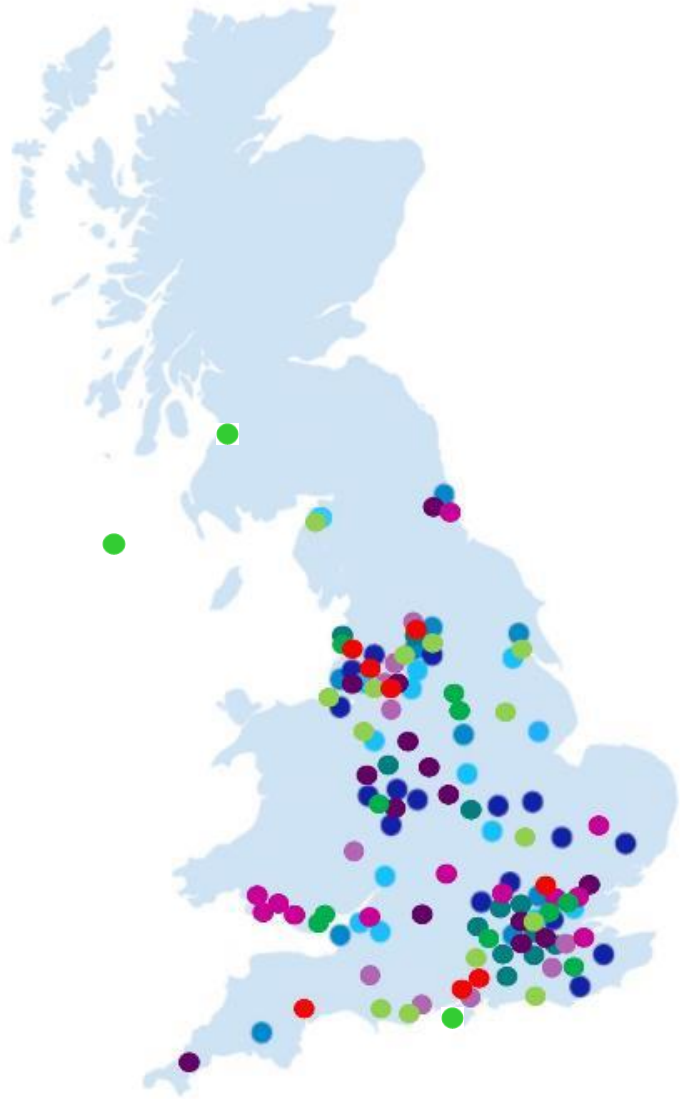

Version Six Updated February 2018, with 2017/19 HRG4+ Codes
NHS
Ambulatory Emergency Care Network
Contains updated surgical section with new clinical scenarios
Directory of Ambulatory Emergency Care for Adults
Click here to get started
Previous version August 2016

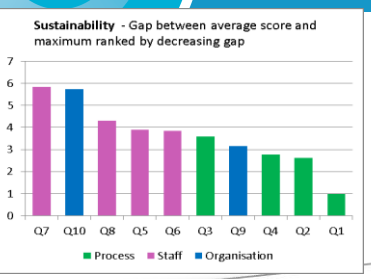

Key Questions
Is the patient sufficiently stable to be managed in AEC (usually NEWS <=4?)
Is the patient functionally capable of being managed in AEC whilst maintaining their safety, privacy and dignity?
Is there an existing outpatient or community service that could more appropriately meet the patients needs?
Would the patient have been admitted if AEC was not available?

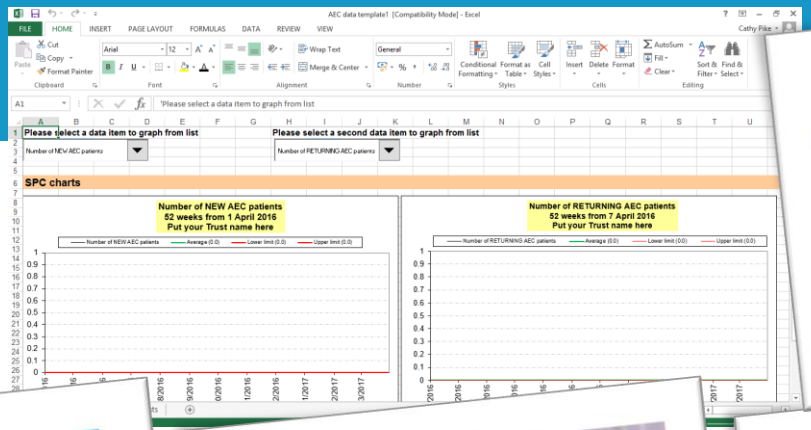
At the heart of it

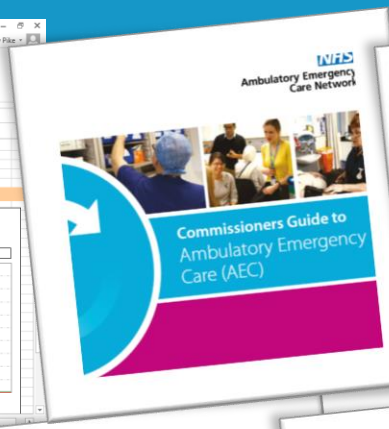
- **Culture** – the enthusiasm and belief that SDEC offers a timely, high-quality clinical service
- **Communication** – early provision of accurate information for patients
- **Staffing** – clinical staff providing high-quality clinical assessments; this is best delivered by senior doctors (usually consultants) and senior nurses as nurse practitioners with clinical and prescribing skills
- **Collaboration** – this is related to culture, and describes how the AEC service links with referral departments (ED and primary care), diagnostics and specialist services
- **Location** – co-location of AEC services with an ED or acute medical unit (AMU) improves collaborative working with the AEC team, with a reported increase in throughput of 50%
- **Facilities** – this will vary depending on the number of patients and the case mix
- **Partners** – including the wider healthcare system (eg community services, local authorities and social services) in the planning and organisation of AEC to meet the needs of older patients.

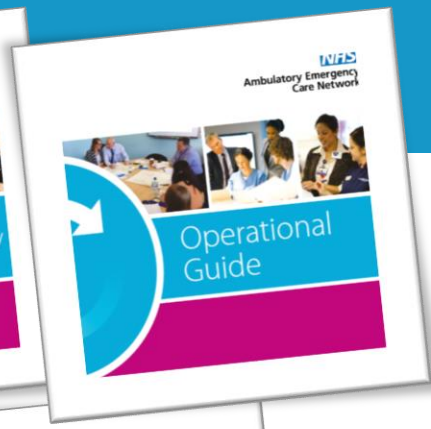
Starting small tests of change




Sustainability - Gap between average score and maximum ranked by decreasing gap
7
6
5
4
3
2
1
0
Q7
Q10
Q8
Q5
Q6
Q3
Q9
Q4
Q2
Q1
Process
Staff
Organisation


AEC data template1 [Compatibility Mode] - Excel
Please select a data item to graph from list
Please select a second data item to graph from list
SPC charts
Number of NEW AEC patients
52 weeks from 1 April 2016
Put your Trust name here
Number of RETURNING AEC patients
52 weeks from 7 April 2016
Put your Trust name here

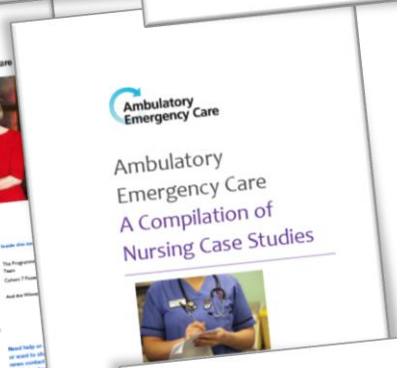

NHS
Ambulatory Emergency Care Network
Commissioners Guide to
Ambulatory Emergency Care (AEC)


NHS
Ambulatory Emergency Care Network
Operational Guide


Ambulatory Emergency Care
NHS Elect
Directory of Ambulatory Emergency Care for Adults
Click here to get started

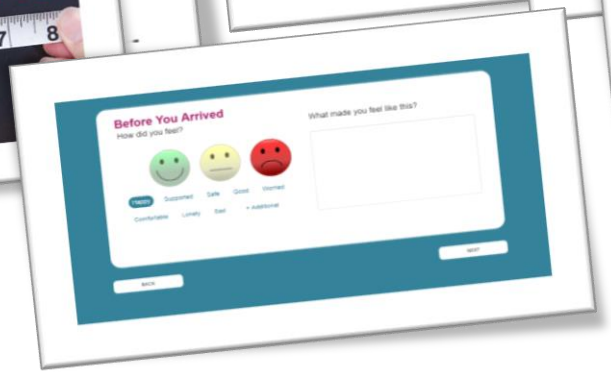

Ambulatory Emergency Care
We work with healthcare teams across England & Wales


AEC: Cohort 7 Special Edition Newsletter March 2016
Caroline Dove, CEO, NHS Elect


Ambulatory Emergency Care
Ambulatory Emergency Care
A Compilation of Nursing Case Studies

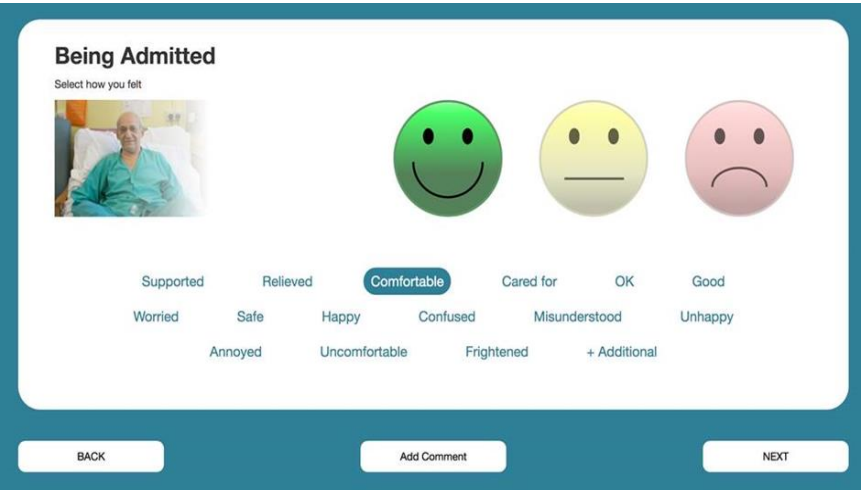

NHS
Surgical Ambulatory Emergency Care Network
Surgical Ambulatory Emergency Care Network Toolkit

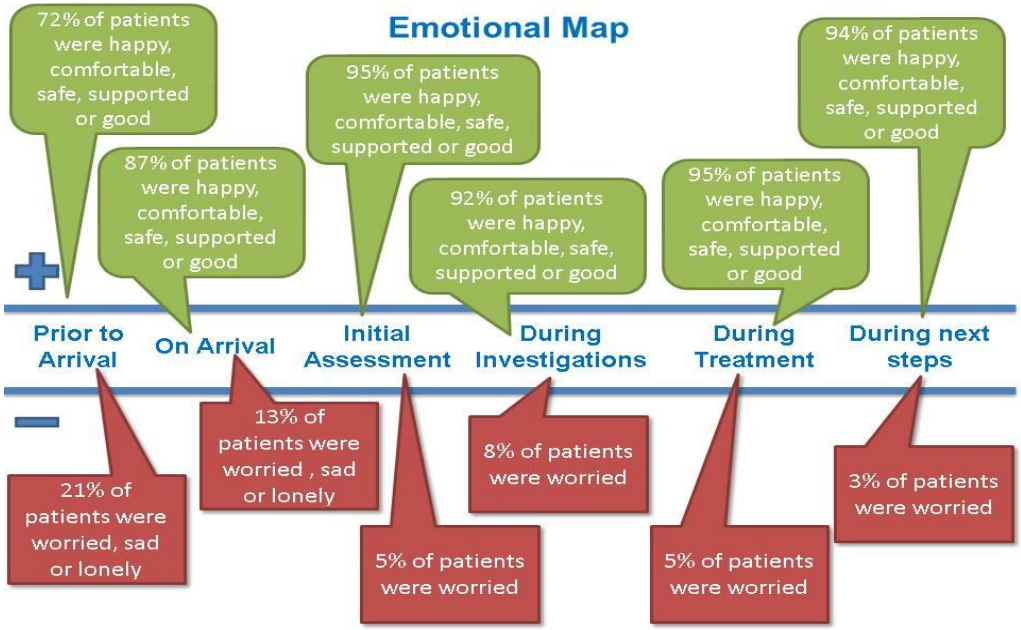

NHS Elect
Guide to Measurement for Improvement


Before You Arrived
How did you feel?
What made you feel like this?


Ambulatory Emergency Care
Ambulatory Emergency Care
A Compilation of "Best Practice" Case Studies
case study

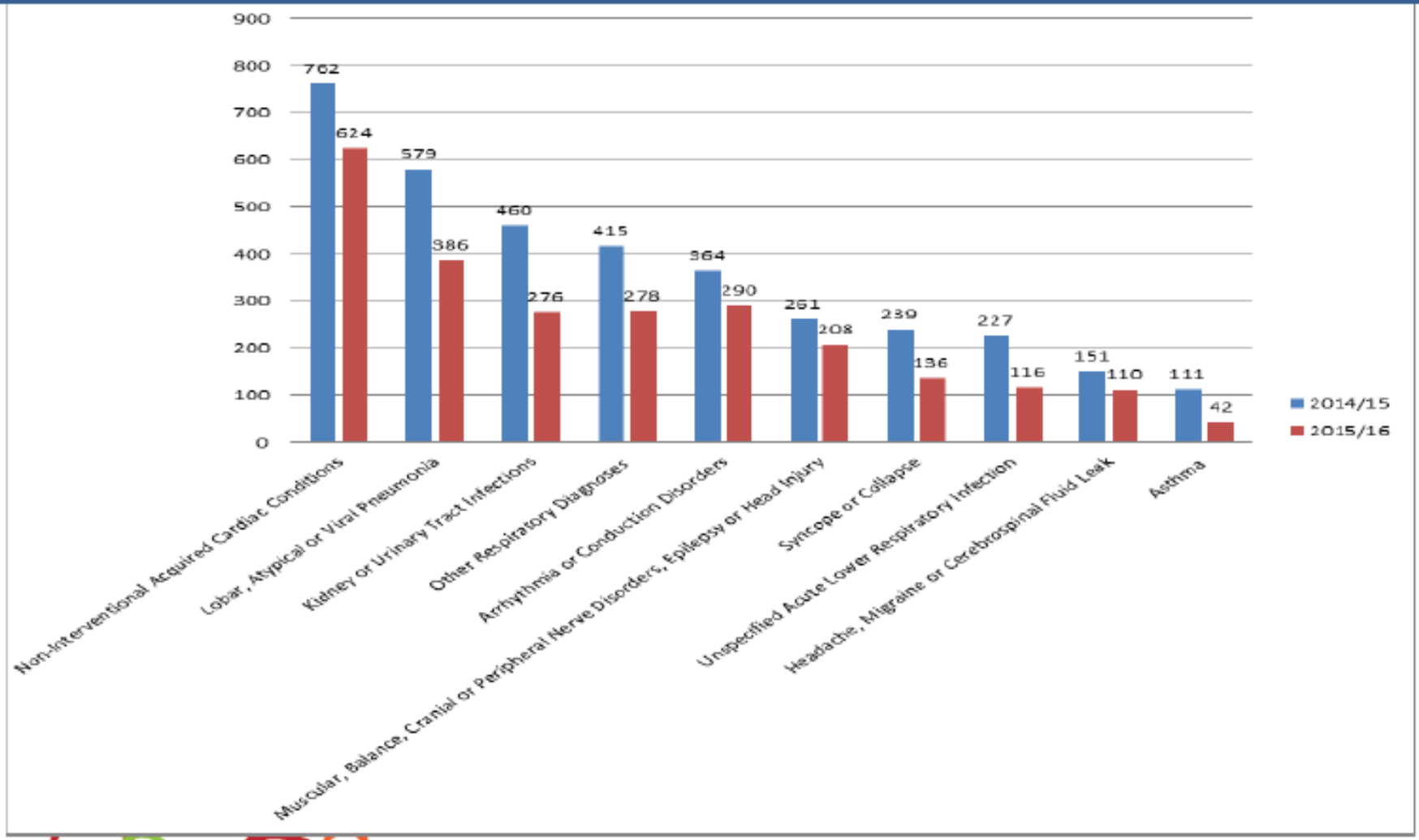
Co-design with patients

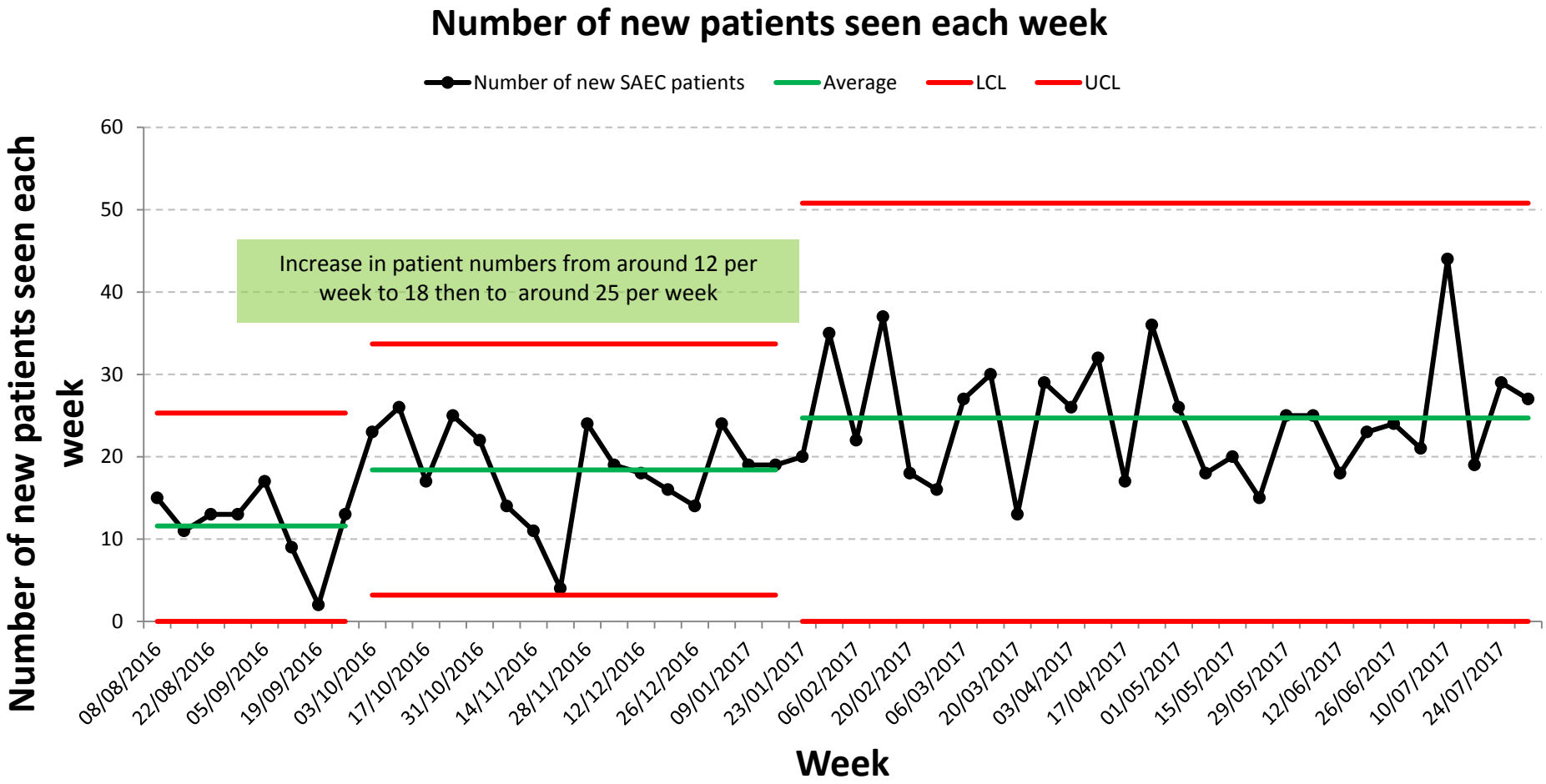




South Warwickshire NHS
NHS Foundation Trust

AEC - Reduction in the number of admissions by condition




Number of new patients seen each week
Number of new SAEC patients
Average
LCL
UCL
Increase in patient numbers from around 12 per week to 18 then to around 25 per week
Number of new patients seen each week
Week
60
50
40
30
20
10
0
08/08/2016
22/08/2016
05/09/2016
19/09/2016
03/10/2016
17/10/2016
31/10/2016
14/11/2016
28/11/2016
12/12/2016
26/12/2016
09/01/2017
23/01/2017
06/02/2017
20/02/2017
06/03/2017
20/03/2017
03/04/2017
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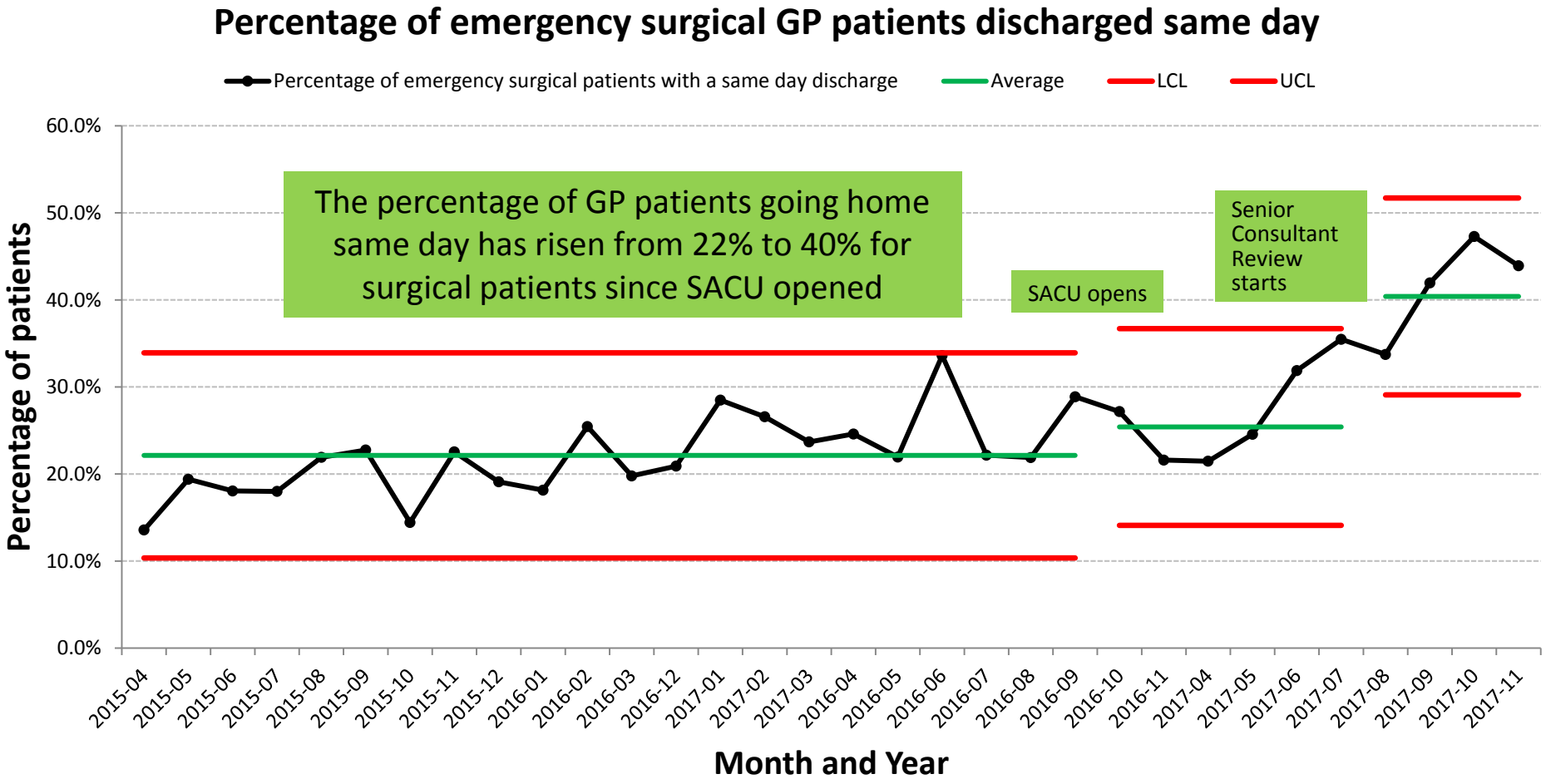
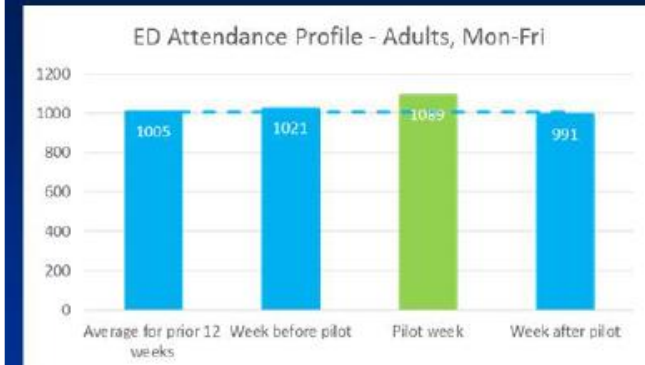
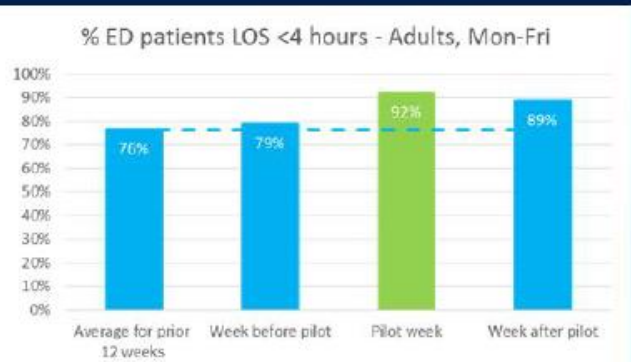
29/05/2017
12/06/2017
26/06/2017
10/07/2017
24/07/2017

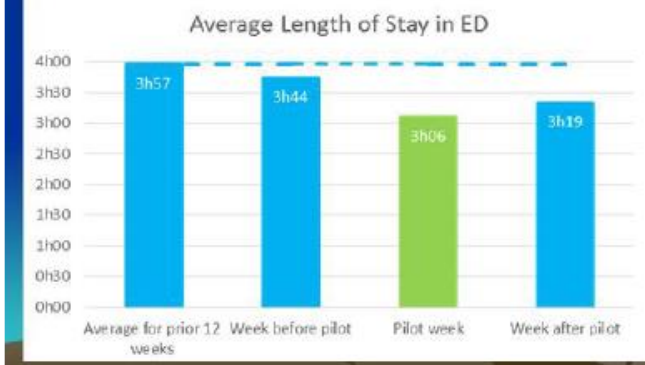

Percentage of emergency surgical GP patients discharged same day
Percentage of emergency surgical patients with a same day discharge
Average
LCL
UCL
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
Percentage of patients
The percentage of GP patients going home same day has risen from 22% to 40% for surgical patients since SACU opened
SACU opens
Senior Consultant Review starts
2015-04
2015-05
2015-06
2015-07
2015-08
2015-09
2015-10
2015-11
2015-12
2016-01
2016-02
2016-03
2016-12
2017-01
2017-02
2017-03
2016-04
2016-05
2016-06
2016-07
2016-08
2016-09
2016-10
2016-11
2017-04
2017-05
2017-06
2017-07
2017-08
2017-09
2017-10
2017-11
Month and Year

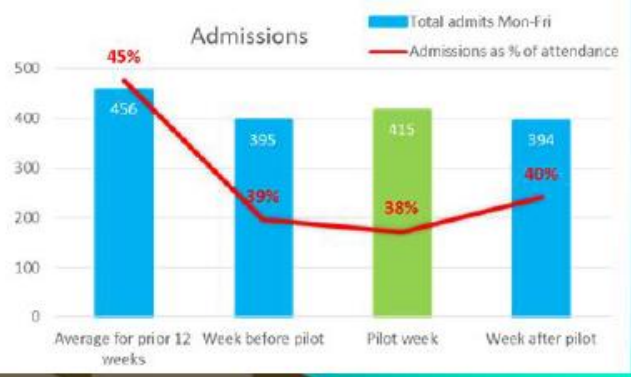
Impact on The Hospital

Barts Health NHS
NHS Trust





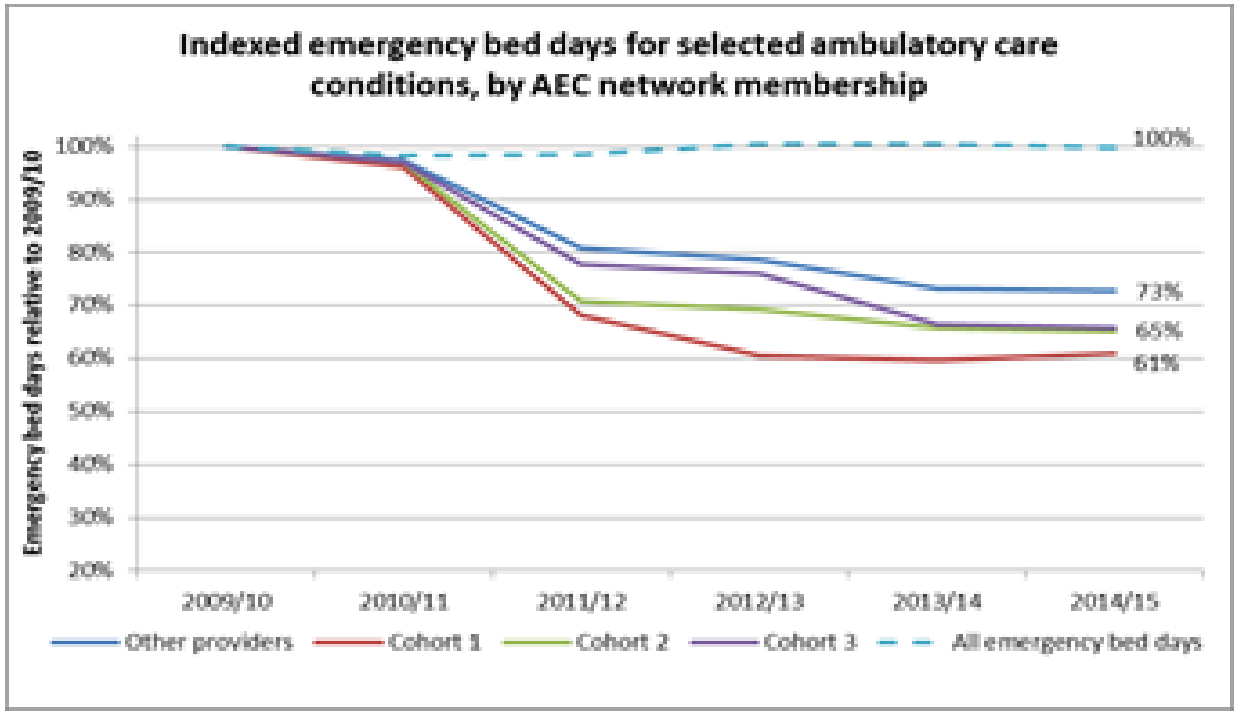




evidence for
better health care

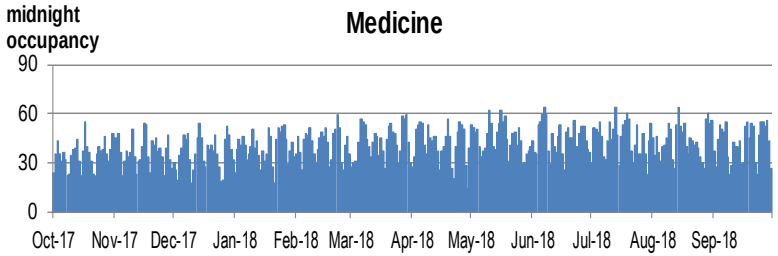
nuffieldtrust

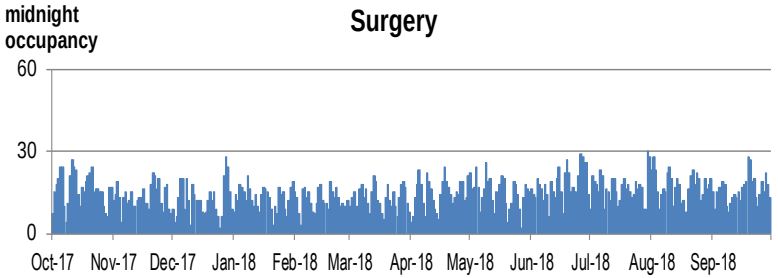
Results – Change in bed days by analysis cohort



Ambulatory care - If 50% attends were admitted for 24 hours and 50% admitted for 48 hours…

Northumbria Healthcare NHS Foundation Trust





63 medicine beds

27 surgery beds

85 co-located beds

*based on activity in the period Oct-17 to Sep-18; 90% occupancy levels; no. of beds sufficient on 95% of nights in the period

108 wte nurses

£6m ward costs

building a caring future

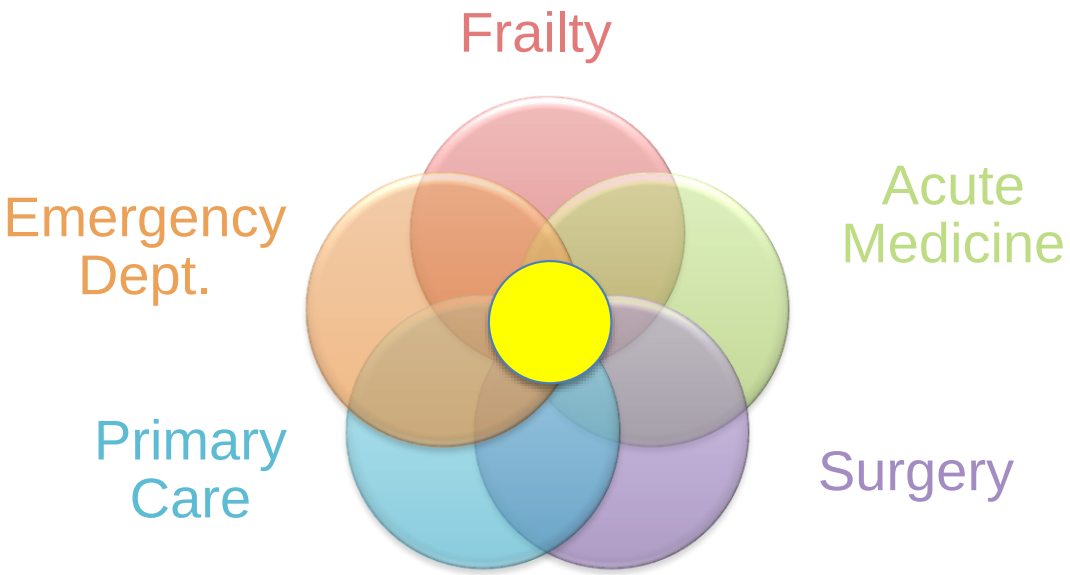
HOSPITAL | COMMUNITY | HOME

High performance of AEC Units

- 82.2% (all 84.1%) of patients had EWS < 30 minutes of arrival
- 95% (all 91.6%) of patients reviewed < 4 hours
- 73.8% (all 62.8%) of patients requiring consultant review were seen <12 hours after arrival

- Senior clinical input is needed at the point of referral, to redirect suitable patients to ambulatory care.
- Clear exclusion criteria based on the National Early Warning Score (NEWS2) should be developed to maximise patient flow to ambulatory care.
- Where possible, the SDEC service should be located close to ED.
- Staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the same
- The time standards in SDEC should match the clinical quality indicators for ED
- Patients should be informed early in their journey (ideally in the ED or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight, to manage their expectations and those of their family.
- Secondary and primary care services should be geared around patient needs and work together to provide ongoing care outside of hospital, to avoid a full admission.
- day.
- Staff training is needed across the local healthcare system to ensure that appropriate patients are streamed to ambulatory care.
- Comprehensive records must be kept and discharge summaries sent to primary care within 24 hours.
- Providers must work with commissioners to agree how SDEC activity will be recorded, reported and funded.
- Clear measures must be adopted and monitored to assess the impact, quality and efficiency of the service.

AEC = The Bright Spot



Thank you for listening

vincent.connolly@nhs.net

deborah.thompson17@nhs.net

AEC at NHS Elect
Suite 2, Adam House
7-10 Adam Street
London, WC2N 6AA

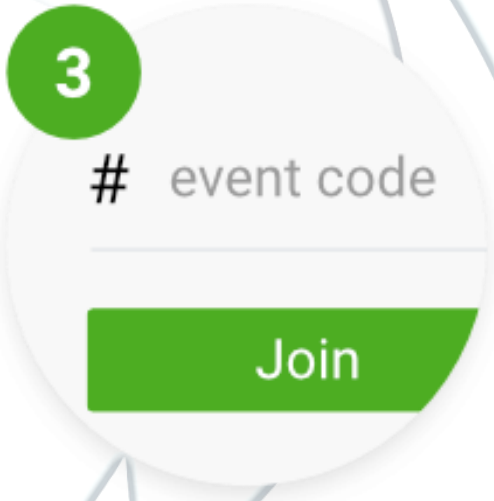
Tel: 020 7520 9088
Email: aec@nhselect.org.uk
www.ambulatoryemergencycare.org.uk

Slido Event Evaluation

Access our event evaluation in 3 easy steps

1. Go to any web browser from any device

2. Go to slido.com



3. Type in the event code **#SDEC190619**

Wants and Offers

- Think about what you '***want***' to know about AEC and the knowledge you have to '***offer***' about developing AEC services
- On **red** card write down what you would like to know about AEC
- On **green card** write down what you can offer – make sure you also print your name on the card as we may ask you to share your offer in the next session
- Once you have completed your cards leave them on your tables and then off to lunch!
- We will share our knowledge in the next session

Where's SDEC?

Tom Hughes
Consultant / Hon Sen. Lecturer in EM,
John Radcliffe Hospital, Oxford
Clinical Lead for ECDS

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

Emergency Care Data Set

Urgent & Emergency Care “Flying Blind”

- Commons Health Select Committee 2013

- Started 2015
- Finished 2019

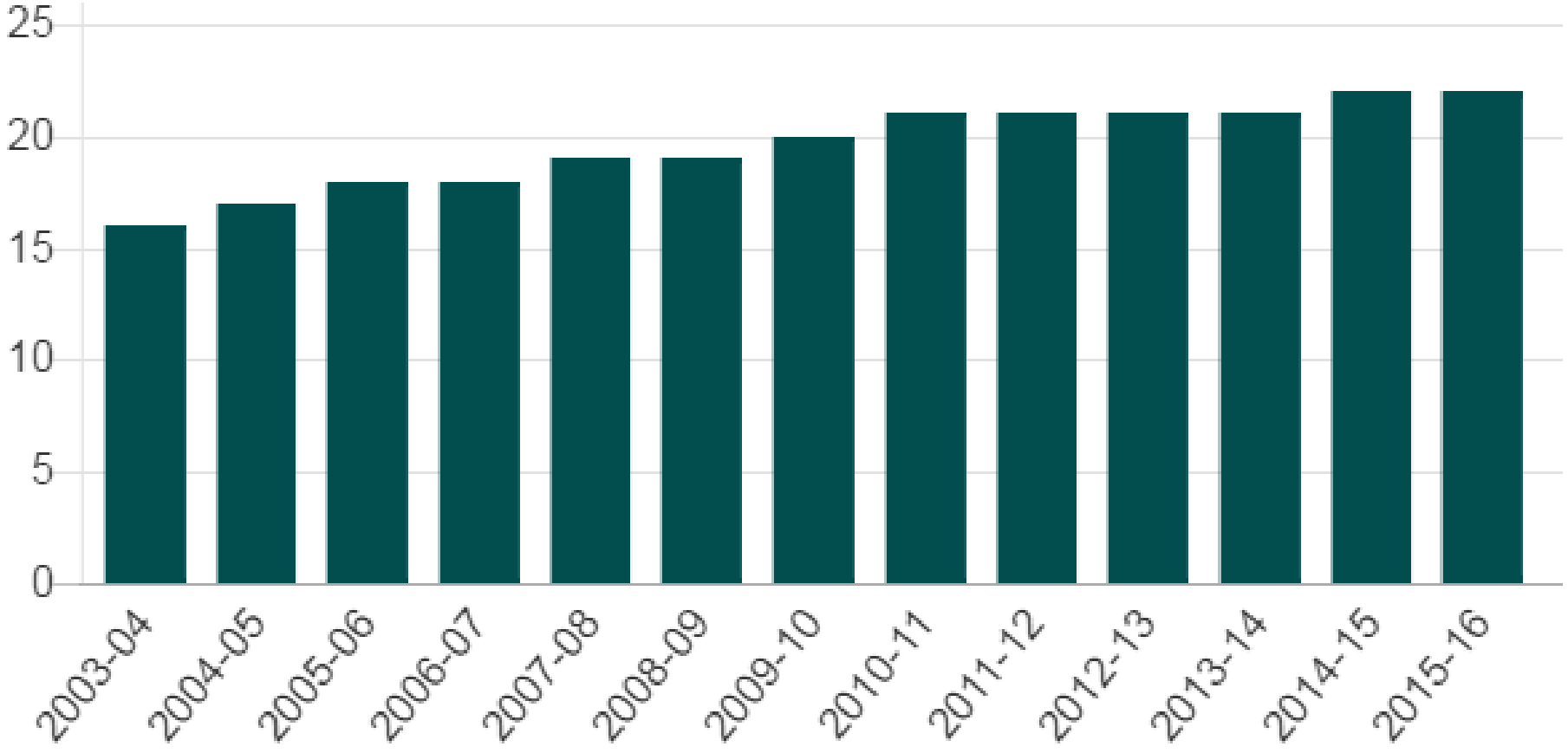
Approx. 200 Type 1 / 2 EDs [+ UTCs]

40 different IT suppliers


KKG 27P

Increasing demand for urgent treatment

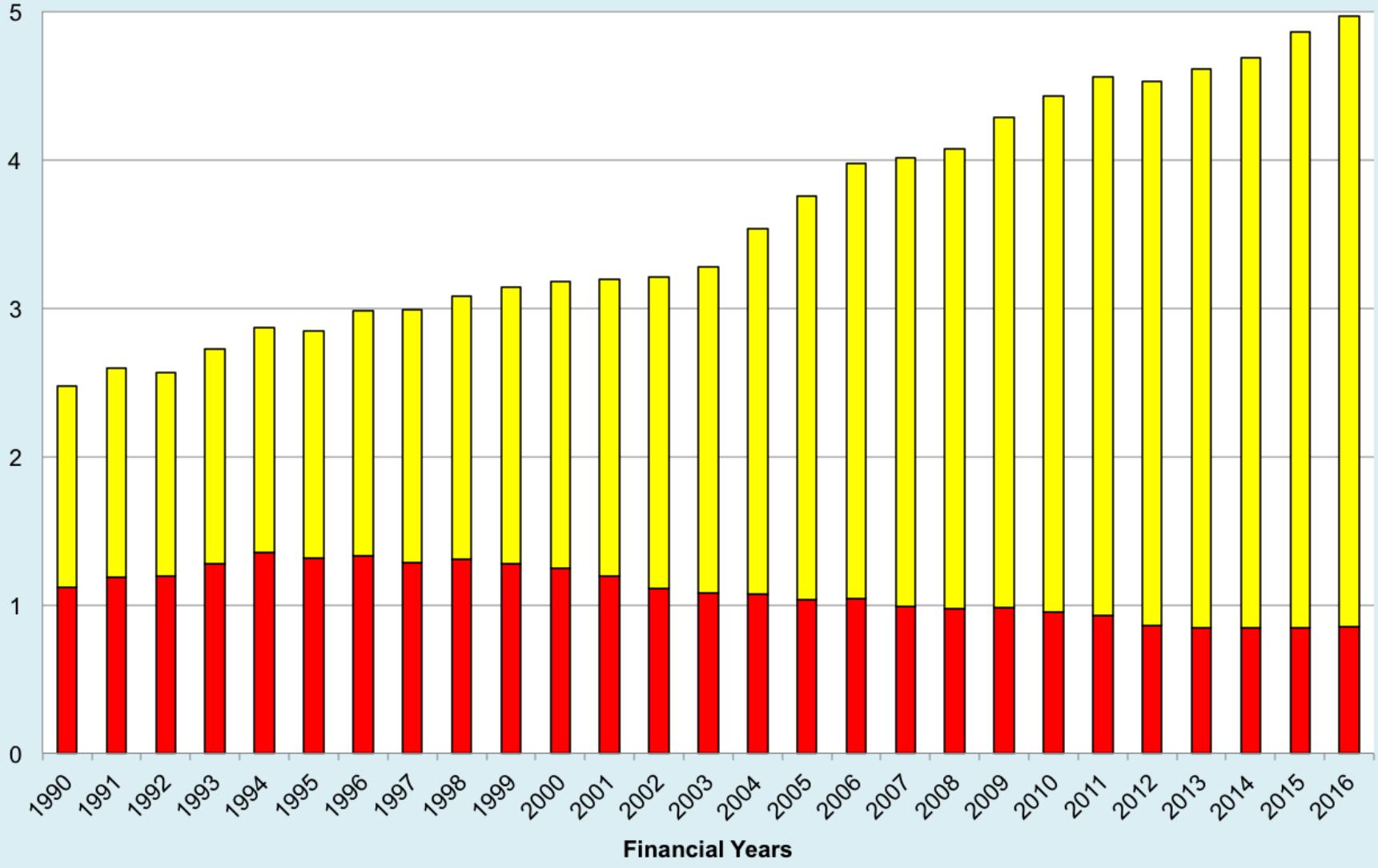
Visits to A&E in England (in millions)



Source: IFS

BBC

NHS Hospital Emergency Admissions [millions patients] from Emergency Department (yellow) vs GP (red)



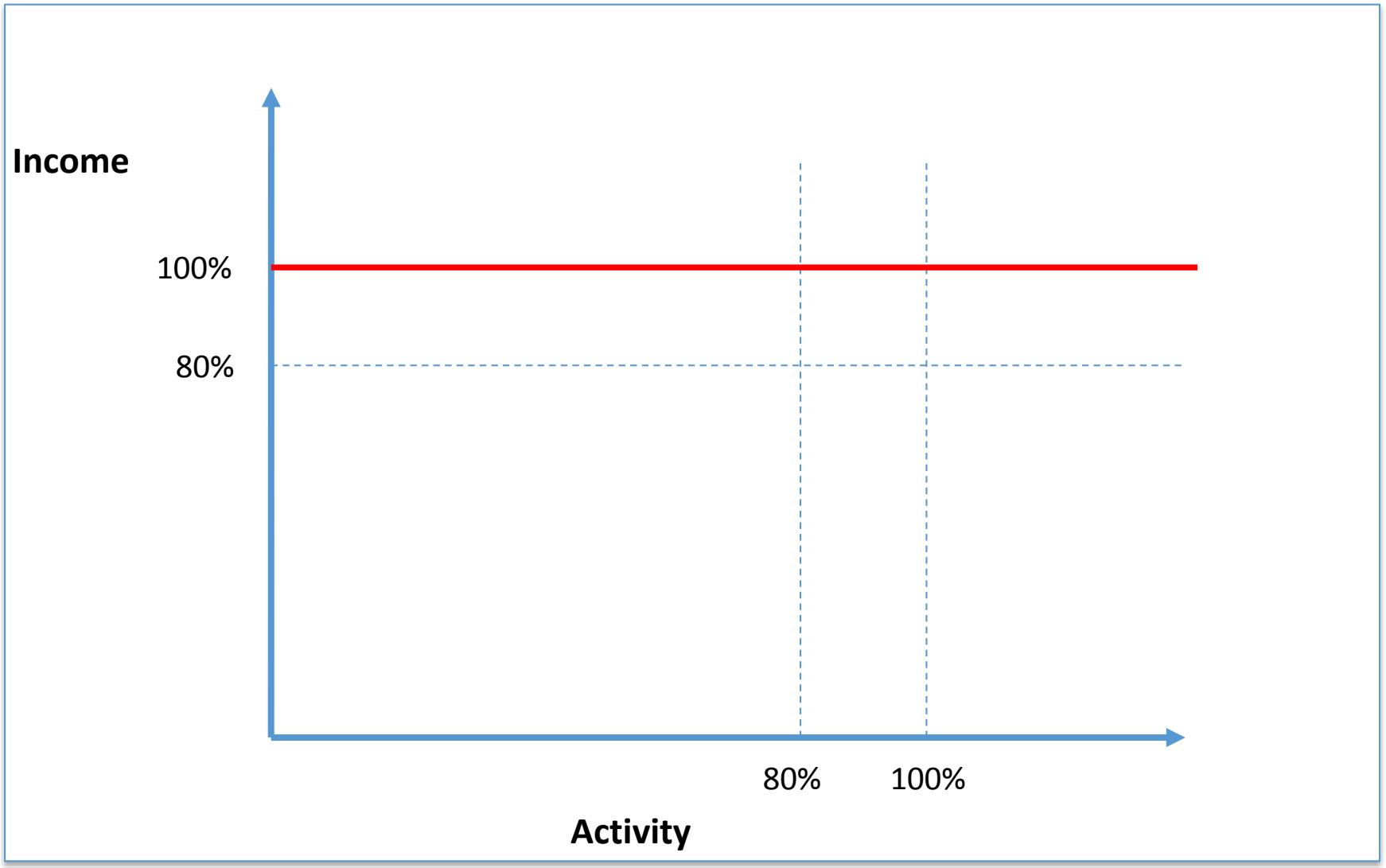
SDEC / AEC history

- Best Practice Tariff 2012-19
  - Now Blended Payment

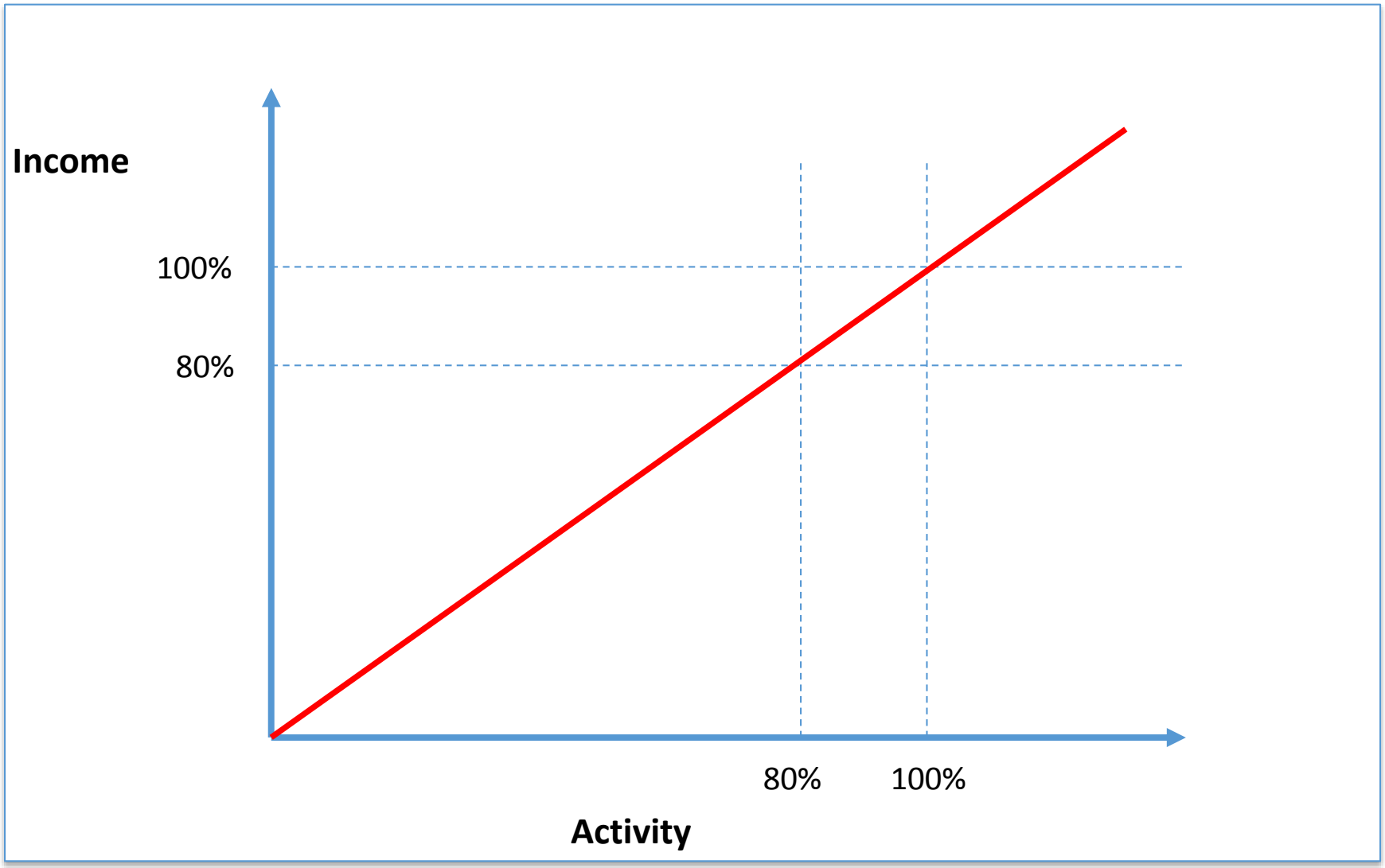
Aims

- Incentives for defined conditions
- Move to process driven SDEC

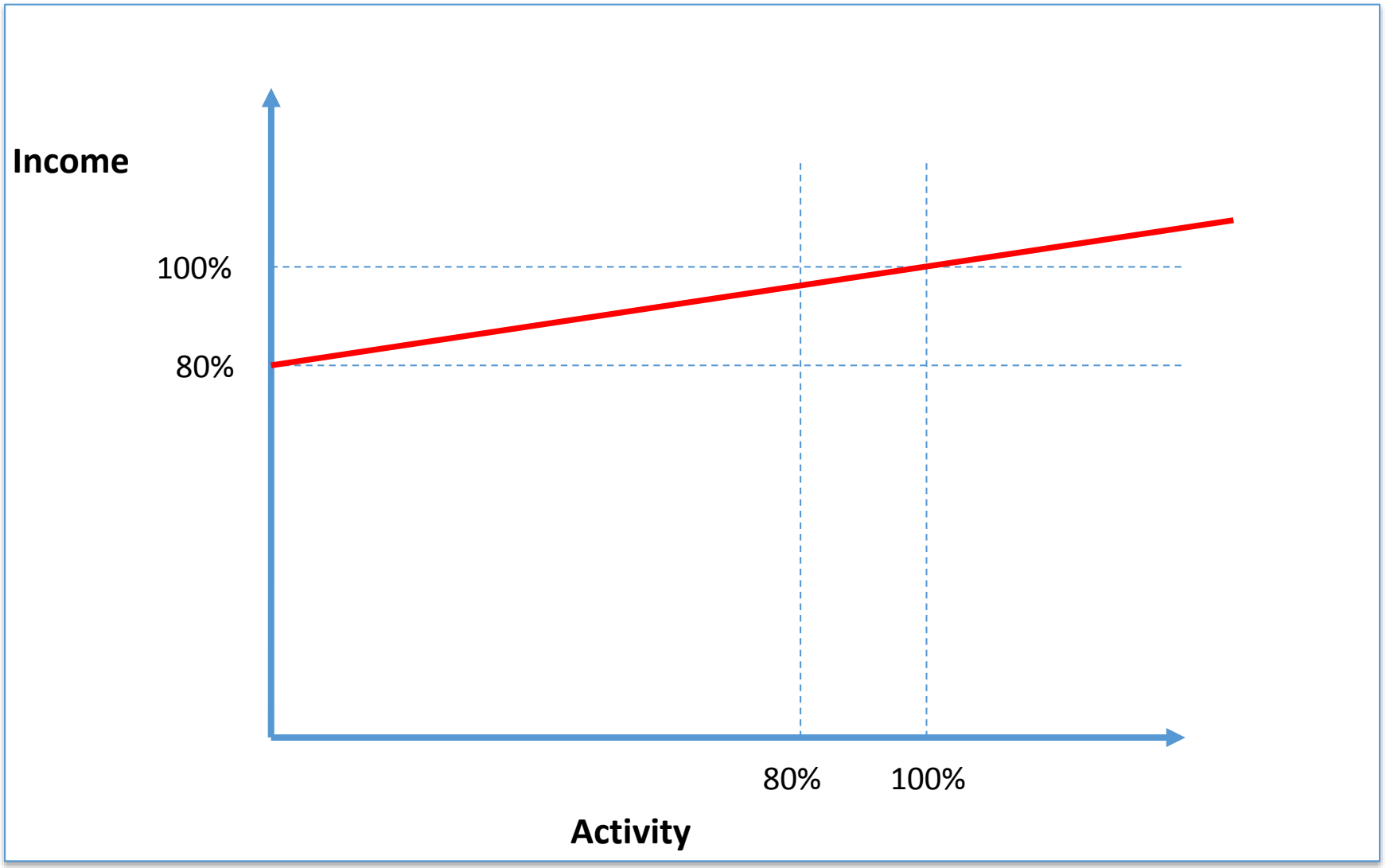
Block Tariff



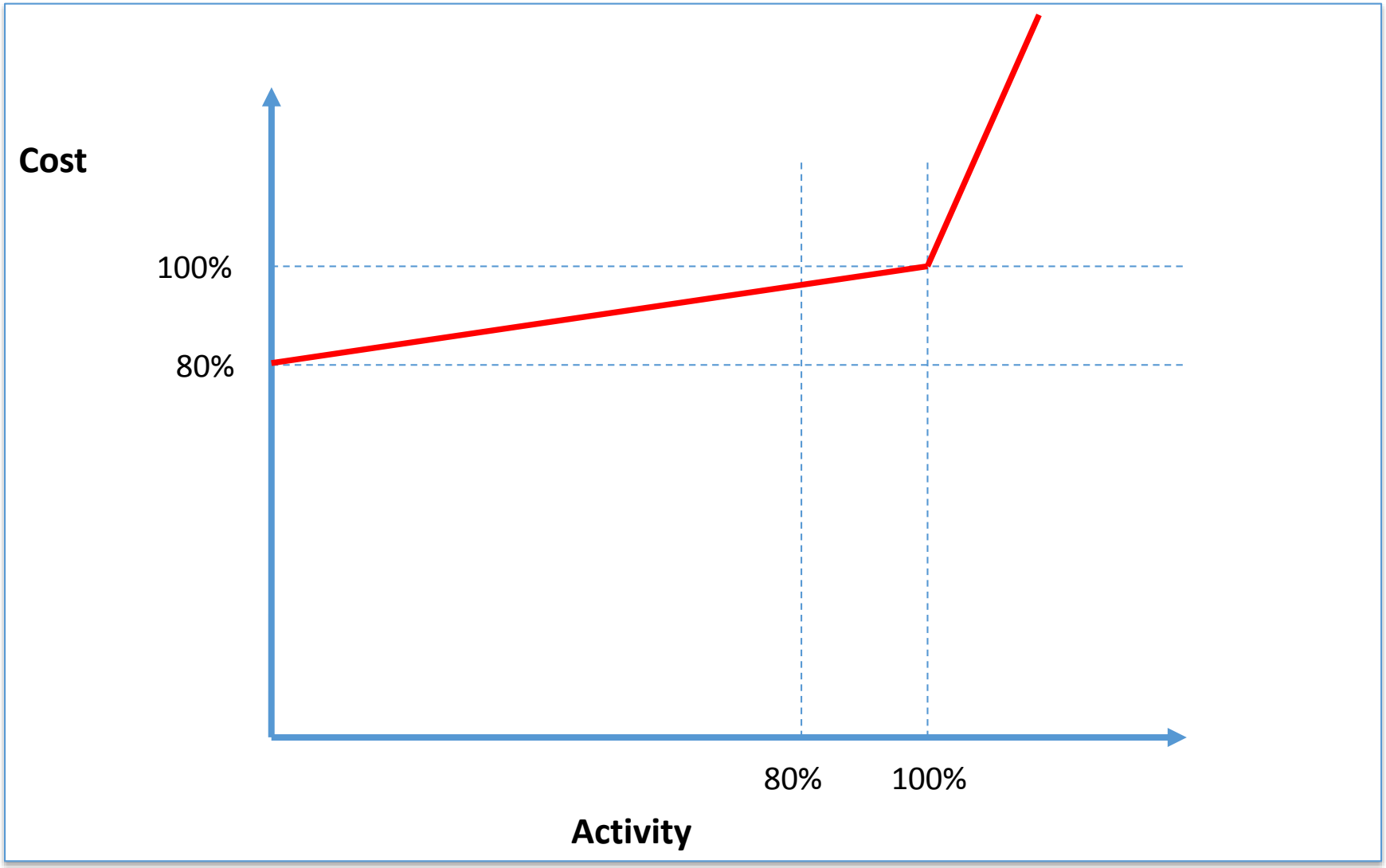
PbR Tariff (HRGs = DRGs)



Blended payment



Cost to provider / staff / patient



Best Practice Tariff

- Variable take up
- ? Level of activity
- ? All SDEC recorded
- BPT not claimed
  - Local arrangements – recorded as OP/ ED
  - Block tariff

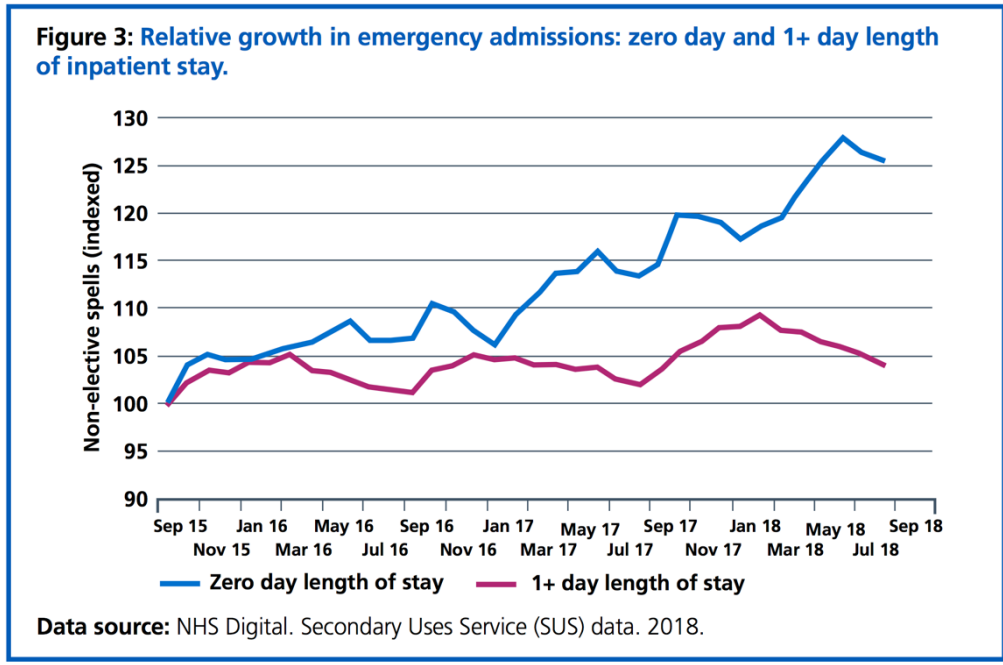
OR

  - Not doing SDEC

Success ?

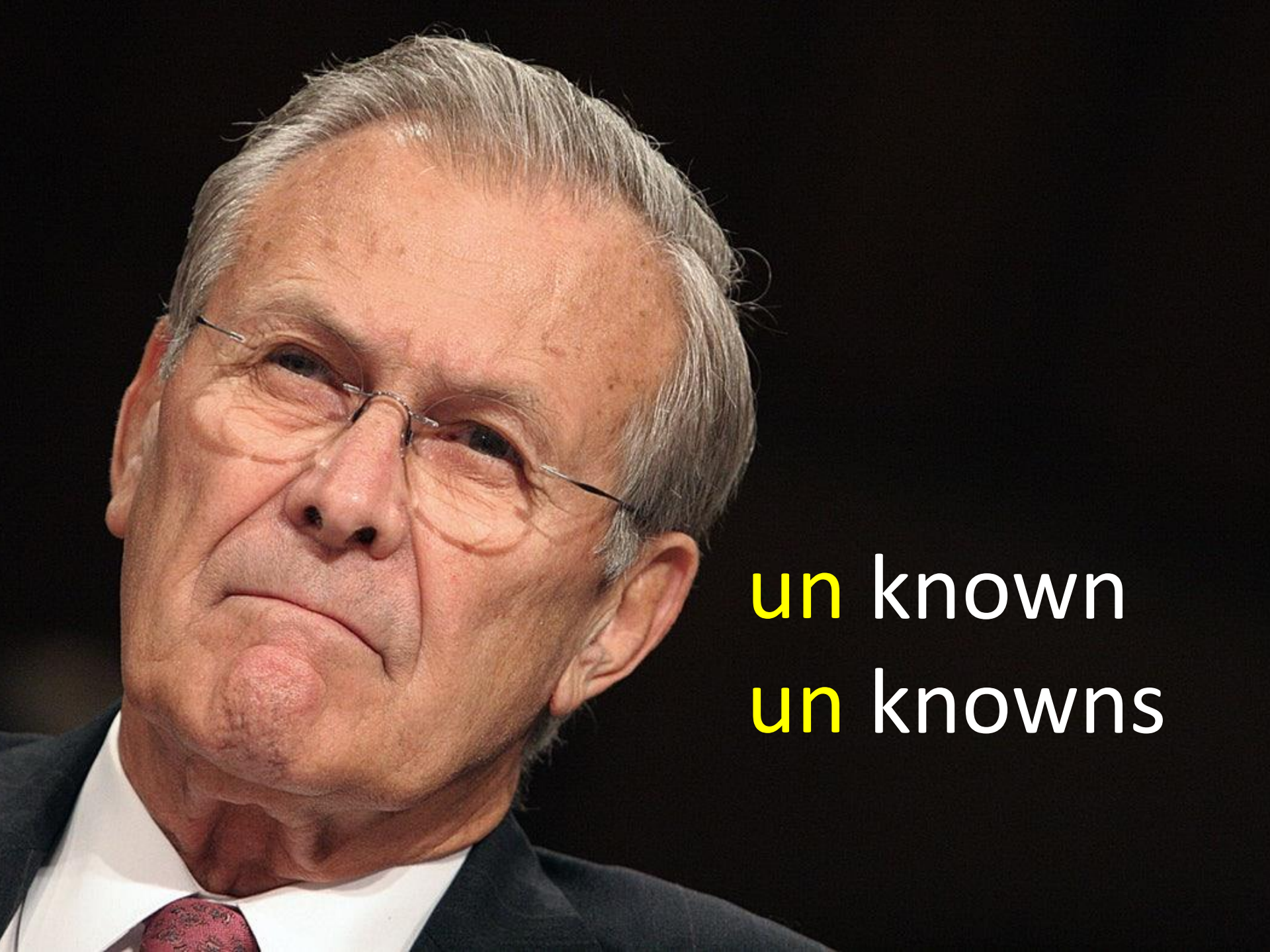
Zero Day LoS

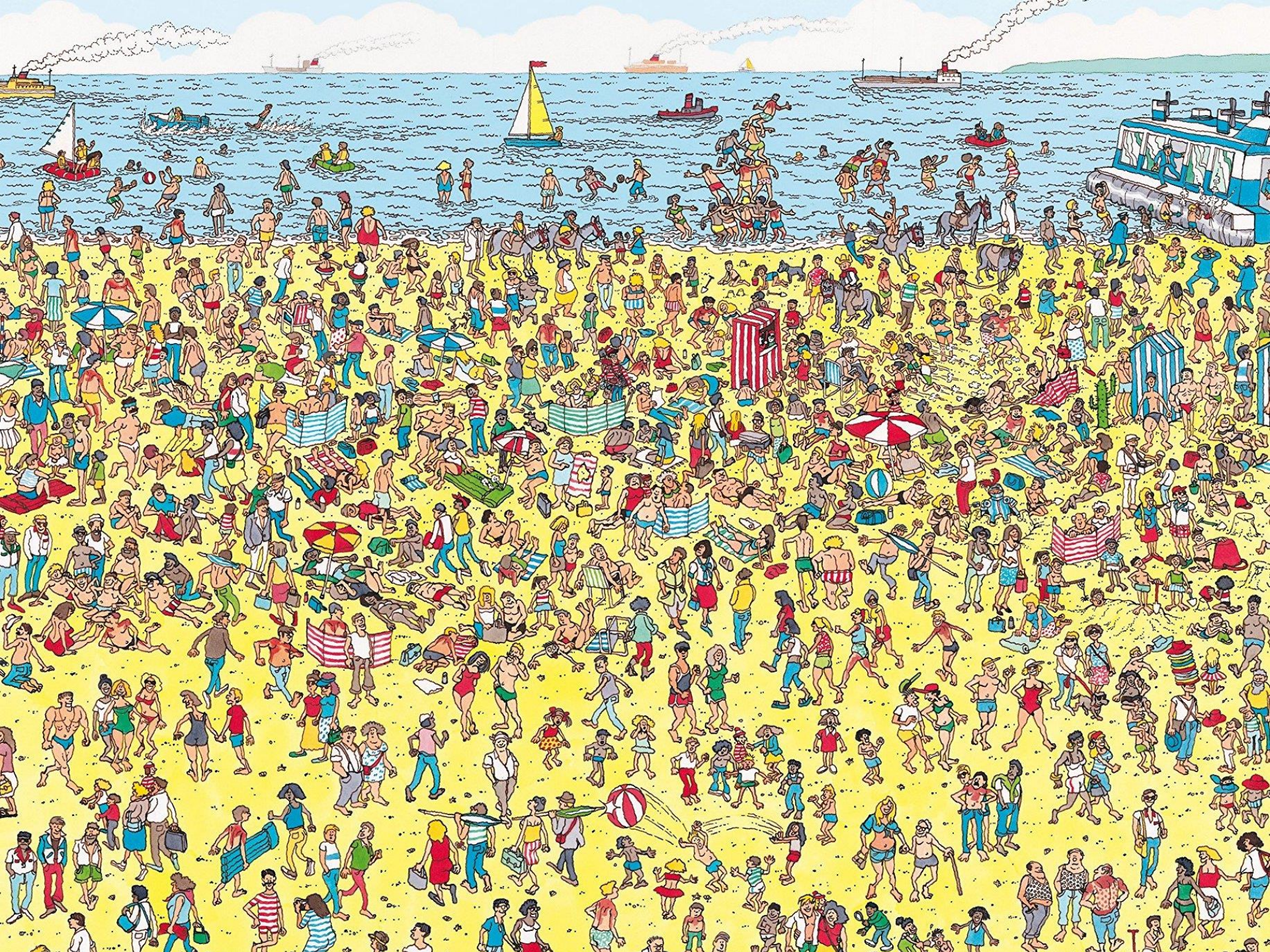
^ 9.6%

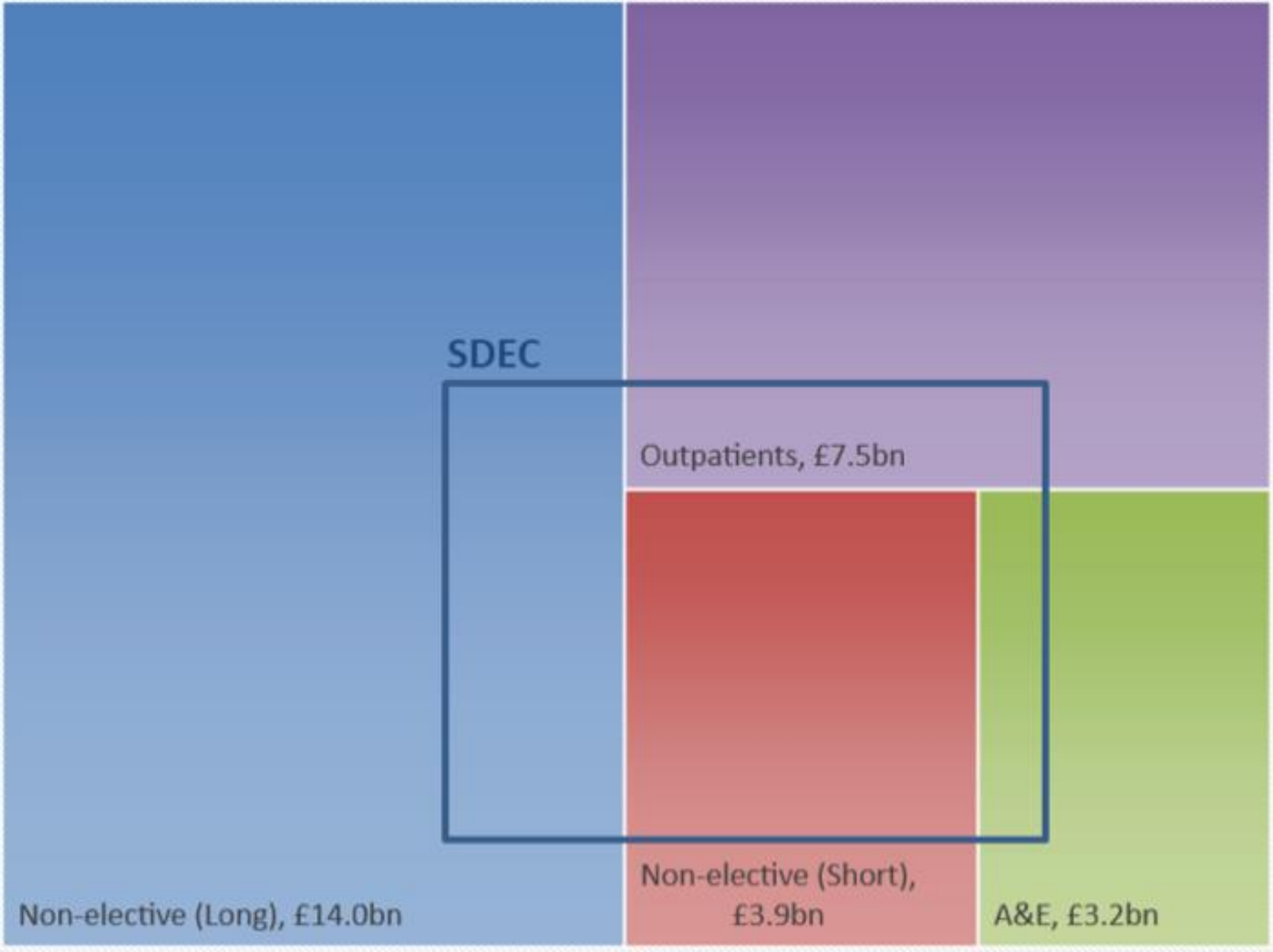


- ? Zero / Low value-added SDEC
- ? High value-added SDEC
- ? Gaming
- ? Breach avoidance

Expanding rapidly, we don't know why


un known
un knowns




SDEC
Outpatients, £7.5bn
Non-elective (Short), £3.9bn
A&E, £3.2bn
Non-elective (Long), £14.0bn

Why not use ECDS for SDEC?

- Baked in from the start
  - Worked with AEC Network
- Includes the Best Practice Tariff items

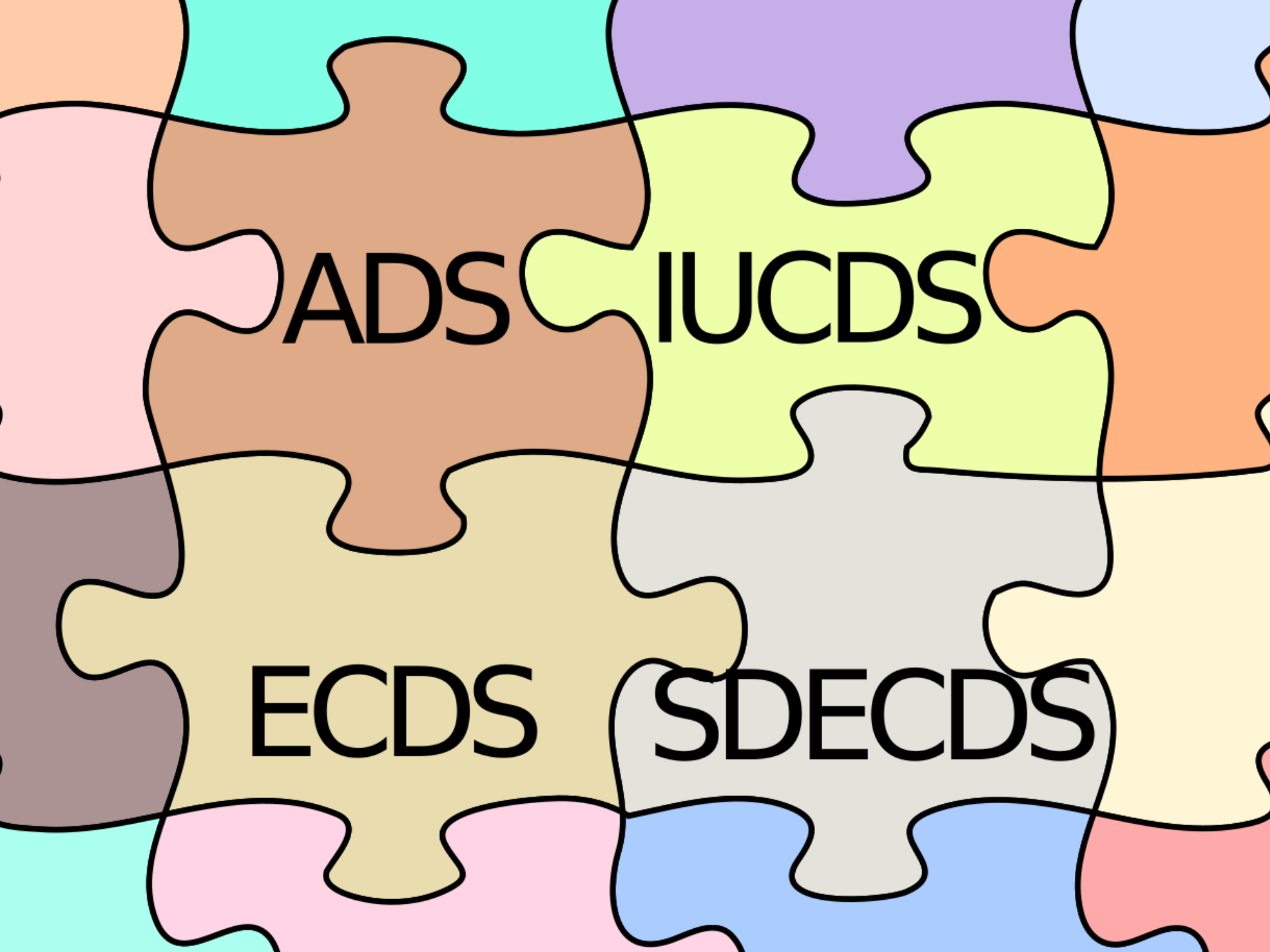
- Time based, milestones
- Input & Output metrics
  - Chief Complaint & Acuity
  - Diagnosis & Suspected / Confirmed

Changing to ECDS / SDECDS

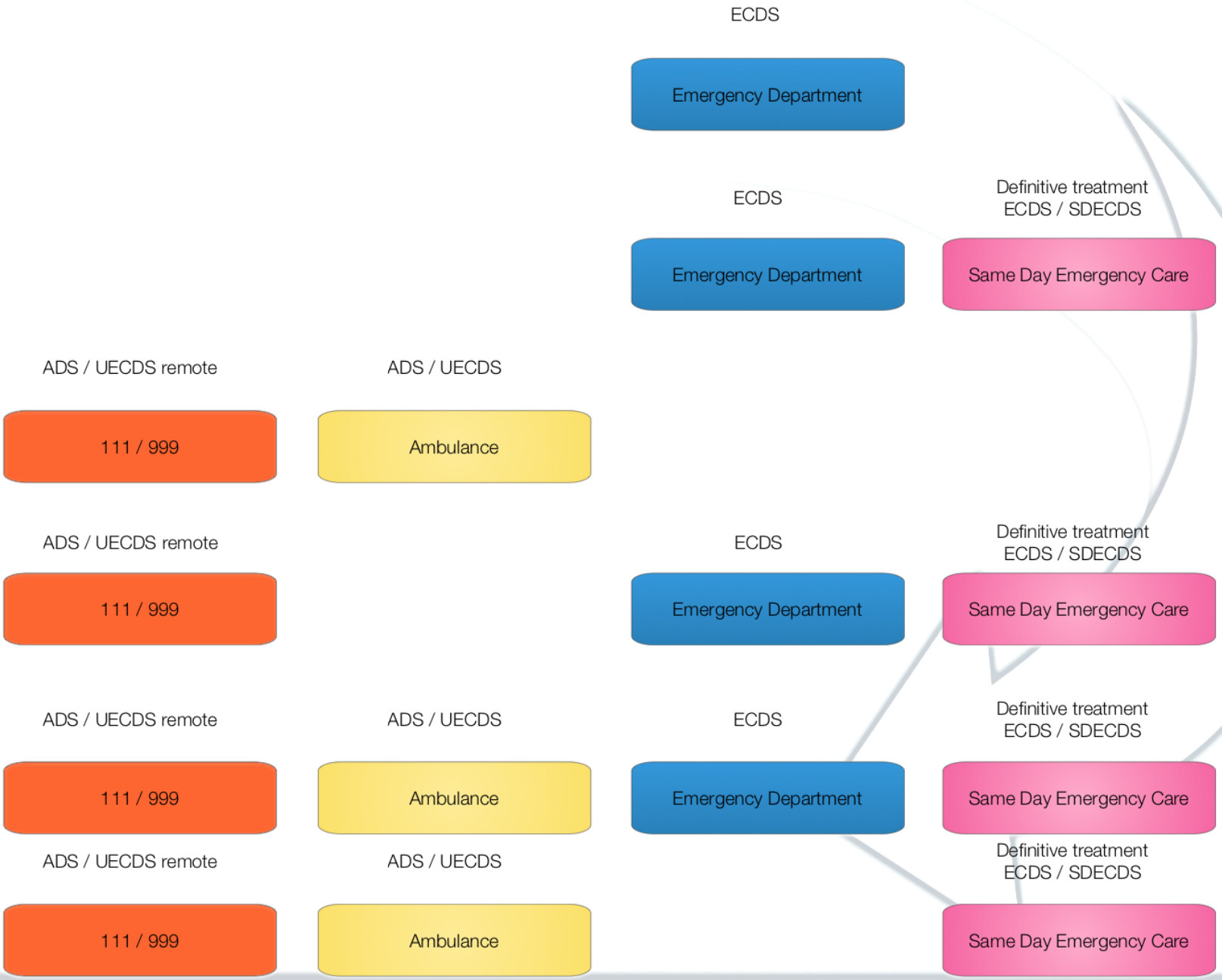
Is the existing data

- Valid ?
  - Does it measure SDEC accurately?
- Reliable ?
  - Is it consistent from provider to provider
- Available ?

The sky will not fall in if we change to ECDS


ADS
IUCDS
ECDS
SDECDS

Urgent and Emergency Care : Modular Data Set



Process Re-engineering

SDEC Short-term aims

- Count SDEC consistently
- Enable tariff – value-based commissioning
- Encourage centralisation / critical mass

SDEC Long-term aims

- Co-located with ED
- Flexible patient flow / staffing
- Process model vs. condition model

Where we are now

Piloting ECDS in SDEC – 10 Trusts

- First site live (Wexham Park)

Summary

1. The world has changed
    - Patients have changed
    - Can’t keep doing the same thing
2. Existing data
    - Not valid
    - Not reliable
    - Not available
3. We need a system that measures and rewards excellent SDEC patient care

"If you can't measure it, you can't improve it.”

Peter Drucker

Working together to Maximise SDEC at Pace
Rachel Vokes

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

Wants and Offers - Groups Available

Topic	Offer from
Measurement	Susanna Shouls
Recording and Reporting	Tom Hughes
ED	Baz Senn
Frailty	Deborah Thompson and Newcastle
SDEC Principles	Nick Scriven
National Priorities	Rachel Vokes/Cliff Mann

Wants and Offers - Sharing

- The ‘offers’ have been themed into groups
- Select a group – the owner of the ‘offer’ will share their experience for 2-3 minutes and then discuss
- A facilitator will take notes – the facilitator and ‘offer’ owner stay at the table for the duration of the session
- 15 minutes per round and move on to the next table

- ***Move on when time is up***

- ***At the end Facilitators will feedback 2 points each***

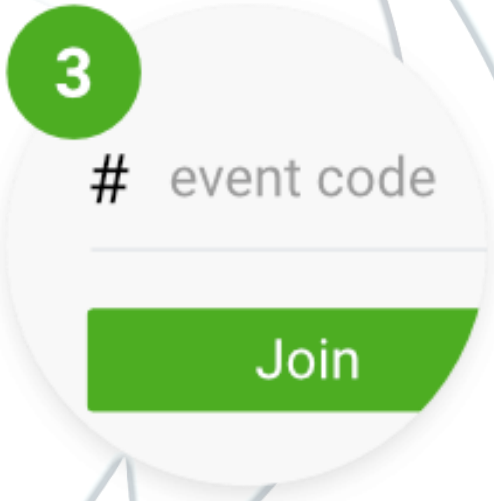

IT IS LUNCH TIME

Slido Event Evaluation

Access our event evaluation in 3 easy steps

1. Go to any web browser from any device

2. Go to slido.com



3. Type in the event code **#SDEC190619**

AEC in Emergency Care

Dr Cliff Mann

National Clinical Advisor

Co-Chair SDEC Programme Board

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

Key points

EM and SDEC

Frailty and SDEC

"I call it 'zero'."

The Royal College of Emergency Medicine

The RCEM Ambulatory Emergency Care toolkit

Delivering same day emergency care from the ED

som on the moor

THE SOCIETY FOR ACUTE MEDICINE

10-11 October 2019
Harrogate Convention Centre

SDEC

AM

Diagnosis > Symptom

EM

Symptom > diagnosis

Table 1: The 12 most frequent diagnoses presenting to the CDU in 2012

Principal diagnosis	Number of patients admitted to the CDU
Chest pain; unspecified	219
Headache	177
Other chest pain	94
Unspecified head injury	82
Cellulitis of lower limb	78
Unspecified convulsions	73
Syncope and collapse	61
Paracetamol overdose	38
Loss of consciousness of brief duration (< 30 minutes)	37
Lumbar and other intervertebral disc disorders with radiculopathy	37
Migraine; unspecified	36
Low back pain	35

Last 1000 Days

65% of acute bed days are occupied by people over 65

65%

65+

75% of delayed discharge bed days are occupied by people over 75

75%

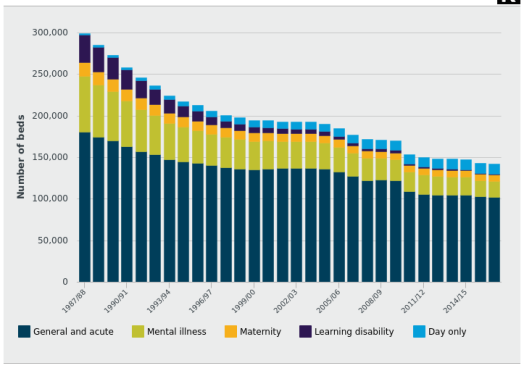
75+

100% projected increase in people over 85 between 2010 and 2030

100%

85+

Figure 4: Average number of beds available by category, 1987/8-2016/17

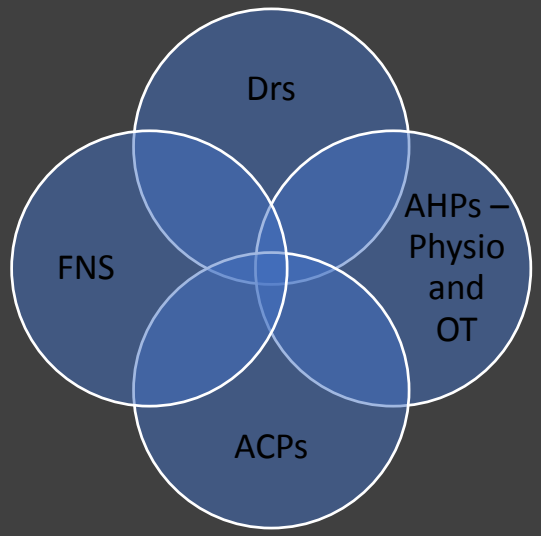


Source: NHS England 2017a

Note: The drop in bed numbers between 2009/10 and 2010/11 is likely to be attributable to a change in data-recording methodology between these years. This means comparisons across the period are subject to some uncertainty.

Why?

How to determine if frail



Clinical Frailty Scale*

1 **Very Fit** – People who are robust, active, energetic and motivated. These people commonly exercise regularly. They are among the fittest for their age.

2 **Well** – People who have **no active disease symptoms** but are less fit than category 1. Often, they exercise or are very **active occasionally**, e.g. seasonally.

3 **Managing Well** – People whose **medical problems are well controlled,** but are **not regularly active** beyond routine walking.

4 **Vulnerable** – While **not dependent** on others for daily help, often **symptoms limit activities.** A common complaint is being "slowed up", and/or being tired during the day.

5 **Mildly Frail** – These people often have **more evident slowing,** and need help in **high order IADLs** (finances, transportation, heavy housework, medications). Typically, mild frailty progressively impairs shopping and walking outside alone, meal preparation and housework.

6 **Moderately Frail** – People need help with **all outside activities** and with **keeping house**. Inside, they often have problems with stairs and need **help with bathing** and might need minimal assistance (cuing, standby) with dressing.

7 **Severely Frail** – **Completely dependent for personal care**, from whatever cause (physical or cognitive). Even so, they seem stable and not at high risk of dying (within ~ 6 months).

8 **Very Severely Frail** – Completely dependent, approaching the end of life. Typically, they could not recover even from a minor illness.

9. **Terminally Ill** - Approaching the end of life. This category applies to people with **a life expectancy <6 months**, who are **not otherwise evidently frail.**

Scoring frailty in people with dementia

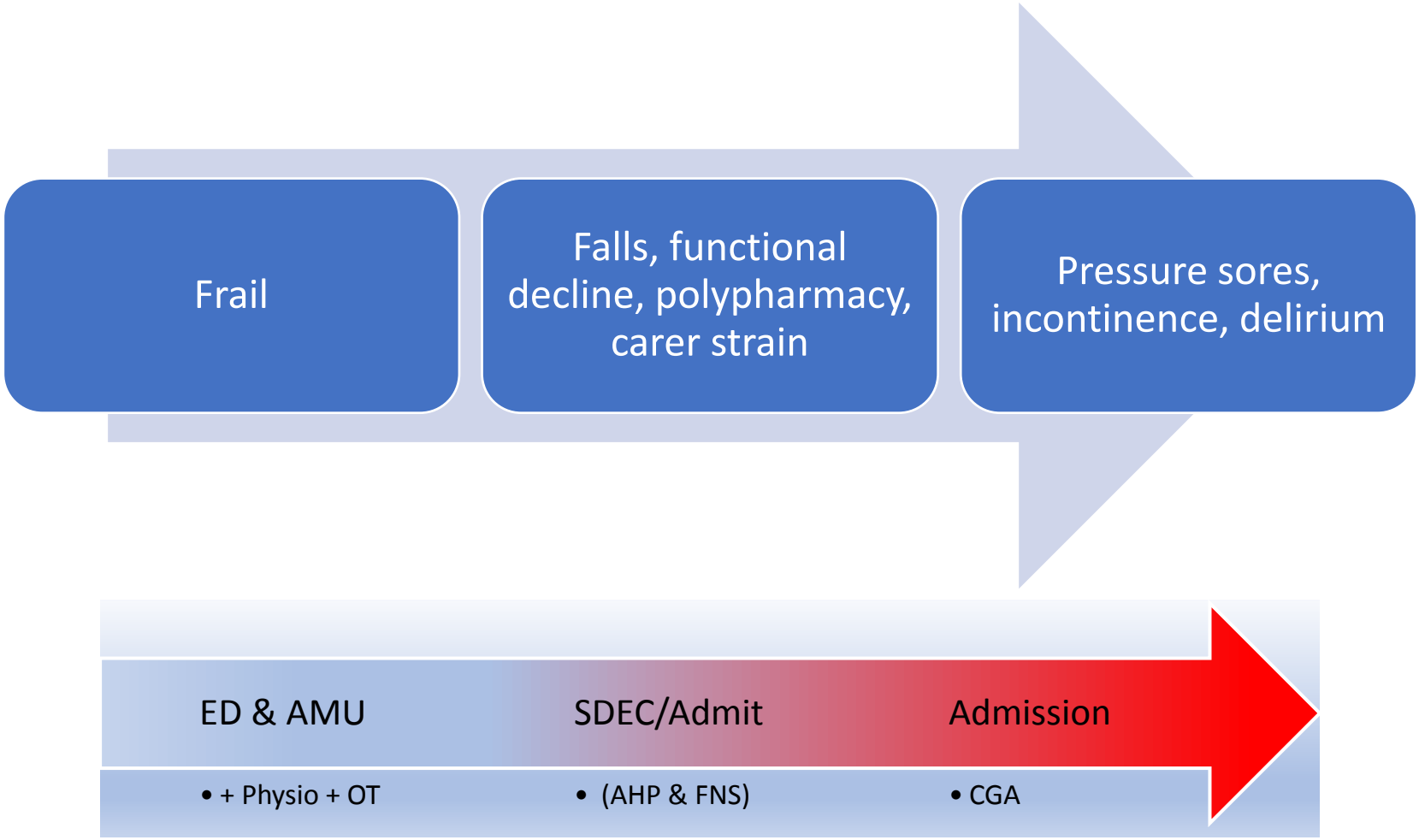
The degree of frailty corresponds to the degree of dementia. Common **symptoms in mild dementia** include forgetting the details of a recent event, though still remembering the event itself, repeating the same question/story and social withdrawal.

In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

In **severe dementia**, they cannot do personal care without help.

* 1. Canadian Study on Health & Aging, Revised 2008.
2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

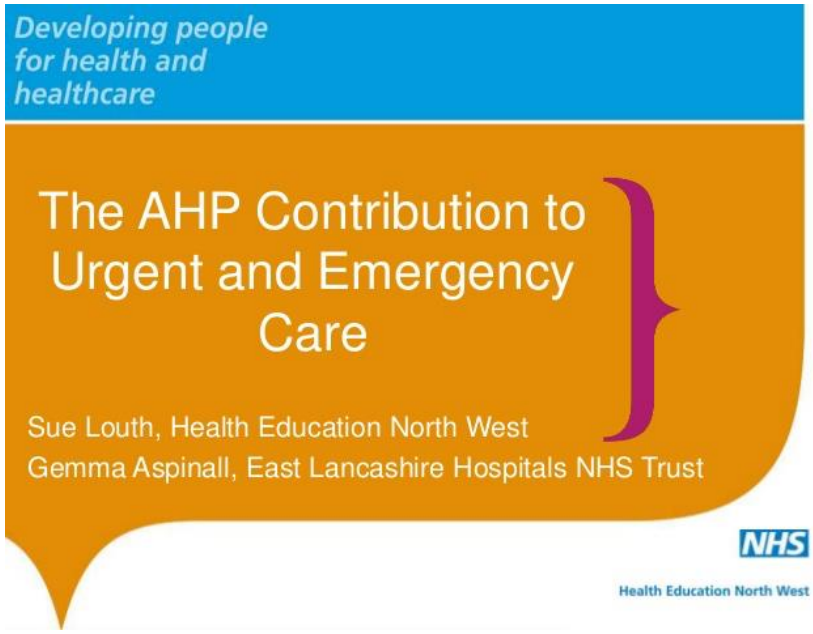
DALHOUSIE UNIVERSITY *Inspiring Minds*


Frail
Falls, functional decline, polypharmacy, carer strain
Pressure sores, incontinence, delirium
ED & AMU
SDEC/Admit
Admission
• + Physio + OT
• (AHP & FNS)
• CGA

Allied health professions supporting patient flow: a quick guide

Published by NHS Improvement and NHS England

April 2018



Patients 2016-19

- **2224 patients**, 82% over 80 years
  - (32% over 90)
- **78% of patients** with a Rockwood Score of 6, 7 or 8
- **29% have a formal diagnosis of dementia**
- Delirium screening in **59% patients** - 25% +ve
- 14.5% **may** have an undiagnosed dementia

- **Outcomes**
- 30% discharged home
- 20% to AMU
- 20% Frailty Unit
- 20% to community bed

End of Life

½ million people die in England each year

½ die in hospital

¾ are admitted acutely

Figure 1: Percentage of deaths (persons, all ages) in hospital, care home, home and hospice, England, 2016

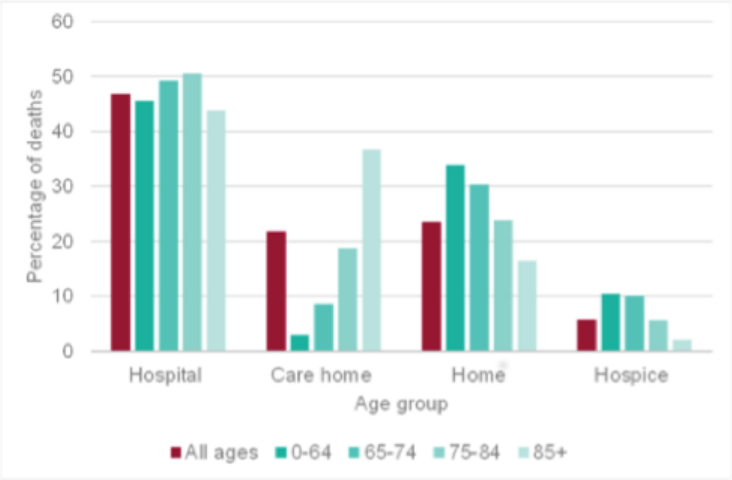
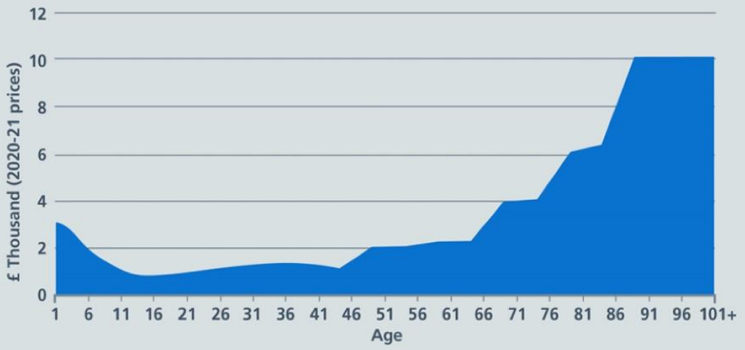
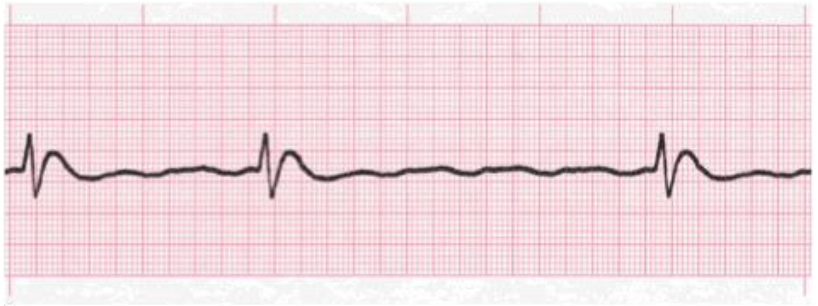


Figure 1: Health care spending rises sharply with age



What to do

- **Of 3115 patients seen** > 1yr ago, **960 (31%) had died** within a year of ED presentation



- Of **647 patients seen** over 1000 days ago, **383 (59%) had died**

Working with SAM to develop the SDEC model

Dr Nicholas Scriven, President, Society of Acute Medicine

Same Day Emergency Care – Standards for Ambulatory Emergency Care

Background

- Increasing activity/acuity nationally
- AEC departments growing in demand
- Managing acute patients as a zero LOS, that previously would have had an admission
- AEC Network/Directory
- RCPE/SAM working group - Standards for AEC/SDEC

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SAMBA data

Ambulatory Emergency Care (AEC)

- 103 hospitals had an AEC service as part of acute medicine (83% of total hospitals, 95.3% of hospitals submitting complete data for this question)
- The majority of AEC units use a combination of trolleys, chairs and separate clinic rooms.
- The median number of trolleys and chairs per unit was 8 (range 1 - 54)
- The median number of clinic rooms per unit was 3 (range 1 - 9)
- 68% of AEC units were separate from AMU
- 49.6% (46.8%) of hospitals had access to speciality 'hot' clinics

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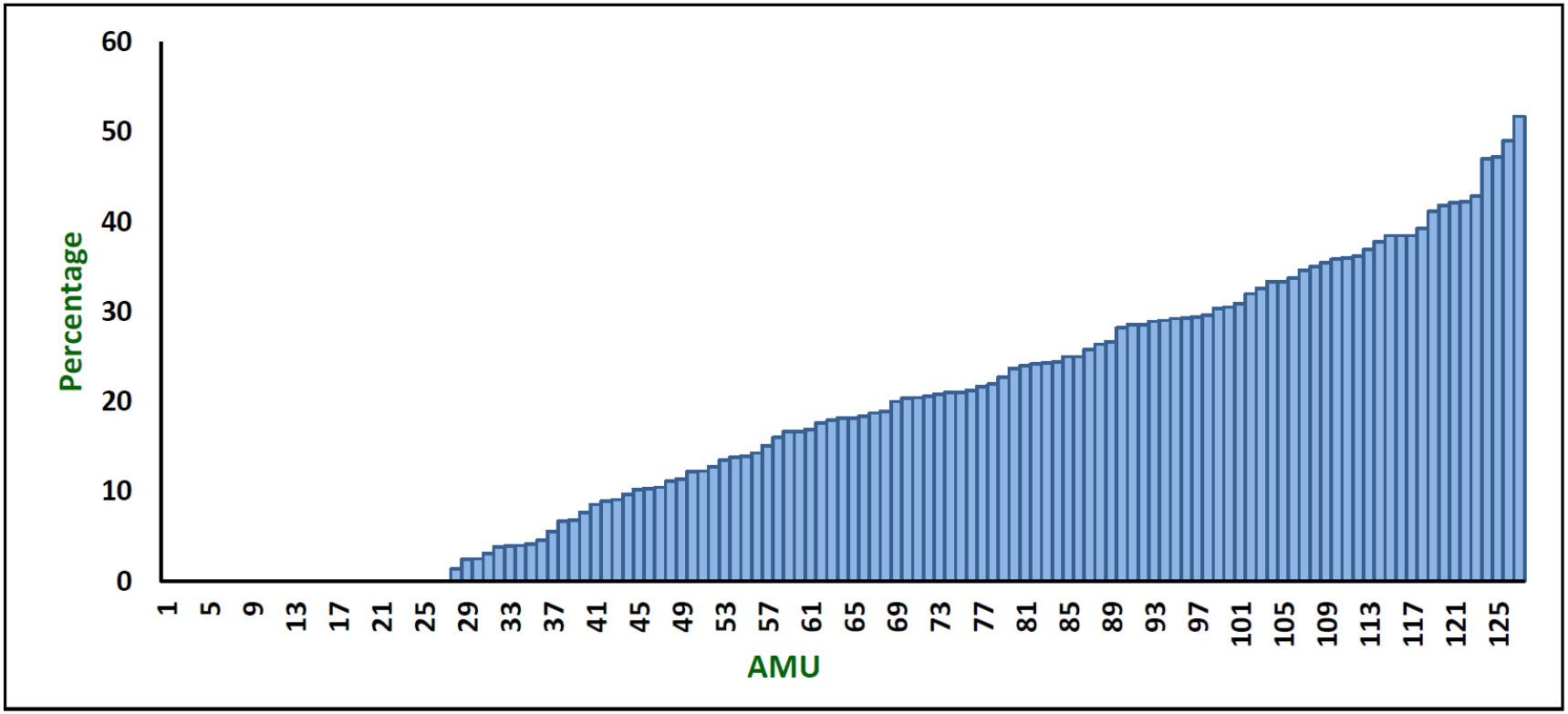
Figure 6 Variation in Percentage of Initial Medical Assessments Undertaken in AEC



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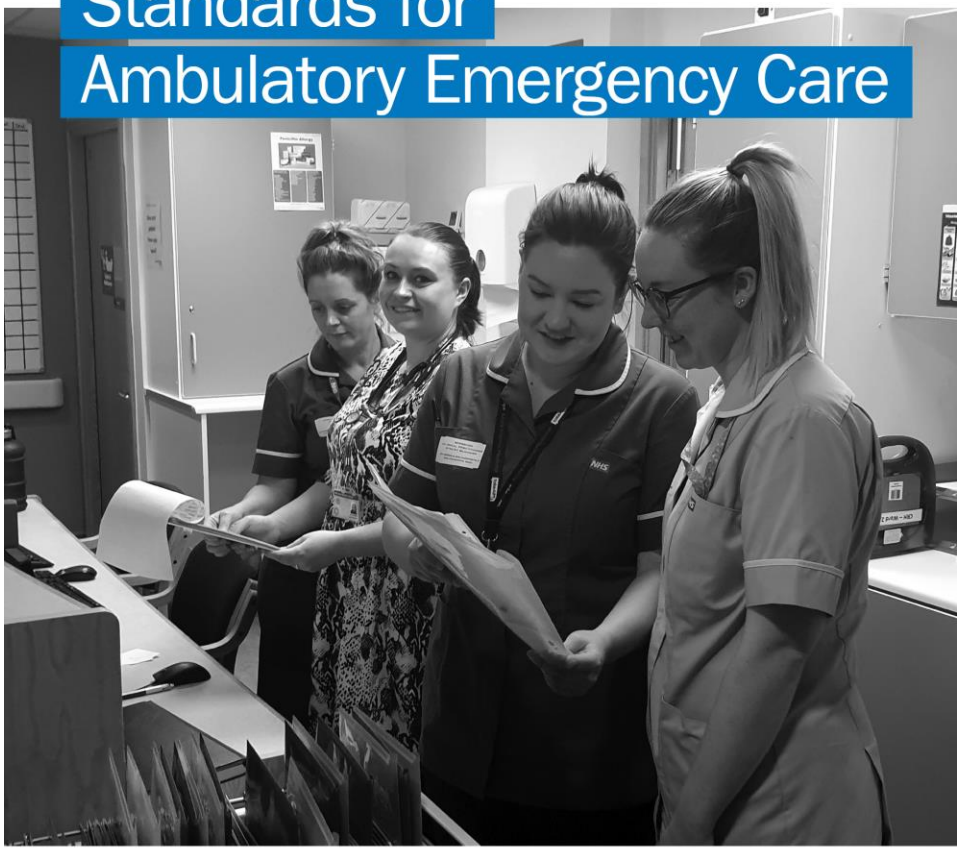
Standards for Ambulatory Emergency Care



Report of a working group for Royal College of Physicians of Edinburgh and Society for Acute Medicine

1. Patient feedback

All units undertaking AEC should regularly survey a representative and consecutive number of patients treated in this manner. This should take the form of a short questionnaire. At least 5% of all patients should be surveyed and the total time spent in the unit for each patient calculated.

Survey results should be used by the multi-disciplinary team (MDT) in a dedicated meeting to identify possible areas for quality improvement at least every 6 months. Although more challenging, one of the surveys should take place in the winter months.

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2. Waiting times should be minimised

a. Observations contributing to a NEWS2 score (National Early Warning Score version 2 - a system to standardise response to acute illness) should be obtained within 30 minutes of a patient's arrival.
b. Patients should be seen promptly and certainly within one hour by a clinician who has the capabilities to assess and investigate the patient's symptoms and signs. This clinician should have immediate access to a more senior clinical decision maker for review when the presentation proves more complex.
c. A validated risk stratification tool for specific conditions should be used to guide management including the need for investigation.

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3. Physician input

A consultant physician should be available on the hospital site day and night throughout the opening times of the AEC unit to review AEC patients.

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4. Overall Leadership

A nominated clinician from the MDT should take responsibility for the overall leadership of the AEC unit to ensure there are active clinical governance and quality improvement processes and strategies.

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5. Diagnostics

AEC unit patients should have the same access to urgent investigations as inpatients or patients attending the emergency department In order to minimise patient waits monitoring of waiting times for diagnostics, including the generation of reports, should occur at least monthly and discussion held with relevant departments to ameliorate delays.

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6. Performance review

Review of AEC performance should occur regularly using at least the metrics suggested by the AEC network.
Additional measures that are relevant to the local health system may also be needed to understand factors influencing performance.
Results should be reviewed with the aim of quality improvement.

7. Monitoring/safety

Non-attendance of patients who have been referred to the AEC unit should be reviewed. If a patient does not attend and cannot be contacted this should be communicated with the relevant GP practice.

Similarly, robust systems must be in place to ensure that patients do not get lost whilst under the care of the ambulatory unit including those in any ‘virtual ward’ or undergoing investigation.

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8. Communication

A same day discharge summary for a single episode of care should be created at the end of the AEC episode and sent to the GP and given to the patient. This should include details of investigations undertaken, any new therapies instigated and the follow up plan required and arranged.
If there are multiple attendances then it is mandatory that the primary care team receives regular communication, with the mechanism and content defined locally.
In either circumstance it should be clearly communicated when the AEC episode has been completed and continuing management has been transferred back to the care team in the community.

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9. Operational model

Each unit should have a standard operational policy that defines the specific clinical pathways that have been developed and should also define the local arrangements that exist to ensure that the AEC unit does not become the default referral pathway for patients who would be managed more appropriately by a particular specialty or if in-patient care is required.

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10. Commissioning

All patient pathways should be adequately defined and resourced in association with the commissioning organisation (where applicable) to avoid duplication and provide clarity of care for specific conditions.

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11. Information to patients

During the period of care under the ambulatory team, patients should have clear written instructions for actions to take if they feel they are deteriorating or if they wish to discuss concerns prior to their next scheduled visit.

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12. Use of resource

Activity within AEC must be protected including during periods of escalation when the hospital is under pressure. Loss of this activity will undoubtedly make the acute pressures worse. AEC units should not be used for the non-acute management of long term conditions.

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13. Infrastructure/environment

The infrastructure and space in the AEC unit must be adequate and reviewed regularly for the throughput and the needs of patients anticipated. Waiting areas should be equipped with adequate seating, refreshment facilities, TV and toilets.

14. Information

All patients referred to the AEC unit should have an explanation of the service and reassurance that it can provide safe and effective care including the need for escalation of care if this is thought to be necessary.

15. Privacy and dignity

A private area must be available where all confidential conversations should be conducted.

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Thank you

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of PHYSICIANS
of EDINBURGH

am
FOR ACUTE MEDICINE

Developing a dashboard for AEC

Susanna Shouls
Measurement Lead – AEC Network
NHS Elect

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

What do you picture when someone says “Dashboard”?

No wonder some people react like this when we talk about data and dashboards

Almost every dashboard was heavily skewed to financial data

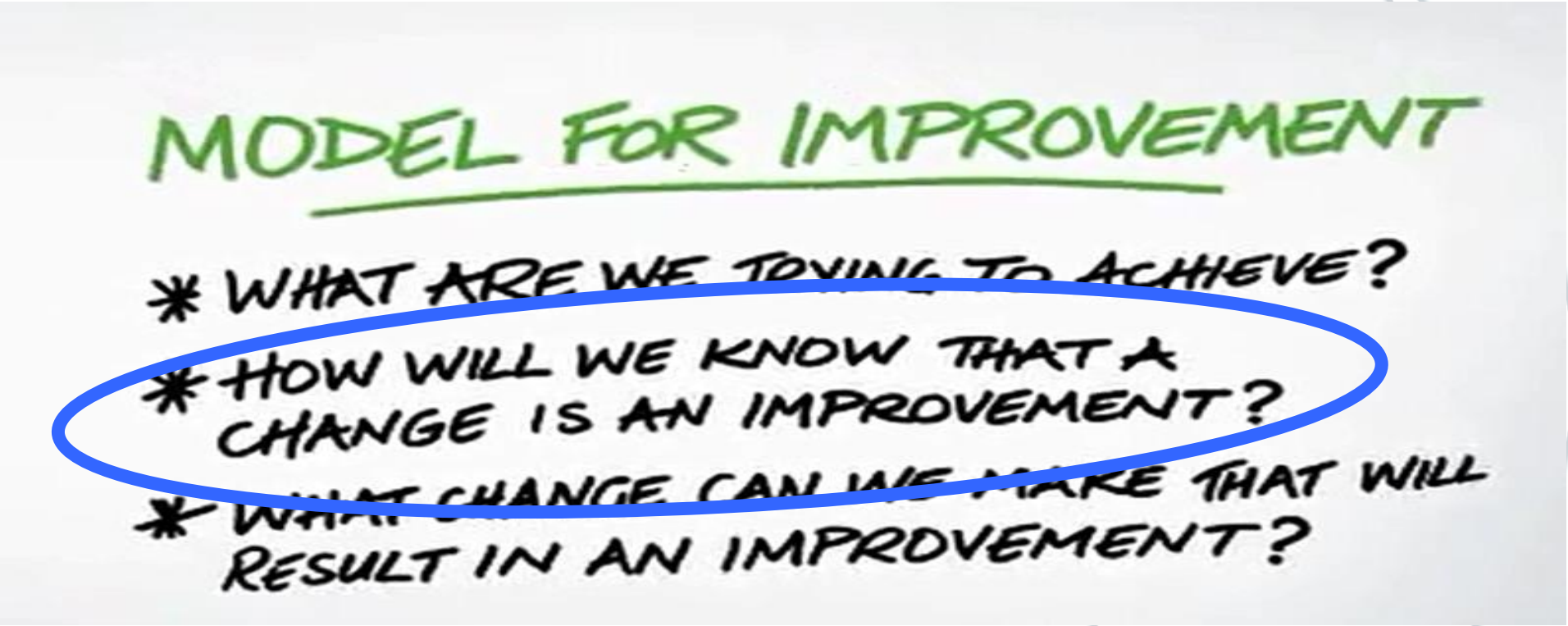
Almost every image of a dashboard was "just too much"!

The dashboards had no clear message, clear aim or clear sense of what the users are trying to achieve

We could not tell if things were changing over time

That is doing my head in!

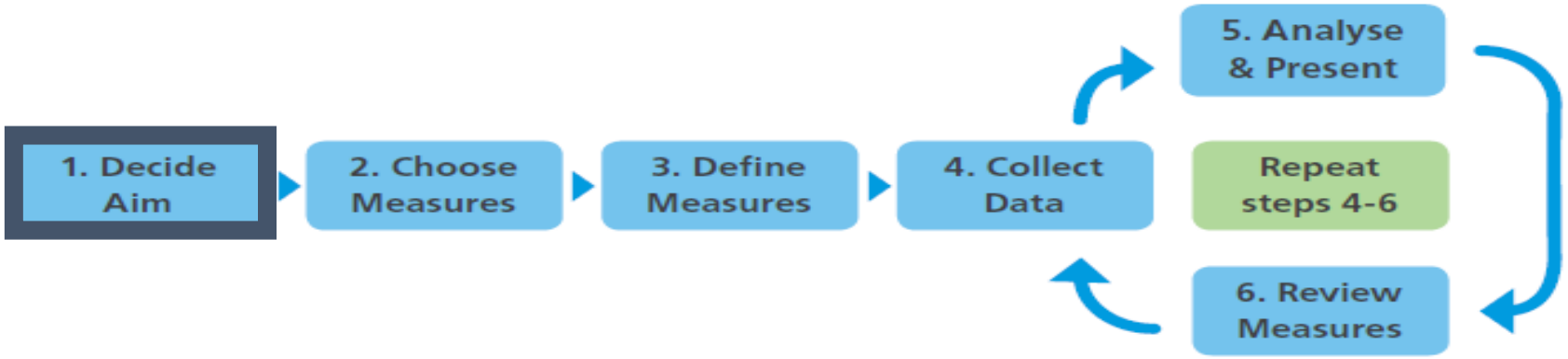
Measurement for improvement



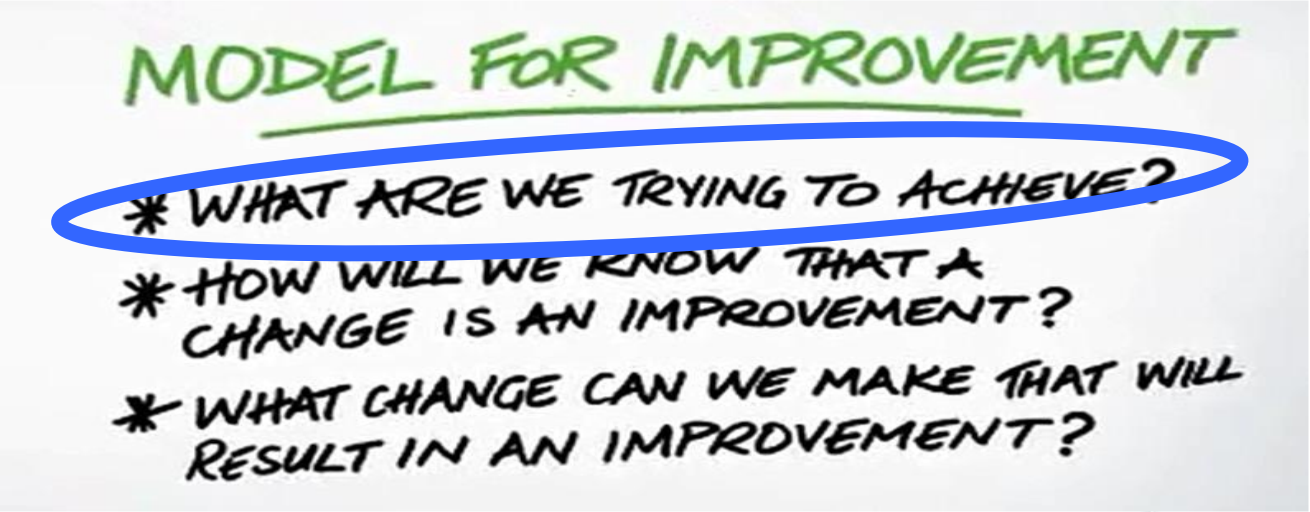
Reference: Langley et al 1996

Good measurement doesn't happen by magic

Before you can develop a dashboard, you need to work your way through the seven step process for Measurement for Improvement



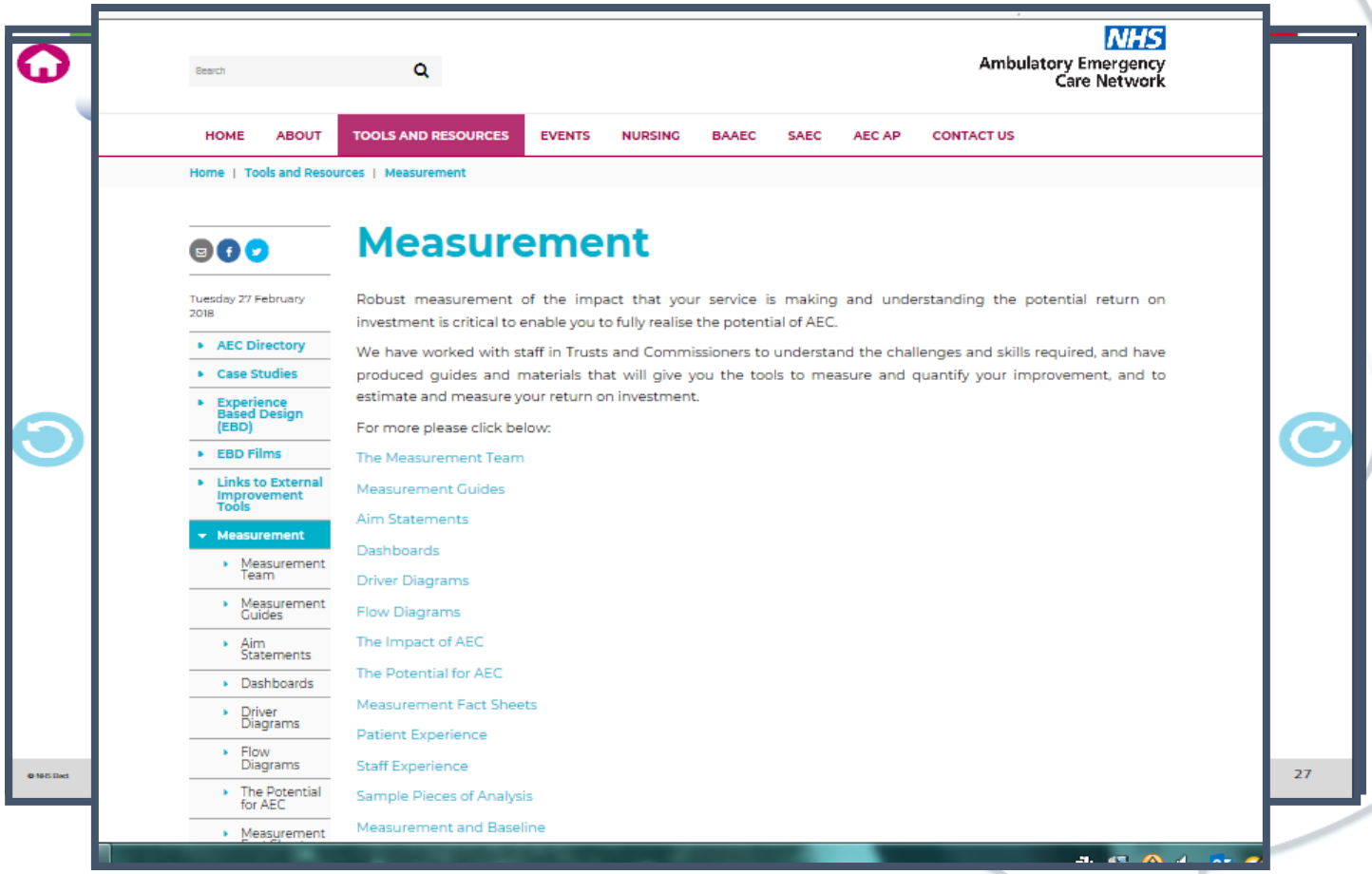
What are we aiming to achieve?



To reduce the number of emergency medical patients who are admitted to hospital for 1-2 nights at least

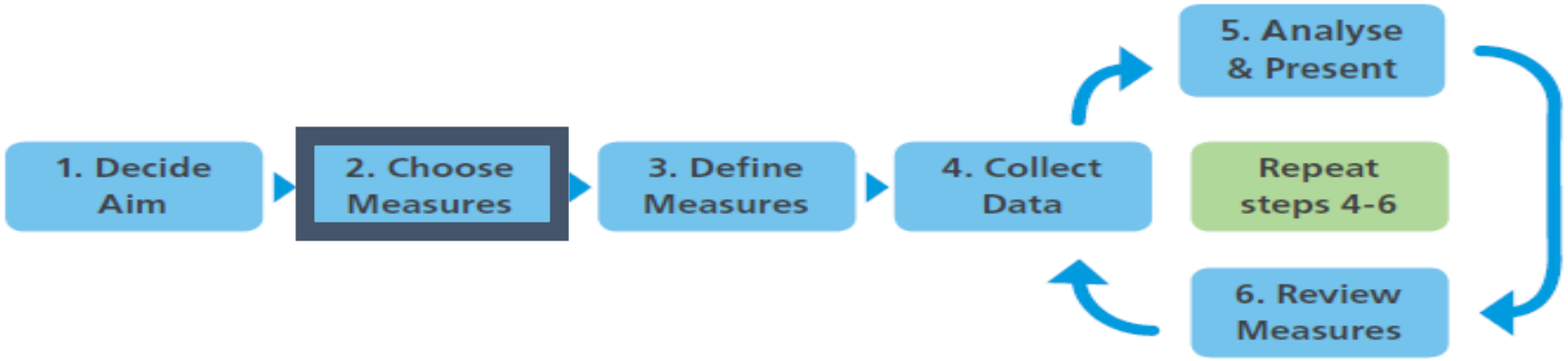
To reduce the time from presentation [illegible] procedure for emergency surgical patients to access

Signposting you to some help



Good measurement doesn't happen by magic

Before you can develop a dashboard, you need to work your way through the seven step process for Measurement for Improvement



Measuring change in a system context

Input	Process	Outcome
Staff time and resources used by your service	The care plans, protocols and policies which staff use to care for patients	The effect on the patient of how you use the inputs and follow the process

Source: “Evaluating the Quality of Medical Care”, Donabedian A, 1966

So you need three types of measures

Process measure

Process measures show how well we do what we say we do

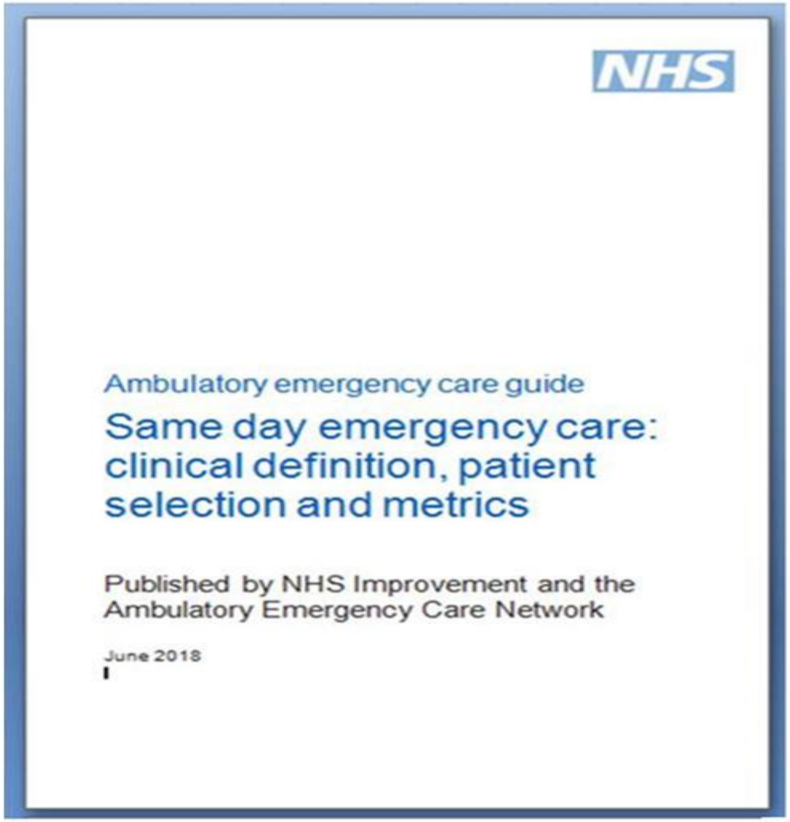
Outcome measure

Outcome measures show the impact of what we do on patients/our aim

Balancing measure

Balancing measures show any unintended consequences of a change

Three recommended measures



Ambulatory emergency care guide

Same day emergency care: clinical definition, patient selection and metrics

Published by NHS Improvement and the Ambulatory Emergency Care Network

June 2018

Balancing measure

The number of new non-elective presentations

managed by AEC/SDEC unit

within the previous 7 days

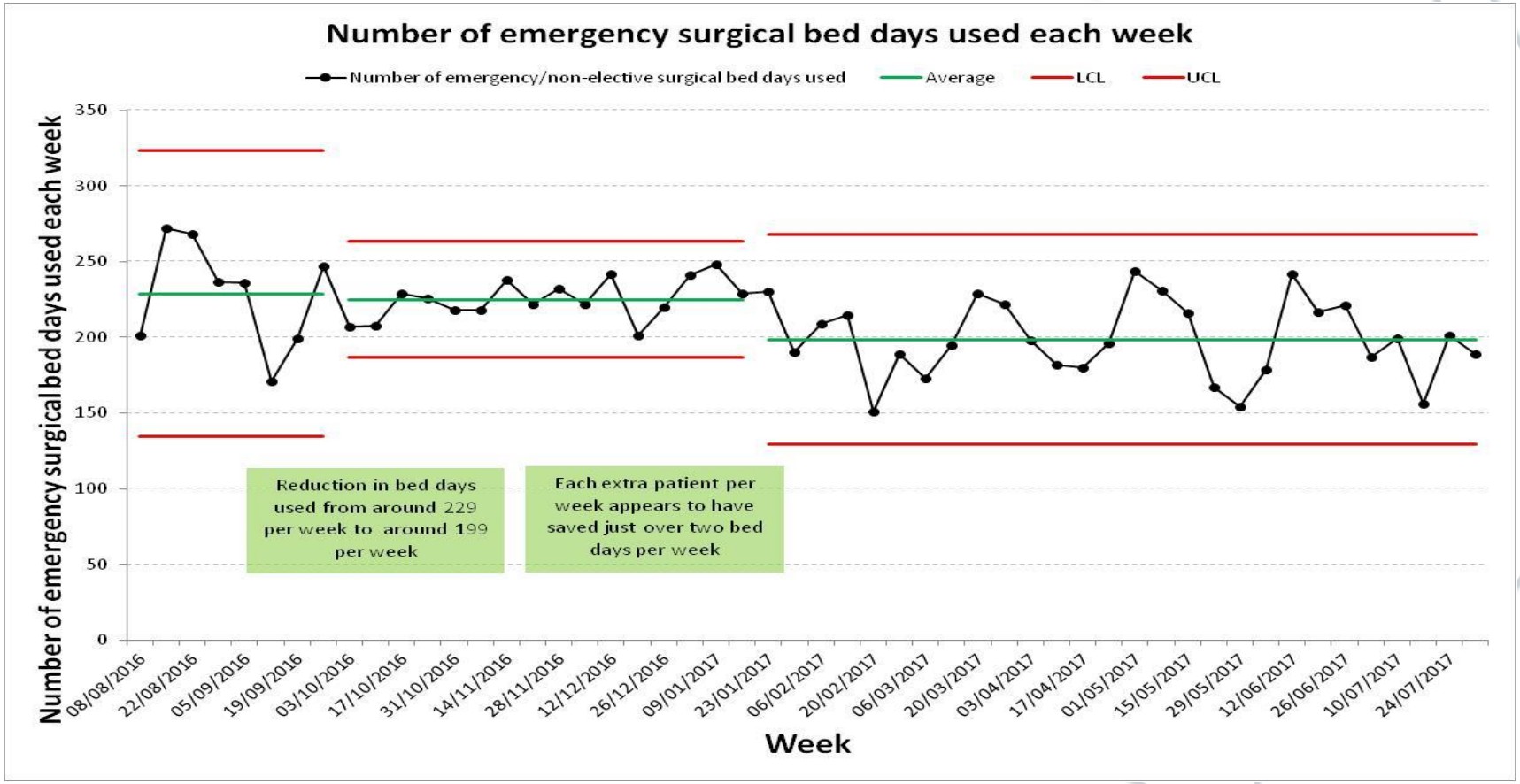
What presentation style to use

"We strongly recommend AEC/SDEC present these data items as daily run charts (or, better, **statistical process control charts**)

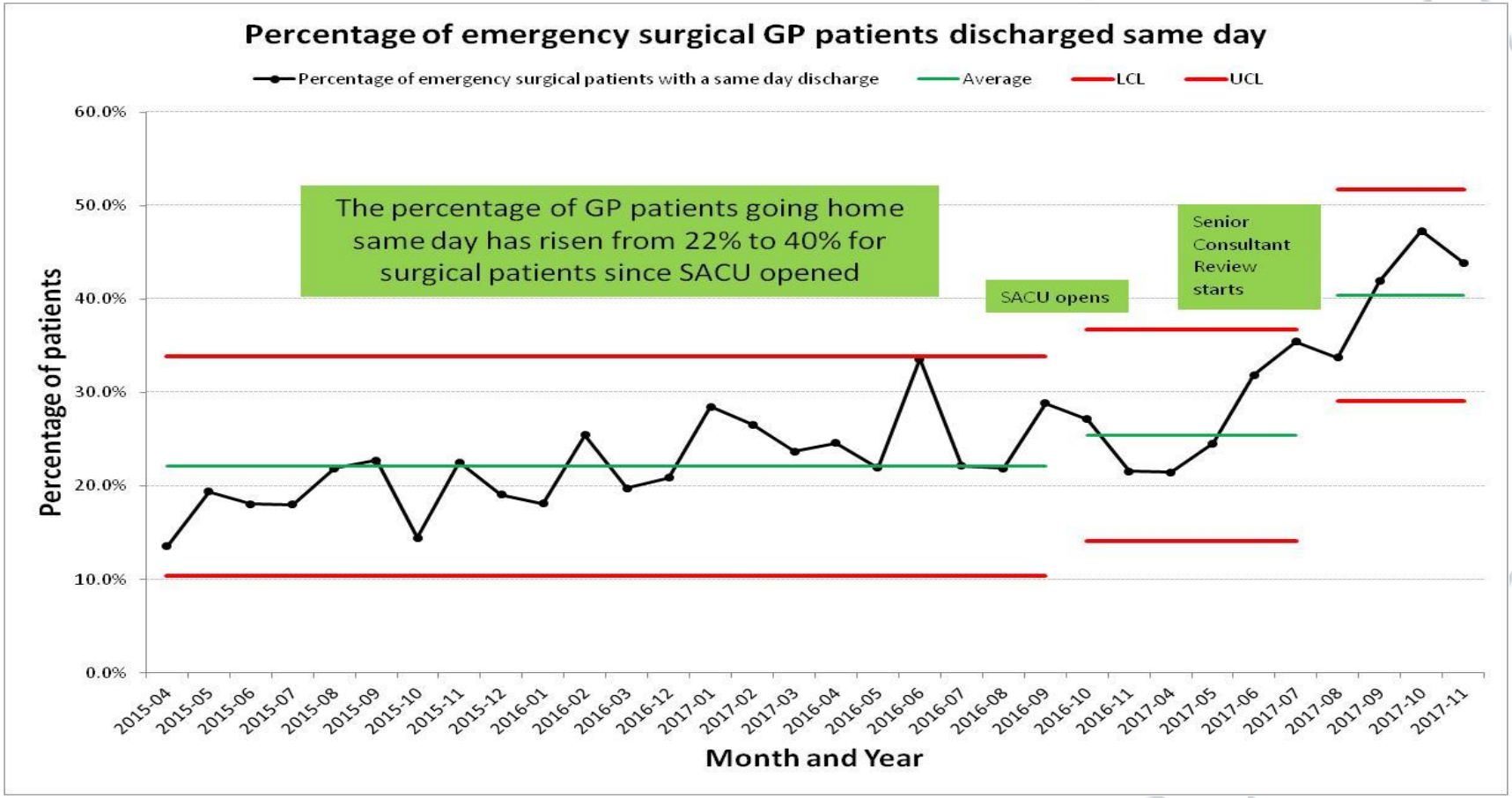
with appropriate explanation for special cause events

and **annotate the implementation of any changes** where there is an improvement in the data."

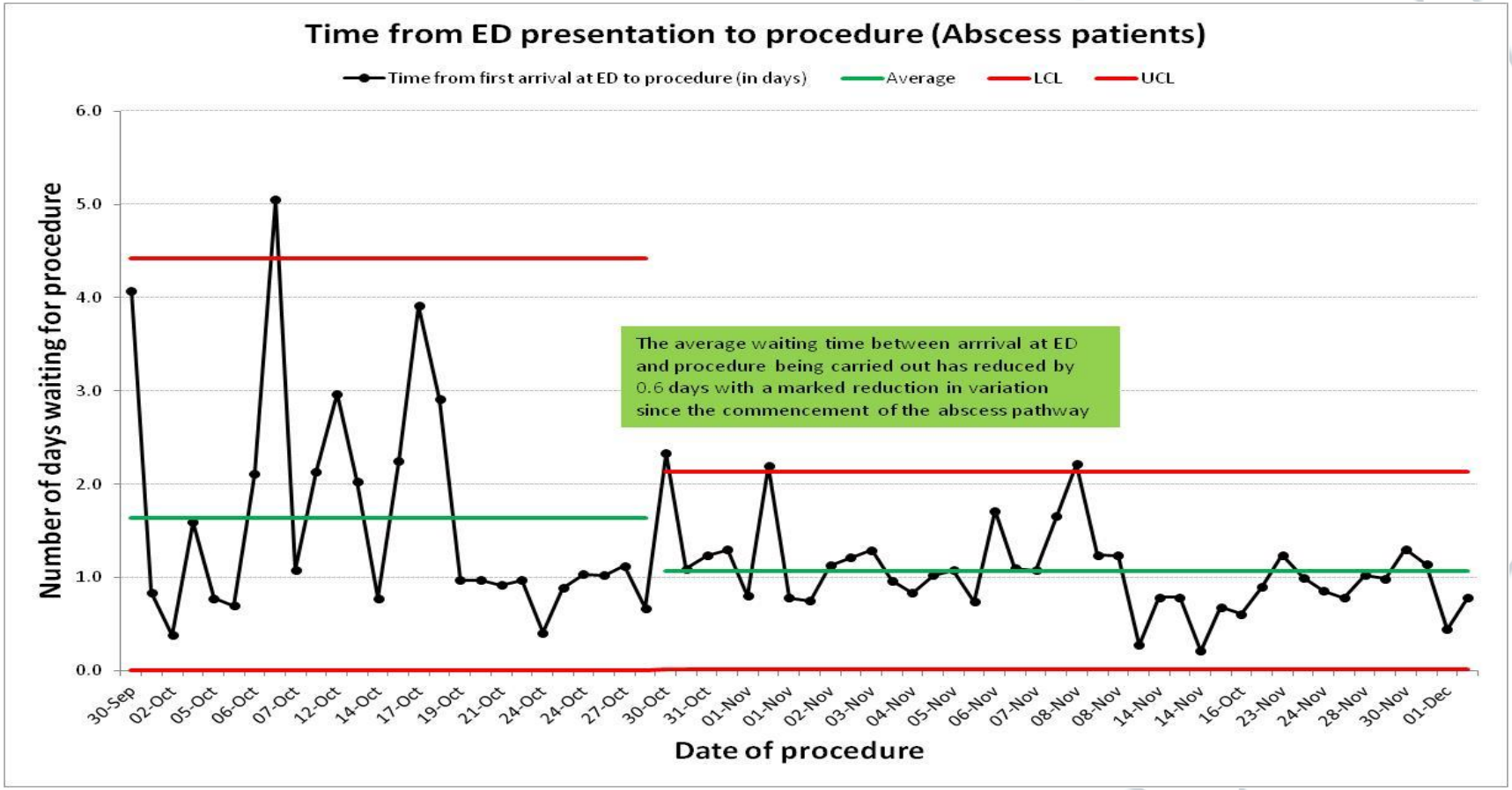
Wythenshawe Hospital
Surgical AEC Network Cohort 1



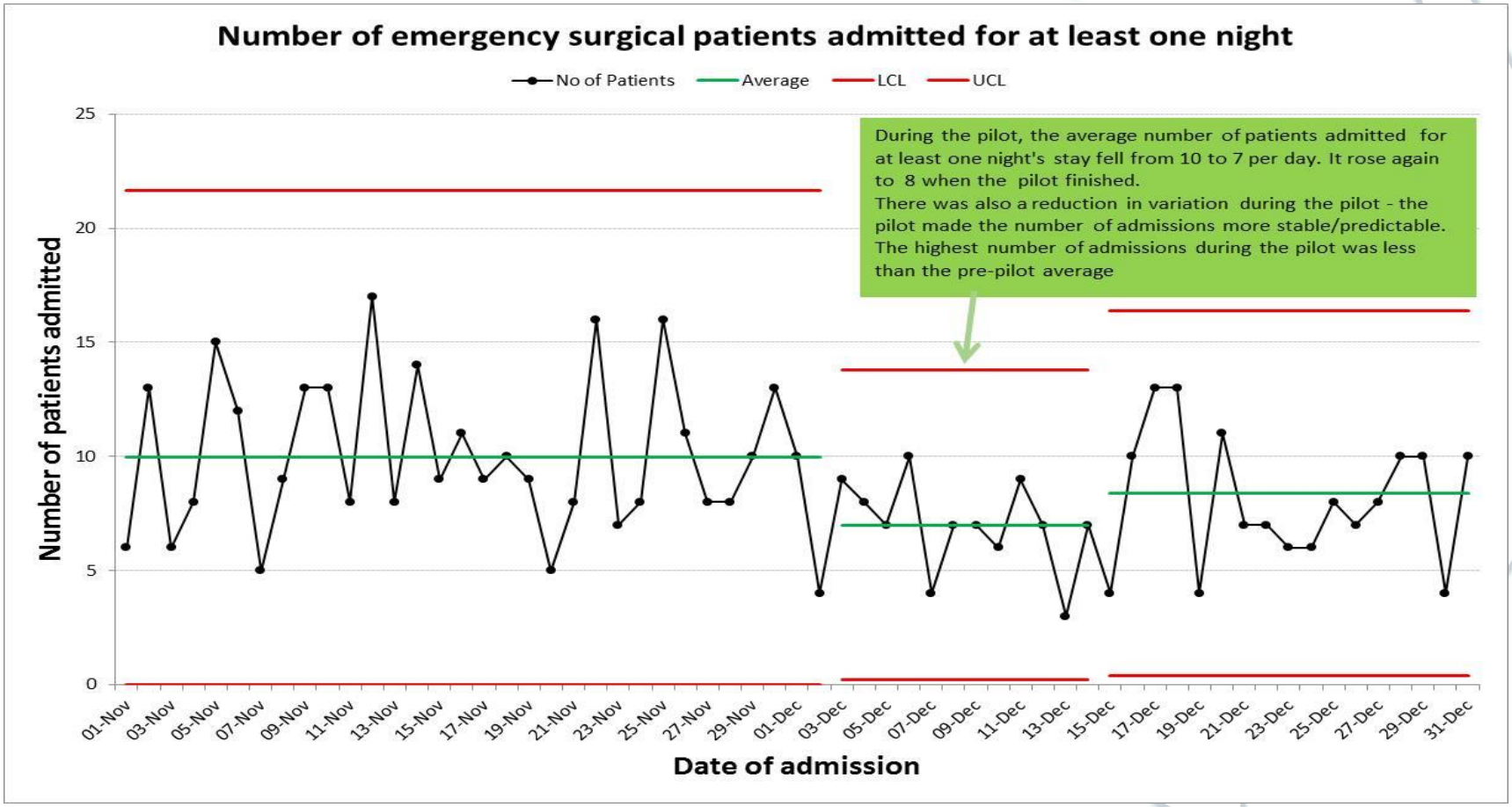
Leighton Hospital
Surgical AEC Network Cohort 1



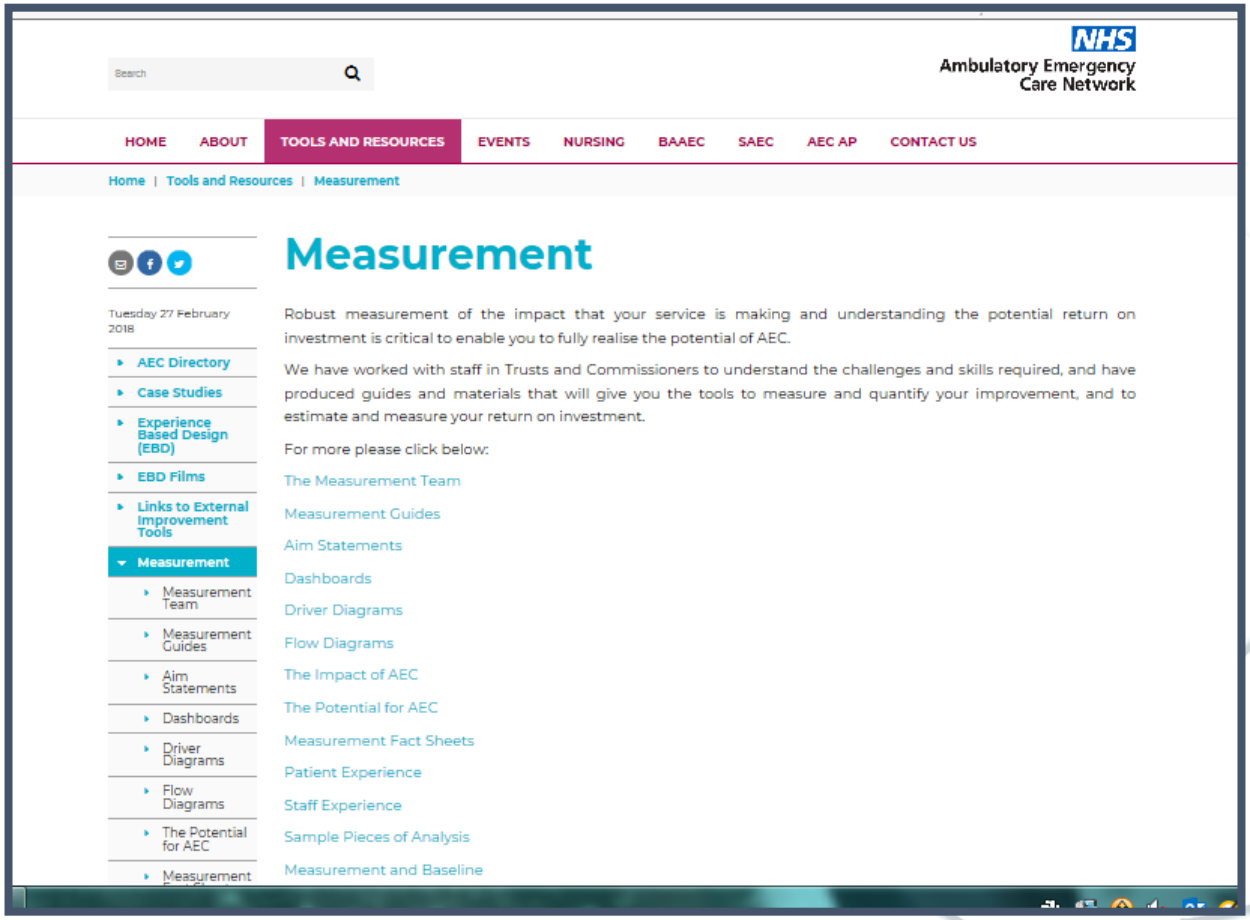
Royal London
Surgical AEC Network Cohort 1



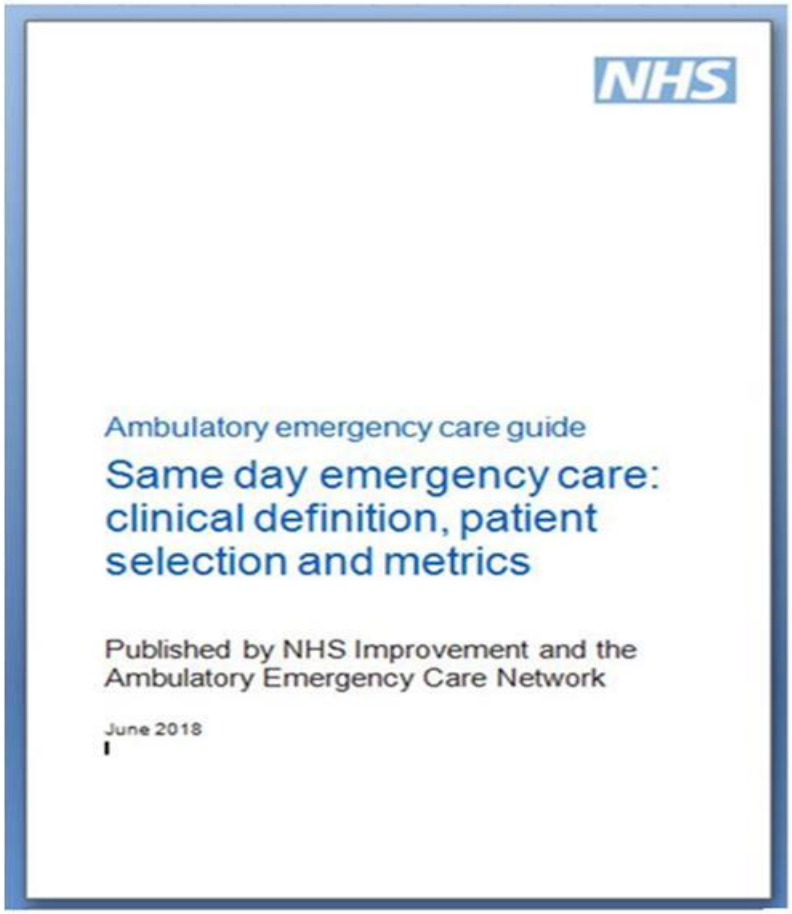
West Suffolk Hospital
Surgical AEC Network Cohort 2

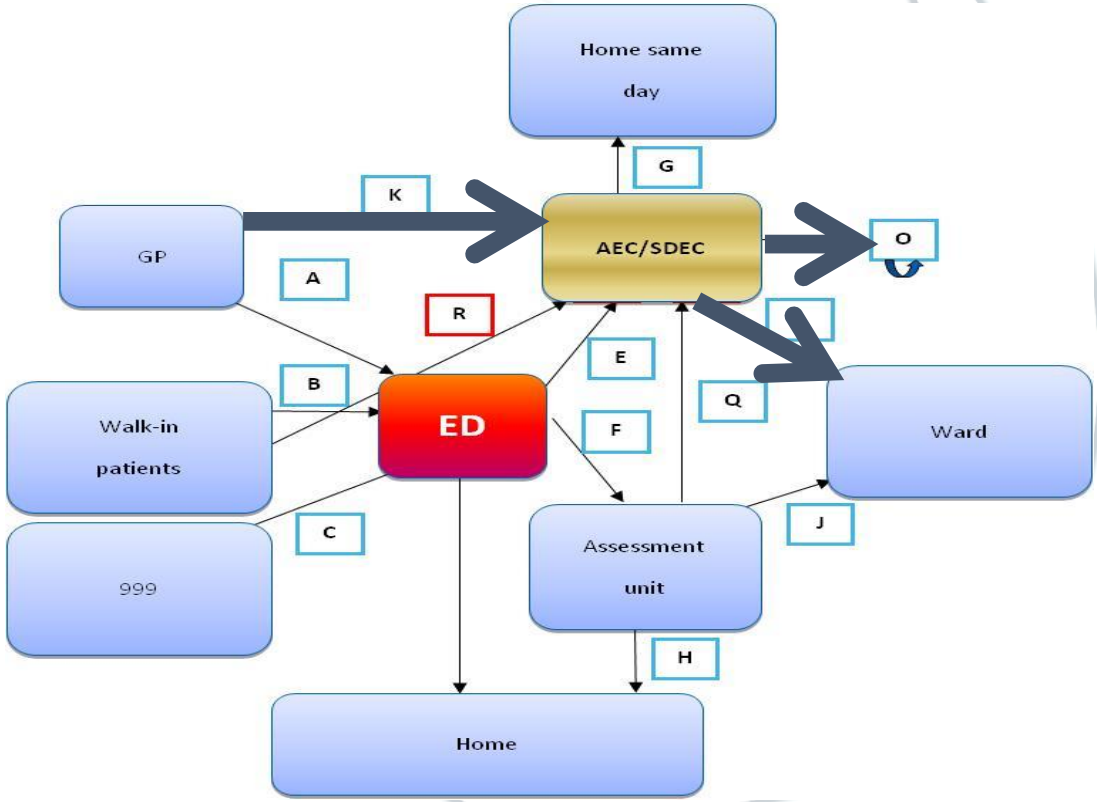


More help is available



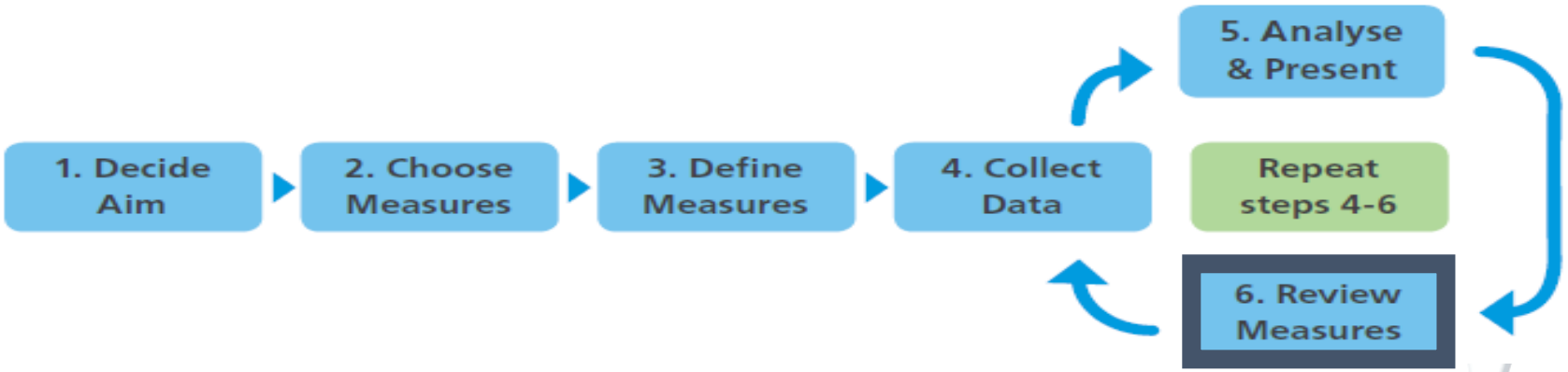
Measuring your process





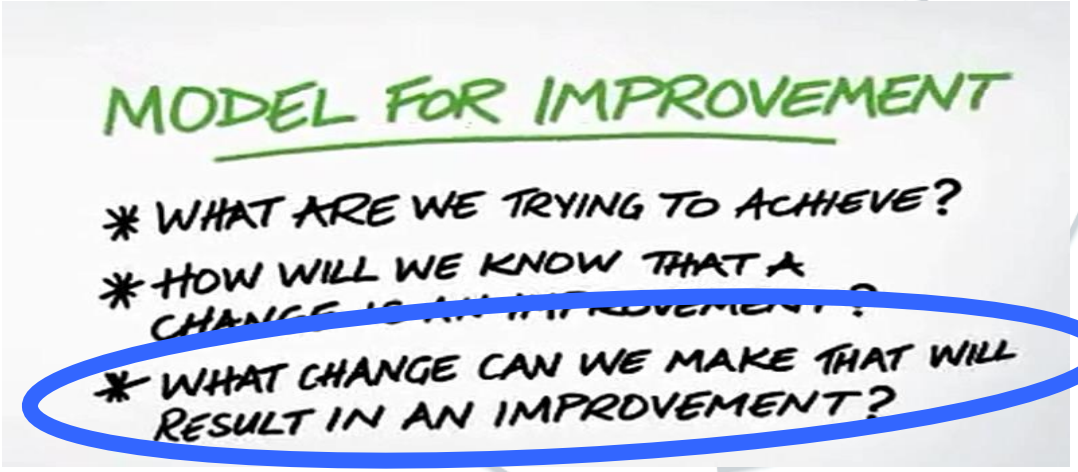
High level Driver Diagram from AEC Network

Reviewing and using your measures

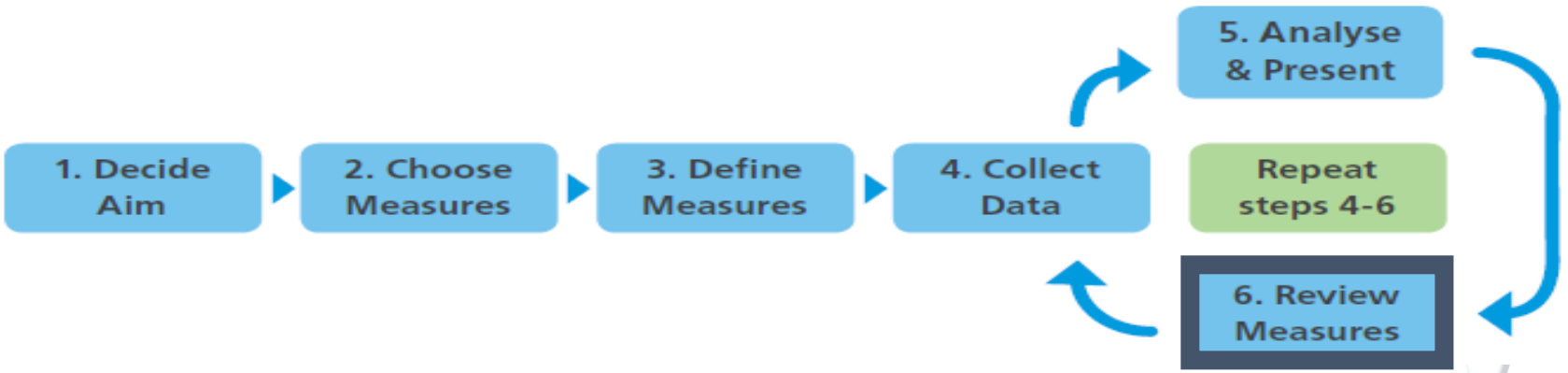


It is a waste of time collecting and analysing your data if you don't take action on the results

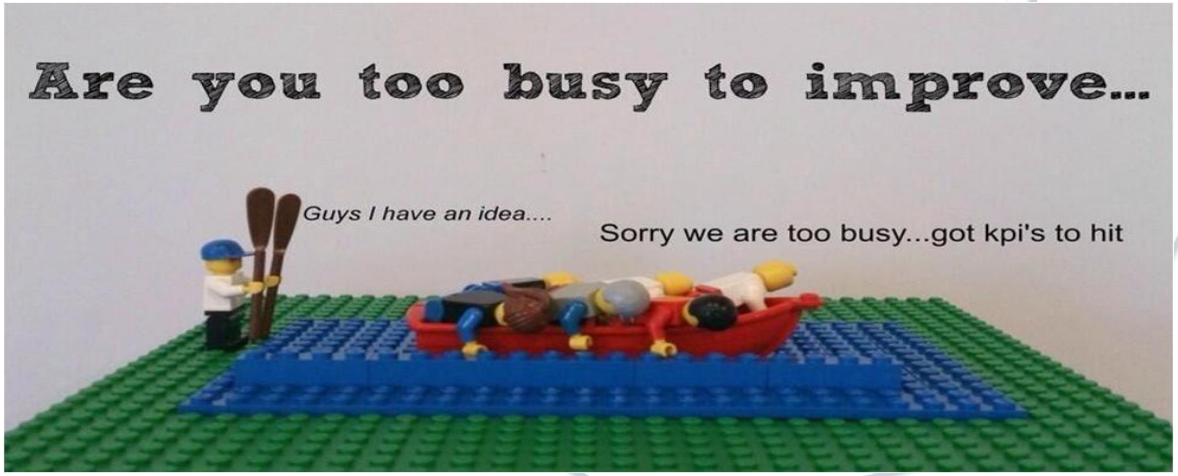
How, when and where you sit down as a team to look at your data and **use it to drive changes to your system** is something you need to think through



Reviewing and using your measures



That meeting needs to gear up to become the engine that drives **change and measureable improvement**



Some practical things to take away

- Set up a regular SDEC/AEC meeting
- Generate ideas for changes you want to make
- Agree a clear aim for each change
- Decide what measures fit that aim well
- Engage with data/analytics/IT people
- Review existing SDEC/AEC data pack
- Find out more about 7 step model for Measurement for Improvement
- Look at the AEC Network website measurement section
- Get some help and advice around SDEC/AEC data

Close
Dr Cliff Mann

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

And finally!

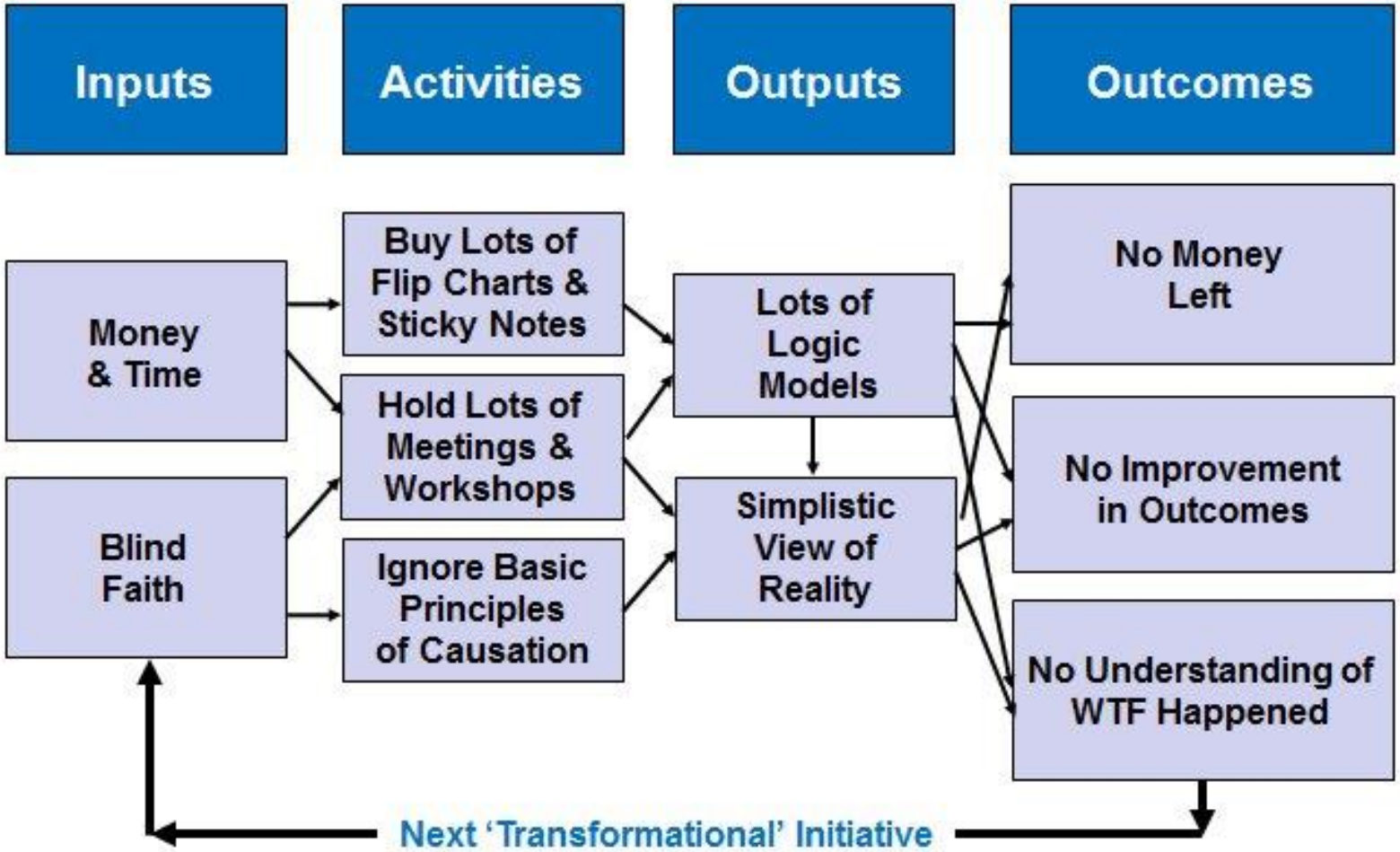
Almost home

SDEC

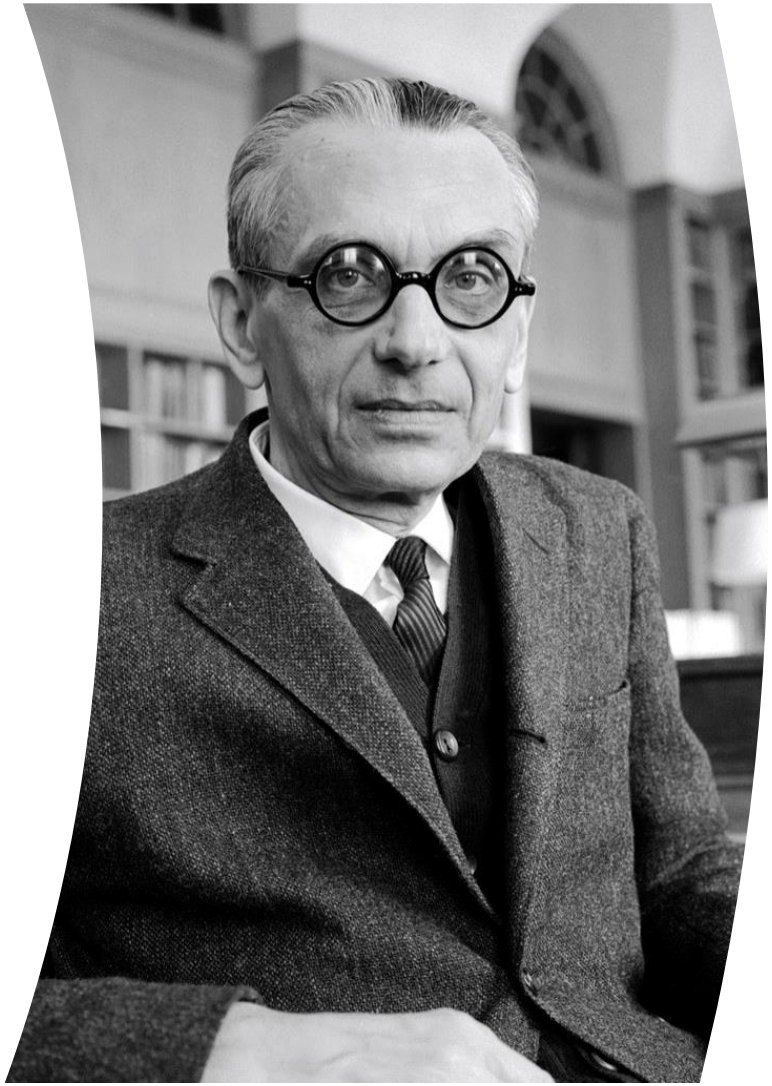
Enables patients with an acute illness or injury who would hitherto have been admitted to a hospital bed for Ix and Rx to be safely managed without admission.

SDECDS will allow us to properly count and record this activity

Payment systems will increasingly recognize and promote SDEC

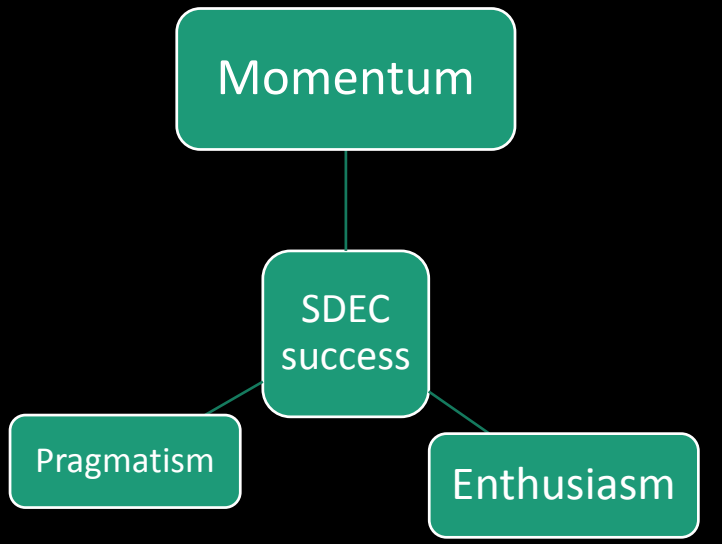

Inputs
Activities
Outputs
Outcomes
Money & Time
Blind Faith
Buy Lots of Flip Charts & Sticky Notes
Hold Lots of Meetings & Workshops
Ignore Basic Principles of Causation
Lots of Logic Models
Simplistic View of Reality
No Money Left
No Improvement in Outcomes
No Understanding of WTF Happened
Next 'Transformational' Initiative

Definitions



- That which is consistent will be incomplete
- That which is complete will be inconsistent

If we succeed



From a fifth to a third will release 4% of acute hospital bed capacity

Better for SDEC patients

Better for admitted patients

- acute
- elective

SDEC (AEC) = (SAU) + (PAU) + (CDU) + (AMU)+ (EPAC)

A good SDEC service accepts an admission rate of about 15%

- ie prediction is difficult – especially about the future!

Most pathways have a differential diagnosis related element. The ‘false +ve’ rate will vary e.g. PE vs SAH

We haven't got all the answers - and probably never will. The clinical imperative is our motivation

Thankyou

All slides will be available via the website

All feedback will be used to inform the other workshops

- Then you will get the attendance certificate

Delighted by the participants/ participation

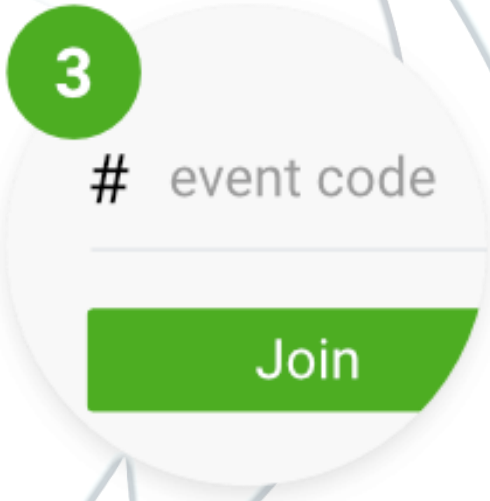
Workforce – examples yes: stipulation no

Slido Event Evaluation

Access our event evaluation in 3 easy steps

1. Go to any web browser from any device

2. Go to slido.com



3. Type in the event code **#SDEC220519**

Useful Links

The SDEC programme website is:

https://improvement.nhs.uk/resources/same-day-emergency-care/

The SDEC programme email address is nhsi.sdec@nhs.net

The Ambulatory Emergency Care Network website is: www.ambulatoryemergencycare.org.uk

The AEC Network email address is aec@nhselect.org.uk

If you want to tweet about this event or anything relating to same day emergency care please use **#NHSSDEC** to spread the conversation a little wider