

Same Day Emergency Care

Regional Workshop

21st May 2019



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

AEC in Emergency Care

What is SDEC?

Coffee Break

Working together to understand what is needed to maximise SDEC at pace

Lunch

Working with the SAM to Develop the SDEC Model

SDEC Dataset

Showcase sites

Acute Frailty and SDEC

Developing a Dashboard for AEC

16:30 Next Steps and Close



Slido - Event Evaluation

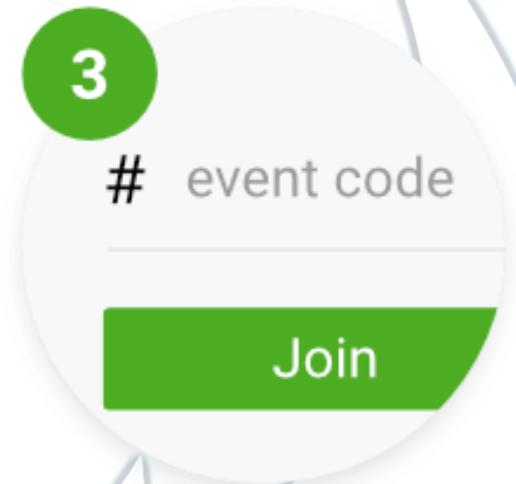
Access our event evaluation in 3 easy steps



1. Go to any web browser from any device



2. Go to slido.com



3. Type in the event code **#SDEC210519**

Same Day Emergency Care

Dr Cliff Mann

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

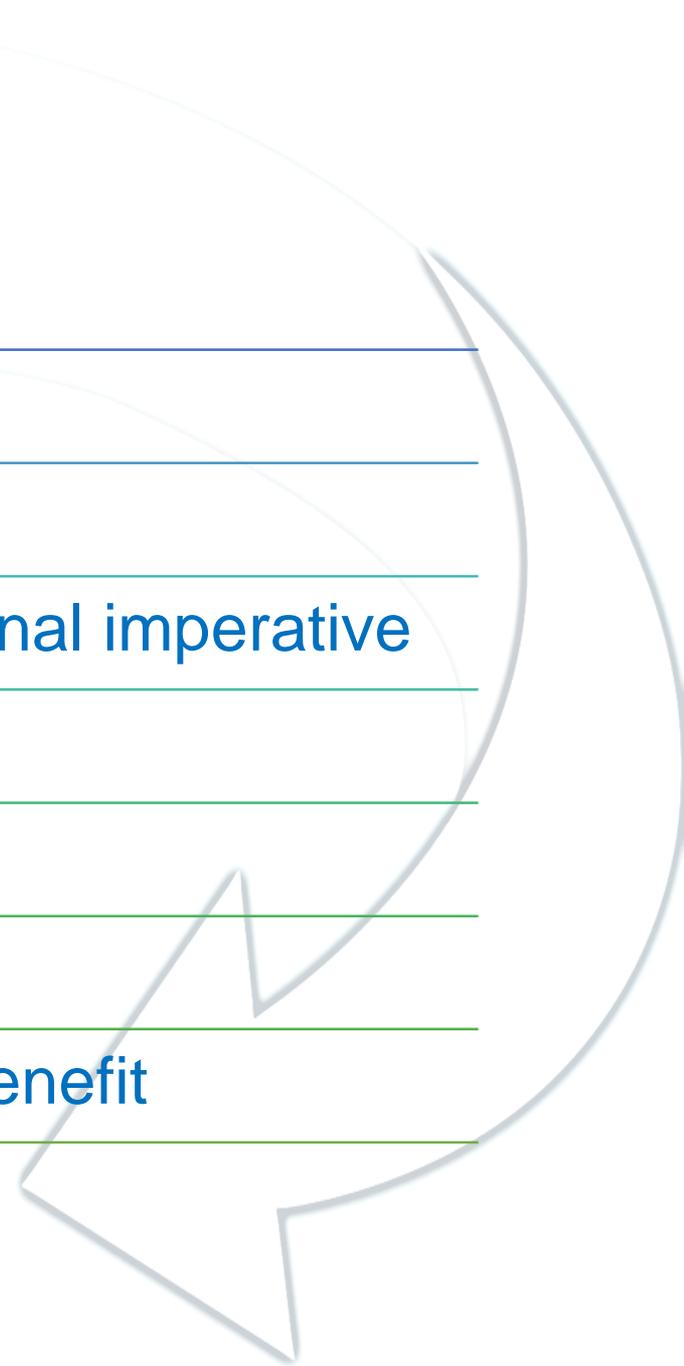
We are here because

This works

Most trusts already do some of this

If we did more – more patients would benefit

It would be cost (? Price) efficient



Another transformational project, perhaps?

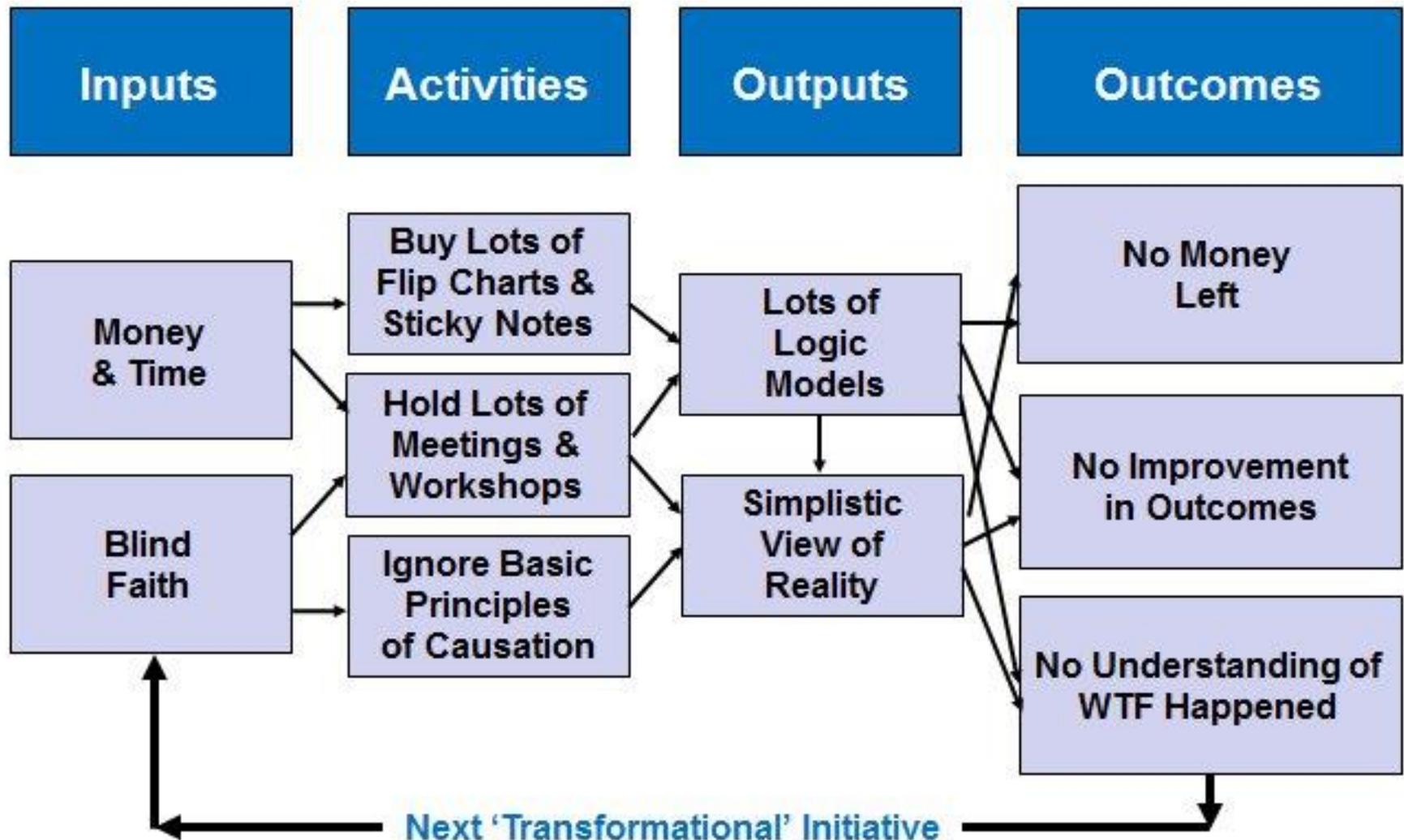
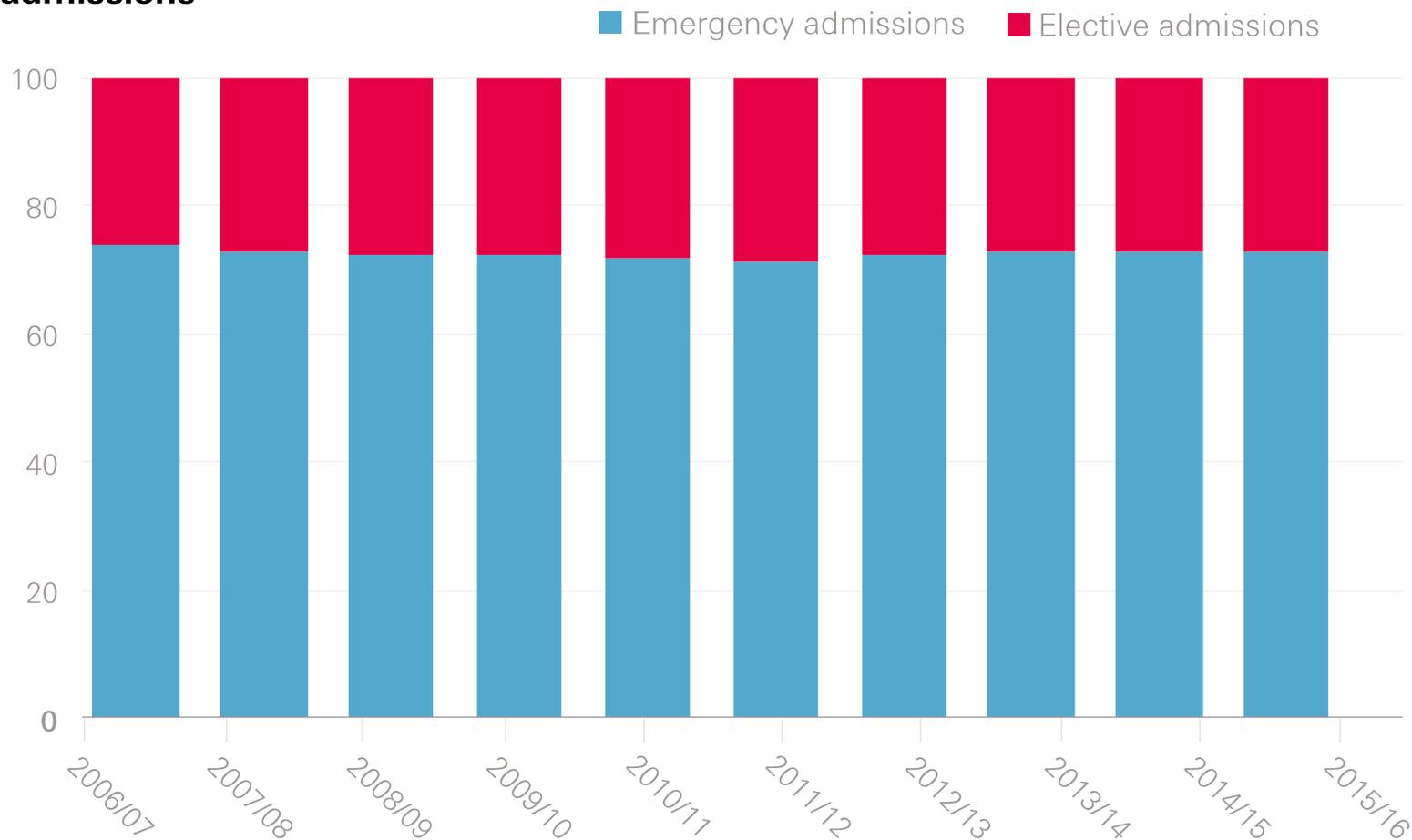


Figure 5:[†] Proportion of total bed days for emergency admissions and elective admissions



* 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.

1.30. Under this Long Term Plan, every acute hospital with a type 1 A&E department will move to a comprehensive model of Same Day Emergency Care. This will increase the proportion of acute admissions discharged on the day of attendance from a fifth to a third

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

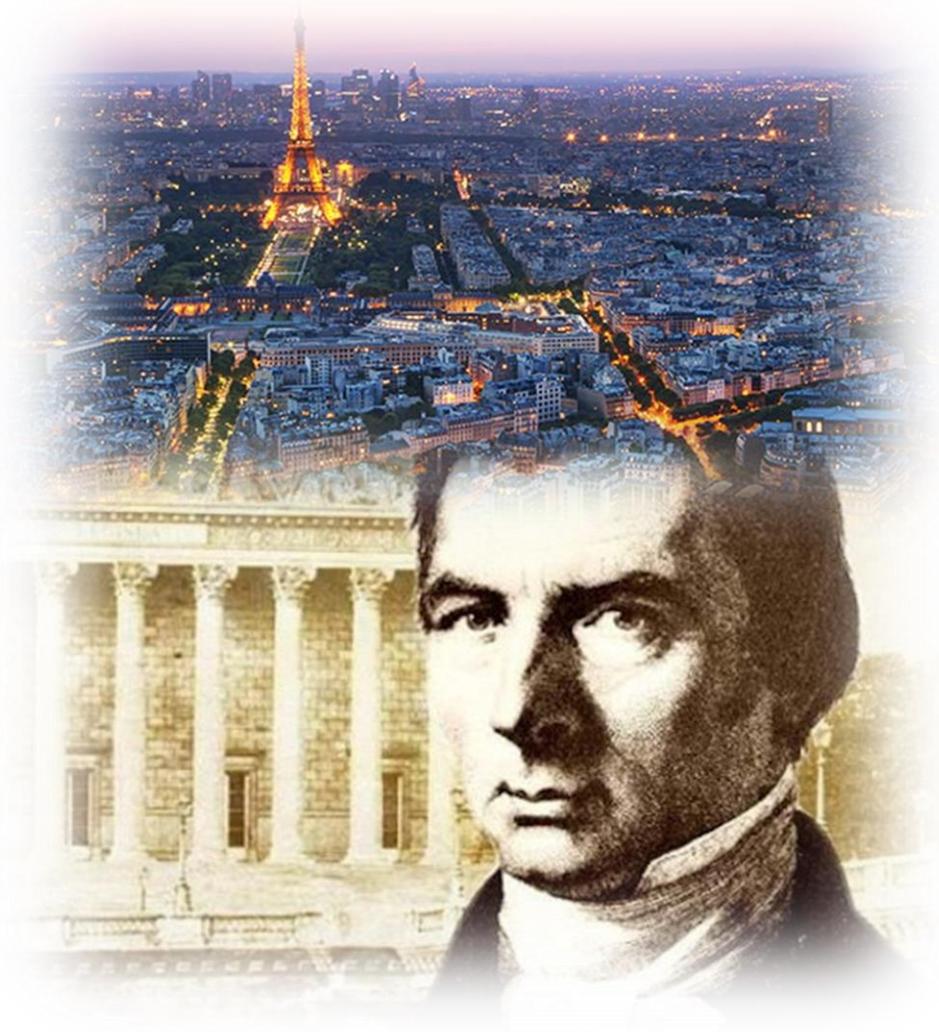
CQUINS

AECN led
accelerator
programmes

Milestones for urgent and emergency care

- In 2019 England will be covered by a 24/7 Integrated Urgent Care Service, accessible via NHS 111 or online.
- All hospitals with a major A&E department will:
 - Provide SDEC services at least 12 hours a day, 7 days a week by the end of 2019/20
 - Provide an acute frailty service for at least 70 hours a week. They will work towards achieving clinical frailty assessment within 30 minutes of arrival;
 - Aim to record 100% of patient activity in A&E, UTCs and SDEC via ECDS by March 2020
- Test and begin implementing the new emergency and urgent care standards arising from the Clinical Standards Review, by October 2019
- Further reduce DTOC, in partnership with local authorities.
- By 2023, CAS will typically act as the single point of access for patients, carers and health professionals for integrated urgent care and discharge from hospital care.

Paris will be fed



Ambulatory
Emergency Care

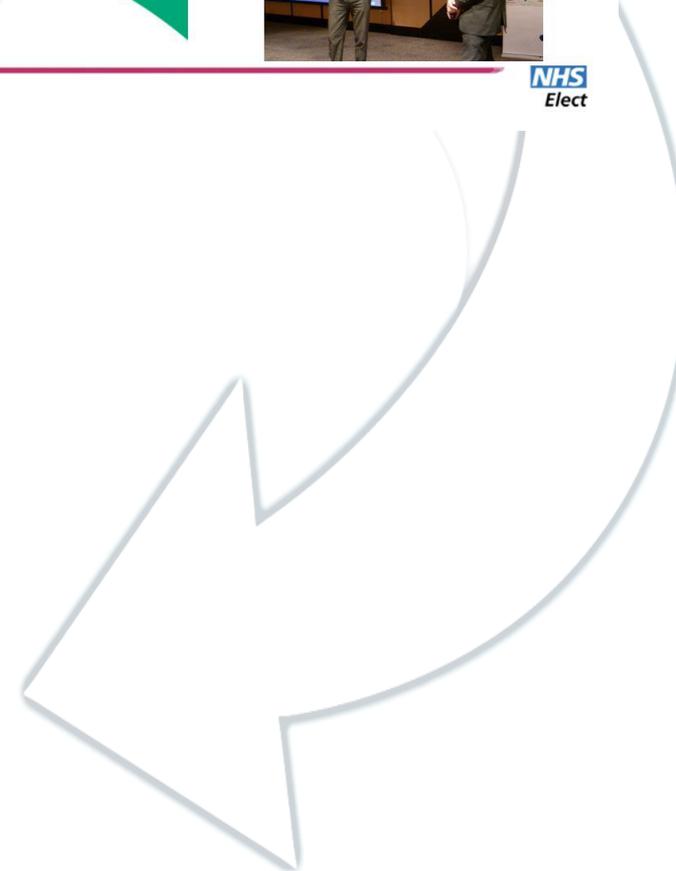


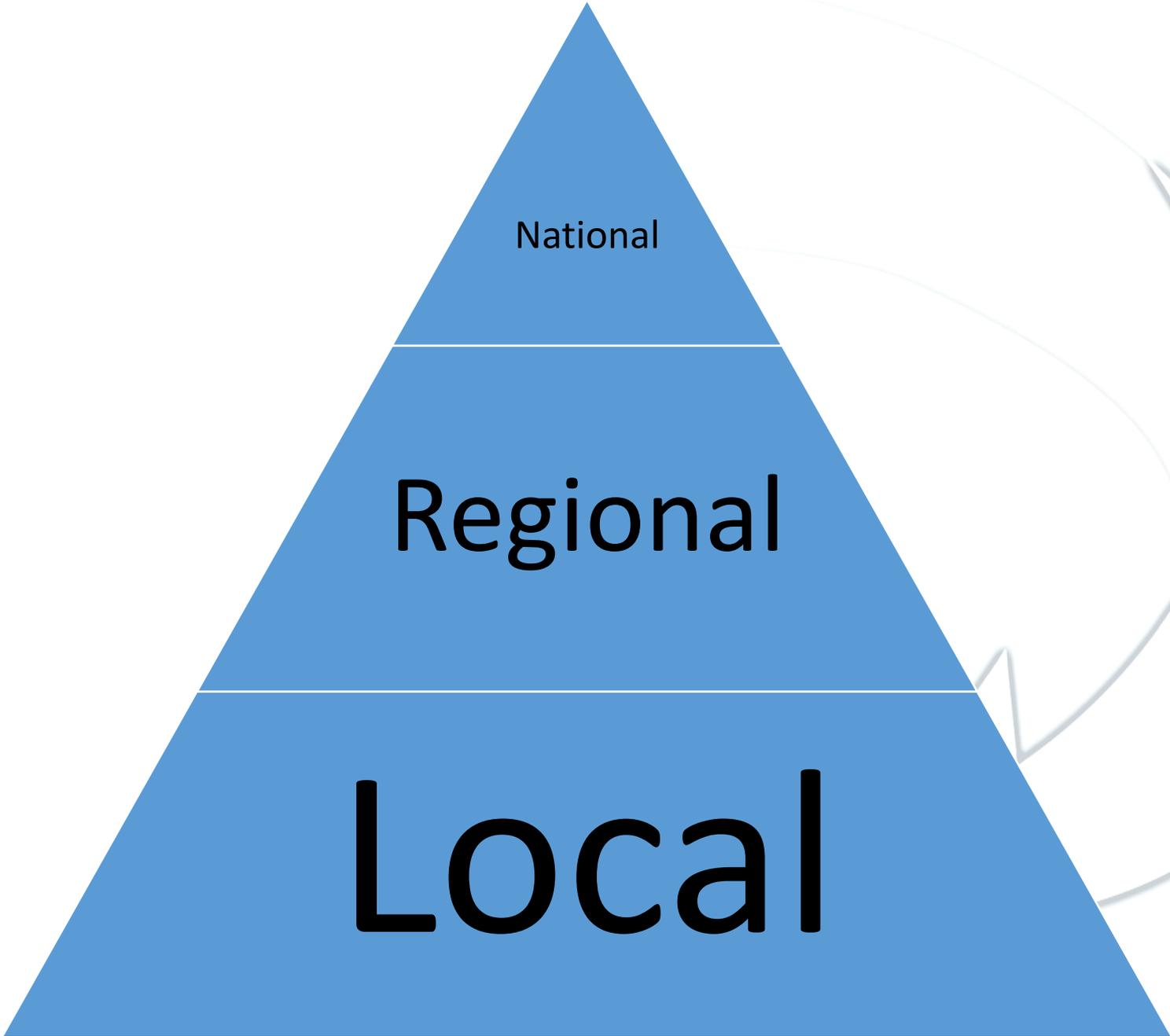
The bigger picture



© NHS Elect

NHS
Elect





National

Regional

Local

National tasks

Signal

Count

Pay





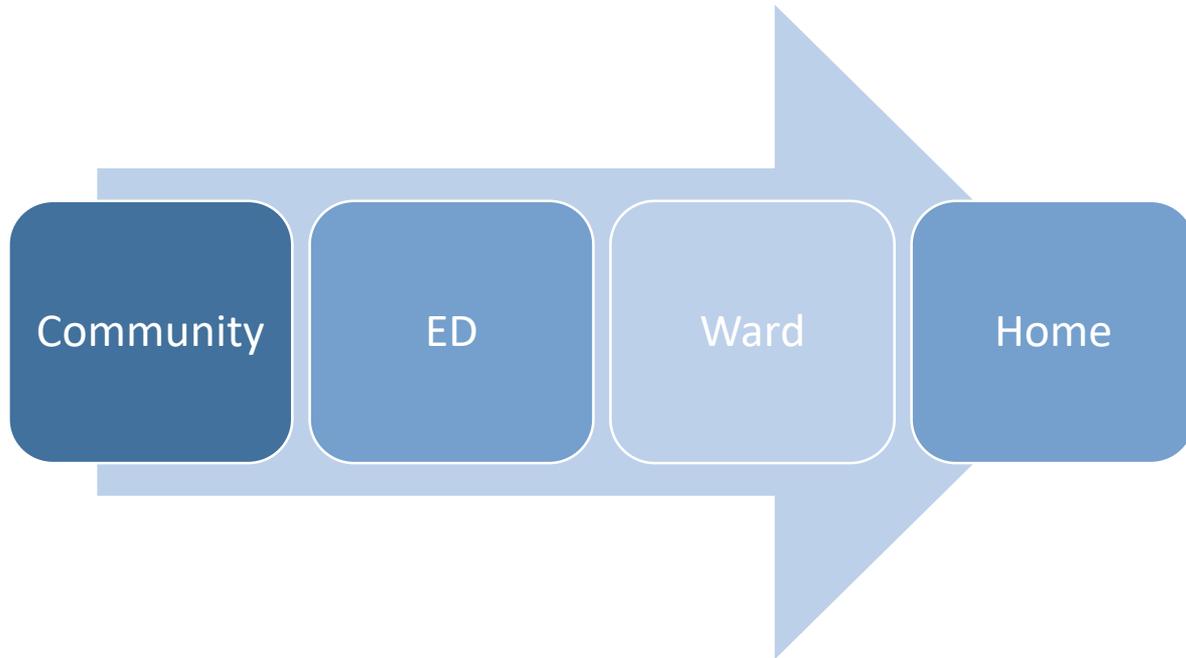
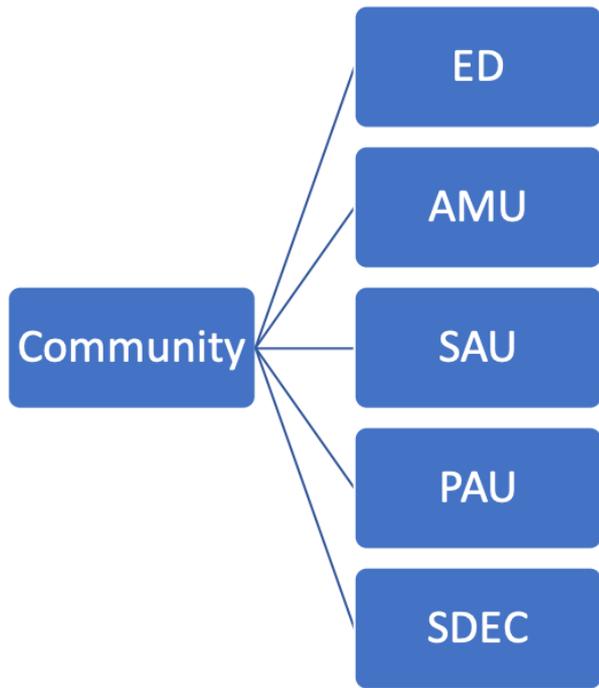
SDEC

≠ ZLoS

≠ A Place/
Site Code/
Ward

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





one



two

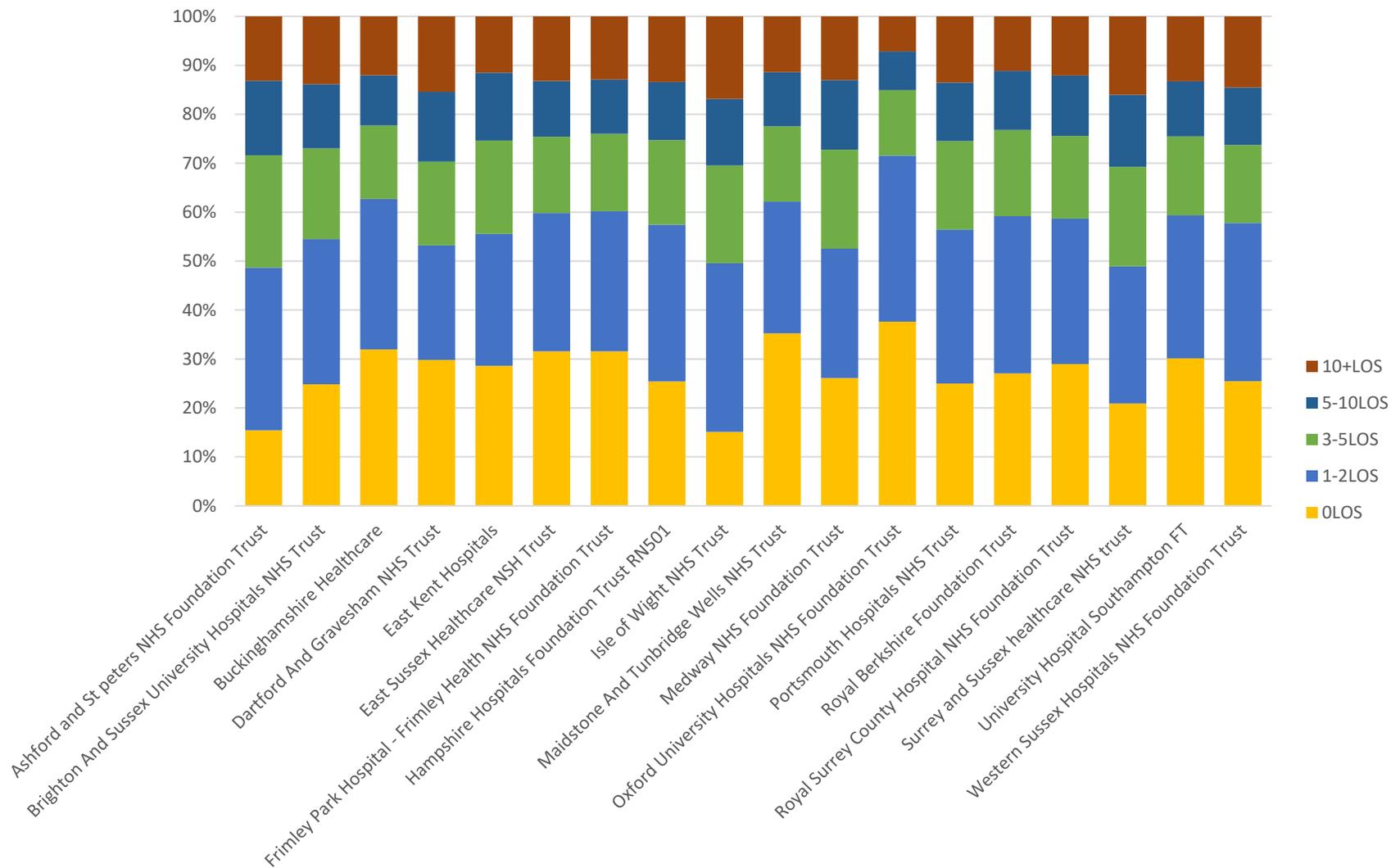


three



| 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 names | | 230456007 | G419 |
| Epilepsy : absence | we have different types of epilepsy but not by these names | | 79631006 | G403 |
| Epilepsy : focal | we have different types of epilepsy but not by these names | | 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 pulmonale | 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 |

South East LOS



SDEC

Star-chamber
approach

ICD/SnoMed/
ECDS codes agreed

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



Incentives

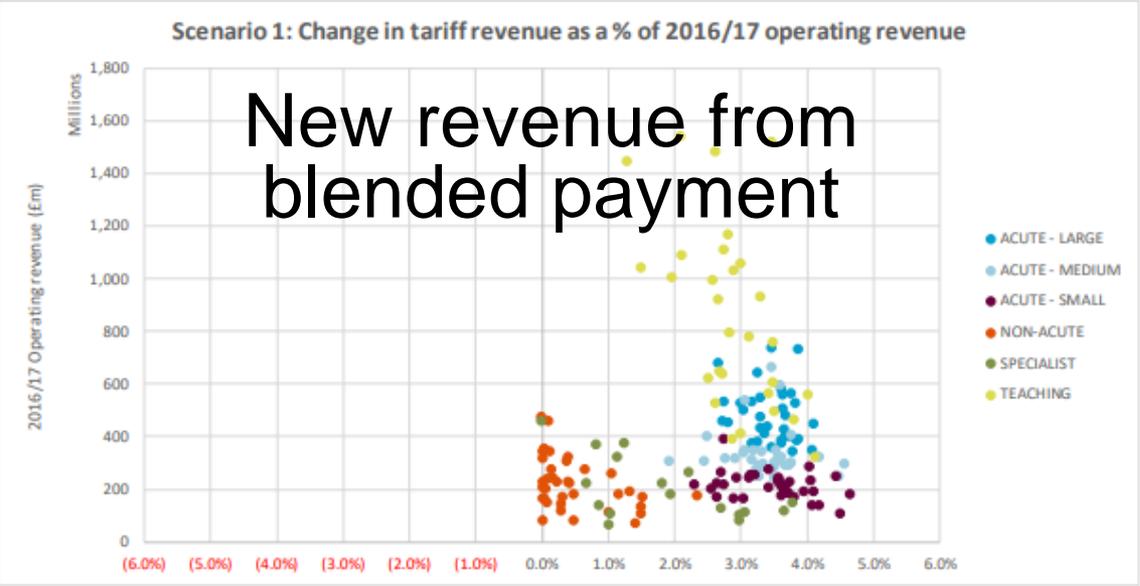
3 CQUINS \cong £500k
per trust pa

Pneumonia

Pulmonary Embolus

Atrial Fibrillation

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



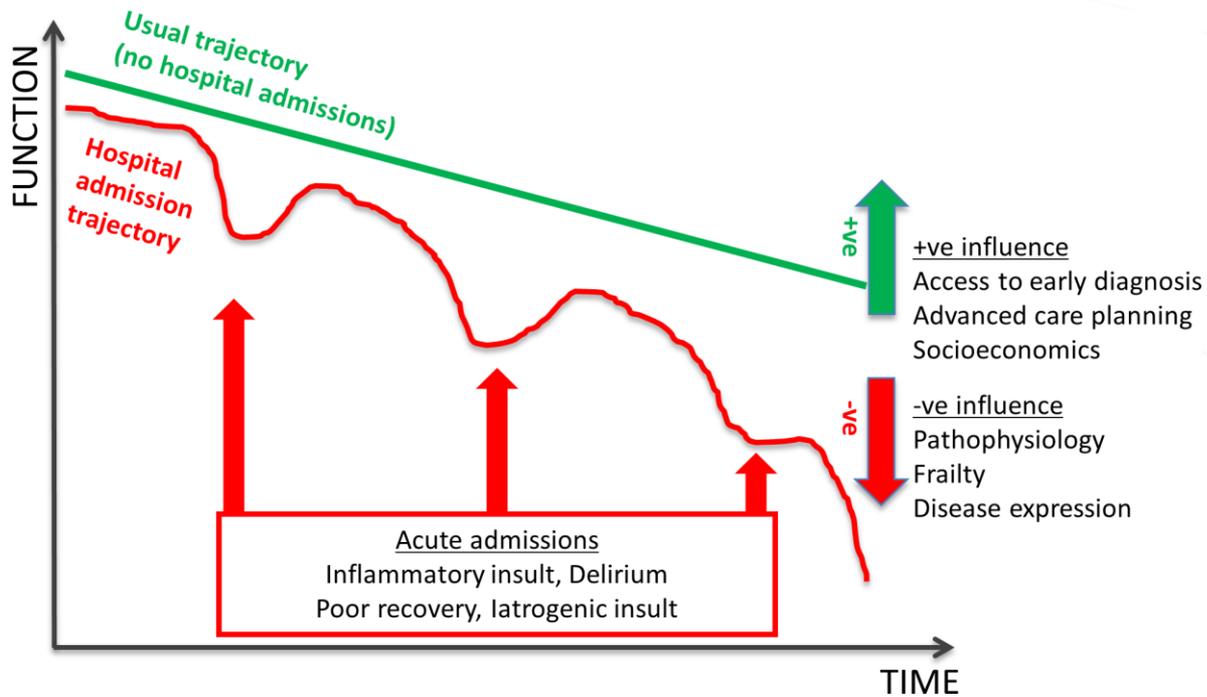
Fiscally prudent



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



“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”



Last
 1000
 Days



Better for

Patients
who can be
managed
without
admissions

Patients
who
require
admission

Hospitals

The NHS

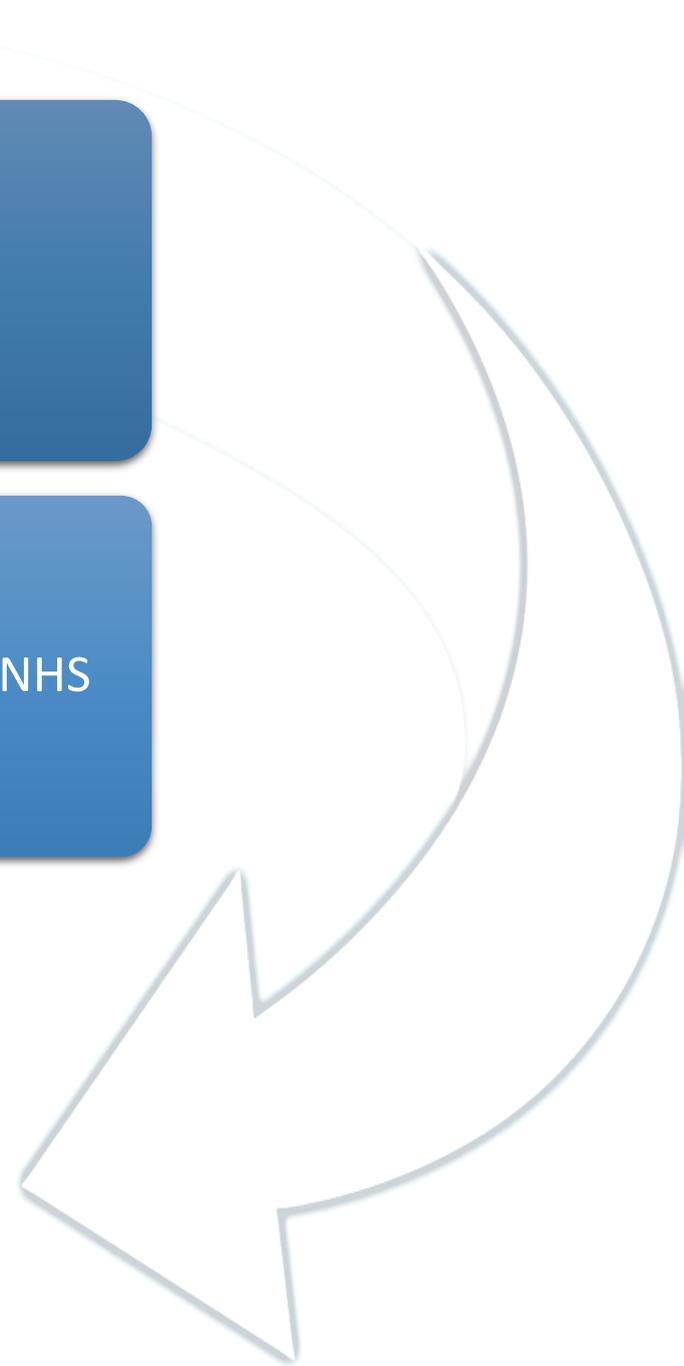
SDEC



NZLoS



4% bed occupancy



Strategic Vision

Mark England

Deputy National Director of Emergency and Elective Care

[NHS England and NHS Improvement](#)

SDEC Workshop

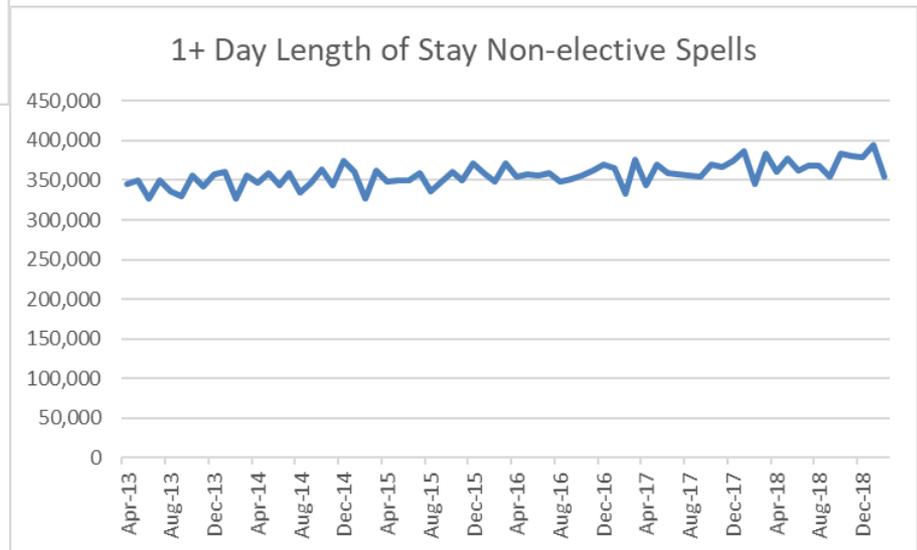
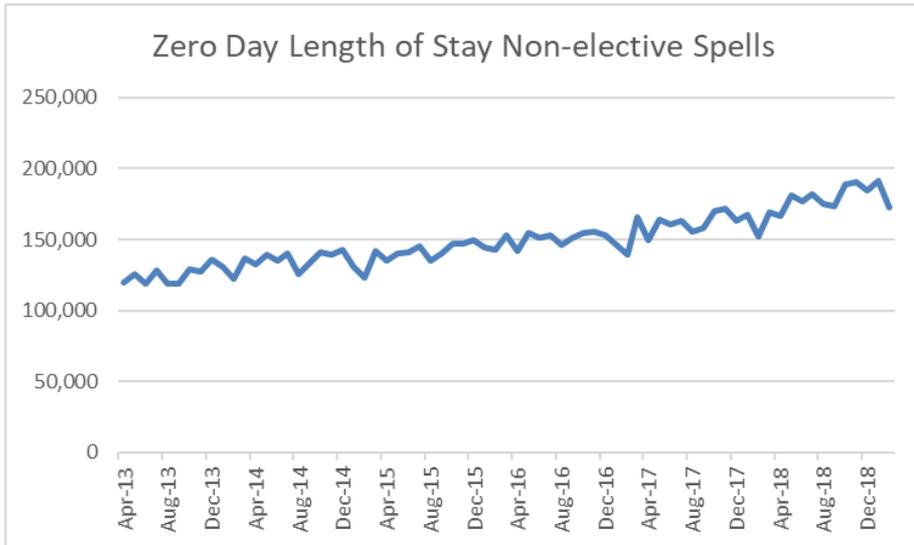
April 2019

Mark England – Deputy National Director of Emergency and Elective Care NHSI/E

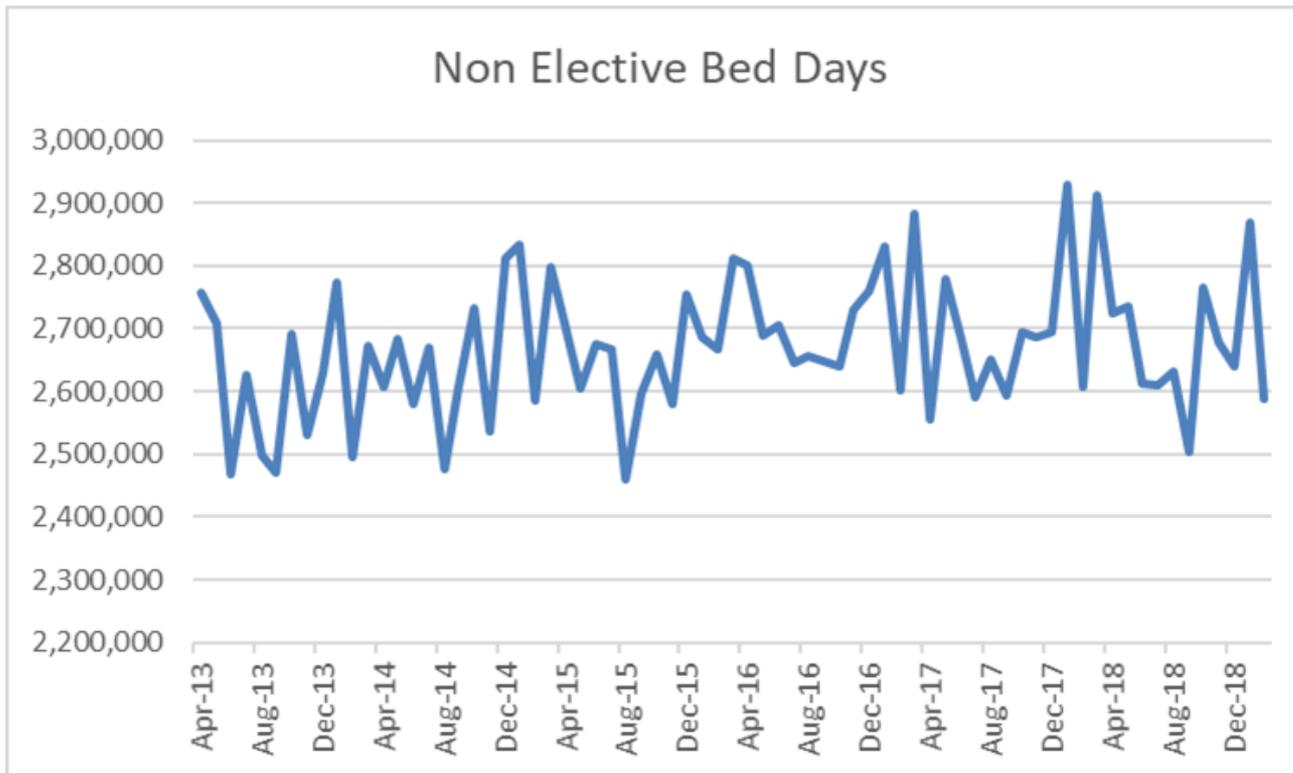
NHS England and NHS Improvement



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.

**NHS Operational
Planning and
Contracting Guidance
2019/20**

National SDEC CQUINs published for 2019/20

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

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?]



The NHS Long Term Plan



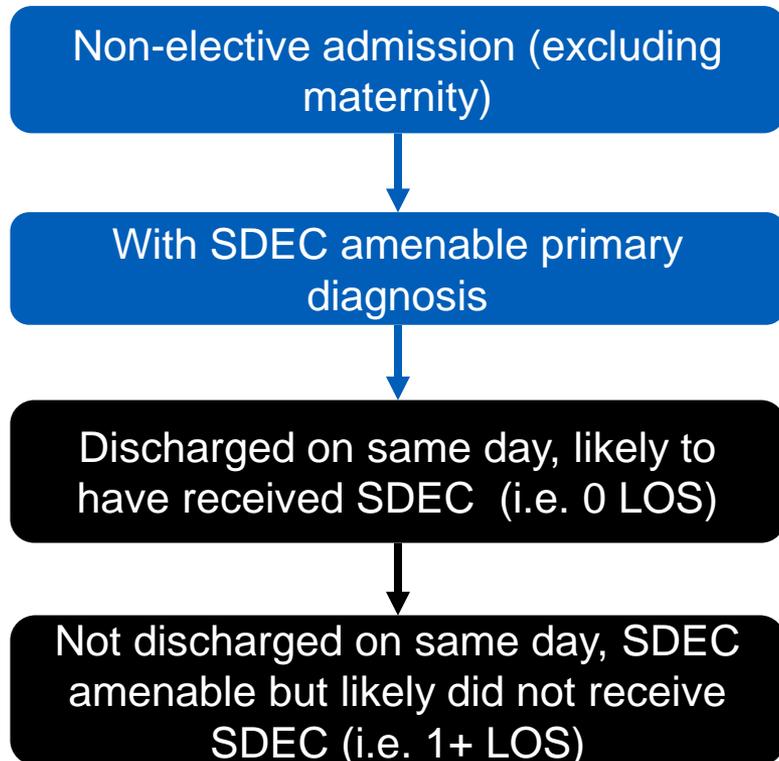
SDEC – Patient Level Information Cost System (PLICS) Analysis

April 2019

NHS England and NHS Improvement



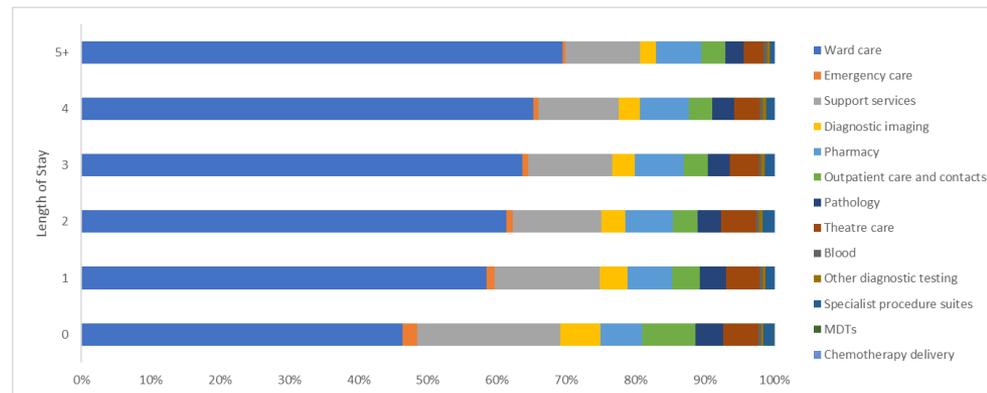
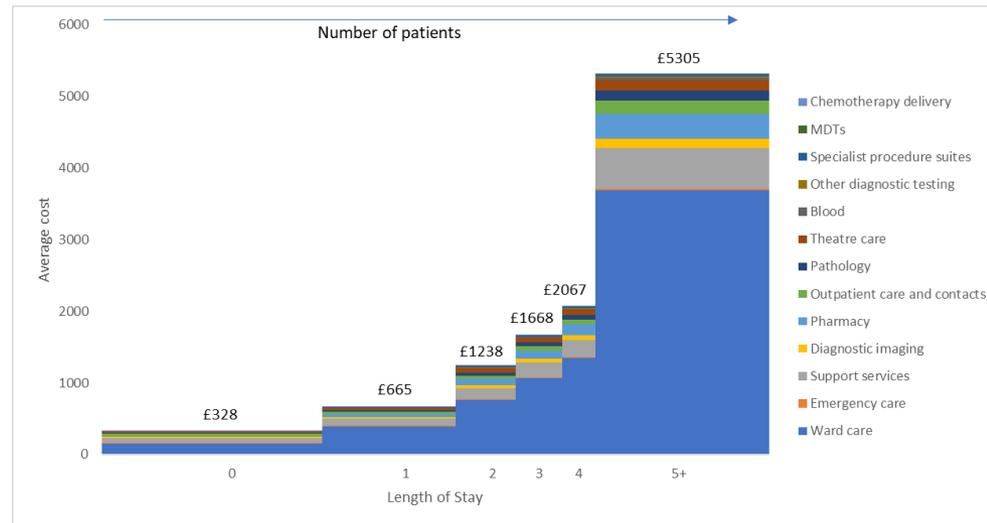
The approach used to identify SDEC amenable patients



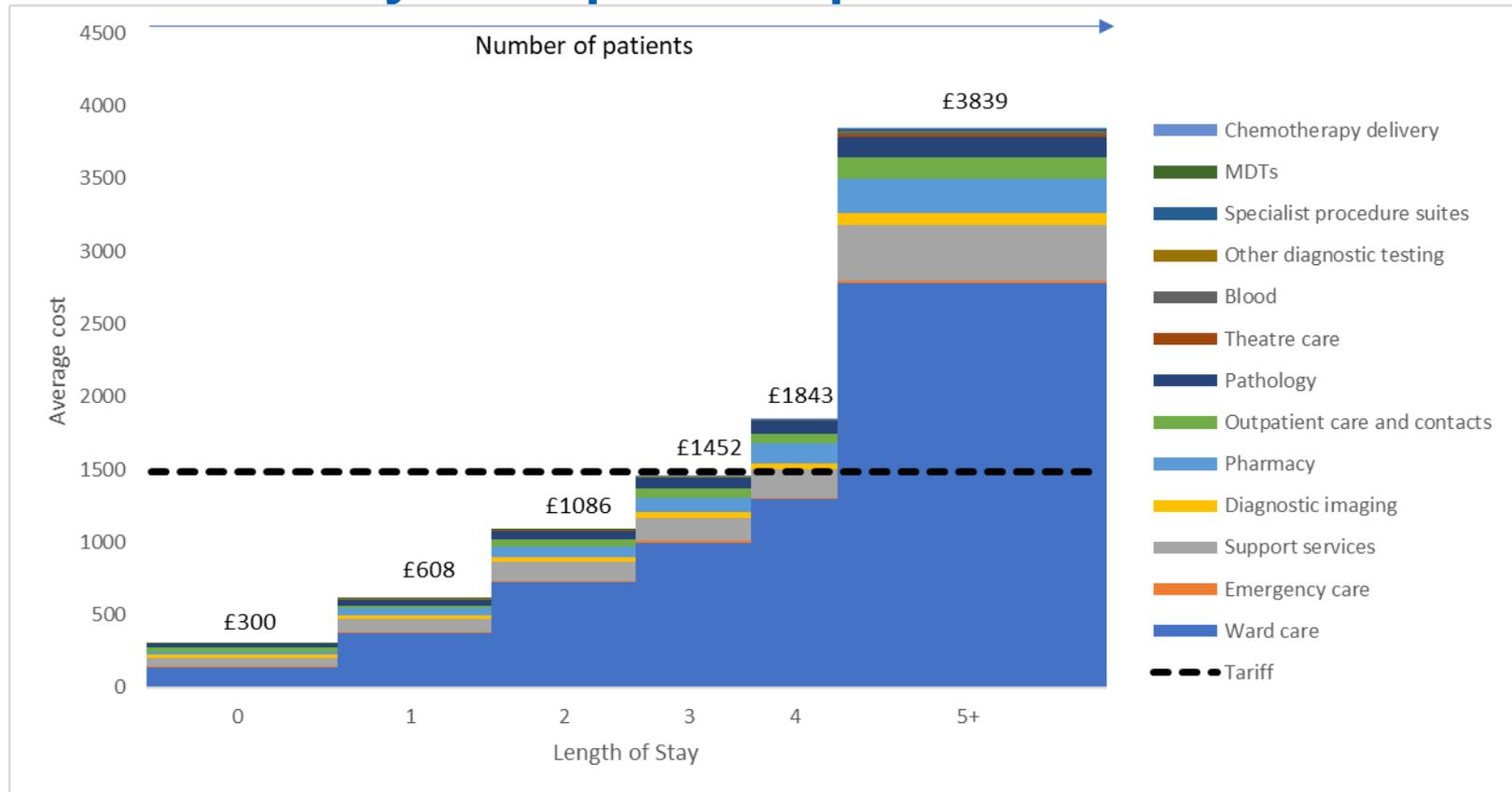
- We identify SDEC and potential SDEC spells in 2017/18 PLICS data. This covers 69 acute trusts.
- This approach was applied as a way to analyse historic data and thus applies contemporaneous information on diagnoses amenable to SDEC treatment from the Directory of Ambulatory Emergency Care for Adults (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.

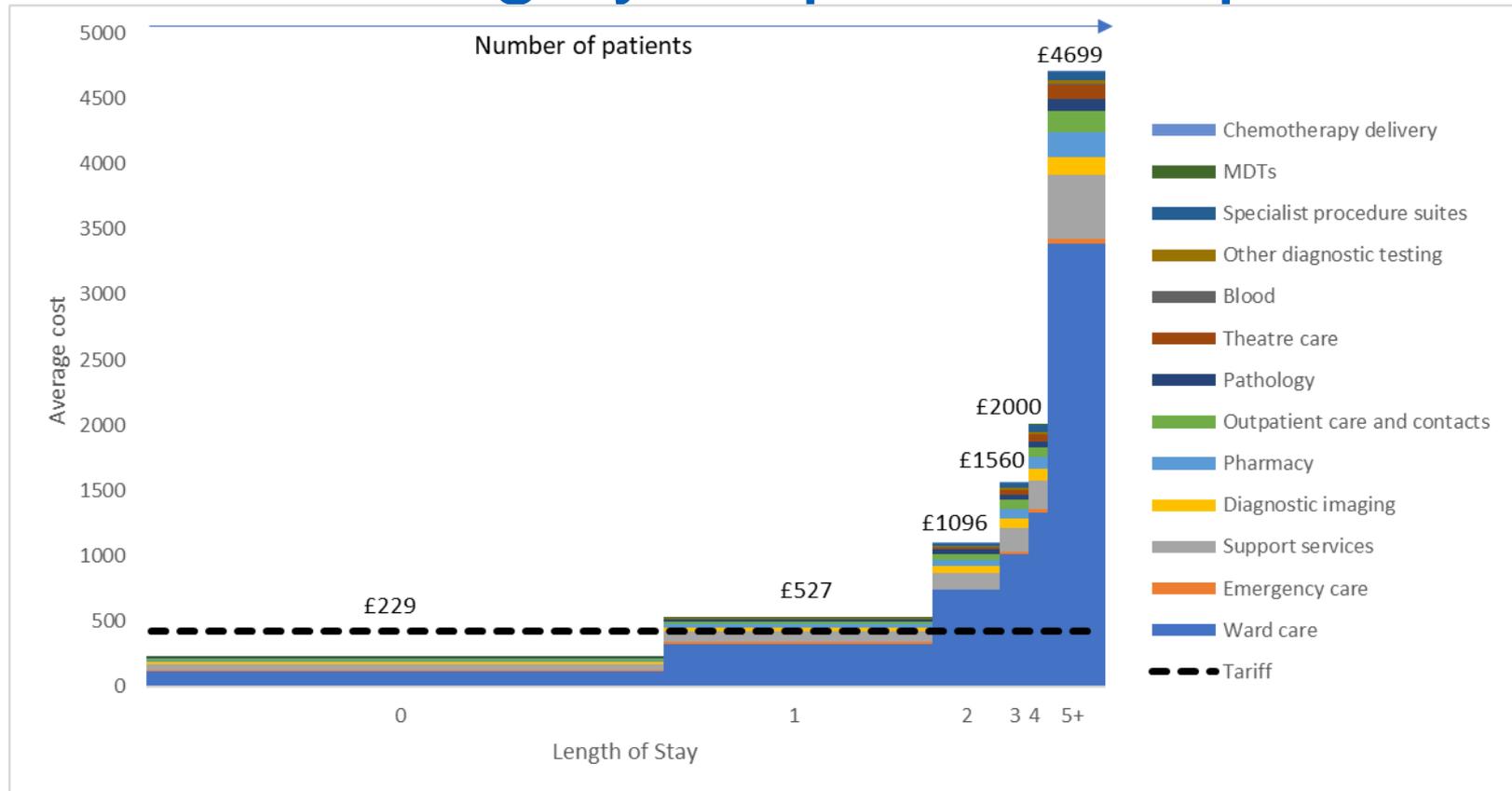


Community-acquired pneumonia



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 |

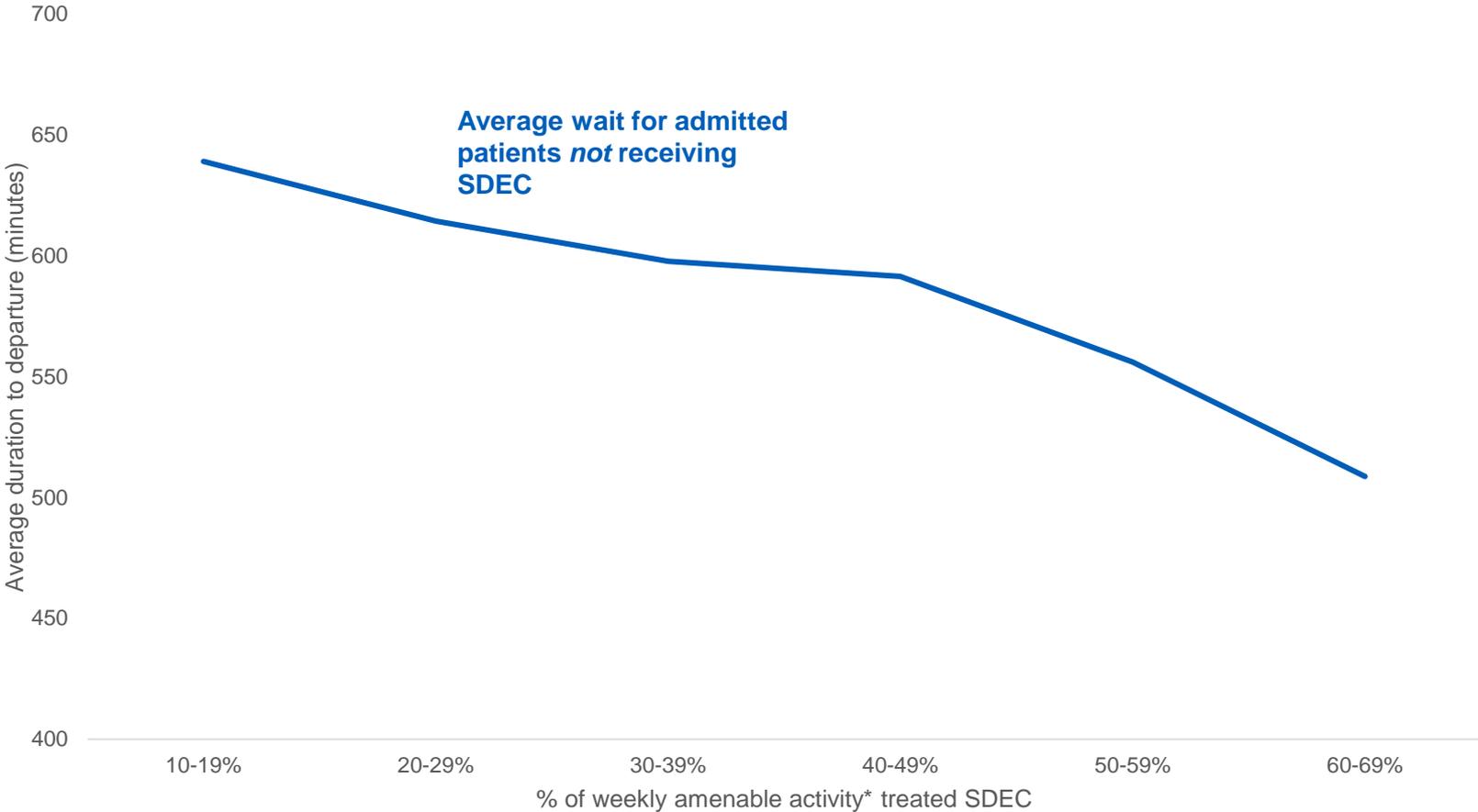
* The average trust is based on the 69 trusts in the PLICS dataset with substantial NEL activity in FY2017/18.

^ 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

AEC in Emergency Care

Dr Tara Sood

RCEM AEC Toolkit

Dr Tara Sood

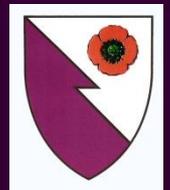
Consultant Emergency Medicine

Royal Free London NHS Foundation Trust

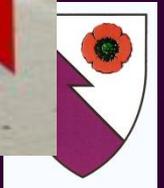
Chair RCEM Ambulatory Emergency Care Special Interest Group

NHSI Clinical Lead SDEC (RCEM)

The Royal College of Emergency Medicine

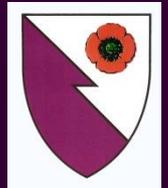


Drivers For Change





The Royal College of Emergency Medicine

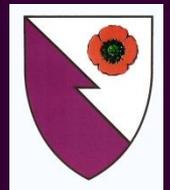


Other Drivers

- Patient expectation

NHS LONG TERM
PLAN

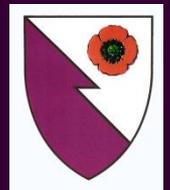
- Financial issues
- Demographic changes
increasing demand
- Workforce issues



Key Ingredients

Same day emergency care can be successfully achieved by:

- Early senior decision making
- Streamlining access to diagnostic services
- Collaborative working
- Providing an environment that supports same day emergency care



Who Does This ?

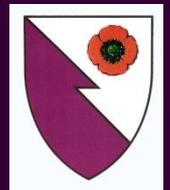
Emergency Physicians

Acute Physicians

Acute Surgeons

Frailty Teams

Specialist teams e.g. renal , O&G





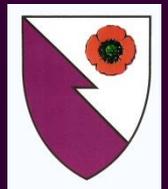
The Royal College of
Emergency Medicine

The RCEM Ambulatory Emergency Care toolkit

Delivering same day
emergency care from the ED


Ambulatory Emergency
Care Network

January 2019



Principles of Delivering AEC from the ED

- Patient Identification
- Working closely with specialist colleagues
- Patient streaming
- AEC environment
- Patients that should not be streamed to AEC
- A comprehensive record must be in place
- Patient information
- Secondary and Primary care services
- Clear Measures
- AEC Activity



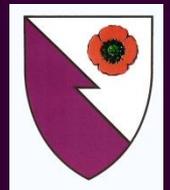
Work Closely With Specialist Colleagues

To standardise care according to best practice

To use local expertise

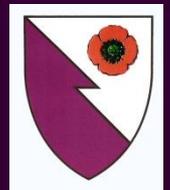
To share resources

To ensure that there are no adverse effects on ED flow



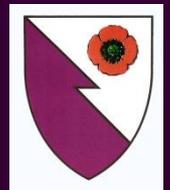
Patient Streaming

- Patients with certain clinical conditions may be streamed directly to the AECU
- The most appropriate service to meet the patient needs should be selected
- In a significant proportion of cases, patients will have their pathway initiated in the ED and then continued on an AECU or equivalent ED observation ward.



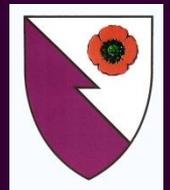
AEC Environment

- The practice of observational medicine is embedded into Emergency Medicine Practice.
- Location of an area providing ambulatory emergency care activity close to an AMU is recognised as improving patient flow by up to 50%

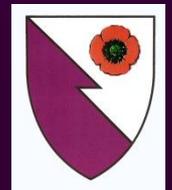
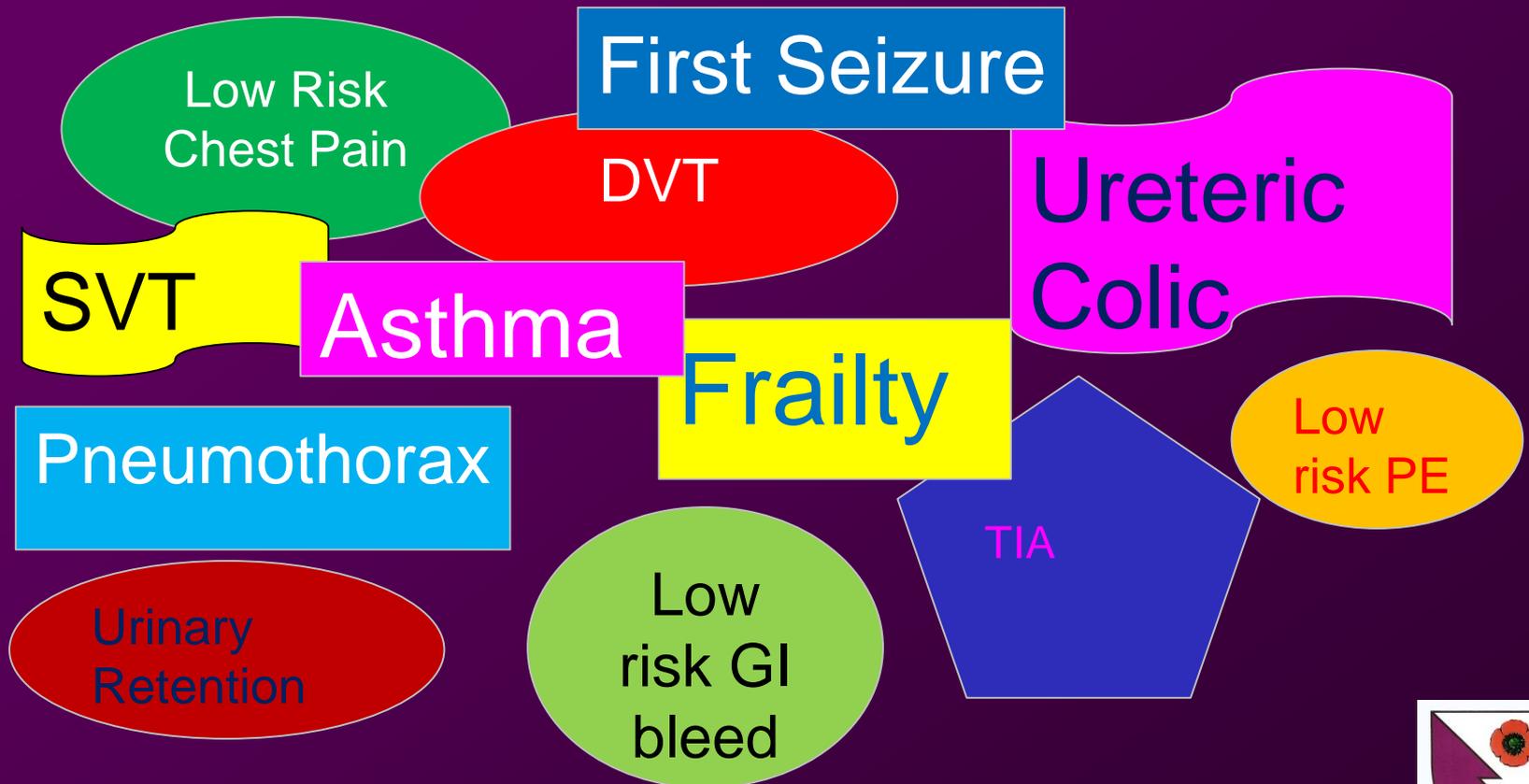


Observational Medicine

- Observation Medicine & Same Day Emergency Care is a vital function of main ED activity
- ED Clinical Decision Units provide a key contribution to delivery of Same Day Emergency Care by:
 - Providing an ideal platform for same day emergency care
 - “Gatekeeping” the in-hospital bed base
 - Improving safe discharge from the ED



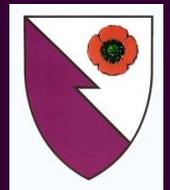
Delivering Ambulatory Care from the ED



Patients that should NOT be streamed to AEC

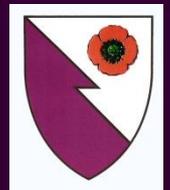
- Type 2 and Type 3 ED attenders (Minors)
- Type 1 ED patients who will breach the 4-hour standard but whose clinical care can be completed in the ED, or are awaiting ward admission
- Clinically unstable patients

The AECU is NOT a discharge lounge or “overflow” unit for other services



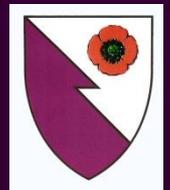
Secondary and Primary Care Services

- Secondary and Primary Care services must work together
- AEC can be particularly valuable in the assessment and management of frail patients



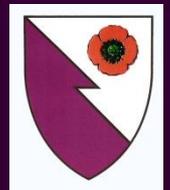
Clear Measures Should be in Place

- reduction in the number of emergency bed days used
- reduction in the number of patients admitted to hospital for <24 hours
- improved experience for patients
- improved staff experience
- improved quality of care
- improved safety
- improved patient flow
- improved ambulance turnaround
- reduction in readmissions
- reduction in incidents in emergency care



AEC Activity

- Dashboard – with appropriate data set
- Appropriate process and outcome metrics
- Tariff





RCEM VISION 2020

Fixing Emergency Department **Staffing, Systems & Support**
to deliver excellent patient centred care

Staffing

Workforce

Recruiting and retaining a safe level of a trained clinical workforce to meet demand



Leadership

Developing leaders to be role models and inspire the values and aspirations of emergency medicine



Training

Enhancing the training environment to attract and retain high quality staff



Sustainable Careers

Defining careers that are successful, satisfying and sustainable



Systems

Eliminate Exit Block

Eliminating exit block and crowding in Emergency Departments to ensure quality patient care



Integrate Emergency Department 'Front Door'

Resourcing EDs to better 'stream' patients to best treatment for their needs



Reconfiguration & Integration

Reorganising services to provide better, faster care



#RCEMsolutions

Support

Quality Indicators

Improving measurement of performance, safety and evidence based clinical care



Safety & Best Practice

Establishing better ways of sharing best practice and delivering safer care supported by technology



Data & Information

Using data effectively to better understand patient need & design care services

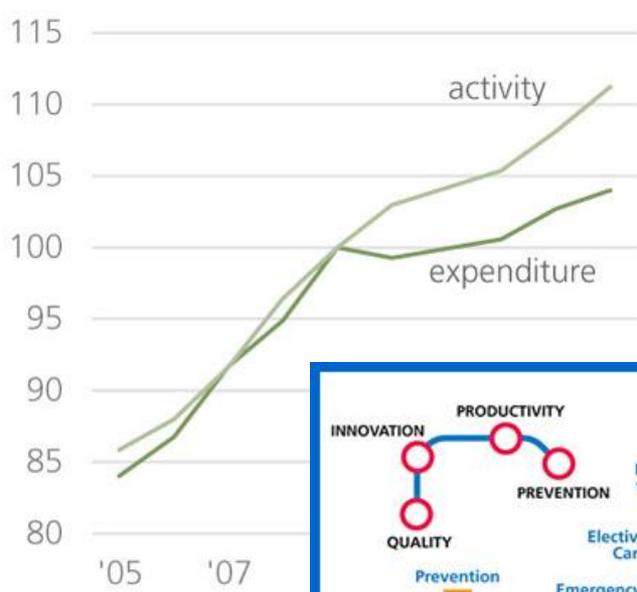


rcem.ac.uk/vision2020

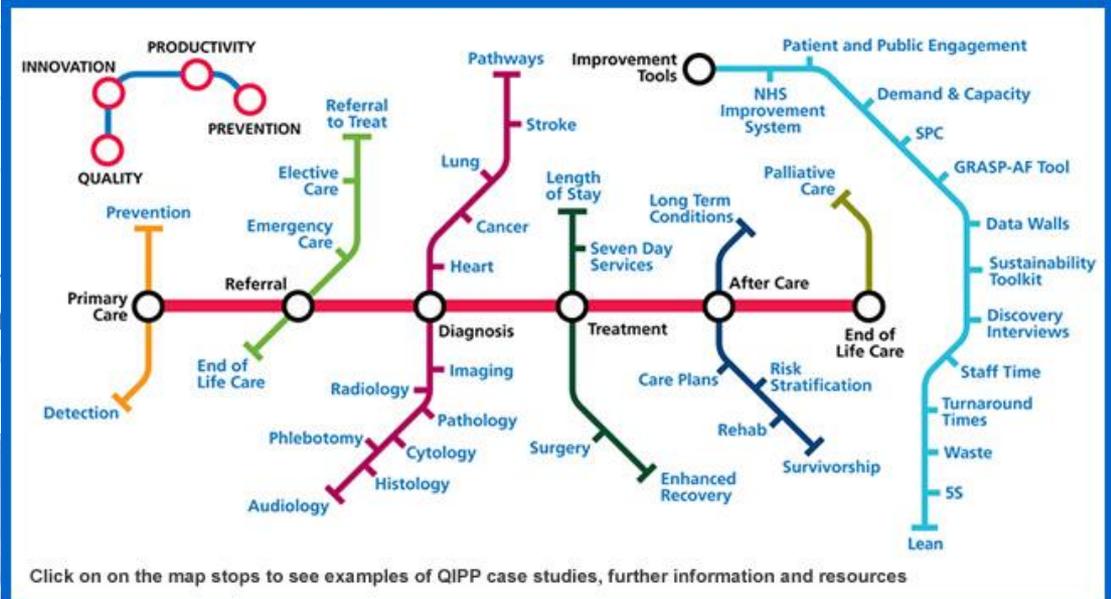


What is SDEC?

Jay Banerjee



* spell of hospital in under the care of for 2014/15 are a p data to Jan-15 and



Click on on the map stops to see examples of QIPP case studies, further information and resources



The NHS needs to be more productive - or is it more efficient?

kingsfund.org.uk/blog

95% of increase in short stay admissions

- Urinary disorders
- Gastroenteritis / colitis
- Tonsillitis
- Cellulitis
- Pneumonia (unspecified)
- GORD
- Convulsions
- Abscesses, carbuncles



Patients

PROCESSES

- Time based
- Service based
- Time in hospital?
- Meaningful time?
- Self management?
- Access to care?
- Respect for values?

OUTCOMES

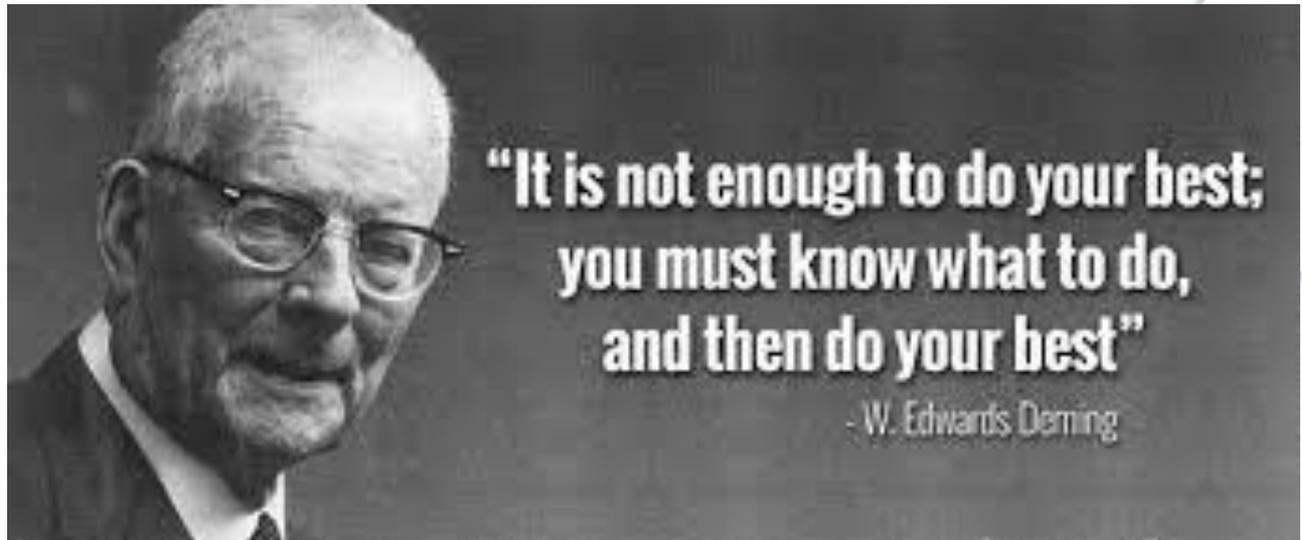
- Admission.....
- Morbidity....
- Satisfaction?
- Carer burden?
- Autonomy?
- Mood?
- PPC/PPD?

Some influencers on U&E care decision making

- Improving diagnostics – HS Trop; high resolution CT
- Improving evidence on risk – hospital admission does not stop falls; 300 falls in AF/yr
- Improving evidence on effectiveness – NOACs
- Improving person centredness – end of life evidence, shared decision making
- Improving evidence of impact of patient groups – frailty and how it influences outcomes

Other influencers

- Educating patients
- Improving access
-doing our best.....



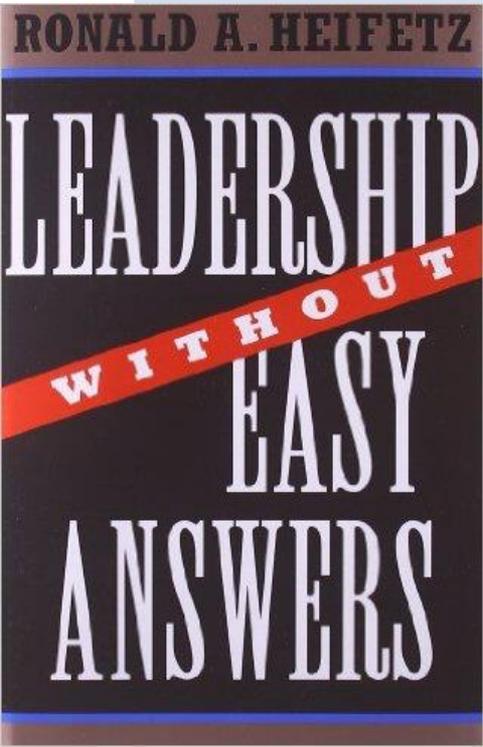
Challenge

TECHNICAL

- Problem is well defined
- Solution is known/ can be found
- Implementation is clear

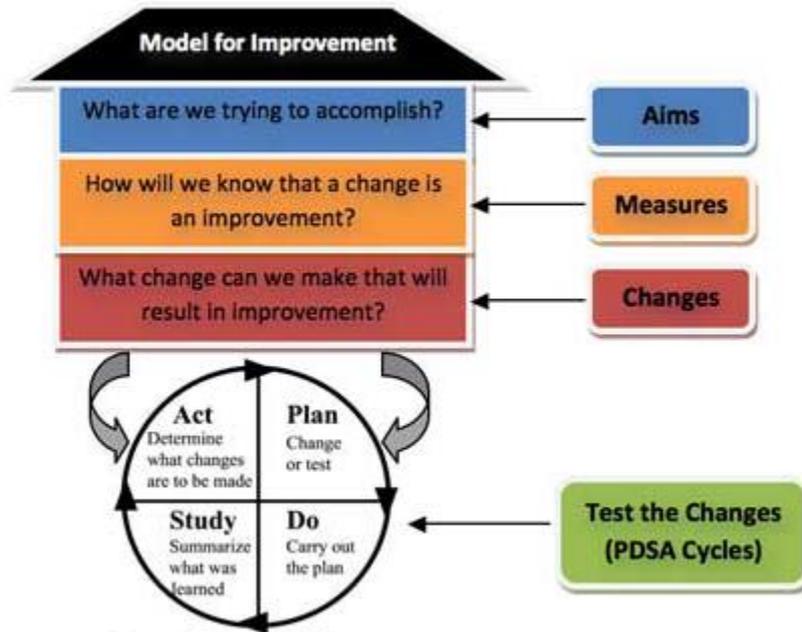
ADAPTIVE

- Challenge is complex
- To solve requires transforming long-standing habits and deeply held assumptions and values
- Involves feelings of loss, sacrifice (sometimes betrayal to values)
- Solution requires learning and a new way of thinking, new relationships



Small steps lead to big changes

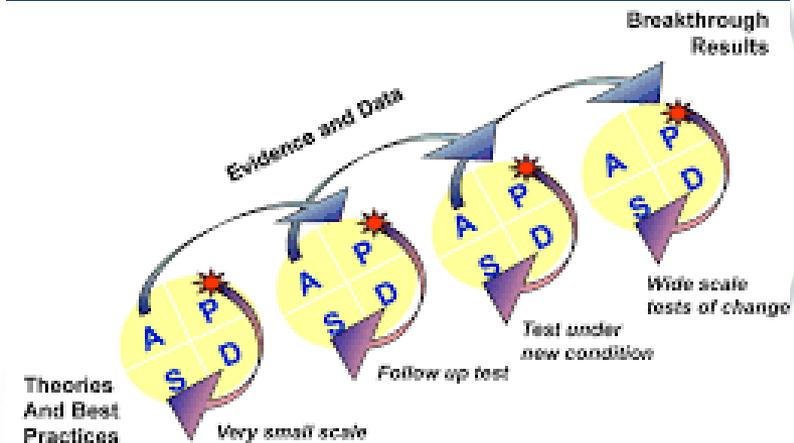
We accelerate change and improve our quality of HIV care by using the Model for Improvement



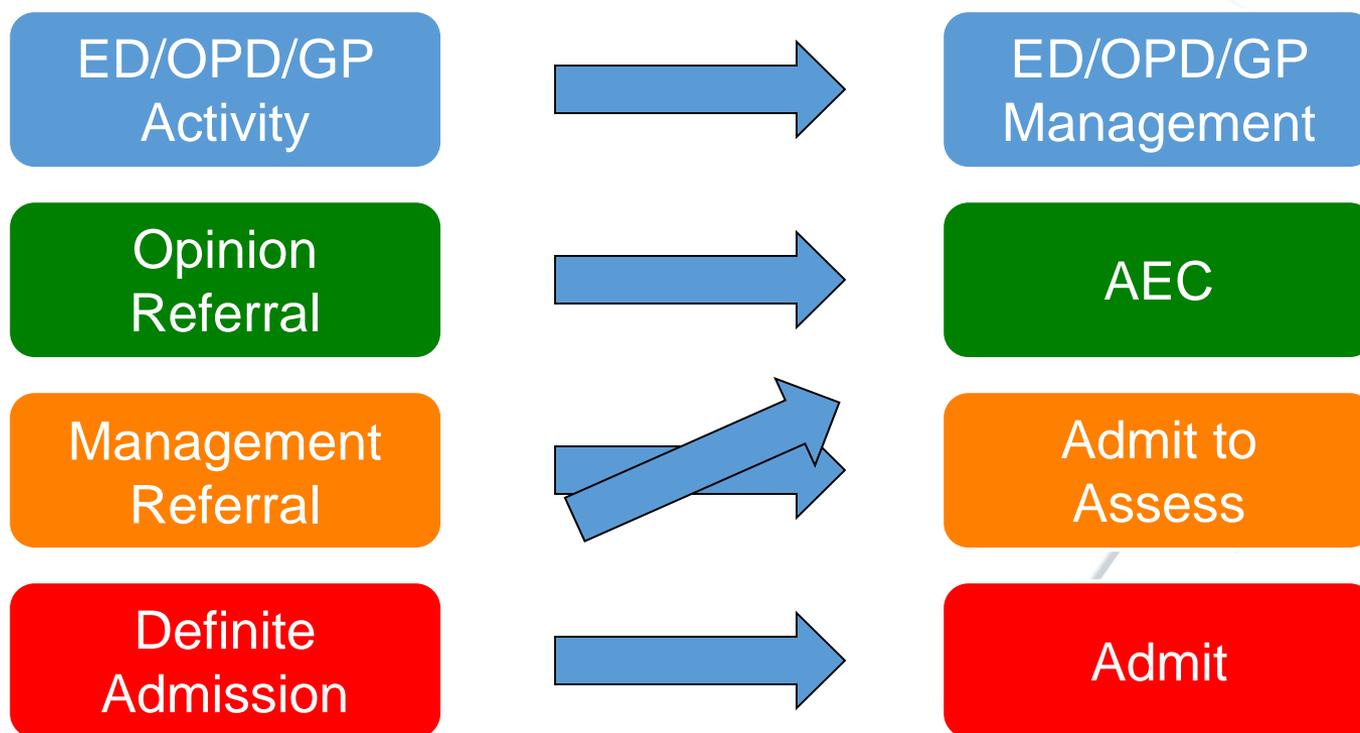
Source: Langley *et al.* (1996)

Langley *et al.* (1996). *The Improvement Guide*, Jossey-Bass: San Francisco

Building Knowledge with PDSA Tests



Right patient, right place



UPDATE - Directory of AEC

Version Five Updated July 2016, with 2014/15 HRG Codes



Ambulatory
Emergency Care

NHS
Elect

Contains
seven new
clinical
scenarios

Directory of Ambulatory Emergency Care for Adults

[Click here to get started](#)



Previous version September 2014

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?

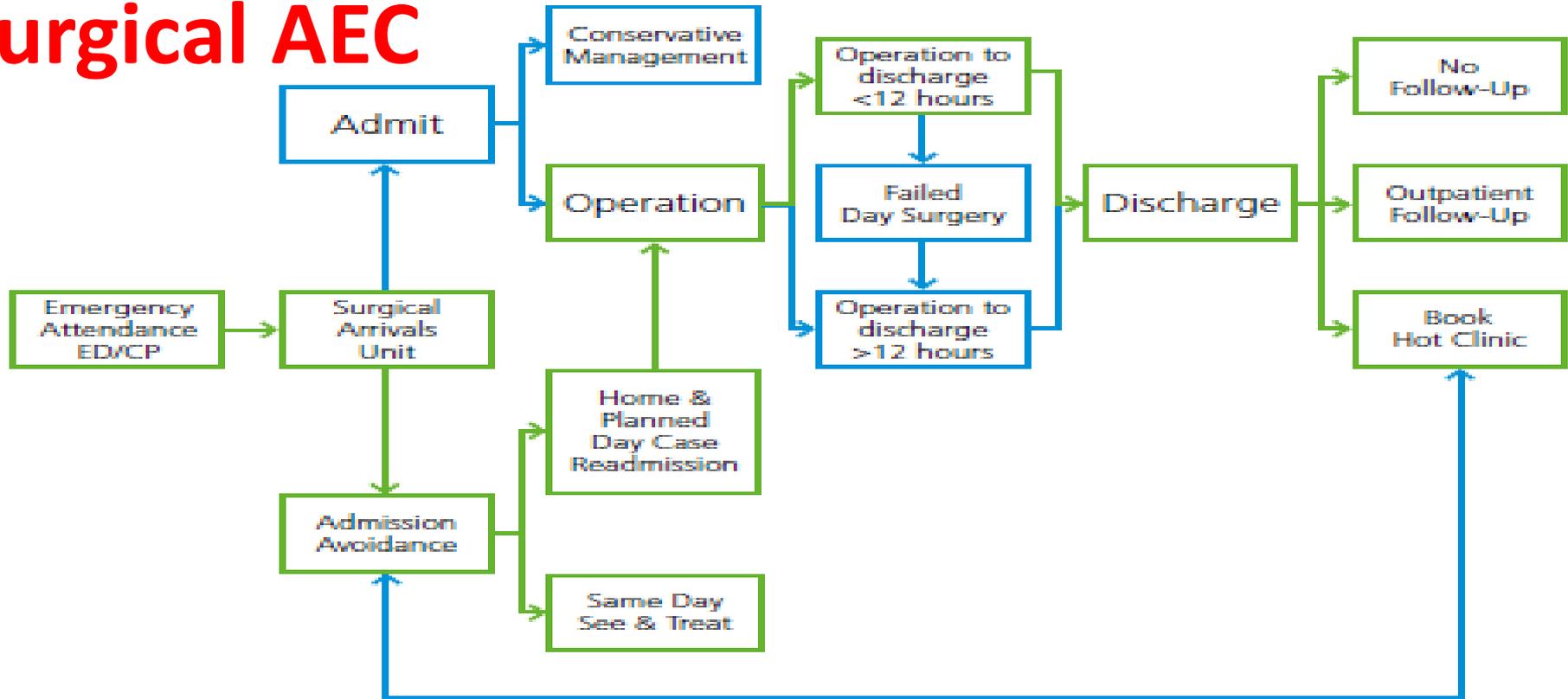
Would the patient have been admitted if AEC was not available?

The 4Ps Model of AEC

- Passive – receive referrals
- Pathway driven - restricted to agreed pathways
- Pull – senior clinician takes the call
- Process driven – all patients considered for AEC

Diagram 2 Emergency Surgery Flow

Surgical AEC



& Medical Procedures

Appendicectomy (laparoscopic)

Arthroscopy

Biopsy

- lymph node
- temporal artery

Evacuation retained products of conception

Incarcerated Hernia

- inguinal
- para-umbilical
- femoral

Incision & Drainage of Abscess

- axillary
- groin
- neck
- perianal
- pilonidal

K – wiring

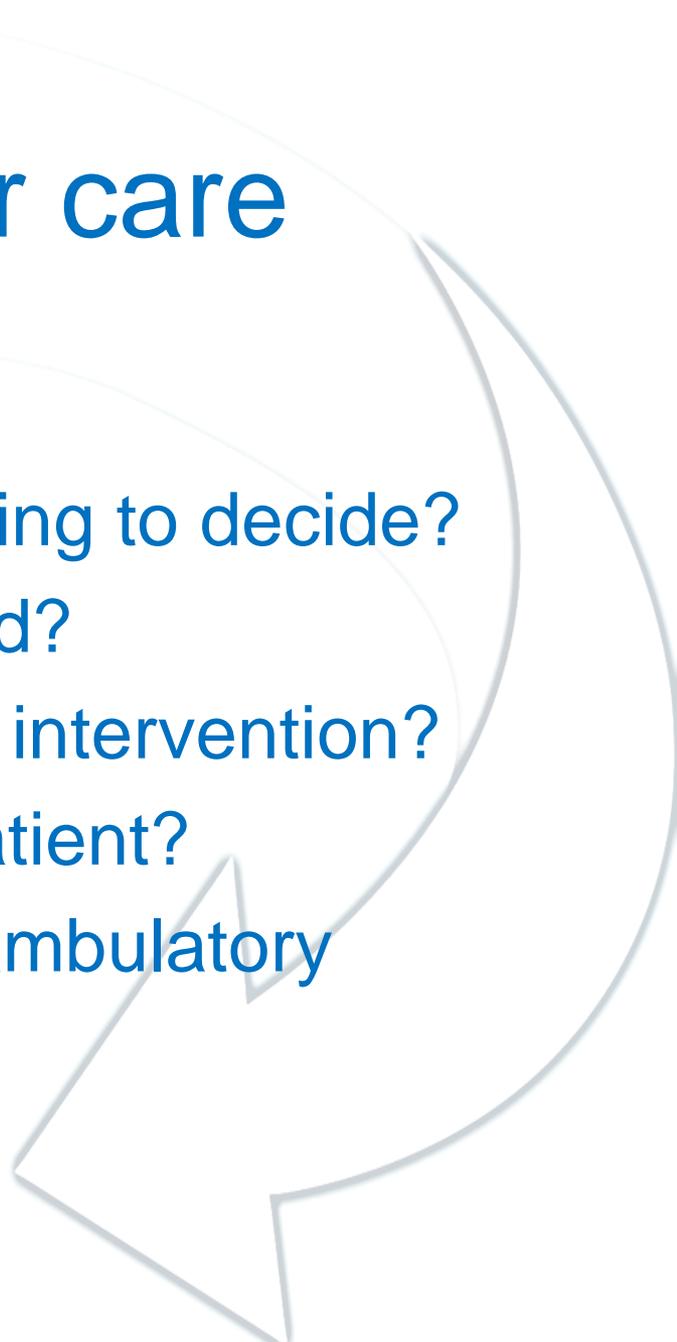
- finger or wrist

Laparoscopic ovarian cystectomy

Reduction and internal fixation

Tendon repair

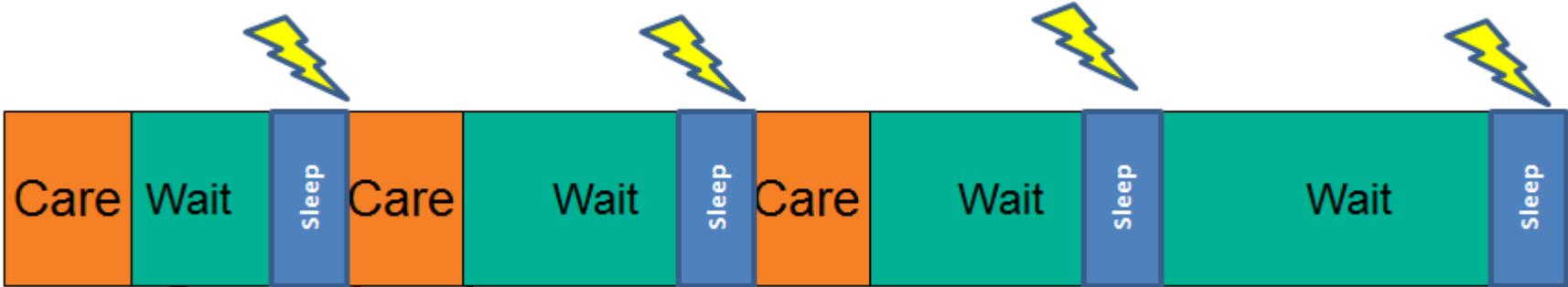
Maximising front door care

- ED and beyond but not too far!
 - Deciding to admit versus admitting to decide?
 - Who would prefer to be admitted?
 - When is an admission an acute intervention?
 - Is the care ambulatory or the patient?
 - Which specialties can support ambulatory care?
 - Who are the generalists?
- 

Key message - Beds aren't capacity

“Beds are where patients wait for the next thing to happen”

We should think:
You only get care from a bed if that is the only way we can deliver your care



What is SDEC?

- Ambulatory **emergency care** (AEC) is a service **that** provides **same day emergency care** to patients in hospital.
- Patients are assessed, diagnosed, treated and are able to go home the **same day**, without being admitted overnight.
- Who can be managed under these criteria?
- What is you need to deliver it? Plan, people, place, process, passion and PDSA

Figure 2 2x2 matrix illustrating “right patient, right place” is it effective?

| | Managed in AEC | Not managed in AEC |
|------------------------|--|--|
| | conversion | |
| Appropriate in AEC | Box 1: Success % conversion from AEC service to admission Clinical outcomes/experience | Box 2: Missed opportunity % HRG/ICD-10 clinical scenarios Casefile review |
| Not appropriate in AEC | Box 3a: Wasted capacity Some HRGs may indicate Low conversion rates Casefile review | Box 4: Appropriate Emergency inpatient/outpatient care |
| | Box 3b: Potential clinical risk Patients NEW's score High conversion rates Casefile review | |

Maximising potential



Heart

Failure

Pathway

**Define who can
go home**

&

**Define who
needs specialist
care**

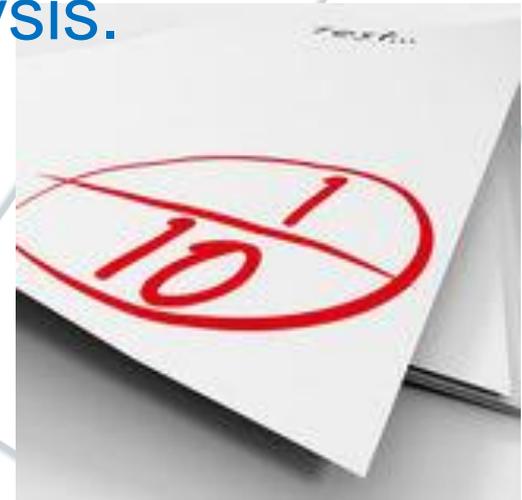
Inclusion/exclusion criteria

- The more criteria there are the more complicated the system becomes.
- Complex systems need simple rules.
 - Is the patient clinically stable?
 - Is the patient functionally capable of receiving care in AEC?
 - Would the patient otherwise have been admitted?
 - Could their needs be better met in an alternative outpatient/community service?
- Assumes good knowledge of the local health system.



Scoring systems

- Aim to reduce unhelpful variation by using common objective measures.
- Accessible to outsiders.
- Can support new or junior team members.
- Useful for audit and statistical analysis.
- Useful for benchmarking.
- Only one part of the toolkit.
- Can incorporate risk stratification.



Glasgow Admission Prediction Score*

| Variable | | Points | |
|----------------------|-----------|--------------------|---|
| Age | | 1 point per decade | *Cameron A, et al (2014) A simple tool to predict admission at the time of triage. <i>Emerg Med J (online)</i> doi: 10.1136/emmermed-2013-203200. |
| NEWS | | 1 point per NEWS | |
| Triage Category | 3 | 5 points | |
| | 2 (or 3+) | 10 points | |
| | 1 | 20 points | |
| Referred by GP | | 10 points | |
| Arrived by Ambulance | | 5 points | |
| Admitted <1 year ago | | 5 points | |
| | | | Cutoff 18 |

Use of GAPS in AEC

- GAPS is a good multi-dimensional measure of “sickness”, laden with prognostic information.
- It has the potential to be used as way of controlling for case mix when comparing the performance of different units, or the same unit over time.
- Low scores predict discharge from the front door, shorter hospital stays, lower mortality and a lower likelihood of re-attendance.
- At GRI Patients with a low score are moved to a rapid assessment area, managed by a medical nurse practitioner and senior acute physician. Discharge rates typically exceed 80%, and many patients are fed into ambulatory care pathways.
- Another option especially useful in those units that are co-located with ED.

What makes it work?

- Senior decision makers and simple rules.
- Knowledge of the AEC provision and system admission alternatives
- Decisions NOT tests.
- Consistency of AEC provision.
- AEC capacity not used by inappropriate activity.
- Role modeling during “pull” from ED
- Clear consistent clinical conversations at point of referral.
- Today’s work done today.
- Working as a system.

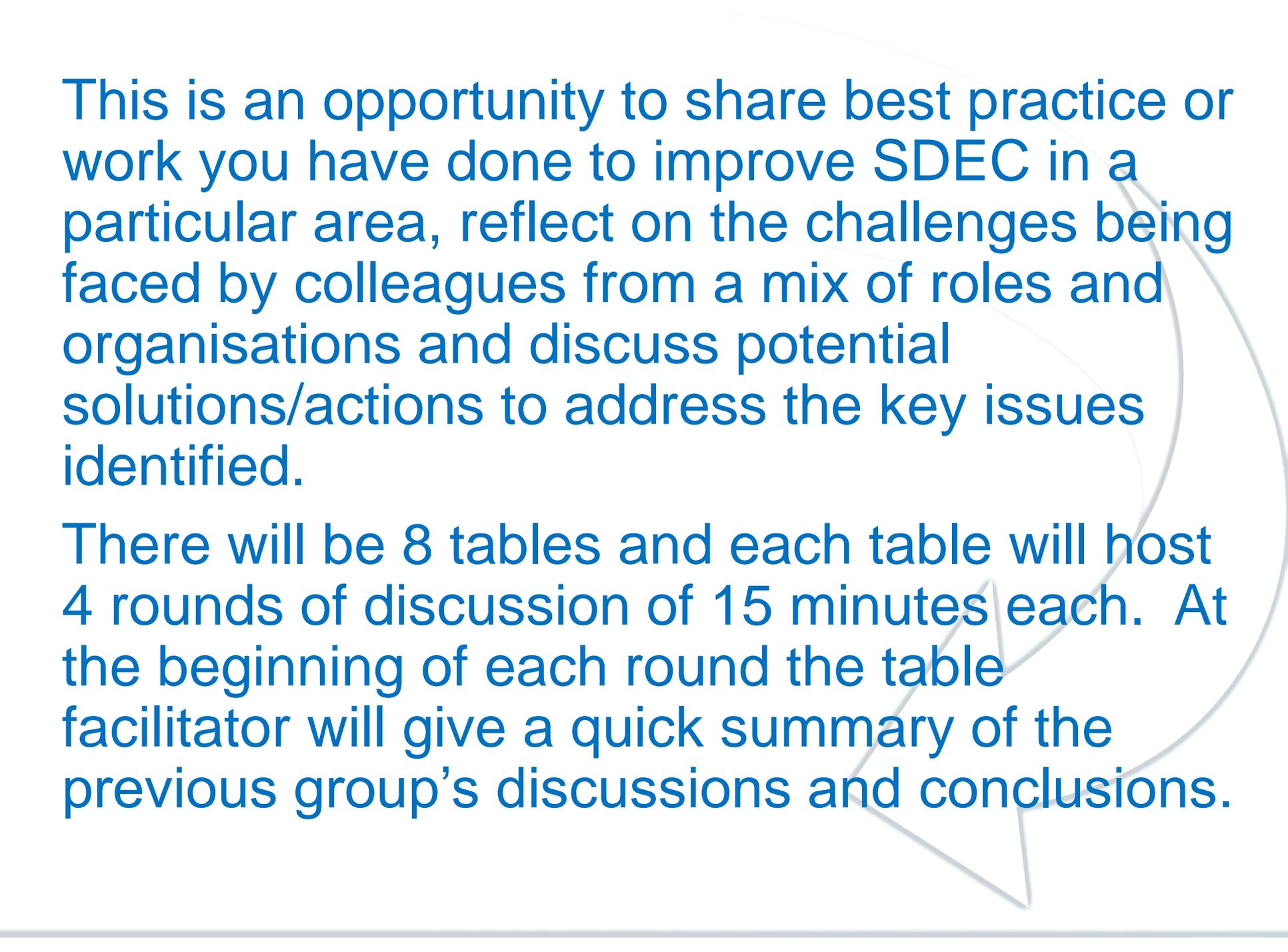




Surgical AEC – Mr Arin Saha



Working together to Maximise SDEC at Pace Deborah Thompson



This is an opportunity to share best practice or work you have done to improve SDEC in a particular area, reflect on the challenges being faced by colleagues from a mix of roles and organisations and discuss potential solutions/actions to address the key issues identified.

There will be 8 tables and each table will host 4 rounds of discussion of 15 minutes each. At the beginning of each round the table facilitator will give a quick summary of the previous group's discussions and conclusions.

Table Topics

- National SDEC priorities
 - ED
 - SDEC principles
 - Frailty
 - High volume pathways
 - Measuring the impact of SDEC
 - Patient Experience
 - Non-medical roles
- 





IT IS LUNCH TIME



Working with SAM to develop
the SDEC model
Julia Nixon, Society of Acute
Medicine



Same Day Emergency Care – Standards for Ambulatory Emergency Care



Background

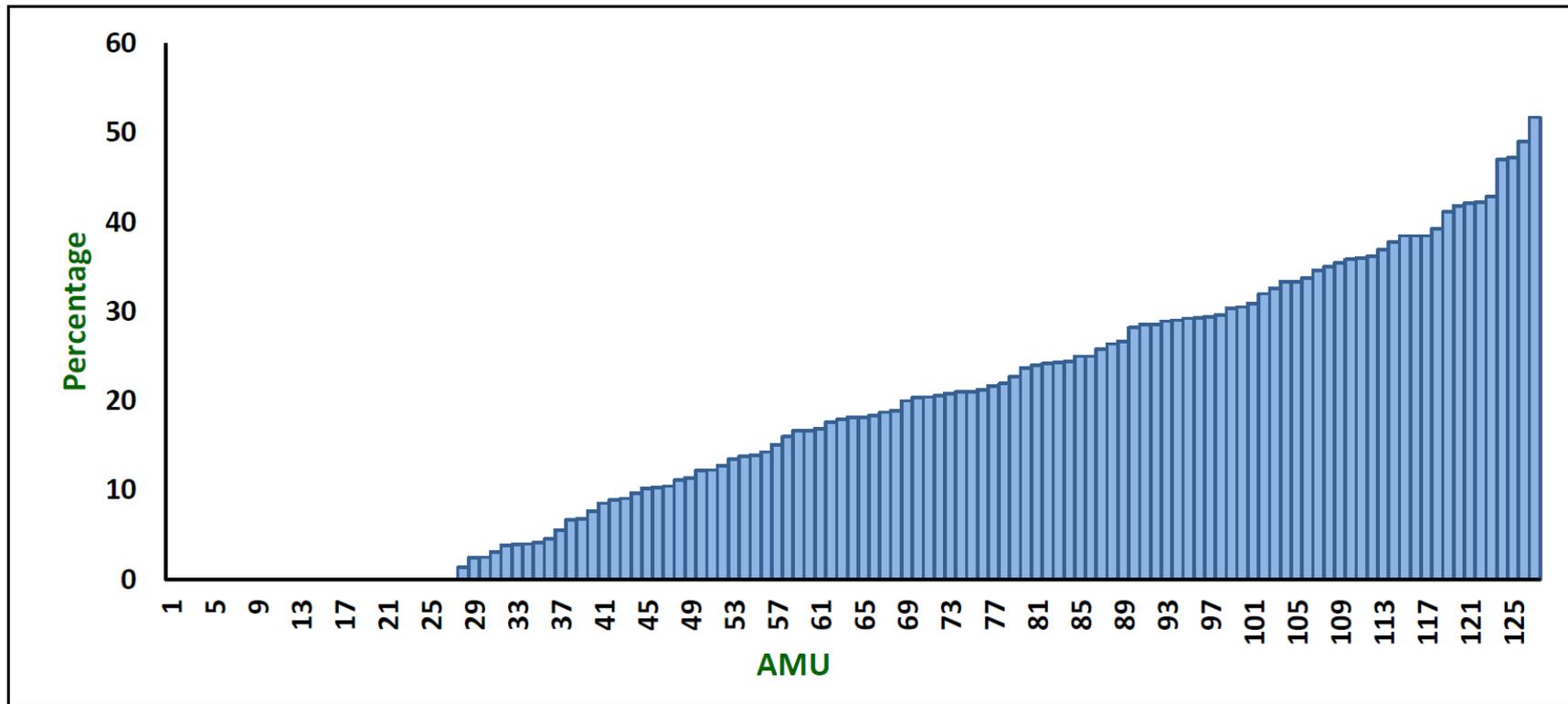
- Increasing activity/acuity nationally
- AEC departments growing in demand
- Managing acute patients as a zero LOS, that previously would have had an admission
- AEC Network/Directory
- RCPE/SAM working group - Standards for AEC/SDEC

SAMBA data

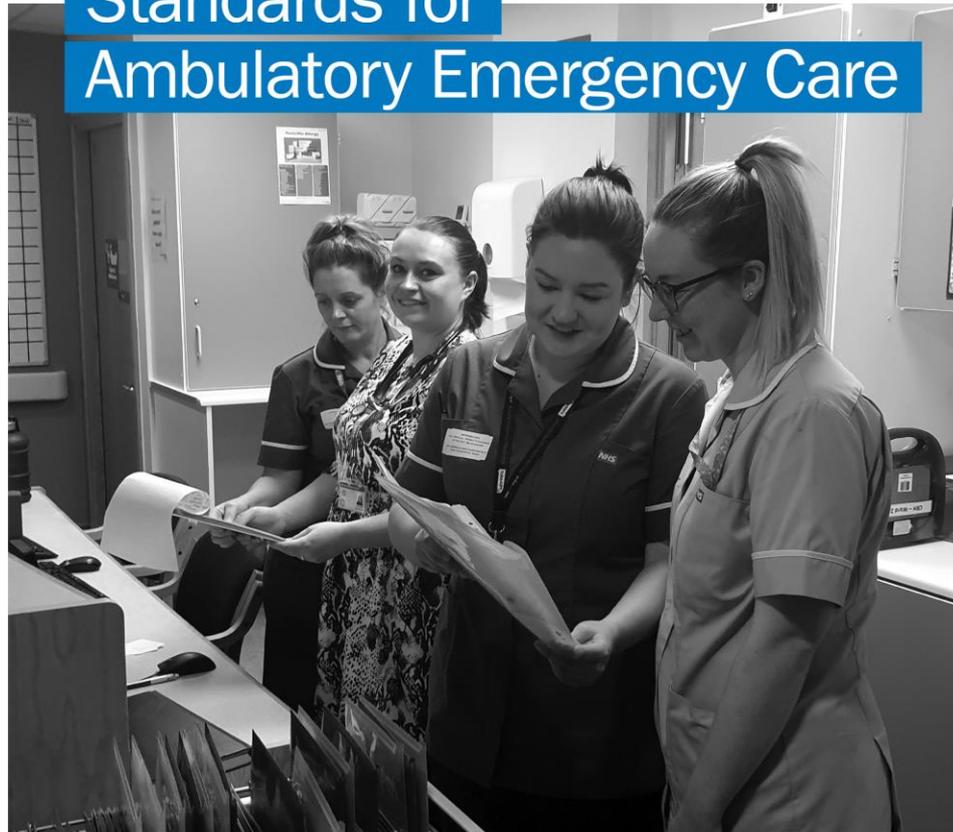
Ambulatory Emergency Care (AEC)

- 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

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



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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

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.

Thank you



ROYAL COLLEGE
of PHYSICIANS
of EDINBURGH



Where's SDEC?

Tom Hughes

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

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





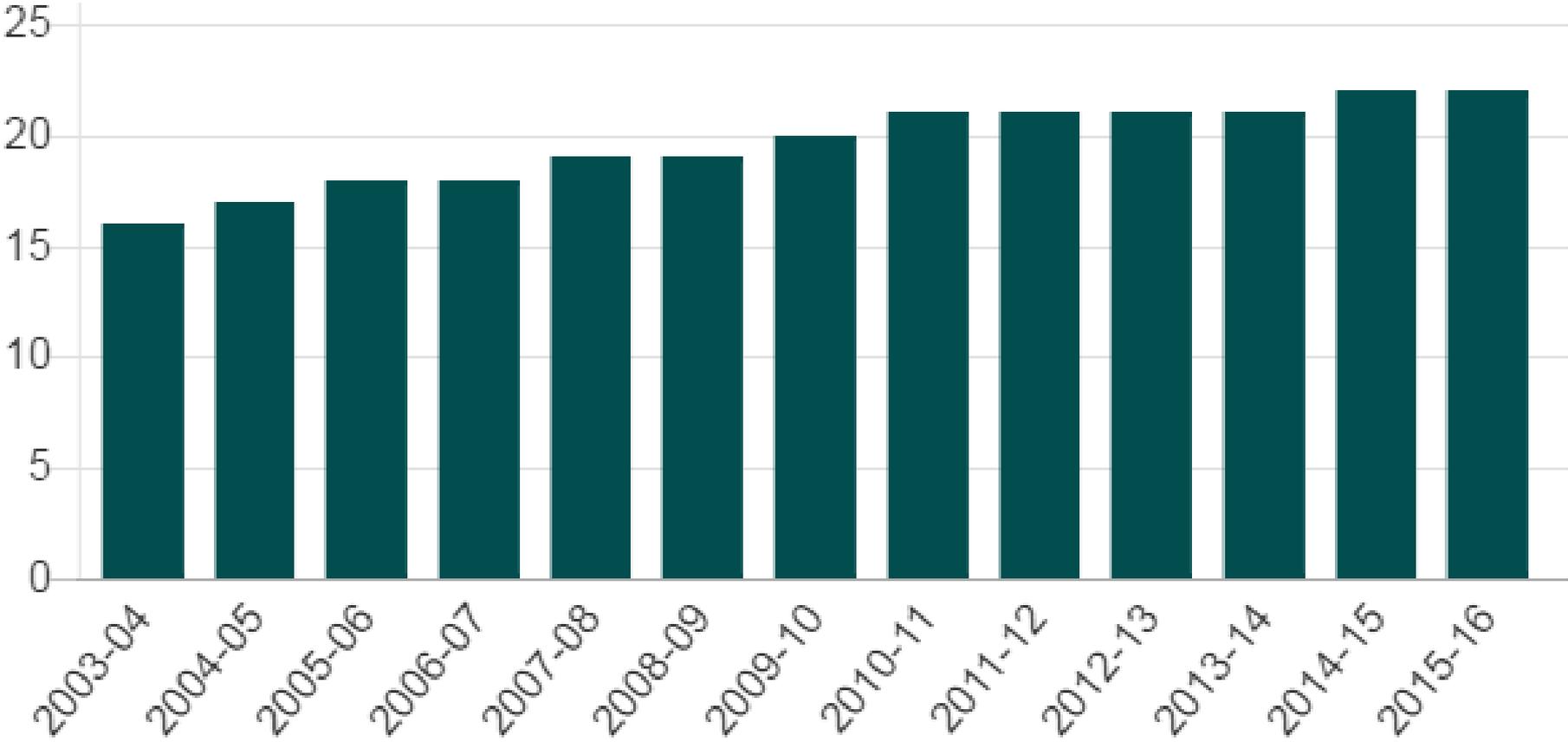
KKG 27P

KWLEBOD ICHYO DE MORGANTIC
CWASARLETH AMBUWLANS



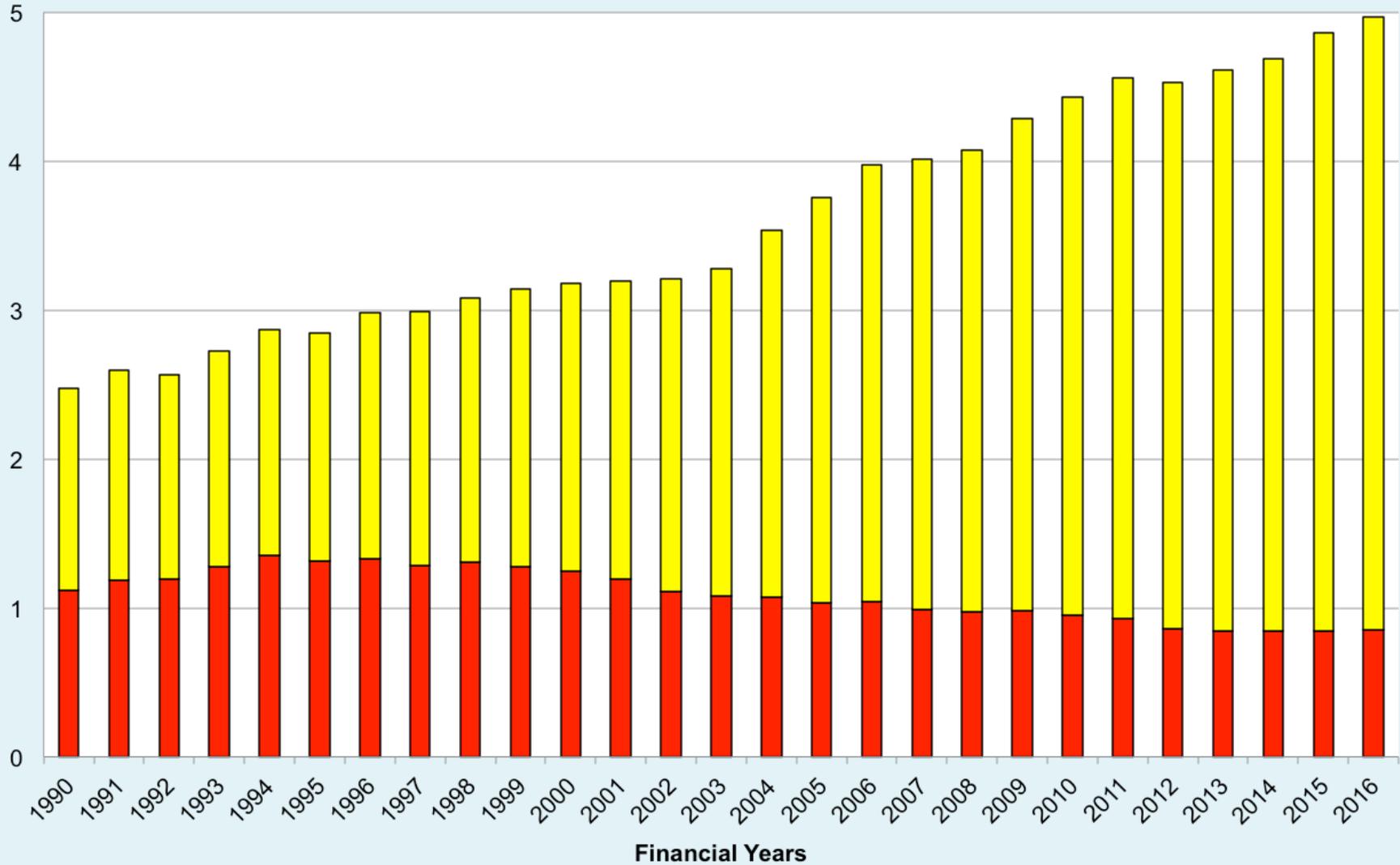
Increasing demand for urgent treatment

Visits to A&E in England (in millions)



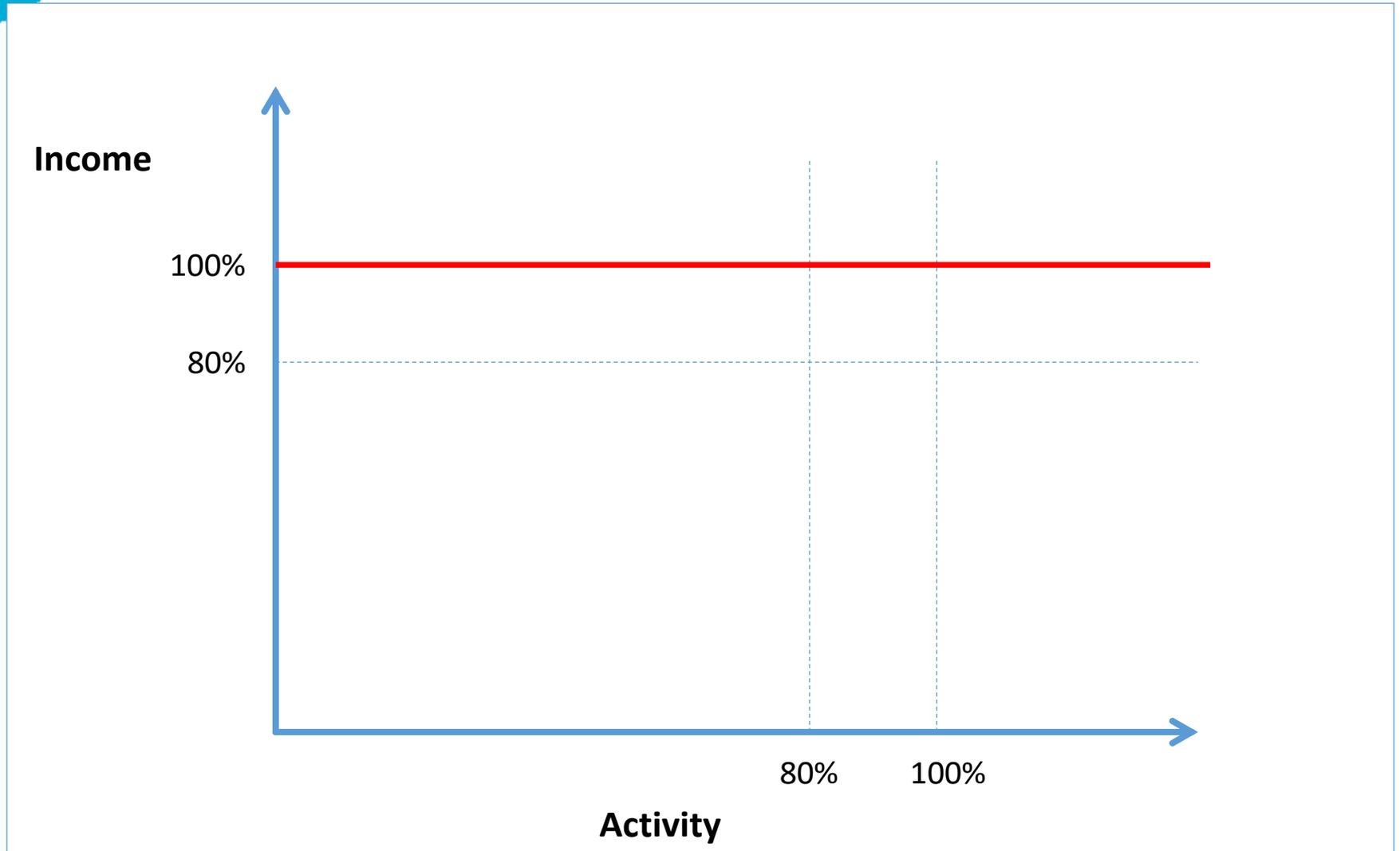
Source: IFS

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



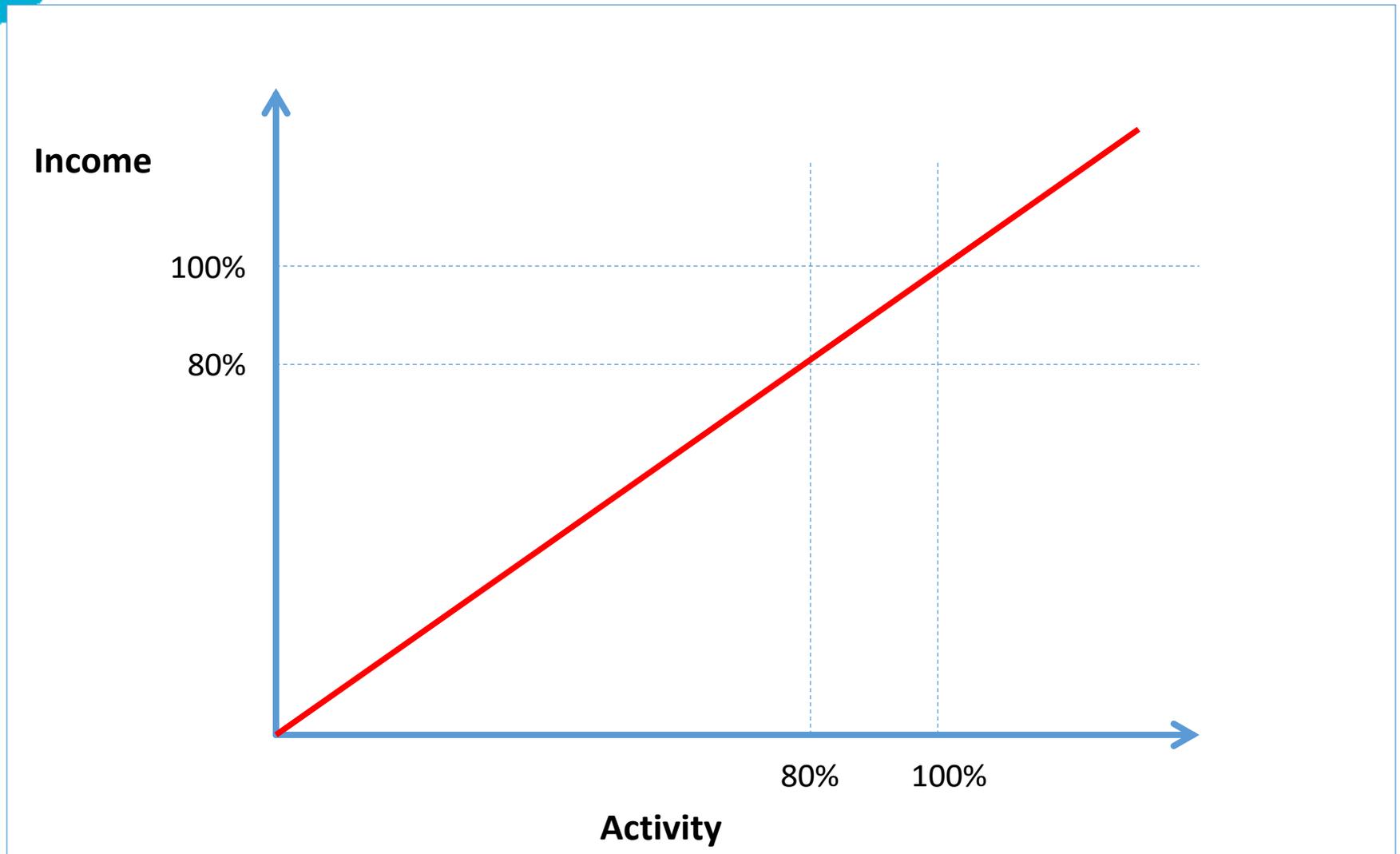


Block Tariff



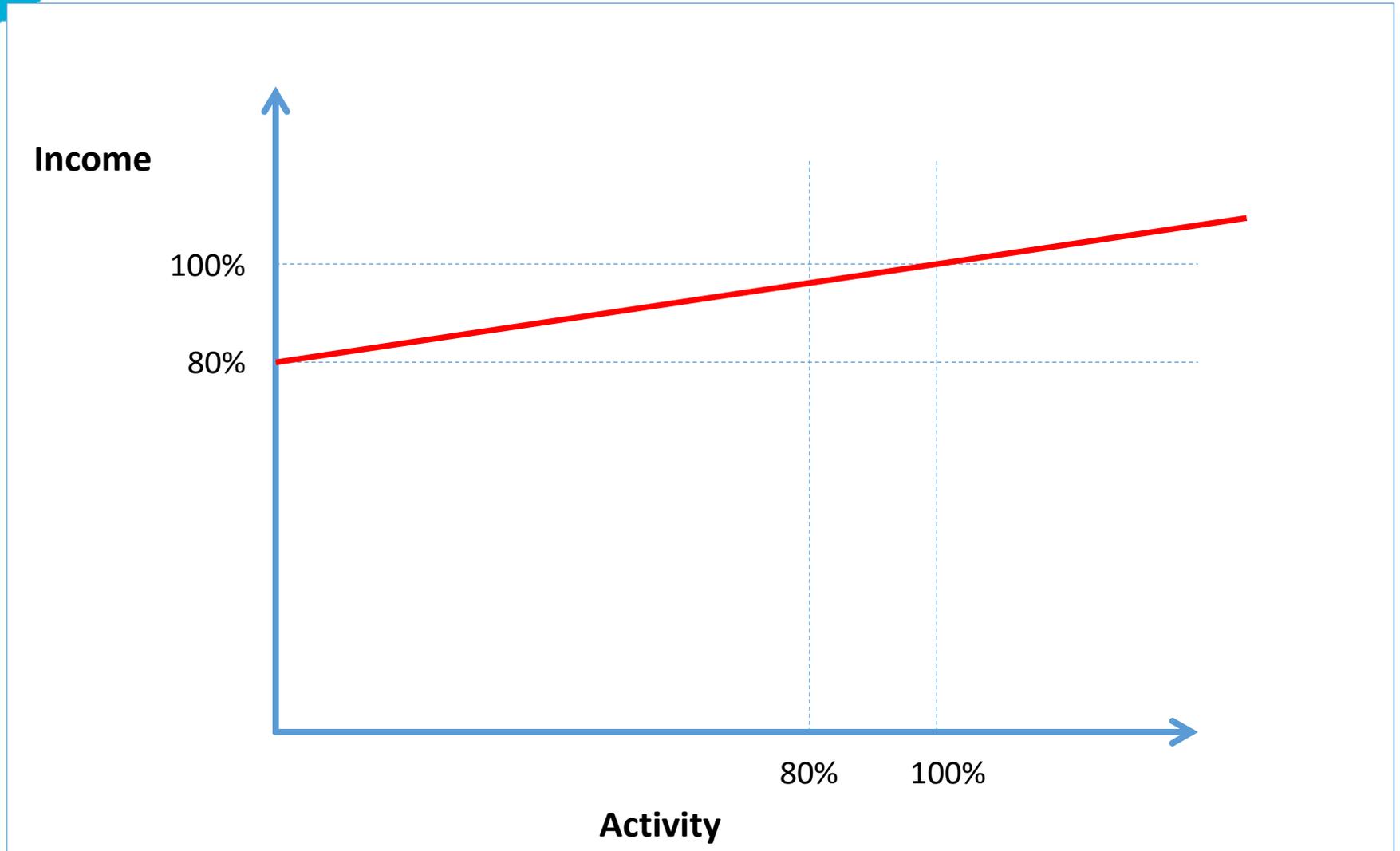


PbR Tariff (HRGs = DRGs)





Blended payment

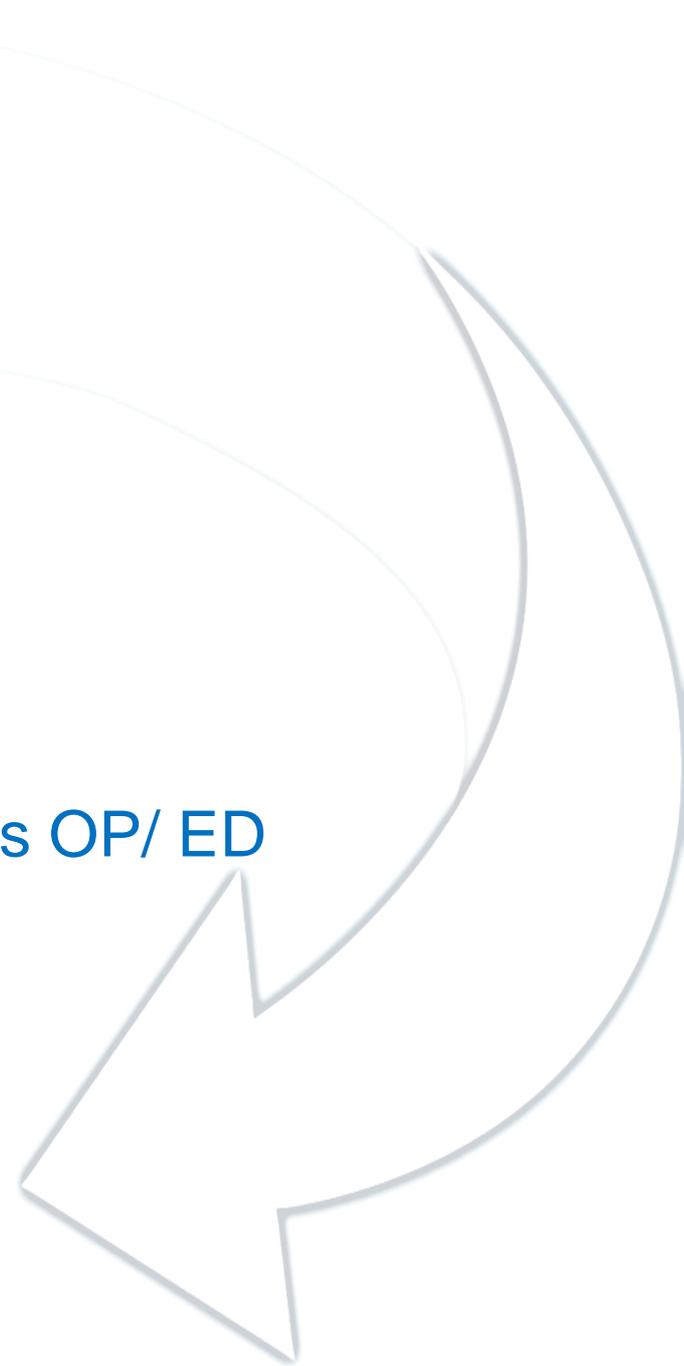


Best Practice Tariff

- 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 admissions

^ 9.6% (2017-18)

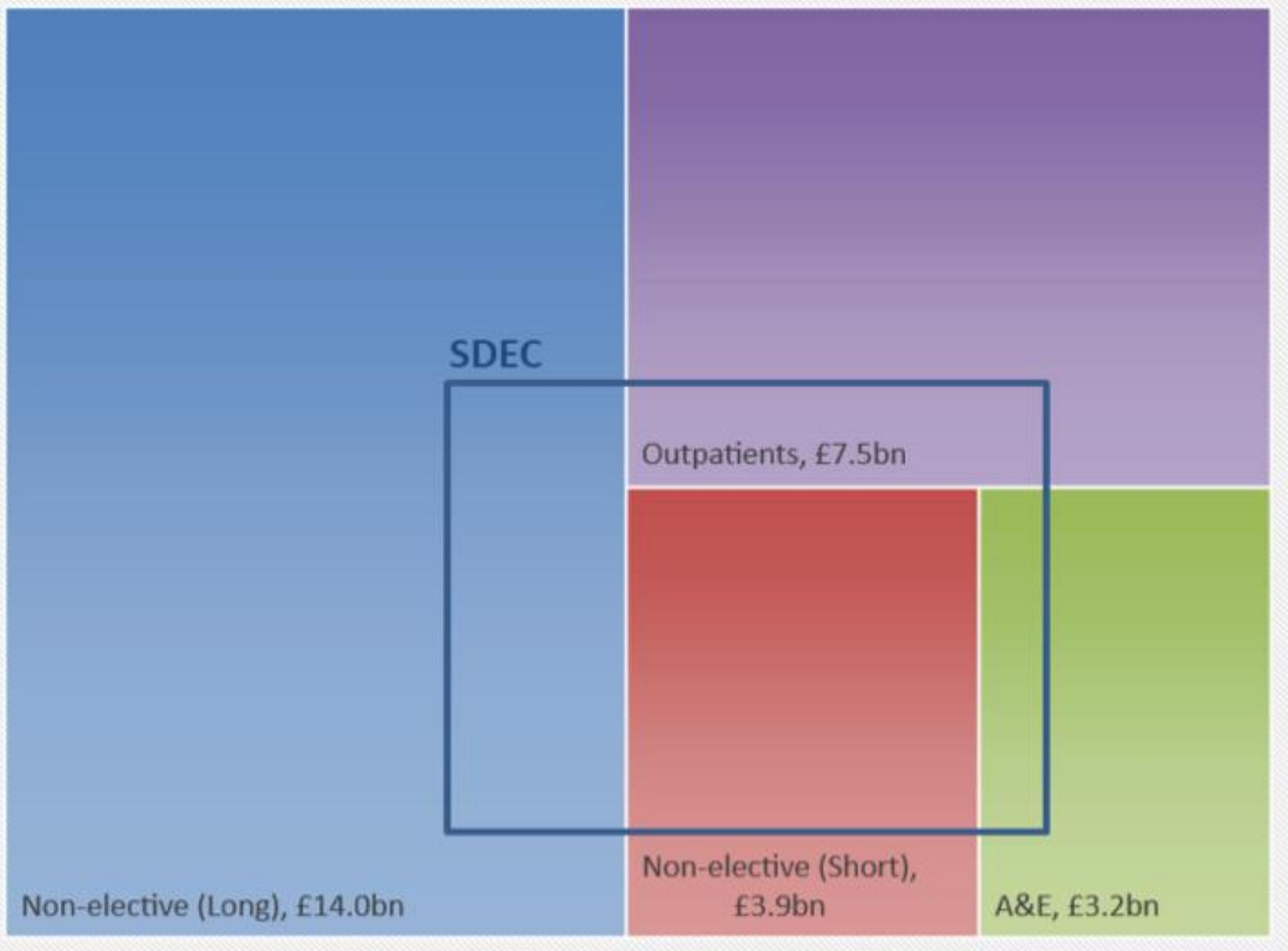
- ? Zero / Low value-added SDEC
- ? High value-added SDEC
- ? Gaming
- ? Breach avoidance

Expanding rapidly, we don't know why



known
unknowns





SDEC

Outpatients, £7.5bn

Non-elective (Short),
£3.9bn

A&E, £3.2bn

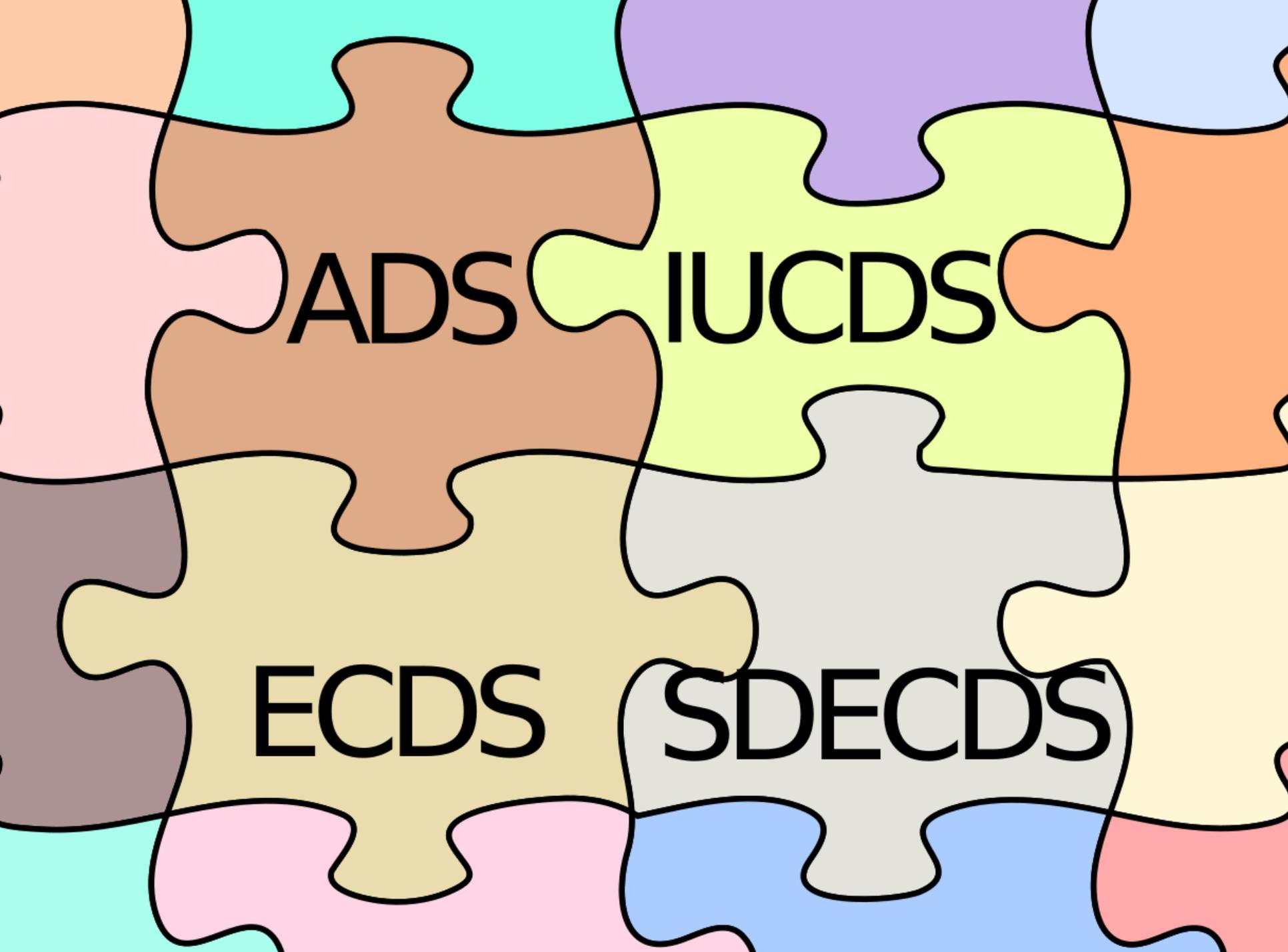
Non-elective (Long), £14.0bn

Why use ECDS for SDEC?

- Baked in from the start
 - Worked with AEC Network
- Time based, milestones
- Input & Output metrics
 - Chief Complaint & Acuity
 - Diagnosis & Suspected / Confirmed







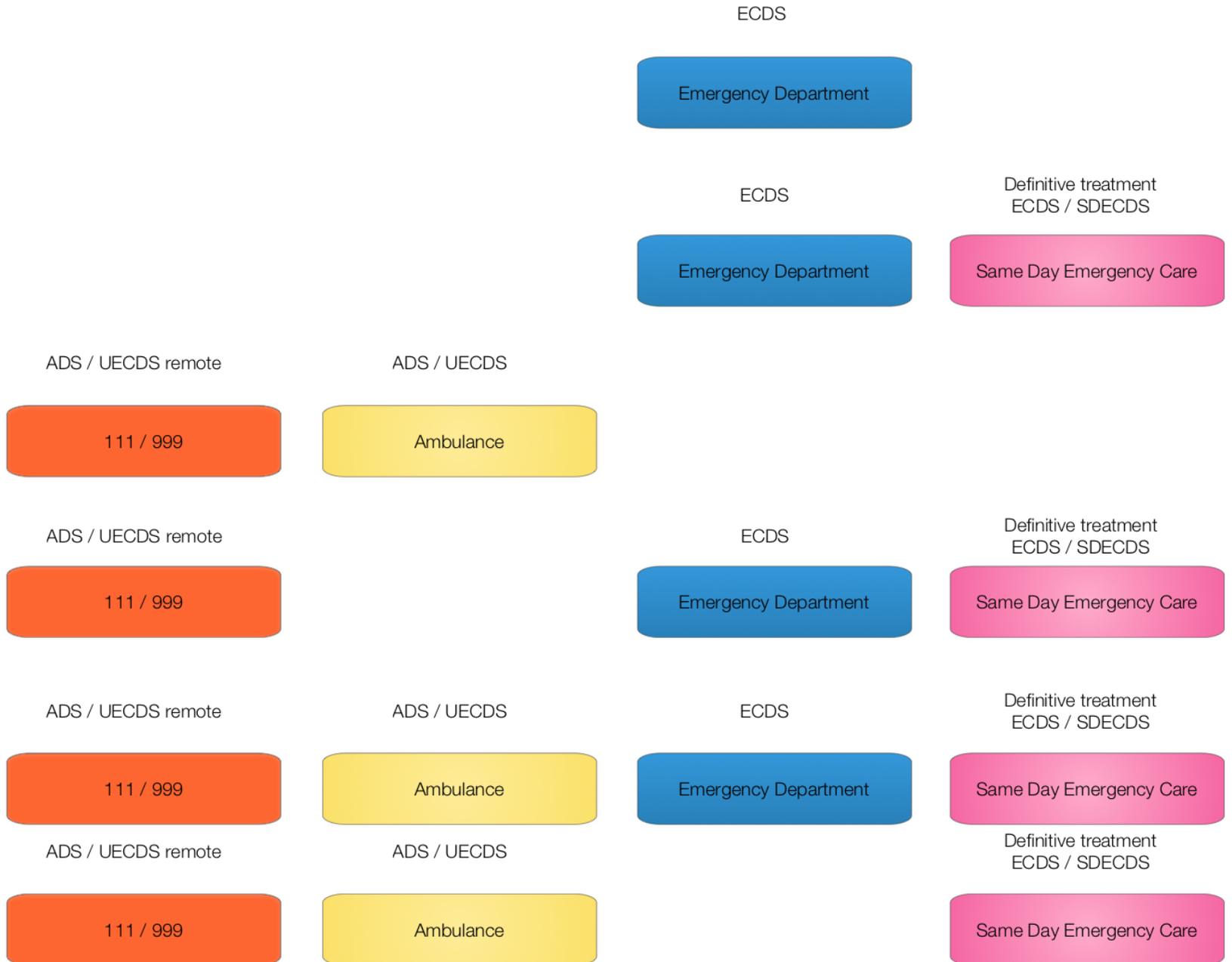
ADS

IUCDS

ECDS

SDECDS

Urgent and Emergency Care : Modular Data Set



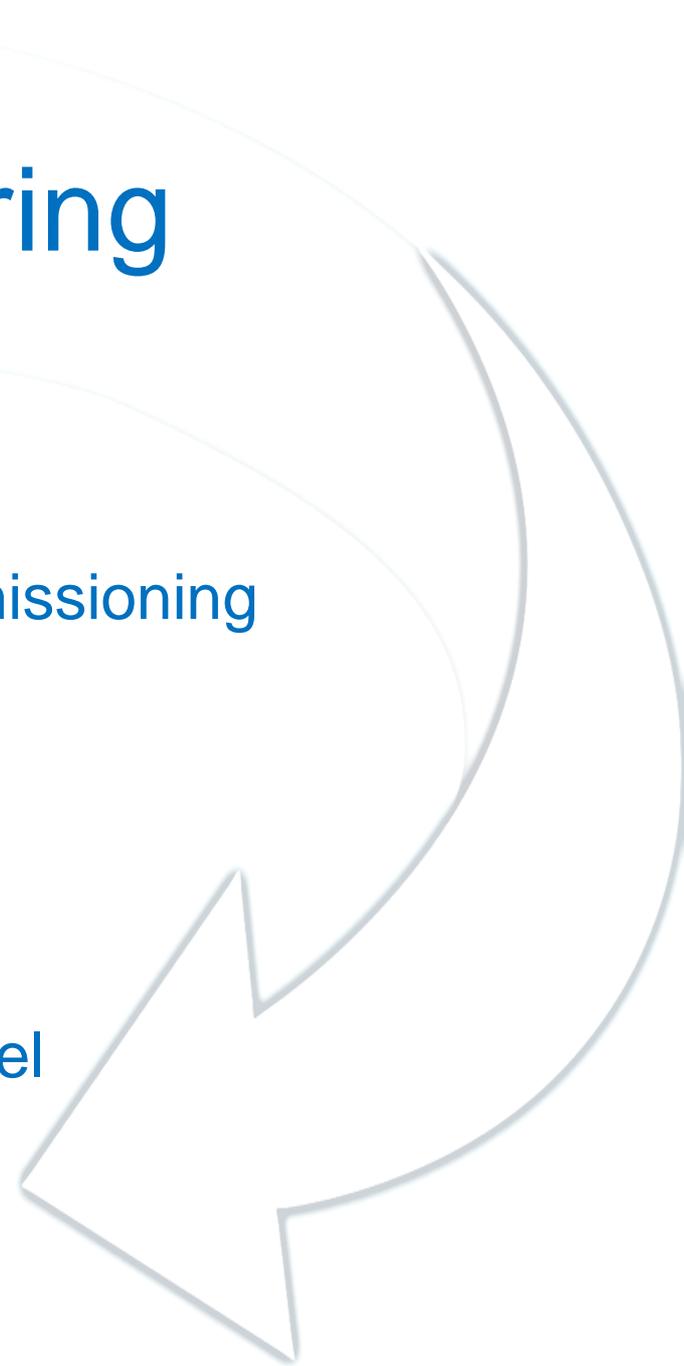
Process Re-engineering

SDEC Short-term aims

- Count SDEC consistently
- Enable tariff – value-based commissioning

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

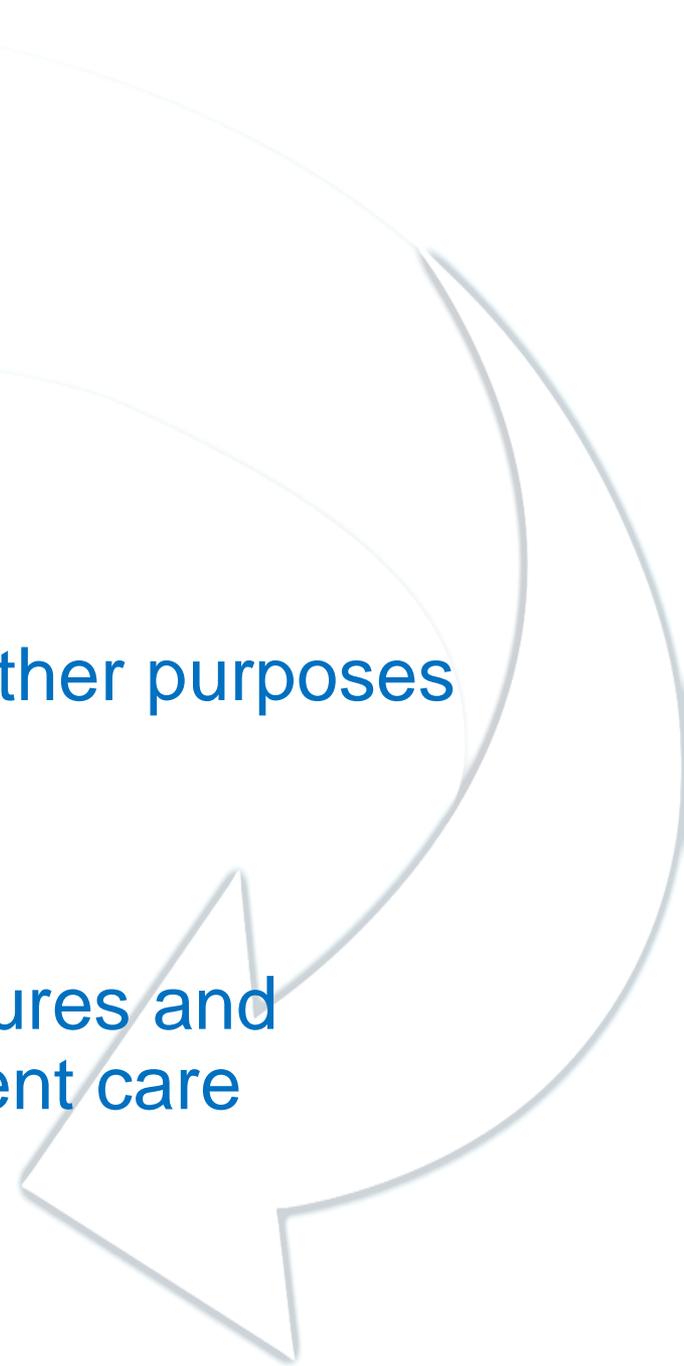
1. The world has changed

- Patients have changed
- Can't keep doing the same thing

2. Existing data – collected for other purposes

- Not valid
- Not reliable

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



Same Day Emergency Care & Acute Frailty

Regional Event, Leicester: May 21st 2019

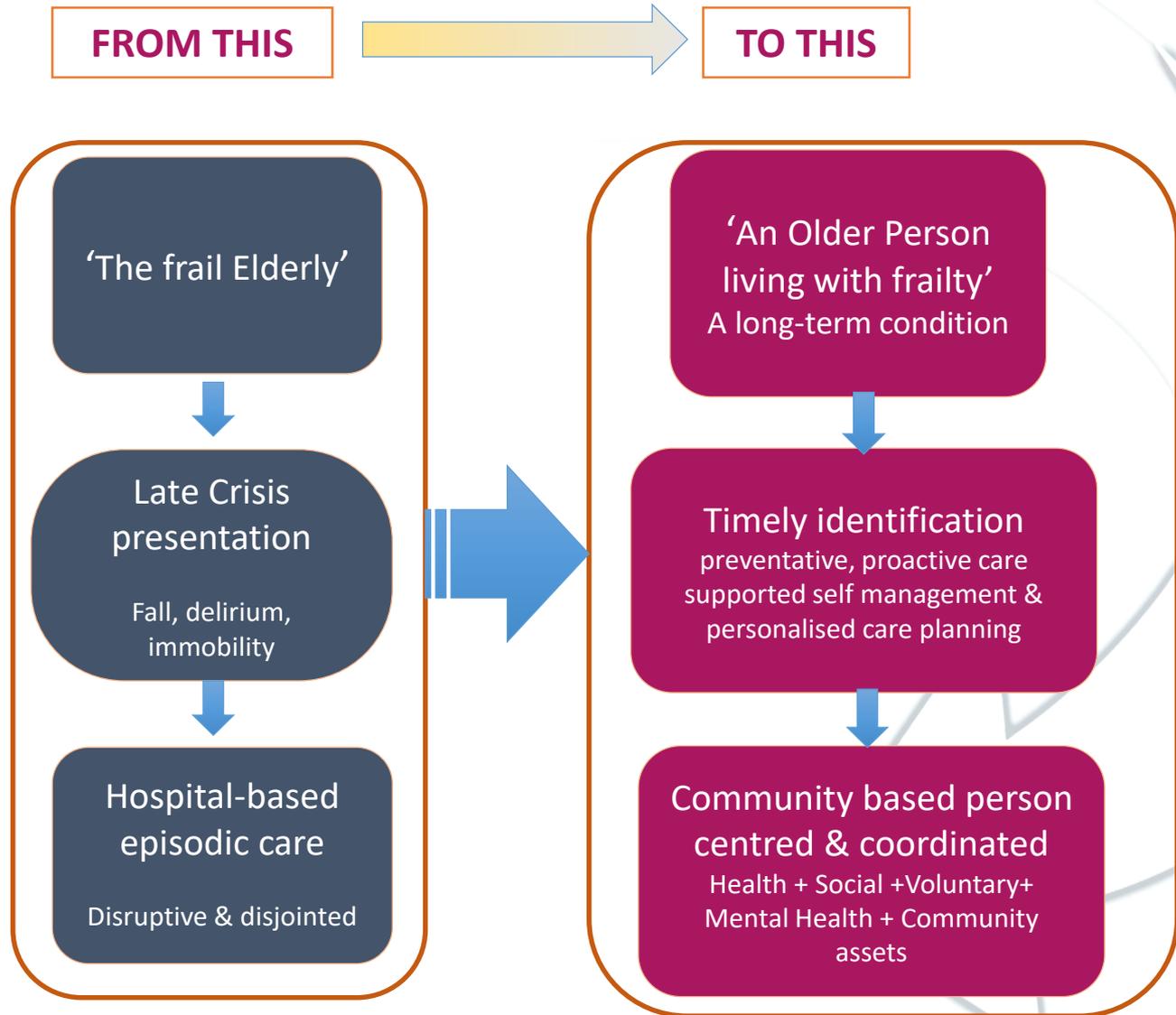
Finbarr C Martin
Emeritus Geriatrician and
Professor of Medical Gerontology

SDEC Frailty Sub-Group Lead

Putting SDEC in policy context



What's the national approach?



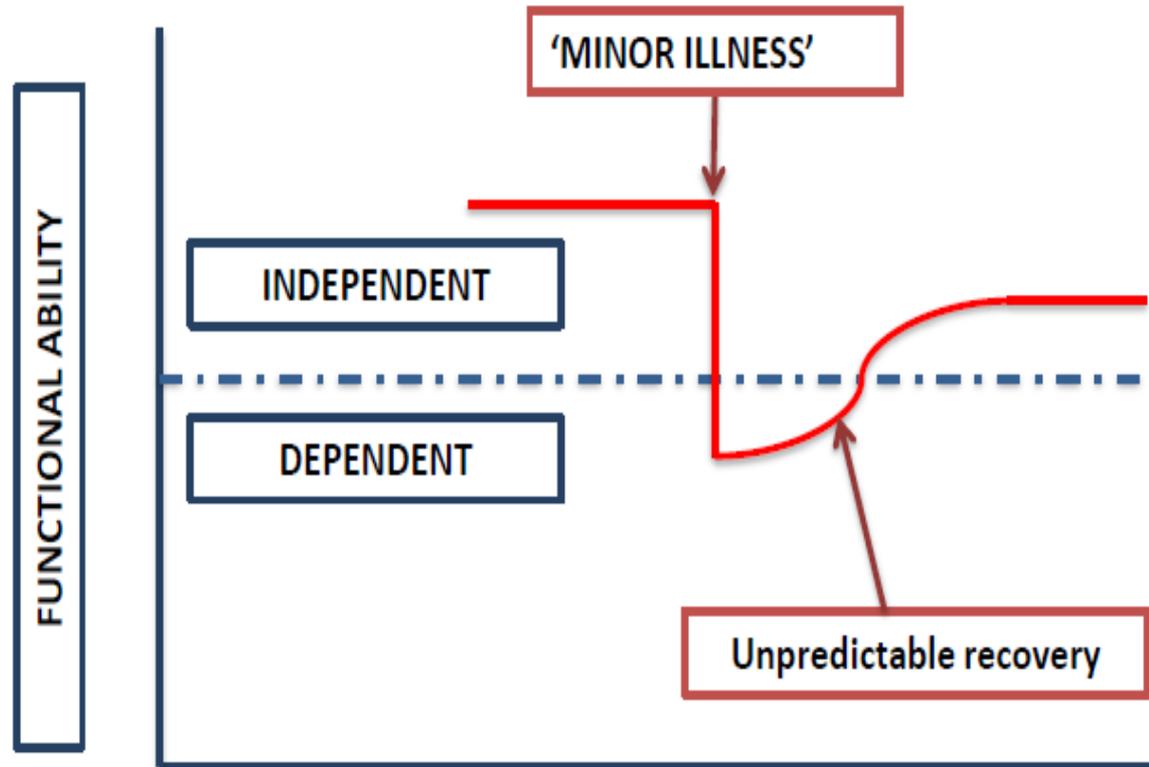
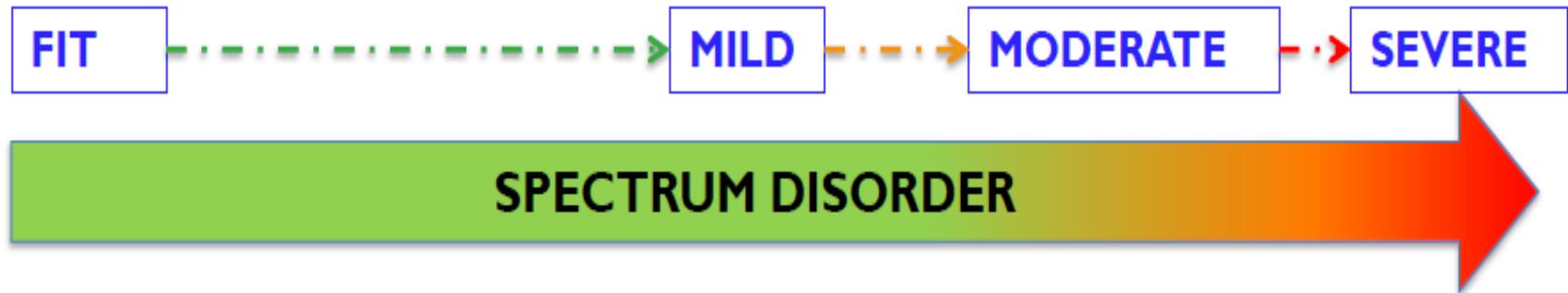
Slide courtesy of Martin Vernon and NHS England

What is frailty?

- *“a condition or syndrome which results from a multi-system reduction in reserve capacity to the extent that a number of physiological systems are close to, or past the threshold of symptomatic failure. As a result the frail person is at increased risk of disability or death from minor external stresses.”*

(Campbell and Buchner, 1997)

"A long-term condition characterised by lost biological reserves across multiple systems & vulnerability to decompensation after a stressor event"



Clinical challenge

- Non-specific presentations can be underestimated
- It takes time to identify key issues

Three part system challenge

- Age attune community services to prevent deterioration
- Provide community alternative urgent responses
- Age attune the hospital to optimise the approach to the modern patient

What are we trying to achieve?

Right patient, right place and right time etc etc

- Admit the patient who can benefit and get the issues clear at the outset
- Don't admit the patient who will not benefit
- Don't admit if the benefit can be achieved as well and as efficiently somewhere else, eg at home

.....*In a little more detail*

What are we trying to achieve?

| | |
|-------------------------|--|
| Frail and acutely ill | <p>Admission is probably useful and necessary</p> <ul style="list-style-type: none">• Identify geriatric syndromes that will impact the next few days eg delirium• Build in a CGA approach to maximise function• Anticipate discharge and post acute needs |
| | <p>Admission is probably NOT useful</p> <ul style="list-style-type: none">• Identify palliative needs: ? end of life care |
| | <p>Admission might be useful but is not necessary</p> <ul style="list-style-type: none">• Discharge to competent service for medical and other interventions and support• Liaise with hot clinics /CGA |
| Frail + not acutely ill | <ul style="list-style-type: none">• Discharge +/- urgent functional support• Rehabilitation to increase reserve and resilience to future events |
| | |

What are we trying to achieve?

| | |
|-------------------------|--|
| Frail and acutely ill | <p>Admission is probably useful and necessary</p> <ul style="list-style-type: none">• Identify geriatric syndromes that will impact the next few days eg delirium• Build in a CGA approach to maximise function• Anticipate discharge and post acute needs |
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| Frail + not acutely ill | <ul style="list-style-type: none">• Discharge +/- urgent functional support• Rehabilitation to increase reserve and resilience to future events |
| | |

What is frailty made of and
how is it measured?



Different concepts, each with its own usefulness

Phenotype

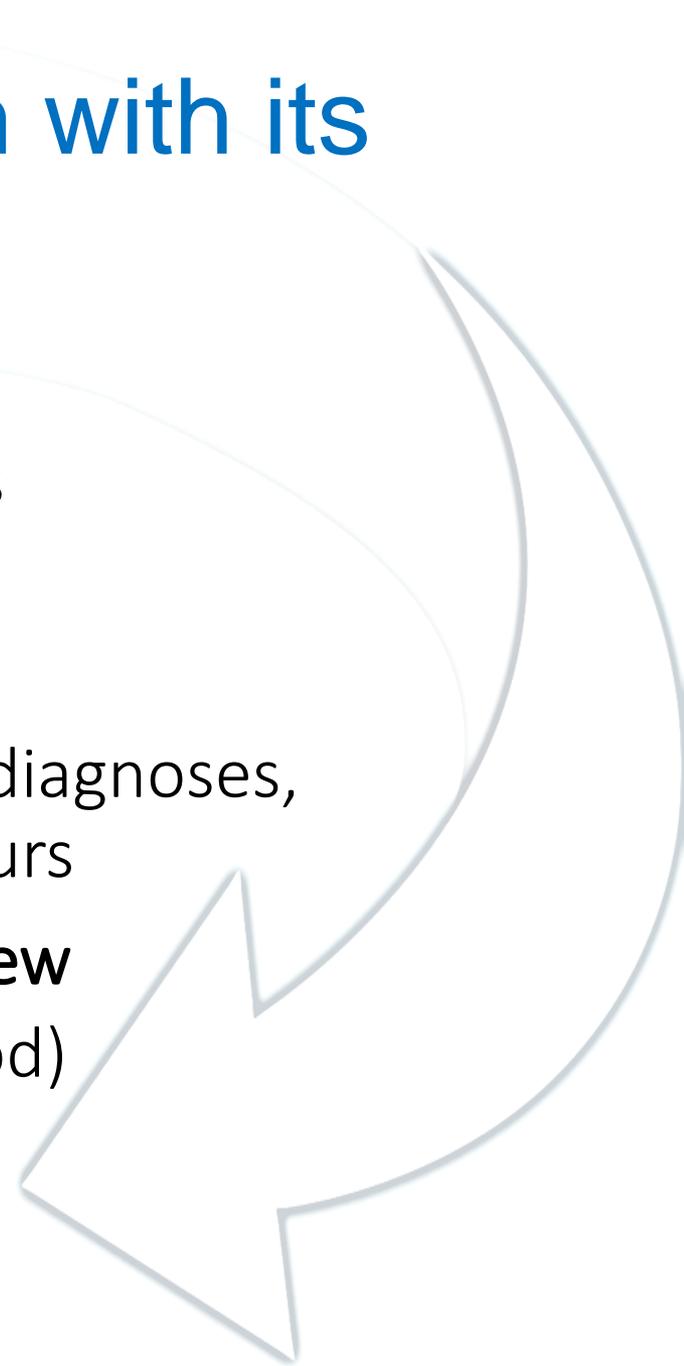
- specific measurable impairments
- distinct from co-morbidity

Deficit accumulation model

- risk prediction using symptoms, diagnoses, disability + impairments + behaviours

Clinical impression based on an overview

- eg Clinical Frailty Scale (Rockwood)



Fried's phenotype approach

Fried LP et al J Gerontol A Biol Sci Med Sci 2001; 56: M146-56

| Weight loss | Self-reported weight loss of more than 4.5 kg or recorded weight loss of "5% per year |
|------------------------|--|
| Exhaustion | Self-reported exhaustion on US Center for Epidemiological Studies depression scale ⁷³ (3–4 days per week or most of the time) |
| Low energy expenditure | Energy expenditure <383 kcal/week (men) or <270 kcal/week (women) |
| Slow gait speed | Standardised cut-off times to walk 4.57 m, stratified by sex and height |
| Weak grip strength | Grip strength, stratified by sex and body-mass index |

Categories

| Number of factors | |
|-------------------|-----------|
| 0 | Not frail |
| 1-2 | Pre-frail |
| 3-5 | Frail |

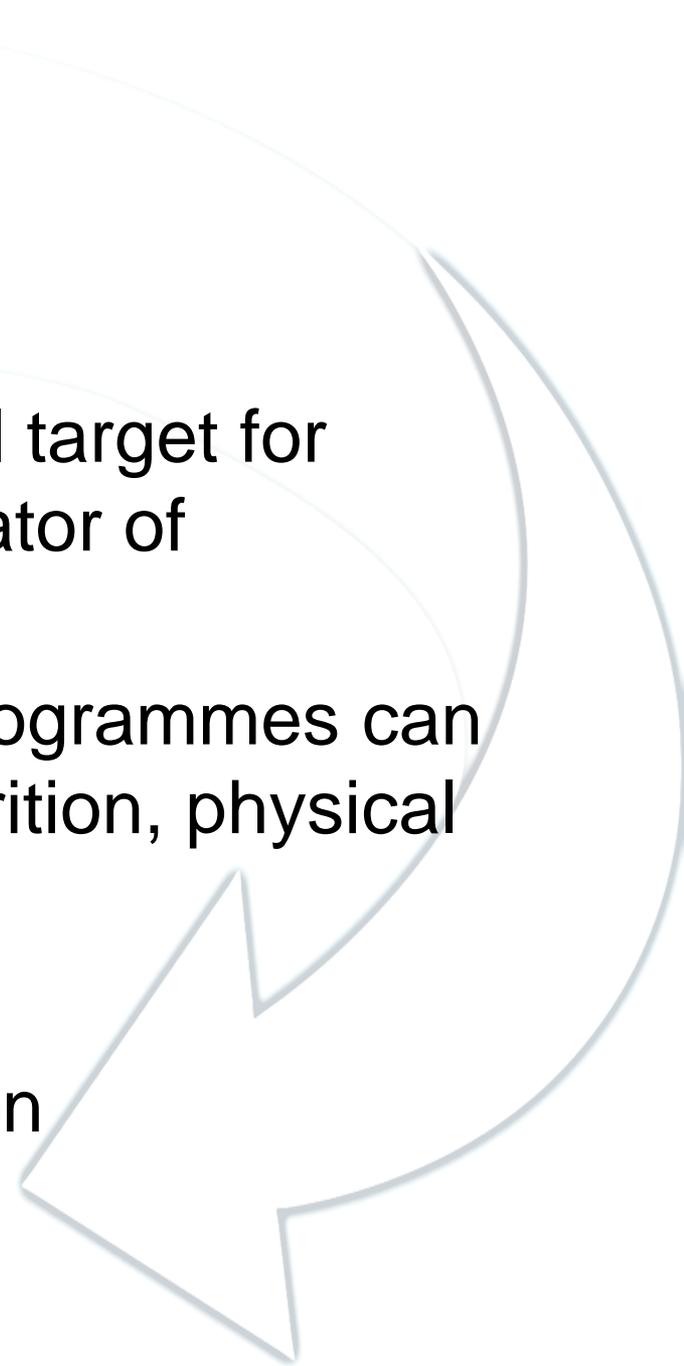


How does this help?

- Establishes frailty as a potential target for intervention as well as an indicator of vulnerability
- Community based treatment programmes can focus on strength, balance, nutrition, physical activity etc

in addition to

- the current emphasis on function



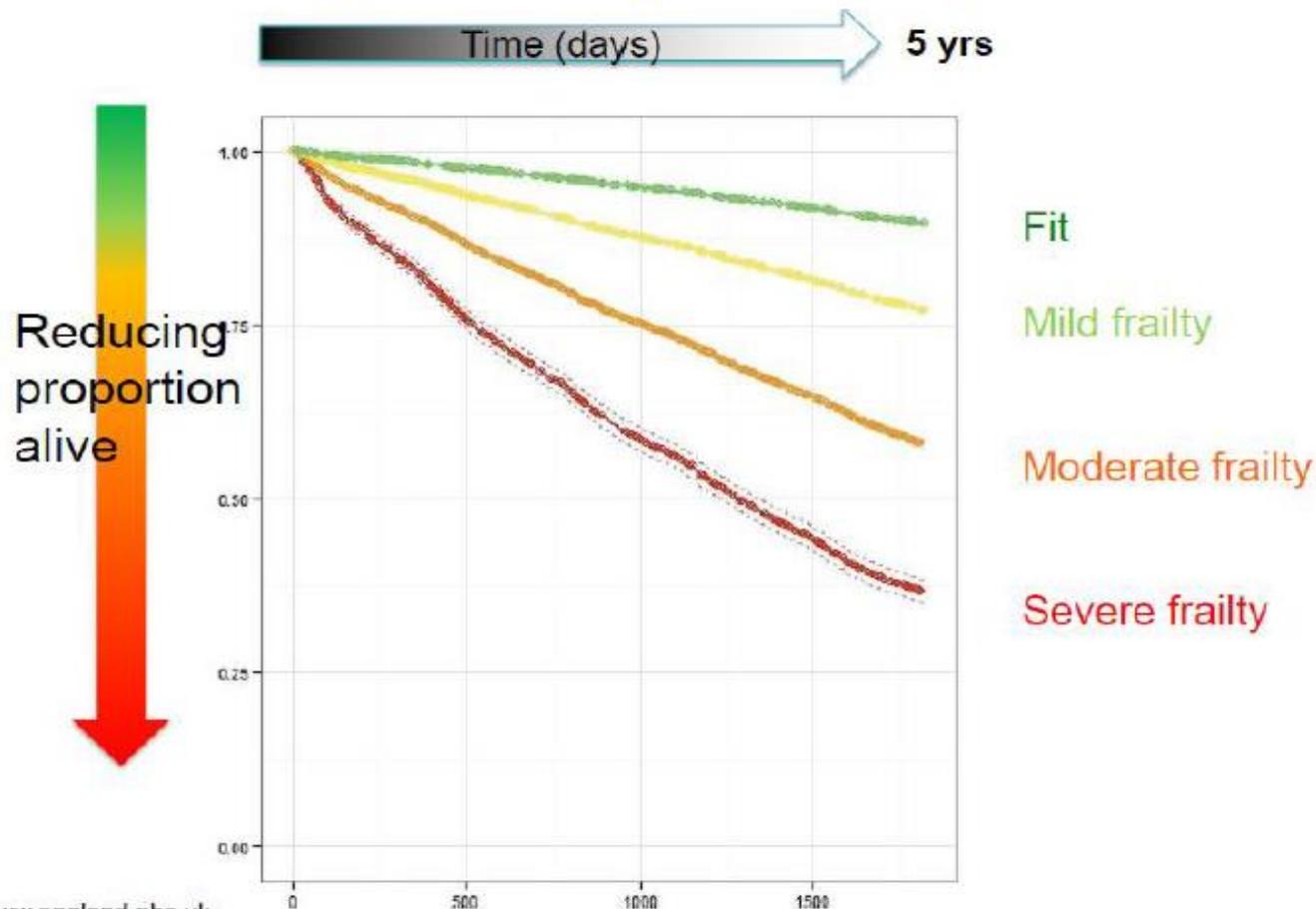
Deficit accumulation approach

- Each “deficit” has equal weighting
- Each dichotomised (0/1) or trichotomised (0, 0.33, 0.66, 1.0)
- Add all individual item scores
- Divide by number of items
- Thus the Frailty Index score is between 0 and 1
- Predictive ability improves with more parameters , >30 is enough!
- Good evidence for all outcome prediction

Rockwood et al JAGS 2006; 54:975-979

eFI: the deficit approach from routine primary care data

Frailty is not good for you



How does this help?

- Enables targeting in primary and community care for issues such as
 - Medication reviews and de-prescribing
 - Advance care planning

(What matters to you)



Case finding – a simple tool

- CFS based on how the patient was **TWO** weeks ago
- Ask them, families or carers. Can the ambulance service help?

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.

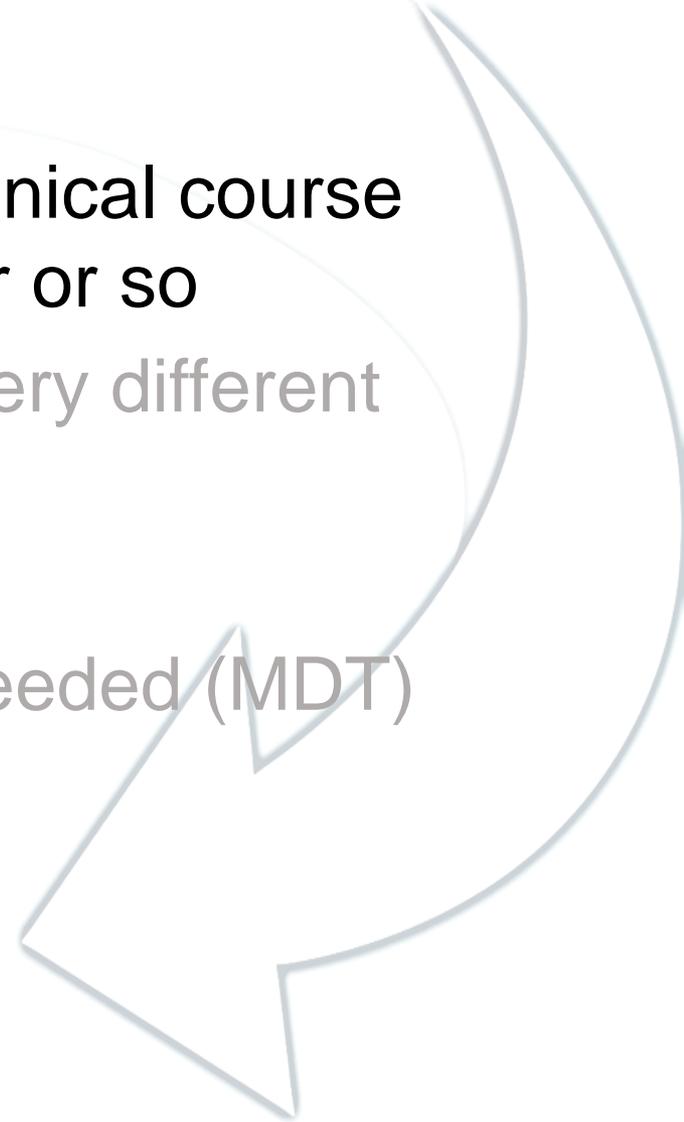
In **severe dementia**, they cannot do personal care without help.

* 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.

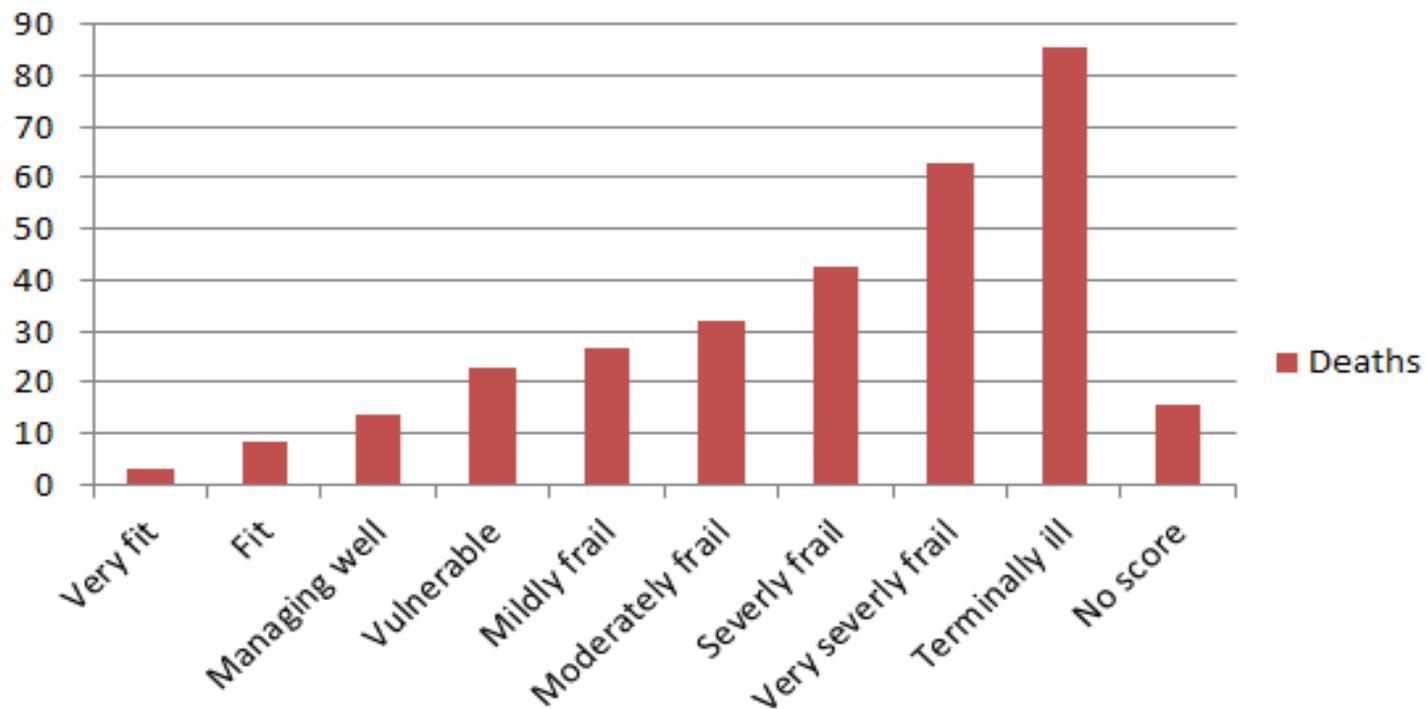
How does this help?

- Provides a guide to the *likely* clinical course now and over the following year or so
- Alerts you to the *possibility* of very different priorities for care
 - .. *What matters to you?*
- Therefore what *skills* may be needed (MDT)



Percentage of deaths by CFS score post discharge for NEL >65 admissions who had a death date recorded by 4 April 2018

(Admissions between April – Dec 2017)



Courtesy of David Hunt from
West Sussex Hospitals

How does this help?

- Provides a guide to the *likely* clinical course now and over the following year or so
- Alerts you to the *possibility* of very different priorities for care
 - ..*What matters to you?*
- Therefore what *skills* may be needed (MDT)

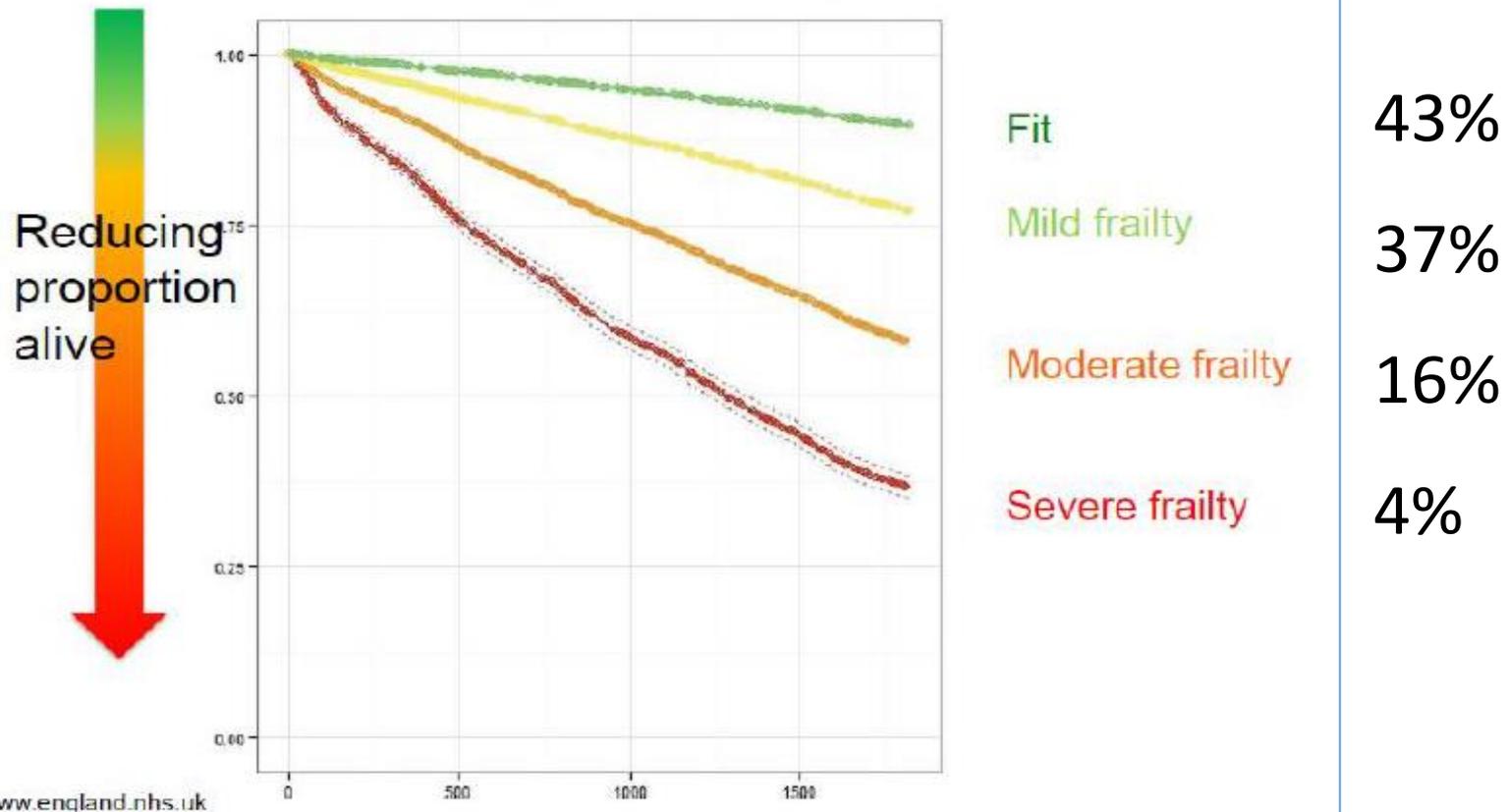
How common is frailty?



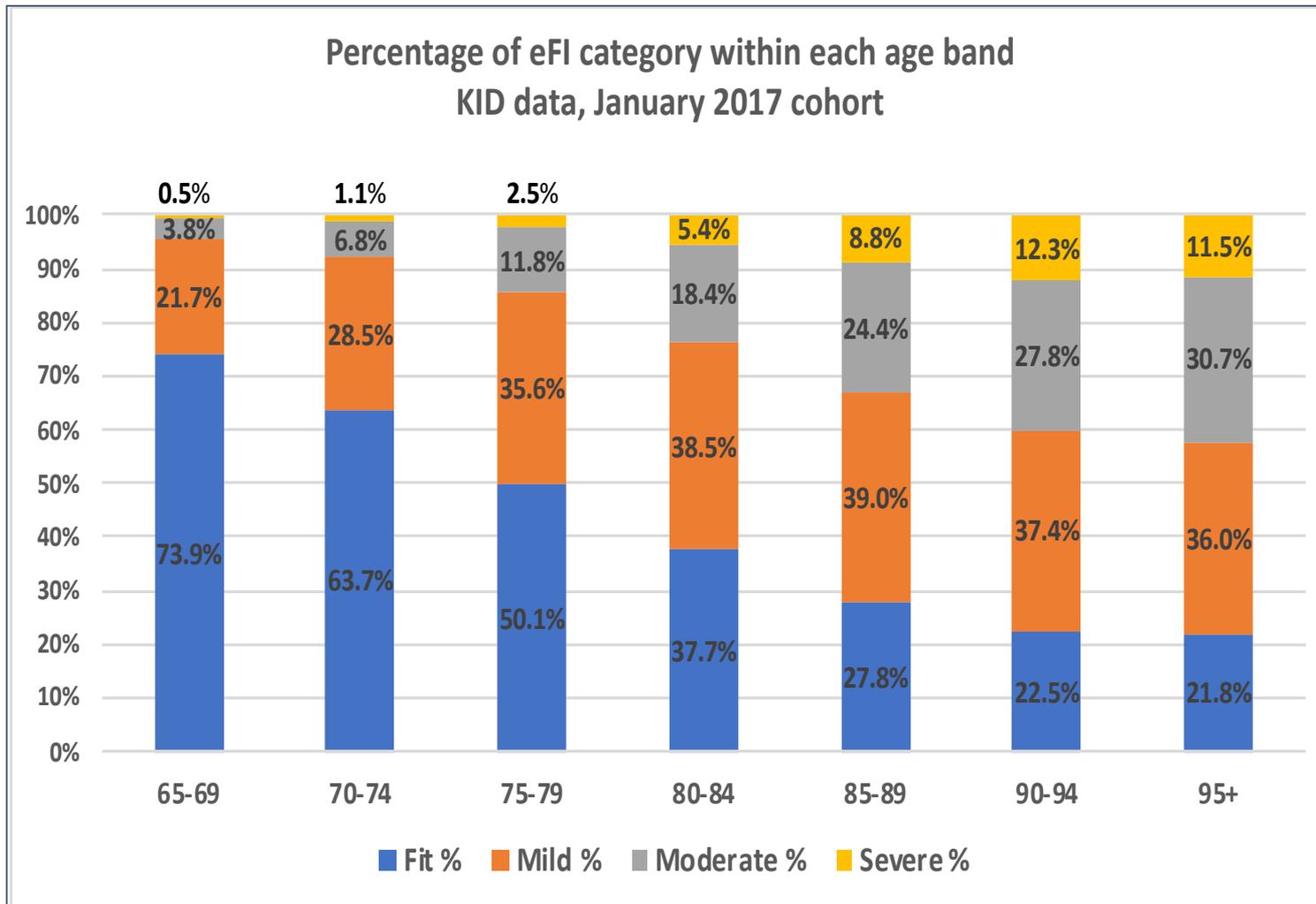
eFI: the deficit approach from routine primary care data

% 5 year survival curves

Time (days) → 5 yrs



Distribution of Frailty in old age (eFI)



Older people, frailty, hospital use and outcomes



• Older People: HES codes to identify frailty:

- - Unspecified protein-energy malnutrition
- - Dementia+ or Incontinence+
- - Somnolence, Very low level of personal hygiene
- - Difficulty in walk Senility, Falls
- - 'Z-codes' – functional limitations

| Activity type (frail older people) | England |
|--|---------|
| Percentage of total admissions | 57% |
| Percentage of total bed days | 87% |
| Percentage of emergency readmissions within 90d | 84% |
| Percentage of deaths within 90 days of admission | 84% |

- **Frailty associated c delirium, falls and deconditioning**
- **20% experience 80% of harms (75+patients)**

Slide courtesy of the Acute Frailty Network

What we know what makes a
difference



Comprehensive Geriatric assessment for the older or frail patients

Cochrane Review 2017 of CGA for older people admitted to acute hospital vs usual care

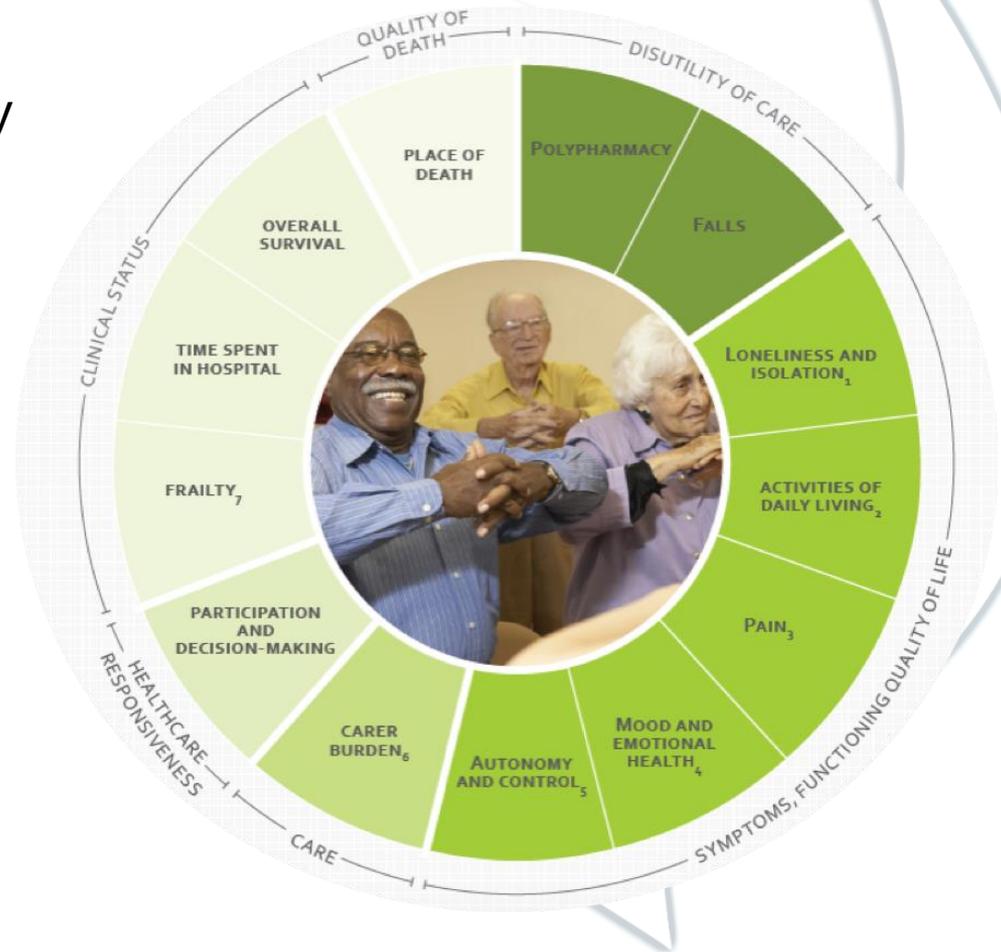
- 29 trials recruiting 13,766 participants across nine, mostly high-income countries.
- alive and at home in 3-12 months: risk ratio (RR) 1.06, 95% confidence interval (CI) 1.01 to 1.10
- Reduced likelihood of being in a nursing home at 3 to 12 months follow-up: RR 0.80, 95% CI 0.72 to 0.89
- Small increase in costs: very likely is cost-effective

Lessons from the Acute Frailty Network

- Early identification of frailty with the Clinical Frailty Scale can become as routine as early identification of acuity with the NEWS
- Any trained staff member can do this
- Reliable timely responses need clear professional working standards
- ***A flexible multi-disciplinary approach works and helps address staffing gaps***
- Improving responses to frail older people can avert unnecessary admissions and reduces bed use
- Patient experience of ED/AMU can improve

Individualise the focus – What matters?

- **Domains:**
- Symptoms, functioning, quality of life
- Disutility in care
- Care
- Healthcare responsiveness
- Clinical status
- Quality of death
- <http://www.ichom.org/medical-conditions/older-person/>



Examples (see the AFN website)



Styles of responses to frail patients

- Frailty (CFS) assessed by paramedics or ED nurse practitioners and directs patient to specific place or team (but needs to be accompanied by acuity assessment)
- “Frailty” MD team pulls selectively from ED
- Assessment space without beds to avoid immobility and encourage speedy responses
- Frailty used to divide the work in AMUs, with/without dedicated space
- OPAL type assessments in AM ward “next day”

Summary points



RECAP- Why identify frailty?

- ***For those admitted***, rapid access to MDT approach to minimise harms etc
- ***For the uncertain ones***, to factor in frailty to clinical decisions about priorities and discharge plans etc
- ***For those who go home***, to flag up need for interventions to
 - reduce the frailty factors
 - reduce frailty associated risks (eg falls)

Risks for patients if frailty is not recognised and taken into account

- Delirium, falls and pressure sores not prevented
- Deconditioning and slower recovery
- MDT input delayed
- Appropriate goals of care not decided
- Polypharmacy not managed
- Readmissions not prevented
- End of life care missed

Risks for patients if frailty is taken into account without individual assessment

Frailty

- becomes a nihilist connotation
- obscures need for prompt medical response
- everybody's business becomes anybody can do it

Frailism takes the place of ageism

New Frontiers in Frailty conference

Book your place 27th June 2019

An international conference provided by the Acute Frailty Network supported by NHS Improvement.

27th June 2019

9am – 4.30pm, Central London

“The essential event for anyone interested in improving care for older people”

Professor Simon Conroy
University Hospitals of Leicester

Early Bird Rate

Only £125 ~~£149~~

For members of AFN or NHS Elect
(or ~~£400~~ ~~£496~~ for 4)

Only £149 ~~£189~~

For non-members
(or ~~£500~~ ~~£596~~ for 4)

Early bird available until 30th April 2019

Places are limited so please book soon:
www.acutefrailtynetwork.org.uk

To book your place follow this link: <https://www.eventsforce.net/acutefrailtyconference2019>
If you have any questions, please email the AFN team at frailtyevents@nhselect.org.uk or call 020 7520 9091

Showcase Sites: Airedale NHS Foundation Trust

Our AEC transformation Journey

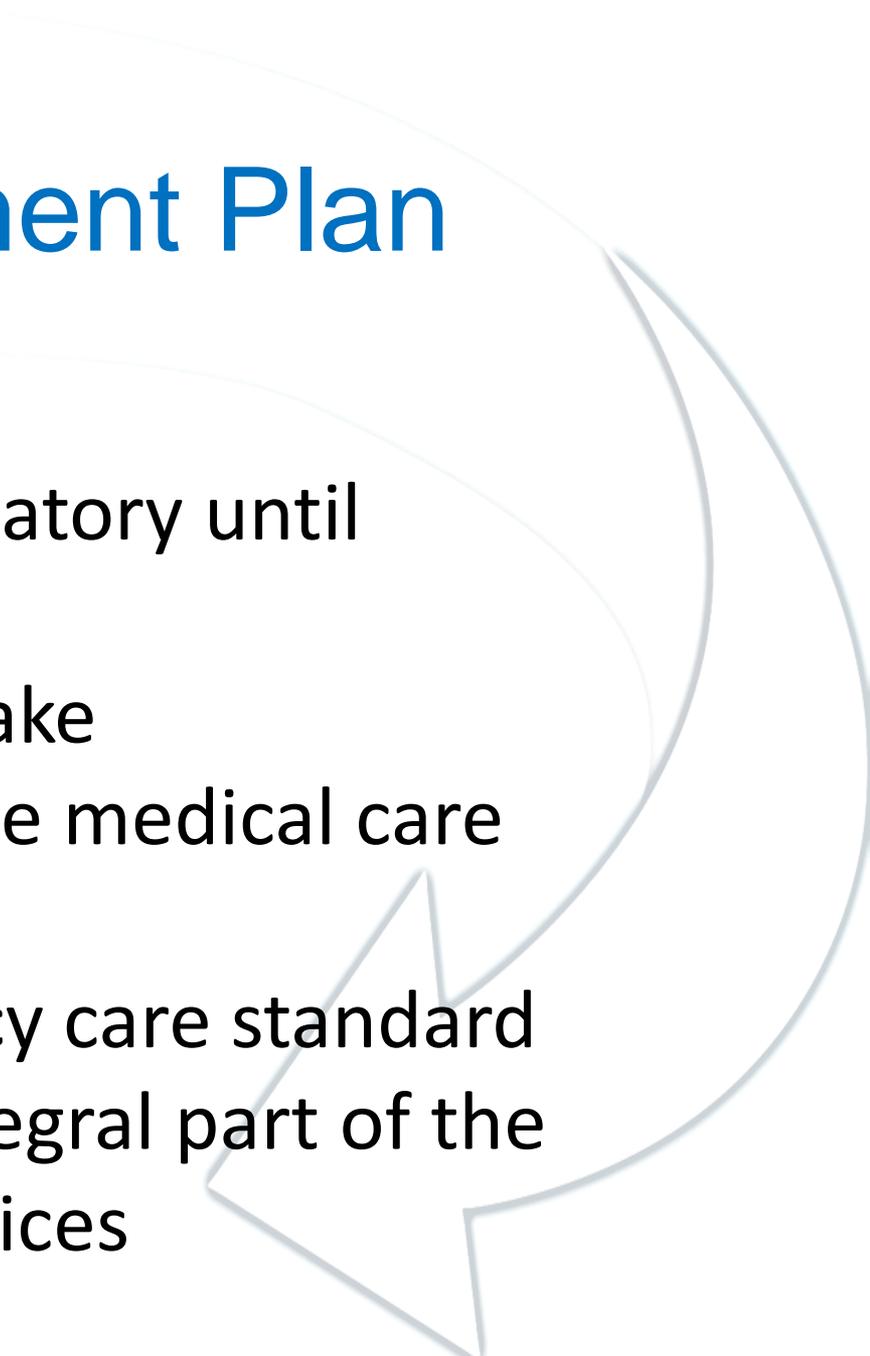
Julia Nixon

Lead for Clinical Transformation/ACP lead
Airedale NHS Foundation Trust

The beginning

- 2013
- 1 Acute Consultant/ 1 ACP
- 2014 – successful business case for 6 WTE ACPs
- Consultant took GP calls and triaged to ACU/AMU
- Average of 5 patients per day Monday to Friday
- 2015 ACP establishment increased to support extended ACU hours and ACP took over the GP calls

2016 – Development Plan

- ‘All patients are ambulatory until proven otherwise’
 - Take 15% of medical take
 - Offer high quality acute medical care with a zero LOS
 - Support the emergency care standard
 - ACU to become an integral part of the urgent care team/services
- 

What we did

- Reviewed the data to understand our potential to grow
 - Reviewed existing pathways and developed new ambulatory pathways
 - Developed a generic referral guide for ED team
 - Extended ACU opening times/consultant access/ACP team
 - Developed a dashboard/KPIs
 - Engaged all our stakeholders including patients
- 

What happened ?

- Increased ACU activity by 98% in first 3 months
- Supported the improvement of the emergency care standard
- Consistently saw >20% of the medical take within 3 months which steadily increased to 29% until 2018
- 2019 – around 35 % of take (40% medical/30% Surgical)

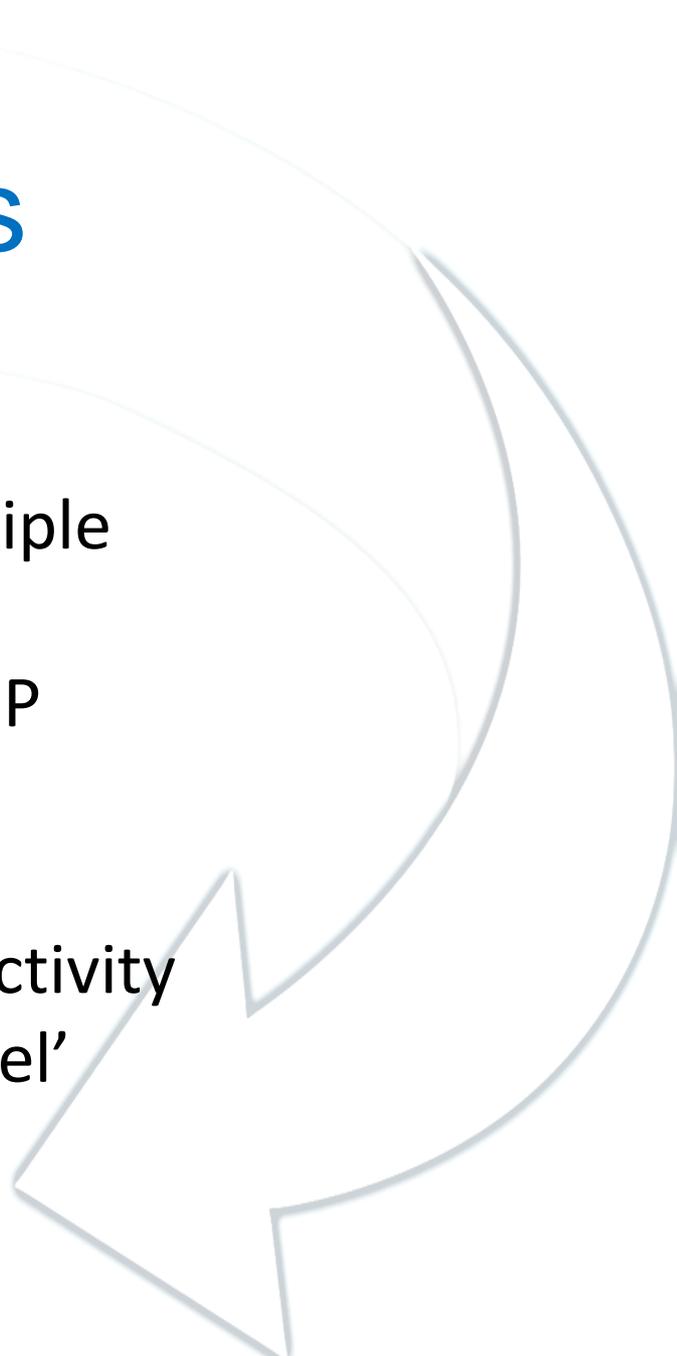
Acute Assessment Unit (AAU)

- Undertook 2 rapid improvement events to plan our new model
 - ACP team heavily involved in planning/PDSA cycles prior to opening
- Opened on 24th April 2018
- April/May saw increased non-elective activity of 11% from previous year
- Combined SAU/AMU/ACU together New opportunities

Acute Assessment Unit (AAU)

- New 6.5 m capital funding to build acute assessment unit (AAU) combining medical/surgical assessment beds and ambulatory care, co-located with ED.
- ACU activity increased by 55%
- Reduction in overall admissions 18% less than previous year, despite overall numbers to the hospital increasing
- ACP team consolidation/development

Pathways Vs process

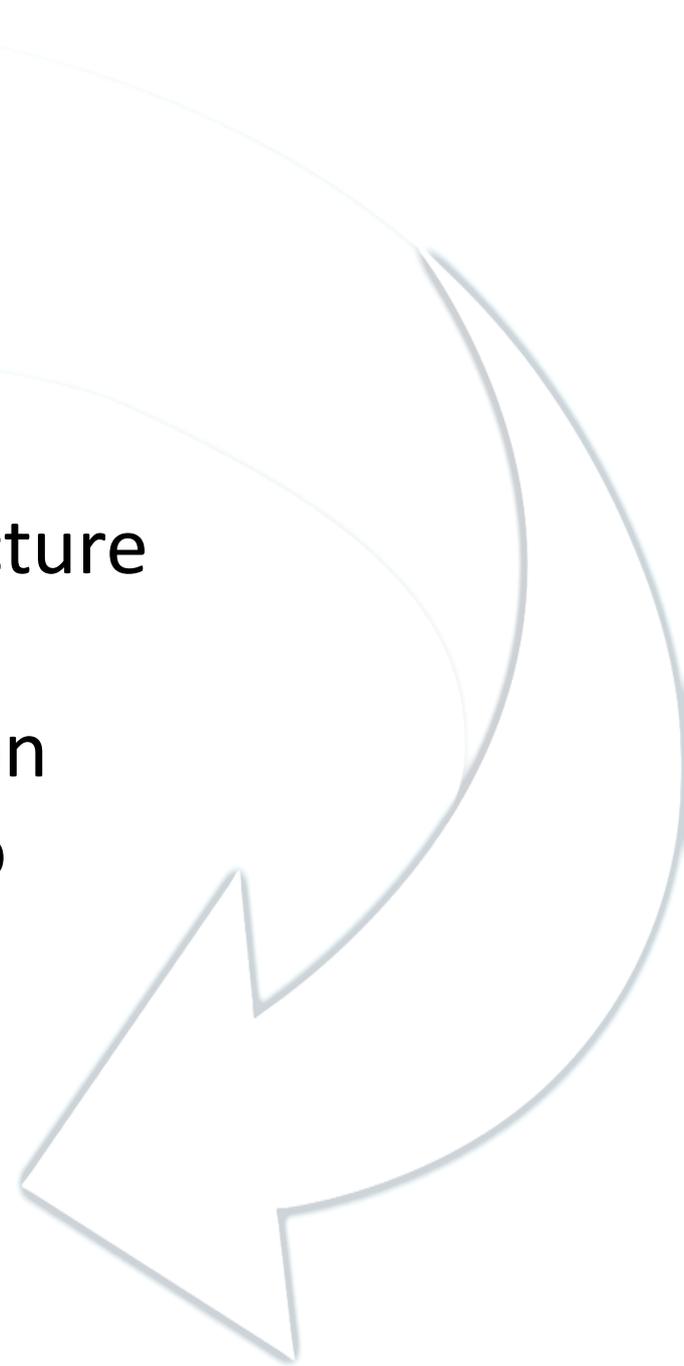
- - Ambulatory Care Pathways
 - Criteria for ACU for triage – Multiple PDSA cycles
 - ACPs take call medical/surgical GP referrals and triage
 - Whole system team working
 - Flex up in response to peak ED activity
 - Developed our ‘urgent care model’
- 

Now 2019

- 35% Medical take (> 40% on weekdays)
- 31% Surgical take
- Opportunities to develop/maximise weekend referrals
- Urgent care model/system approach
- On a background of an increase 12.5% ED attendances from the previous year

Next

- Weekend pathway/process/infrastructure development
- Greater system collaboration
- Continue to flex/respond to activity/acuity changes



Thank you
Questions ?
Julia.nixon@anhst.nhs.uk



Showcase Sites: Surrey and Sussex Healthcare NHS Trust

Medical Ambulatory Emergency Care @ SaSH



Dr Radha Selvaratnam – Acute Physician/AEC Lead

2016/17 – Medical AEC: AMU “Chairs”



- Mon – Fri 8am till 5pm
- Two clinic rooms, one nurse assessment room
- Waiting area off main corridor
- GP expected, A&E referred patients
- TIA, DVT and Follow up clinics
- 1 Junior doctor, 1 Nurse (band 6) , 1 HCA, 1 Admin staff
- AMU consultant covering take



AMU Chairs activity 2015/2016 - 20 months

- 5443 patients seen.
- 10% A&E, 59% GP

Patient and staff survey

- Long waits
- Poor communication
- Lack of space
- Inadequate facilities
- Lack of staff
- Delays - diagnostics, discharge and admission

Waiting times unacceptably long with poor excuses...

About: East Surrey Hospital

Posted via NHS Choices four years ago

You are very high on spin but very low on substance

Treatment suggested at 09.45 by a specialist, not carried out until 19.00!

To take blood took two hours.....

I witnessed doctors walking about like headless chickens, not knowing what rooms to use.

....if you are not getting the simple things right then trust goes out the window.....

Lions lead by donkey's spring to mind.

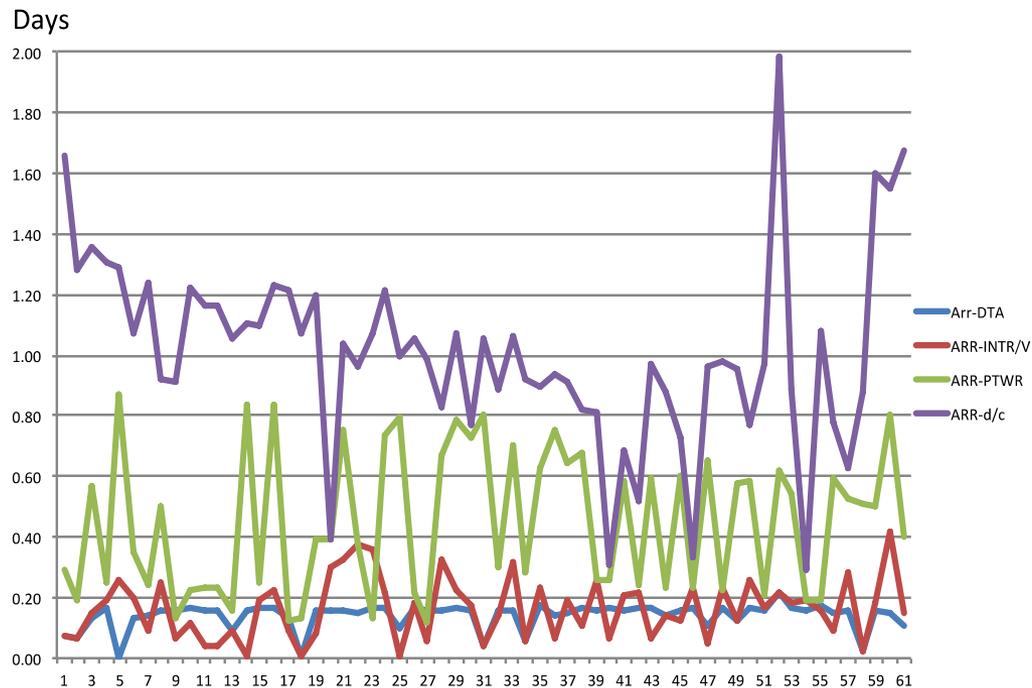
Putting people first

Delivering excellent, accessible healthcare



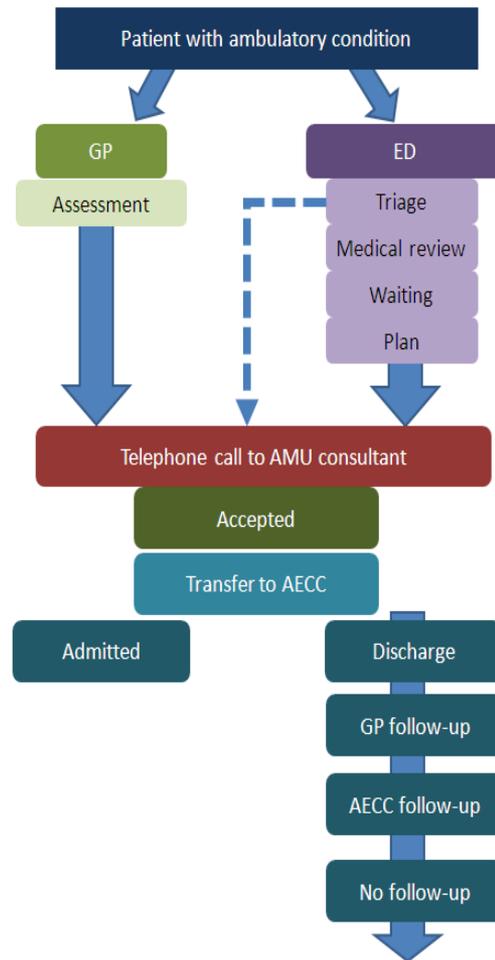
AMU 1 day LOS analysis

Potential Ambulatory patients – LOS 1

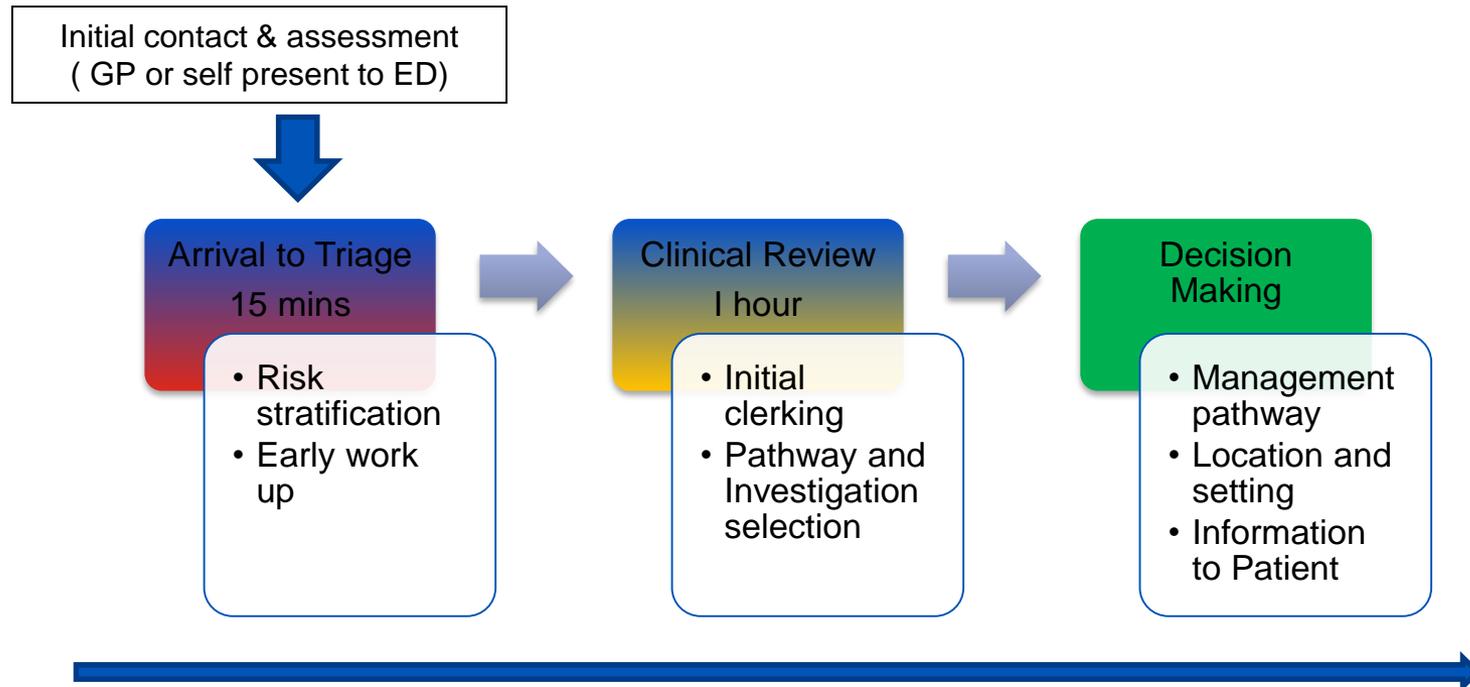


AEC aims

- Improve patient experience
- Improve efficiency and cost effectiveness
- Relieve A&E pressure
- Reduce ambulance wait times
- Reduce length of stay
- Improve GP access for direct medical review



Patient experience



Senior Clinician input through the patient process





Kingsfold Unit – October 2017

Consultant led working with:

- 2 Nurse practitioners
- SpR
- 1 Band 7
- 2 Nurses + 1 NA
- 2 Ward clerks
- Therapists + Pharmacy support
- Porter
- Housekeeper



12 hours a day 7 days week 8am-8pm (admission close at 6pm)

Kingsfold Processes

- Direct access – GP, A&E, Specialty and Community
- Out of hours patients slots
- Paper light - shared access , Data input through Cerner
- Agreed diagnostics turnaround times and slots
- Procedural clinics
- Regular Huddles
- Escalation Plan
- Discharge processes
- Key performance indicators
- Weekly operational meetings

Issues encountered

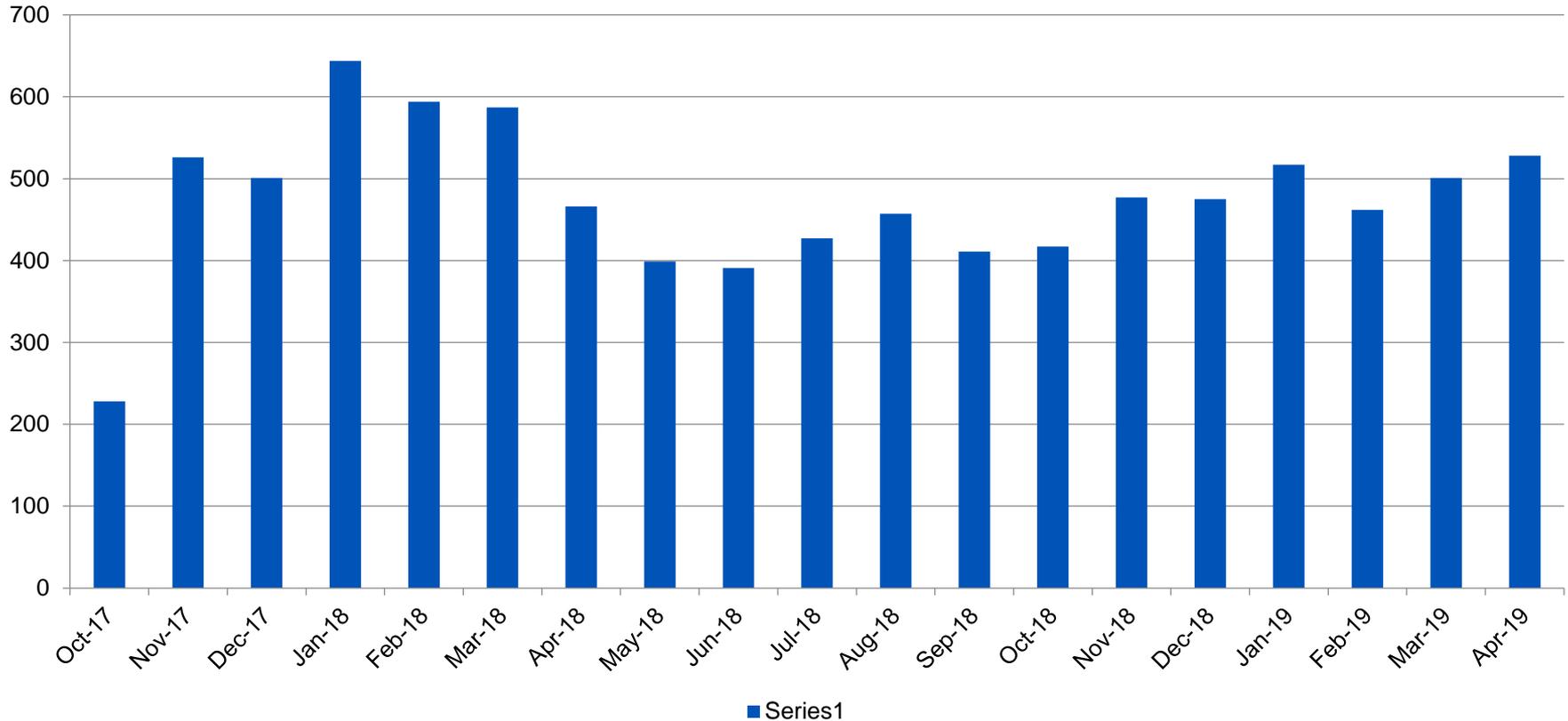
- Managing change
- A&E demand - Escalate to accommodate A&E flow
- Multiple lists
- Location and logistics
- Staffing issues - Phased consultant starts, nursing vacancy
- Late finishes - Staff morale
- Increased demand from specialties
- Management opening unit for overnight patients

Refining the model

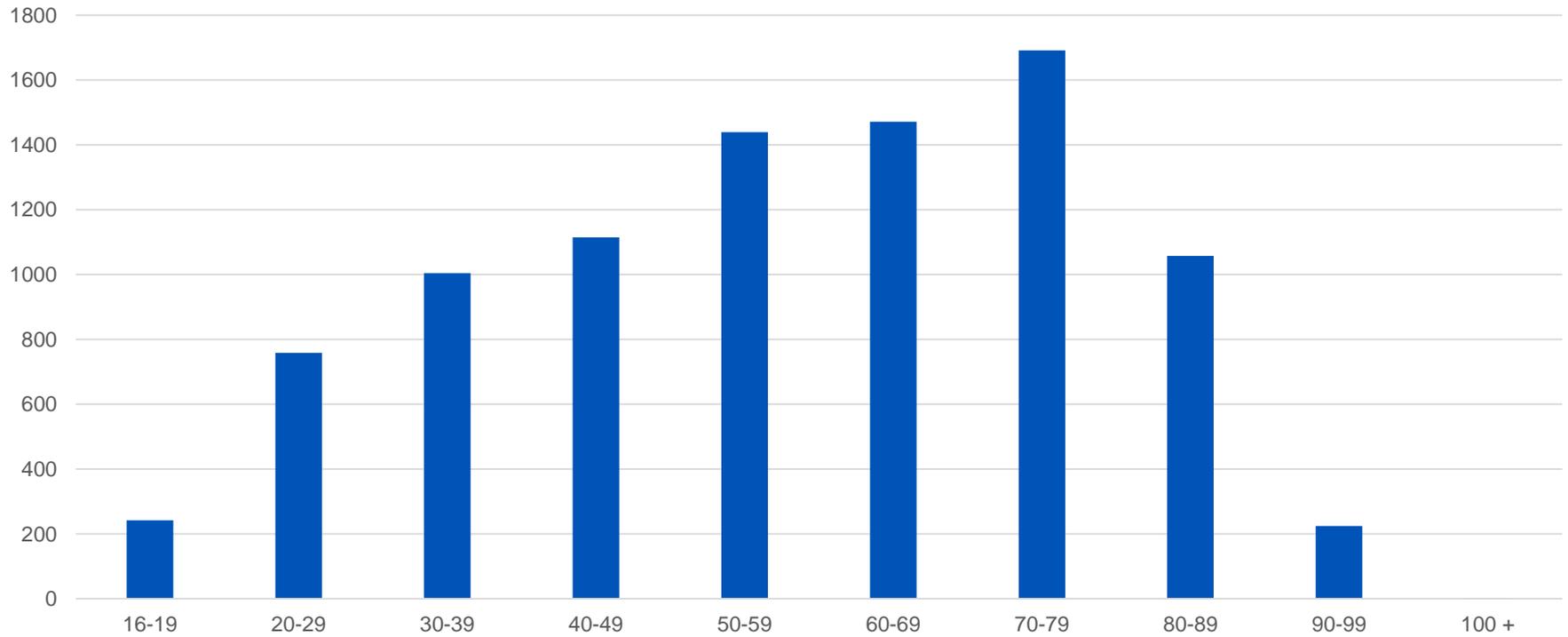
- Junior doctor shift pattern
- Admin time - SPRs/NP
- Reduce unnecessary nursing assessments
- Pharmacy
- Extended portering hours
- IT solution – unified patient list, referral templates
- Telephone Follow-Up Clinics
- Overnight Admission Criteria

Kingsfold Attendances

(Excluding Outpatients)

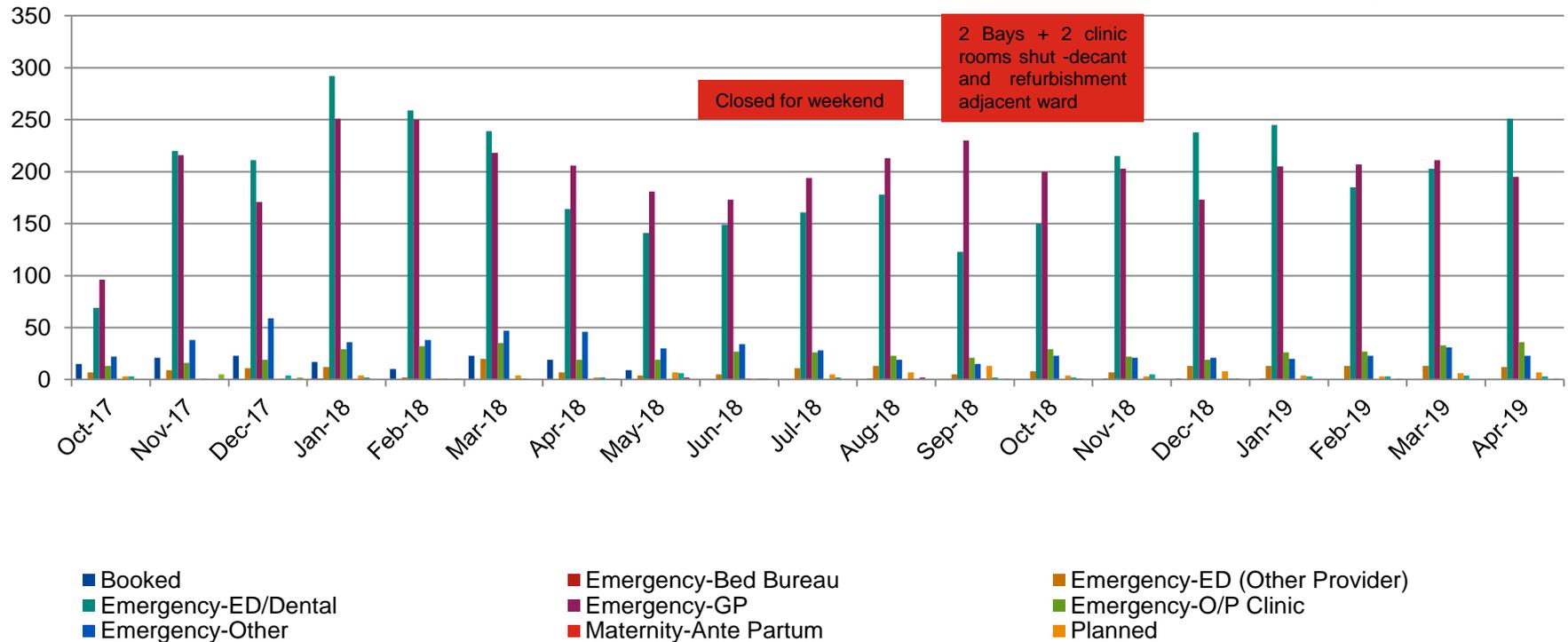


Patient seen by Age



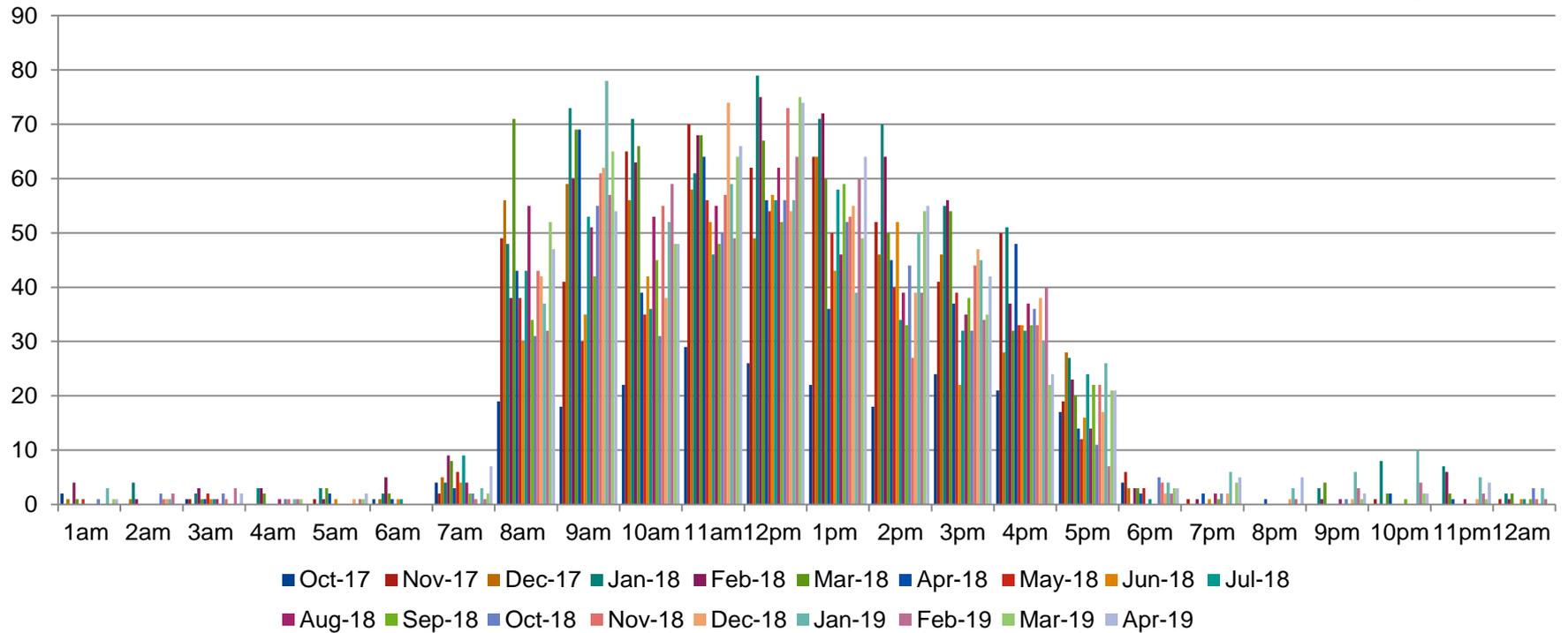
Kingsfold Attendances by source

(Excluding Outpatients)



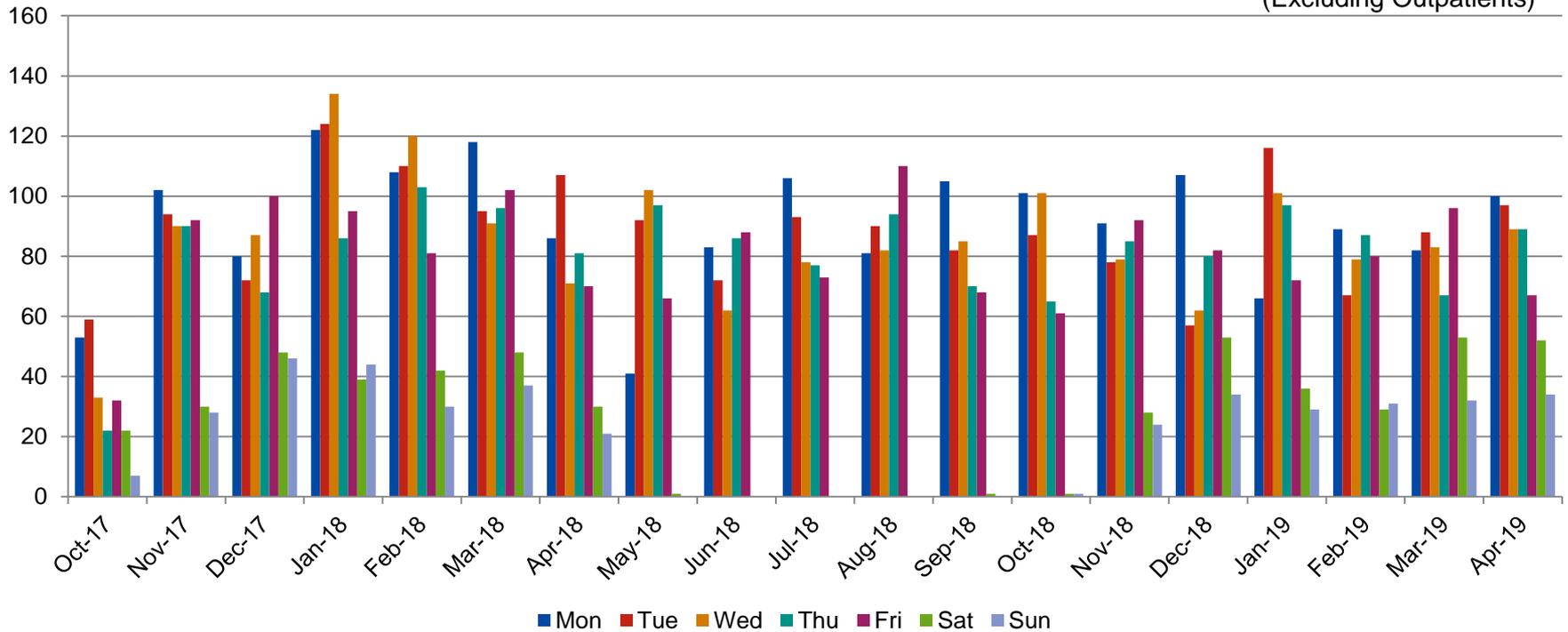
Attendances Arrivals to Kingsfold by hour

(Excluding Outpatients)



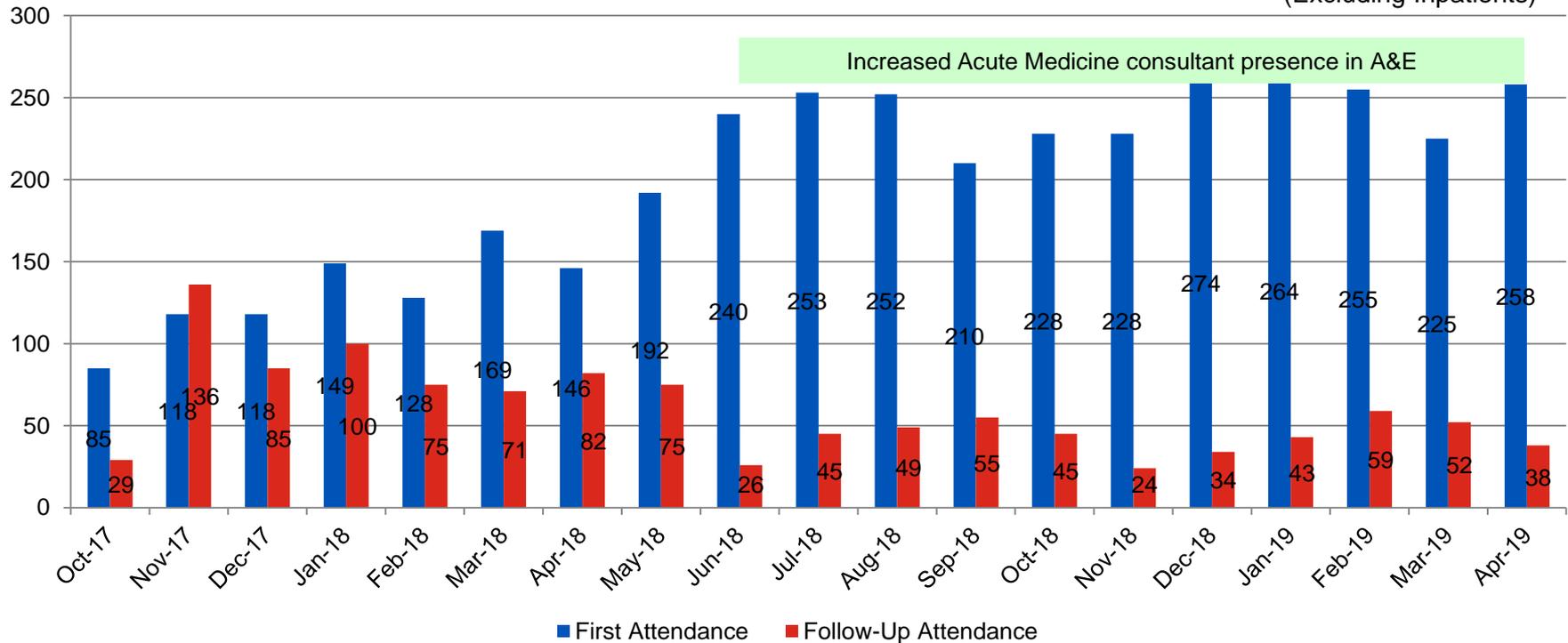
Attendances by weekday

(Excluding Outpatients)

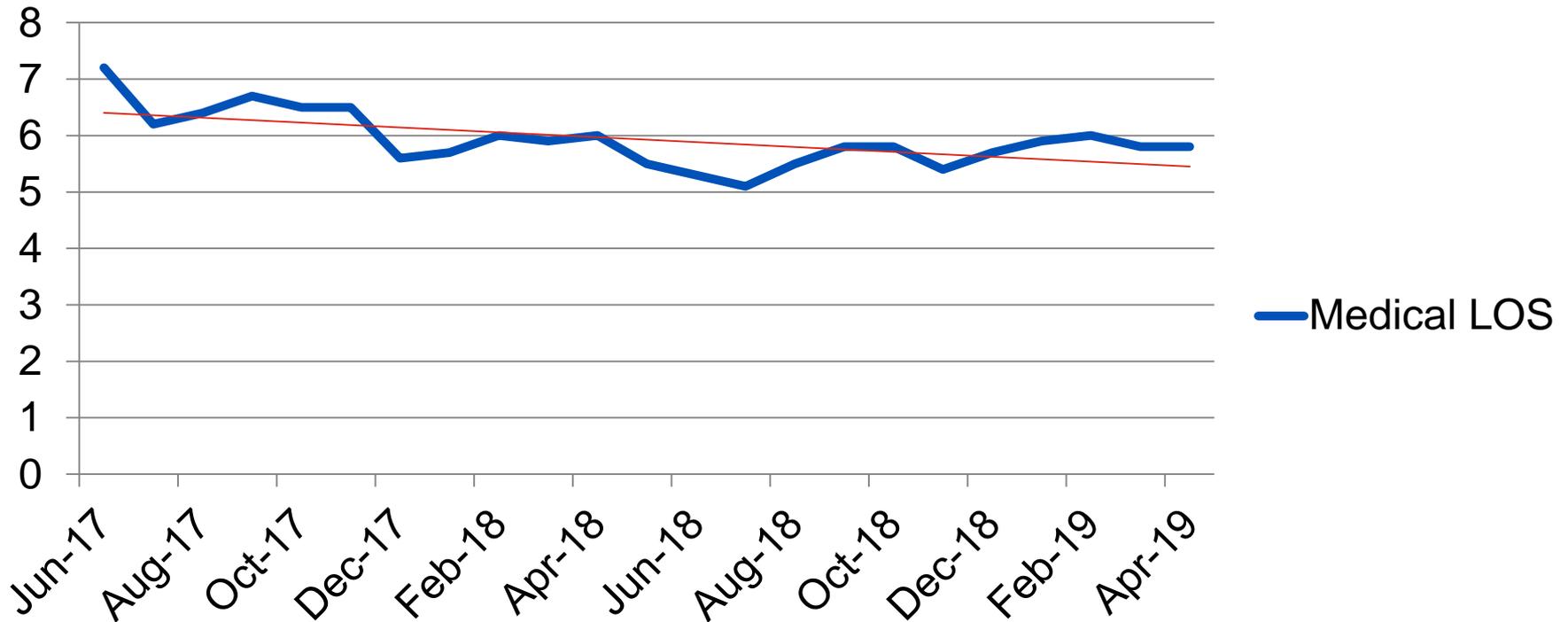


Number of attendances to Kingsfold - All Appointments

(Excluding Inpatients)



Medical LOS



Post implementation review 9 months

- LOS of acute medical patients reduced by 1 day (Jun 17- Jun 18)
- Reduction in Medical escalation beds in Angio Suite.
- Improvement in ED performance
 - 4hr waits (92.8% to 96.9%)
 - Numbers waiting in ED 4-12 hrs (335 to 99)
 - Ambulances wait 30-60 mins (199 to 66) and >60 min (50 to 1)
- **No increase in overall GP referrals.**
- **Overnight patients – 6 Max with escalation nursing staff.**
- **Flexible working to meet demand – Winter / Summer.**
- **Location of the unit – impact on flow.**
- **Number of other hospital services using the services – increase in workload**
 - **Oncology, Gastro, Surgery - pre-assessment clinics**

Patient feedback

‘Kingsfold unit is excellent. Great nursing & care from all.

‘Communication between upstairs and downstairs was superb’

‘we didn’t have to wait at all...getting results the same day was amazing...’

*‘.....These amazing staff deserve 5*****...’*

‘.....I have been really humbled by the amount of work everyone is putting in, redesigning boundaries of care and responsibility, TEAMWORK AT ITS VERY BEST.....’

Developing a dashboard for AEC

Annabel Shaw
Measurement Lead – AEC Network
NHS Elect

AnnabelatAEC@nhselect.org.uk

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!

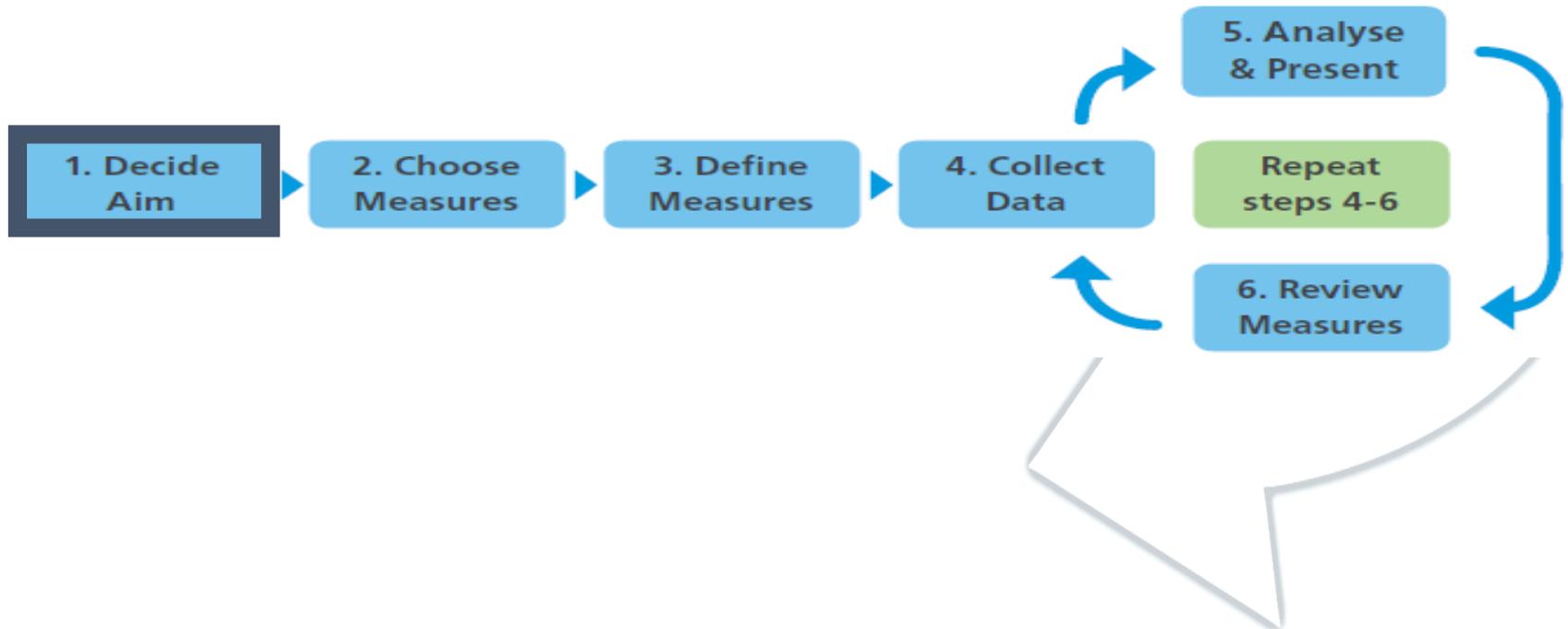
Measurement for improvement

MODEL FOR IMPROVEMENT

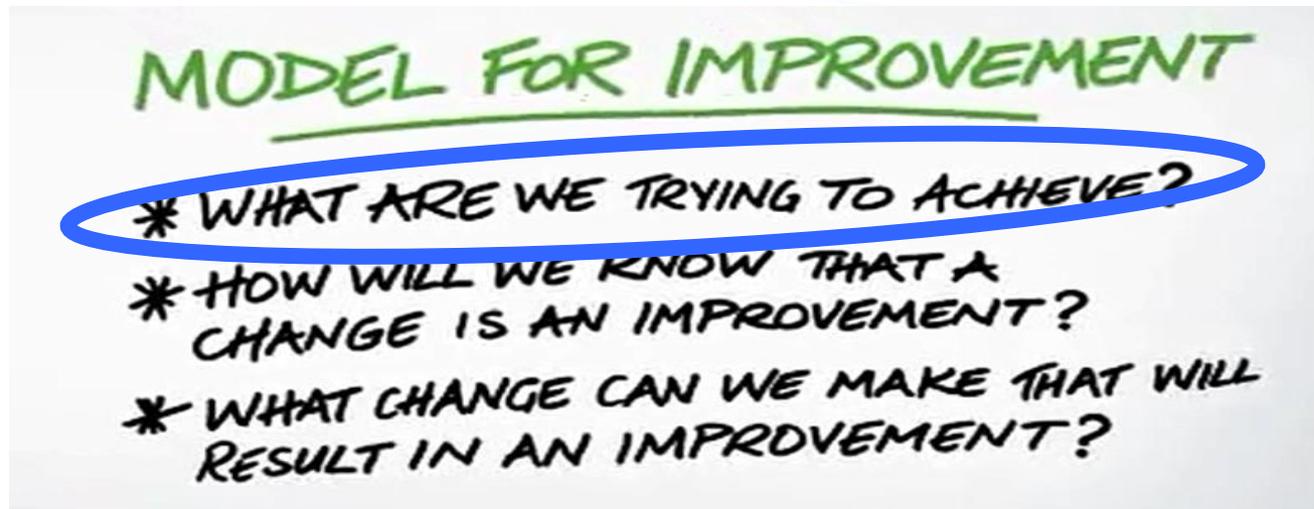
- * WHAT ARE WE TRYING TO ACHIEVE?
- * HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?
- * WHAT CHANGE CAN WE MAKE THAT WILL RESULT IN AN IMPROVEMENT?

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 admissions to the hospital to be admitted to hospital for an emergency for 12 months as a result

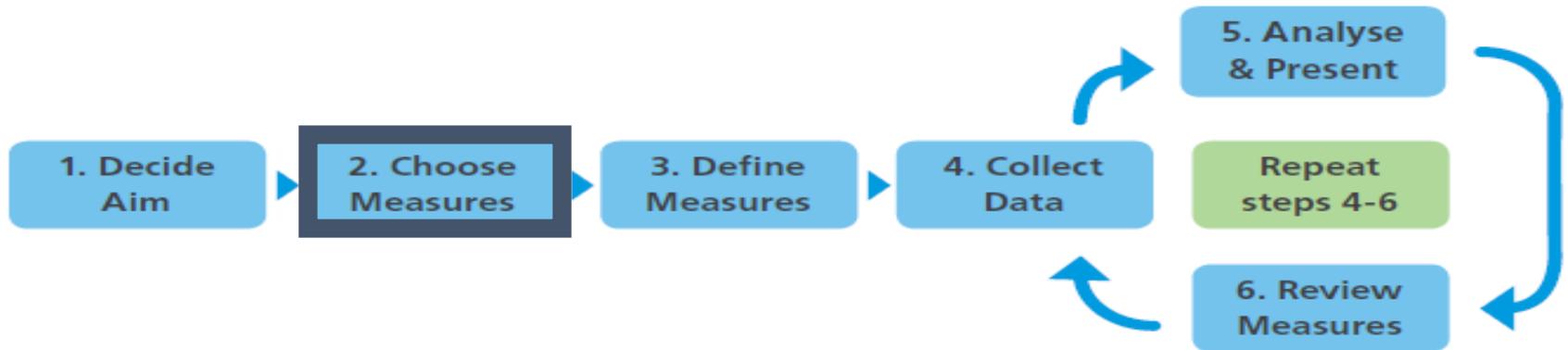
Signposting you to some help

The screenshot shows the NHS Ambulatory Emergency Care Network website. The main heading is "Measurement". The page content includes:

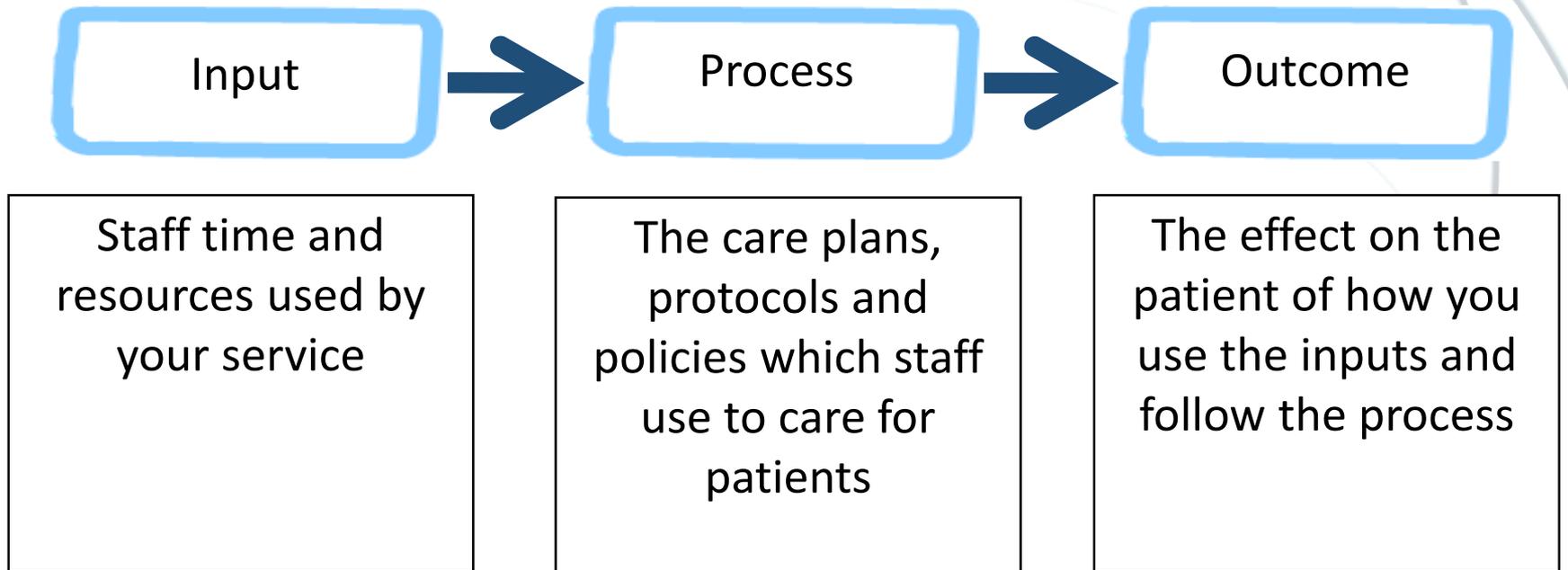
- Search bar at the top right.
- Navigation menu: HOME, ABOUT, TOOLS AND RESOURCES (highlighted), EVENTS, NURSING, BAAEC, SAEC, AEC AP, CONTACT US.
- Breadcrumbs: Home | Tools and Resources | Measurement
- Section header: Measurement
- Text: Robust measurement of the impact that your service is making and understanding the potential return on investment is critical to enable you to fully realise the potential of AEC.
- Text: We have worked with staff in Trusts and Commissioners to understand the challenges and skills required, and have produced guides and materials that will give you the tools to measure and quantify your improvement, and to estimate and measure your return on investment.
- Text: For more please click below:
- List of resources:
 - The Measurement Team
 - Measurement Guides
 - Aim Statements
 - Dashboards
 - Driver Diagrams
 - Flow Diagrams
 - The Impact of AEC
 - The Potential for AEC
 - Measurement Fact Sheets
 - Patient Experience
 - Staff Experience
 - Sample Pieces of Analysis
 - Measurement and Baseline
- Left sidebar menu with "Measurement" highlighted.
- Page number "27" in the bottom right corner.

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



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

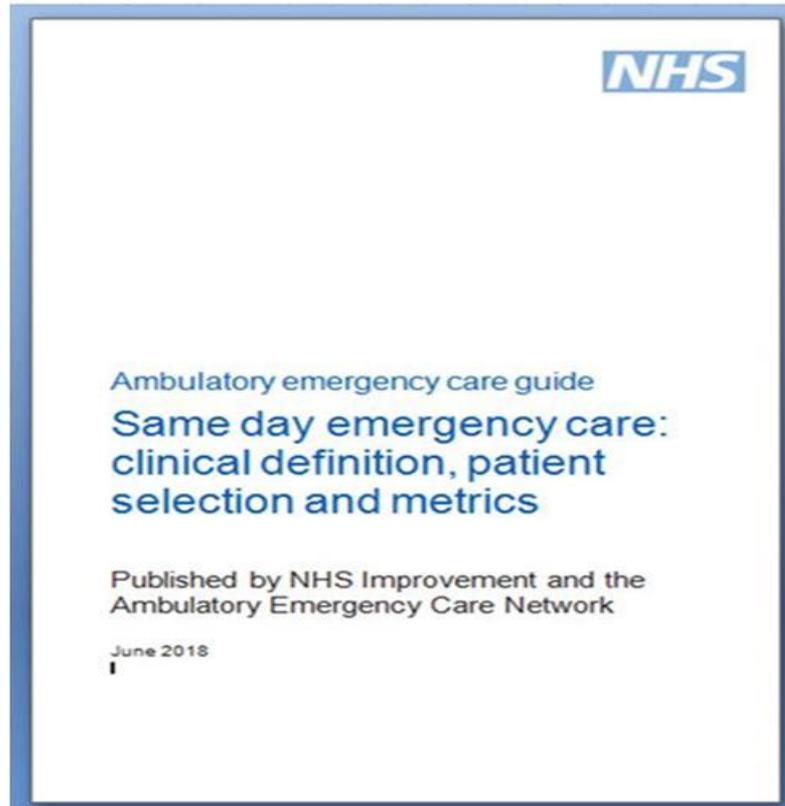
**Outcome
measure**

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



Productivity measure

The number of new non-elective presentations of patients with a condition managed by A&E/A&DE/S&DE unit within the previous 7 days

What presentation style to use

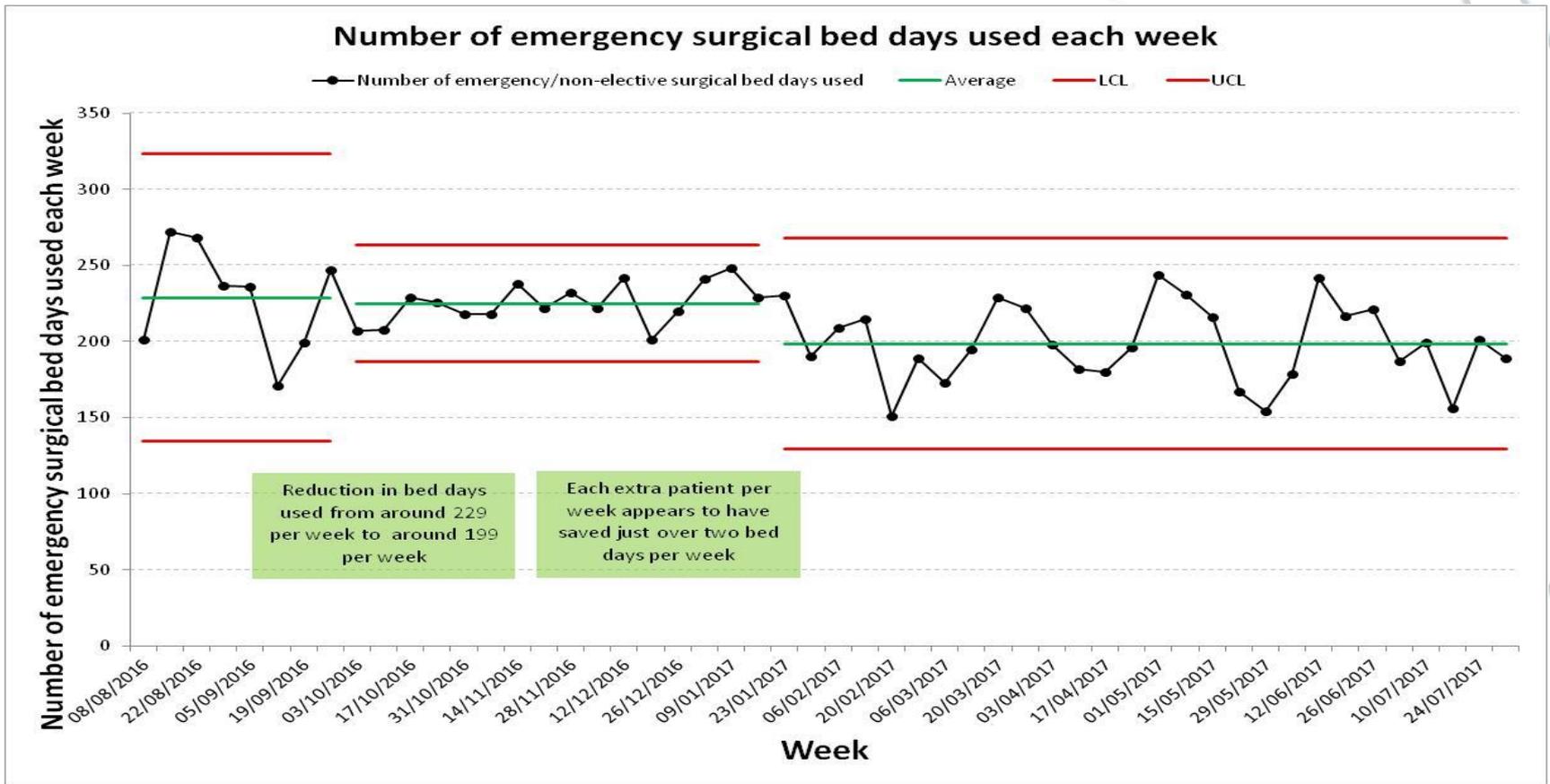
“We strongly recommend AEC/SDEC present these data items as daily run charts (or, better, **statistical process control charts**)

with appropriate explanation for special cause events

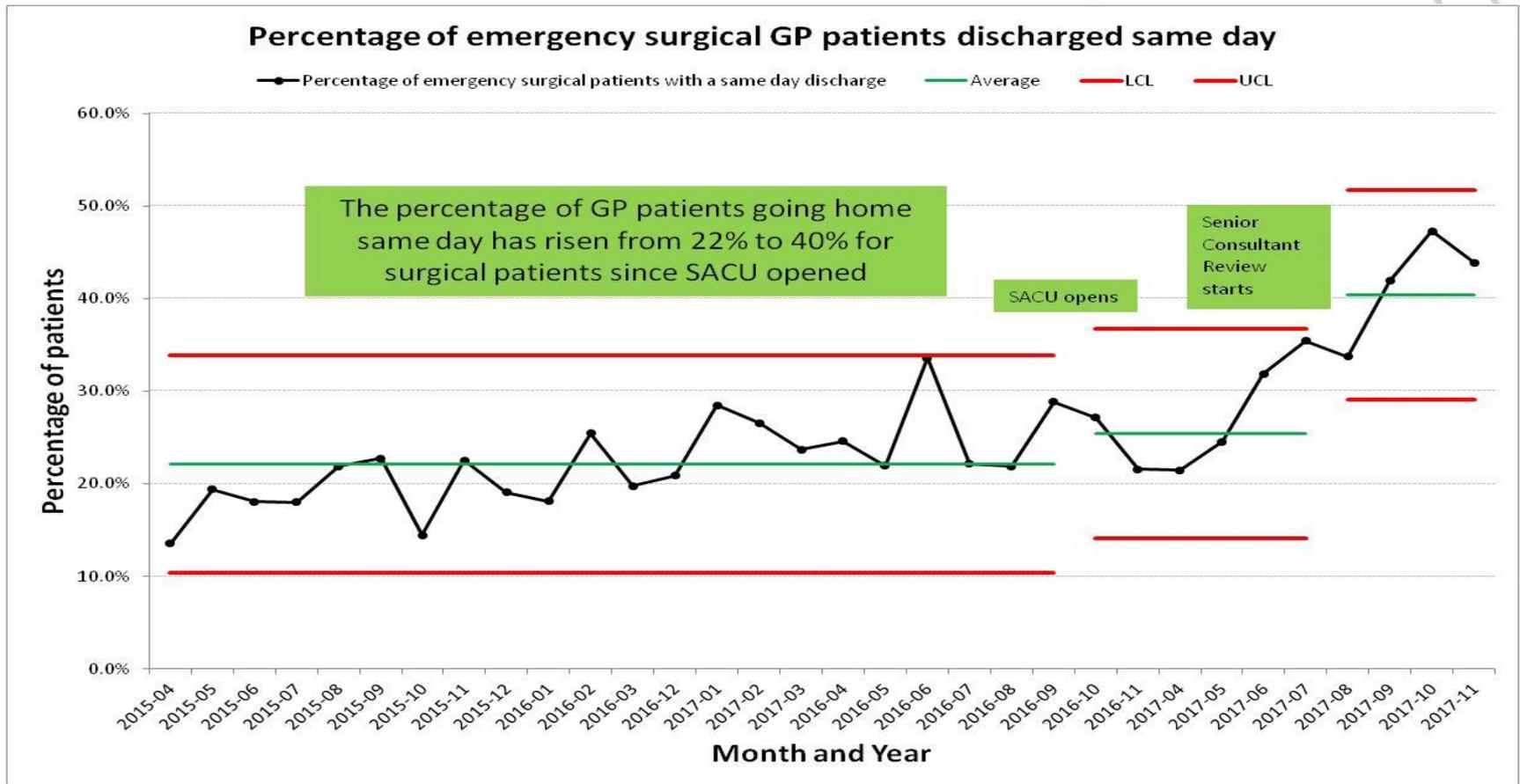
and **annotate the implementation of any changes** where there is an improvement in the data.”



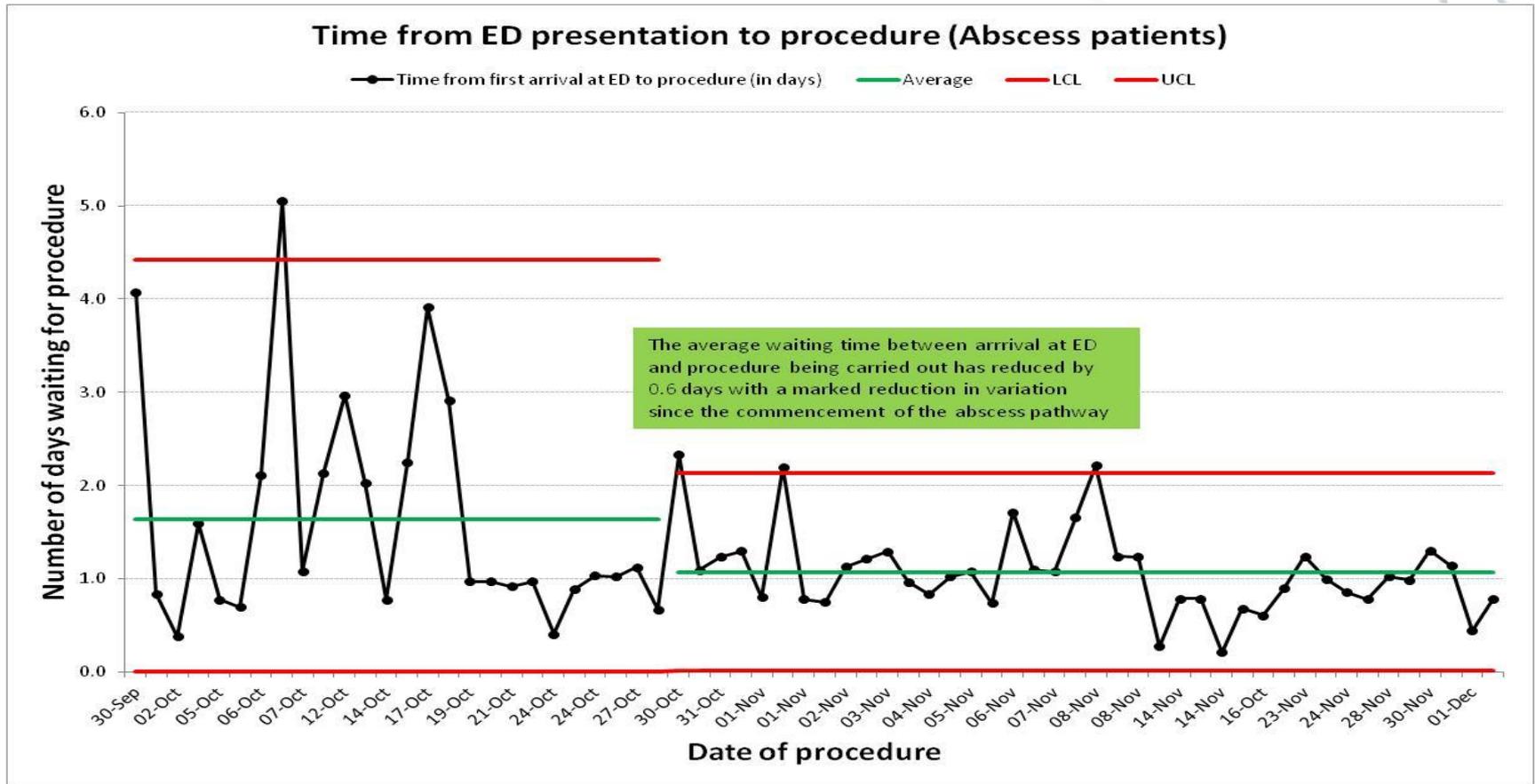
Wythenshawe Hospital Surgical AEC Network Cohort 1



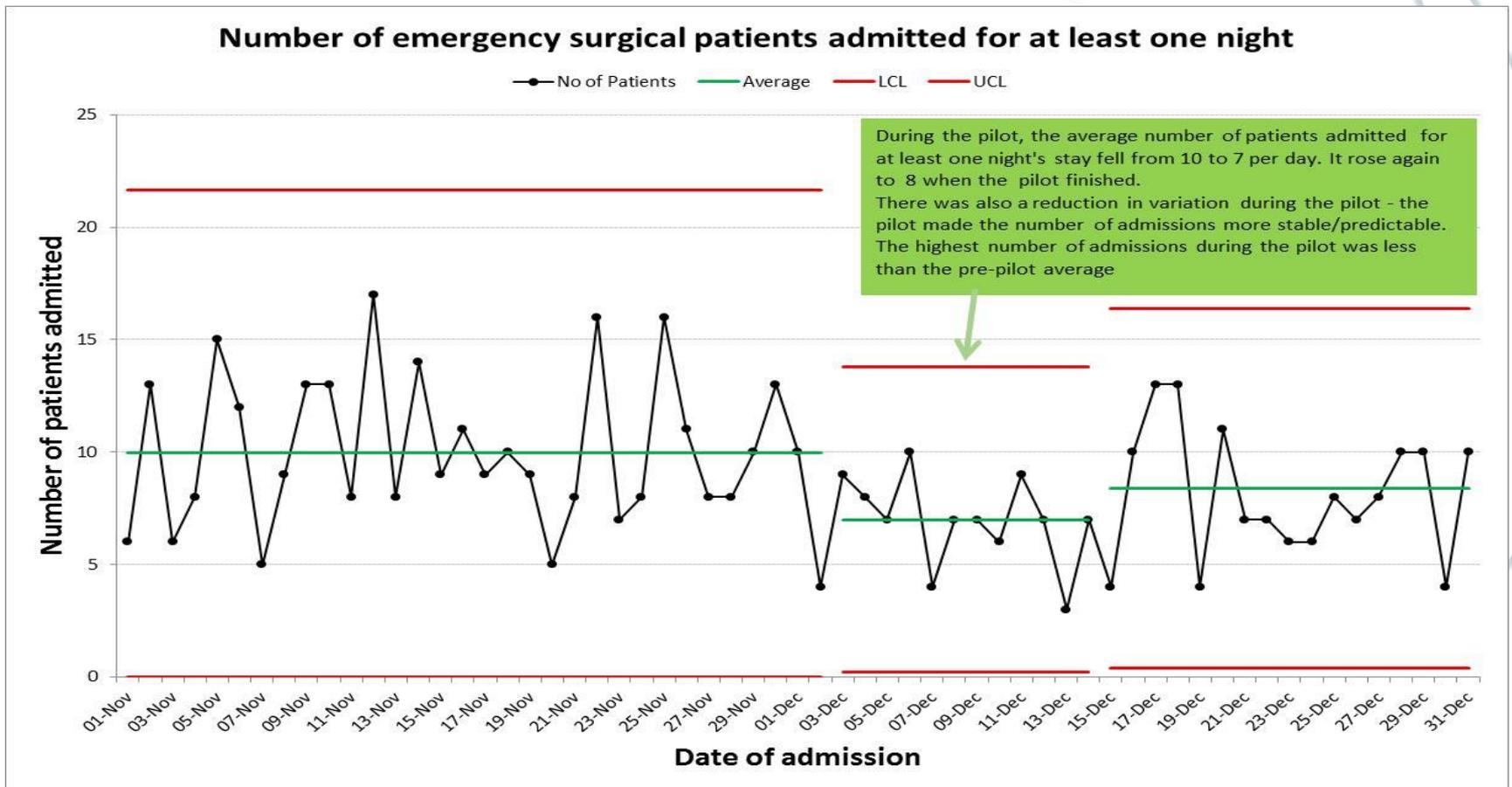
Leighton Hospital Surgical AEC Network Cohort 1



Royal London Surgical AEC Network Cohort 1



West Suffolk Hospital Surgical AEC Network Cohort 2



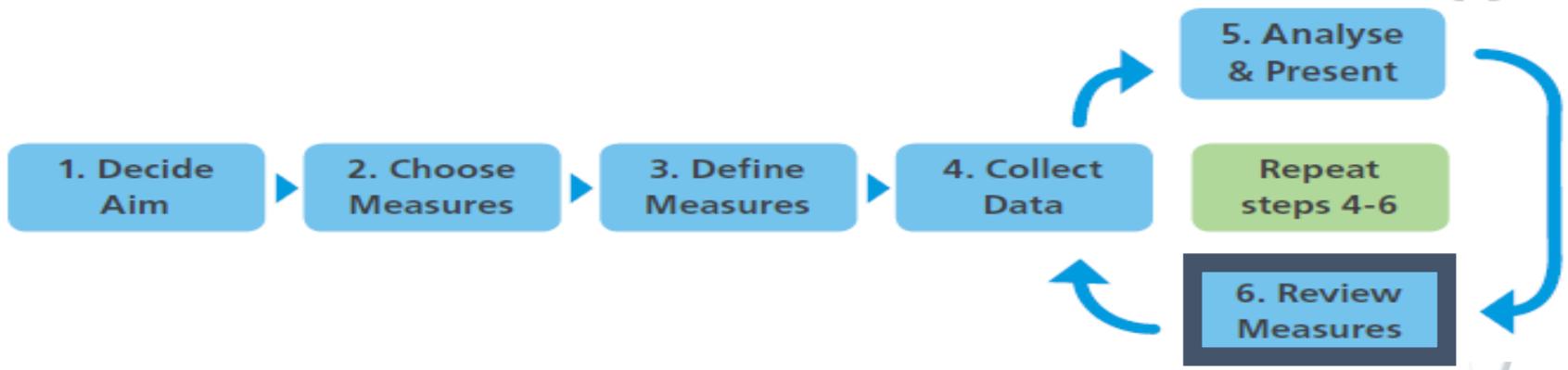
More help is available

The screenshot shows the NHS Ambulatory Emergency Care Network website. At the top right is the NHS logo and the text 'Ambulatory Emergency Care Network'. Below this is a search bar and a navigation menu with links: HOME, ABOUT, TOOLS AND RESOURCES (highlighted), EVENTS, NURSING, BAAEC, SAEC, AEC AP, and CONTACT US. Below the navigation is a breadcrumb trail: Home | Tools and Resources | Measurement. The main content area has a large heading 'Measurement' in blue. To the left of the heading are social media icons for email, Facebook, and Twitter. Below the heading is a date: 'Tuesday 27 February 2018'. The main text reads: 'Robust measurement of the impact that your service is making and understanding the potential return on investment is critical to enable you to fully realise the potential of AEC. We have worked with staff in Trusts and Commissioners to understand the challenges and skills required, and have produced guides and materials that will give you the tools to measure and quantify your improvement, and to estimate and measure your return on investment. For more please click below:'. Below this text is a list of links: The Measurement Team, Measurement Guides, Aim Statements, Dashboards, Driver Diagrams, Flow Diagrams, The Impact of AEC, The Potential for AEC, Measurement Fact Sheets, Patient Experience, Staff Experience, Sample Pieces of Analysis, and Measurement and Baseline. On the left side of the page, there is a vertical menu with a search icon and a list of links: AEC Directory, Case Studies, Experience Based Design (EBD), EBD Films, Links to External Improvement Tools, and Measurement (highlighted). Under the 'Measurement' link, there is a sub-menu with links: Measurement Team, Measurement Guides, Aim Statements, Dashboards, Driver Diagrams, Flow Diagrams, The Potential for AEC, and Measurement.

High level Driver Diagram from AEC Network



Reviewing and using your measures

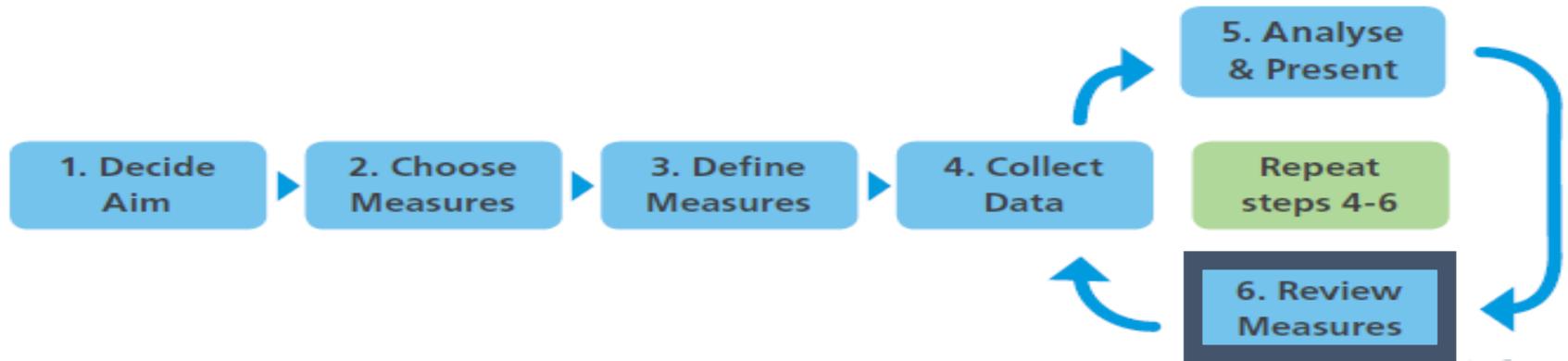


It is a waste of time collecting and analysing your data if you don't take action on the results
use it to drive changes to your system
is something you need to think through

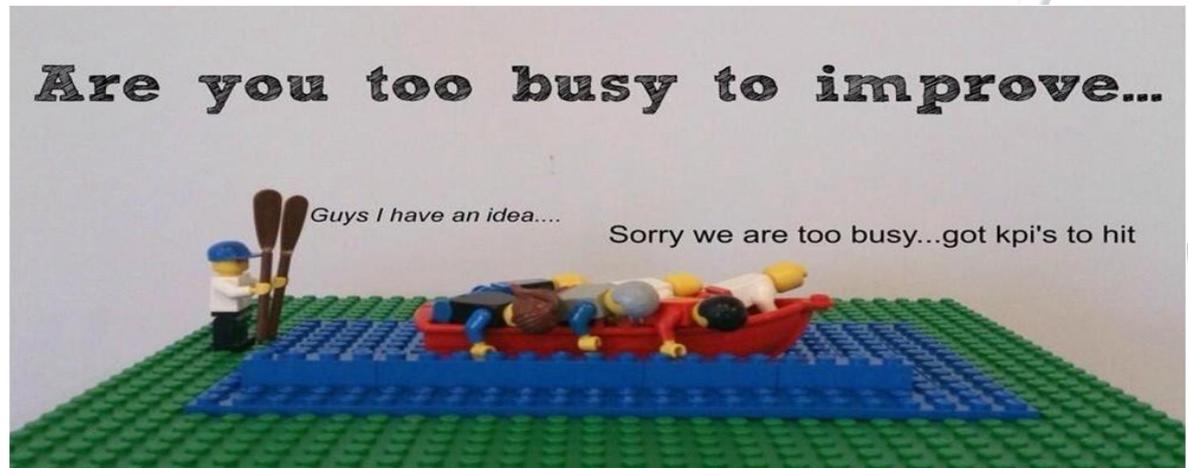
MODEL FOR IMPROVEMENT

- * WHAT ARE WE TRYING TO ACHIEVE?
- * HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?
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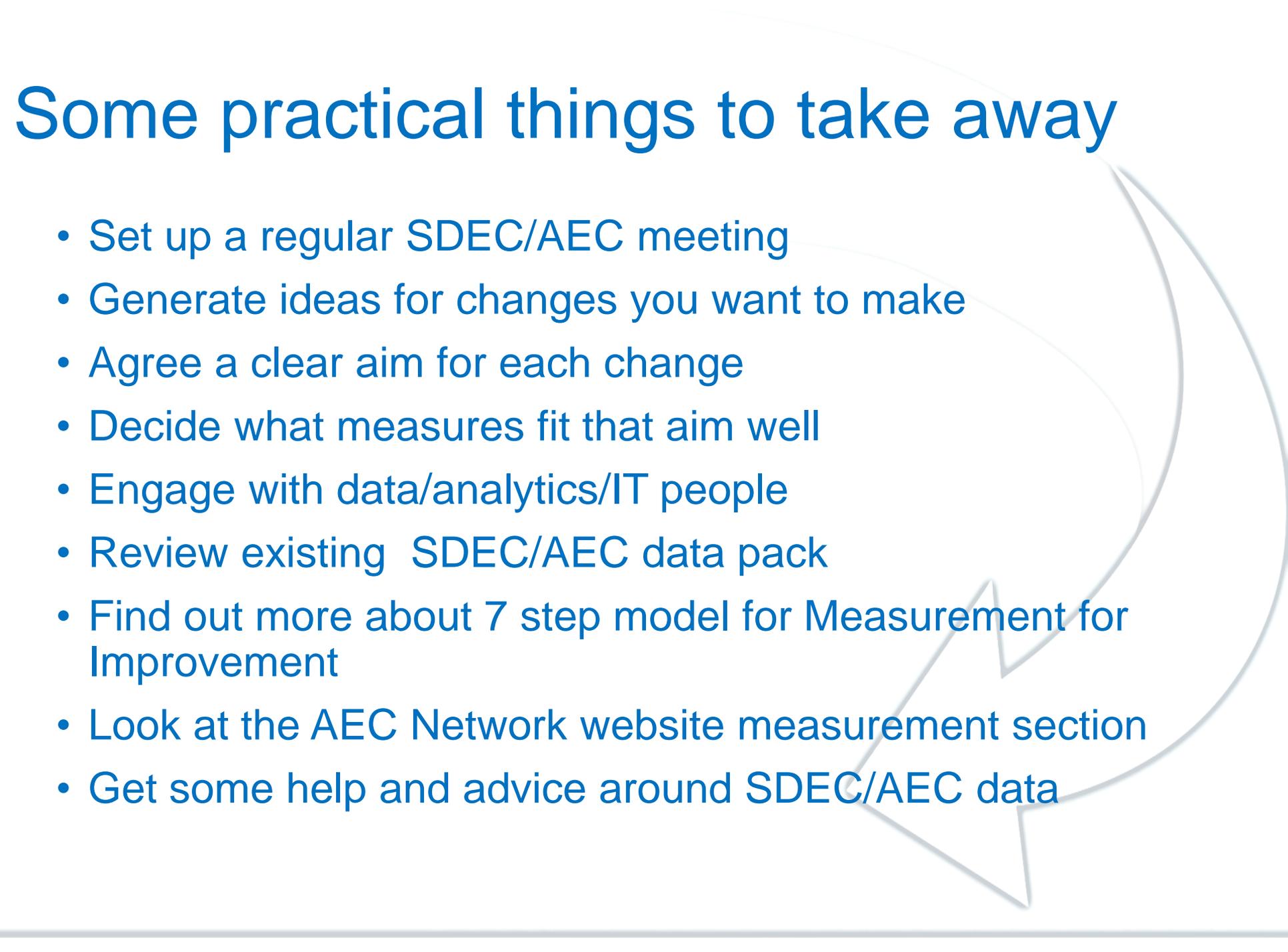
Reviewing and using your measures



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

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

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

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

Slido Event Evaluation

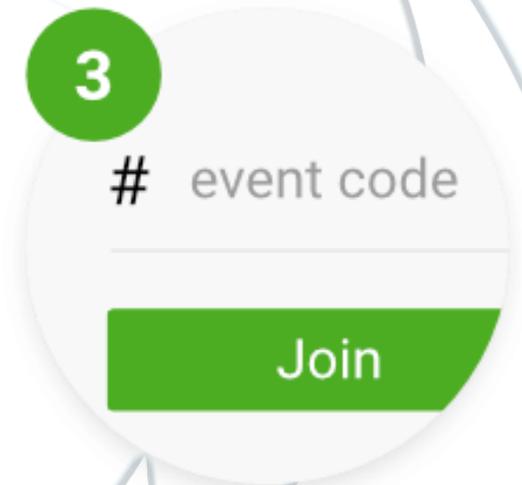
Access our event evaluation in 3 easy steps



1. Go to any web browser from any device



2. Go to slido.com



3. Type in the event code **#SDEC210519**