Same Day Emergency Care

Regional Workshop

24th May 2019

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

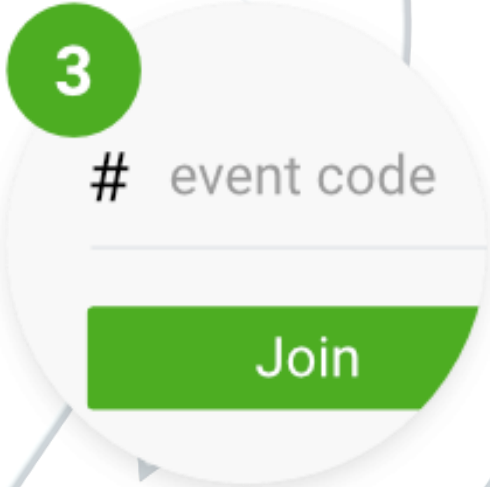
10:00	Welcome and Overview
	Strategic Vision
	AEC in Emergency Care
	What is SDEC?
	Coffee Break
	Working together to understand what is needed to maximise SDEC at pace
	Lunch
	Surgical AEC Principles
	Working with the SAM to Develop the SDEC Model
	SDEC Dataset
	Showcase sites
	Developing a Dashboard 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 **#SDEC240519**

Same Day Emergency Care

Dr Cliff Mann
National Clinical Advisor
Co-Chair SDEC Programme Board

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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?

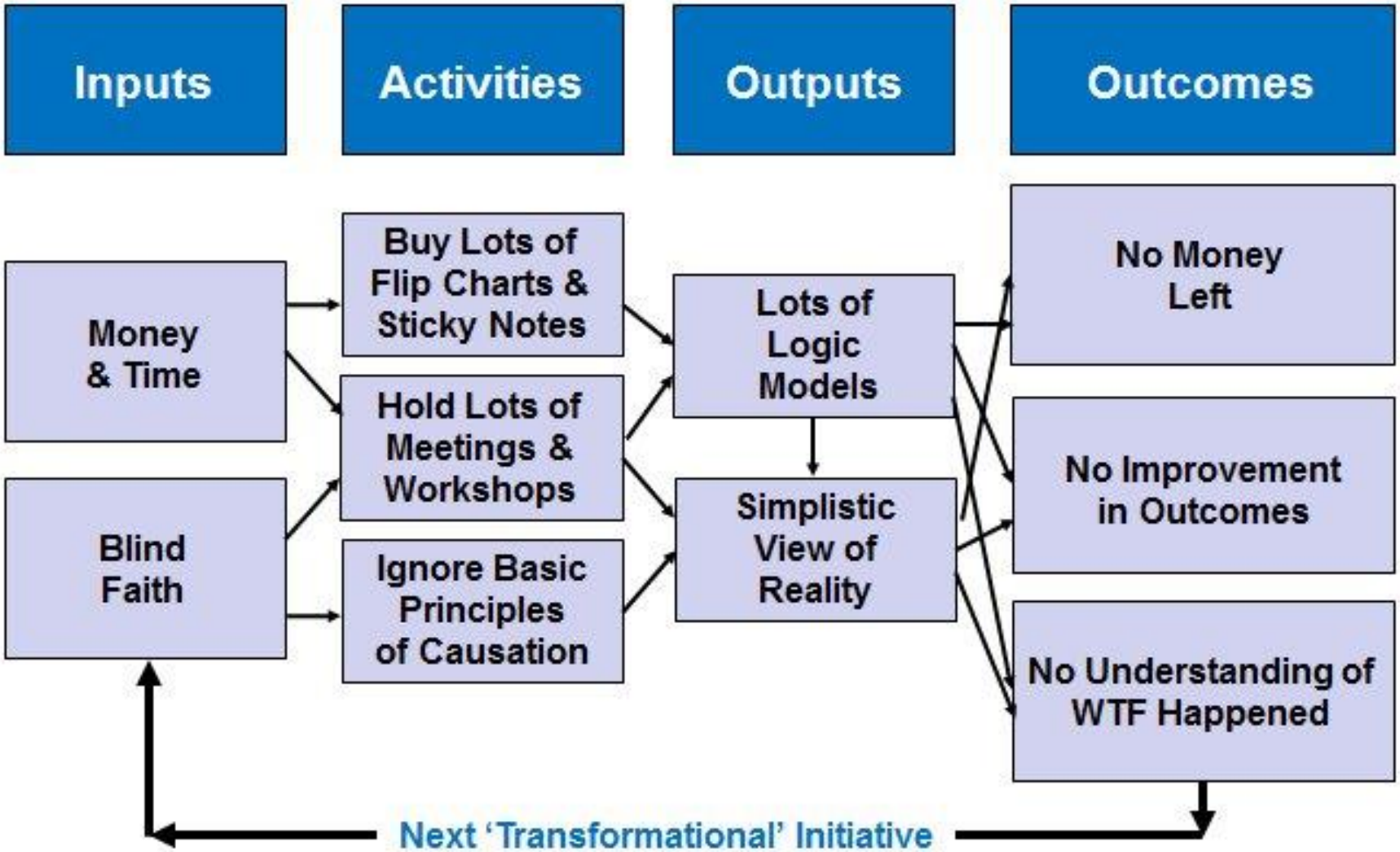
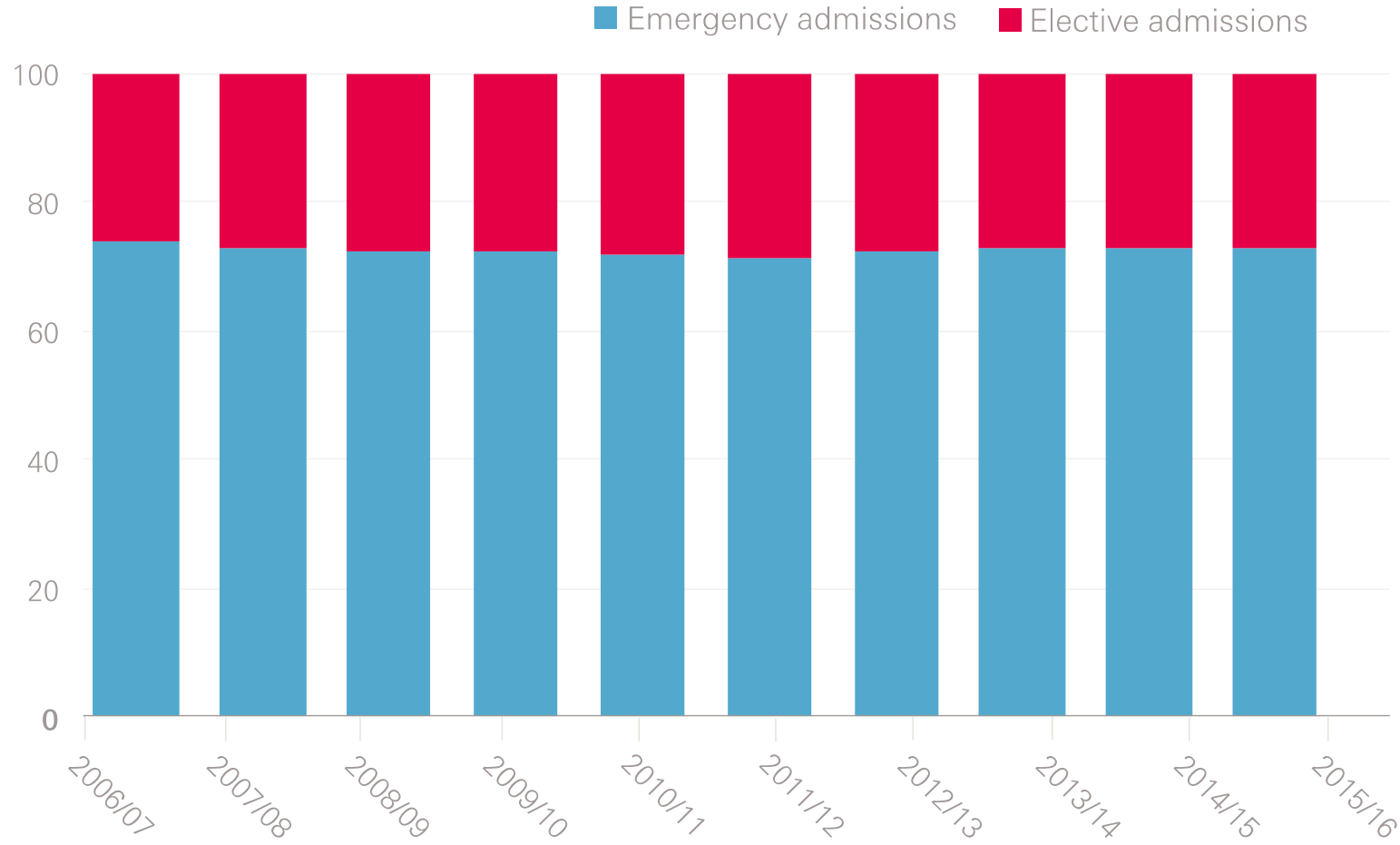


Figure 5:† Proportion of total bed days for emergency admissions and elective admissions



* 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

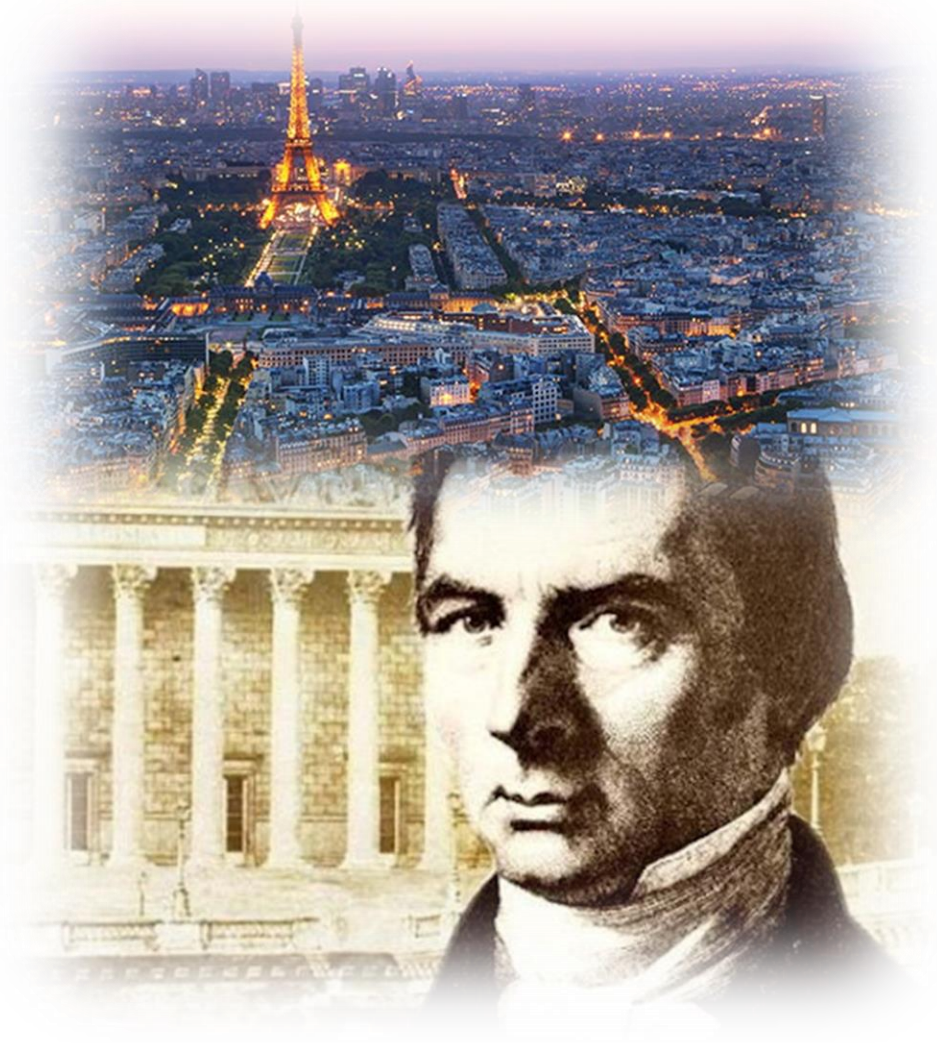
CQUINS

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

SAM

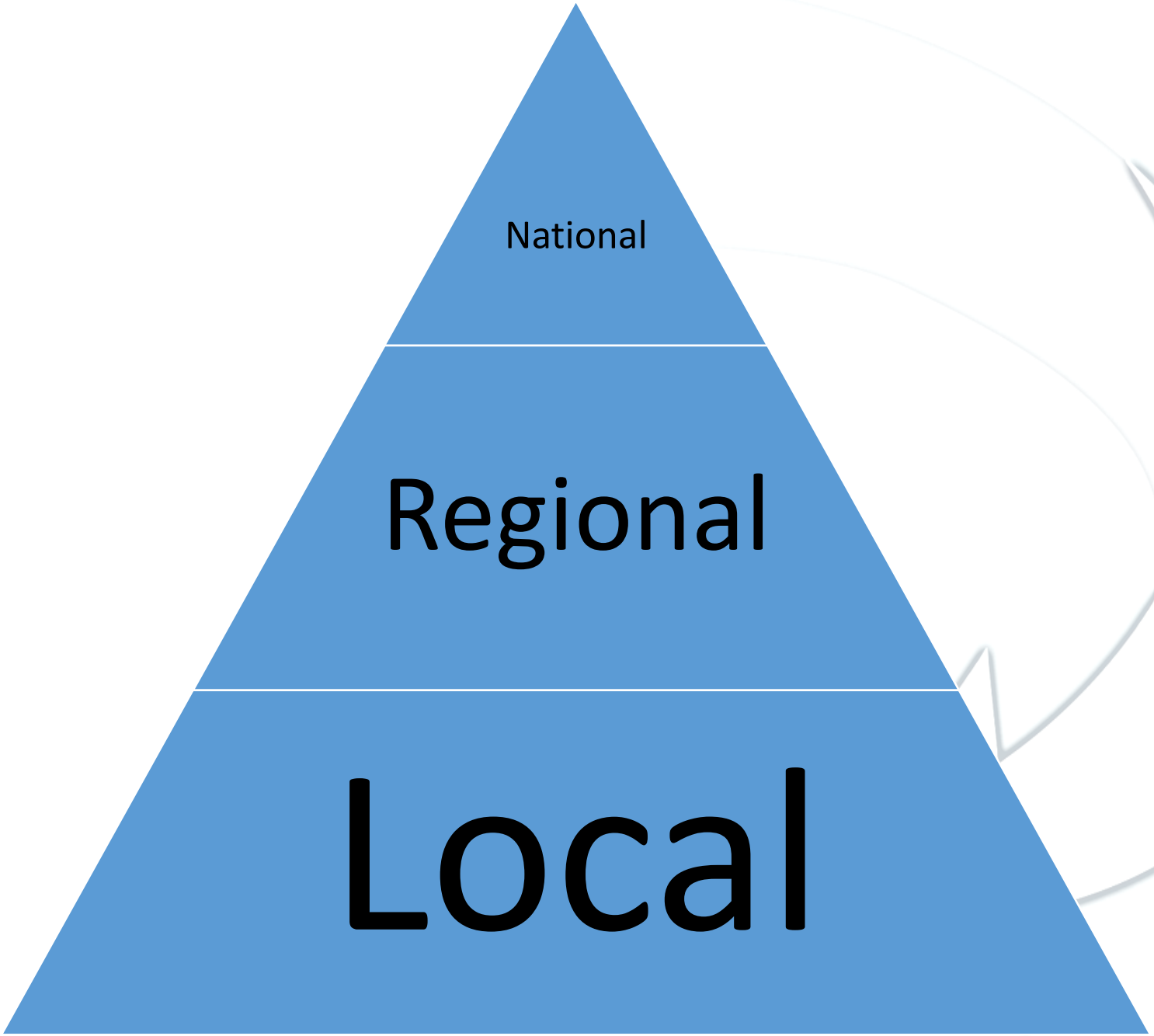
Royal College of Nursing

The College of Emergency Medicine

DH Department of Health

Best Practice Tariffs for Ambulatory Emergency Care

NHS Elect


National
Regional
Local

National tasks

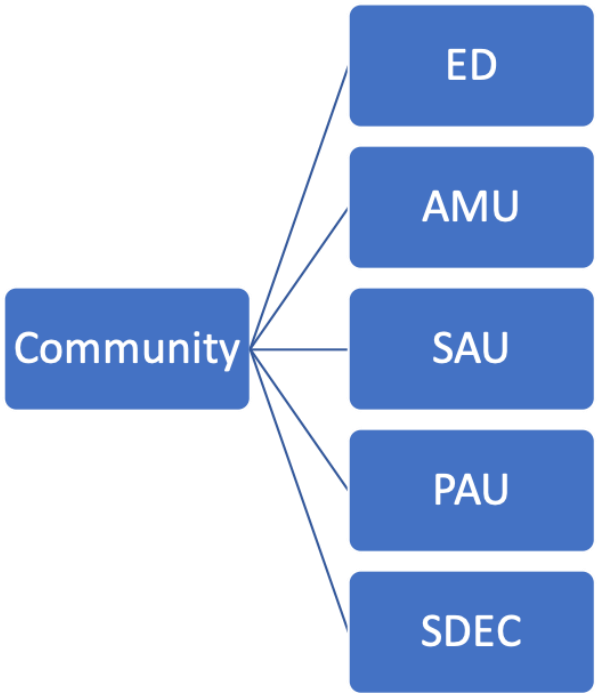
- Signal
- Count
- Pay

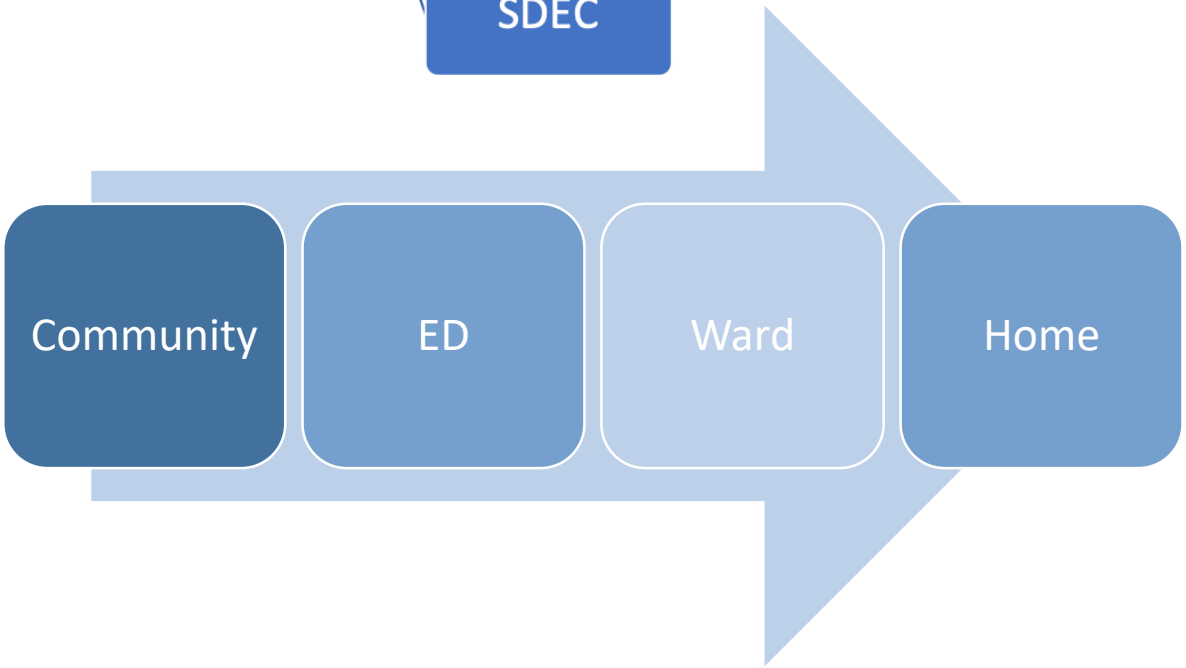
SDEC

≠ ZLoS

≠ A Place/ Site Code/ Ward

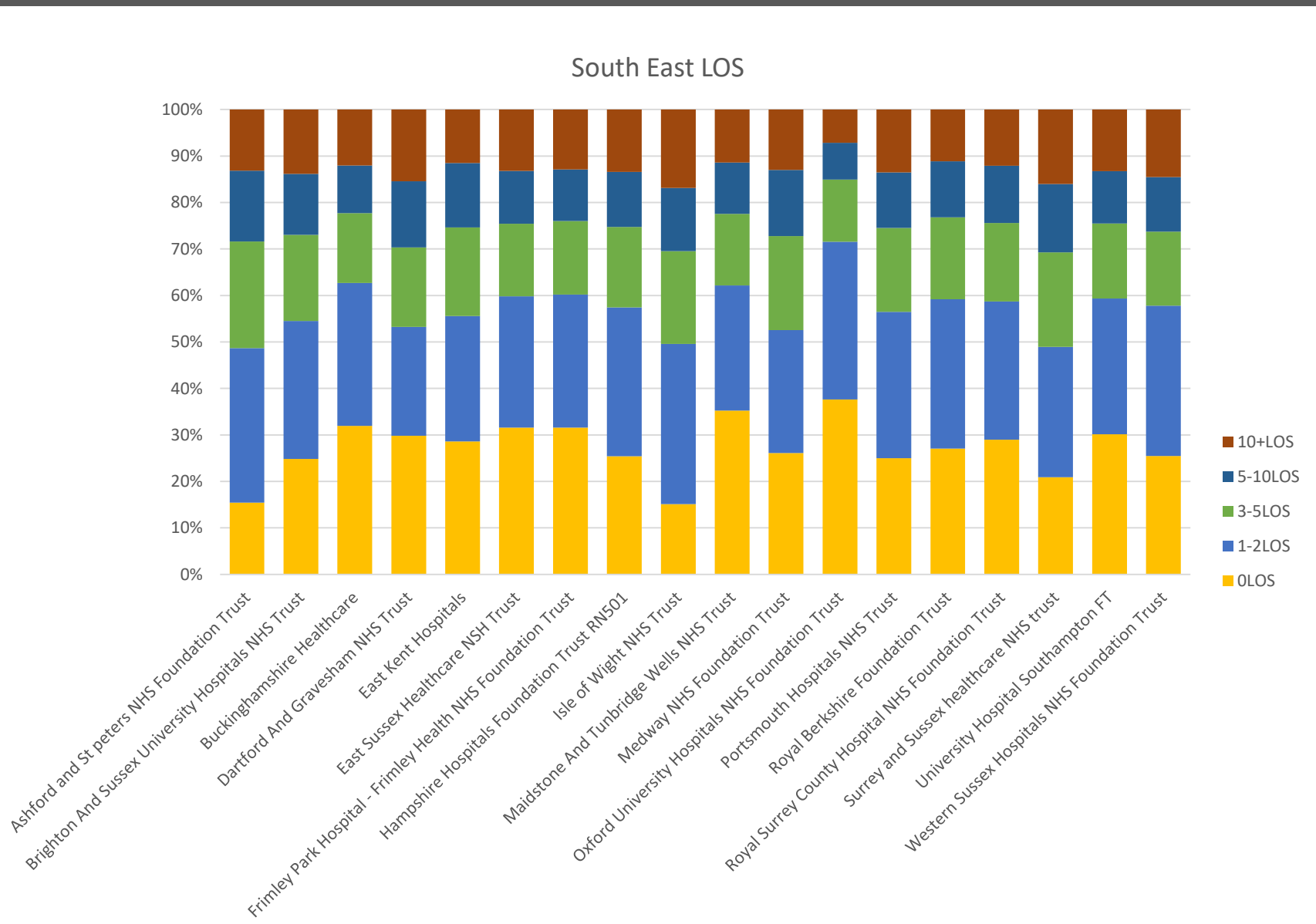
= Diagnosis +/- Ix +/- Rx recorded via SDECDS


Community
ED
AMU
SAU
PAU
SDEC


Community
ED
Ward
Home

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 name	s	230456007	G419
Epilepsy : absence	we have different types of epilepsy but not by these name	s	79631006	G403
Epilepsy : focal	we have different types of epilepsy but not by these name	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 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
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
10+LOS
5-10LOS
3-5LOS
1-2LOS
0LOS
Ashford and St peters NHS Foundation Trust
Brighton And Sussex University Hospitals NHS Trust
Buckinghamshire Healthcare
Dartford And Gravesham NHS Trust
East Kent Hospitals
East Sussex Healthcare NSH Trust
Frimley Park Hospital - Frimley Health NHS Foundation Trust
Hampshire Hospitals Foundation Trust RN501
Isle of Wight NHS Trust
Maidstone And Tunbridge Wells NHS Trust
Medway NHS Foundation Trust
Oxford University Hospitals NHS Foundation Trust
Portsmouth Hospitals NHS Trust
Royal Berkshire Foundation Trust
Royal Surrey County Hospital NHS Foundation Trust
Surrey and Sussex healthcare NHS trust
University Hospital Southampton FT
Western Sussex Hospitals NHS Foundation Trust

SDEC

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

Star-chamber approach

ICD/SnoMed/ ECDS codes agreed

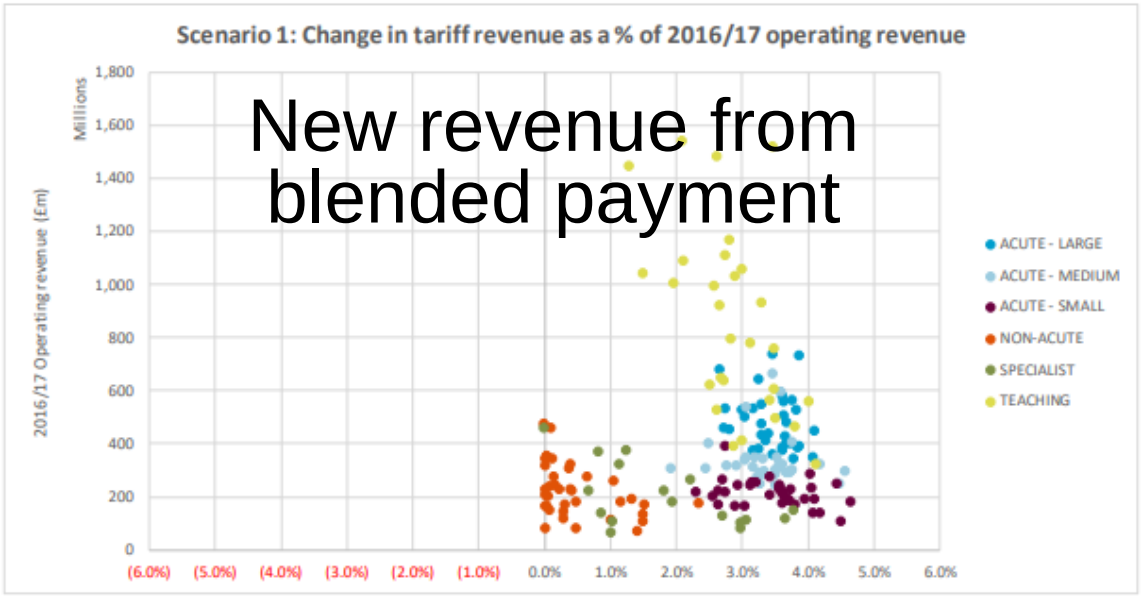

20
20
Bank of
£5

Incentives

3 CQUINS ≅ £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]

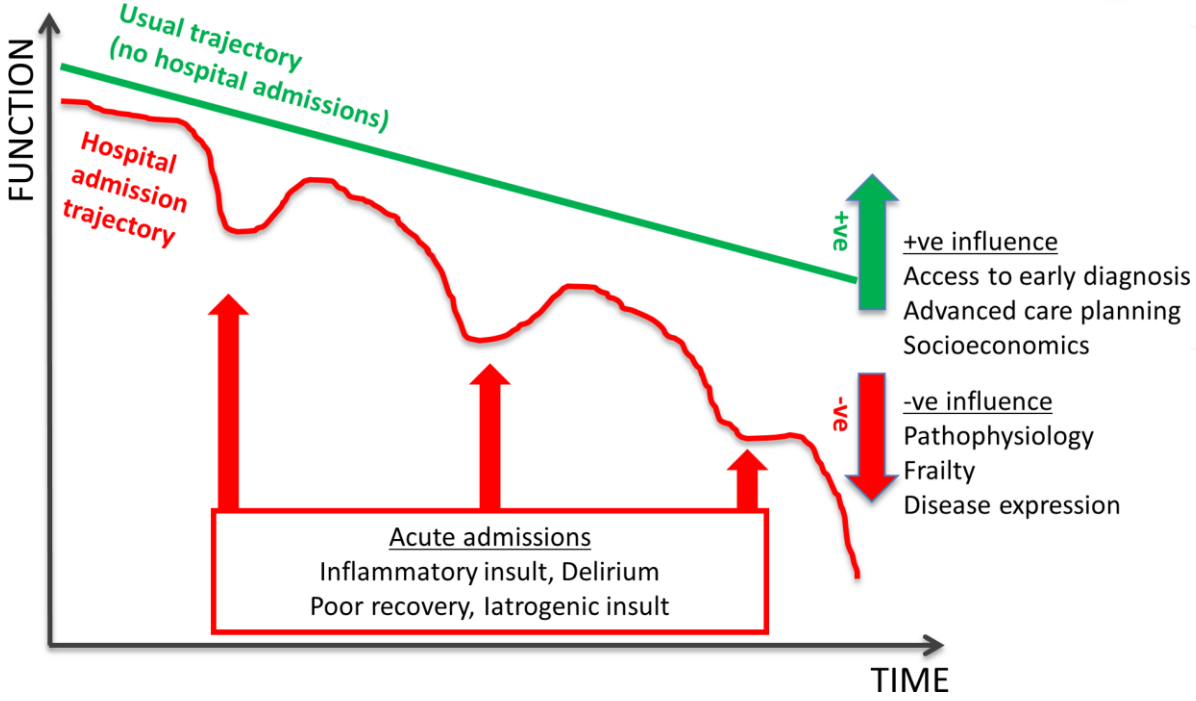


New revenue from blended payment

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

Strategic Vision

Mark England

Deputy National Director of Emergency and Elective Care

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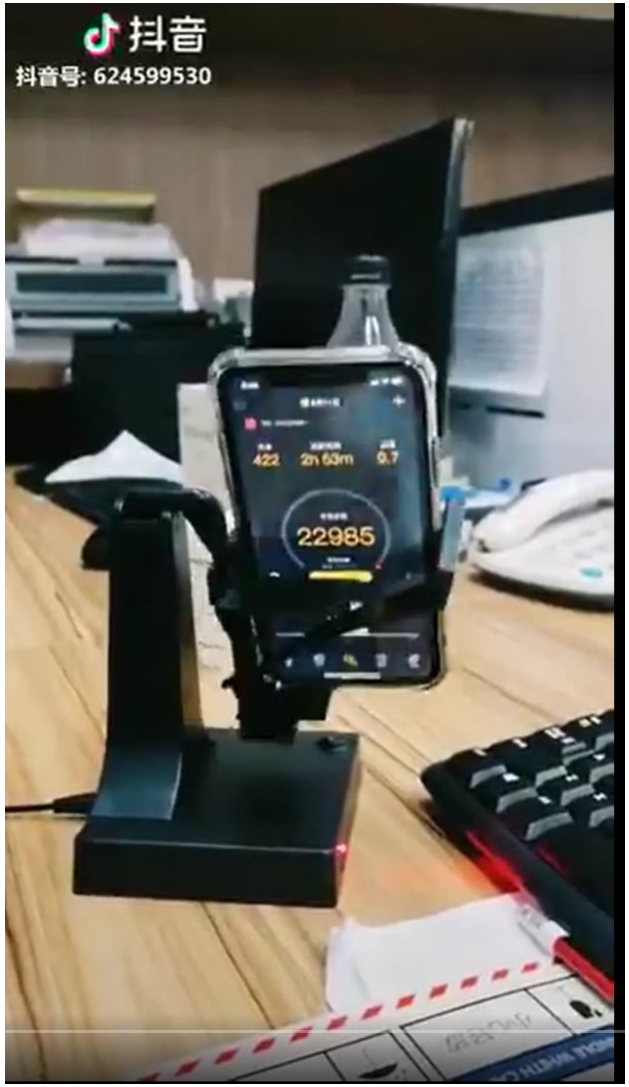
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

SDEC Workshop

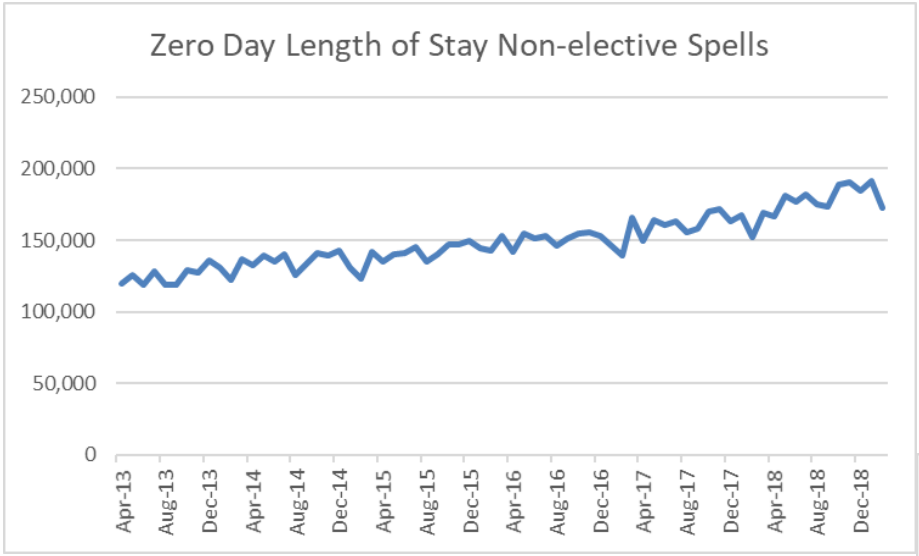
April 2019

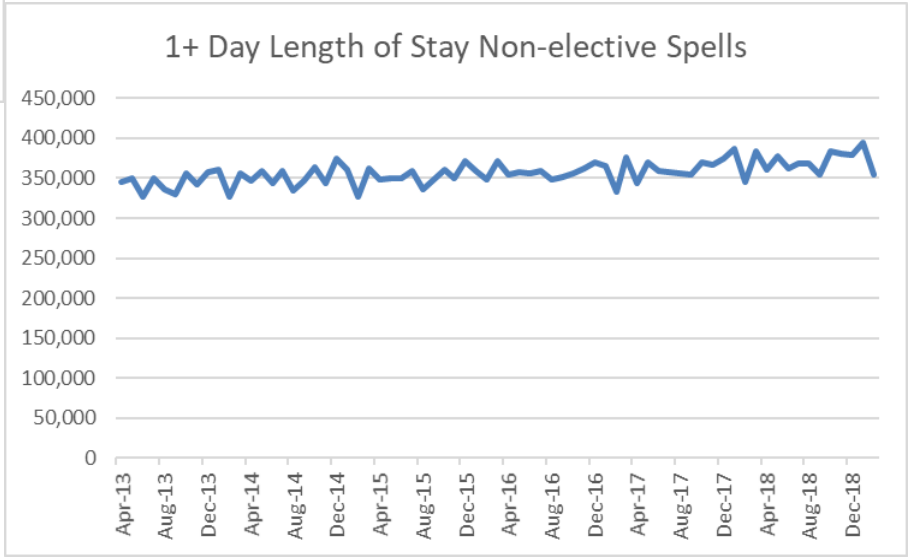
Mark England – Deputy National Director of Emergency and Elective Care NHSI/E

NHS England and NHS Improvement

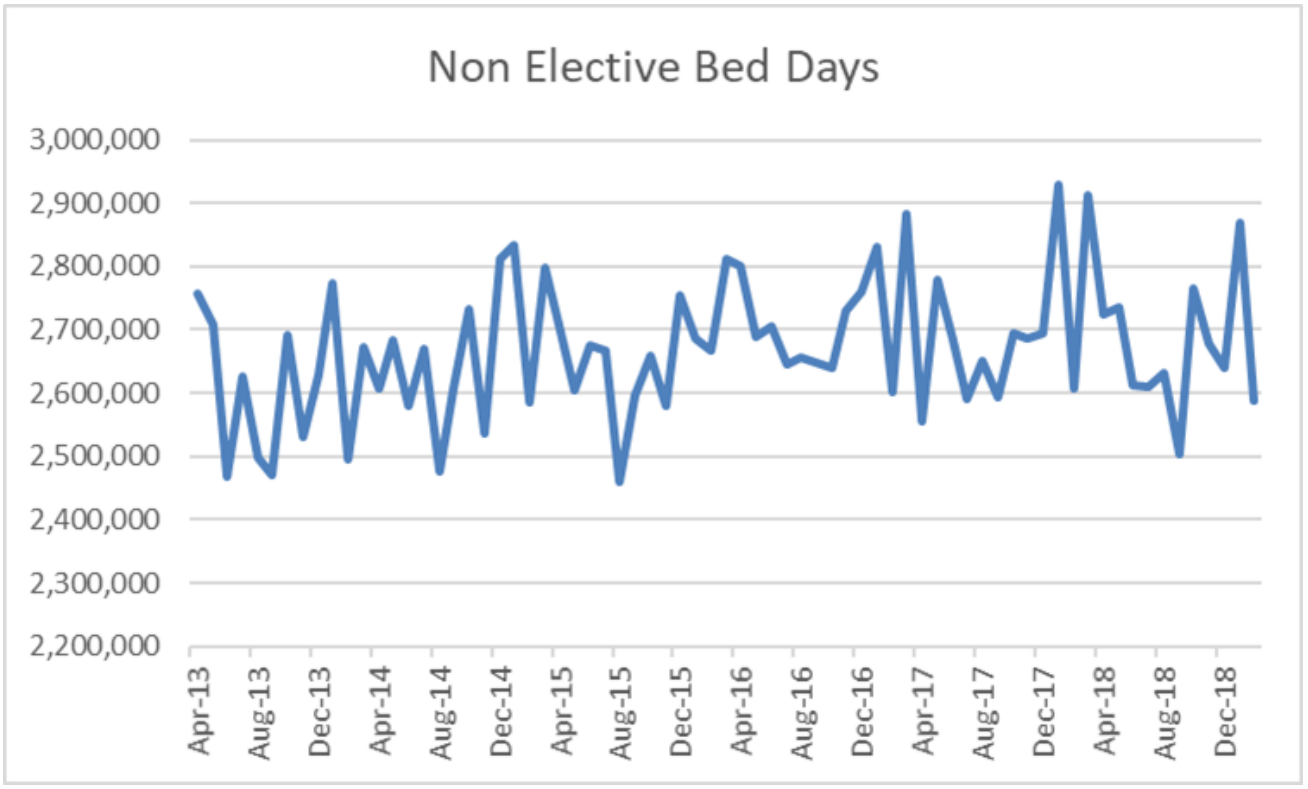

抖音
抖音号: 624599530
422
2h 53m
9.7
22985

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

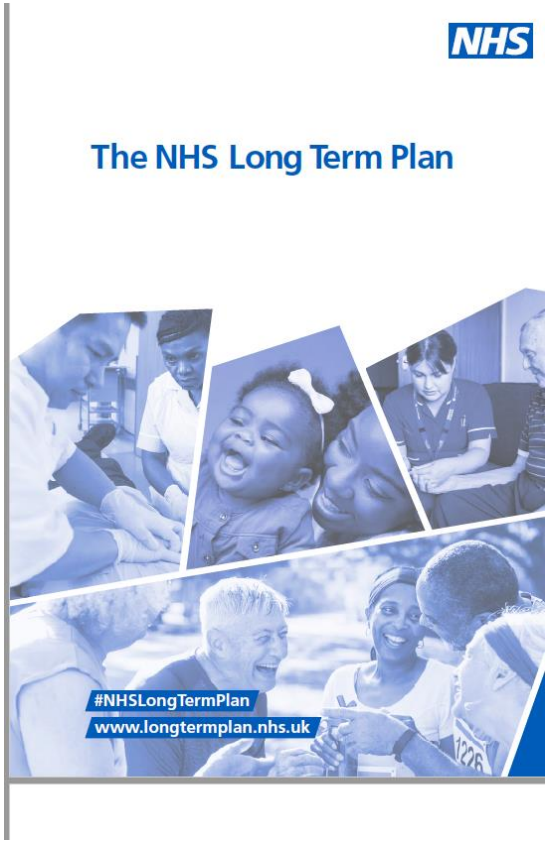
NHS Operational Planning and Contracting Guidance 2019/20

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?]

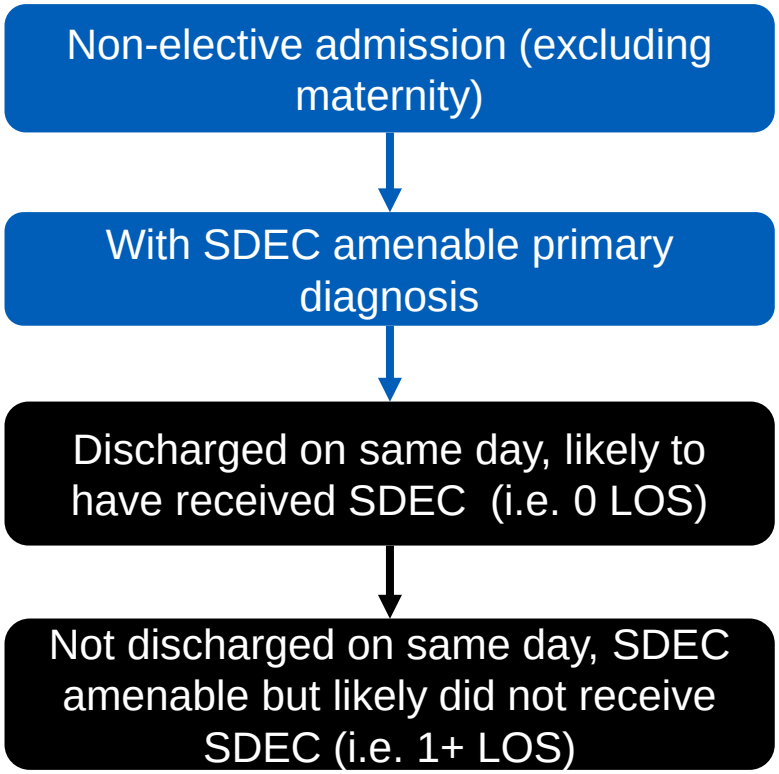


SDEC – Patient Level Information Cost System (PLICS) Analysis

April 2019

NHS England and NHS Improvement

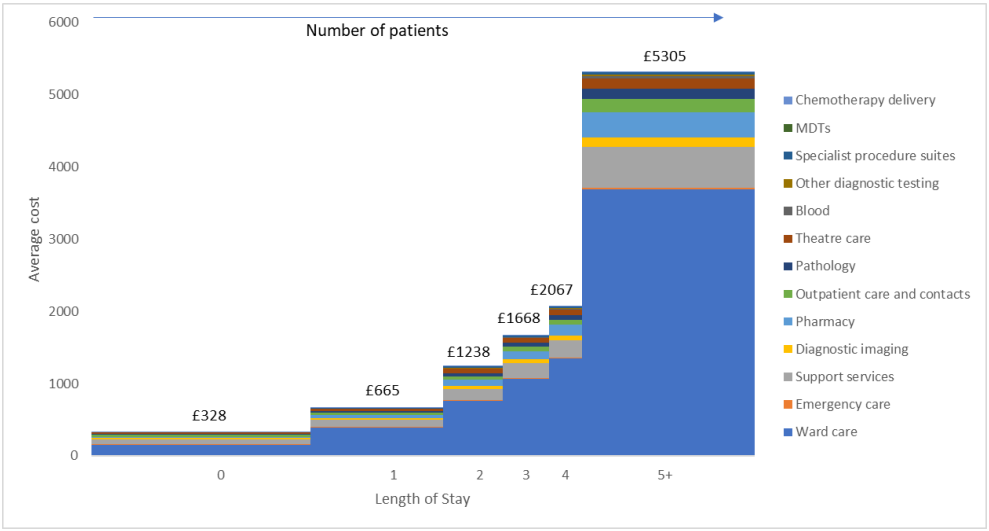
The approach used to identify SDEC amenable patients

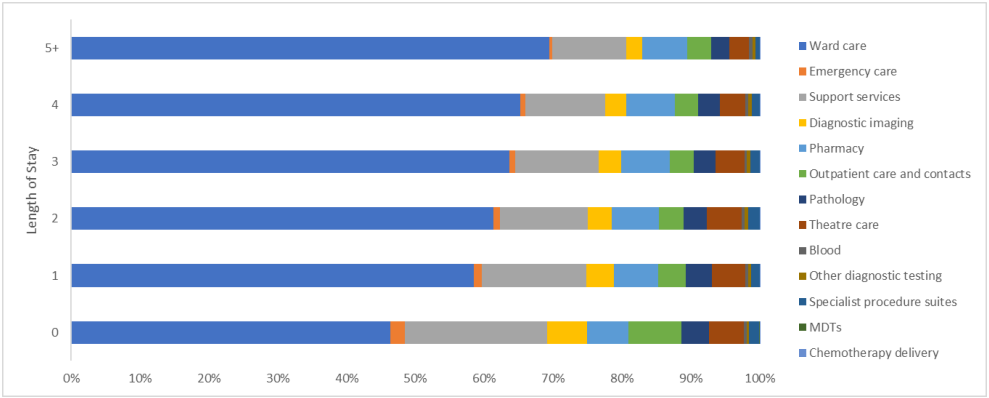


- We identify SDEC and potential SDEC spells in 2017/18 PLICS data. This covers 69 acute trusts.
- This approach was applied as a way to analyse historic data and thus applies contemporaneous information on diagnoses amenable to SDEC treatment from the Directory of Ambulatory Emergency Care for Adults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

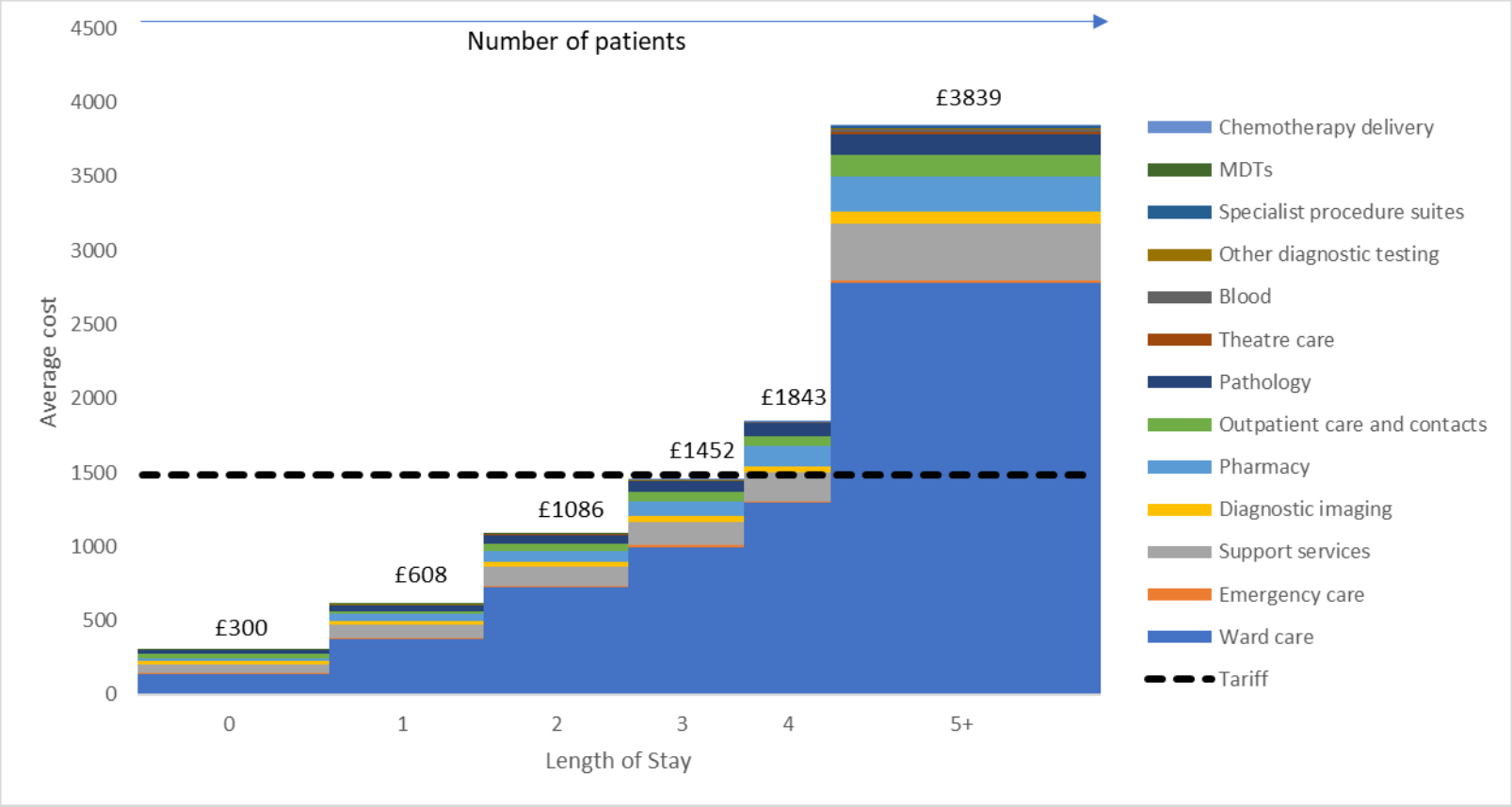
There are large differences in cost per patient as length of stay increases

- 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.



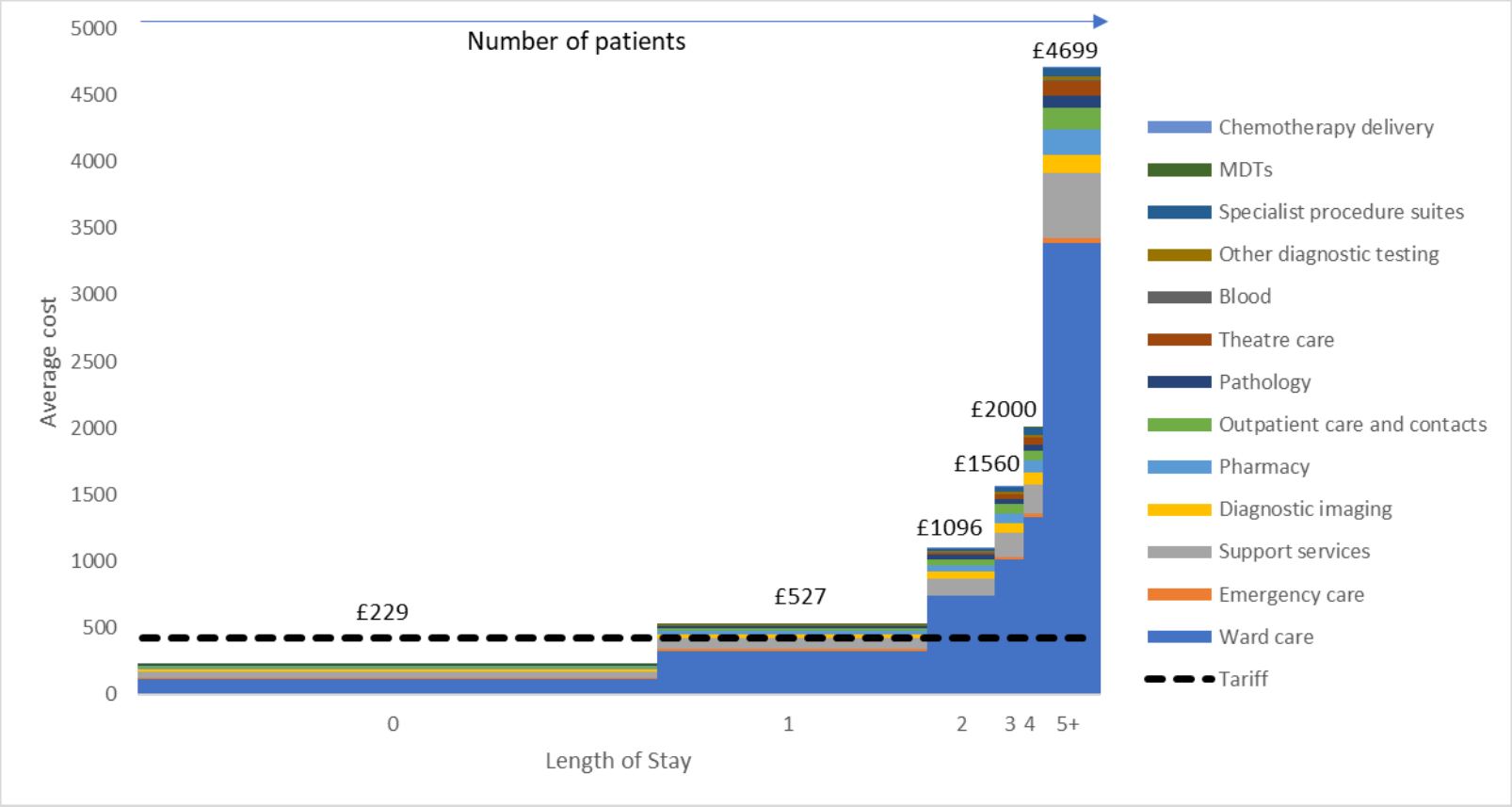


Community-acquired pneumonia



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

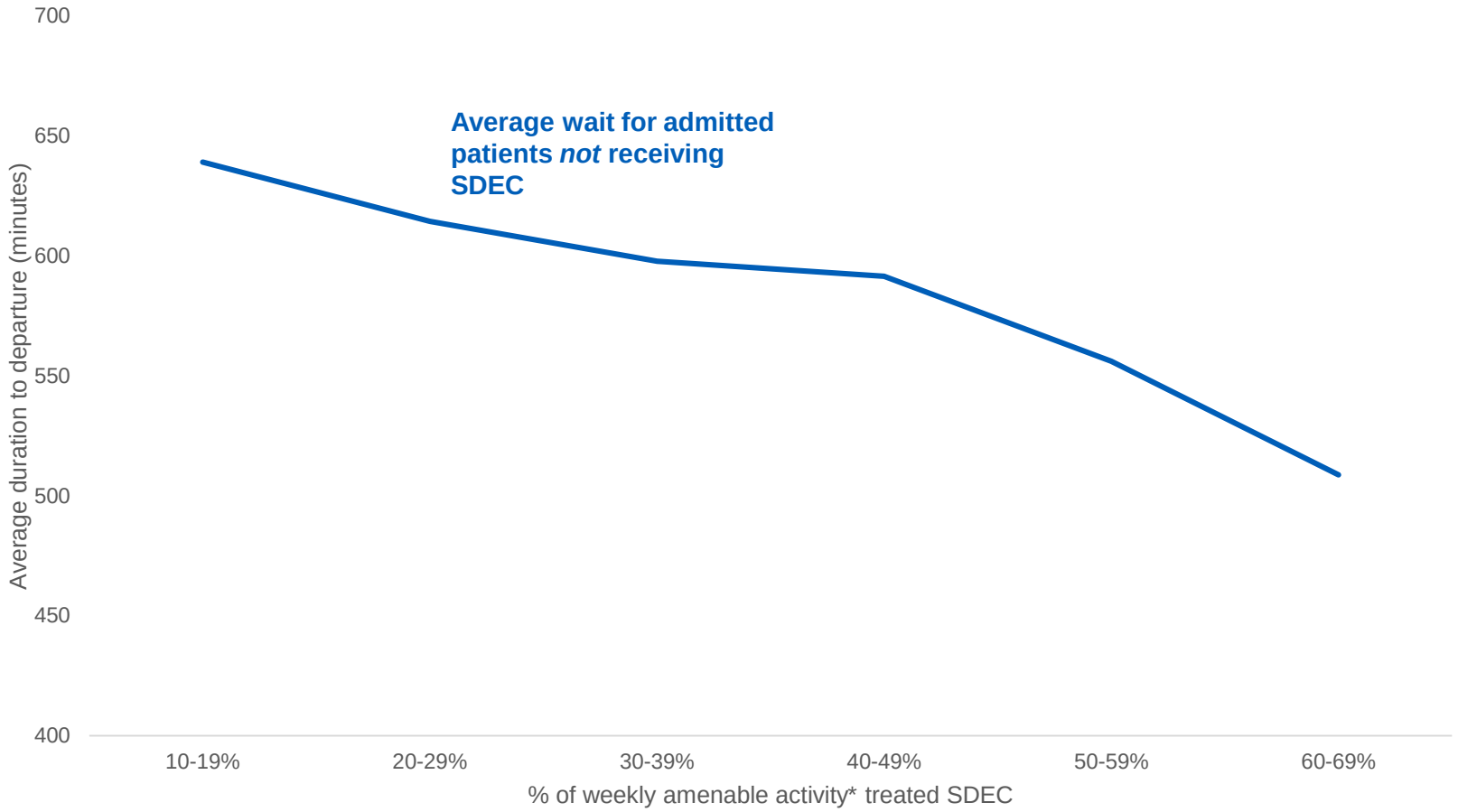
5 Scenarios:	No. of 1+ LOS admissions shifted to 0 LOS		Estimated cost reductions	
	Per year	Per day	Per admission	Per year
A: Increase to AEC Network minimum estimate per condition ^	2,440	7	£715	£1.7m
B: Increase to AEC Network mid point estimate per condition ^	4,154	11	£939	£3.9m
C: Increase to AEC 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

AEC in Emergency Care
Dr Taj Hassan

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

Delivering excellent Same Day Emergency Care

The RCEM AEC Toolkit

Dr Taj Hassan

@RCEMpresident

The Royal College of
Emergency Medicine

Design

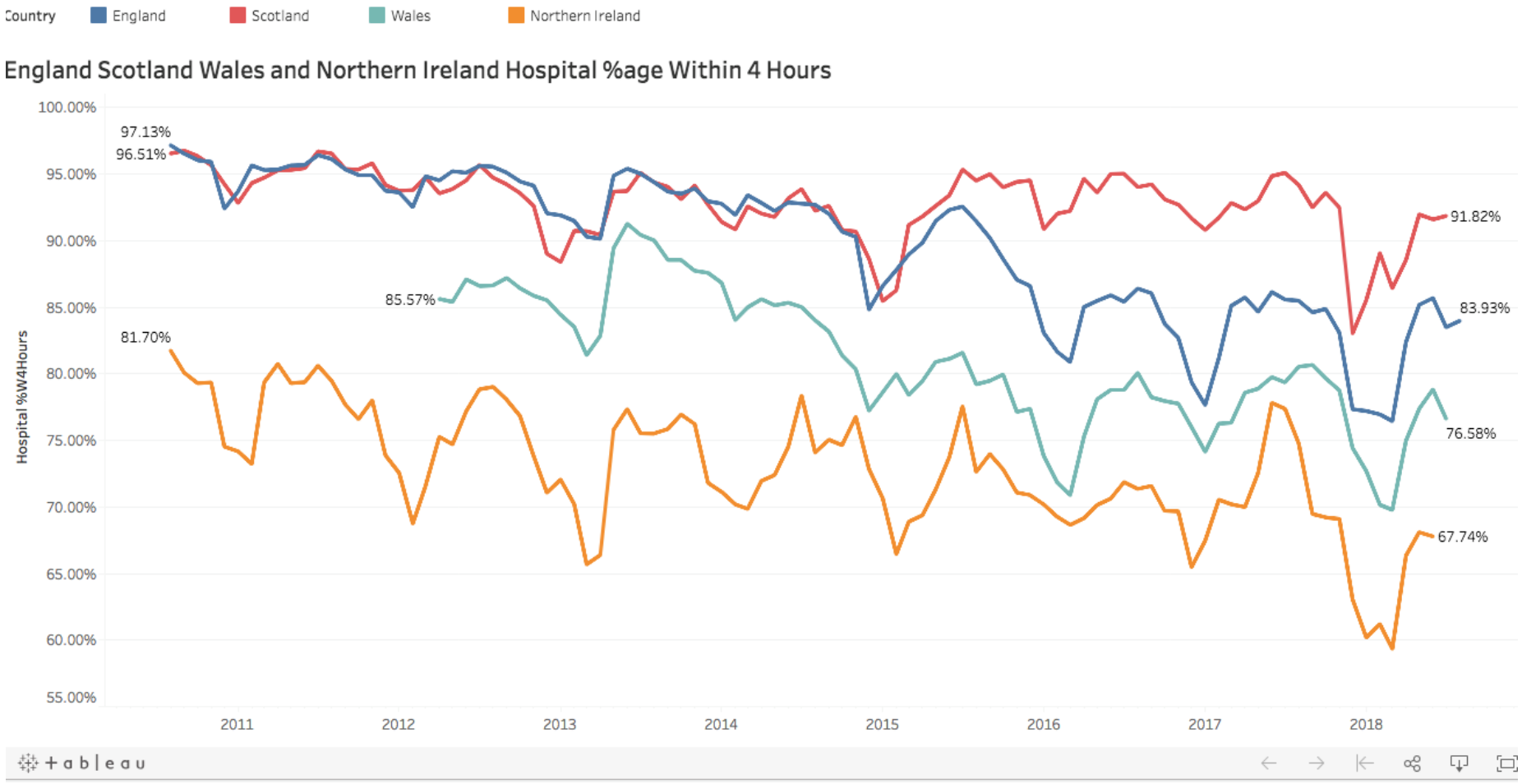
Judgement

Leadership

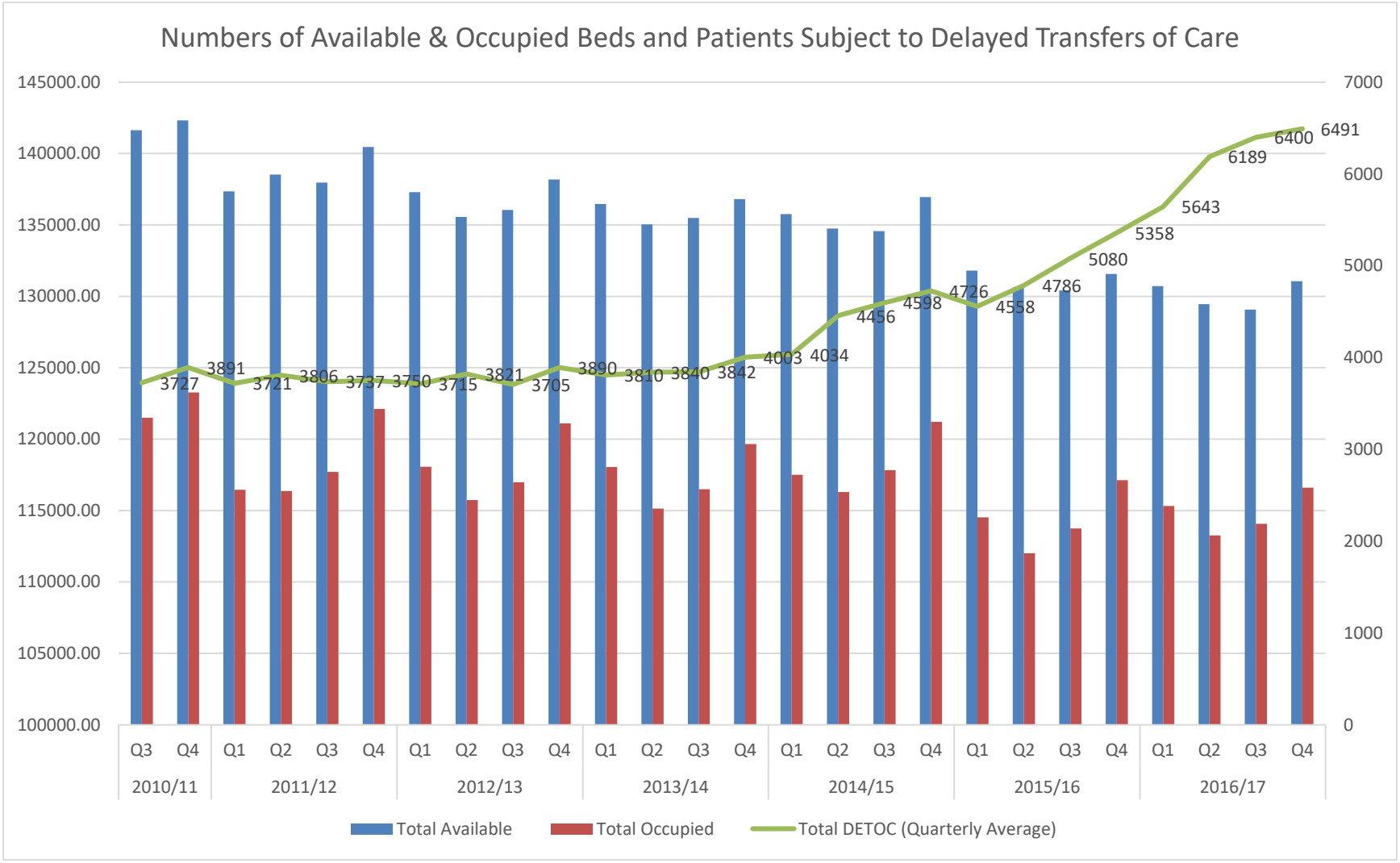
George Donald @GMDonald · Sep 14

UK A&E performance by country, with August data for England -

public.tableausoftware.com/views/AEPerfor...



Not enough acute beds in the system



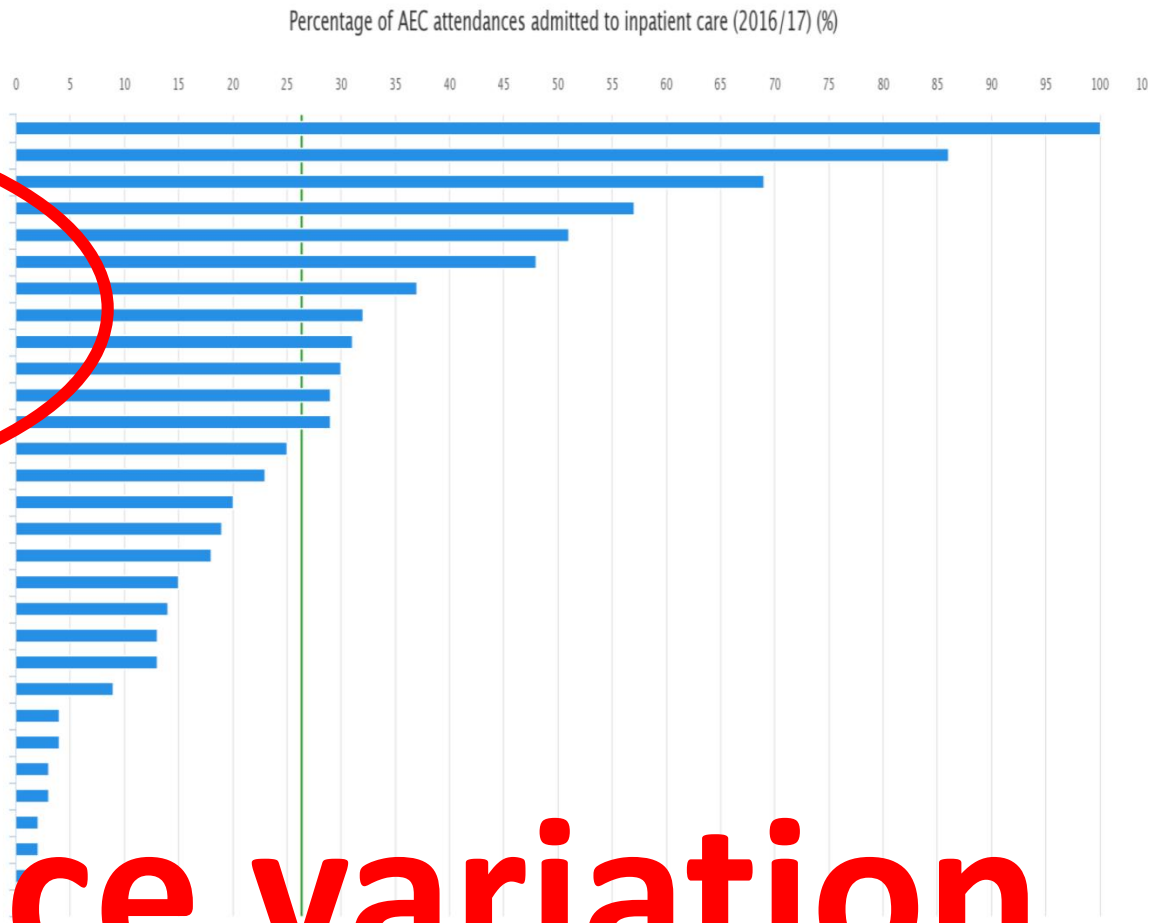
Other Drivers

- Patient expectation
- P
- D
  in
- Workforce issues

NHS LONG TERM PLAN

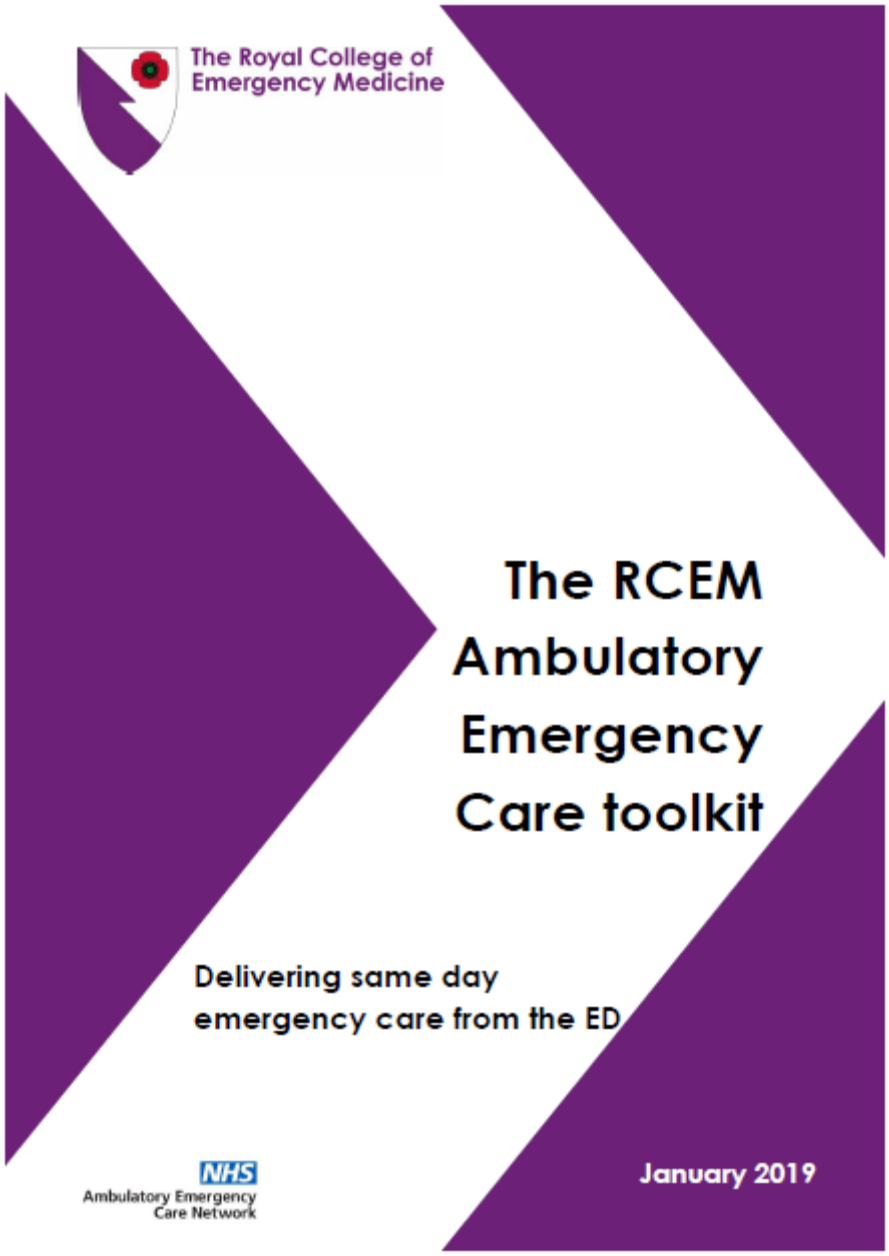
Ambulatory Care: Inpatient care

- The chart opposite shows the percentage of attendances in an ambulatory care unit that converted to an inpatient admission.
- The mean number reported was 26%, which is in line with the overall A&E conversion rate. Around one quarter of AEC sites demonstrated conversion rates of less than 10%.



Reduce variation

NHS Benchmarking Network


The Royal College of Emergency Medicine
The RCEM Ambulatory Emergency Care toolkit
Delivering same day emergency care from the ED
NHS
Ambulatory Emergency Care Network
January 2019

Delivering ambulatory care in the ED – a 'virtual Clinical Decision Unit' concept

Collapse with probable 'first fit'

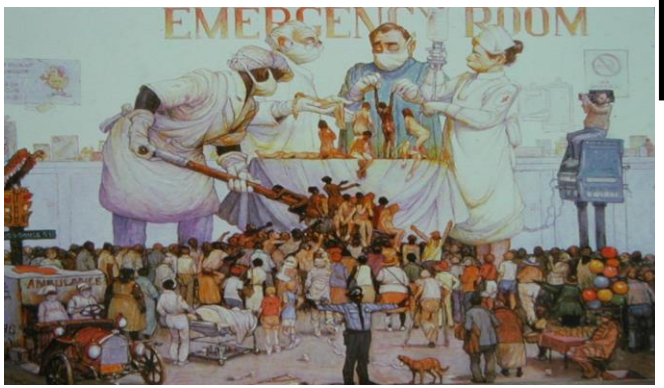
?DVT assessment

Chest pain - ?PE

Asthma

Conscious sedation & MUA

Cellulitis



Self harm - review

Limping child

Head injury - child

Low risk GI bleed

Pneumothorax

Chest pain - ?ACS

Renal colic

COPD exacerbation

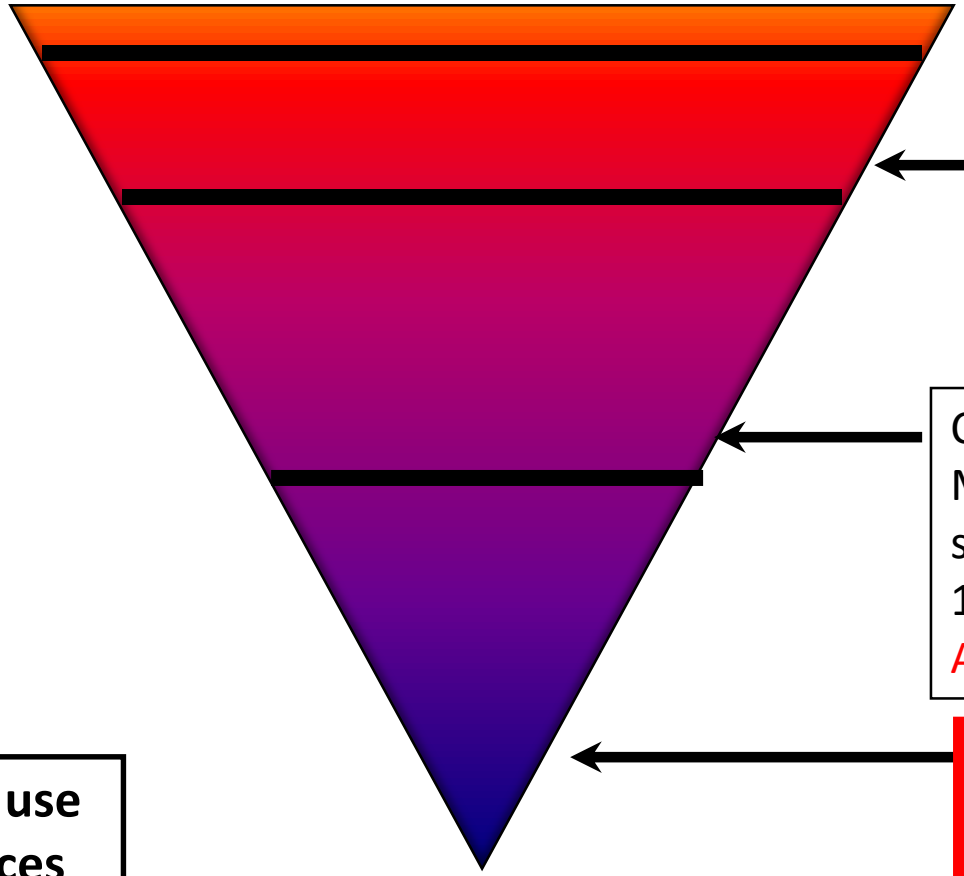
Head injury - adult

Diagnostics
Therapy
Observation

Medically fit elderly requiring Community system support

TIA

Finding the target population for ambulatory assessment and management



Critically ill or Injured – ITU care

Clinically unstable - likely acute severe illness/injury (LOS >4days) – specialty care

Clinically stable - Moderate / high risk of significant illness. (LOS 1-4 days) –specialty care / Acute Medicine / surgery

Clinically stable - possible occult illness /injury with likelihood of early discharge (6-24hrs) – Obs Med (CDU or ED ambulatory care.

Increasing use of resources

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

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

Recognising ‘value for money’ for short stay admissions & ambulatory care – Same Day Emergency Care Tariff development

DH guidance for the PbR Business Rules and National Tariff for 2009-2010

Good IT infrastructure

Tight process mapping of how you code & QA

Build clear concise business plans around the QIPP template that will be easily understood by your COMMISSIONERS!

Review at regular intervals & calibrate to minimise missing out on funding!

Know the key aspects for SDEC vs Admitted Patient Care Tariffs – “ What are the top tips”

Patients that should NOT be streamed to AEC

- Type 2 and Type 3 ED attenders (Min
- Type 1 ED patients who wil
  but whose clinical care
  are awaiting ward

Clinically

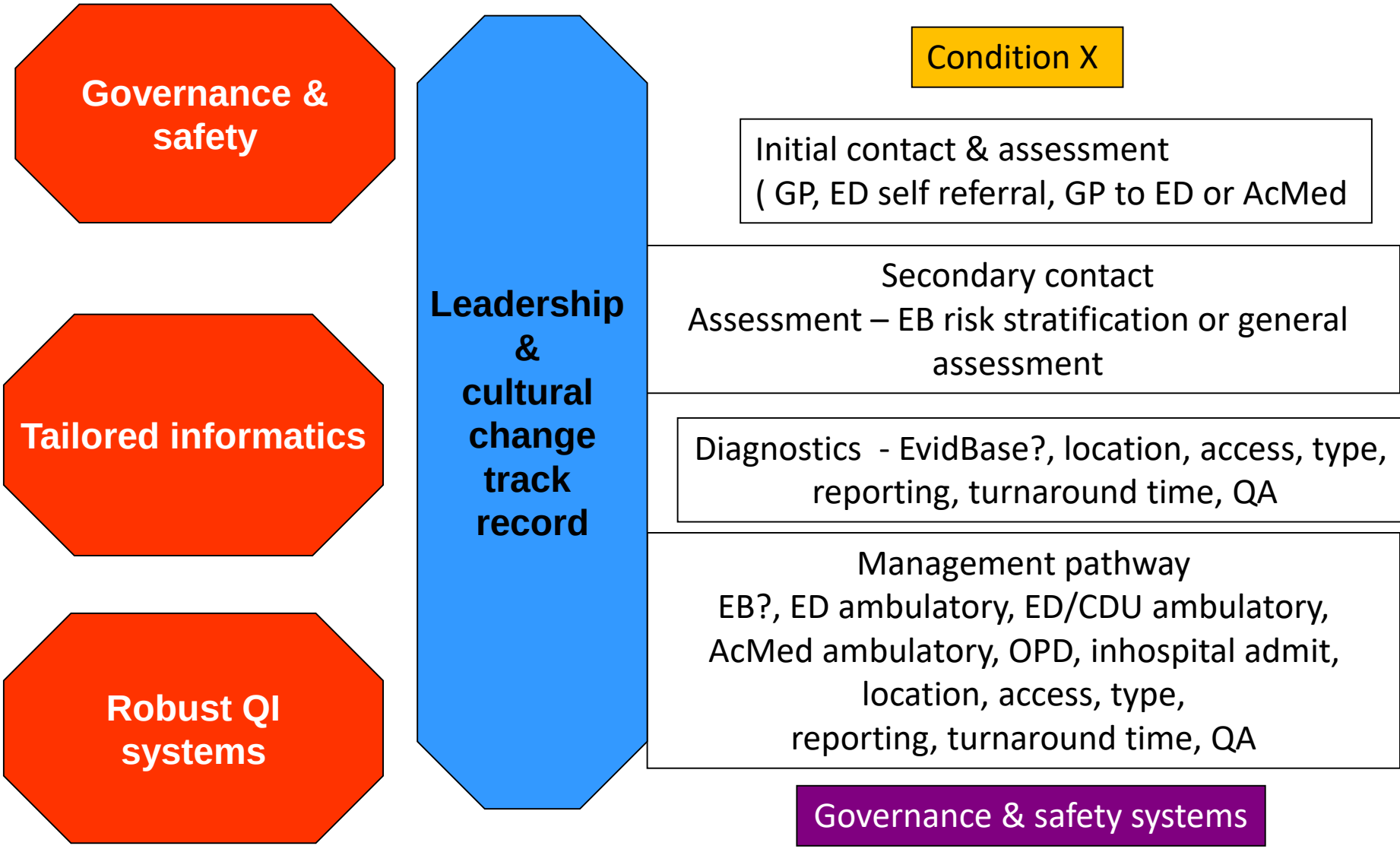
The ge lounge or “overflow” unit for other

Gatekeep your access to AEC / CDU

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

Mapping ambulatory pathways




"Action without vision
is only passing time,
vision without action
is merely day dreaming,
but vision with action
can change the world."
- Nelson Mandela
Design
Judgement
Leadership

What is SDEC?

Dr Vincent Connolly

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

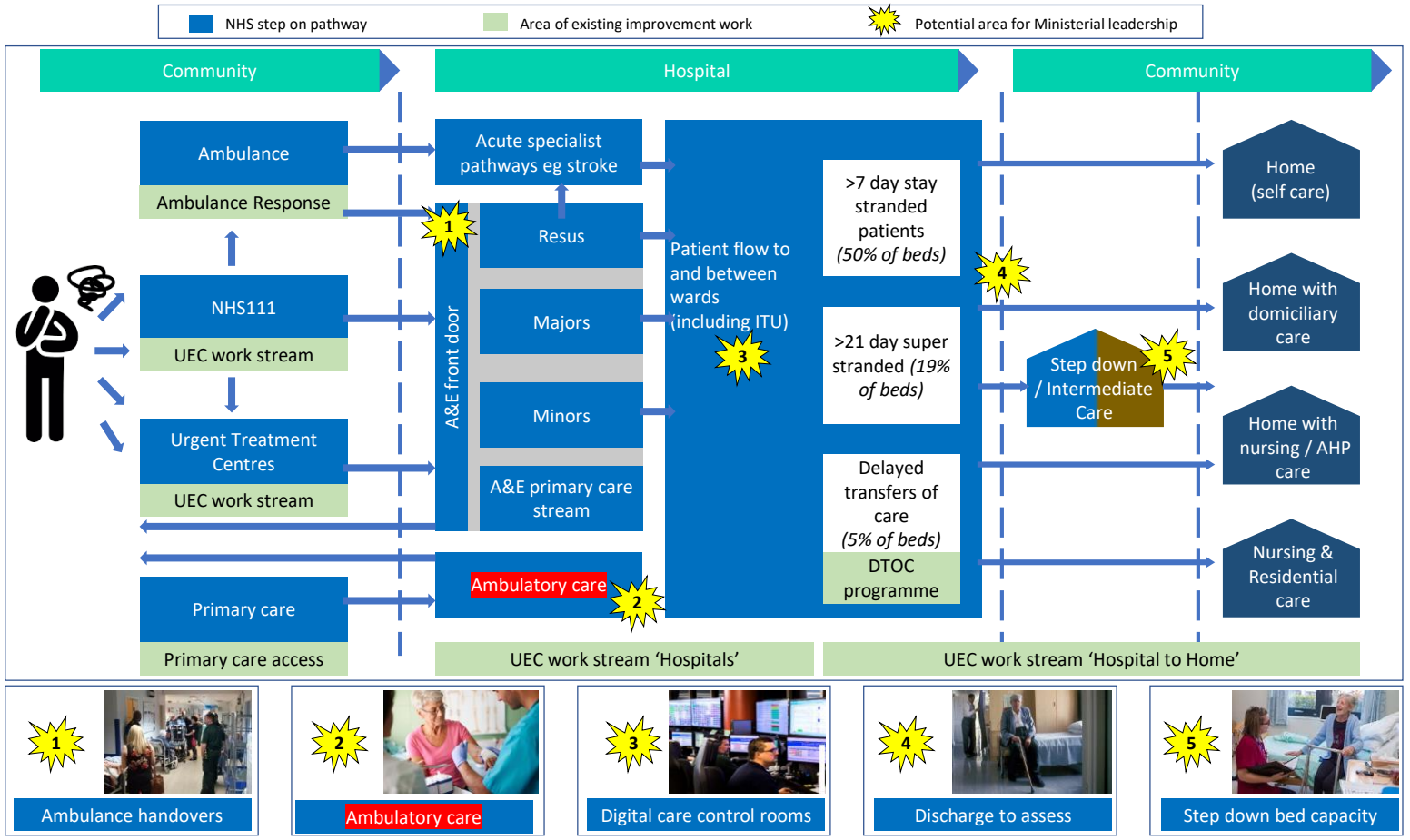
AEC or SDEC

Vince Connolly

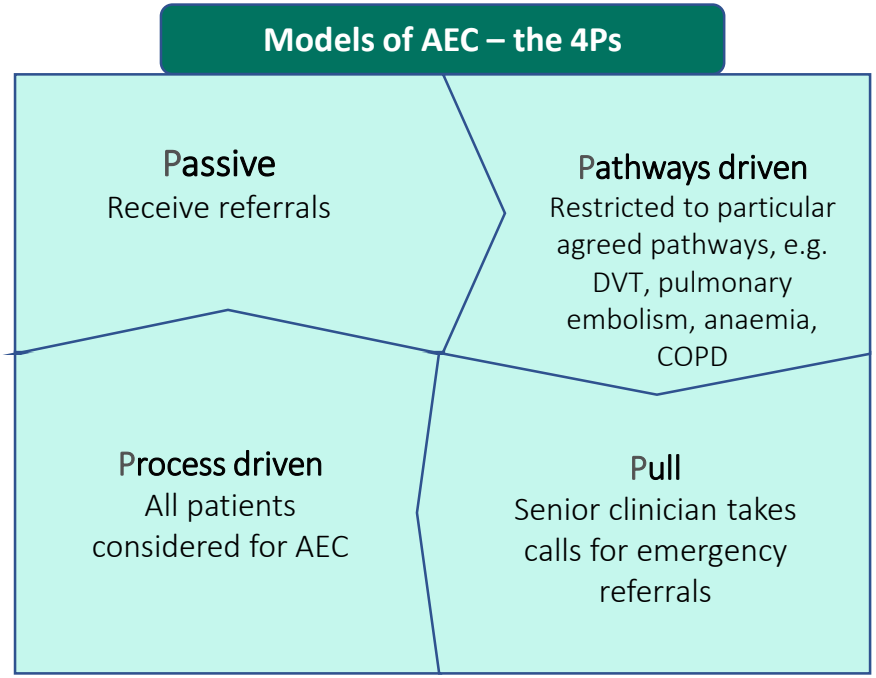
Frailty in AEC/SDEC units

AEC for people who need to lie down = SDEC

The beginning ……..

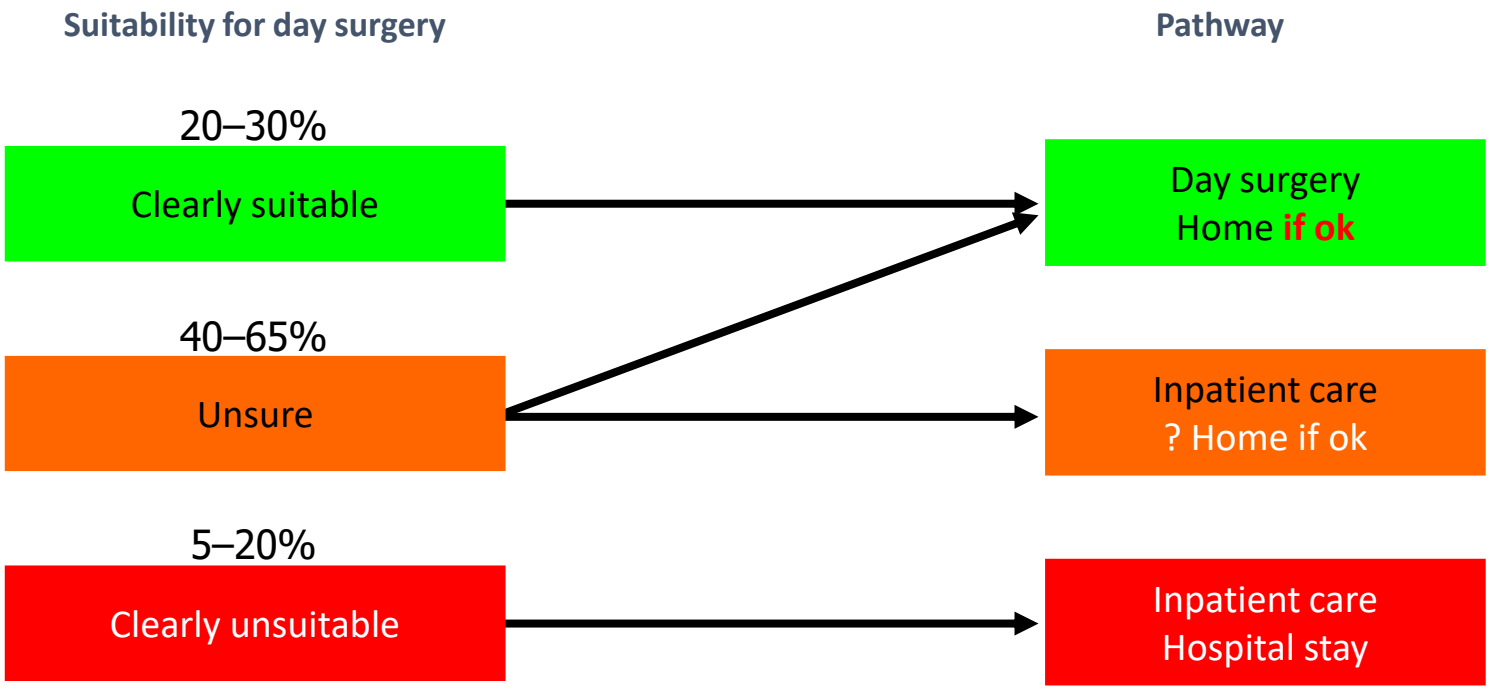

NHS step on pathway
Area of existing improvement work
Potential area for Ministerial leadership
Community
Hospital
Community
Ambulance
Ambulance Response
NHS111
UEC work stream
Urgent Treatment Centres
UEC work stream
Primary care
Primary care access
1
A&E front door
Resus
Majors
Minors
A&E primary care stream
Acute specialist pathways eg stroke
Ambulatory care
2
Patient flow to and between wards (including ITU)
3
>7 day stay stranded patients (50% of beds)
>21 day super stranded (19% of beds)
Delayed transfers of care (5% of beds)
DTOC programme
4
Step down / Intermediate Care
5
Home (self care)
Home with domiciliary care
Home with nursing / AHP care
Nursing & Residential care
UEC work stream 'Hospitals'
UEC work stream 'Hospital to Home'
1
Ambulance handovers
2
Ambulatory care
3
Digital care control rooms
4
Discharge to assess
5
Step down bed capacity

Models of AEC – the 4Ps

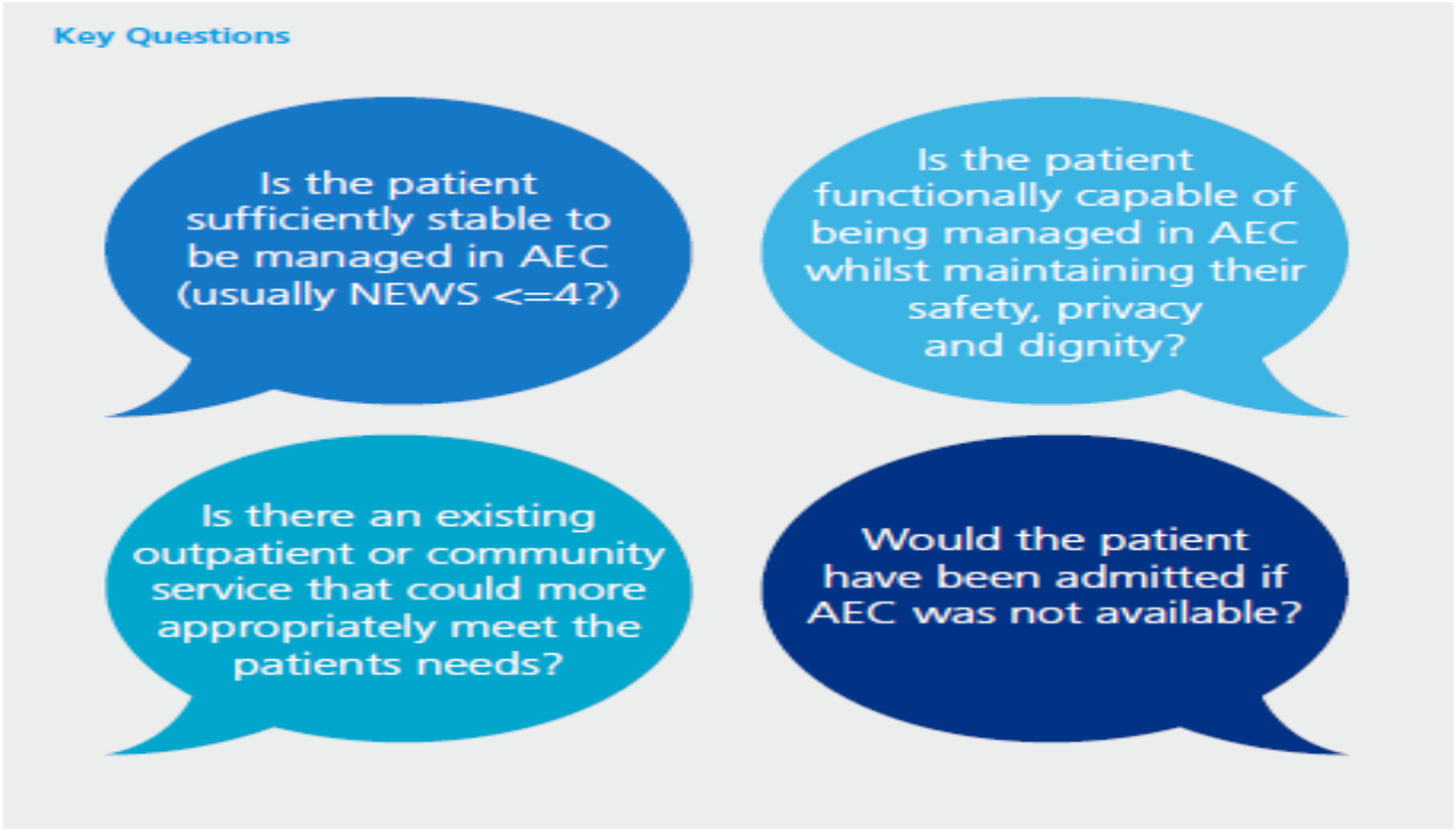



bb.cyclist

Default to Day Surgery



Have a Clinical Conversation



Clinical Scenario

- 17y old woman
- Type 1 diabetes
- Symptomatic
- Blood glucose 27mmol/l
- Blood ketones 2.5
- SDEC?

Clinical scenario

- 55y old male
- Several weeks of intermittent severe headache, left eye pain
- Holding head
- Bloodshot eye
- SDEC?

Clinical Scenario

- 55 y old man
- Drinking
- After several vomits, small amount of haematemesis
- HR 90 bpm BP 128/76
- SDEC?

Clinical scenario

- 55y old man
- In ED
- Drinks 1 l of vodka per day
- Distressed
- Unkempt wants emergency detox
- SDEC?

Clinical Scenario

- 55y male in ED
- Faint lightheaded at the toilet
- Brief LoC
- Previous admission with abdominal pain
- Admit to SDEC ?

Clinical Scenario

- 55 y old man
- Breathlessness, PND, ankle oedema
- HR 120bpm BP 110/70
- ECG tachycardia, non-specific t-wave changes
- Cardiomegaly
- SDEC?

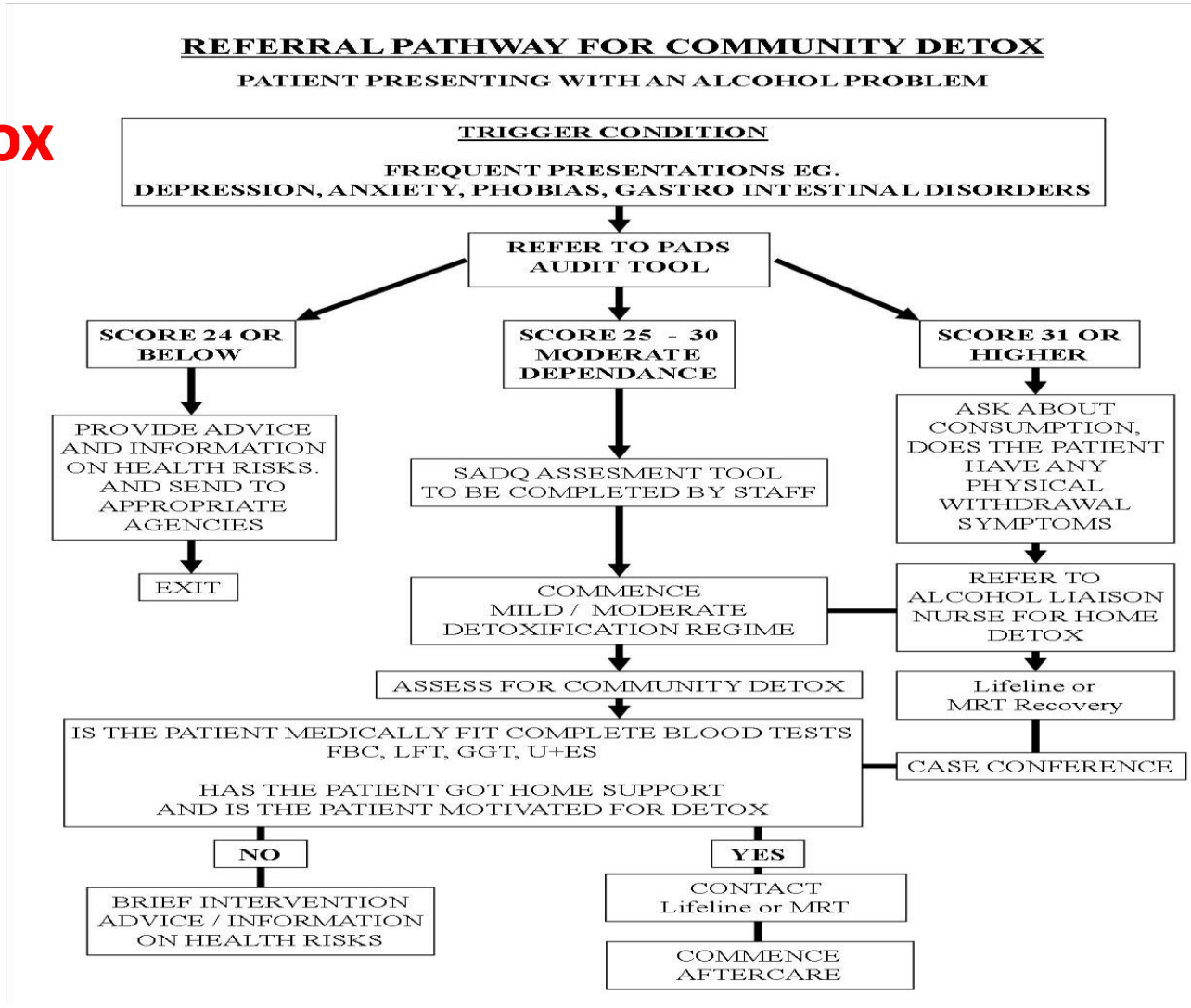
A new patient pathway –

a new compact

Define who can go home

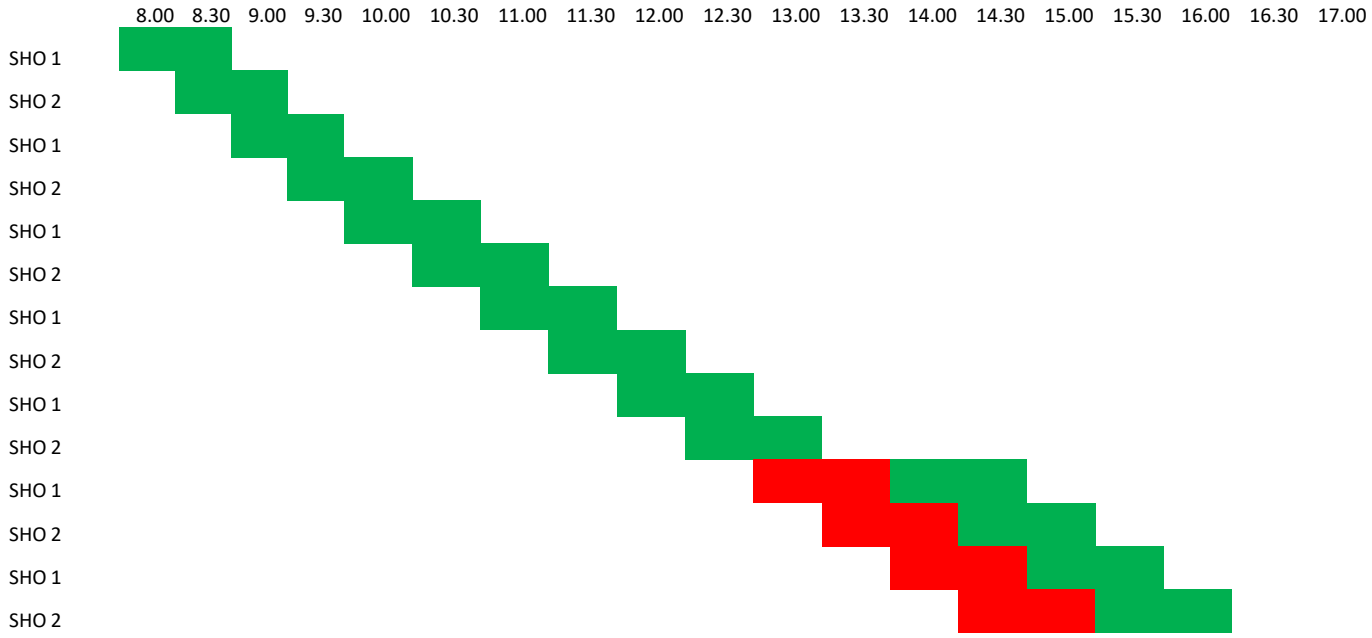
Define who needs specialist care

Community detox pathway

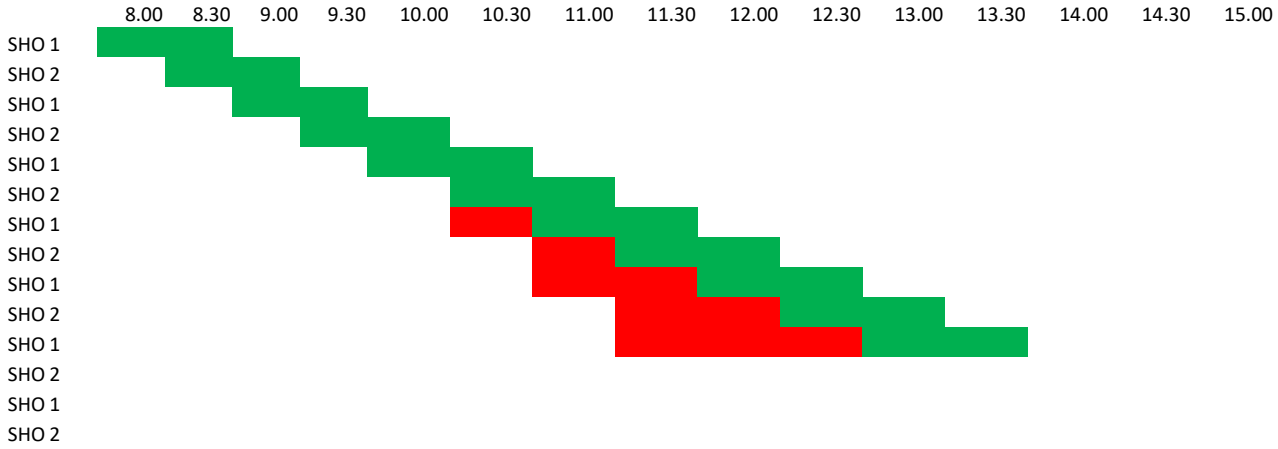


Measure the backlog

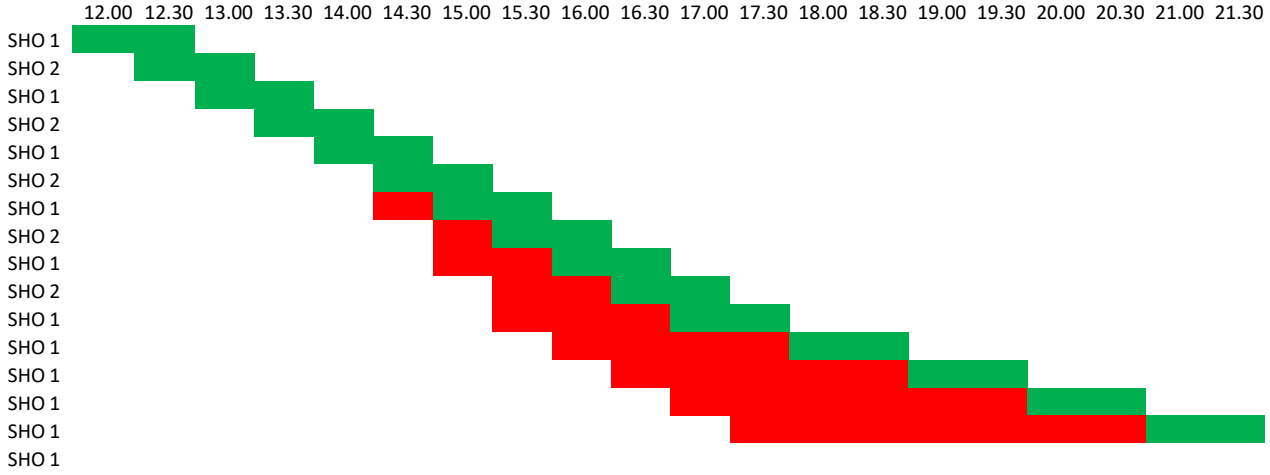
Going for lunch



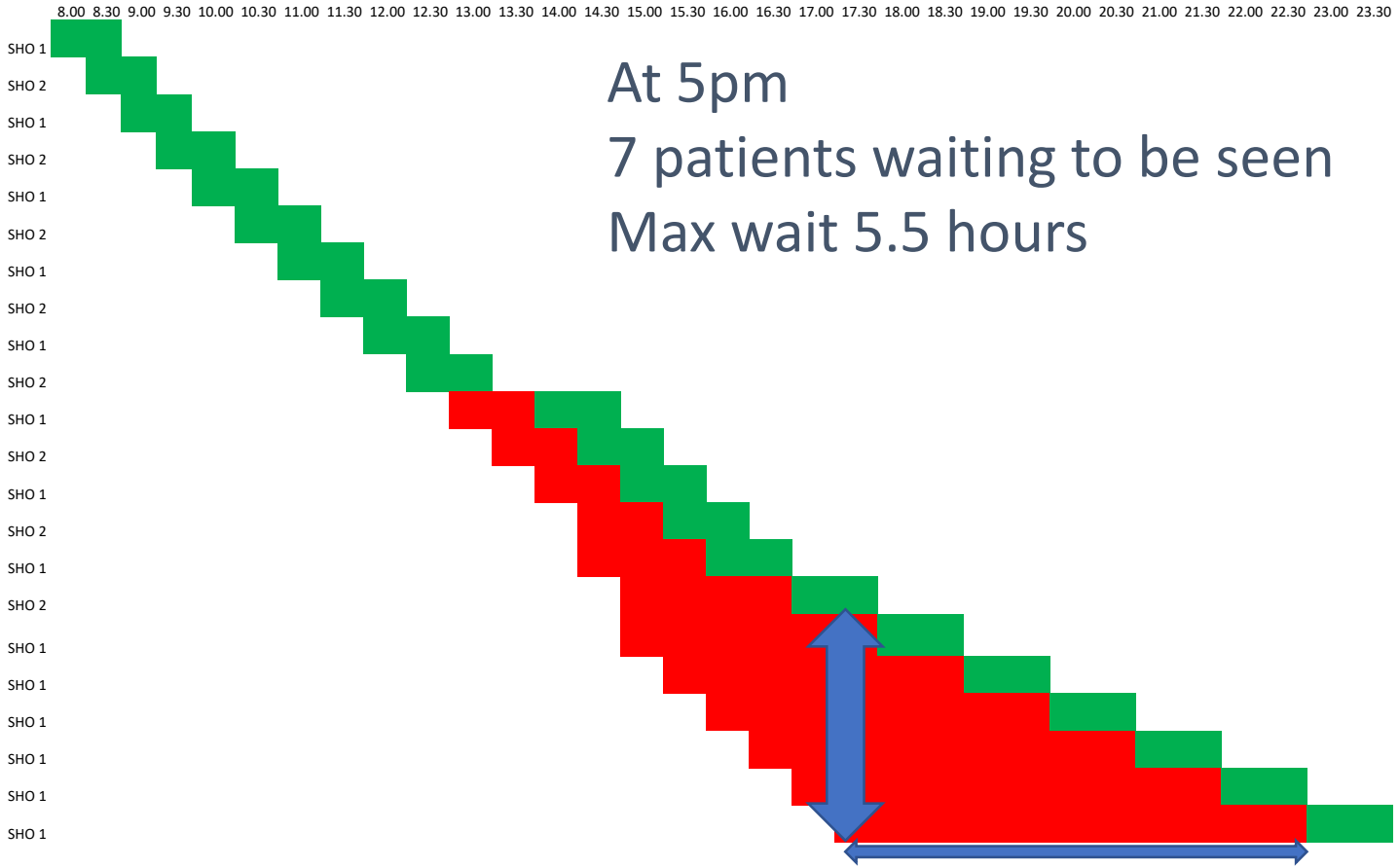
Increased admission rate



Handover at 17.00



Going for lunch & increased admissions & handover



What would a 10% increase in AEC mean in your Trust?

60 admissions per day

6 more admissions avoided

An empty bay on AMU

AEC Efficiency

	Managed in AEC	Not managed in AEC
	Conversion	
Appropriate for AEC	**Group 1: Success** (expect about 10% conversion rate)	**Group 3: Missed opportunity**
Not appropriate for AEC	**Group 4a: Waste** (patient could be managed in another outpatient service)	**Group 2: Success** (appropriate inpatient care)
	Group 4b: Risk (patient too sick/complex at time of selection)	

What's next for AEC?

- All patients to be considered for AEC first by converting patient with National Early Warning Score (NEWS)<3 into AEC
- Winter surge, supporting respiratory patients in AEC
- Integrating frailty into AEC
  - AEC with & in the community, direct admission from ambulance clinicians, transfer to intermediate care services
- Getting capacity and demand (& estates) right
- Getting the enablers right i.e. workforce, digital, counting
- Responding to clinical innovations

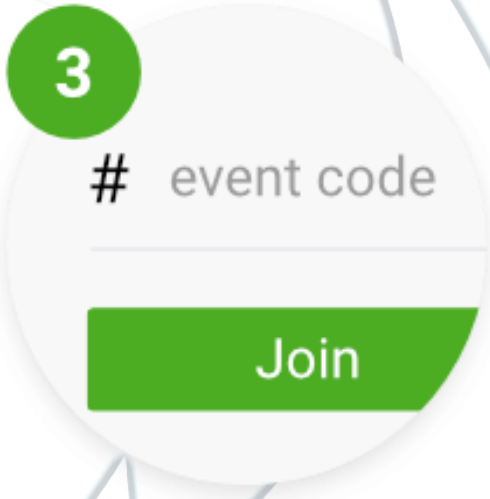
The patient experience

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 **#SDEC240519**

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

Working together to Maximise SDEC at Pace

Wants and Offers

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Wants and Offers - Groups Available

Topic	Offer from
Emergency Department	Cliff Mann
High Volume Pathways	Nick Scriven
Measurement	Annie Shaw
Recording and Reporting	Tom Hughes
SDEC Principles	Vince Connolly / Northumberland CCG – Nicole Mclean
National Priorities	Rachel Vokes
Non-Medical Roles	Andy Mitchell / Warrington Hospital
Surgical AEC	Arin Saha

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

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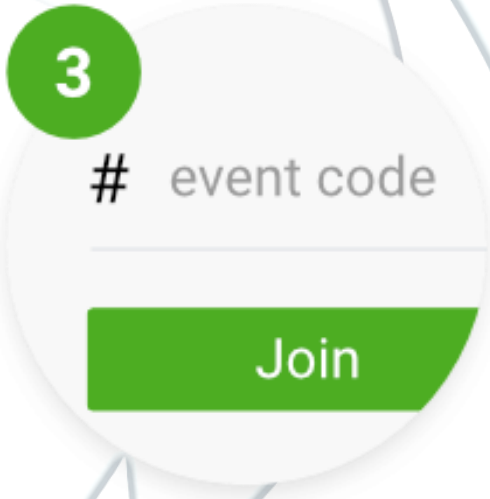

3. Type in the event code **#SDEC240519**

Surgical AEC Principles

Mr Arin Saha, Consultant Surgeon

Principles of surgical ambulatory emergency care

Arin Saha
Consultant in General, Upper GI and Bariatric Surgery, CHFT

National Clinical Lead, Surgical Ambulatory Emergency Care Network, NHS Elect

Chairman, Surgery Same Day Emergency Care Group (sSDEC), NHS Improvements

Friday 24th May, 2019
Same Day Emergency Care (SDEC) Regional Meeting - Leeds

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AIMS OF TODAY

- Give an overview of surgical ambulatory care in the UK at the moment
- Suggest changes
- Discuss the importance of job planning and rotas
- Introduce the sSDEC group

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SURGICAL TRADITIONS are hard to change!

Evidence vs. experience

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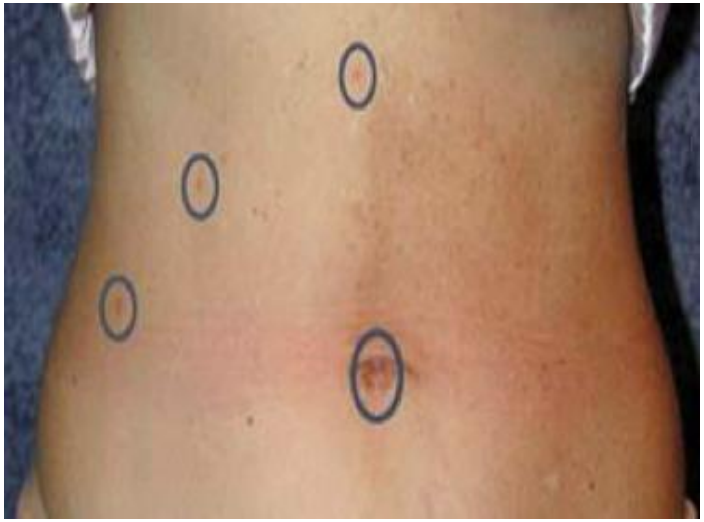

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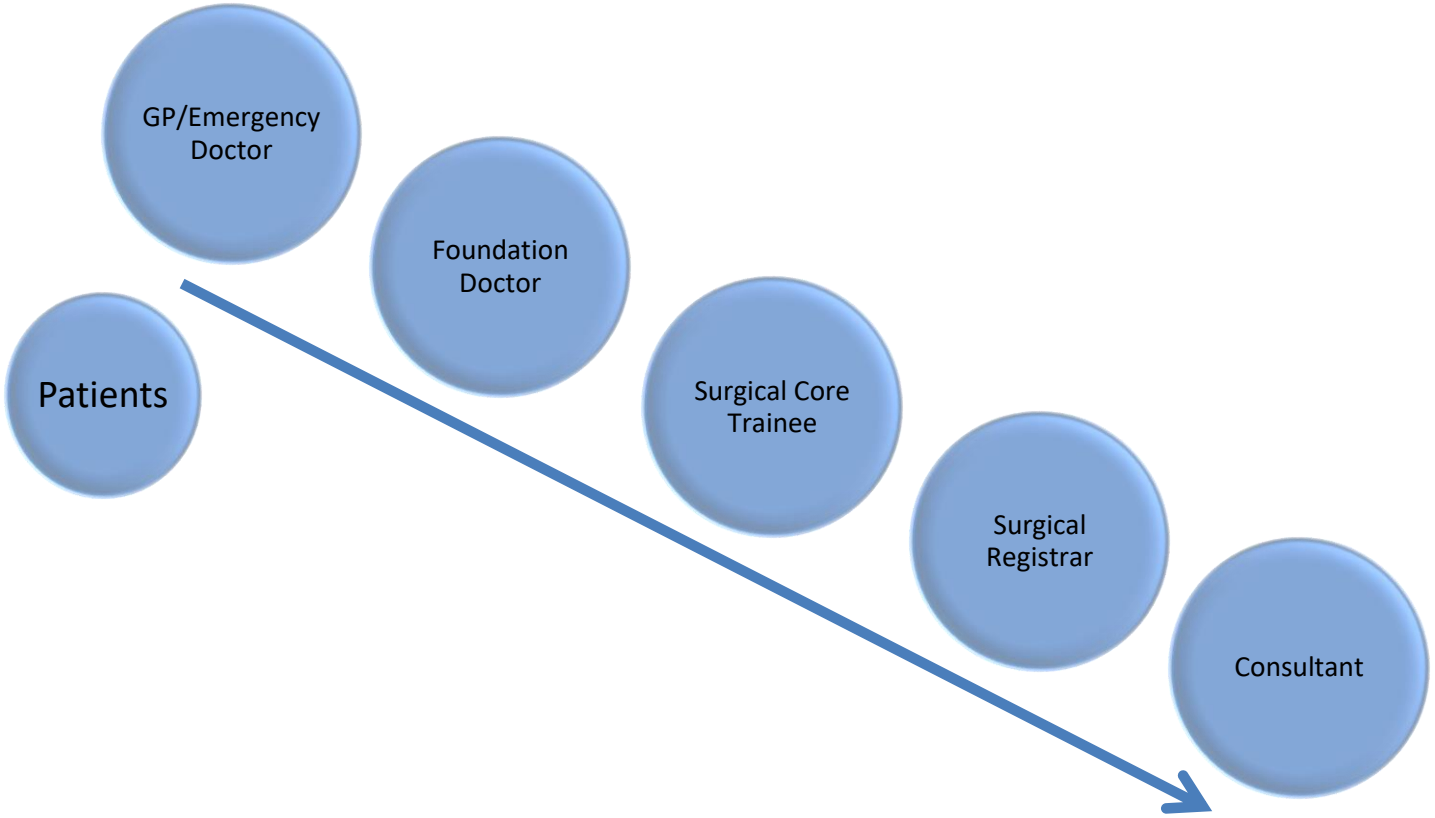

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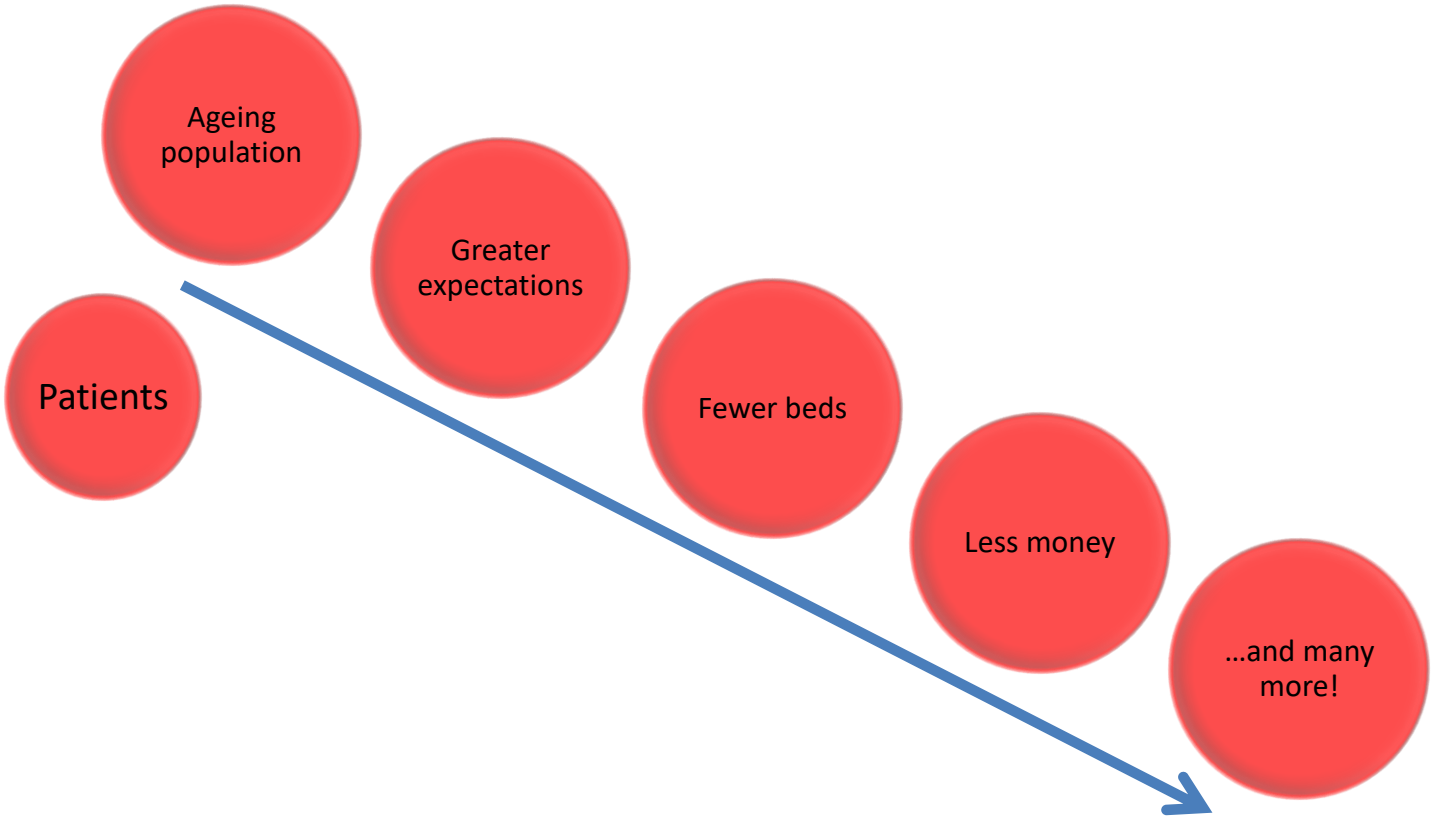

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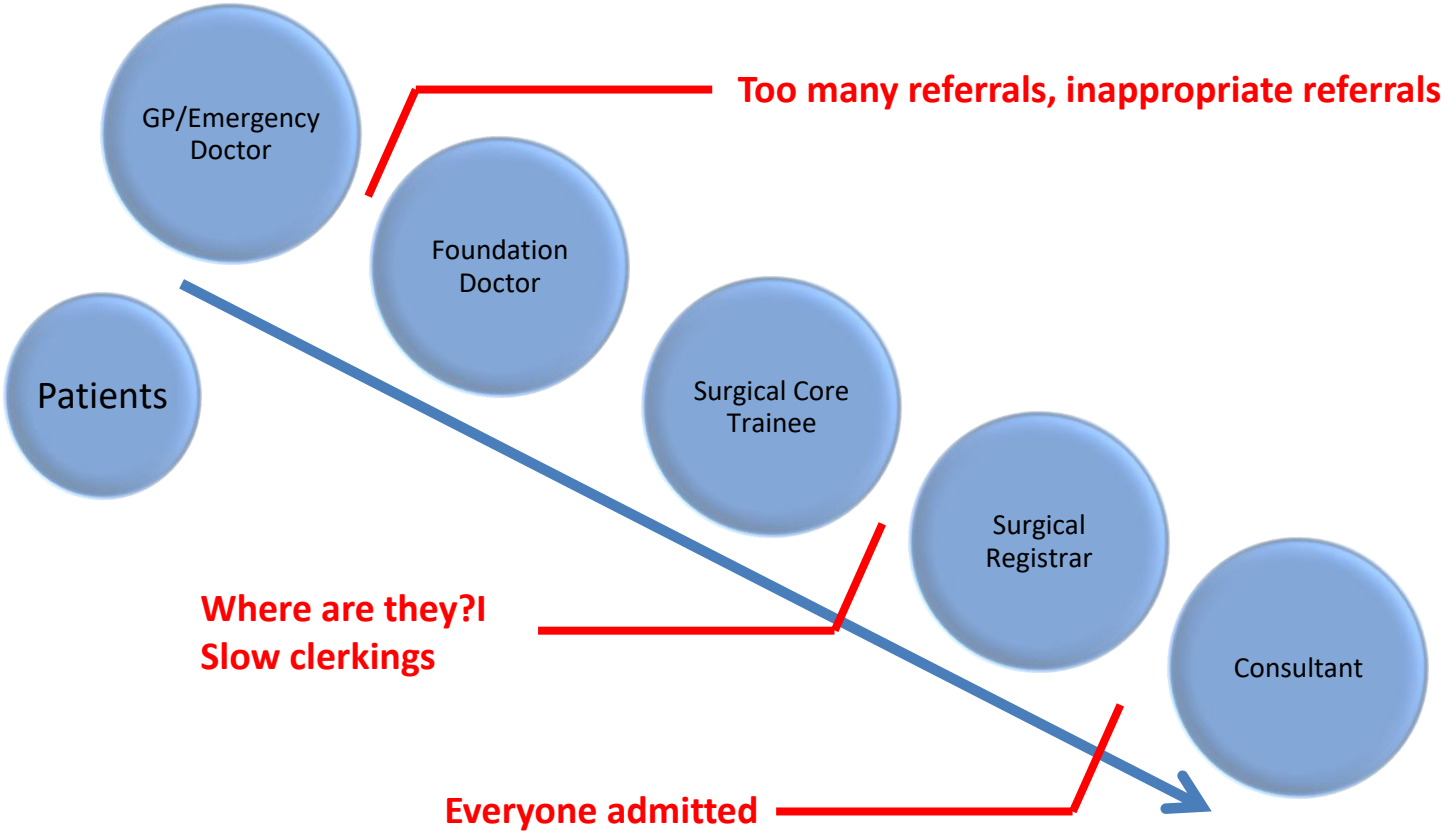

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SURGICAL TRADITIONS are hard to change!

- Unnecessary admissions
- Unnecessary waits
- Poorer outcomes
- Poor patient satisfaction
- An unmanageable take…
  - "…acutes are something you just get through…"

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TIME FOR A CHANGE

- **The aims of ambulatory care – a 'mission statement':**
  - ***Fewer admissions***
  - ***Shorter length of stay***
  - ***Quicker operations***
  - ***Fewer complications***
  - ***A shorter list***
  - ***A manageable take***

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CHANGE IS COMING...

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#asgbi2019

COPING WITH COMPLICATIONS
ASGBI 2019 CONGRESS | TELFORD

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CHANGE IS COMING...

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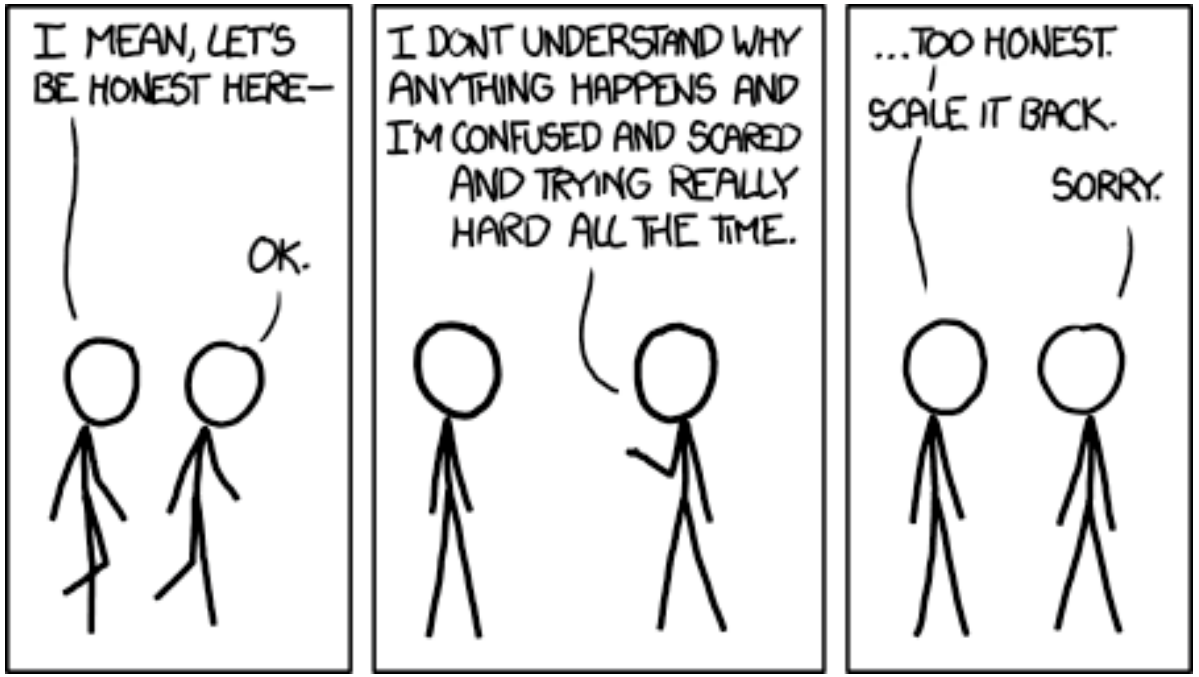
EVERYONE KNOWS THE PROBLEMS

- **Everyone knows the problems, but how do you solve them?**
  - ***Meetings, meetings, meetings…!?***



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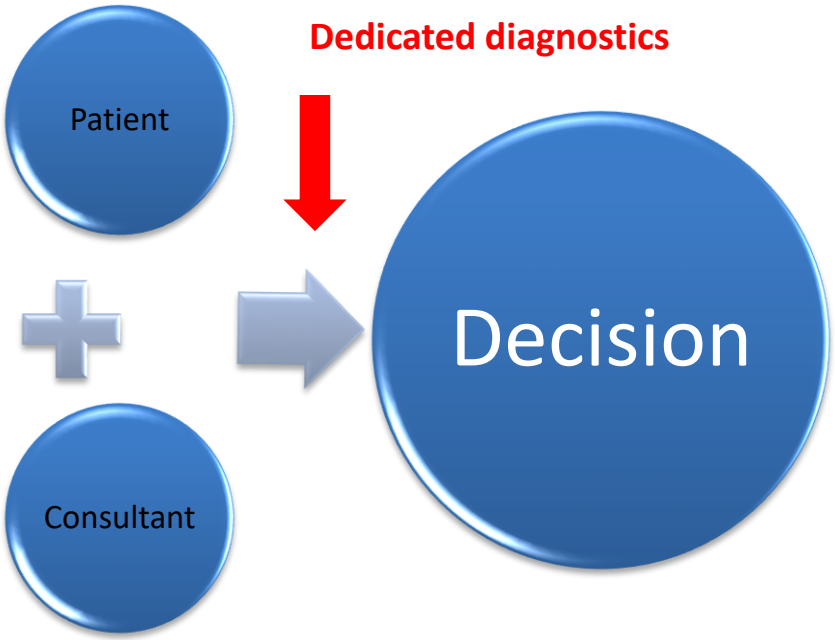
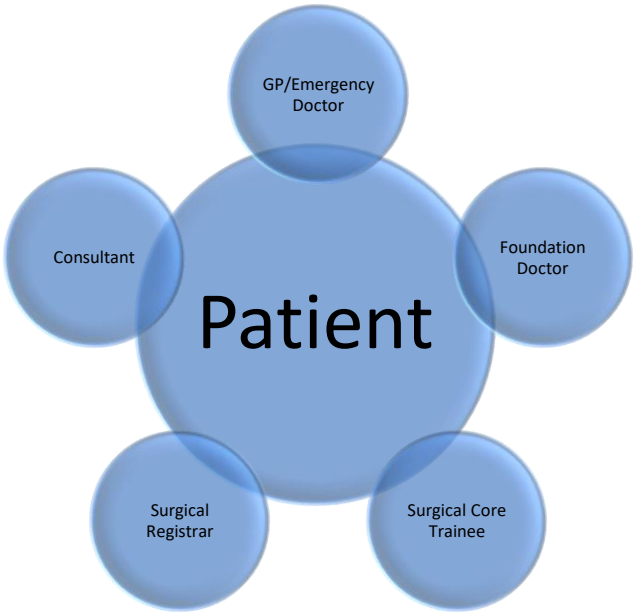
POSSIBLE SOLUTIONS





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LEARNING FROM DAY SURGERY

- Loads!!
  - Appropriate patient selection
  - Appropriate surgery selection
  - Protocols for discharge
  - Ways for contacting the unit
  - Exclusion criteria

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LEARNING FROM DAY SURGERY

- How to push the boundaries and how to measure them
  - BMI?
  - ASA?
  - Admission rate?
  - ***Now, very few absolute contra-indications to day surgery***

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SOMEHOW, the medics took over...

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SOMEHOW, the medics took over…

- 2000s onwards…
  - Increased pressure on beds
  - Many acute medical conditions treated in an AEC unit
  - British Association for AEC (2011)
  - AEC Network
  - Cohorts and National Events

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SURGICAL AMBULATORY EMERGENCY CARE

- Various models of care and themes…
  - Surgical 'hot' clinics
  - Ambulatory pathways
  - Consultant-delivered triage
  - Dedicated ambulatory units
  - All of the above, and more

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SURGICAL AMBULATORY EMERGENCY CARE

- **Surgical ambulatory emergency care** should be to **acutes** what **day surgery** was to electives
- Lobby for proper remuneration for cases
- Develop best practice tariffs
- Workforce planning
- **IT'S NOT ALL ABOUT THE LAPAROTOMIES**

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PRINCIPLES OF SAEC

1. Referrals should be process driven
2. Consultant-led and delivered
3. Rapid access to diagnostics
4. Rapid access to theatre
5. Early supported discharges
6. The Virtual Ward
7. The SAEC should be run from a designated, protected area
8. Nurse Practitioners and other Health Care Professionals
9. Robust documentation and safety-netting
10. Avoid unnecessary referrals to SAEC

DON'T WORRY IF YOU DON'T HAVE ALL OF THESE!

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WHAT DO YOU NEED?

- Enthusiastic core SAEC team
- Management and administrative support
- Involve stakeholders across the pathway
- Clinical leadership (medical and nursing)
- Active Executive involvement and support
- Commissioning involvement and support
- Clear project aim and plan
- Clear operational plan understood by all
- Theatre capacity

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WHAT DO YOU NEED?

A CHANGE IN MINDSET

"Why can't this patient be managed in an ambulatory unit"

rather than

"Why can this patient be managed in an ambulatory unit"

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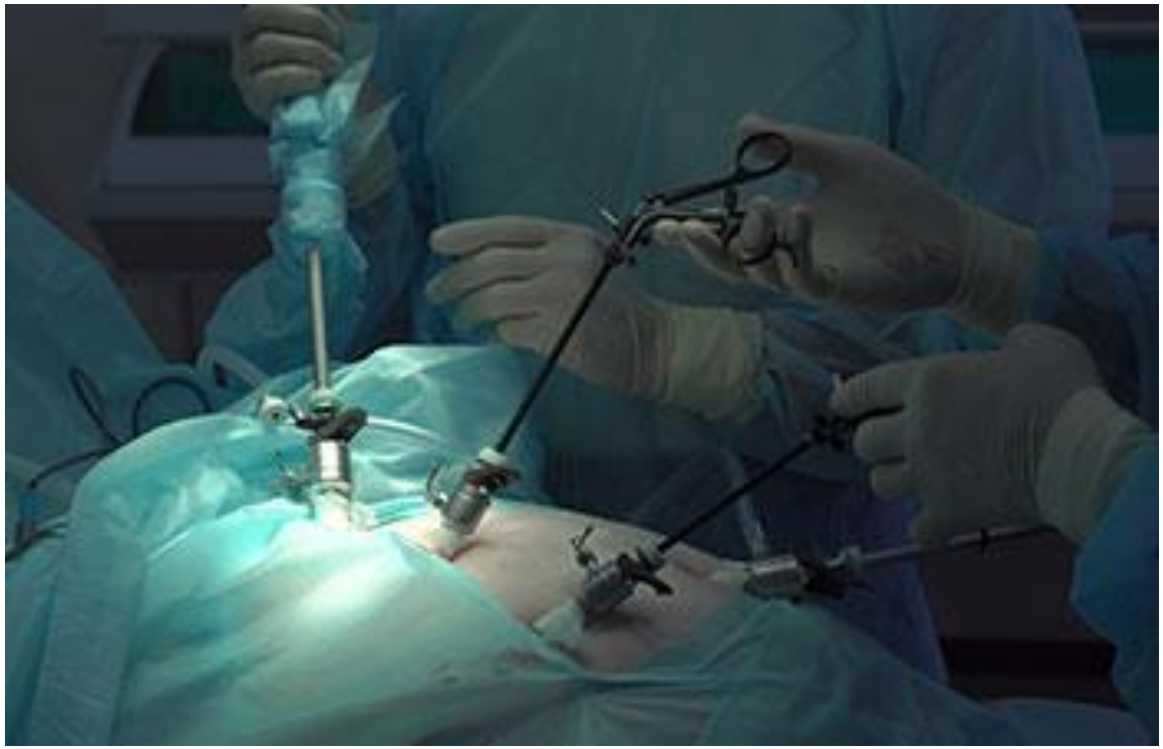
WHAT DO YOU NEED?

A CHANGE IN MINDSET



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AMBULATORY SURGICAL UNITS

- Ambulatory care
  - Estate / Infrastructure
- Urgent bookable lists
  - Job plans
- Increased Consultant input- theatre and front door
  - Job plans
- Increased frequency of ward rounds
  - Job plans
- "Duty Consultant" rather than "on call Consultant"
  - Mindset
- Peri-operative physicians
- Emergency General Surgeons?

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SAU vs SAEC – key differences

- Control the 'Front Door'
- Chairs, not beds
- The waiting room experience
- Regular reviews
- Dedicated imaging slots
- Treatment areas

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POTENTIAL CONVERSION TO SAEC

CONDITION	% SAEC	CONVERSION
Acute abdo pain not requiring operative intervention	30-60%	Moderate
Cutaneous abscess requiring drainage	60-90%	High
RUQ pain	60-90%	High
Non-obstructed hernia	60-90%	High
Haemorrhoids	>90%	Very High
RIF pain	30-60%	Moderate
LIF pain	30-60%	Moderate
Anorectal issues	60-90%	High

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THE FUTURE IS NOW...

Surgeons are needed in A&E to prevent winter crisis

News

Surgeons to guard hospital doors this winter in bid to stop overcrowding

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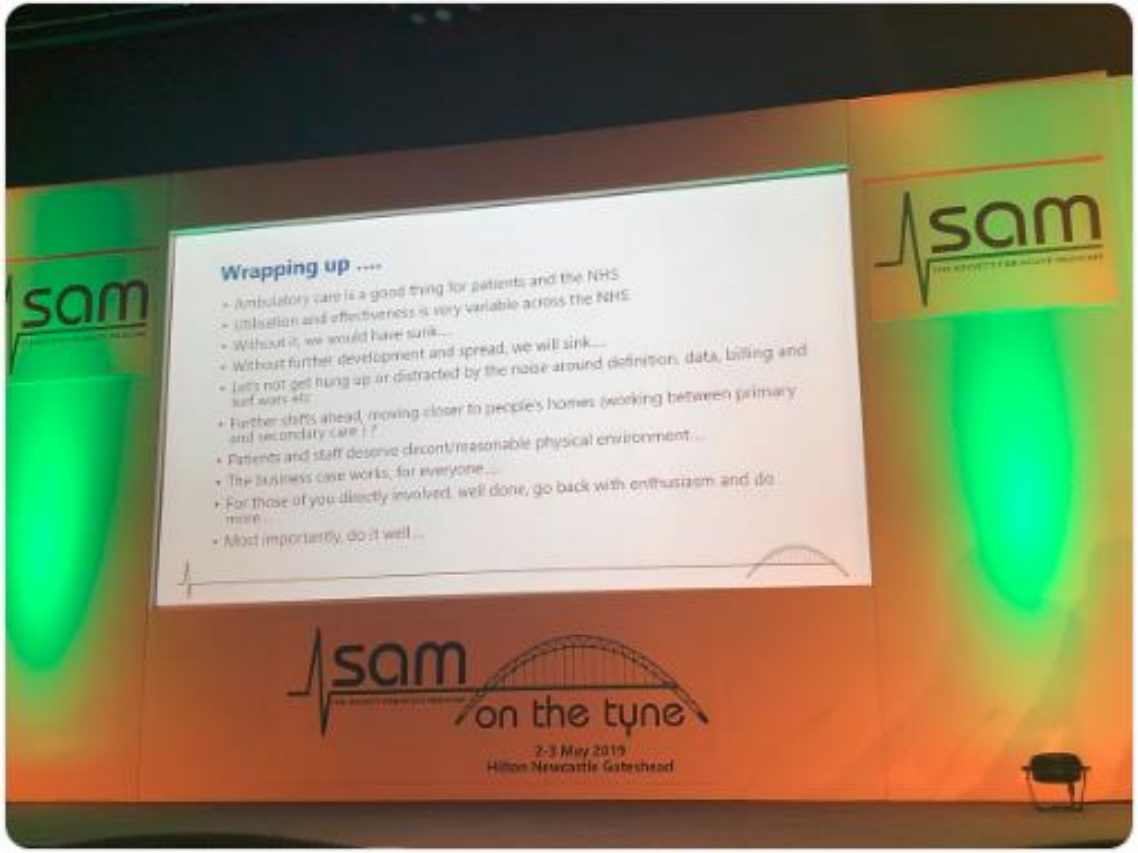
THE FUTURE IS NOW...

AEC Network Retweeted

Ratna Aumeer @Ratna_Aumeer · May 2

Without Ambulatory care, we would have sunk. Without further development in Ambulatory care, we will sink @acutemedicine @aec_network #SAMontheTYNE



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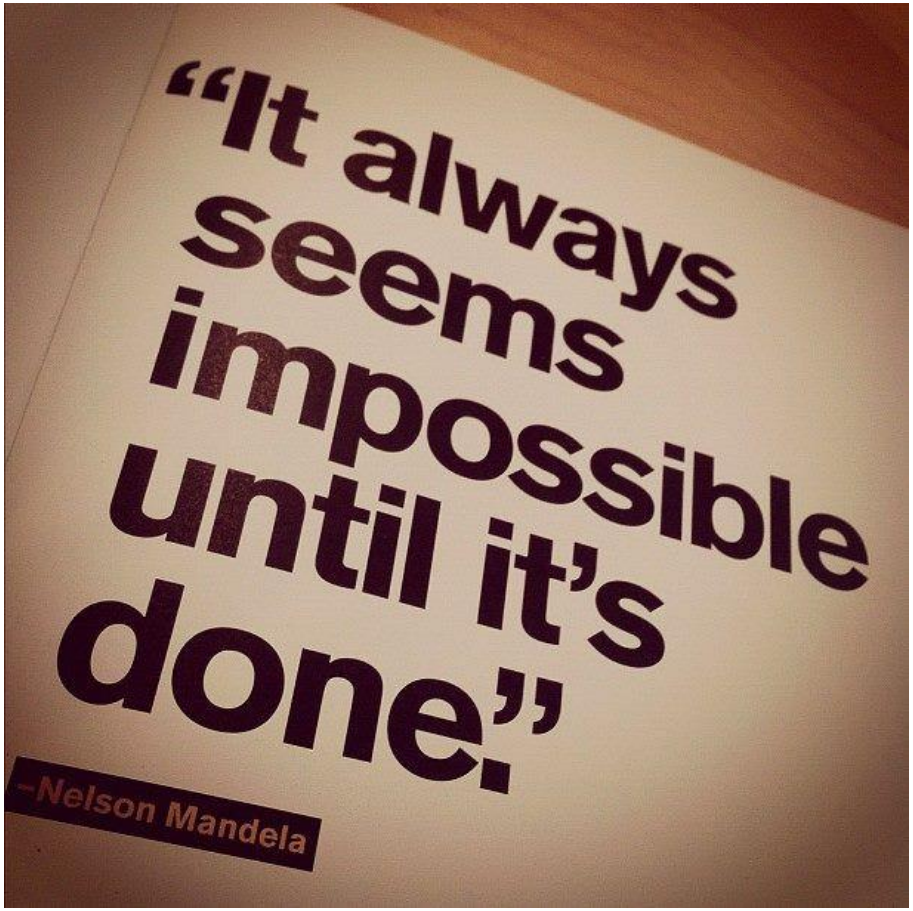
THE FUTURE IS NOW...



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@ArinSaha6

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Ambulatory Emergency Care Network

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NHS Foundation Trust

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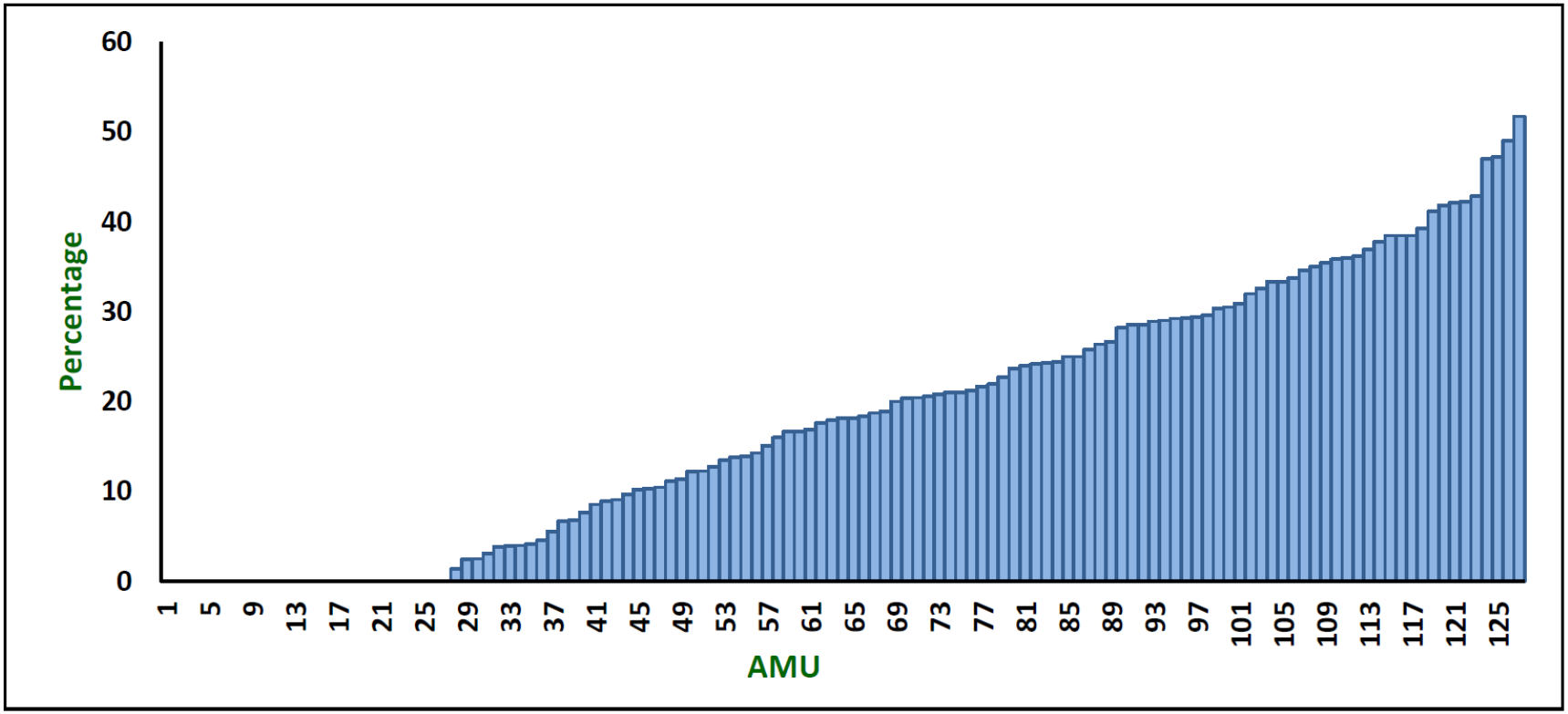
Figure 6 Variation in Percentage of Initial Medical Assessments Undertaken in AEC



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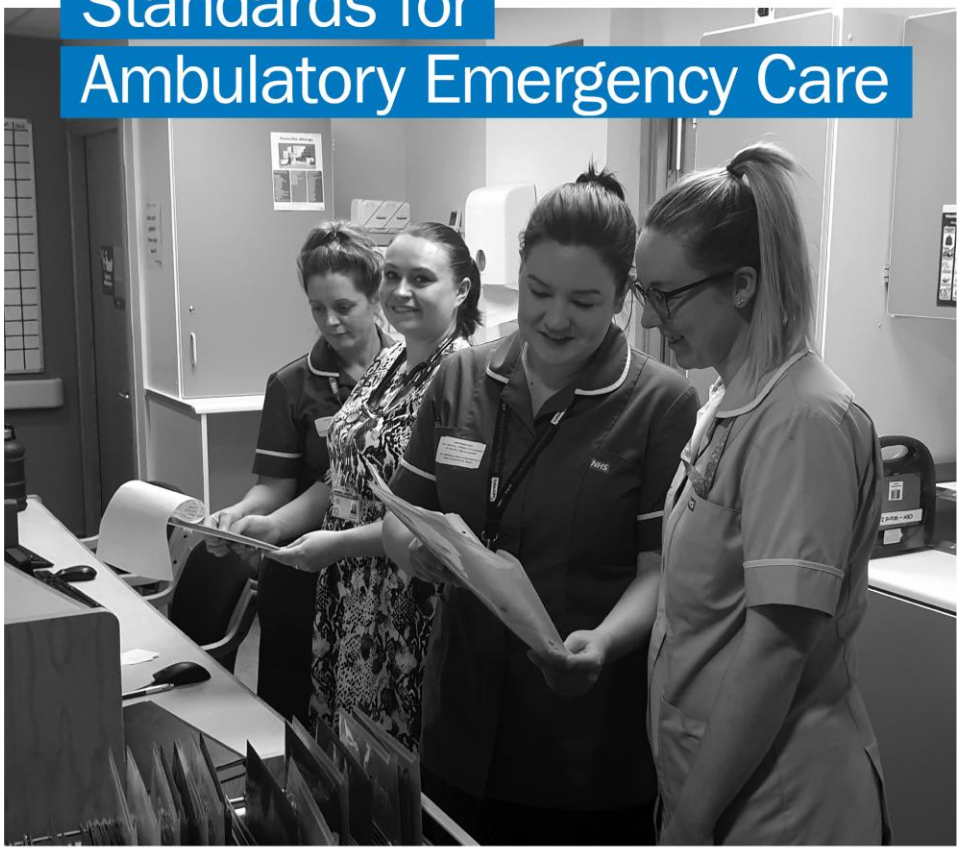
Standards for Ambulatory Emergency Care



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.

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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.

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

sam
THE SOCIETY FOR ACUTE MEDICINE

ROYAL COLLEGE
of PHYSICIANS
of EDINBURGH

am
FOR ACUTE MEDICINE

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

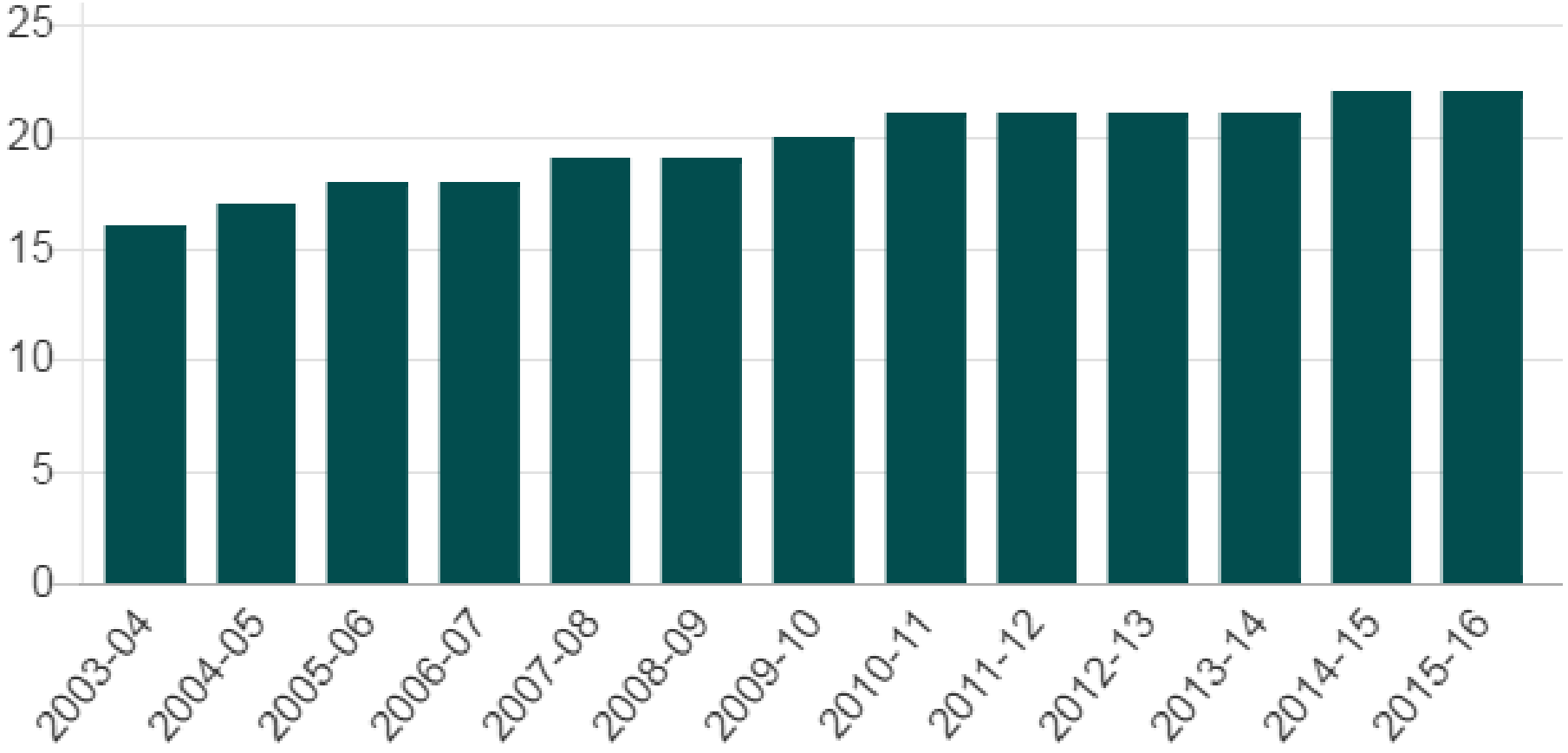
Approx. 200 Type 1 / 2 EDs [+ UTCs]

40 different IT suppliers


KKG 27P

Increasing demand for urgent treatment

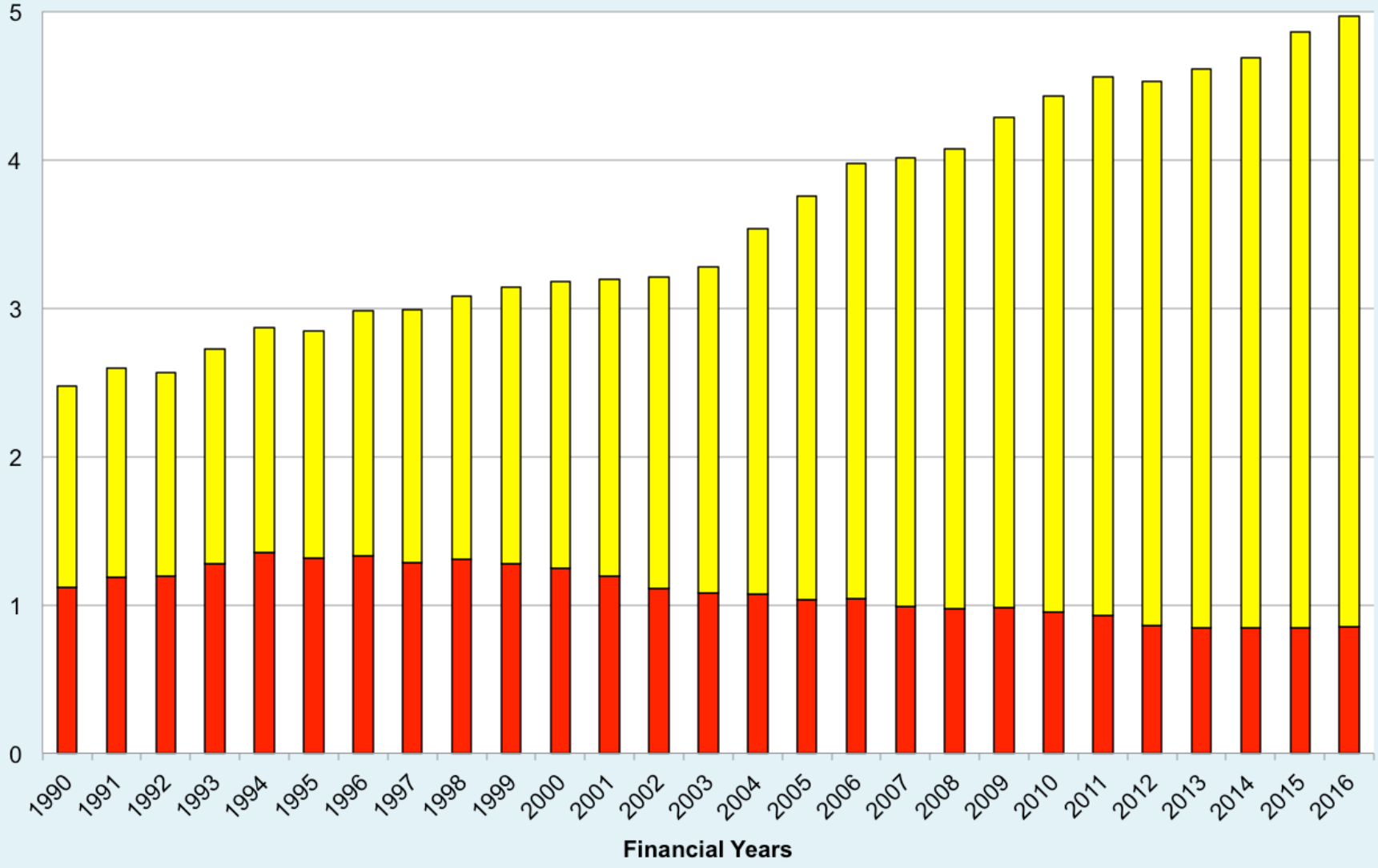
Visits to A&E in England (in millions)



Source: IFS

BBC

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



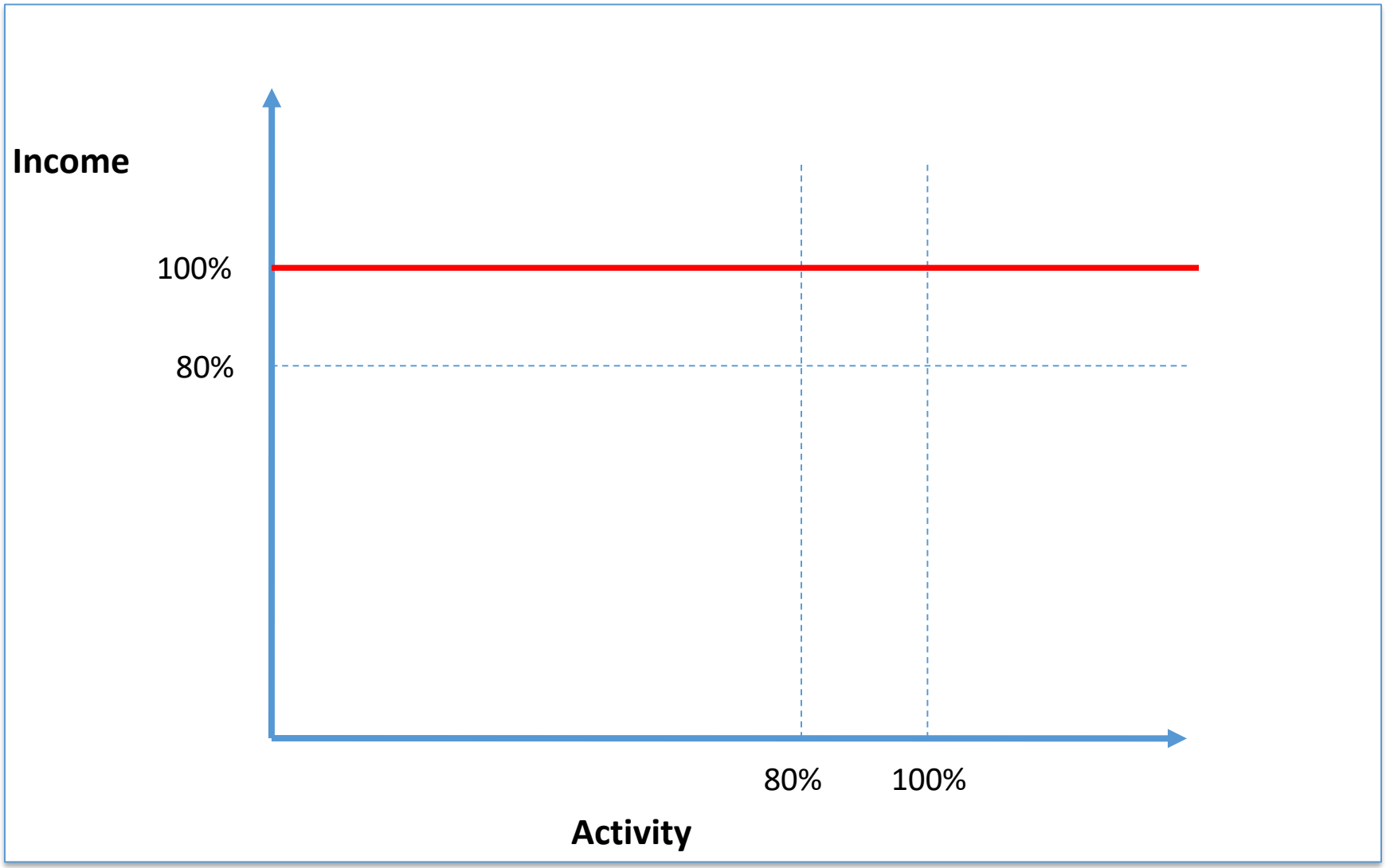
SDEC / AEC history

- Best Practice Tariff 2012-19
  - Now Blended Payment

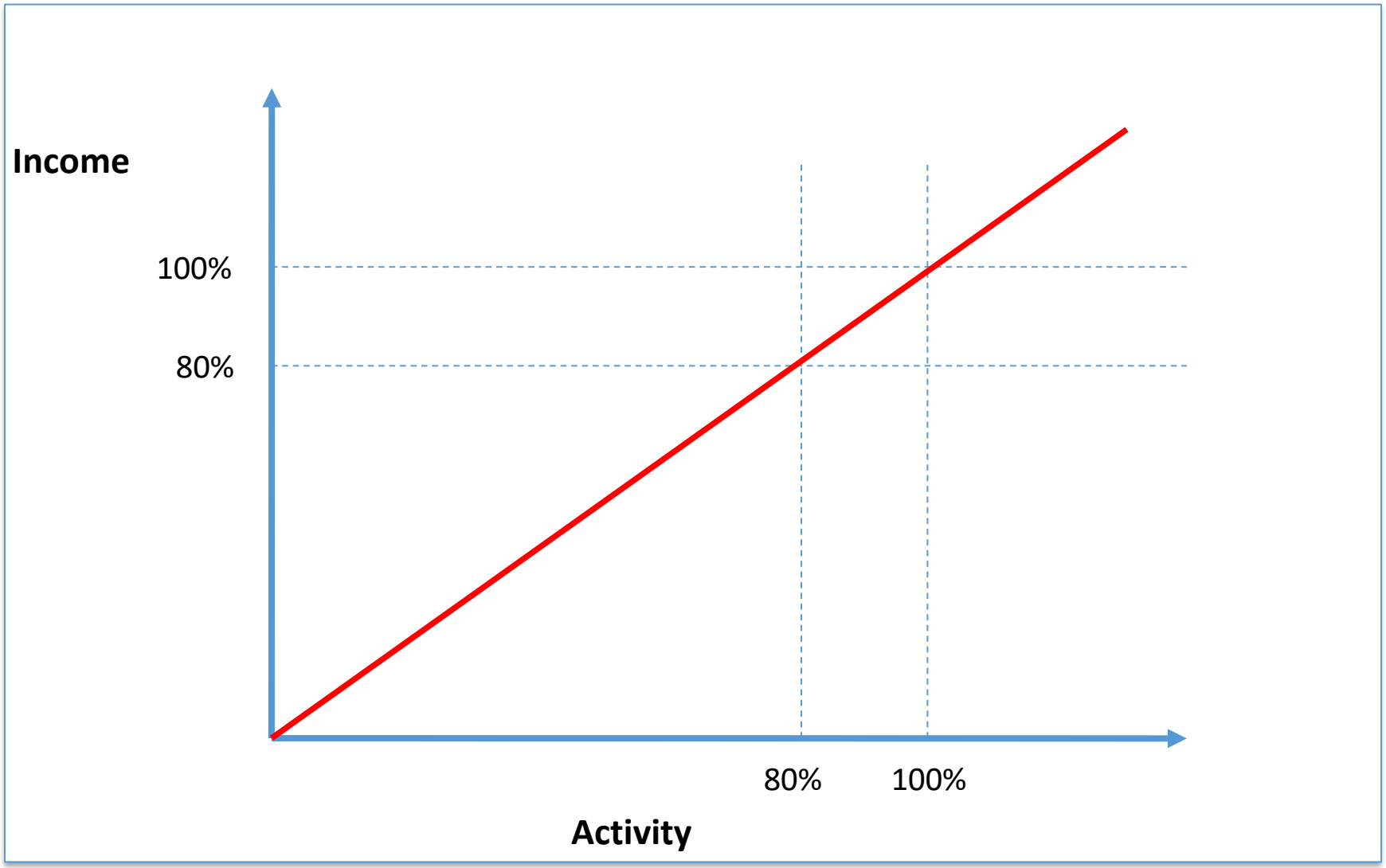
Aims

- Incentives for defined conditions
- Move to process driven SDEC

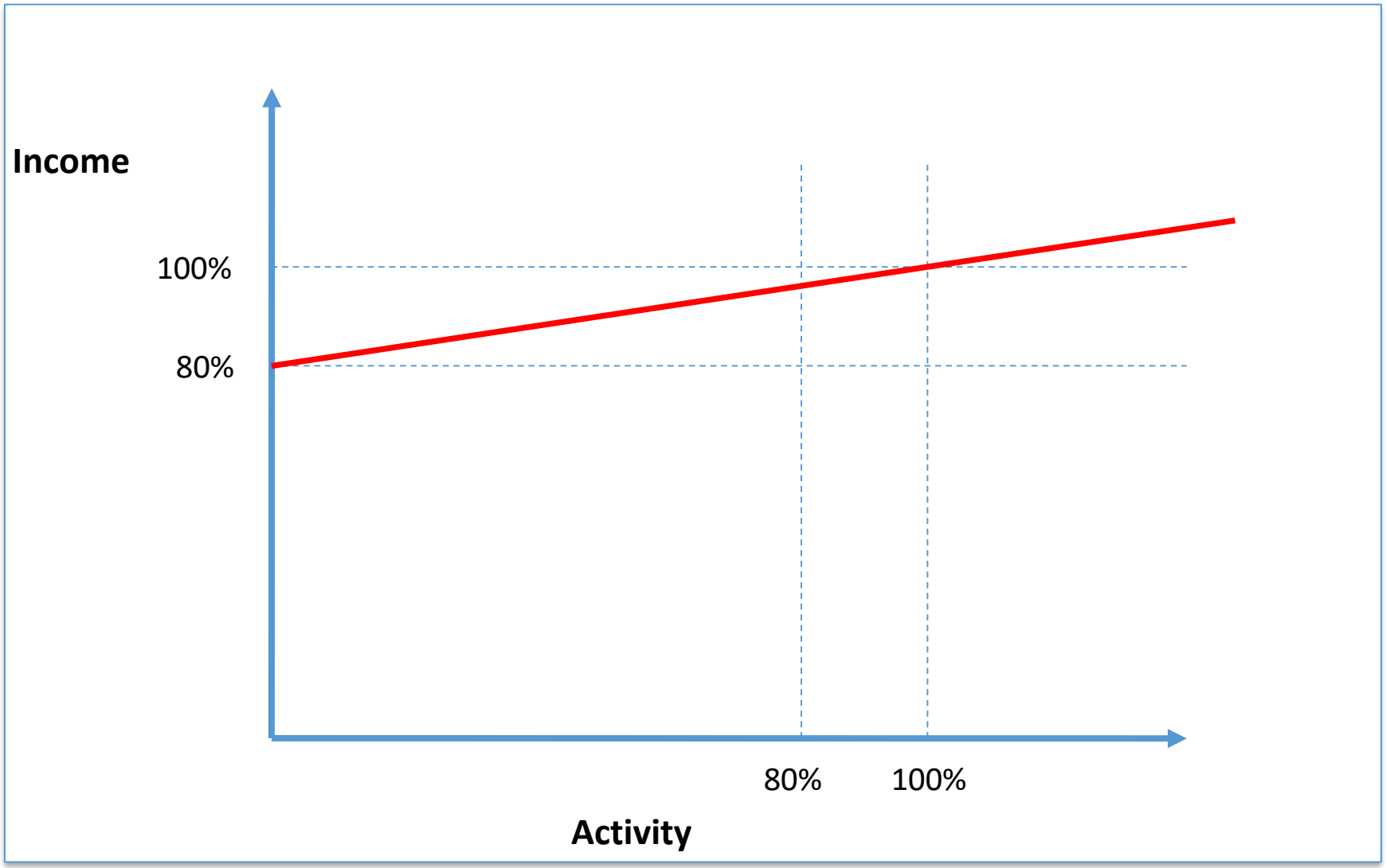
Block Tariff



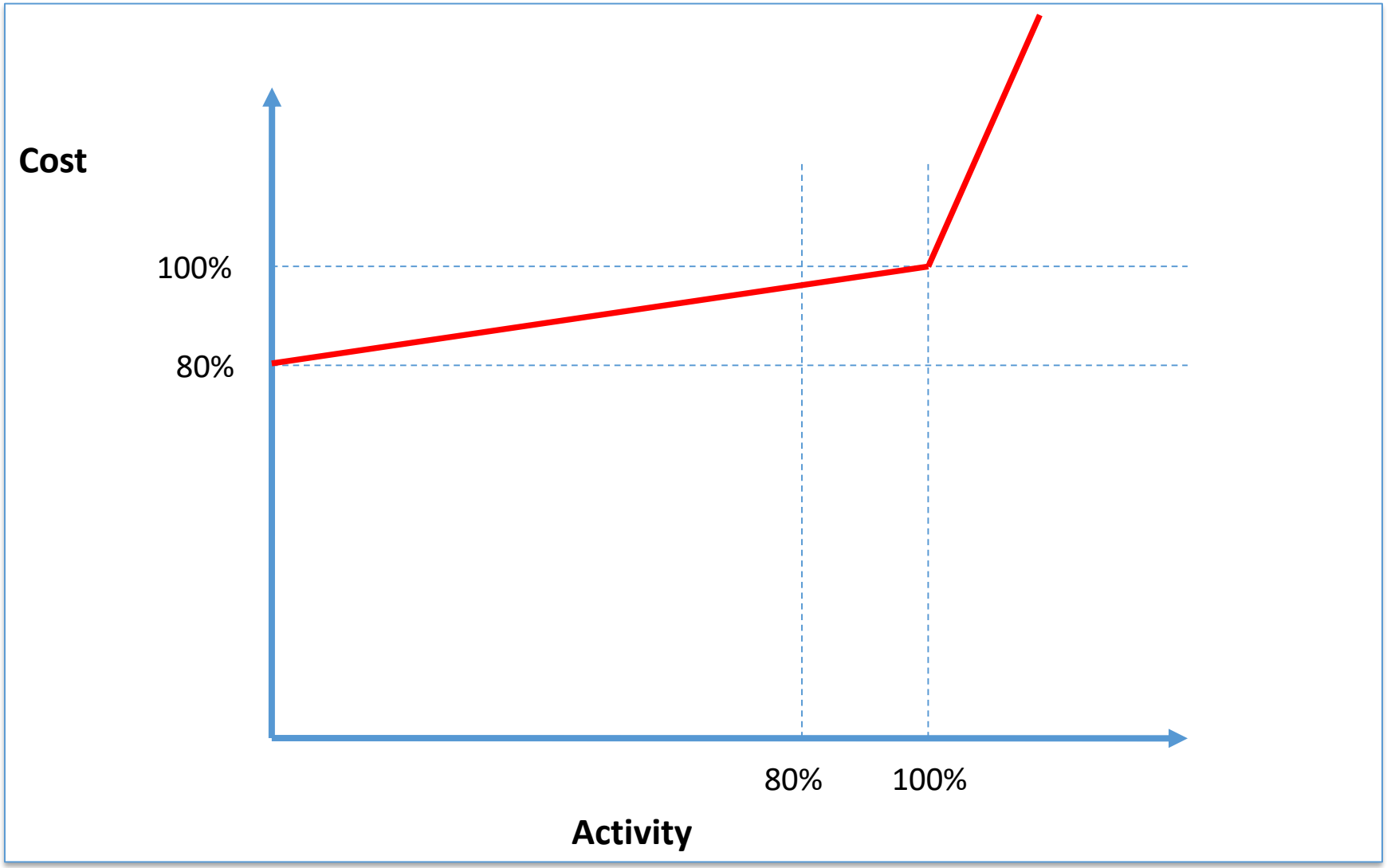
PbR Tariff (HRGs = DRGs)



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

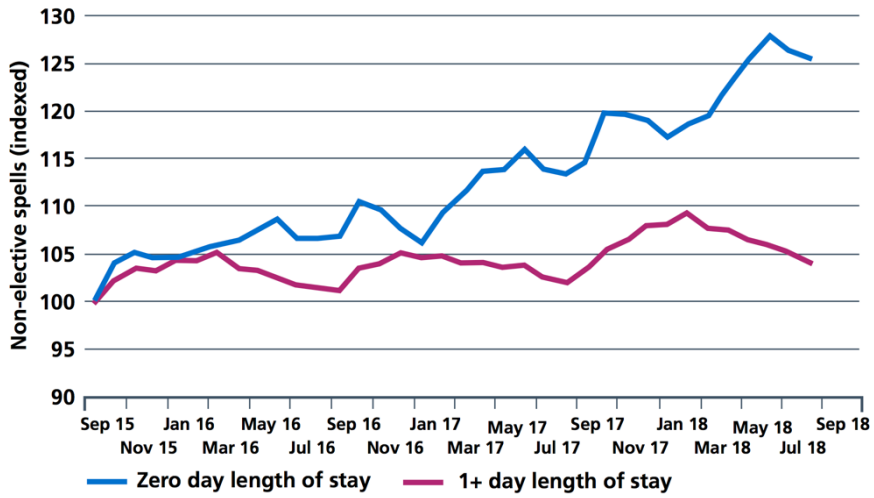
  - Not doing SDEC

Success ?

Zero Day LoS

^ 9.6%

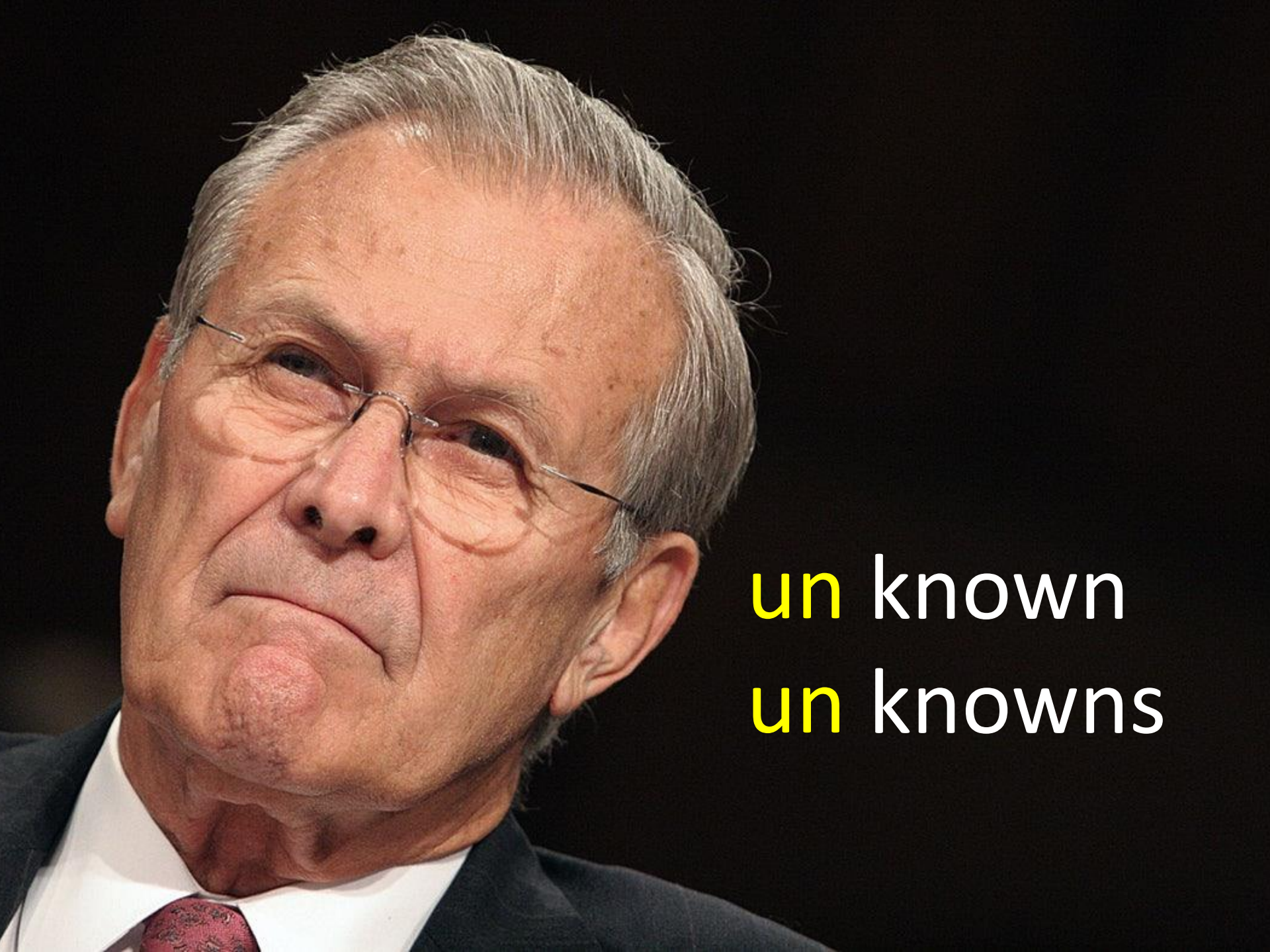
Figure 3: Relative growth in emergency admissions: zero day and 1+ day length of inpatient stay.

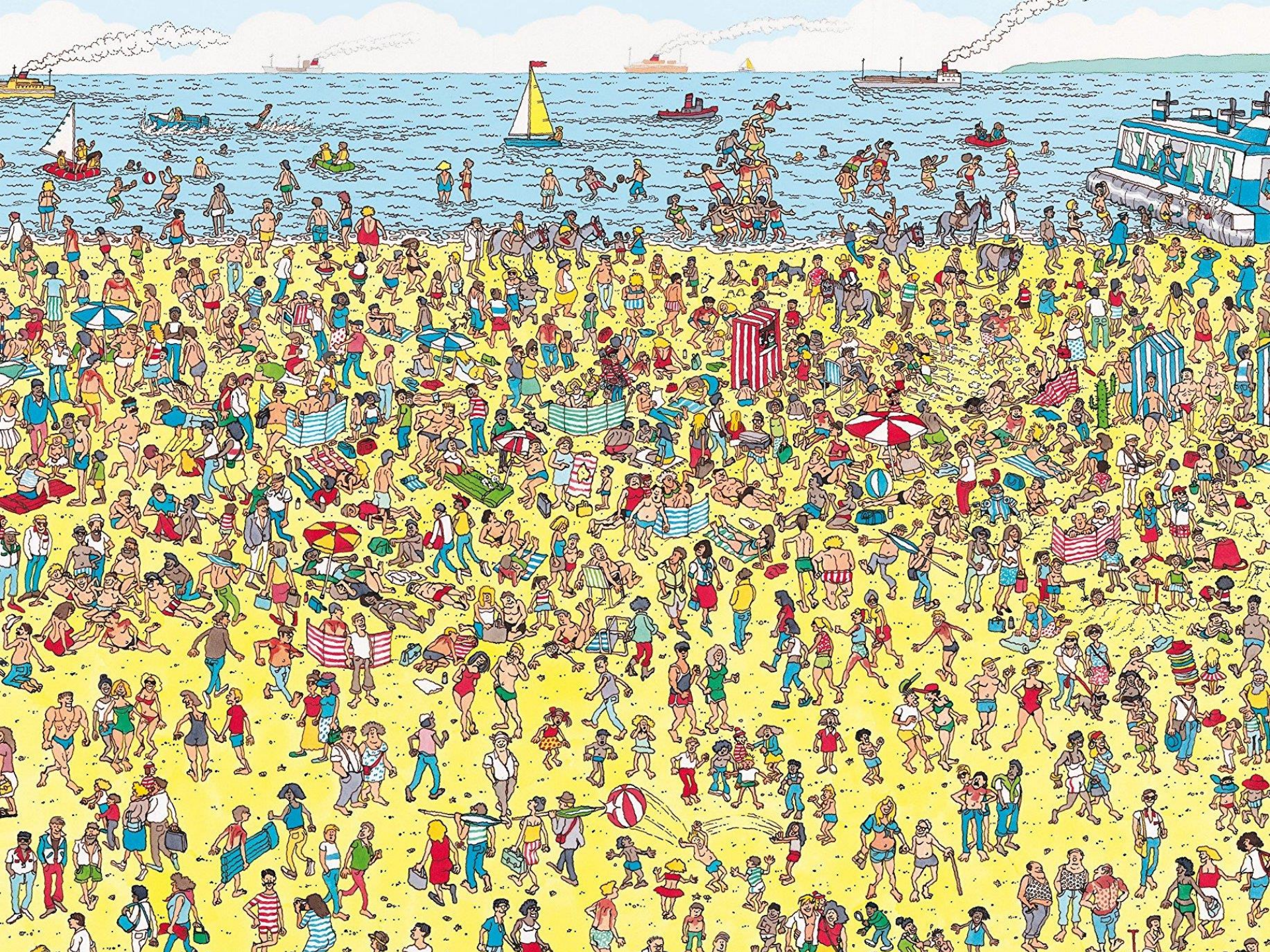


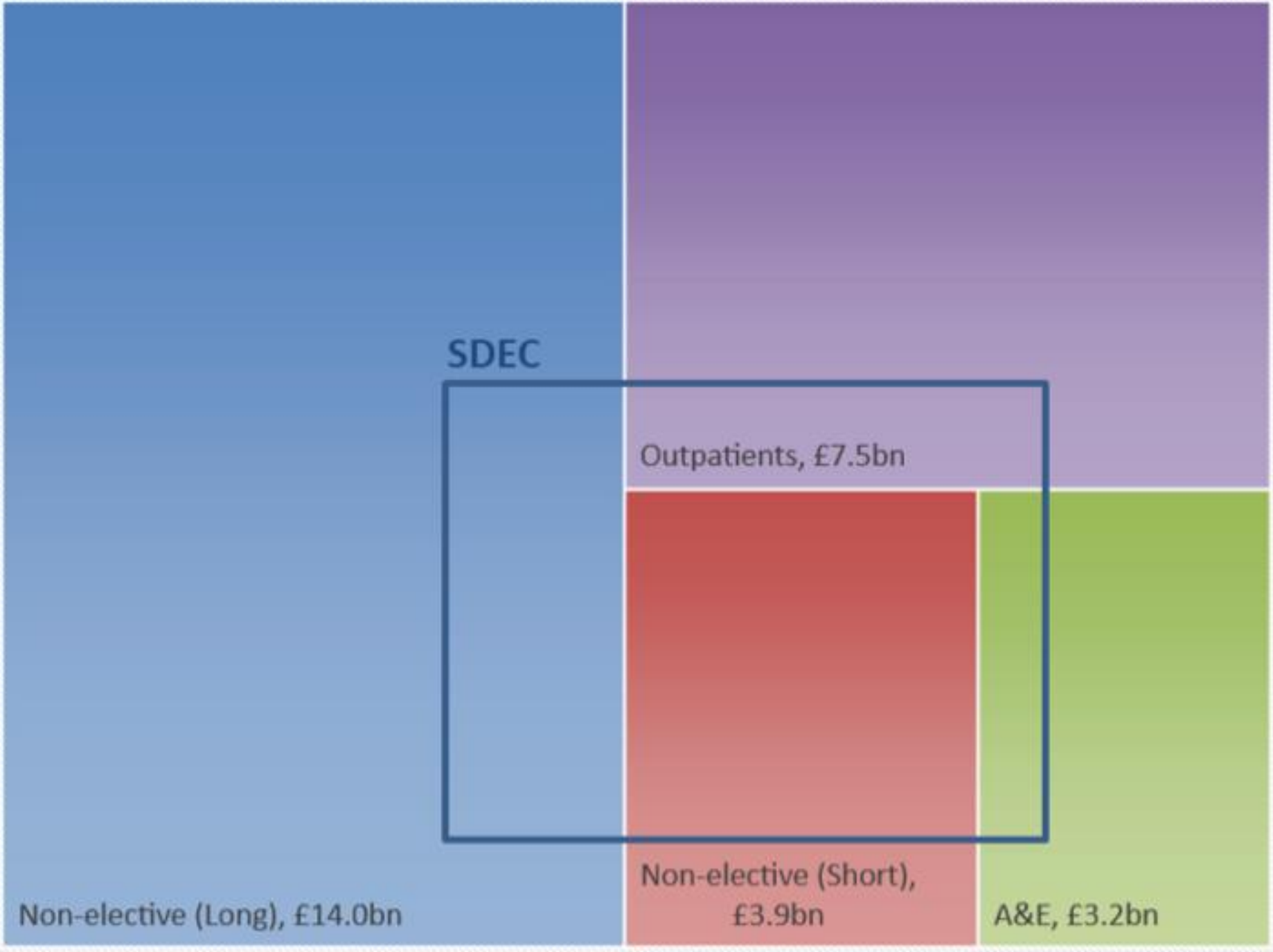
Data source: NHS Digital. Secondary Uses Service (SUS) data. 2018.

- ? 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

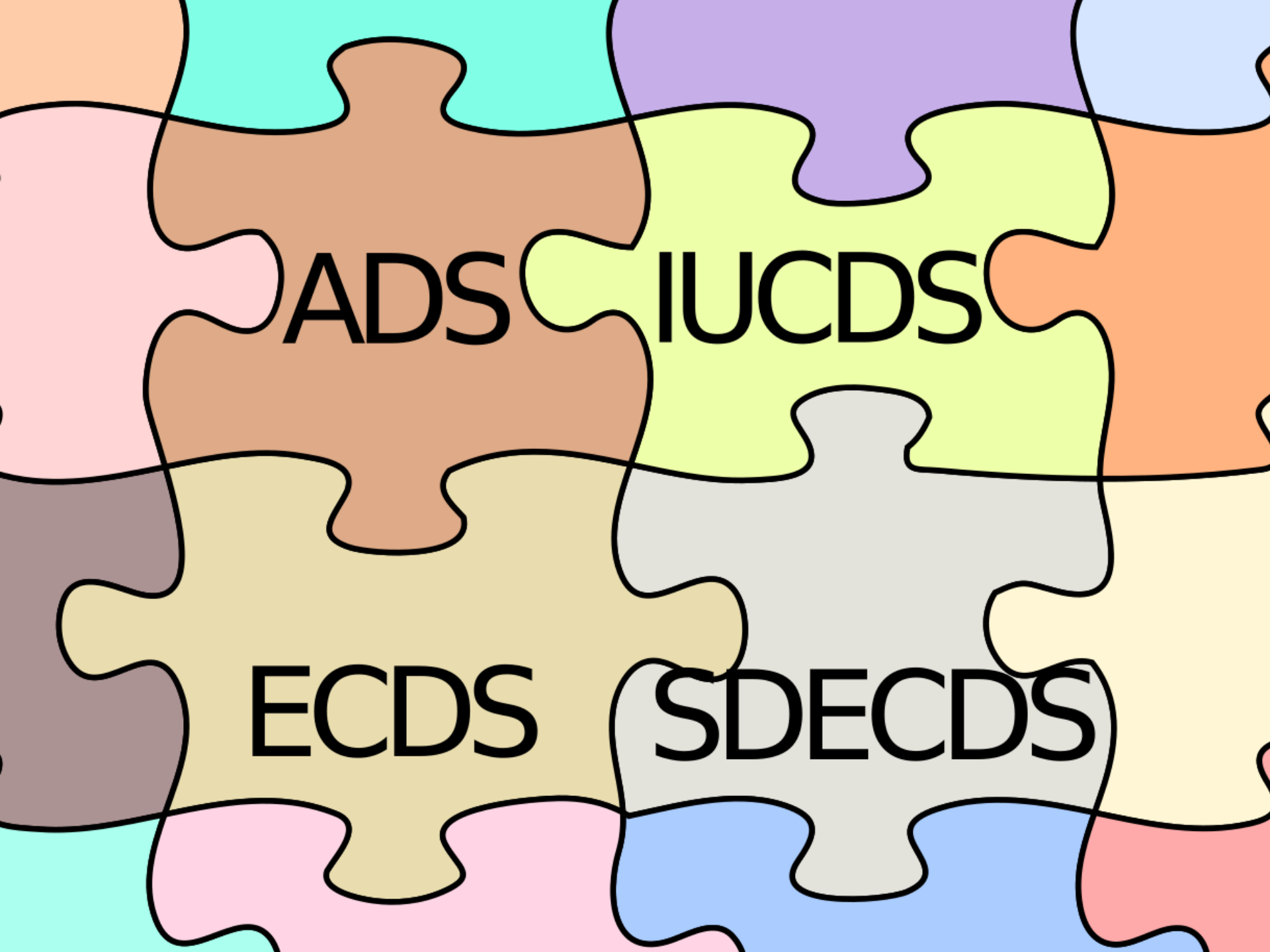
- Time based, milestones
- Input & Output metrics
  - Chief Complaint & Acuity
  - Diagnosis & Suspected / Confirmed

Changing to ECDS / SDECDS

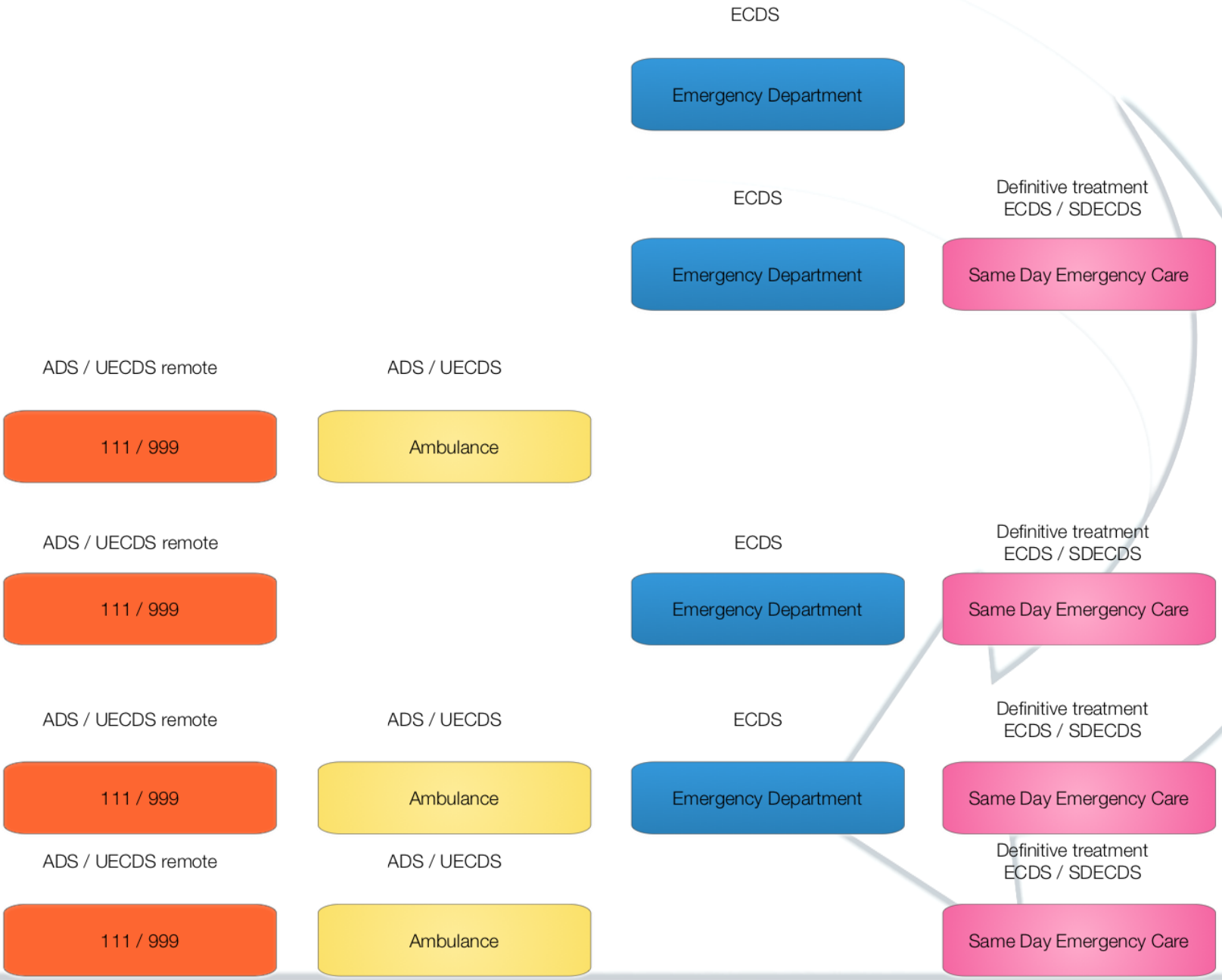
Is the existing data

- 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

Showcase Sites: Calderdale and Huddersfield NHS FT

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

SAEC @ CHFT

Arin Saha
Consultant in General, Upper GI and Bariatric Surgery, CHFT

National Clinical Lead, Surgical Ambulatory Emergency Care Network, NHS Elect

Chairman, Surgery Same Day Emergency Care Group (sSDEC), NHS Improvements

Friday 24th May, 2019
Same Day Emergency Care (SDEC) Regional Meeting - Leeds

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@ArinSaha6

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Ambulatory Emergency Care Network

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Calderdale and Huddersfield
NHS Foundation Trust

A BIT ABOUT US...

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A BIT ABOUT US...

- 11 consultants
  - 6 Colorectal
  - 5 Upper GI / Bariatric
- All on full acute rota
- 200 - 215 emergency laparotomies per year
- 39 - 45 acute referrals per day
- Accredited colorectal cancer and NHS bariatric units
- Trainees from Yorkshire and the Humber Deanery

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THE CHFT 'MISSION STATEMENT'

- **Minimum standards**
  - Two complete consultant ward rounds **of all acute patients** every day (8AM, 6-7PM)
  - 8PM consultant-to-consultant **face-to-face** handover of all acute patients (day and night junior teams present)
  - Patients with NEWS > 5 within the department discussed
  - 8AM and 8PM CEPOD theatre planning meeting
  - Difficult patients reviewed together

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THE CHFT 'MISSION STATEMENT'

- **Minimum standards**
  - Consultant present at **all laparotomies**
  - Investigations ordered when you need them
  - All patients risk assessed
  - HDU/ITU for any predicted mortality >5/10%
  - Surgery performed when needed through the night – **7 days a week**
  - Aim to satisfy minimum standards for sepsis (source control)

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THE CHFT 'MISSION STATEMENT'

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THE HUDDERSFIELD ROTA

Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun
1	48 hours on call		CEPOD	Elective	Elective		
2	Elective	Elective	Elective	Elective	Elective		
3	Elective	Elective	Elective	Elective	Elective		
4	Elective	Elective	Elective	Elective	72 hours on call		
5	CEPOD	Elective	48 hours on call		CEPOD		
6	Elective	Elective	Elective	Elective	Elective		
7	Elective	Elective	Elective	Elective	Elective		
8	Elective	Elective	Elective	Elective	Elective		
9	Elective	Elective	Elective	Elective	Elective		
10	Elective	Elective	Elective	Elective	Elective		

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THE HUDDERSFIELD ROTA

- **Problems with the old rota**
  - Only one 8AM ward round per day
  - Long period of on call → patients 'resuscitated' overnight
  - CEPOD day affected by the '8AM laparotomy'
  - Difficult to maintain 24 hour consultant presence (wards and theatre)

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THE HUDDERSFIELD ROTA

Week	Mon	Tues	Wed	Thur	Fri	Sat	Sun
1	Day	Day	Day	CEPOD	Night	Night	Night
2	Night	Night	Night	Night	Rest		
3	Rest	Rest	Rest	Elective	Elective		
4	Elective	Elective	Elective	Elective	Elective		
5	Elective	Elective	Elective	Elective	Elective		
6	Elective	Elective	Elective	Day	Day	Day	Day
7	CEPOD	Post Take	Elective	Elective	Elective		
8	Elective	Elective	Elective	Elective	Elective		
9	Elective	Elective	Elective	Elective	Elective		
10	Elective	Elective	Elective	Elective	Elective		

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THE CHFT EXPERIENCE

- Time to see a consultant fell from 18 hours to 5 hours
- Halving of laparotomy mortality
- Same day discharge from 19% to 43%
- Trebling of acute laparoscopic cholecystectomy
- Fewer complaints
- Change in culture

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THE CHFT EXPERIENCE

- NOT without cost
  - Job planning
  - Not 'on call' but 'on site'
  - Electives

Predictable On Call

- 5 x 3PA weekdays / 11 weeks
- 2 x 4PA weekend / 11 weeks
- 1/3 PA per night (includes handover)

Unpredictable On Call

- 1.5 PA (each night + CRH On Call)

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WHAT I'VE LEARNT

- Lots of people don't think we have to change
  - "We do all that already"
  - "Our hospital is different to yours"
- Lots of people don't think we can change
  - "My colleagues would never agree to that"
  - "We've got not money – we can't build anything or employ anyone"
- There is amazing work going on every day
- We are terrible at learning from each other

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WHAT I'VE LEARNT

- It's not about the building...

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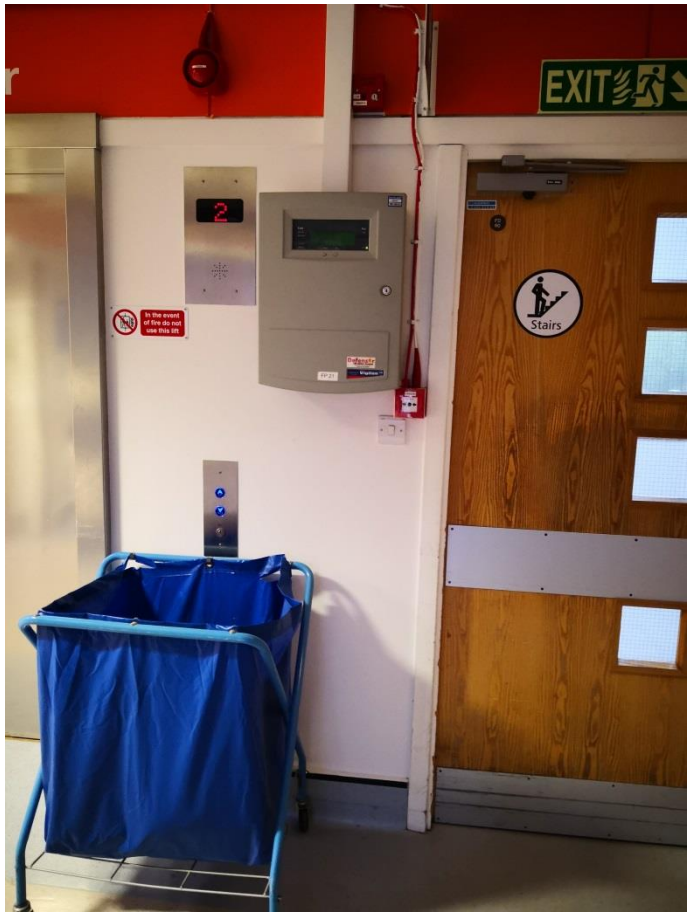
WHAT I'VE LEARNT

- It's not about the space...



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LIFE AT CHFT

- It's about the people...

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LIFE AT CHFT

- It's about the people...

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LIFE AT CHFT

- It's about the people...
  - Work harder when on call **but...**
  - ...patients do better!
  - Extra time off after nights
  - More consultant colleagues
  - Fewer lost sessions

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LIFE AT CHFT

- Sustainable work patterns (even for the senior consultants)
- Can enjoy a beer at the end of the day!
- Everyone needs to embrace the concept
- Change without approval of other departments
  - Anaesthetics / Radiology / Theatre Staff
- Start on a trial basis

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THE FUTURE...

- **Job plan appropriately**
- Listen, listen, listen and develop a system that works for you
- Involve everyone
- Honest and open feedback
- Change the culture and start small
- Get the right people in
- **Get ready and own the change**

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THE FUTURE...it's worth it

ASGBI
Association of Surgeons of Great Britain and Ireland

thebmjawards

Ambulatory Emergency Care

PATIENT SAFETY AWARDS

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Showcase Sites: Surrey and Sussex Healthcare NHS Trust

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

Surrey and Sussex Healthcare NHS Trust

NHS 70 YEARS OF THE NHS 1948 - 2018

Medical Ambulatory Emergency Care @ SaSH

Dr Radha Selvaratnam – Acute Physician/AEC Lead

Putting people first

Delivering excellent, accessible healthcare

CareQuality Commission Inspected and rated **Outstanding**

NHS Surrey and Sussex Healthcare NHS Trust

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 - 20 months

•5443 patients seen.

•10% A&E, 59% GP

Patient and staff survey

- Lack of space, staff
- Inadequate facilities
- Long waits
- Poor communication
- 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! …..

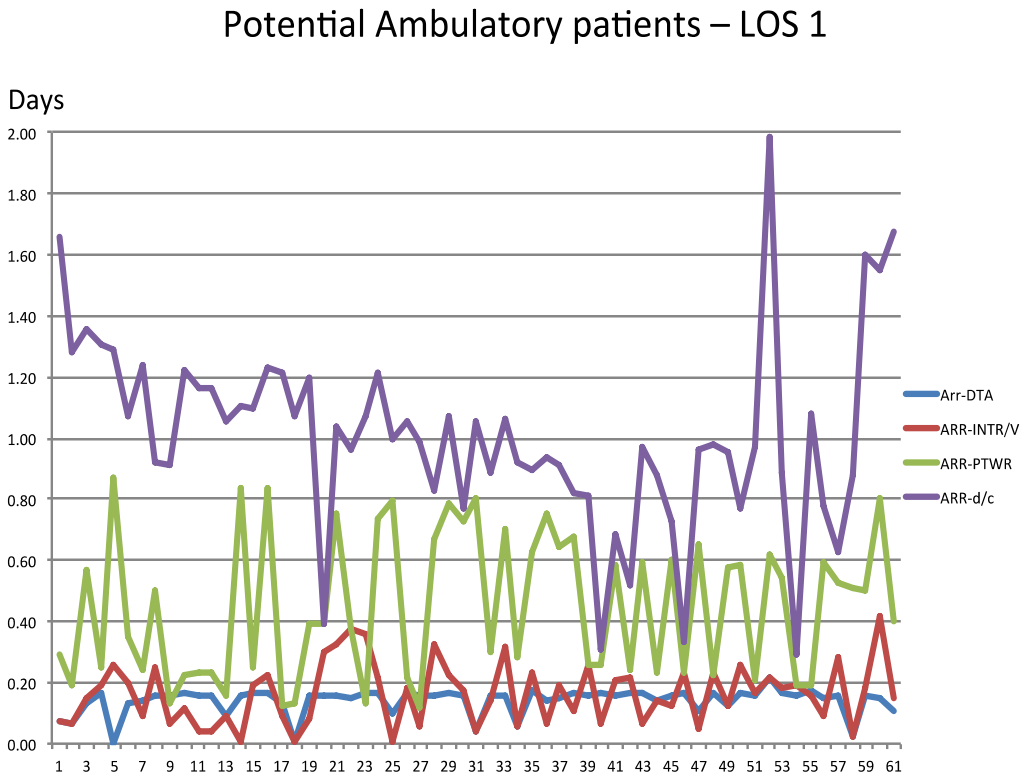
To take blood took two hours…….

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…..

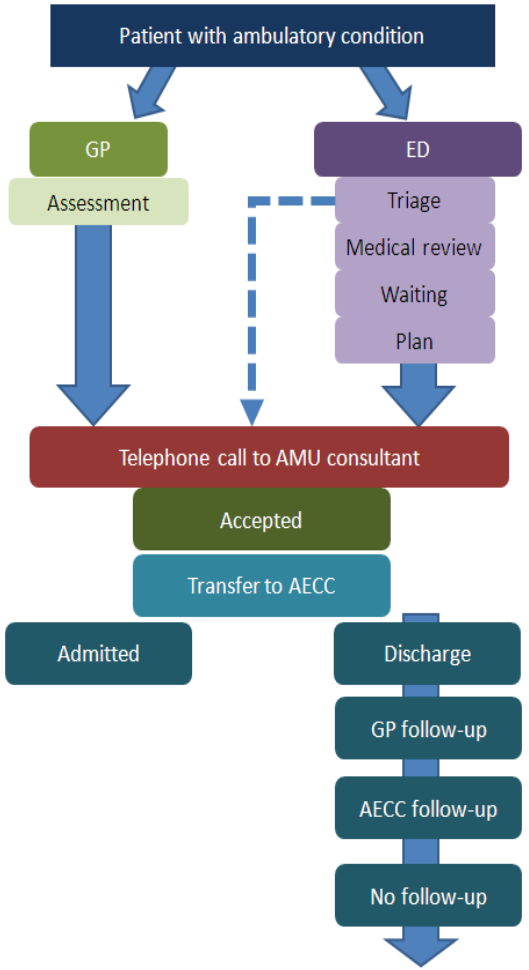
Lions lead by donkey's spring to mind.

AMU 1 day LOS analysis

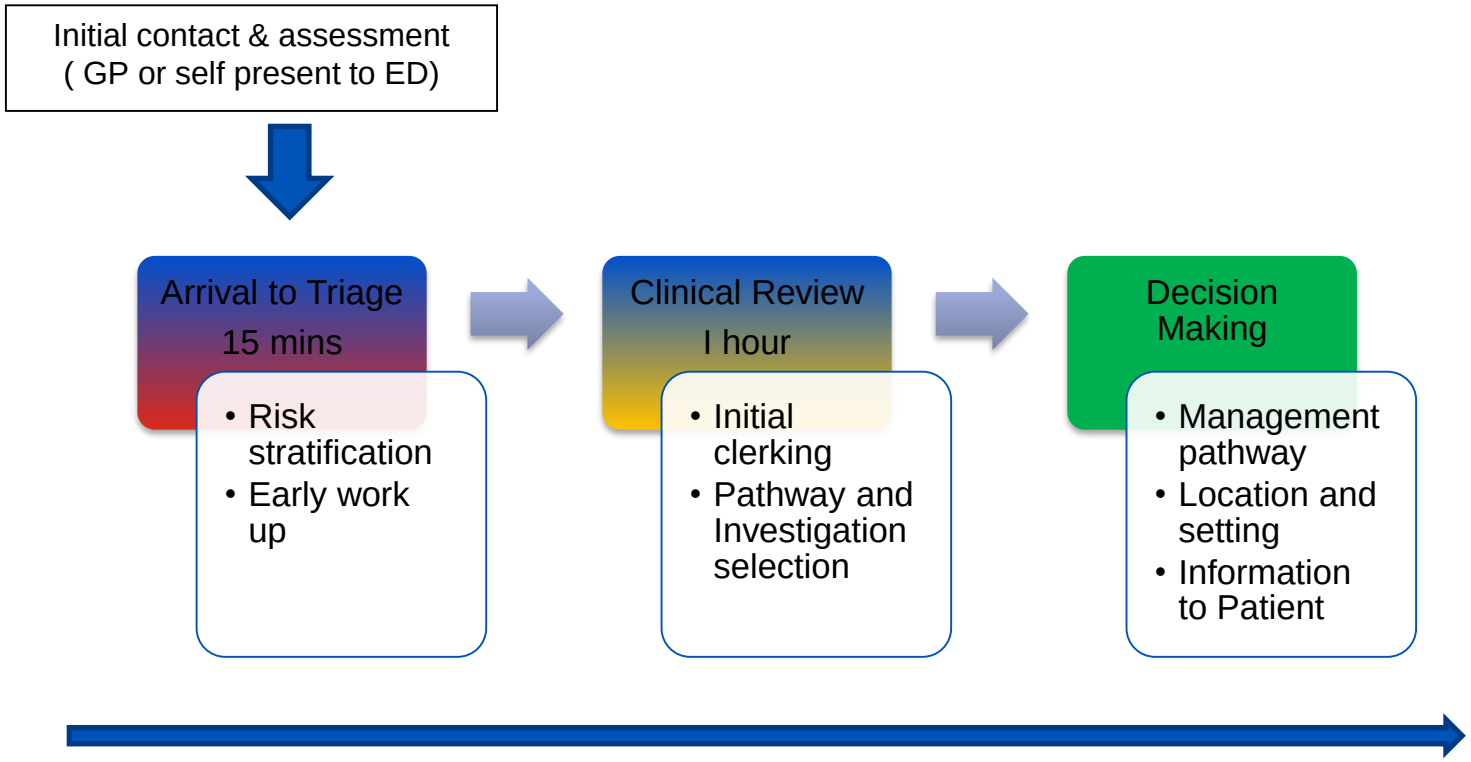


AEC aims

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



Patient experience



Surrey and Sussex Healthcare NHS Trust

NHS 70 YEARS OF THE NHS 1948 - 2018

Putting people first

Delivering excellent, accessible healthcare

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 collection
- Agreed diagnostics turnaround times and slots
- Regular Huddles
- Discharge processes
- Procedural clinics
- Escalation Plan
- Weekly operational meetings

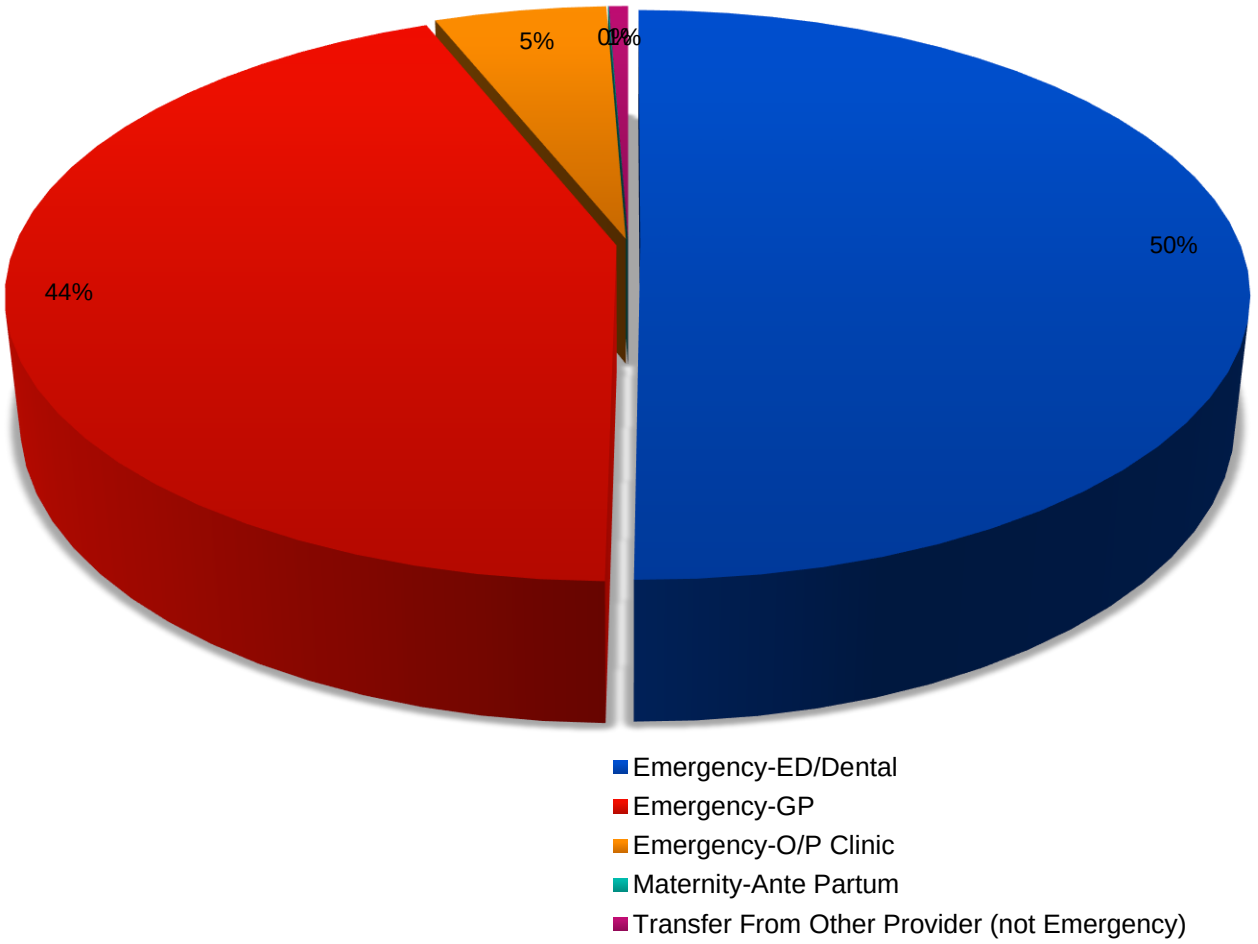
Issues encountered

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

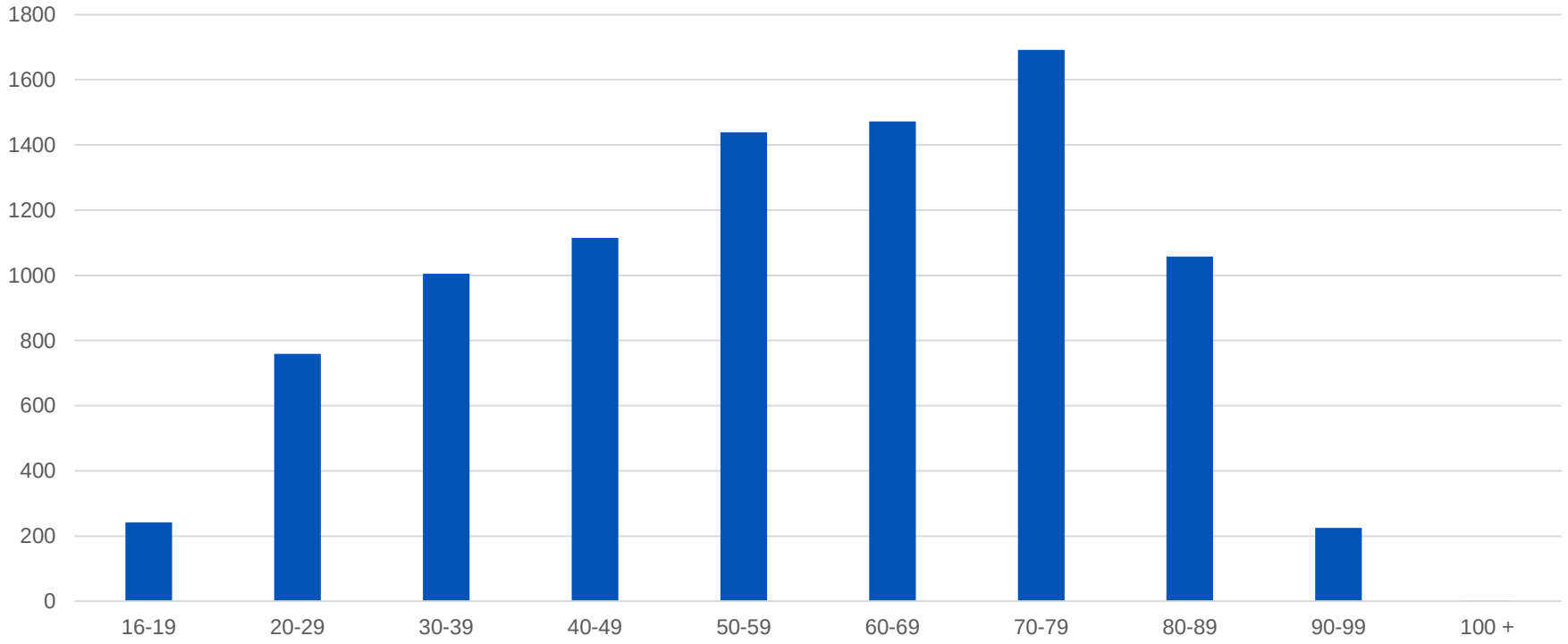
Improving the model

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

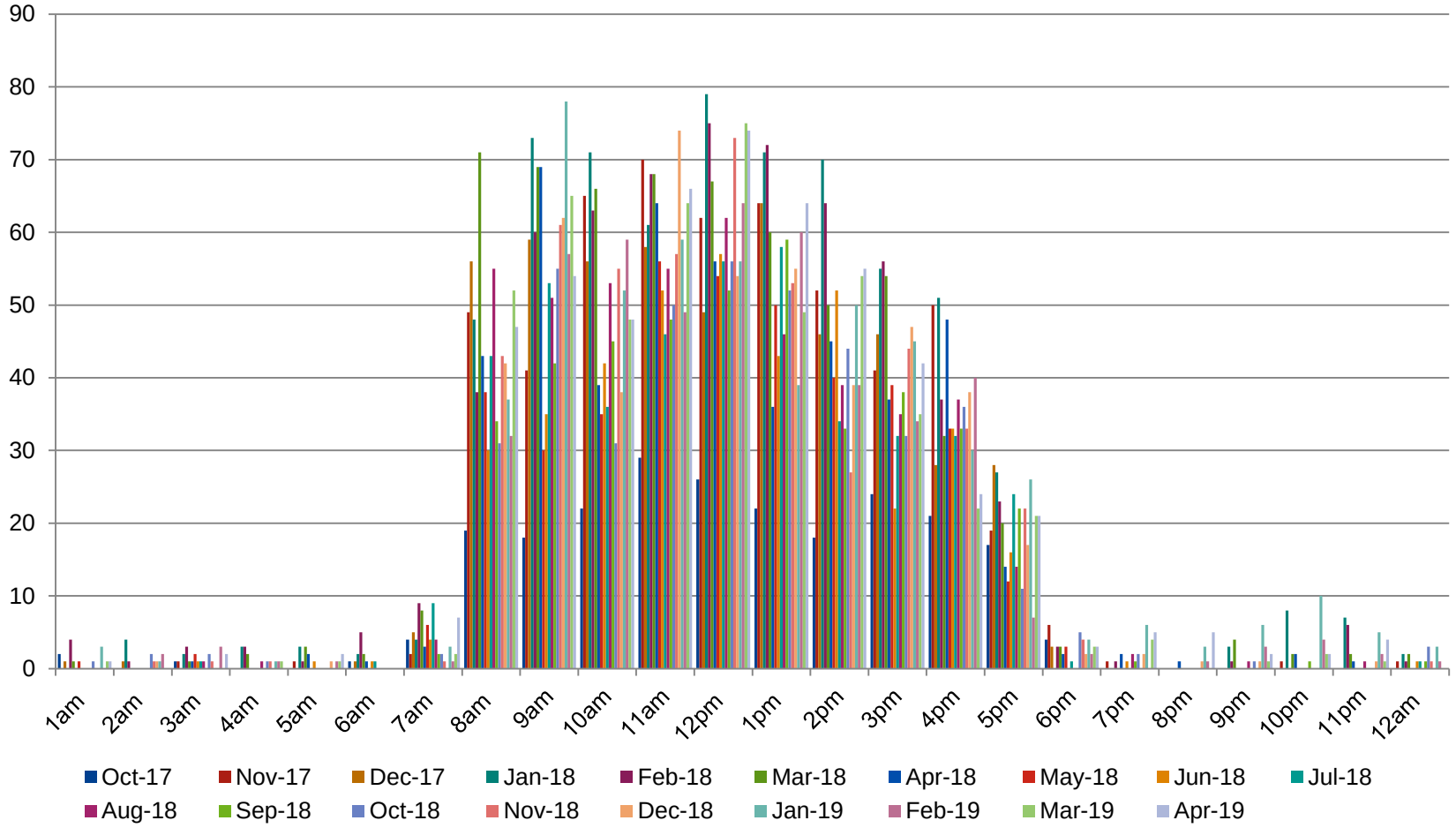
Patient referral by source



Patient seen by Age

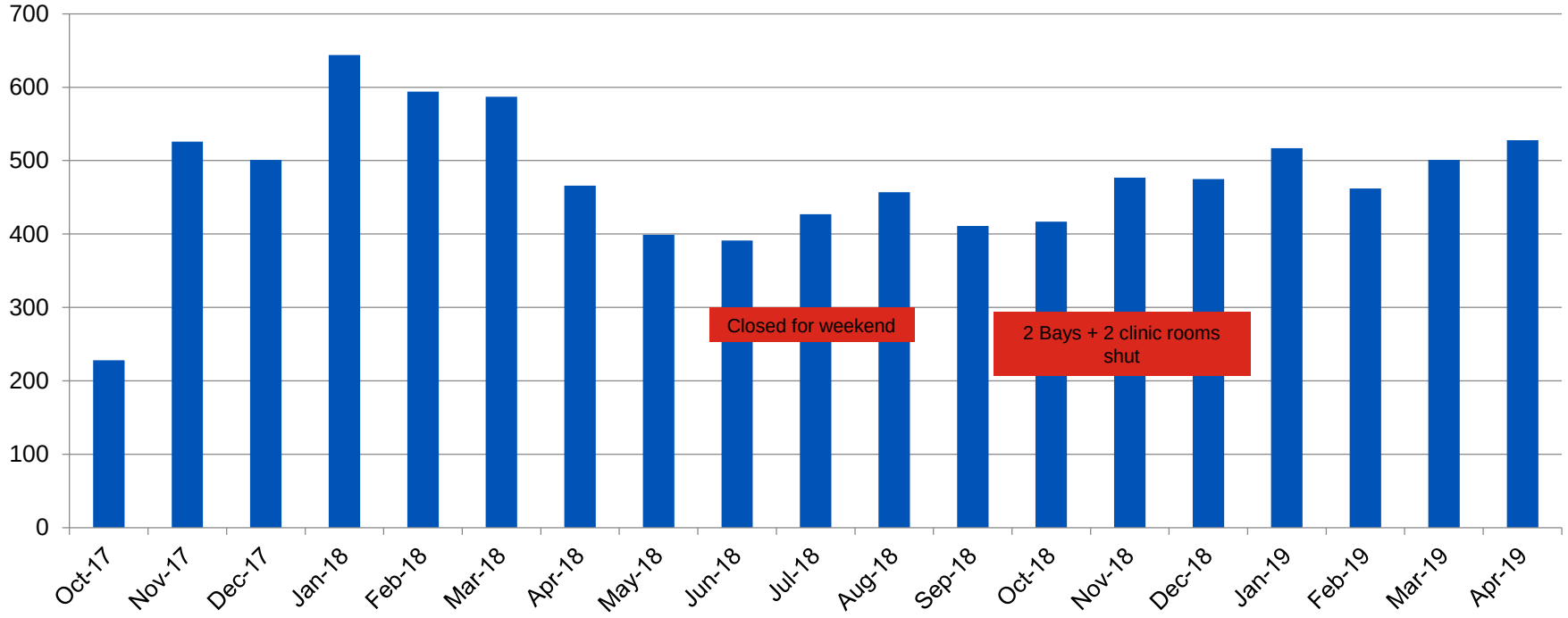


Attendances Arrivals to Kingsfold by hour



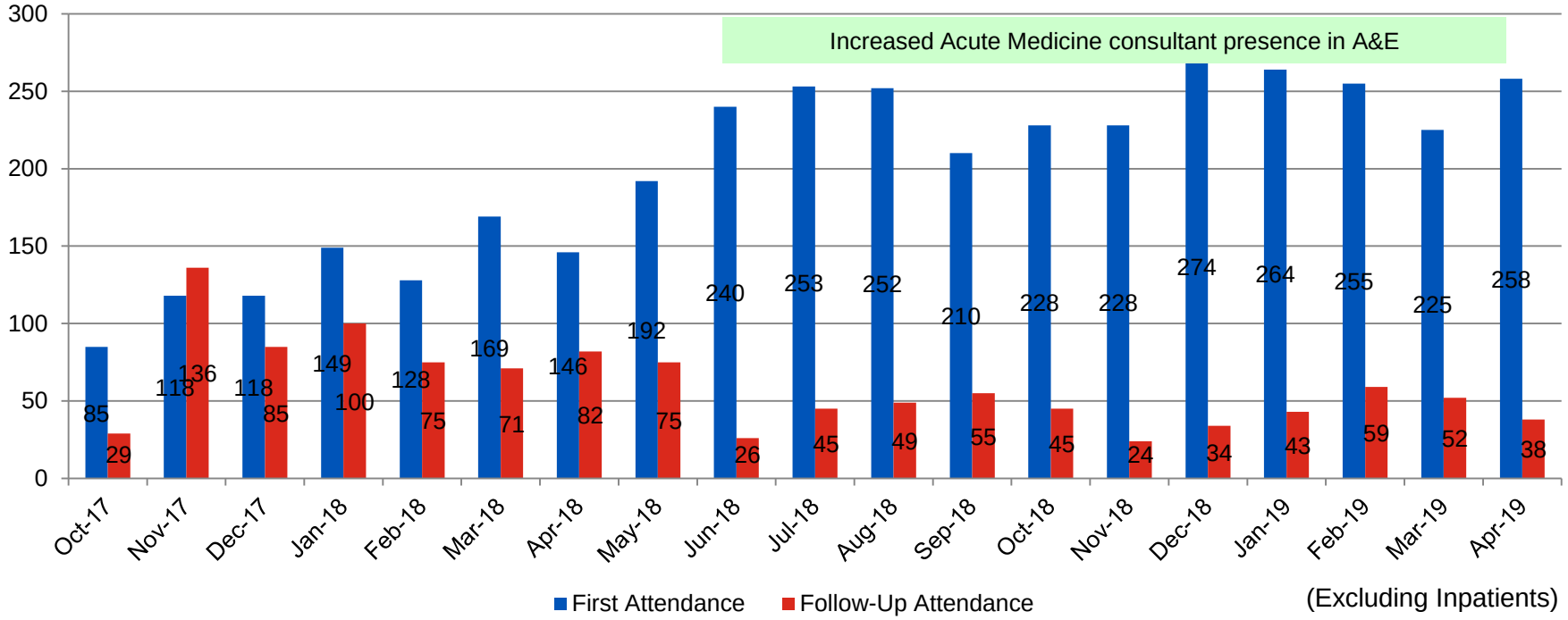
Kingsfold Attendances = 9008

(Excluding Outpatients)



25% of the medical take numbers seen in ambulatory care

Number of attendances to Kingsfold - All Appointments = 4915

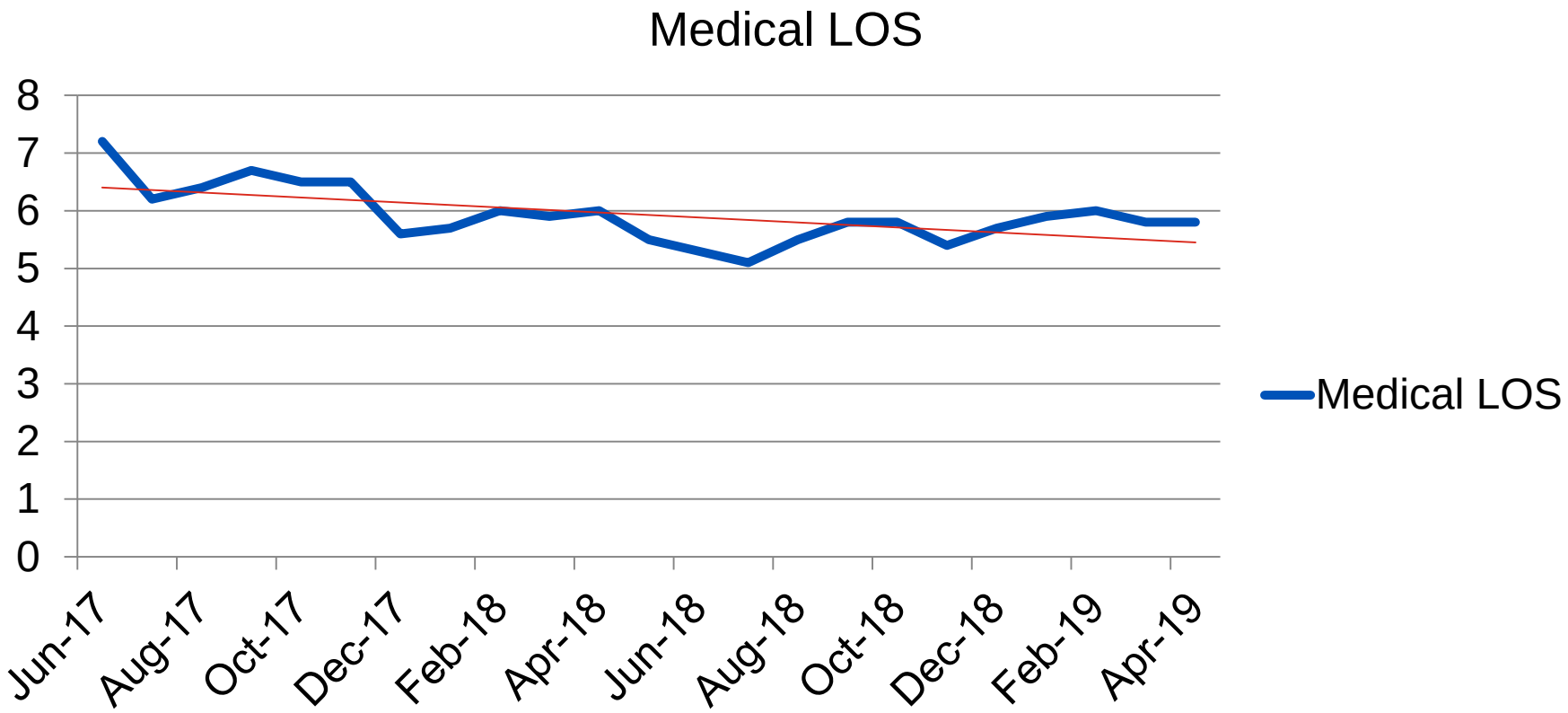


(Excluding Inpatients)

Nurse led infusions + Procedural clinic attendances = 1164

Putting people first

Delivering excellent, accessible healthcare


Medical LOS
8
7
6
5
4
3
2
1
0
Jun-17
Aug-17
Oct-17
Dec-17
Feb-18
Apr-18
Jun-18
Aug-18
Oct-18
Dec-18
Feb-19
Apr-19
Medical LOS

Post implementation review

- LOS of acute medical patients reduced
- Reduction in Medical escalation beds use - 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)
- Overnight patients – 6 Max with escalation nursing staff.
- Flexible working to meet demand – Winter / Summer.
- Location of the unit – impact on flow.
- Other hospital specialties 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…….'

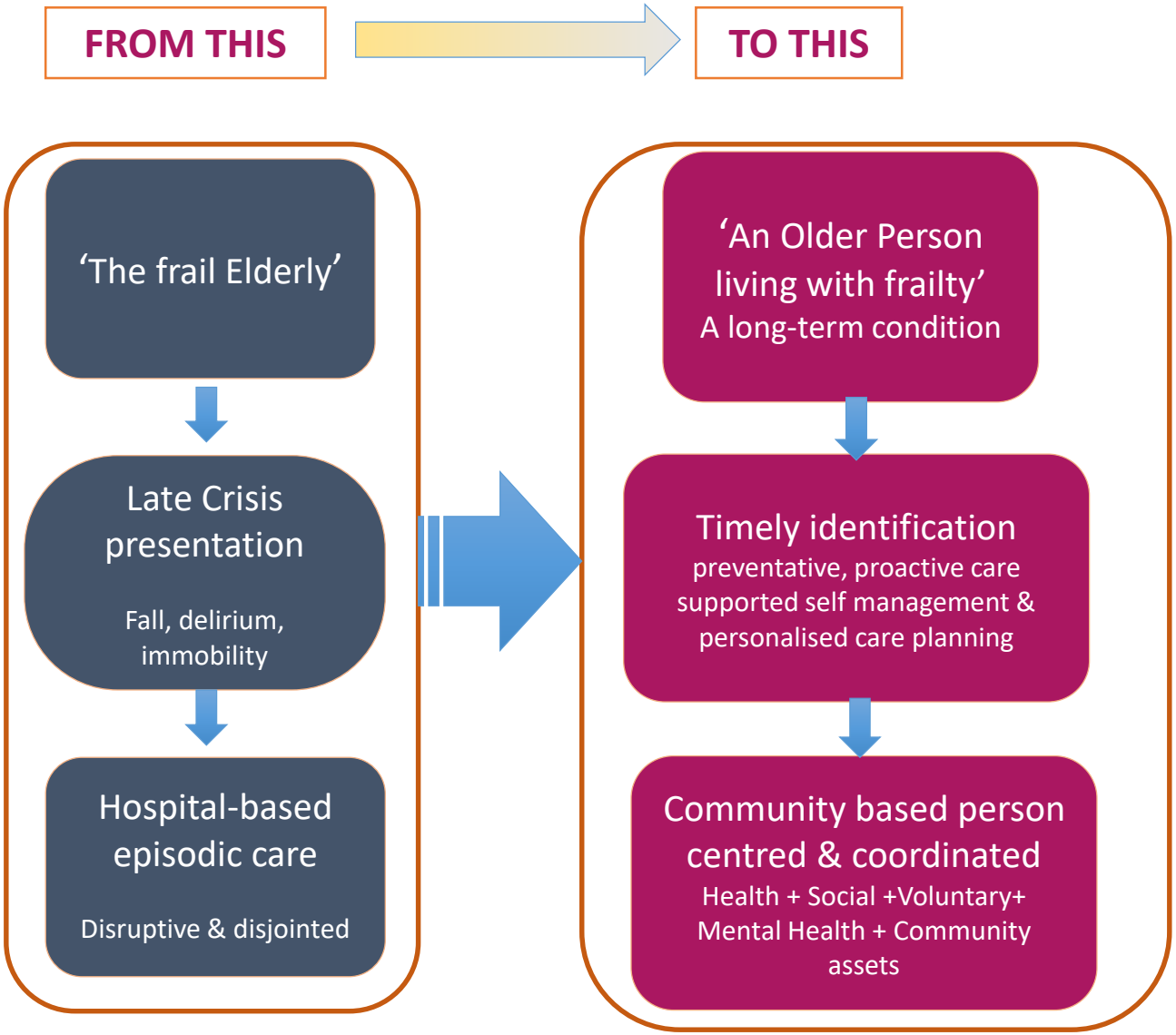
Same Day Emergency Care & Acute Frailty

Regional Event, Leeds: May 24th 2019

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

Putting SDEC in policy context

What's the national approach?



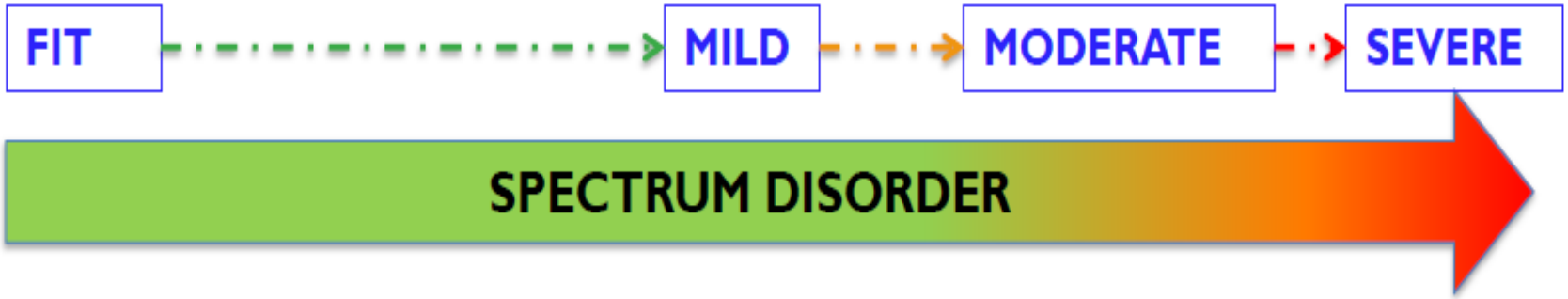
Slide courtesy of Martin Vernon and NHS England

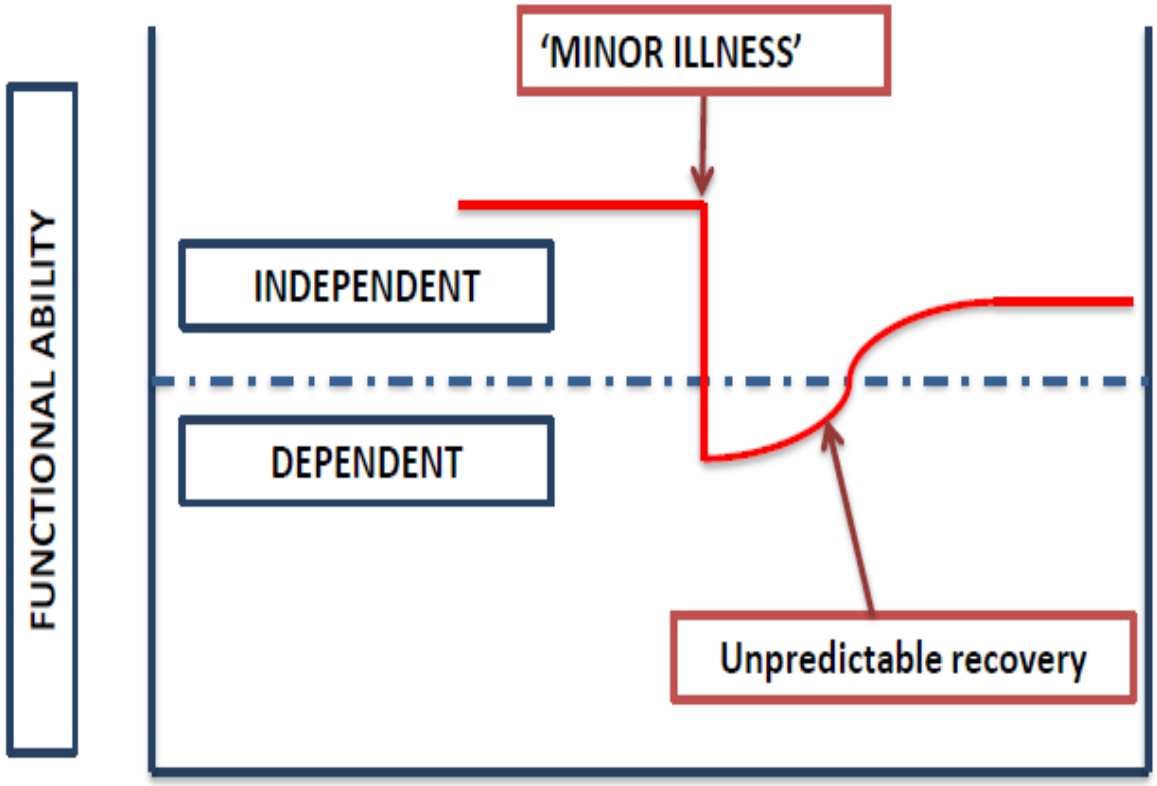
What is frailty?

- *“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	Admission is probably useful and necessary • 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
	Admission is probably NOT useful • Identify palliative needs: ? end of life care
	Admission might be useful but is not necessary • Discharge to competent service for medical and other interventions and support • Liaise with hot clinics /CGA
Frail + not acutely ill	• Discharge +/- urgent functional support • Rehabilitation to increase reserve and resilience to future events

What are we trying to avoid ?

Implications of not identifying frailty

Implications of not identifying frailty

Frail and acutely ill	**Admission is probably useful and necessary** • Harms from delirium, falls and deconditioning
	Admission is probably NOT useful
	Admission might be useful but is not necessary
Frail + not acutely ill	

20% of the75+ patients experience 80% of the harm

10 days in acute hospital leads to the equivalent of 10 years' muscle ageing in 80+

Gill et al (2004). studied the association between bed rest and functional decline over 18 months. They found a relationship between the amount of time spent in bed rest and the magnitude of functional decline in instrumental activities of daily living, mobility, physical activity, and social activity.
Kortebein P, Symons TB, Ferrando A, et al. Functional impact of 10 days of bed rest in healthy older adults. J Gerontol A Biol Sci Med Sci. 2008;63:1076–1081.

Implications of not identifying frailty

Frail and acutely ill	Admission is probably useful and necessary • Harms from delirium, falls and deconditioning • **20% of the75+ patients experience 80% of harms**
	Admission is probably NOT useful • the wrong priorities! harms and no benefits
	Admission might be useful but is not necessary
Frail + not acutely ill	

1000 days…

- 48% of people over 85 die within one year of hospital admission

  Imminence of death among hospital inpatients: Prevalent cohort study. David Clark, Matthew Armstrong, Ananda Allan, Fiona Graham, Andrew Carnon and Christopher Isles, published online 17 March 2014 *Palliat Med*

Focus on

- **what matters to the patient –**
- **not what is the matter with the patient**

Implications of not identifying frailty

Frail and acutely ill	Admission is probably useful and necessary • Harms from delirium, falls and deconditioning • **20% of the75+ patients experience 80% of harms**
	Admission is probably NOT useful • the wrong priorities!
	Admission might be useful but is not necessary • Risk of hospital induced harm • Flow problems persist • Money wasted
Frail + not acutely ill	

Implications of not identifying frailty

Frail and acutely ill	Admission is probably useful and necessary • Harms from delirium, falls and deconditioning • **20% of the75+ patients experience 80% of harms**
	Admission is probably NOT useful • harms and no benefits
	Admission might be useful but is not necessary • Risk of hospital induced harm • Flow problems persist • Money wasted
Frail + not acutely ill	• **If admitted: Ditto** • **If NOT: Risks of readmission not addressed**

SDEC can help us achieve

Frail and acutely ill	Admission is probably useful and necessary • 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
	Admission is probably NOT useful • Identify palliative needs: ? end of life care
	Admission might be useful but is not necessary • Discharge to [illegible] for medical and other interve[illegible]rt • Liaise with hot clinics /CGA
Frail + not acutely ill	• Discharge +/- urgent functional support • Rehabilitation to increase reserve and resilience to future events

SDEC

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)

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.

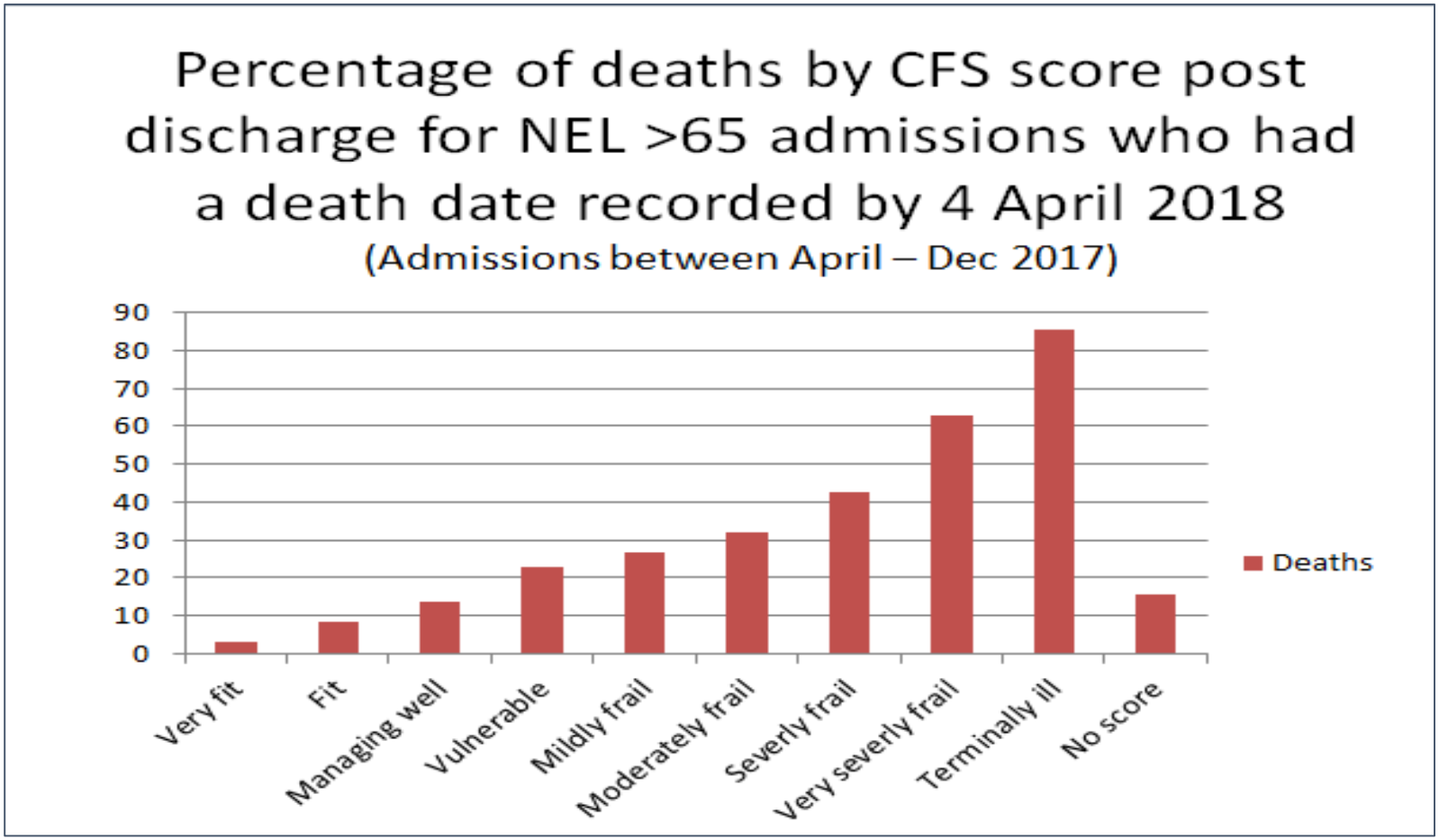
In **severe dementia**, they cannot do personal care without help.

* 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.

DALHOUSIE UNIVERSITY
Inspiring Minds

How does this help?

- Provides a guide to the *likely* clinical course now and over the following year or so



Courtesy of David Hunt from West Sussex Hospitals

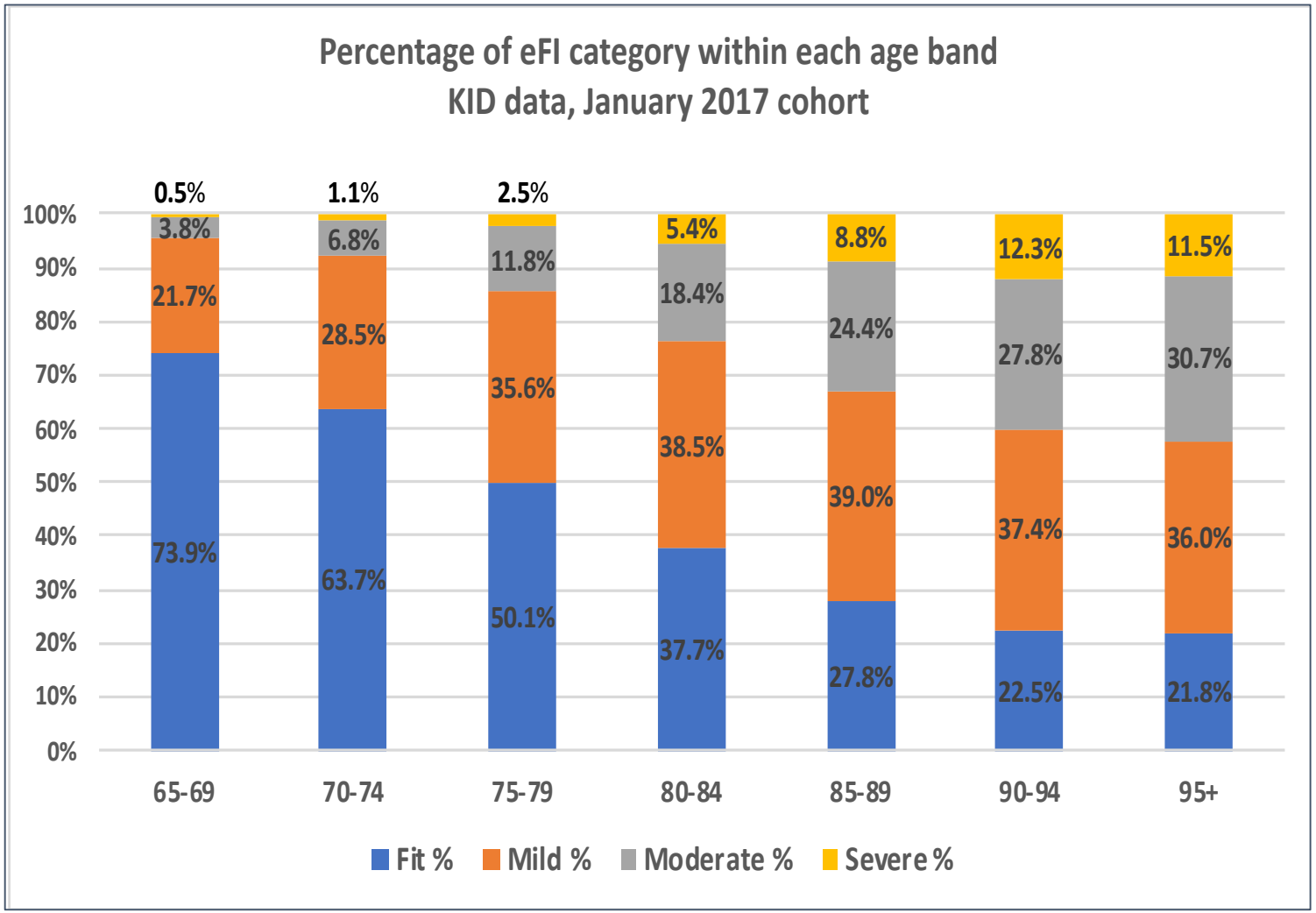
How does this help?

- 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 clinical approach, where and what *skills* may be needed (MDT)

How common is frailty?

Distribution of Frailty in old age (eFI)



NHS England analysis- KID 2017-18

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

Ellis G et al 2017

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

Examples (see the AFN website)

Examples of acute frailty services

- 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

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)

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

Developing a dashboard for AEC

Annabel Shaw
Measurement Lead – AEC Network
NHS Elect

AnnabelatAEC@nhselect.org.uk

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

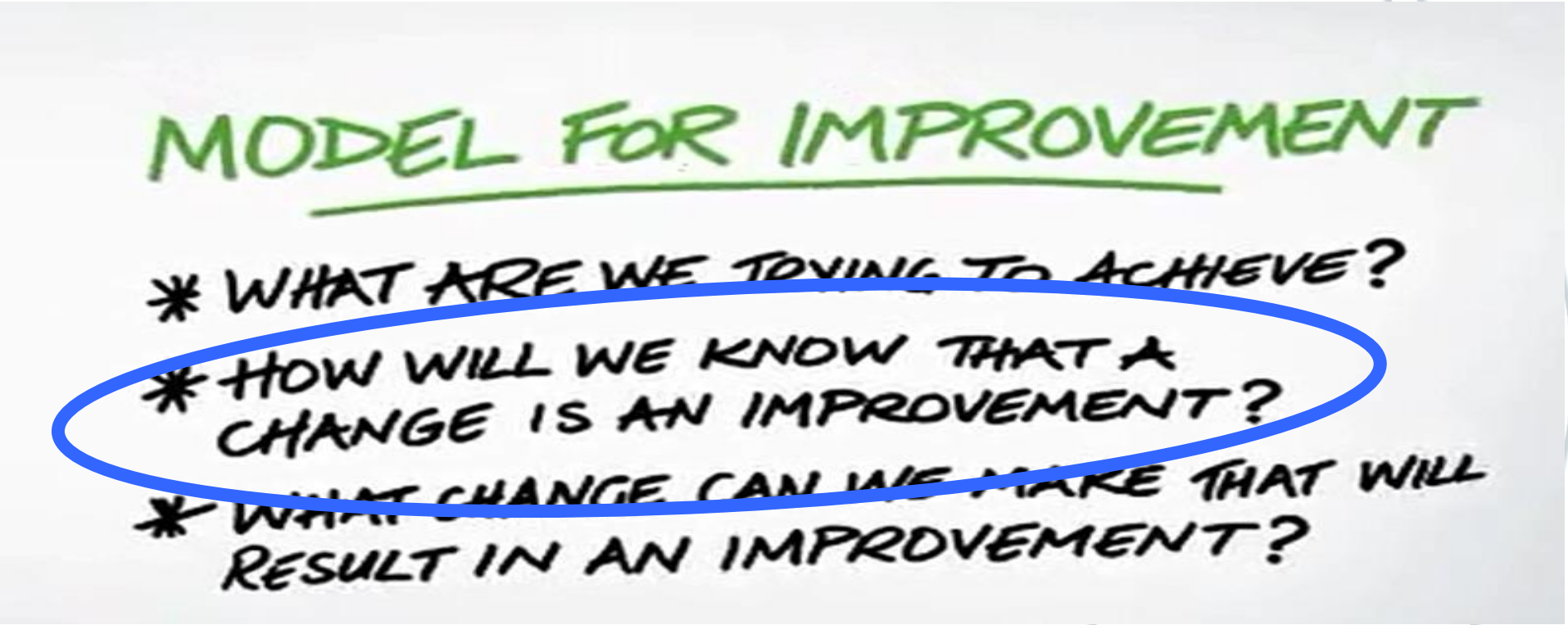
Almost every image of a dashboard was "just too much"!

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!

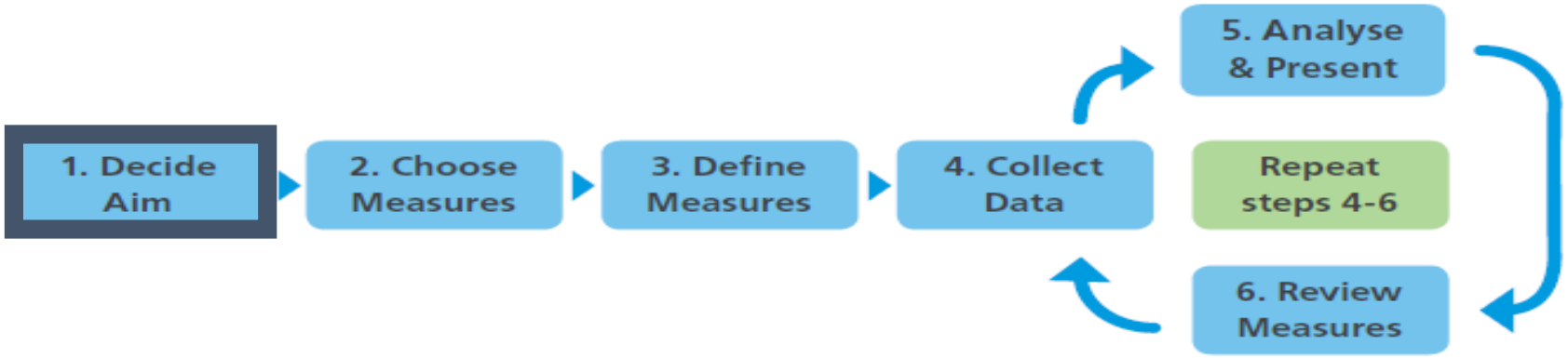
Measurement for improvement



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

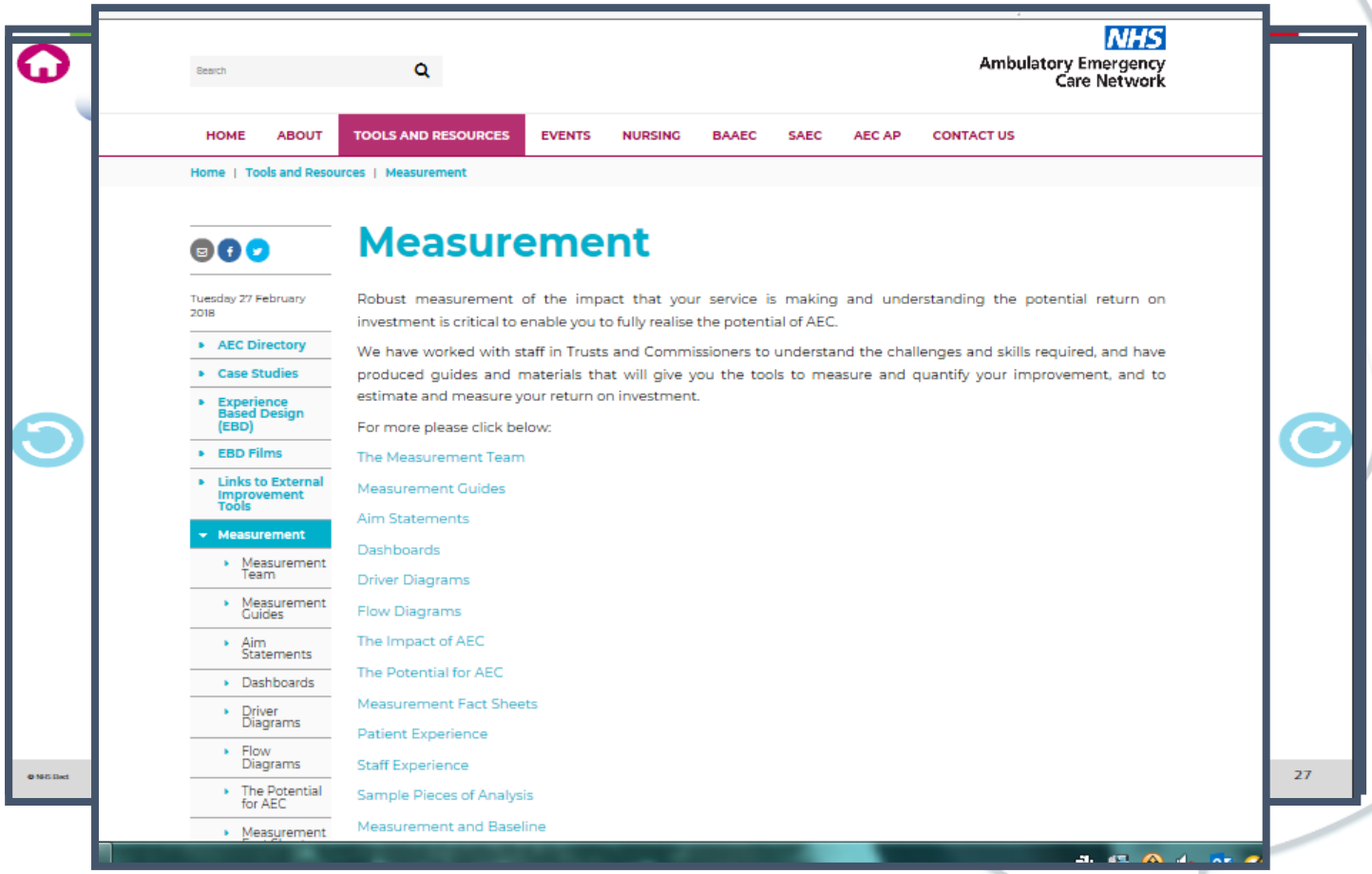


What are we aiming to achieve?

To reduce the number of emergency patients who are admitted to hospital for one night

To reduce the time from presentation at the hospital to surgical procedure for emergency surgical patients with an abscess

Signposting you to some help



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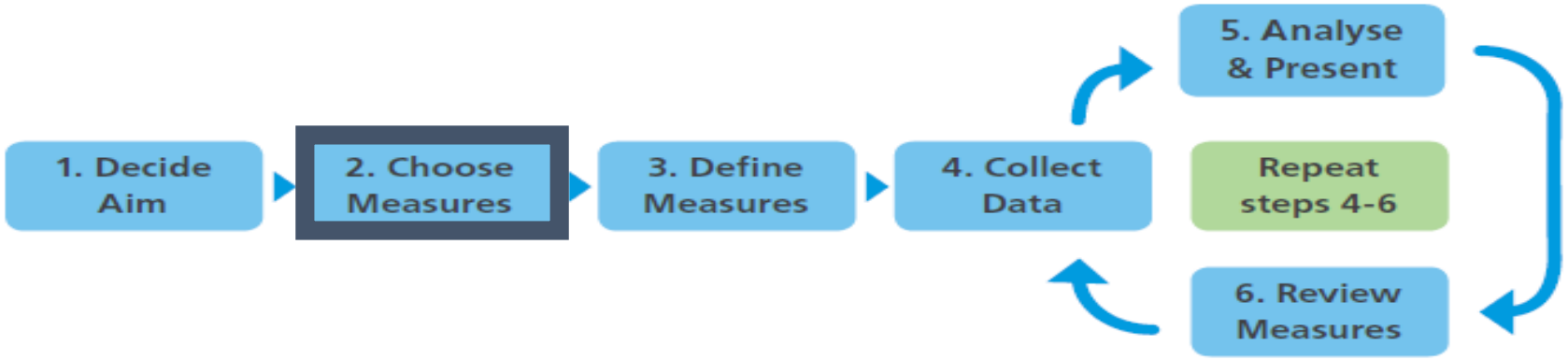


Measuring change in a system context

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

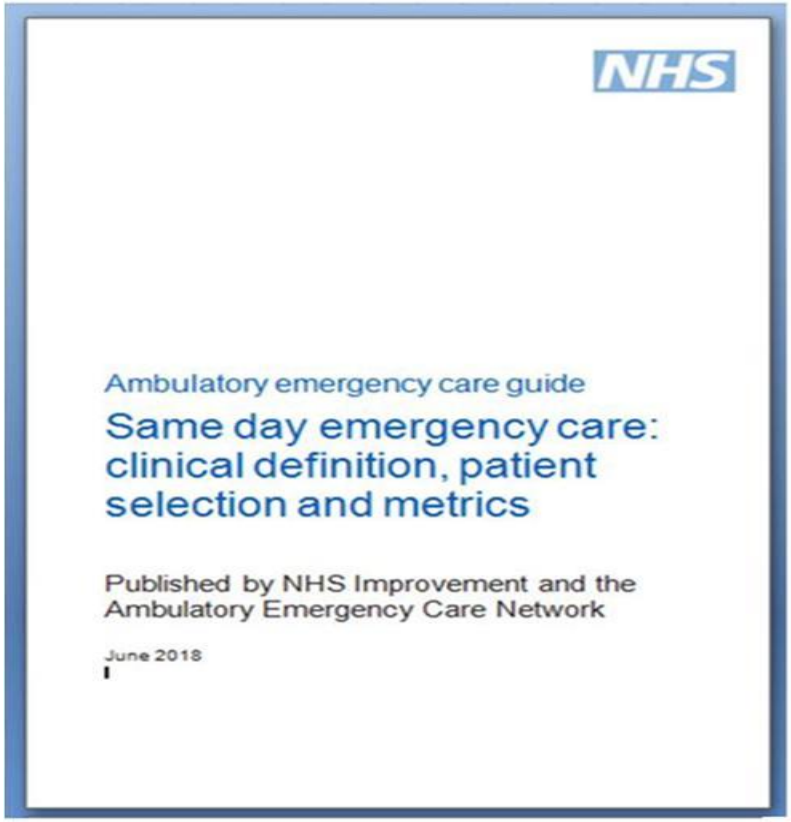
Outcome measure

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



Process measure

The number of new non-elective presentations of patients who are managed in a SDEC unit within the previous 7 days

Balancing measure

The number of new non-elective presentations of patients who are admitted to an AEC/SDEC unit within the previous 7 days

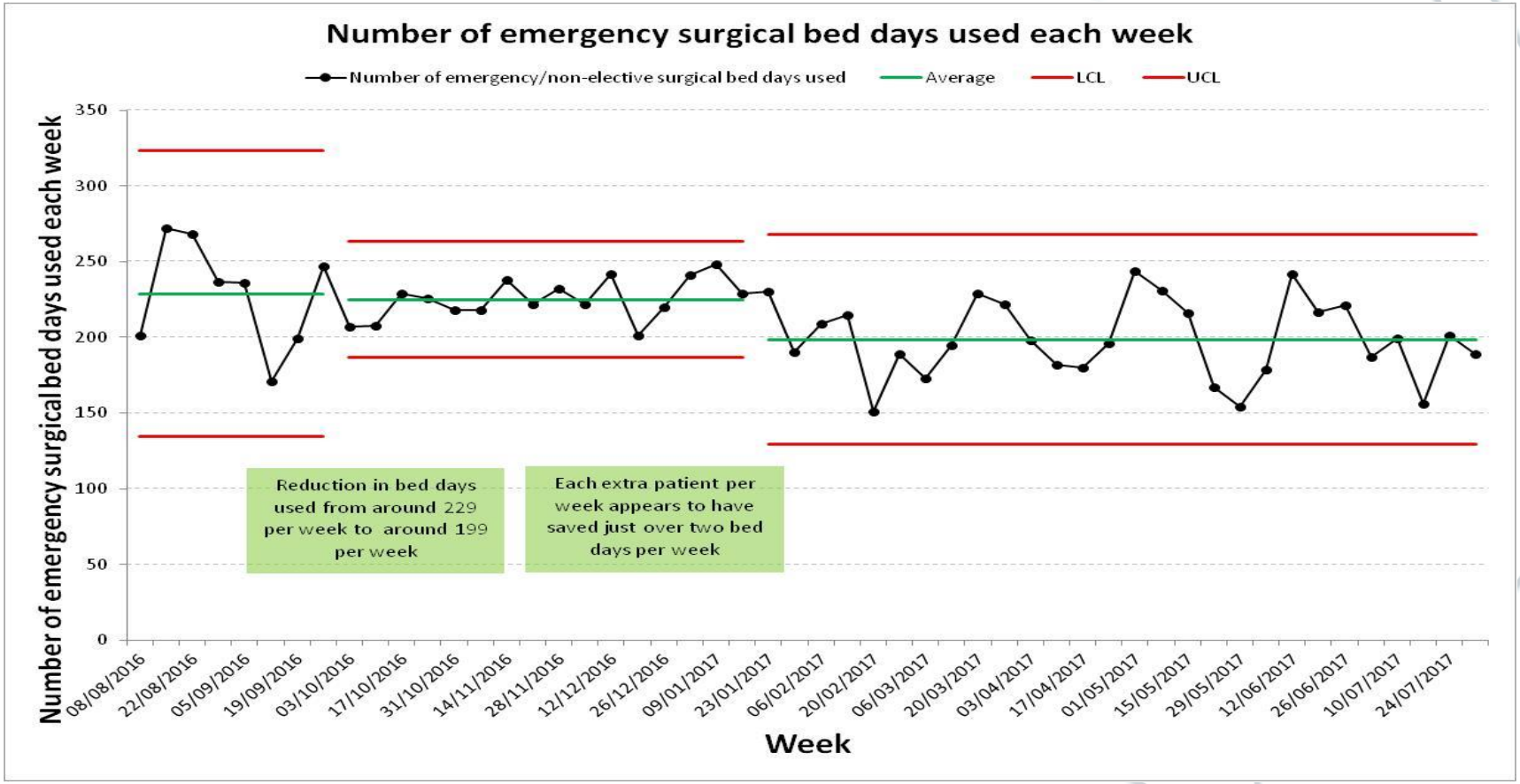
What presentation style to use

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

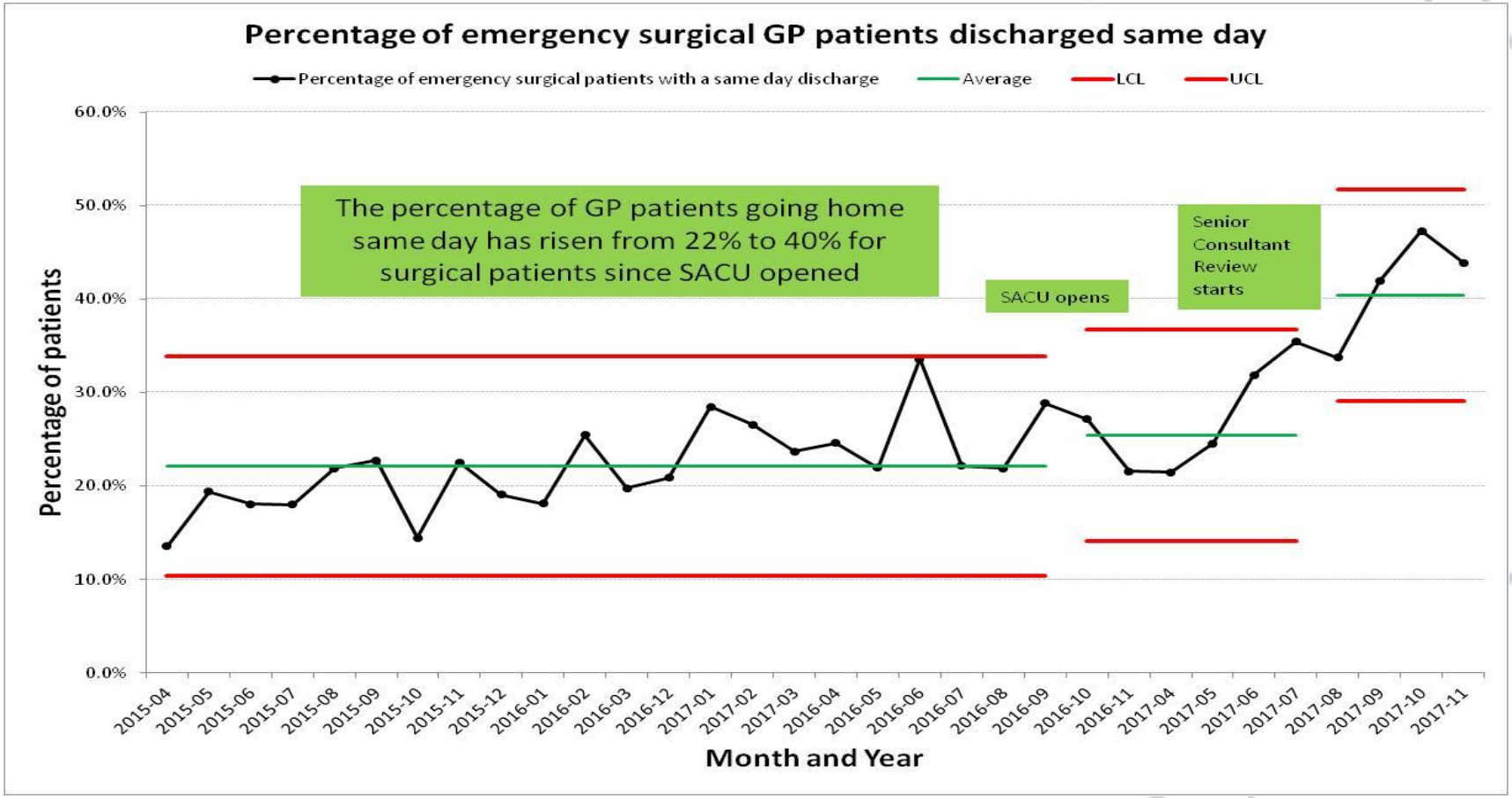
with appropriate explanation for special cause events

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

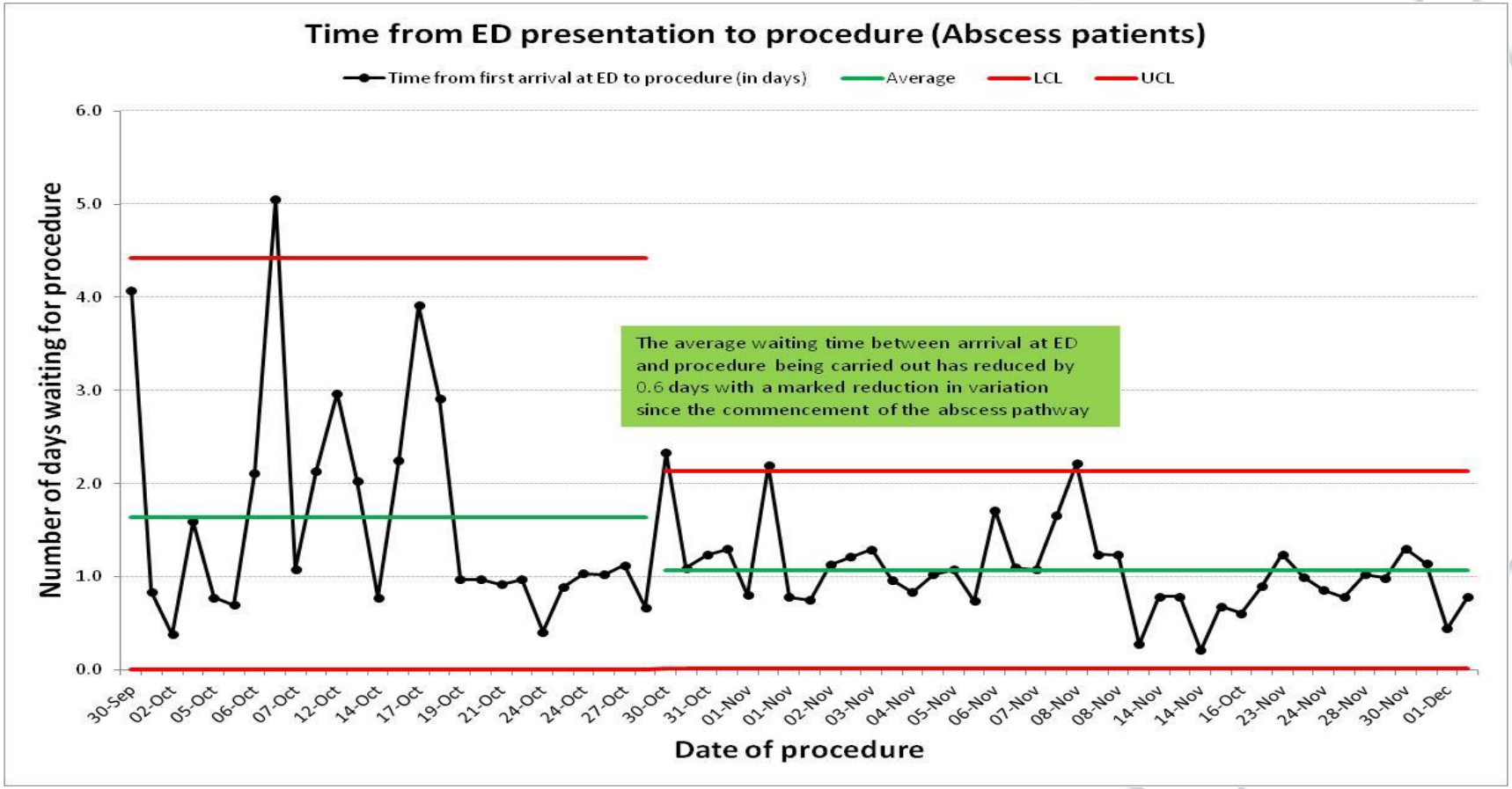
Wythenshawe Hospital
Surgical AEC Network Cohort 1



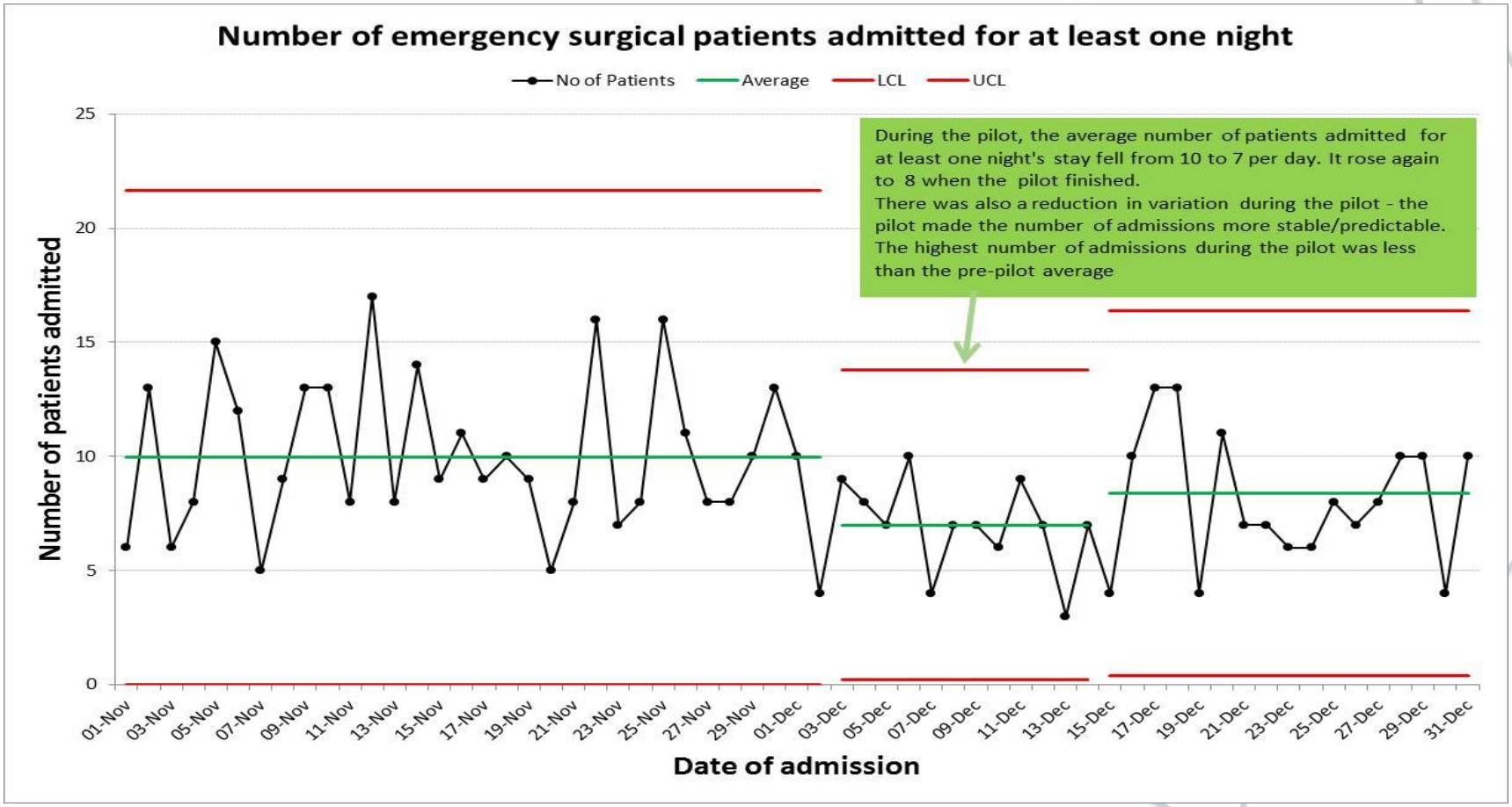
Leighton Hospital
Surgical AEC Network Cohort 1



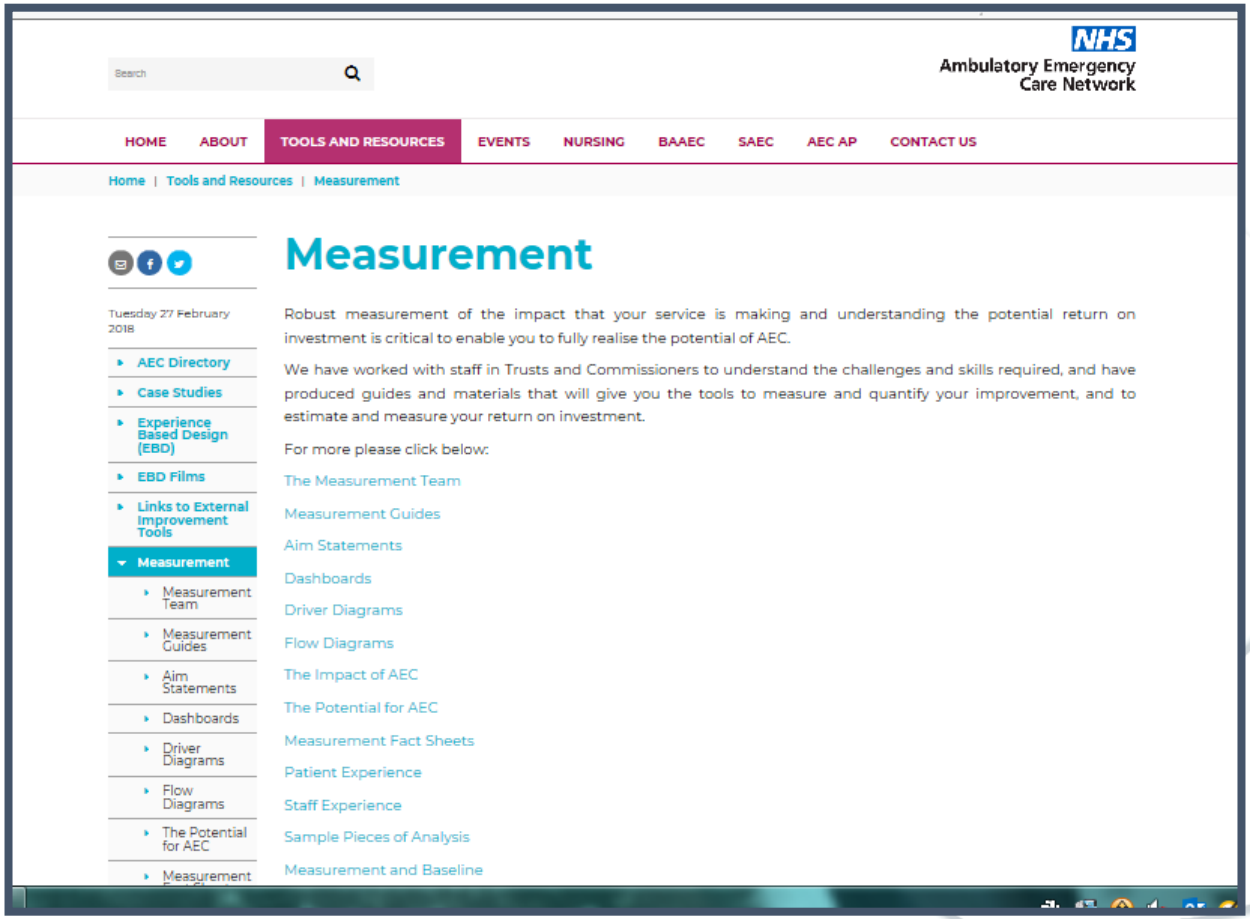
Royal London
Surgical AEC Network Cohort 1



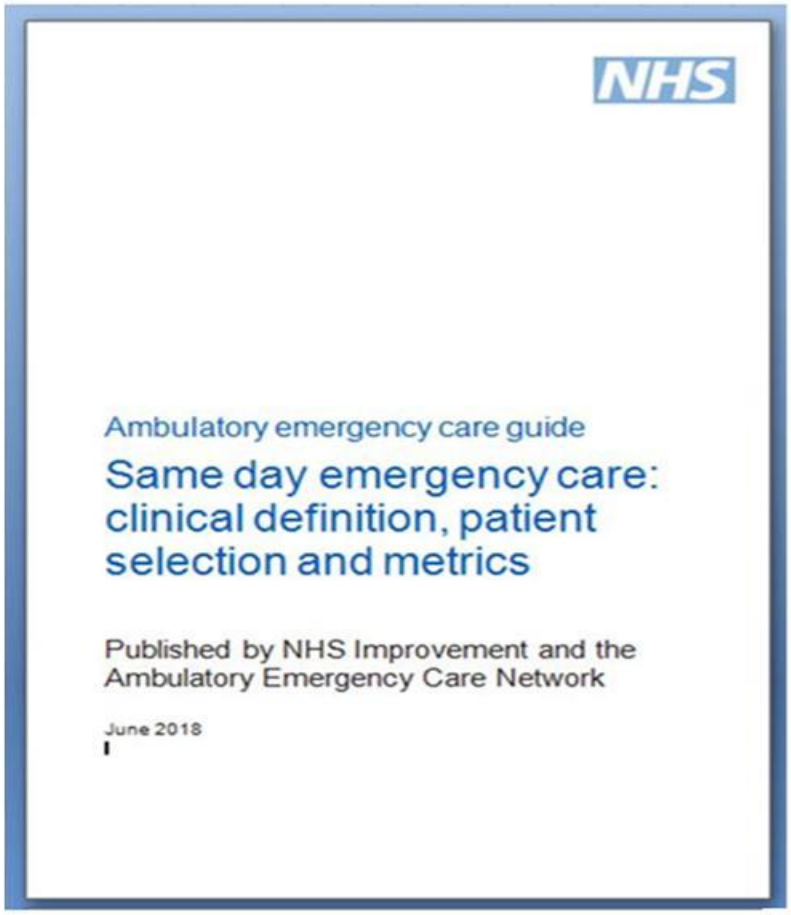
West Suffolk Hospital
Surgical AEC Network Cohort 2

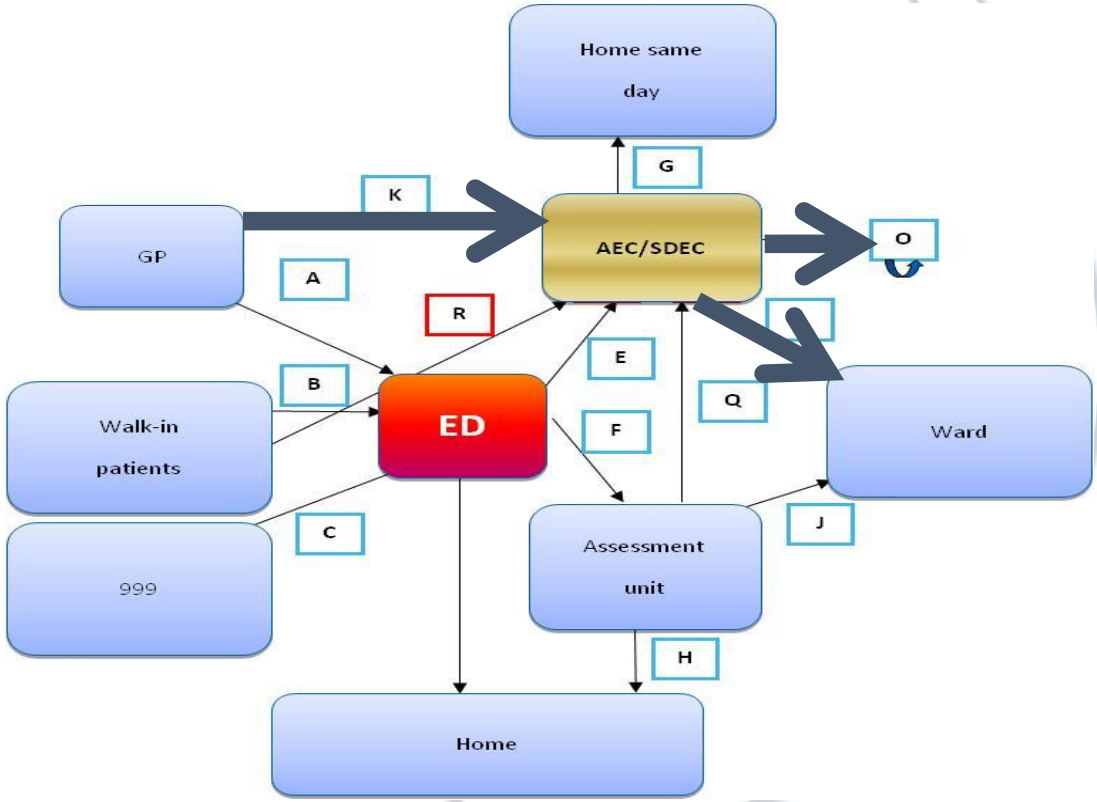


More help is available



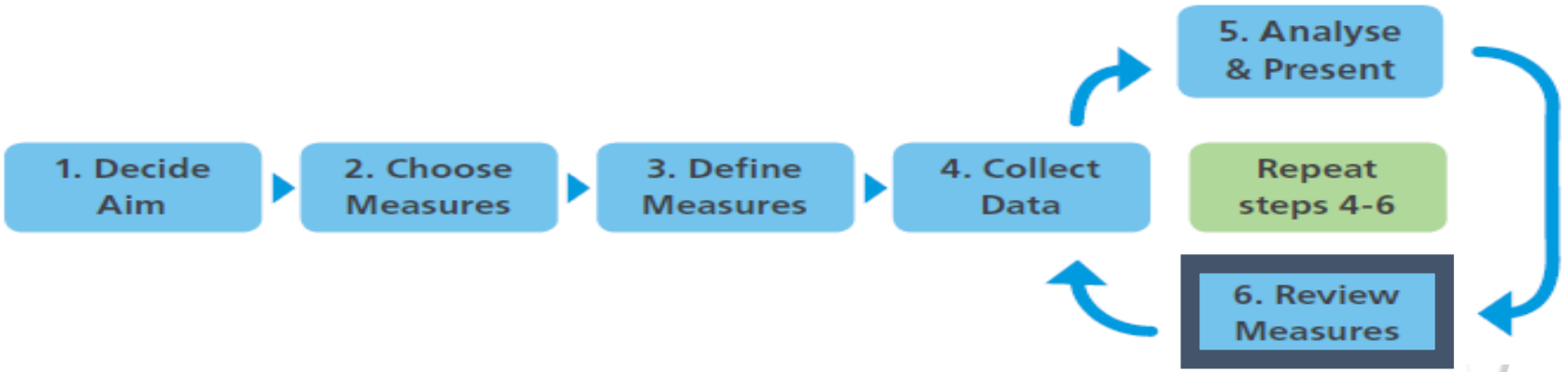
Measuring your process





High level Driver Diagram from AEC Network

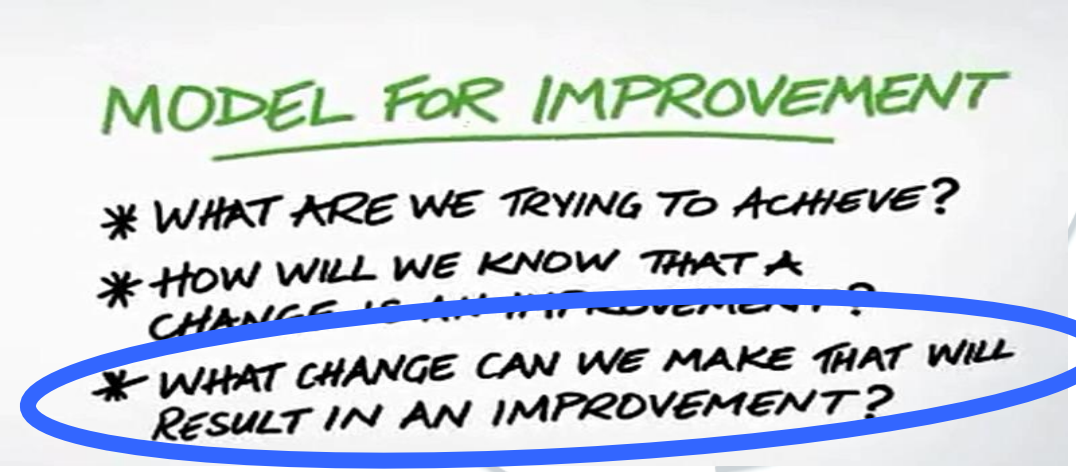
Reviewing and using your measures



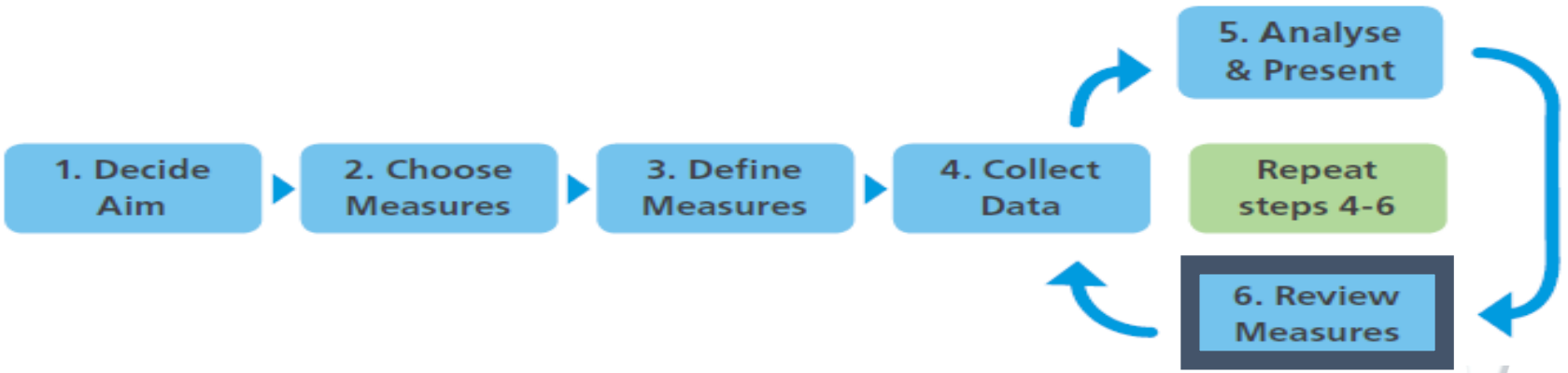
It is a waste of time collecting and analysing your data if you don't take action on the results

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

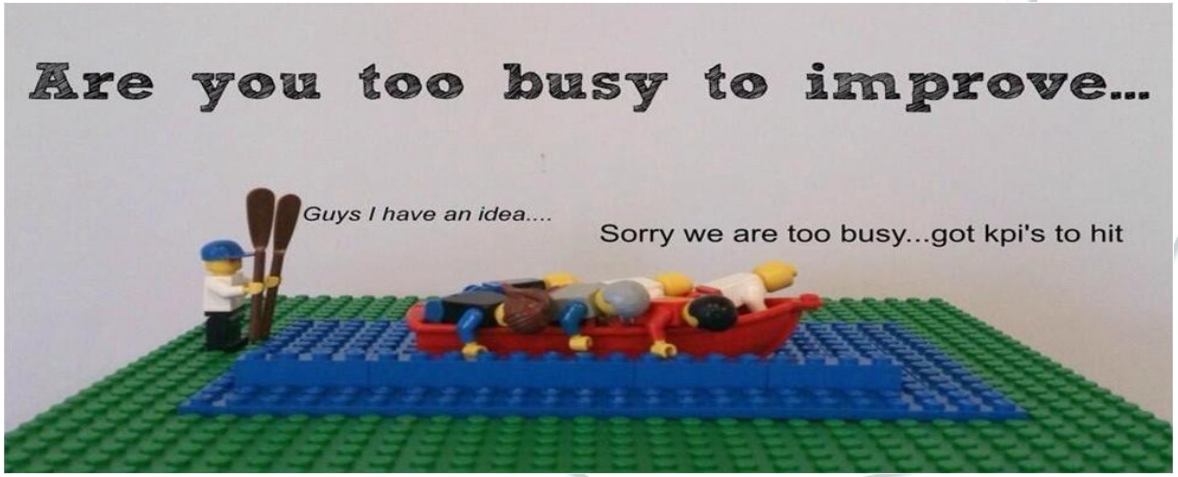
is something you need to think through



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

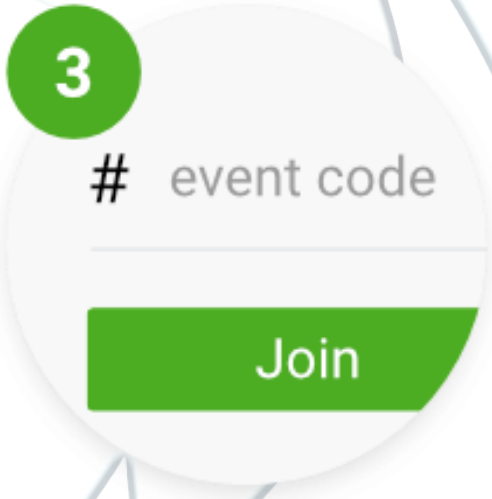
Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network

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**

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