

Same Day Emergency Care

Regional Workshop

29th April 2019



Useful Links

The SDEC programme website is:

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

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

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

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

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

Agenda

10:00 Welcome and Overview

What is SDEC?

Coffee Break

Acute Frailty and SDEC

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

Lunch

Working with the SAM to Develop the SDEC Model

Showcase sites

AEC in Emergency Care

SDEC Dataset

Developing a Dashboard for AEC

Action Planning

16:30 Next Steps and Close



Slido - Event Evaluation

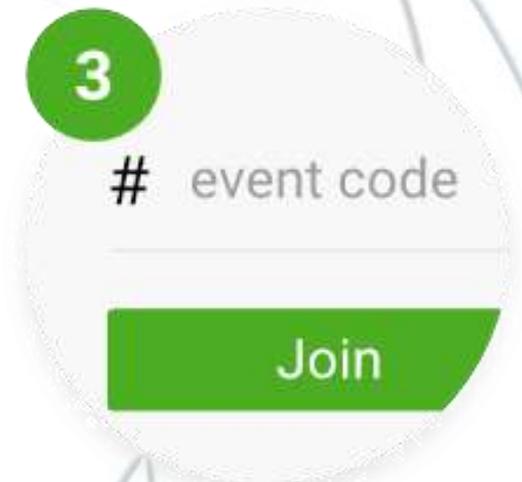
Access our event evaluation in 3 easy steps



1. Go to any web browser from any device



2. Go to slido.com



3. Type in the event code **#SDEC290419**

Same Day Emergency Care

Dr Cliff Mann

National Clinical Advisor

Co-Chair SDEC Programme Board

Thanks for attending

Not here to lecture

Not here to patronize

Not here to claim this is a transformational imperative

We are here because

This works

Most trusts already do some of this

If we did more – more patients would benefit

It would be cost (? Price) efficient



Another transformational project, perhaps?

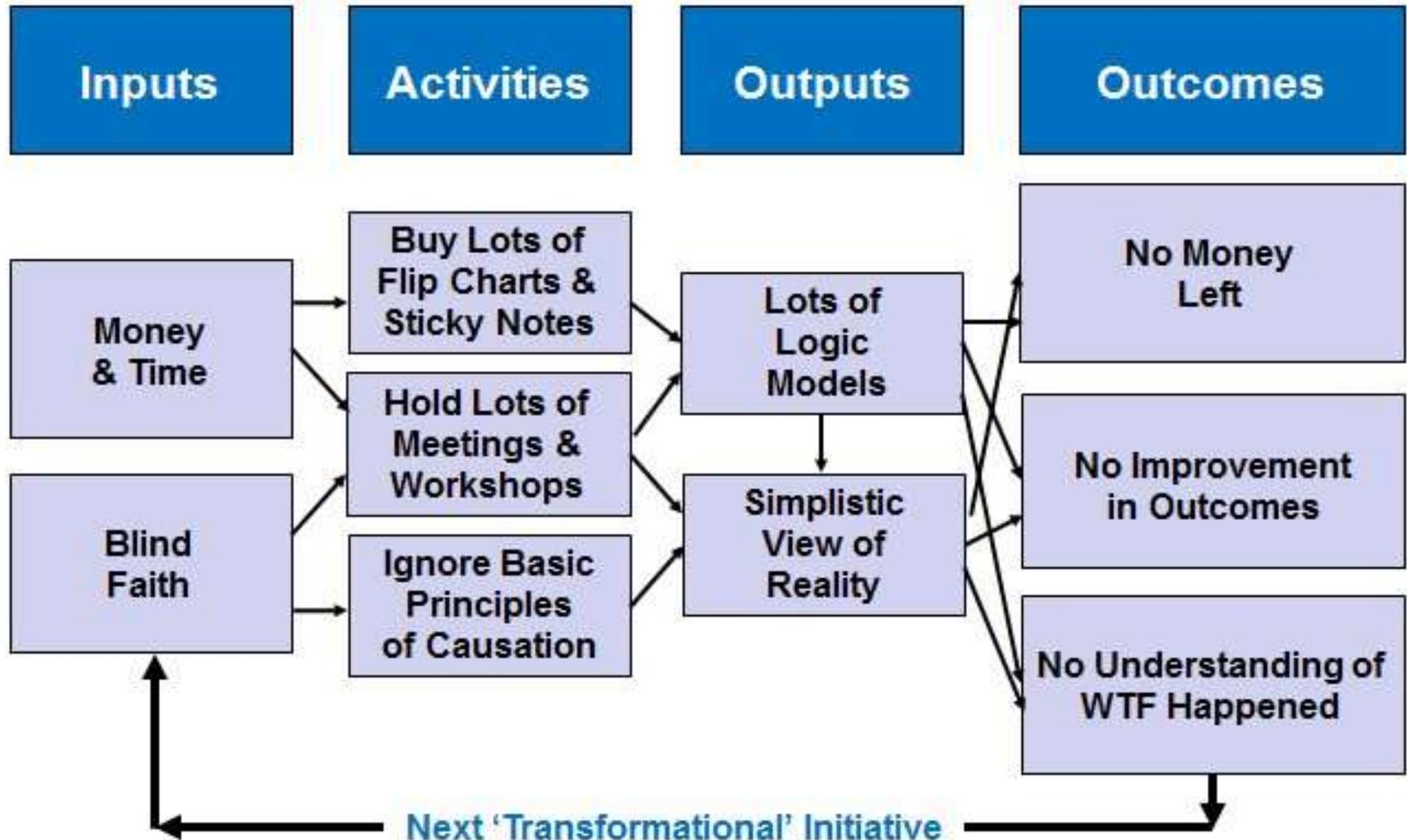
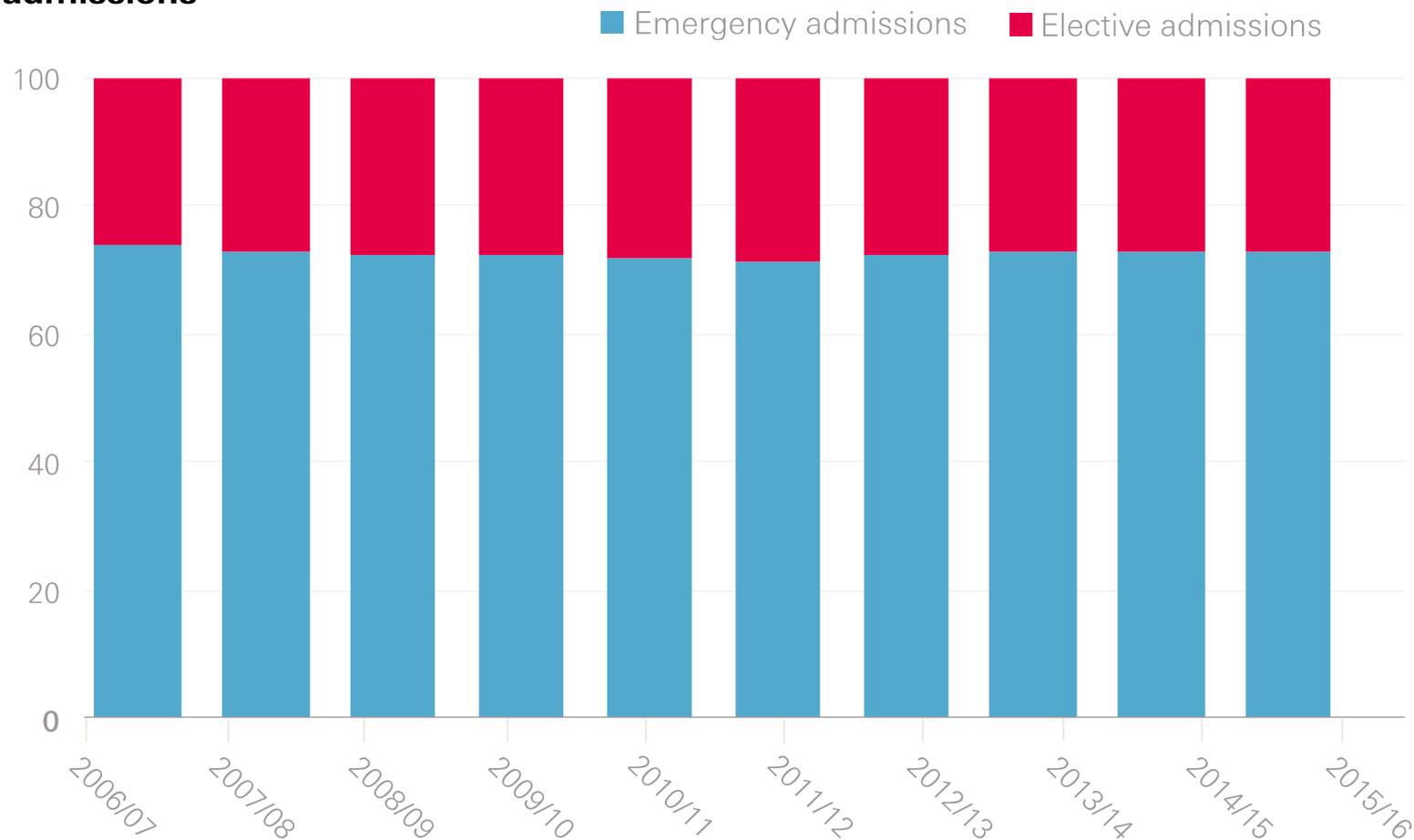


Figure 5:[†] Proportion of total bed days for emergency admissions and elective admissions



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

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

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

SDEC patients
= 22% of all
acute
admissions

(16% ED,
6% direct)

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

= 782,600
fewer MN
stays

= 4% reduction
in bed
occupancy

£1.1
billion

This Year

Regional
Launch
Workshops

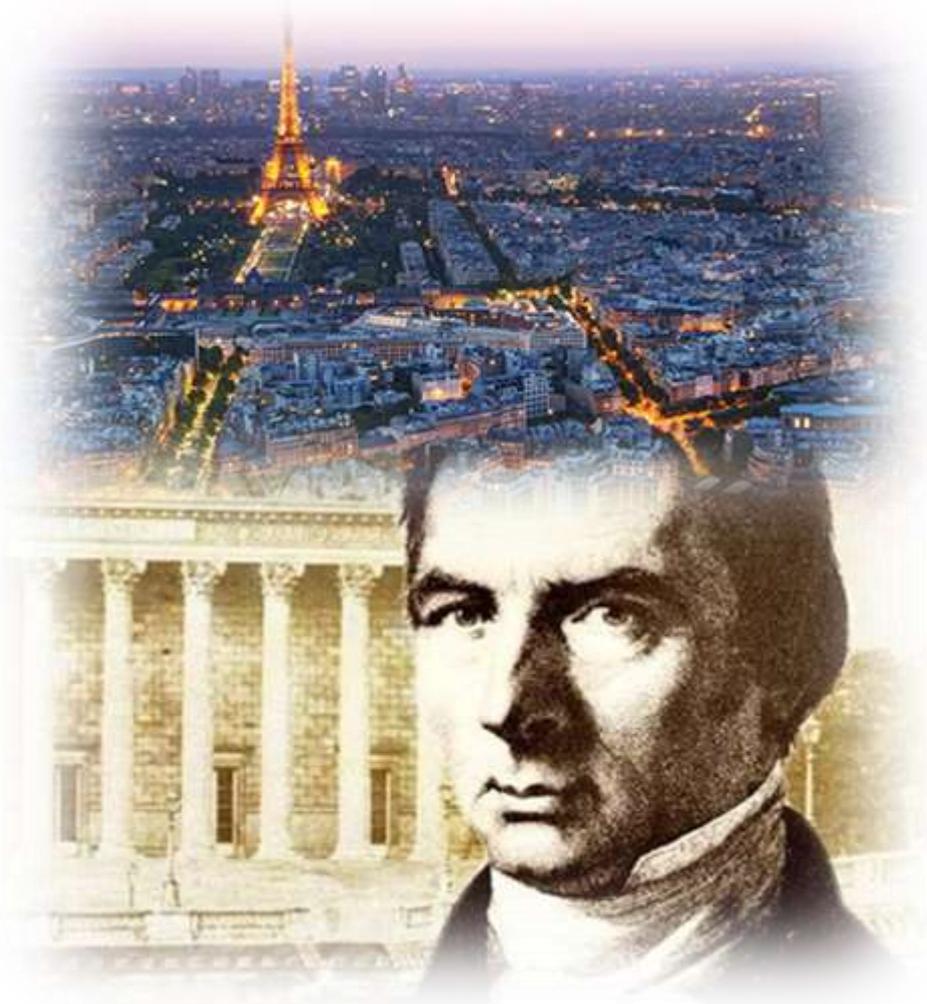
CQUINS

AECN led
accelerator
programmes

Milestones for urgent and emergency care

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

Paris will be fed



Ambulatory
Emergency Care



The bigger picture



© NHS Elect

NHS
Elect





National

Regional

Local

National tasks

Signal

Count

Pay





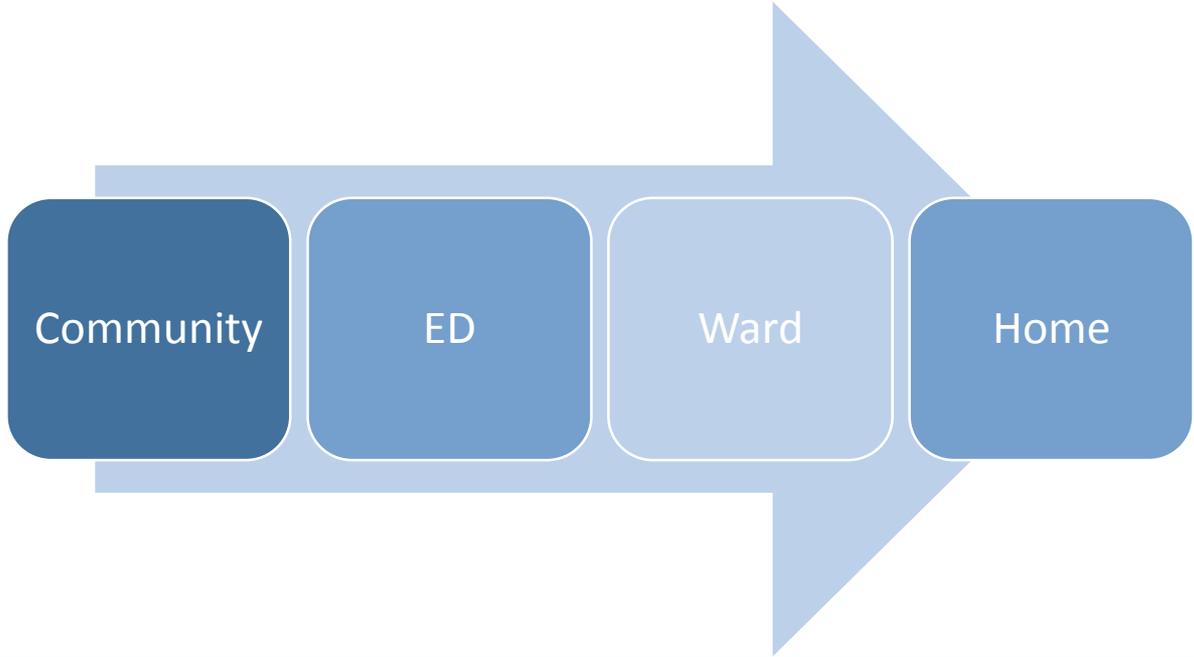
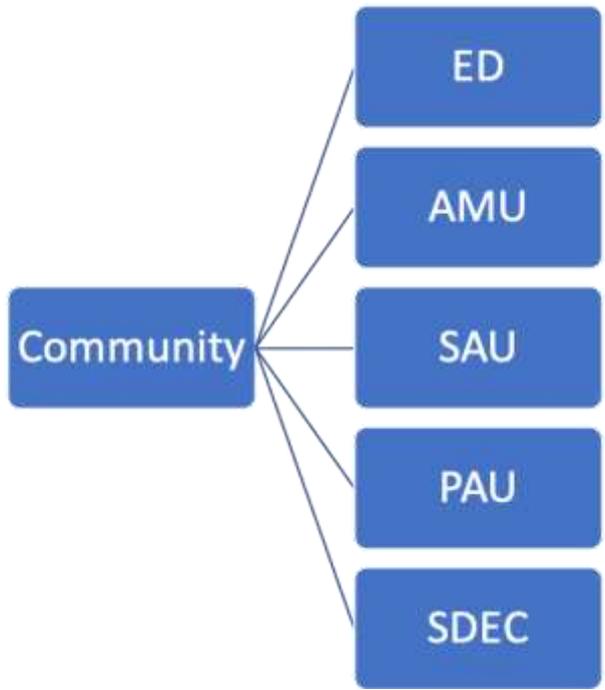
SDEC

≠ ZLoS

≠ A Place/
Site Code/
Ward

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





one



two

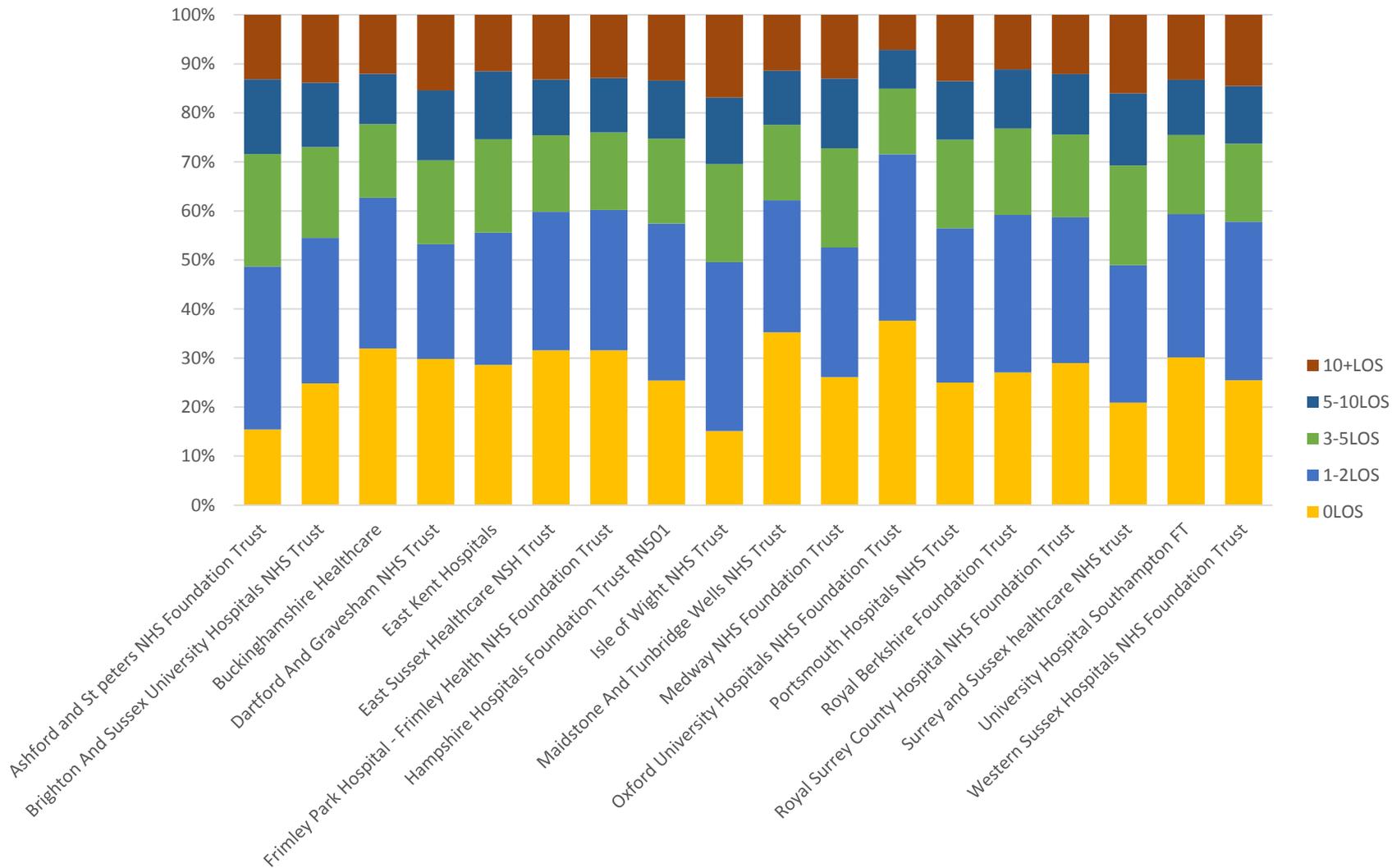


three



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

South East LOS



SDEC

Star-chamber
approach

ICD/SnoMed/
ECDS codes agreed

Agreement with NHS
Digital to record as ECDS
type 5

10 pilot sites currently
testing the proposed
SDECDS

The Royal Free

Northwick Park
Wexham Park

Warrington and Halton
Epsom & Helier

Leeds Teaching Hospital
Northampton

Norfolk & Norwich
City Hospitals Sunderland
Western Sussex Hospitals



Incentives

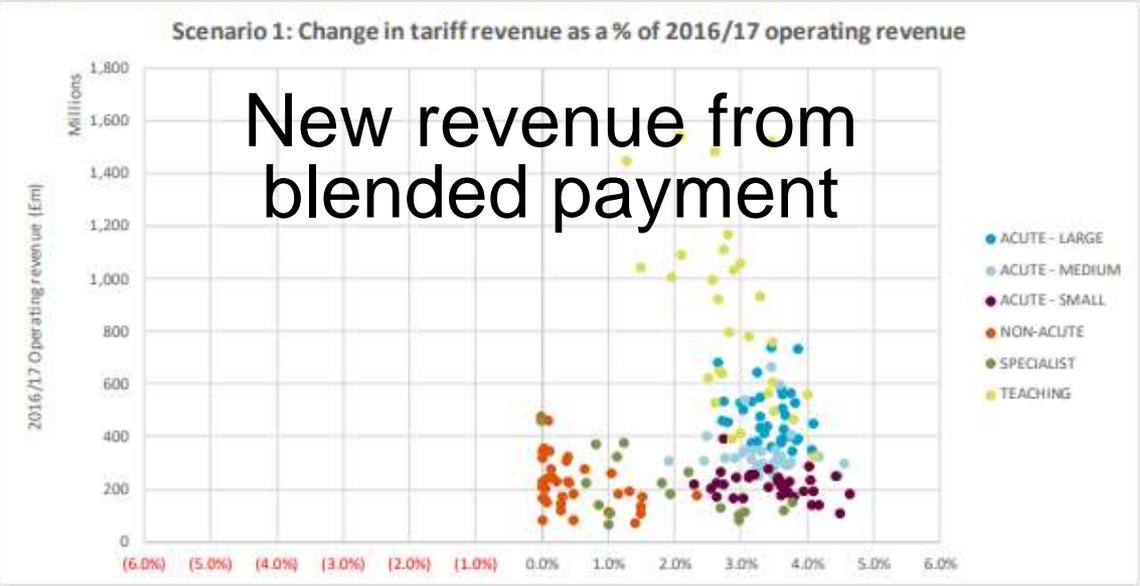
3 CQUINS \cong £500k
per trust pa

Pneumonia

Pulmonary Embolus

Atrial Fibrillation

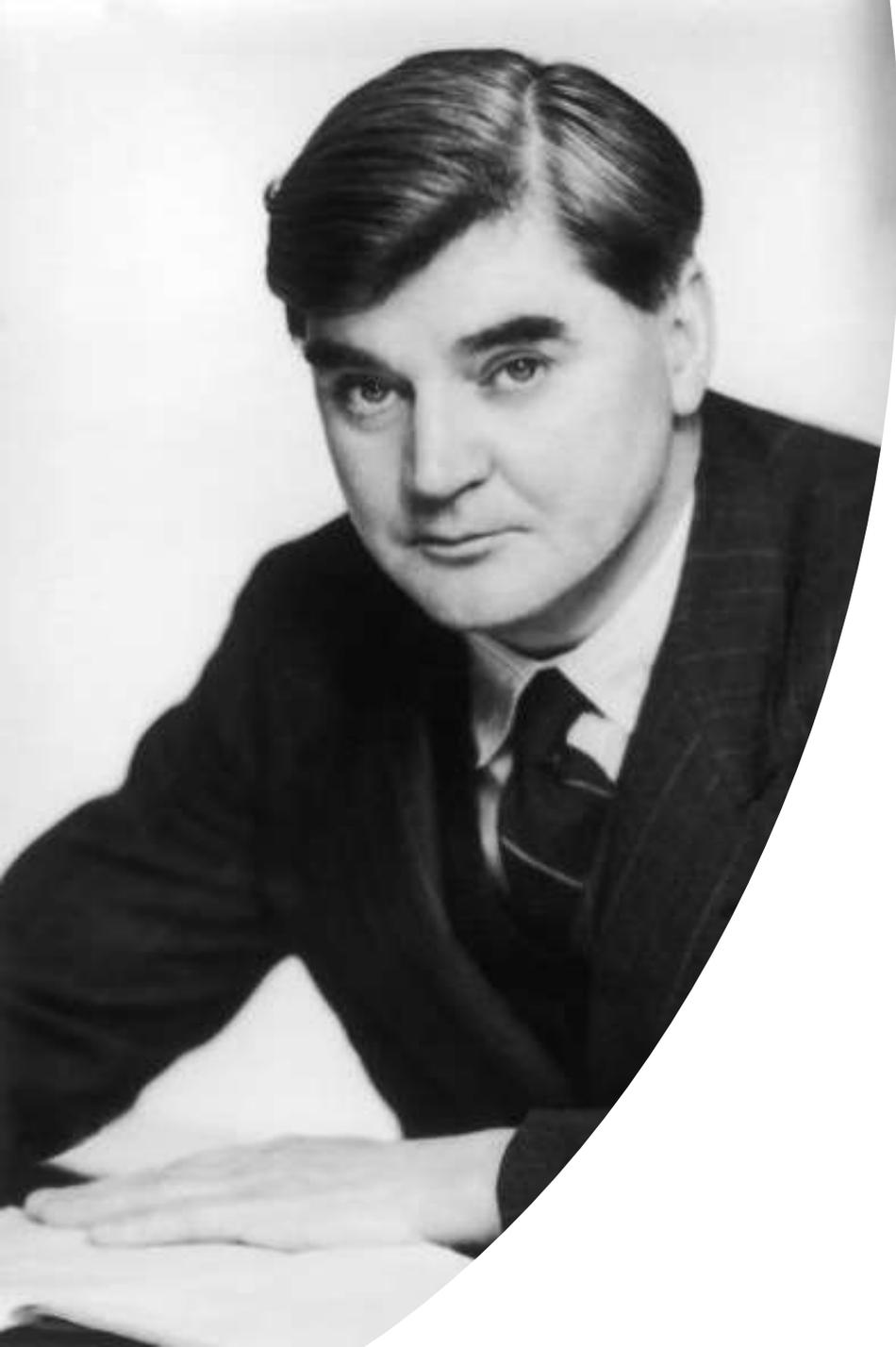
Figure 1: Impact of 2019/20 NTPS proposals on NHS provider tariff revenue (ie what a provider would receive in 2019/20 using proposed new prices, compared to 2018/19), based on 2016/17 activity (scenario 1)²⁶



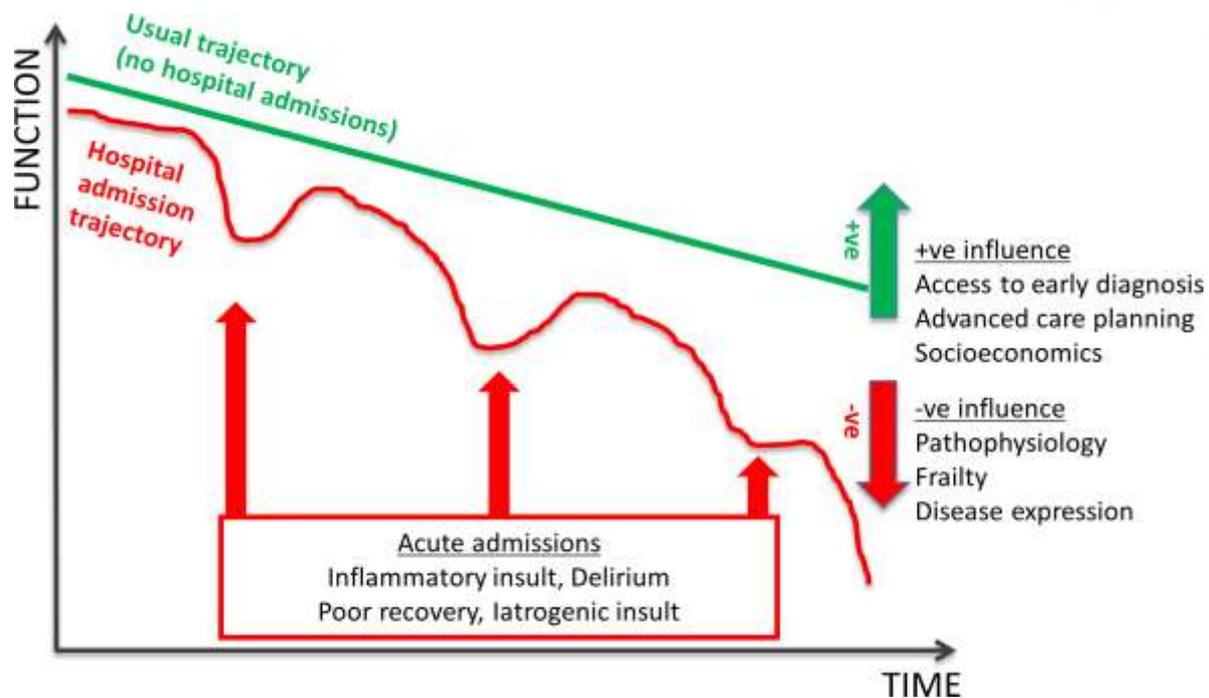
Fiscally prudent



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



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



Last
 1000
 Days



Better for

Patients
who can be
managed
without
admissions

Patients
who
require
admission

Hospitals

The NHS

SDEC



NZLoS



4% bed occupancy



Strategic Vision

Mark England

Deputy National Director of Emergency and Elective Care
NHS England and NHS Improvement

SDEC Workshop

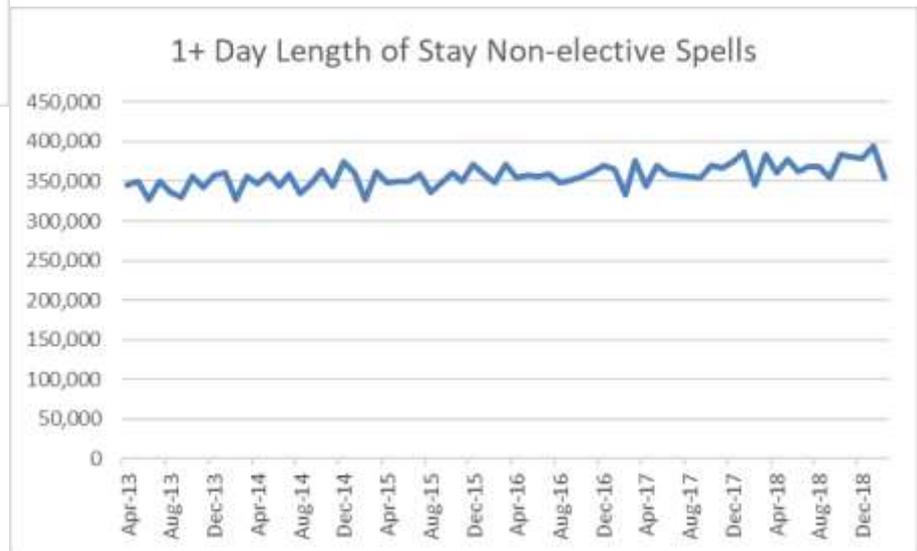
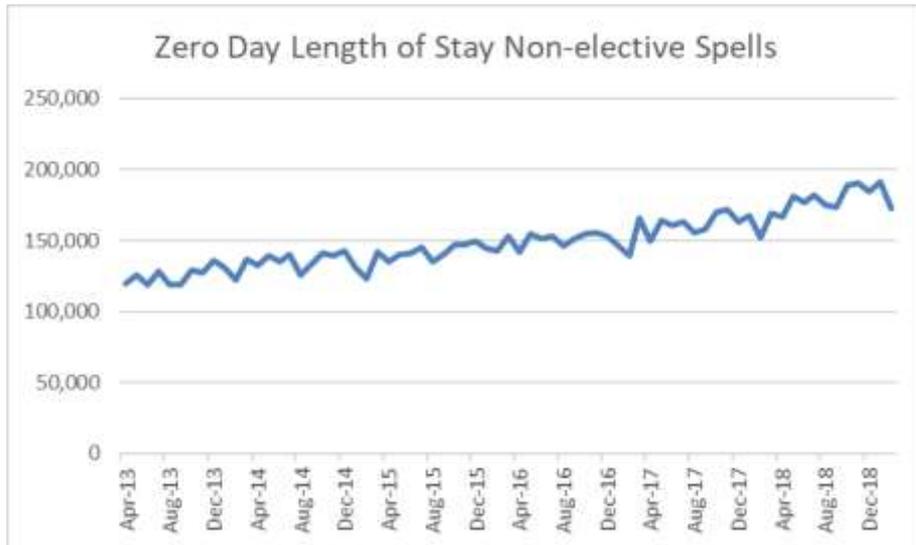
April 2019

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

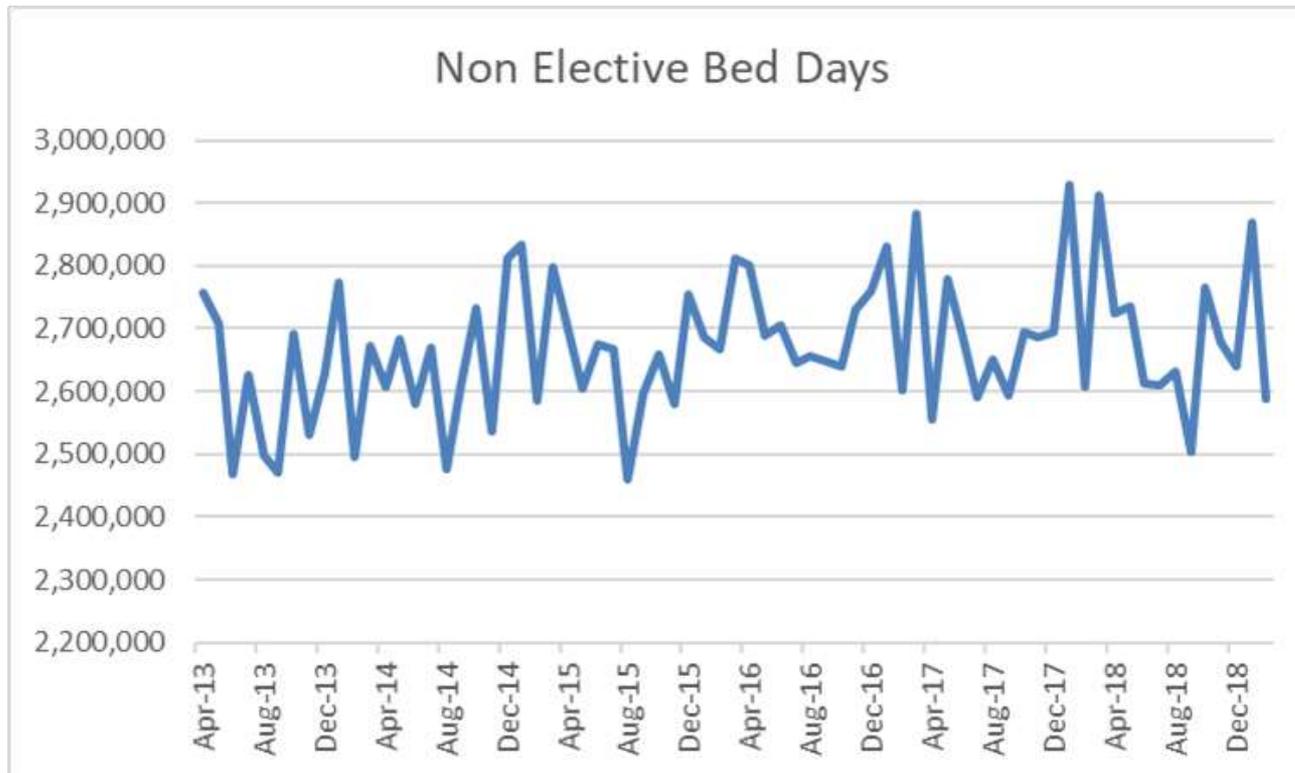
NHS England and NHS Improvement



Non-elective spells at M11



Bed Days at M11



The National Context SDEC (1)



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

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



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

National SDEC CQUINs published for 2019/20

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

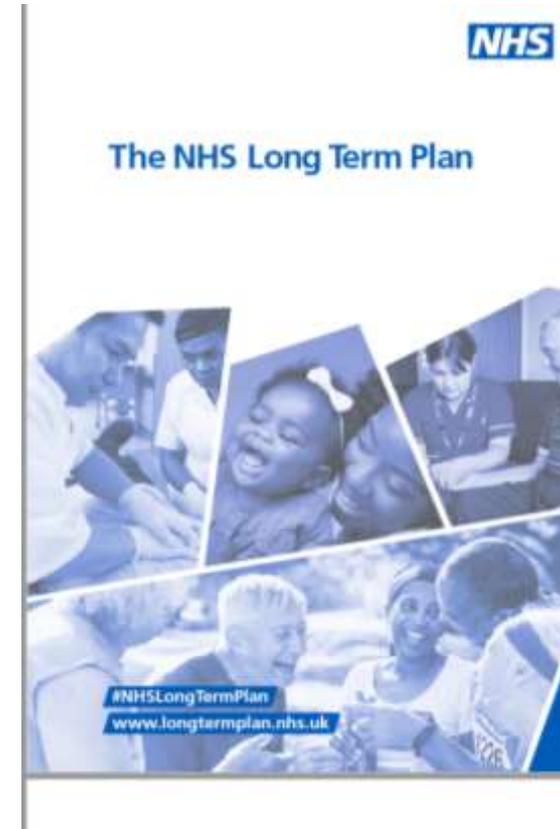
The National Context SDEC (2)



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

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

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



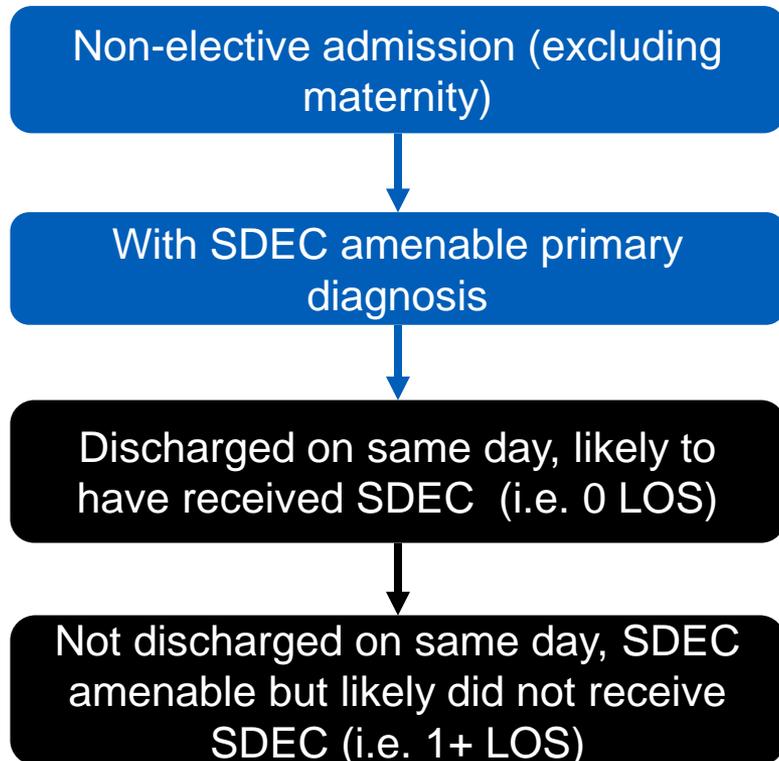
SDEC – Patient Level Information Cost System (PLICS) Analysis

April 2019

NHS England and NHS Improvement



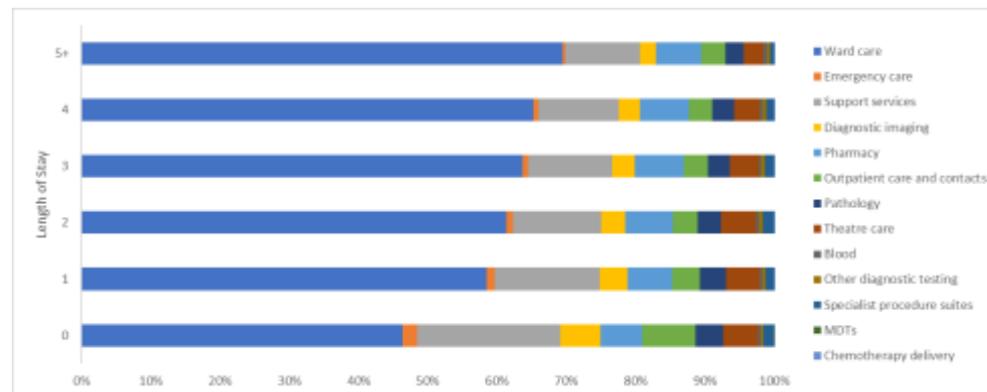
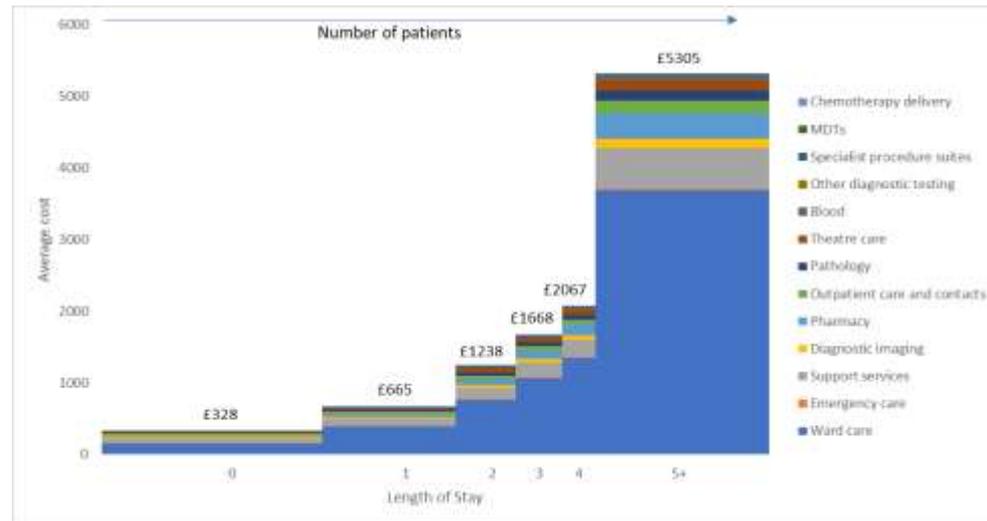
The approach used to identify SDEC amenable patients



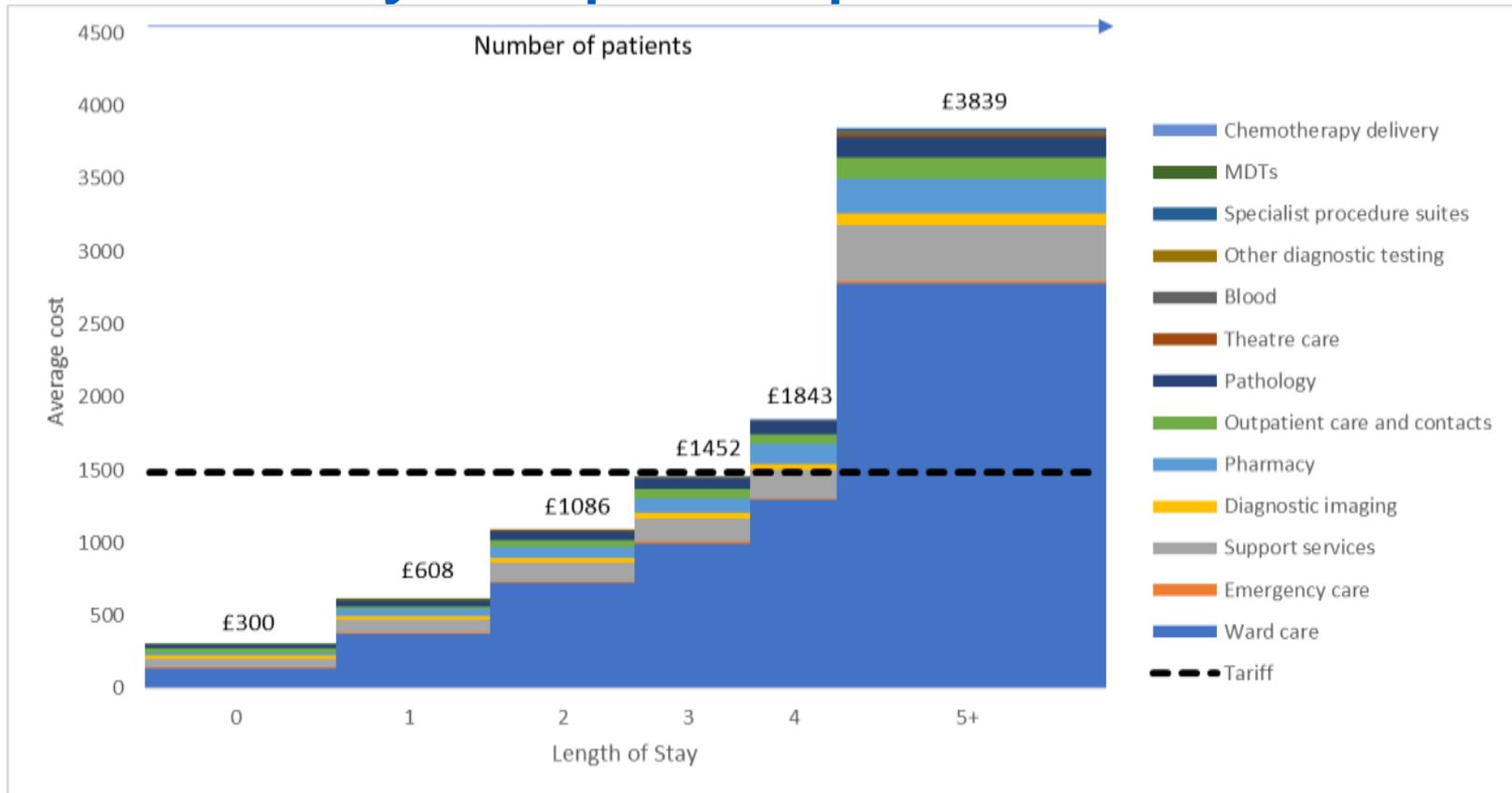
- We identify SDEC and potential SDEC spells in 2017/18 PLICS data. This covers 69 acute trusts.
- This approach was applied as a way to analyse historic data and thus applies contemporaneous information on diagnoses amenable to SDEC treatment from the Directory of Ambulatory Emergency Care for Adults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

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

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

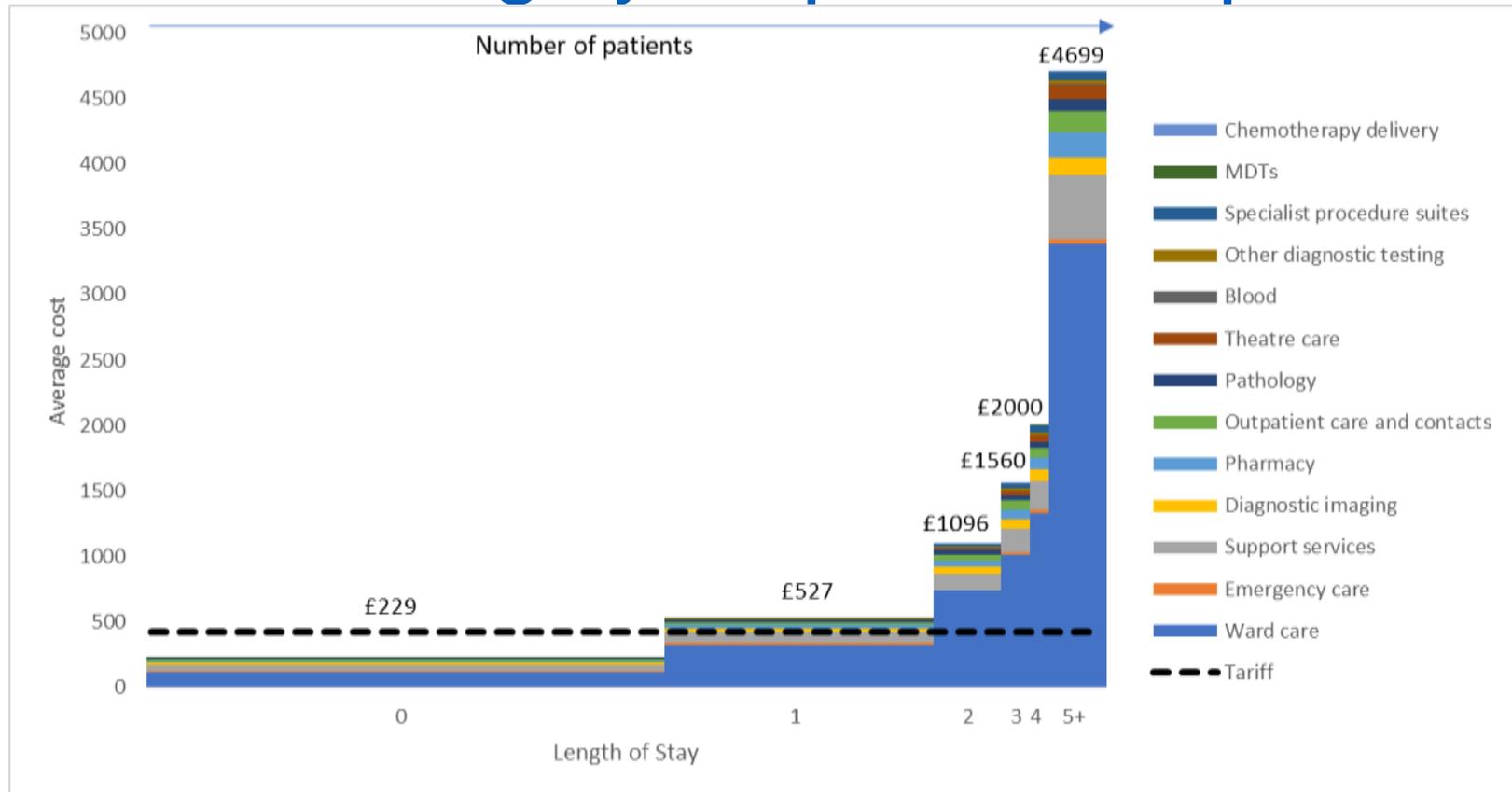


Community-acquired pneumonia



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

Falls including syncope or collapse



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

Cost reductions from additional SDEC amenable patients treated same day

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

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

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

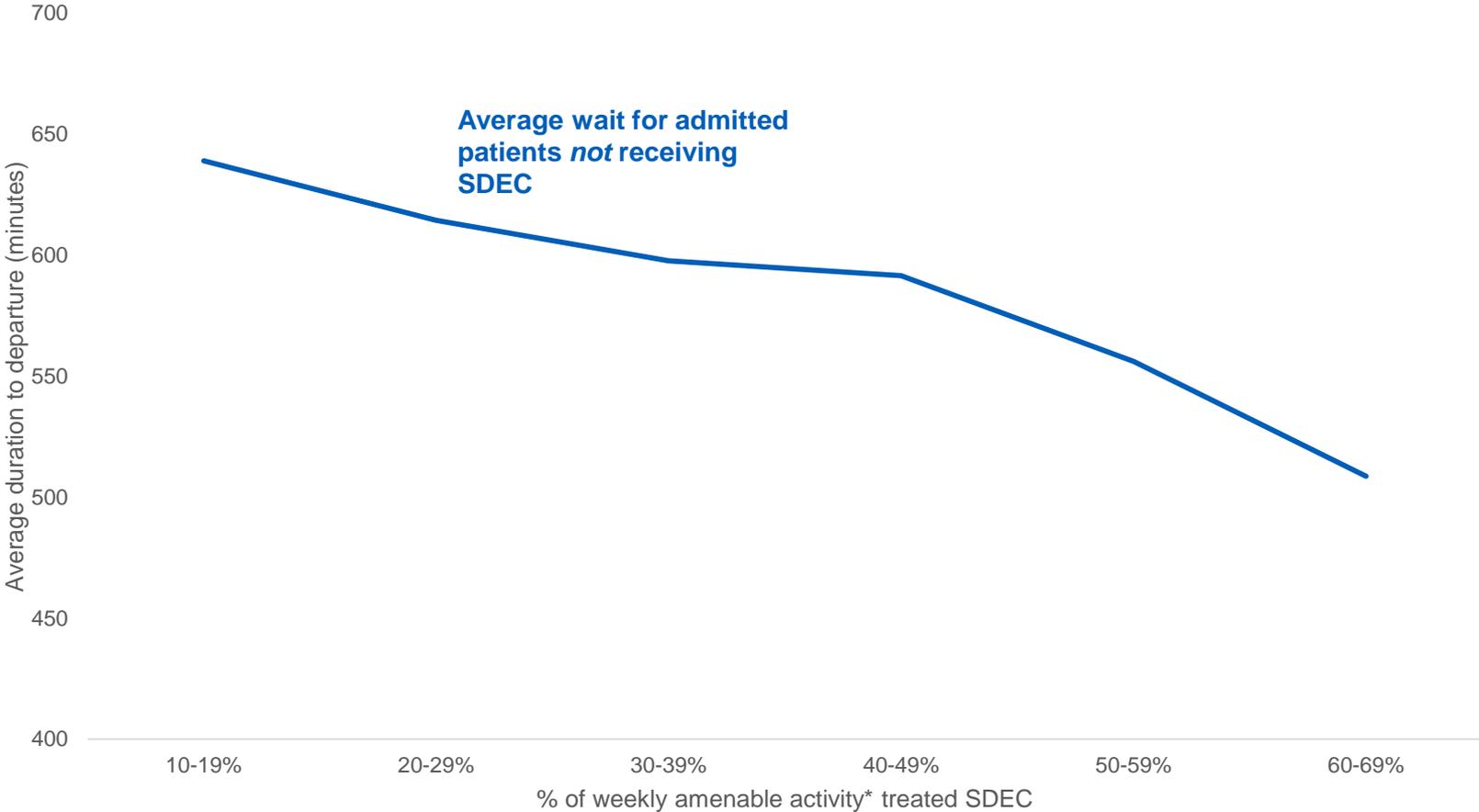
* The average trust is based on the 69 trusts in the PLICS dataset with substantial NEL activity in FY2017/18.

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

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



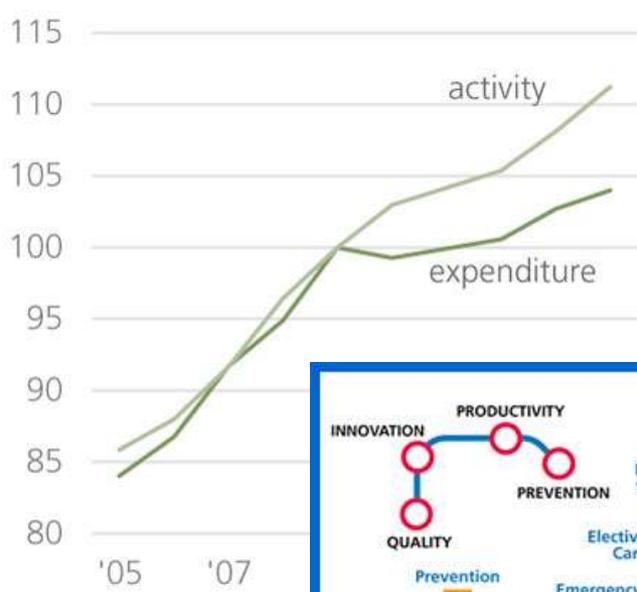
This graph illustrates how increasing SDEC activity affects average time spent in A&E for admitted non-SDEC patients.



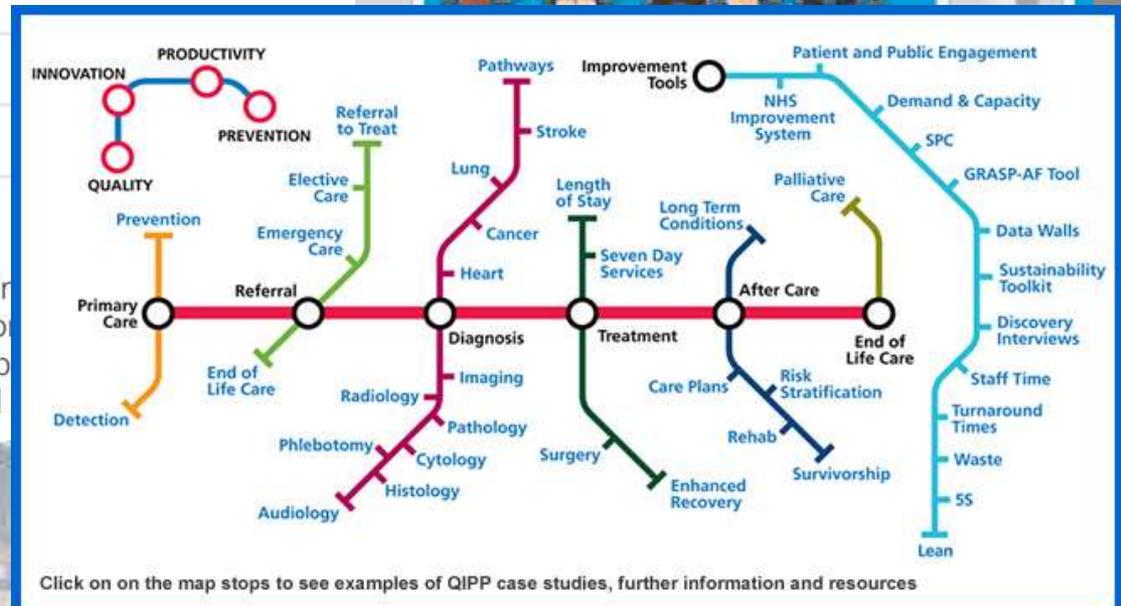
*Patients with an amenable condition, arriving during core AEC unit operating hours

What is SDEC?

Jay Banerjee



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



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

kingsfund.org.uk/blog

95% of increase in short stay admissions

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



Patients

PROCESSES

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

OUTCOMES

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

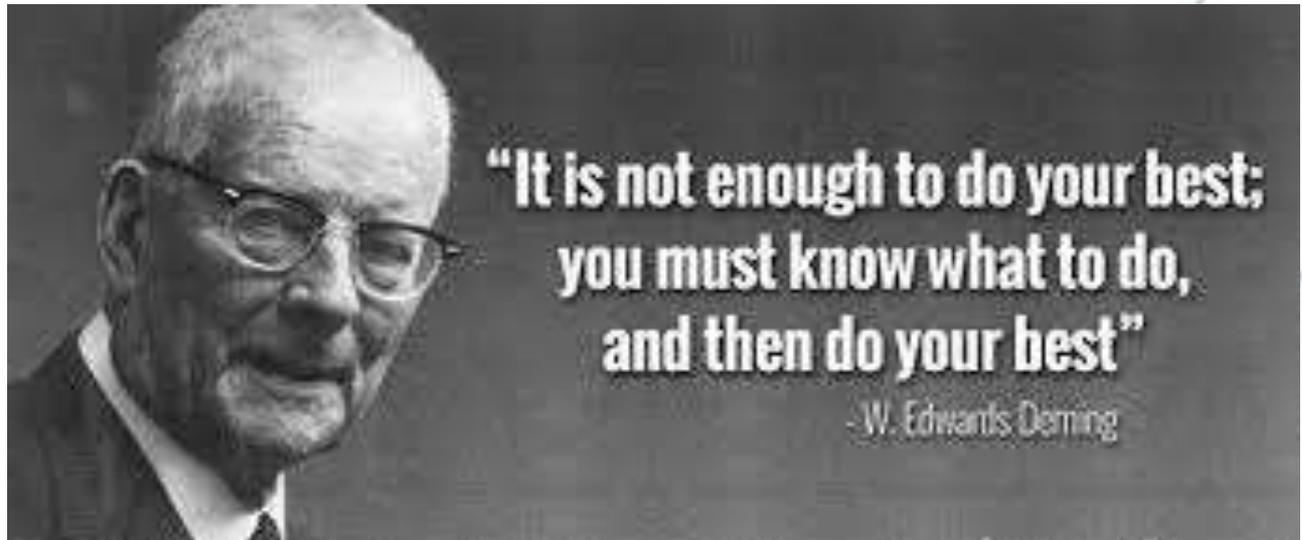


Some influencers on U&E care decision making

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

Other influencers

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



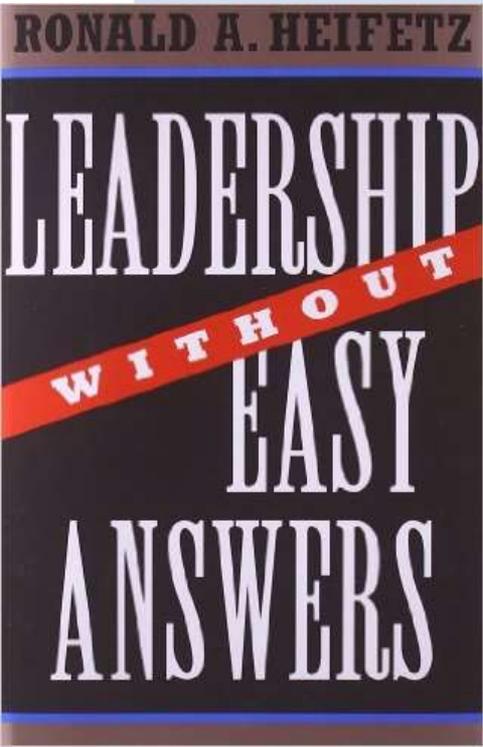
Challenge

TECHNICAL

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

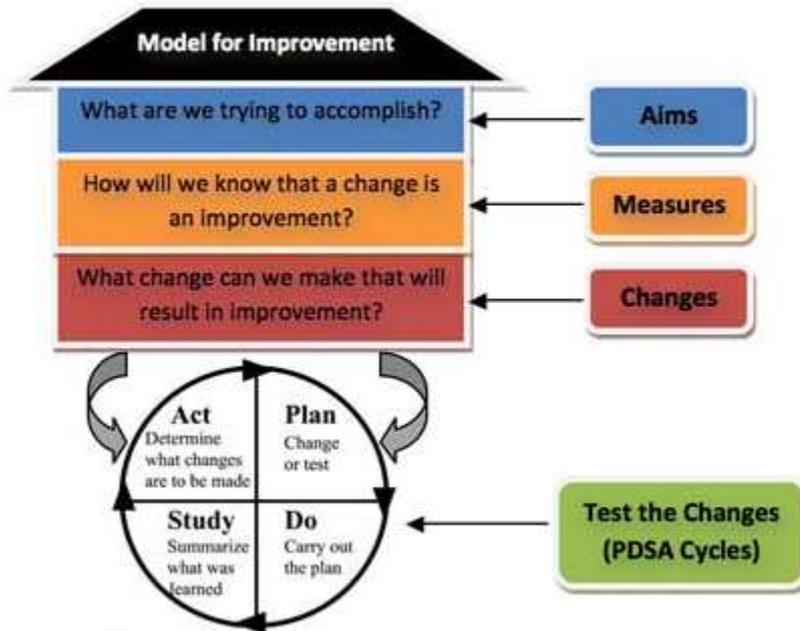
ADAPTIVE

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



Small steps lead to big changes

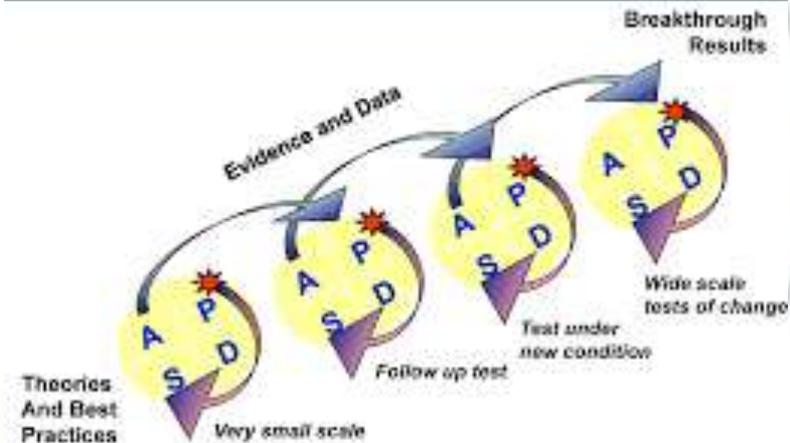
We accelerate change and improve our quality of HIV care by using the Model for Improvement



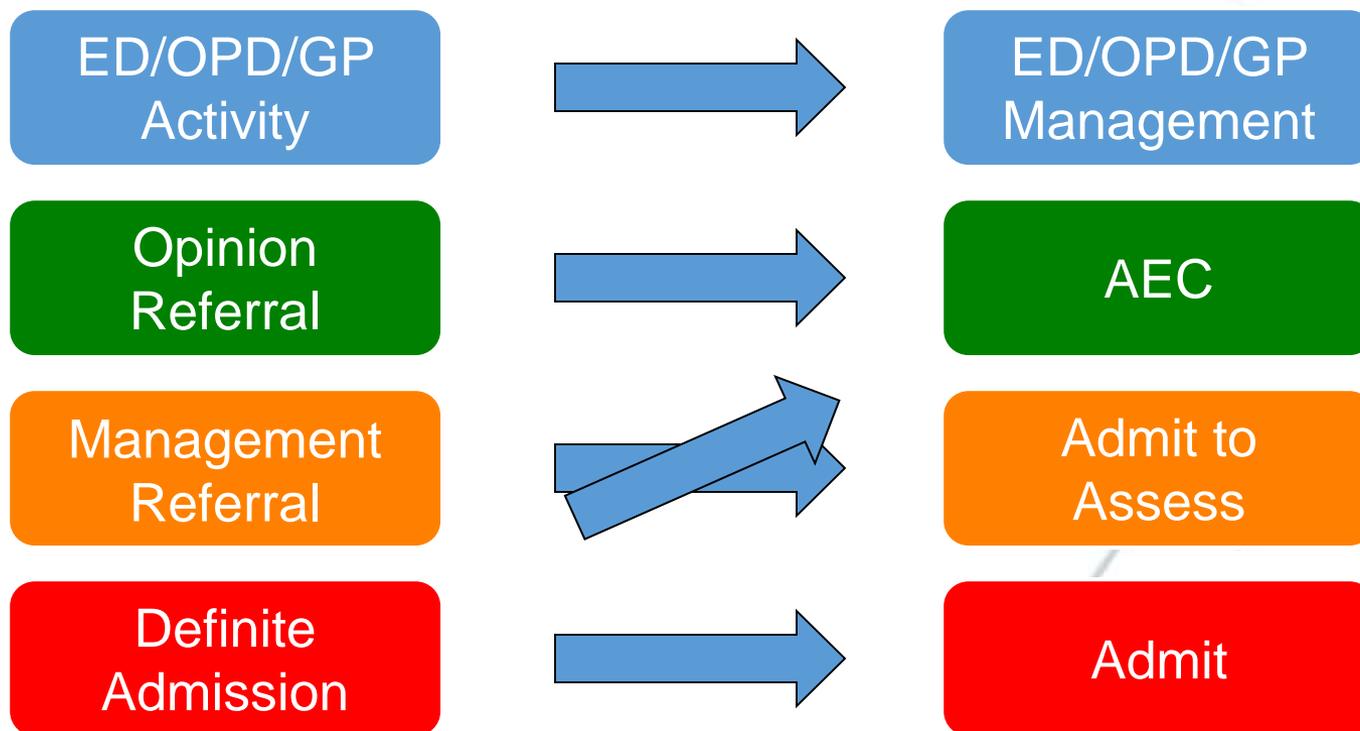
Source: Langley *et al.* (1996)

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

Building Knowledge with PDSA Tests



Right patient, right place



UPDATE - Directory of AEC

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



Ambulatory
Emergency Care

NHS
Elect

Contains
seven new
clinical
scenarios

Directory of Ambulatory
Emergency Care for Adults

[Click here to get started](#)



Previous version September 2014

Key Questions

Is the patient sufficiently stable to be managed in AEC (usually NEWS ≤ 4)?

Is the patient functionally capable of being managed in AEC whilst maintaining their safety, privacy and dignity?

Is there an existing outpatient or community service that could more appropriately meet the patients needs?

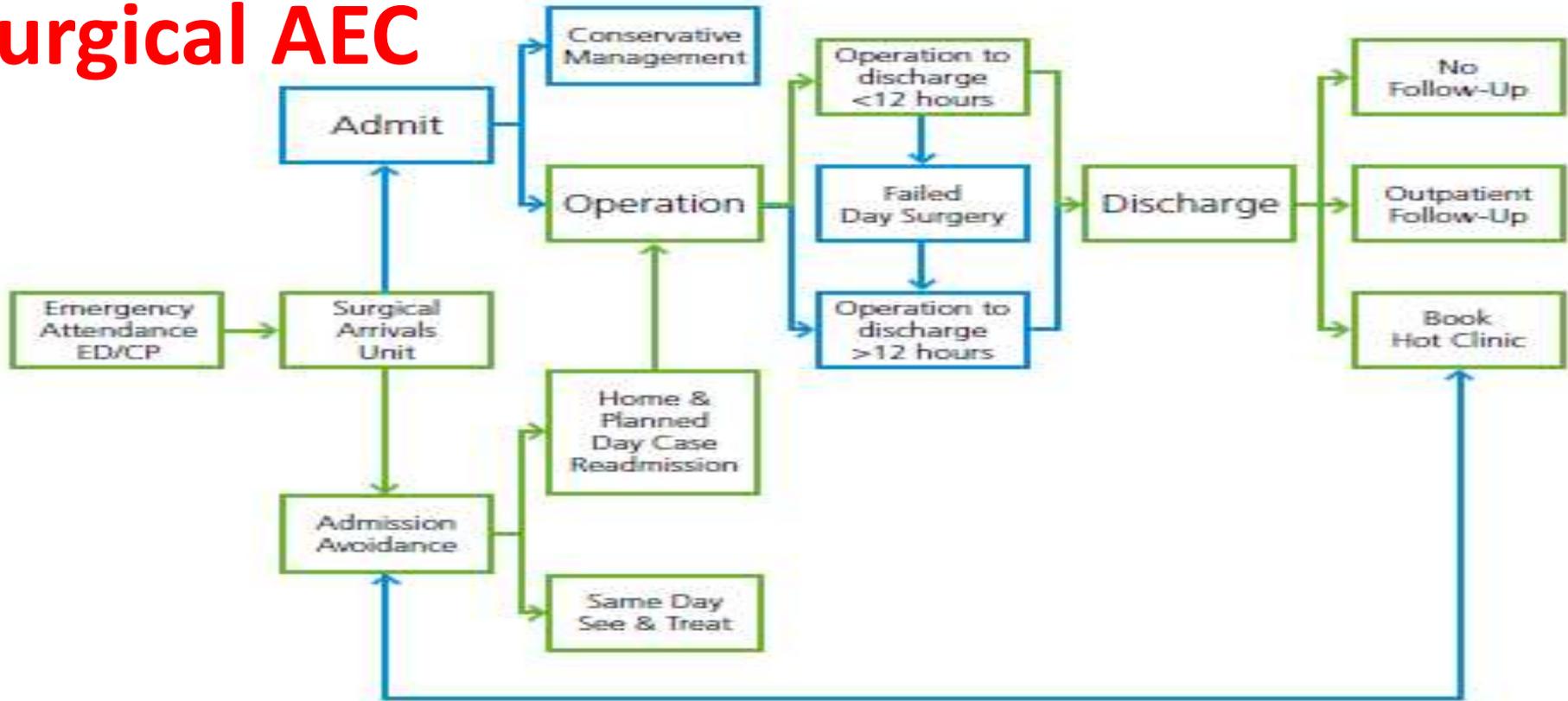
Would the patient have been admitted if AEC was not available?

The 4Ps Model of AEC

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

Diagram 2 Emergency Surgery Flow

Surgical AEC



& Medical Procedures

Appendicectomy (laparoscopic)

Arthroscopy

Biopsy

- lymph node
- temporal artery

Evacuation retained products of conception

Incarcerated Hernia

- inguinal
- para-umbilical
- femoral

Incision & Drainage of Abscess

- axillary
- groin
- neck
- perianal
- pilonidal

K – wiring

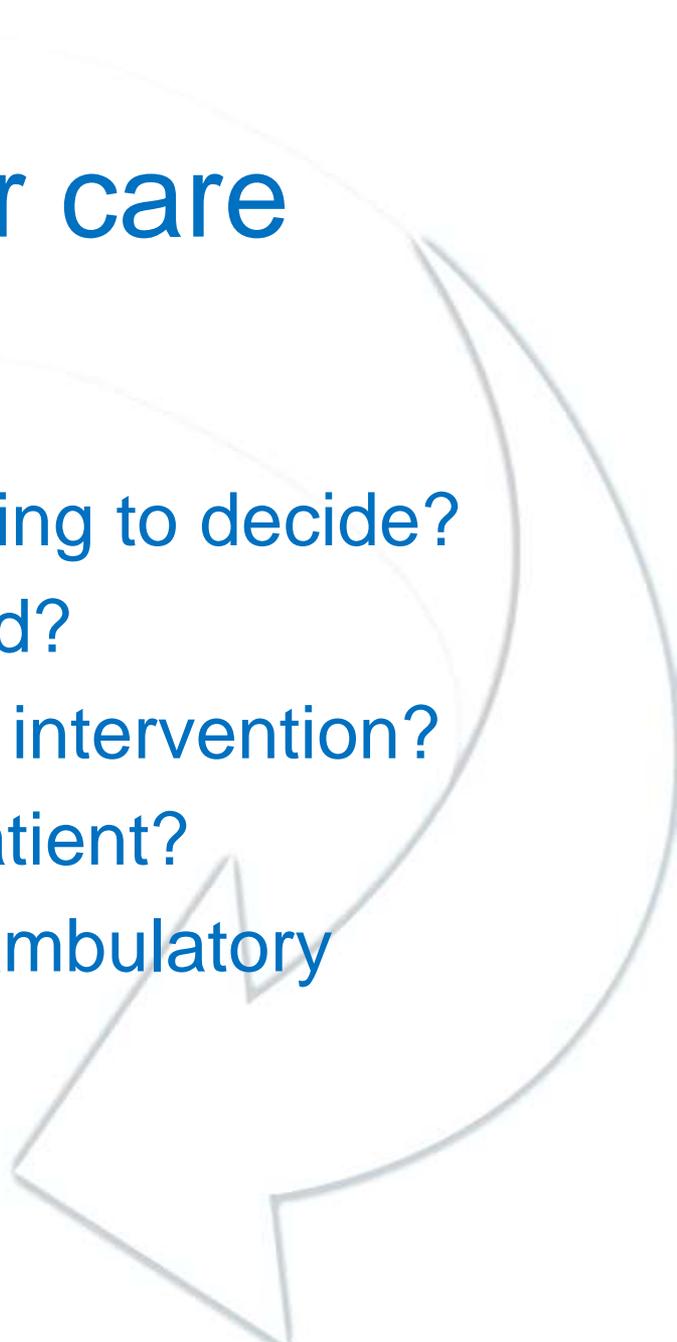
- finger or wrist

Laparoscopic ovarian cystectomy

Reduction and internal fixation

Tendon repair

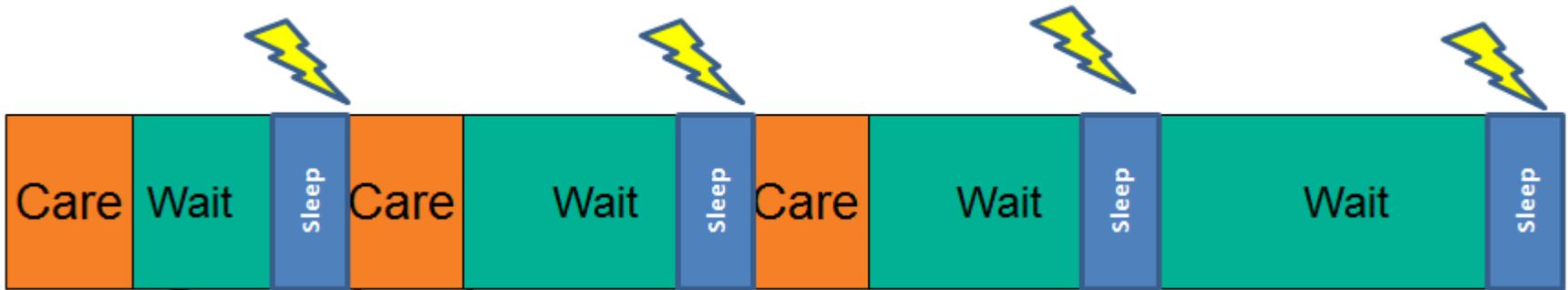
Maximising front door care

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

Key message - Beds aren't capacity

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

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



What is SDEC?

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

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

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

Maximising potential



Heart Failure Pathway

Patient identification sticker

Date:

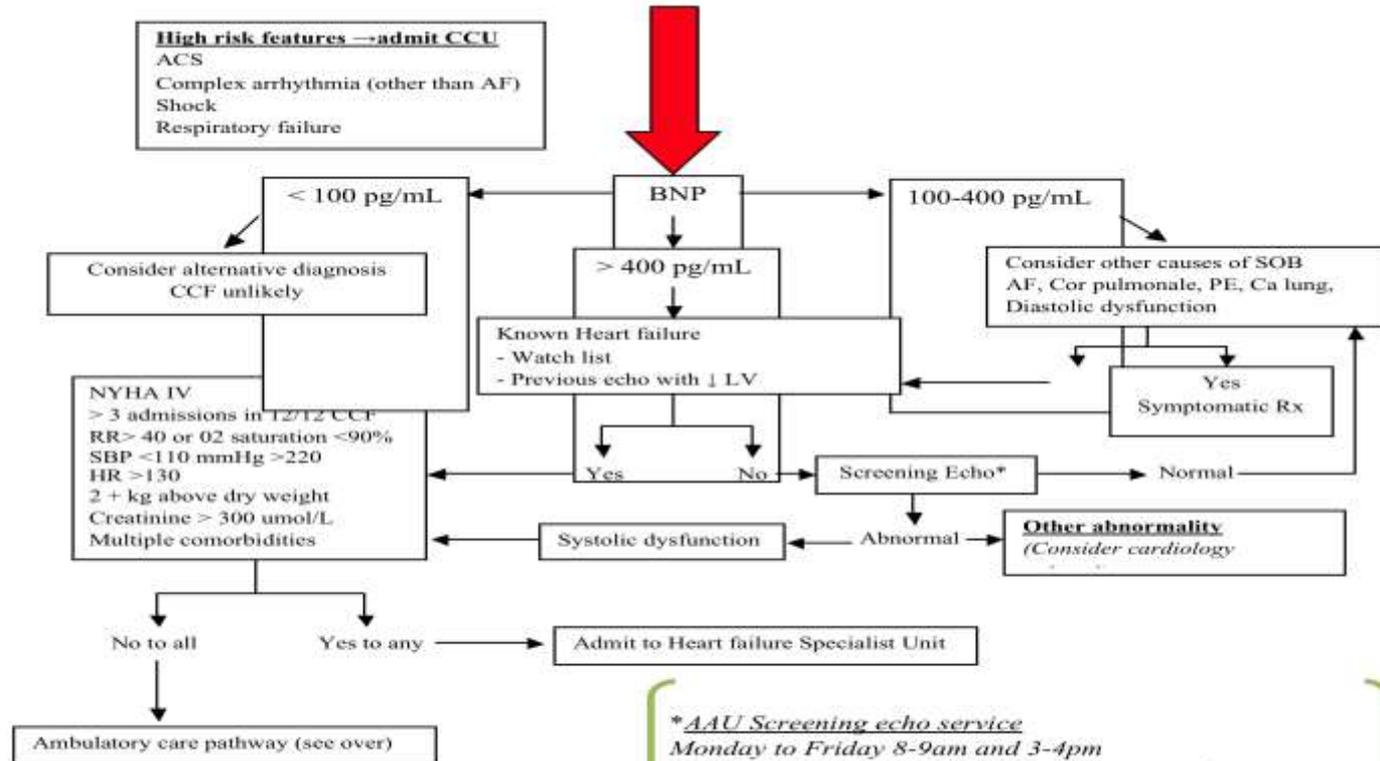
HEART FAILURE ASSESSMENT PATHWAY

Framingham Criteria for suspected heart failure: 2 major or 1 major + 2 minor

- Major**
- PND /orthopnoea
 - ↑ JVP
 - Hepatojugular reflux
 - S3 gallop
 - Basal creps
 - Cardiomegaly on CXR
 - Pulmonary oedema on CXR

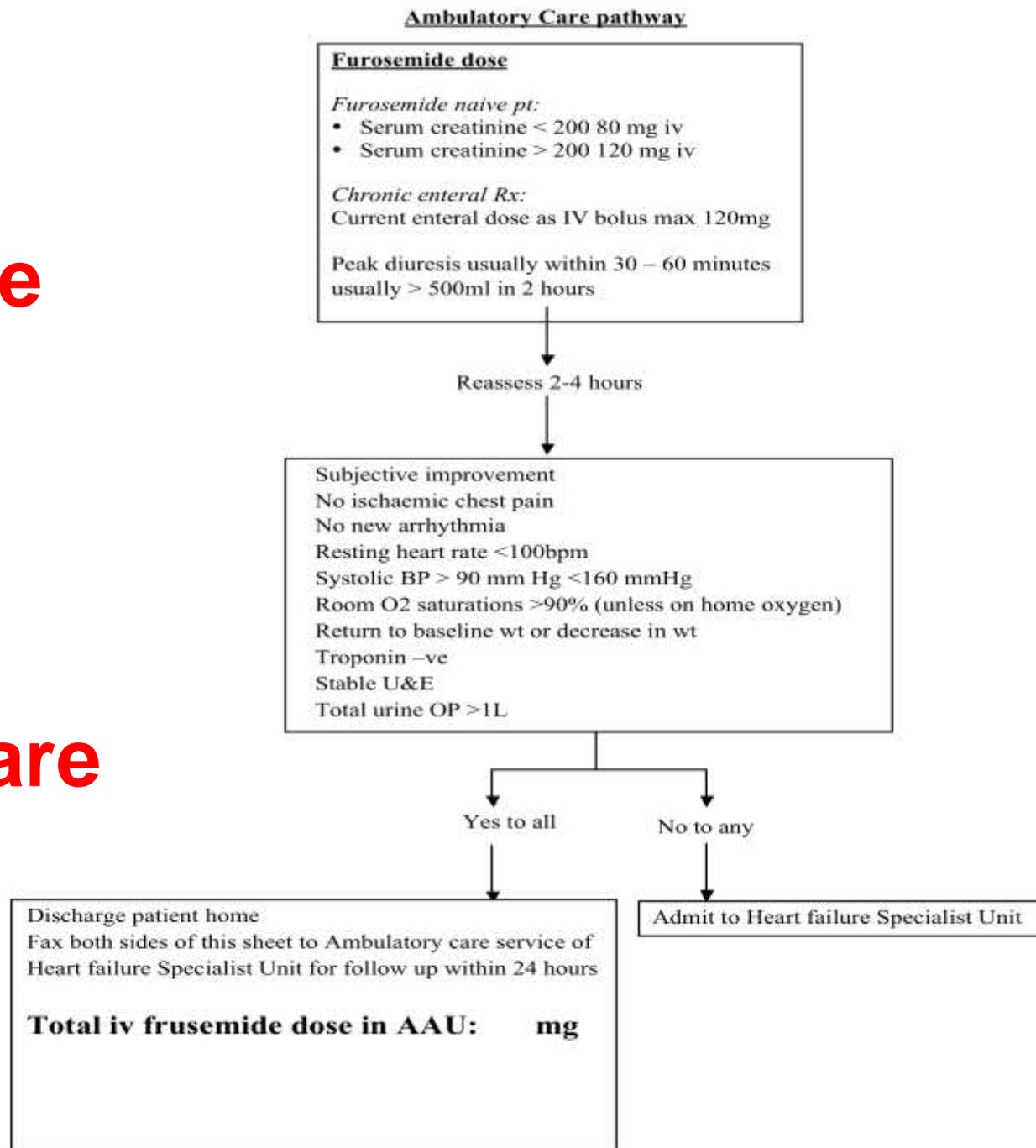
- Minor**
- SOB/e
 - Night cough
 - Ankle oedema
 - HR 120+ bpm
 - Hepatomegaly
 - Pleural effusion

High risk features → admit CCU
 ACS
 Complex arrhythmia (other than AF)
 Shock
 Respiratory failure



**AAU Screening echo service
 Monday to Friday 8-9am and 3-4pm
 All patients that fulfil criteria will be scanned
 All abnormal scans will prompt formal department TTE*

Define who
can go home
&
Define who
needs
specialist care



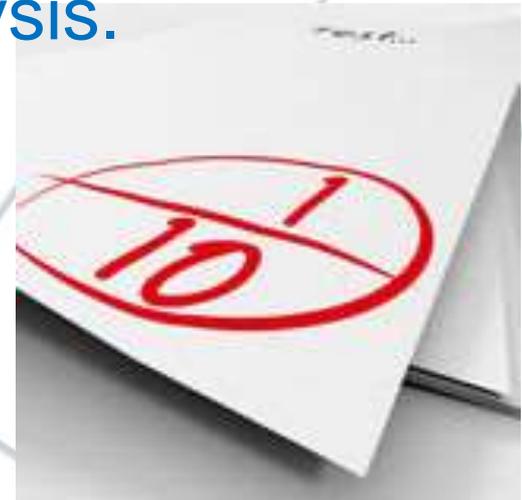
Inclusion/exclusion criteria

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



Scoring systems

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



Glasgow Admission Prediction Score*

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

Use of GAPS in AEC

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

What makes it work?

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



Surgical AEC – Mr Arin Saha





Where's SDEC?

Tom Hughes

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

Emergency Care Data Set

Urgent & Emergency Care “Flying Blind”

- Commons Health Select Committee 2013
- Started 2015
- Finished 2019

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

40 different IT suppliers

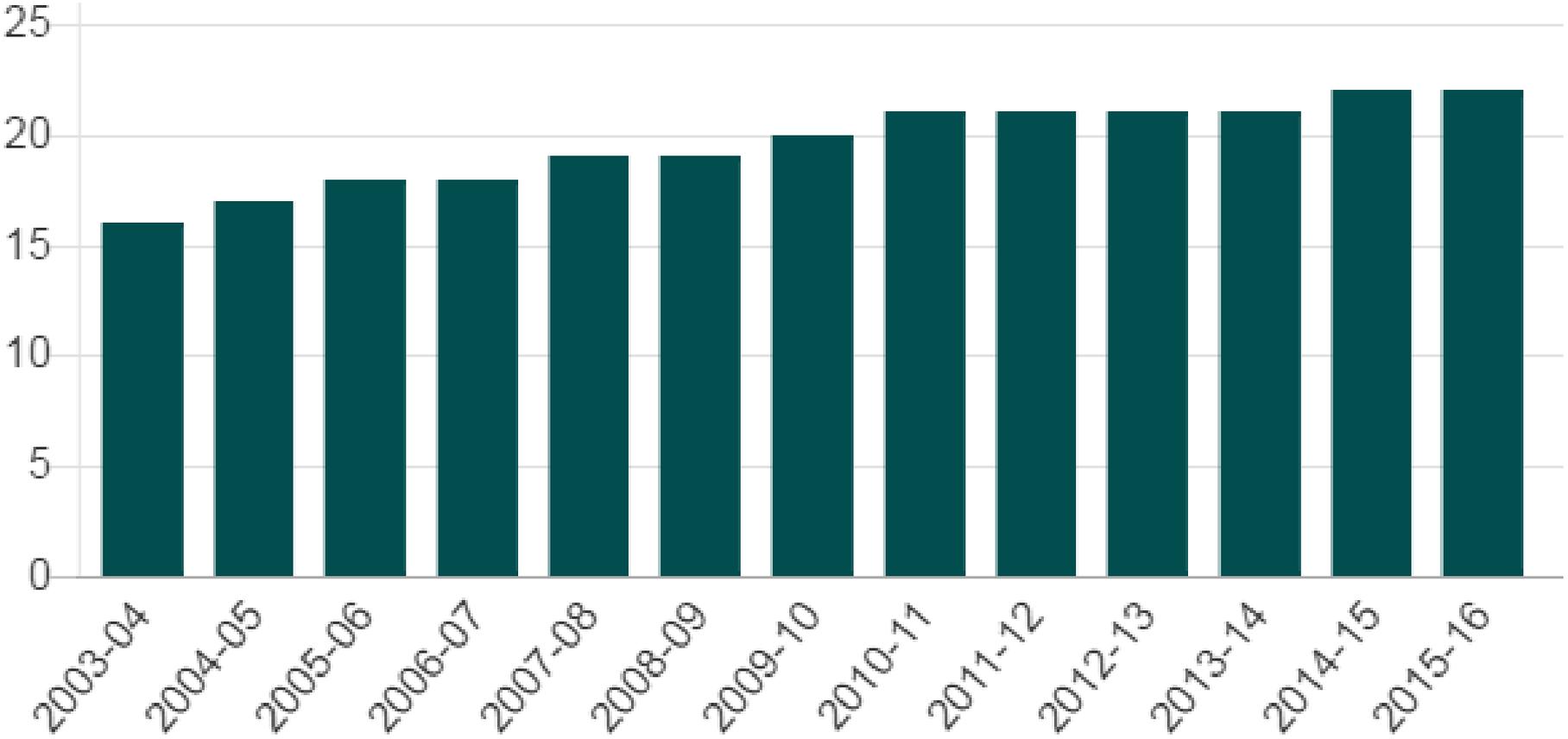






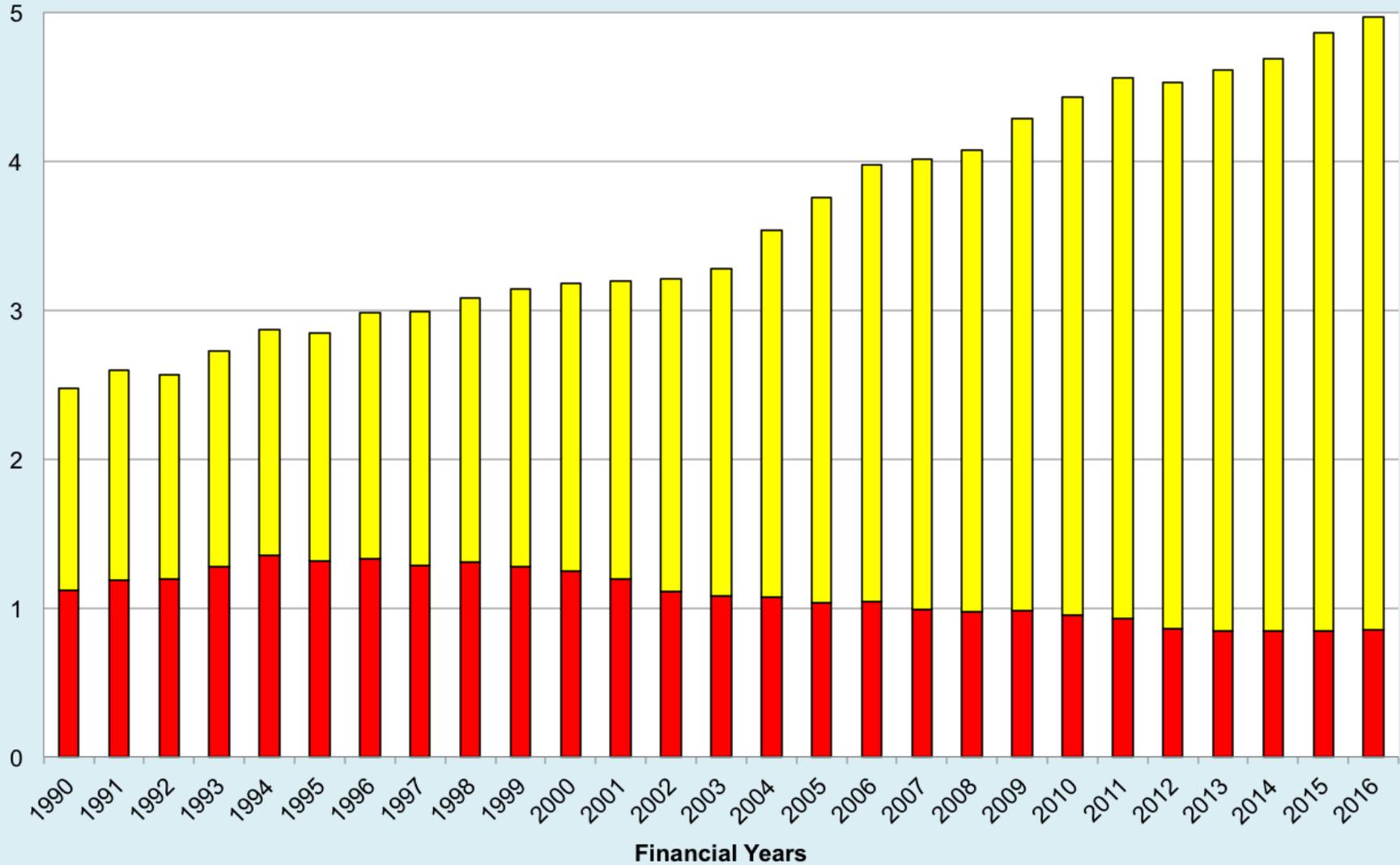
Increasing demand for urgent treatment

Visits to A&E in England (in millions)



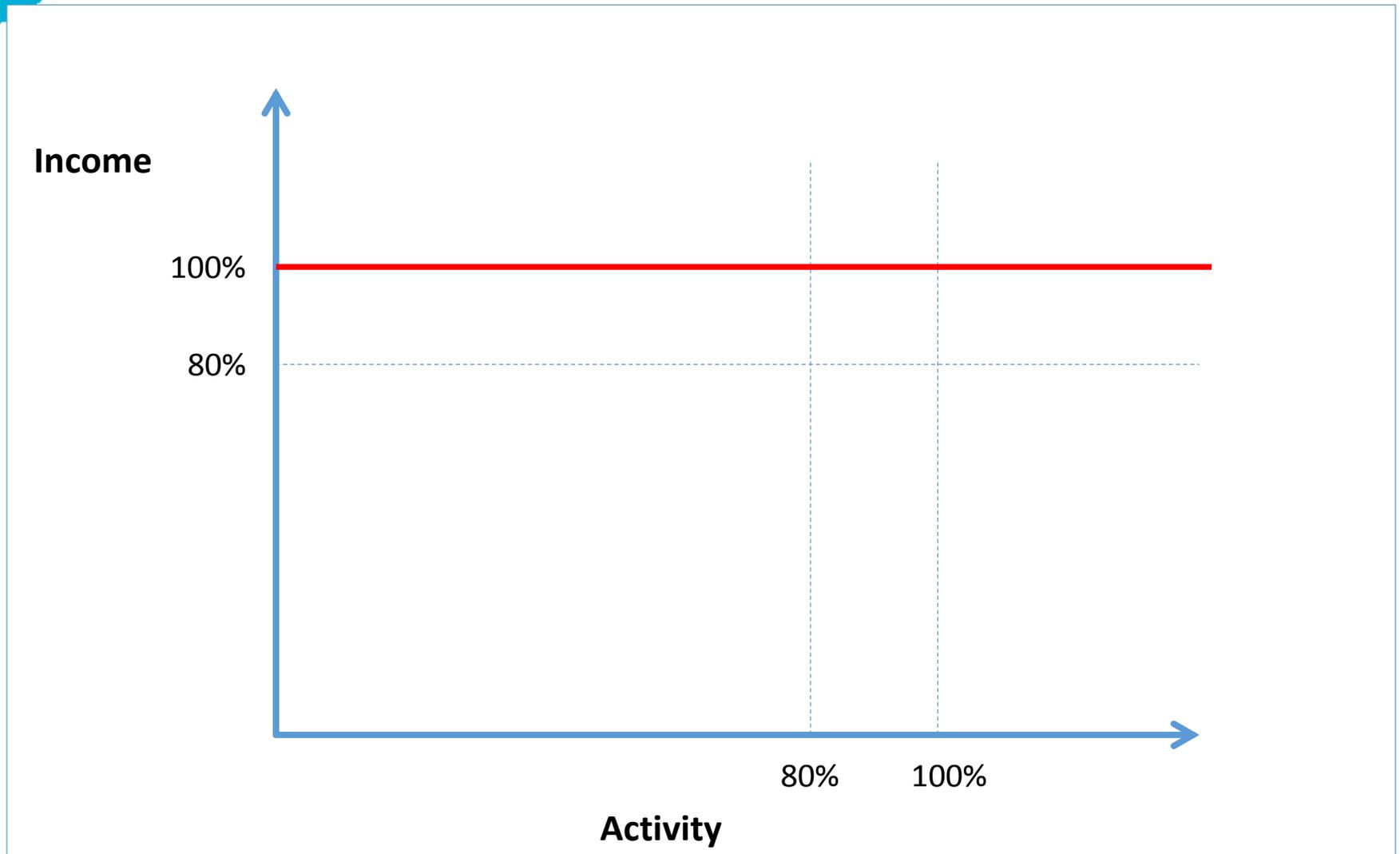
Source: IFS

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



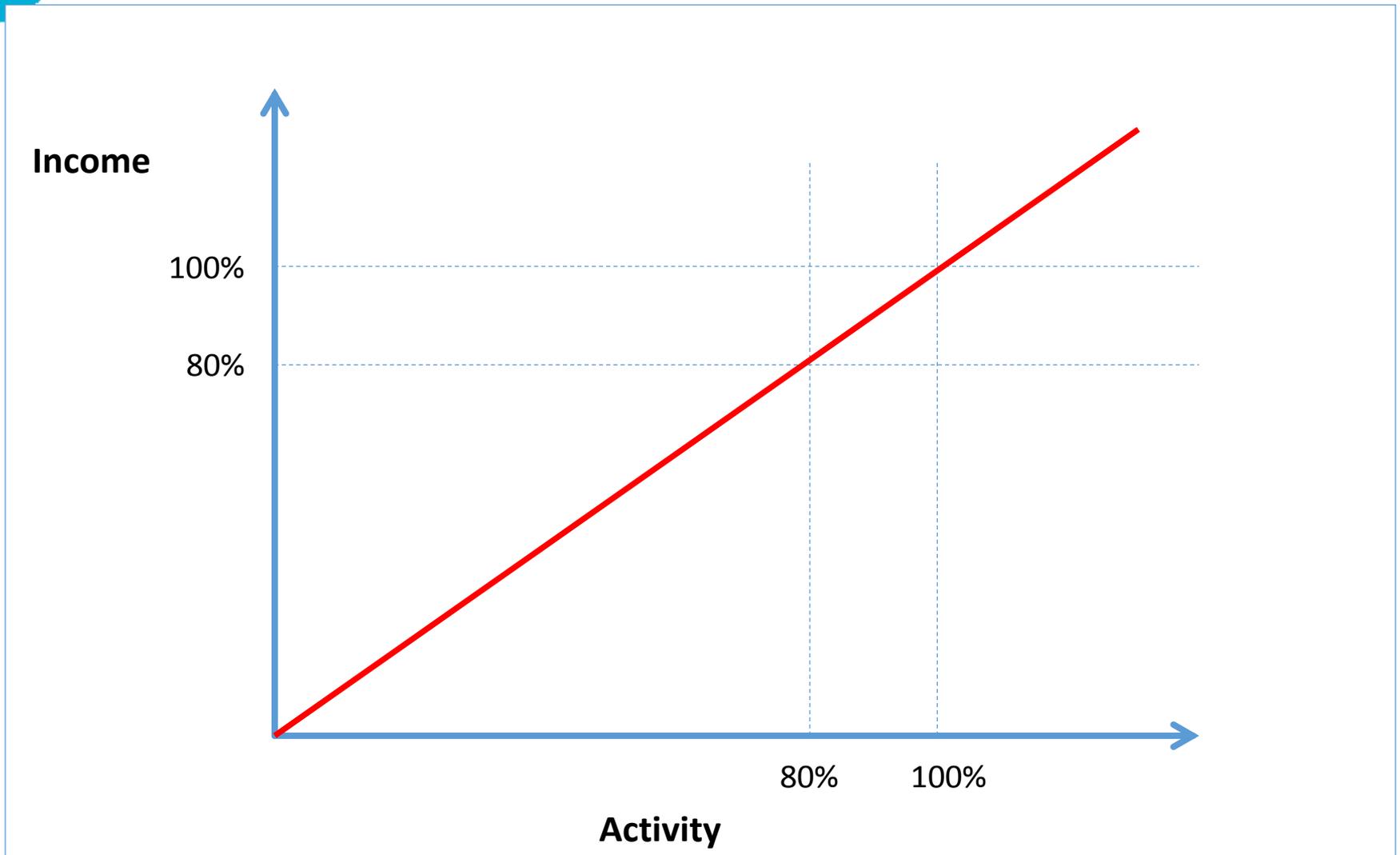


Block Tariff



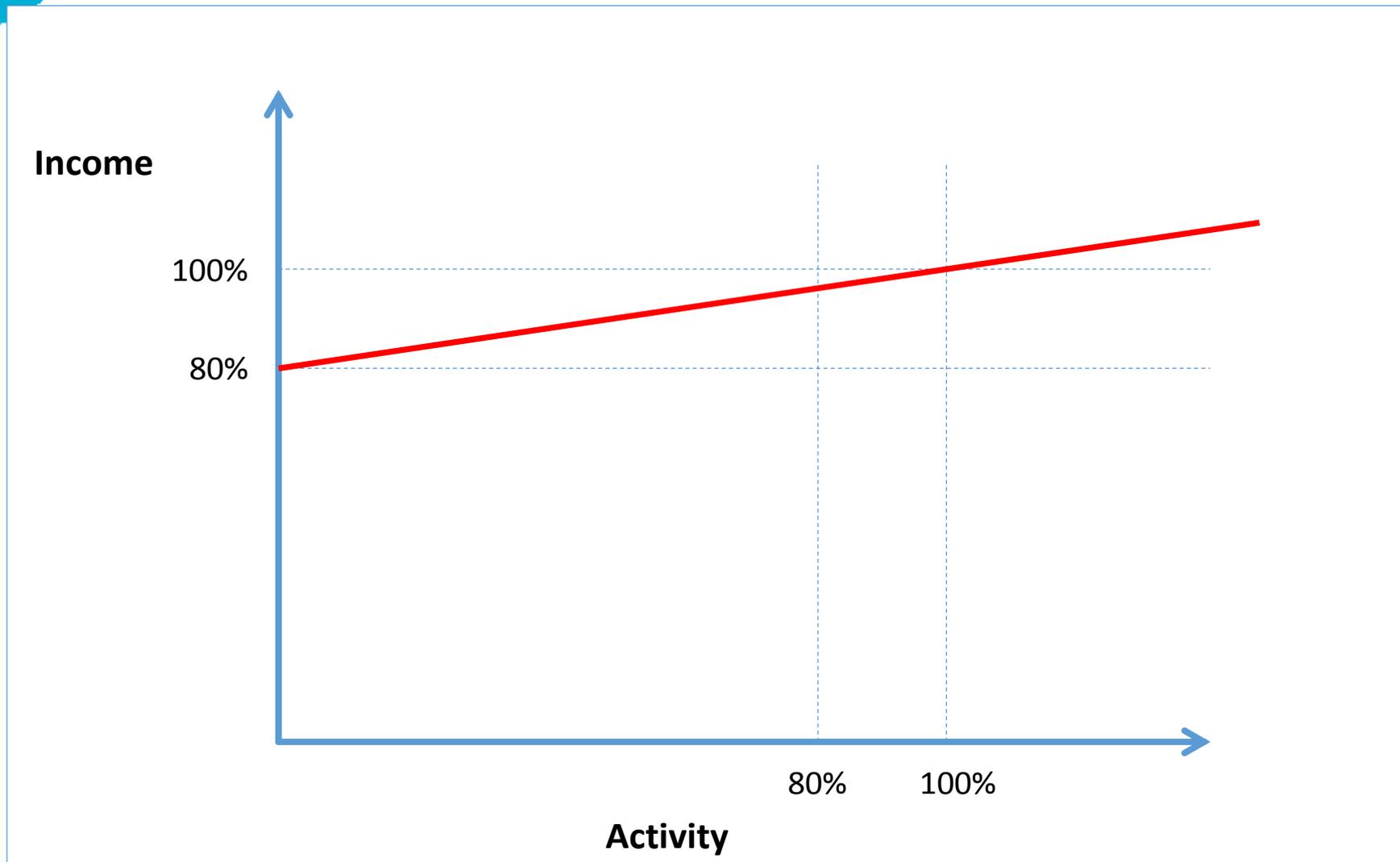


PbR Tariff (HRGs = DRGs)





Blended payment

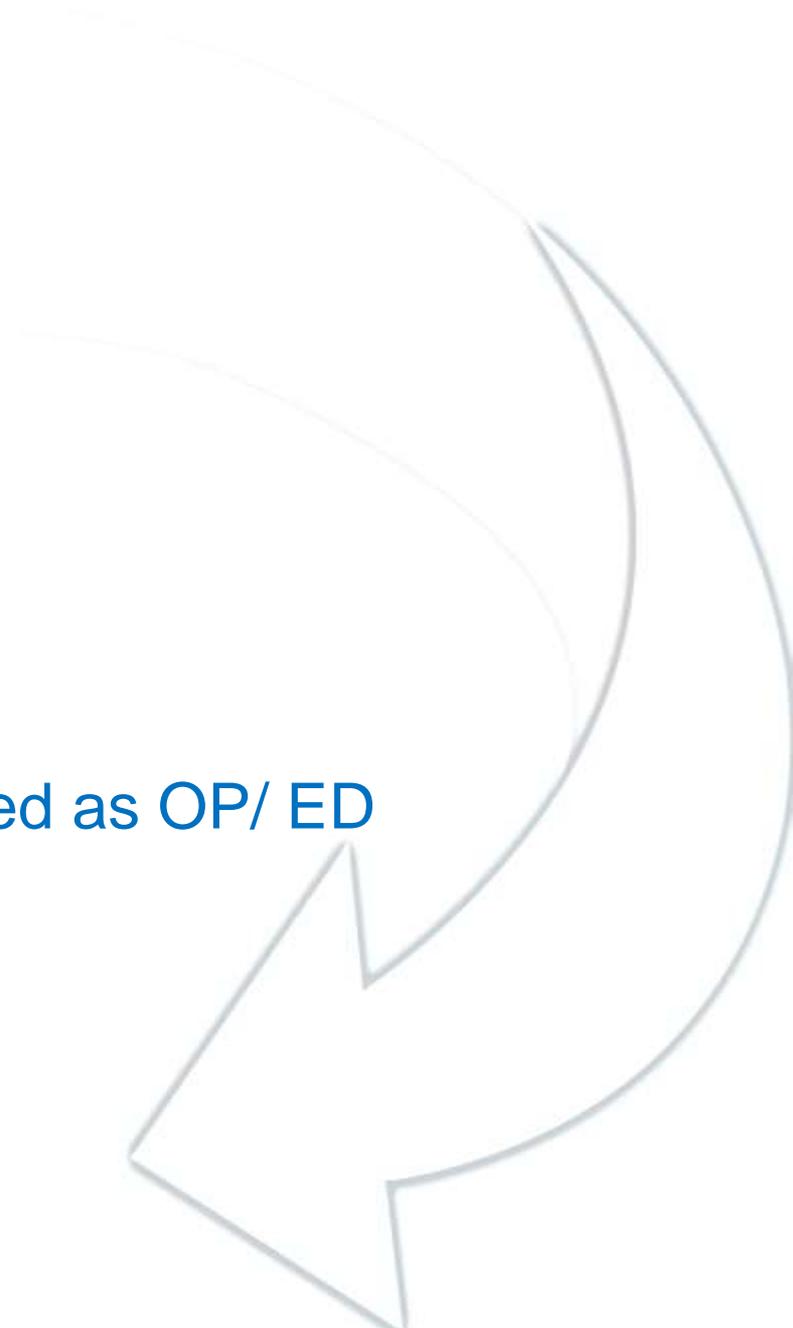


Best Practice Tariff

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

OR

- Not doing SDEC



Success ?

Zero Day LoS admissions

^ 9.6% (2017-18)

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

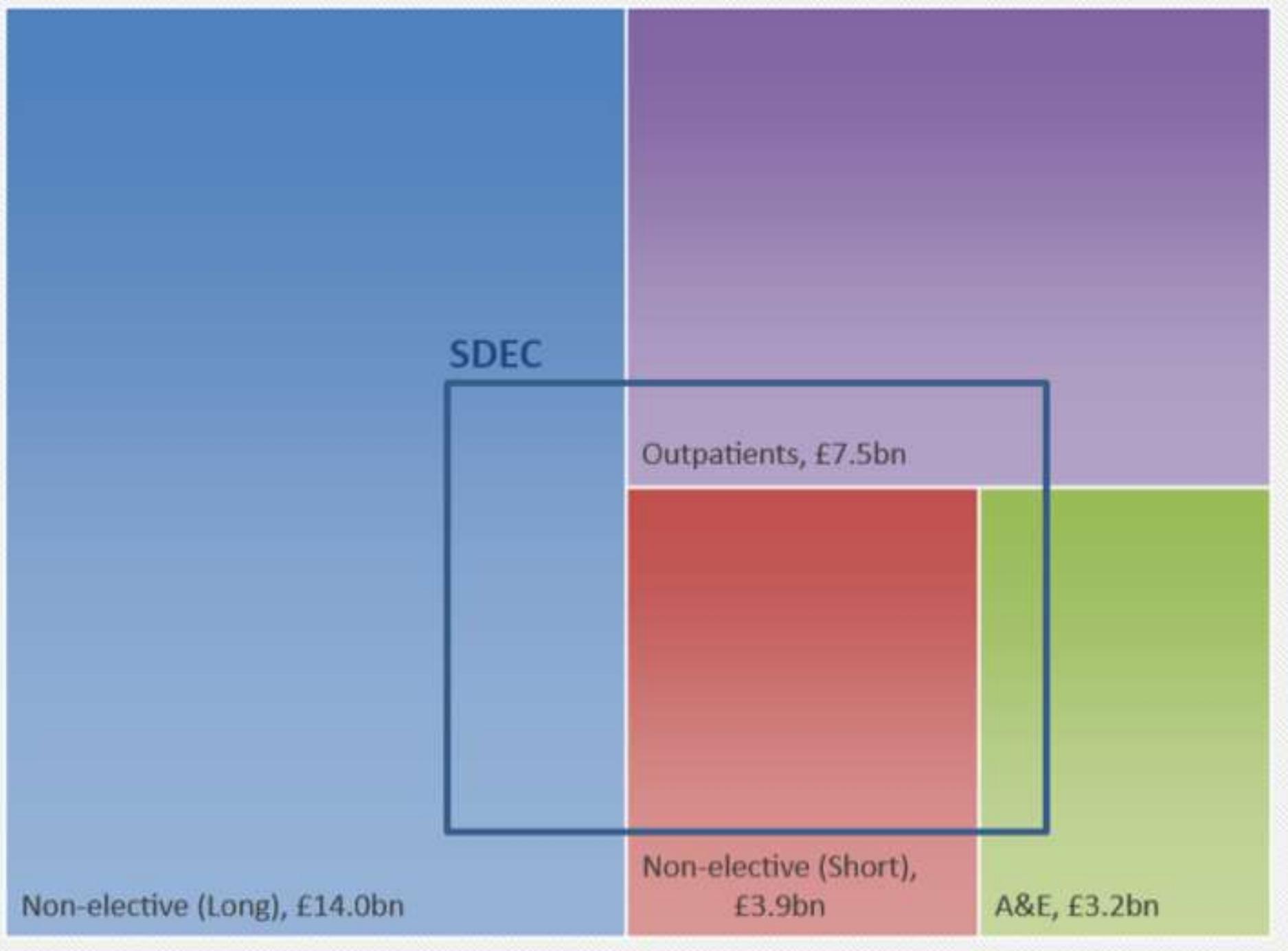
Expanding rapidly, we don't know why





known
unknowns





SDEC

Outpatients, £7.5bn

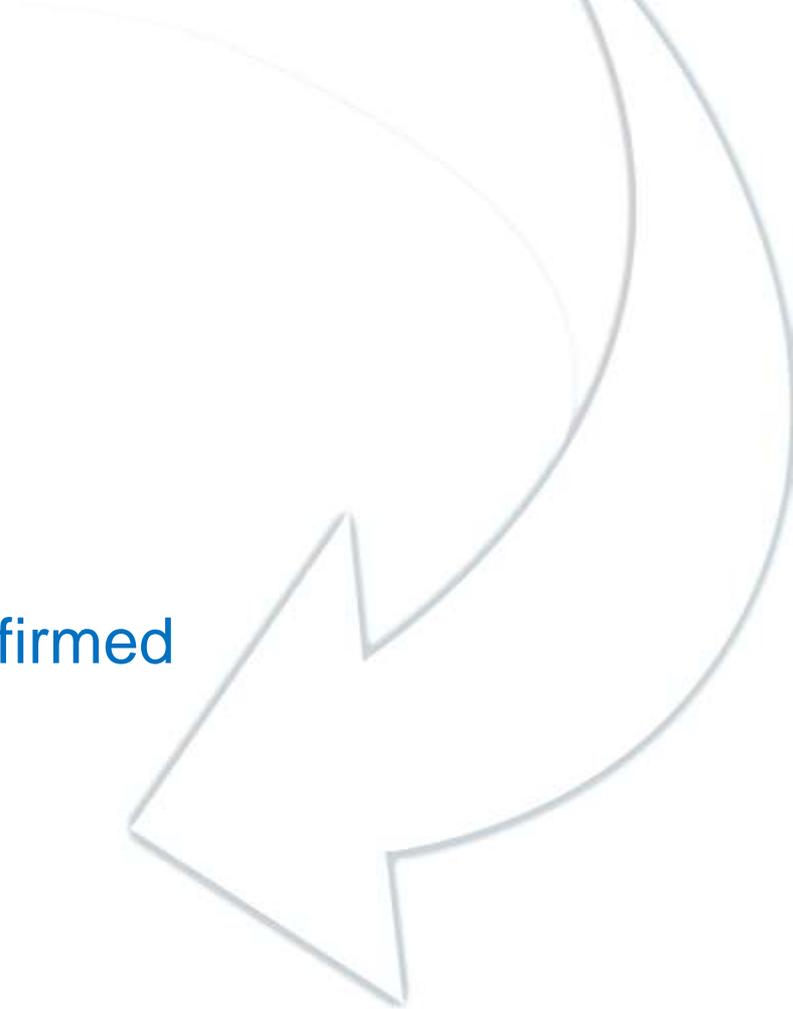
Non-elective (Short),
£3.9bn

A&E, £3.2bn

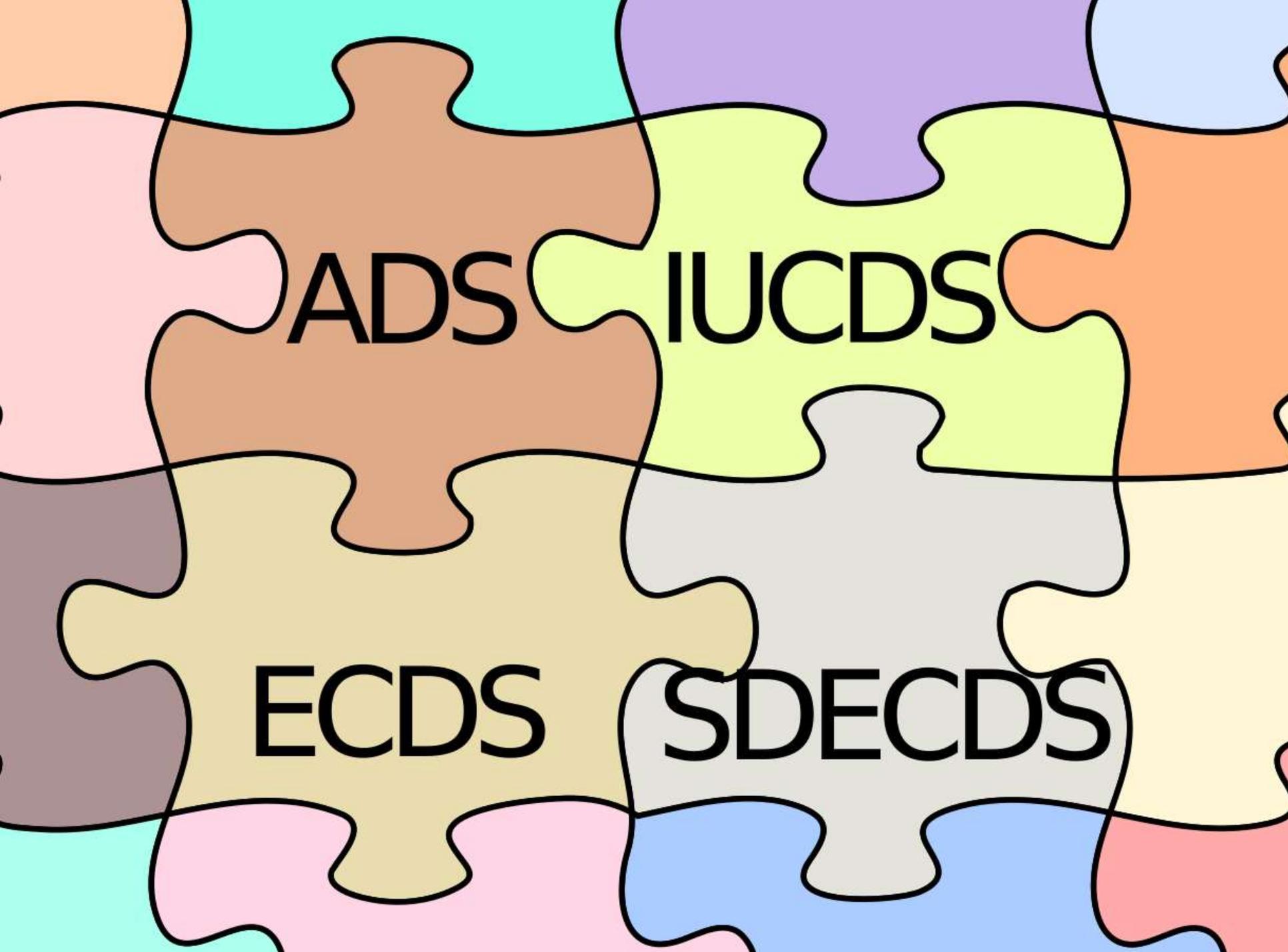
Non-elective (Long), £14.0bn

Why use ECDS for SDEC?

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







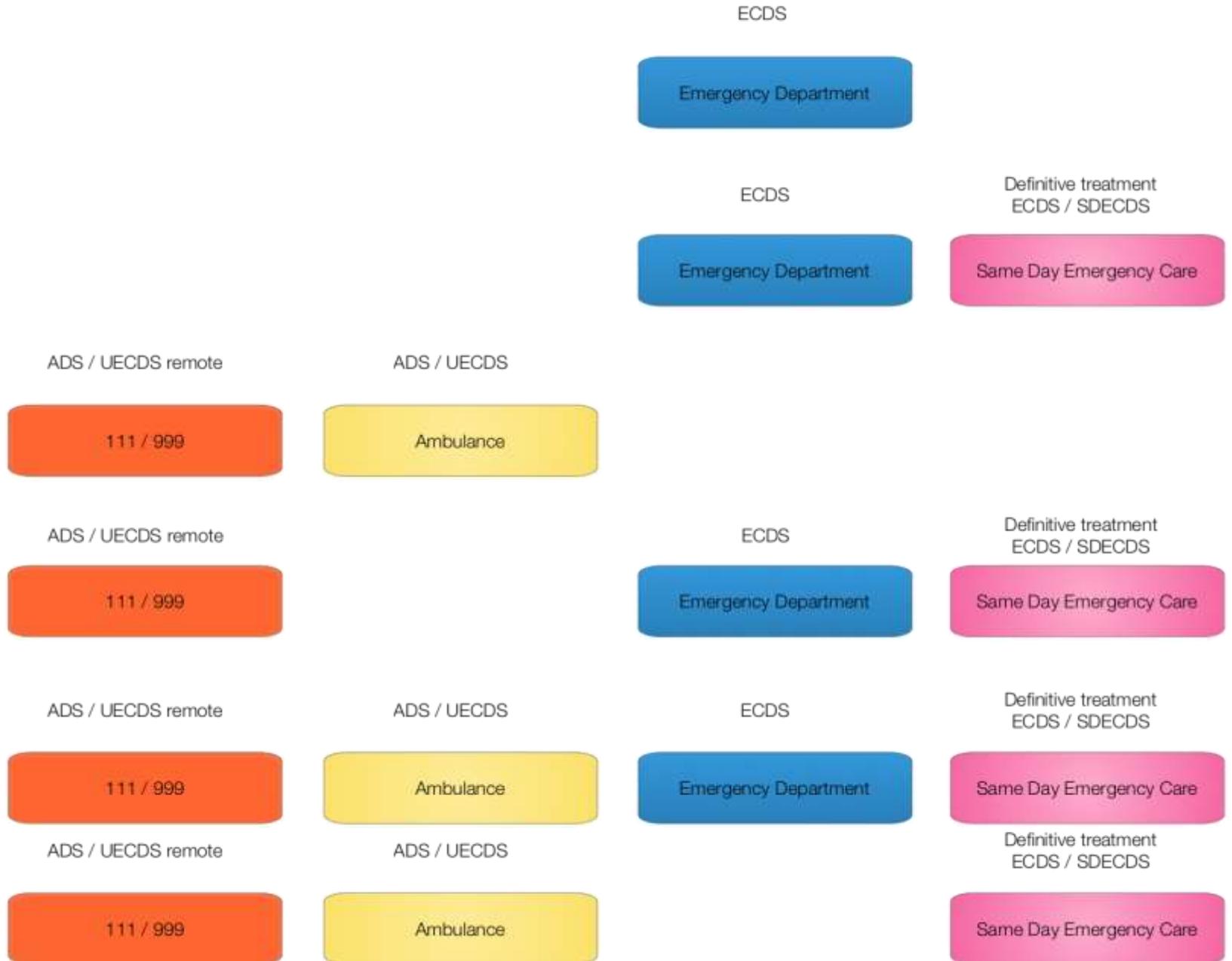
ADS

IUCDS

ECDS

SDECDS

Urgent and Emergency Care : Modular Data Set



Process Re-engineering

SDEC Short-term aims

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

SDEC Long-term aims

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



Where we are now

Piloting ECDS in SDEC – 10 Trusts

- First site live (Wexham Park)



Summary

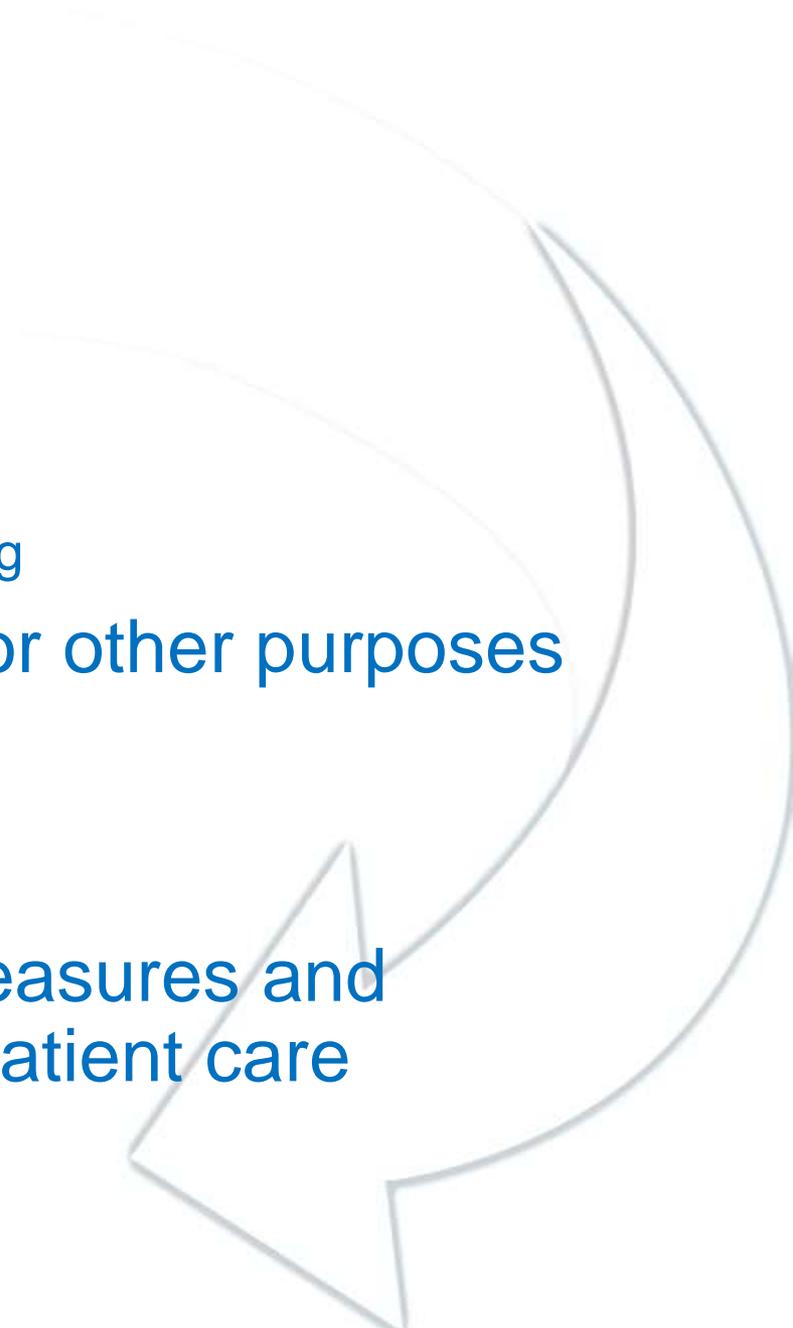
1. The world has changed

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

2. Existing data – collected for other purposes

- Not valid
- Not reliable

3. We need a system that measures and rewards excellent SDEC patient care



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

Peter Drucker



Working together to Maximise SDEC at Pace Deborah Thompson

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

There will be 9 tables and each table will host 4 rounds of discussion of 15 minutes each. At the beginning of each round the table facilitator will give a quick summary of the previous group's discussions and conclusions.

When 4 rounds are completed facilitators will be asked to feedback 3 key points of the discussion. There will be 3 minutes feedback per table.

Table Topics

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





IT IS LUNCH TIME



AEC in Emergency Care

Dr Tara Sood

RCEM AEC Toolkit

Dr Tara Sood

Consultant Emergency Medicine

Royal Free London NHS Foundation Trust

Chair RCEM Ambulatory Emergency Care Special Interest Group

NHSI Clinical Lead SDEC (RCEM)

The Royal College of Emergency Medicine



Drivers For Change





The Royal College of Emergency Medicine



Other Drivers

- Patient expectation

NHS LONG TERM
PLAN

- Financial issues
- Demographic changes
increasing demand
- Workforce issues



Key Ingredients

Same day emergency care can be successfully achieved by:

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



Who Does This ?

Emergency Physicians

Acute Physicians

Acute Surgeons

Frailty Teams

Specialist teams e.g. renal , O&G





The Royal College of
Emergency Medicine

The RCEM Ambulatory Emergency Care toolkit

Delivering same day
emergency care from the ED


Ambulatory Emergency
Care Network

January 2019



Principles of Delivering AEC from the ED

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



Work Closely With Specialist Colleagues

To standardise care according to best practice

To use local expertise

To share resources

To ensure that there are no adverse effects on ED flow



Patient Streaming

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



AEC Environment

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

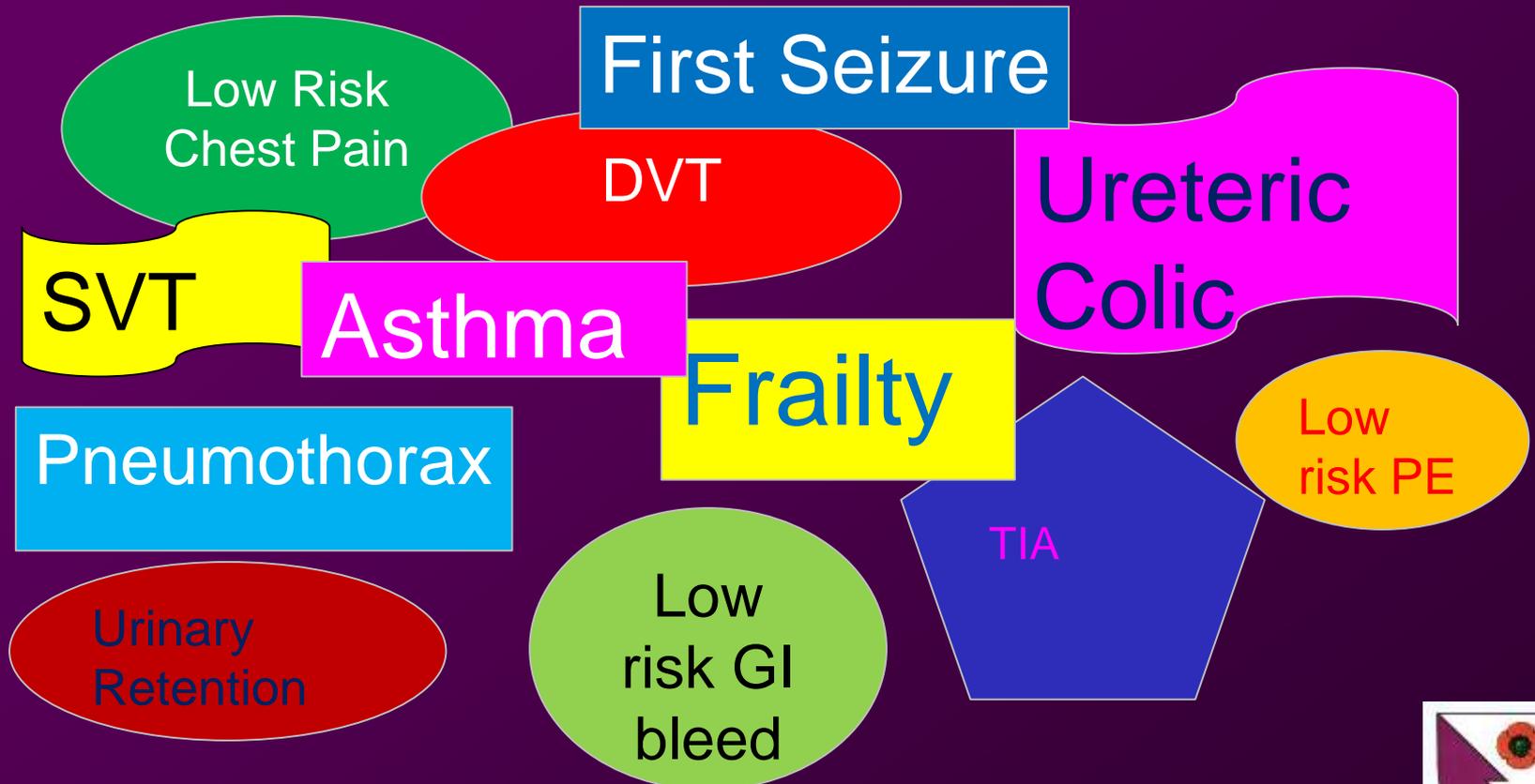


Observational Medicine

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



Delivering Ambulatory Care from the ED



Patients that should NOT be streamed to AEC

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

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



Secondary and Primary Care Services

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



Clear Measures Should be in Place

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



AEC Activity

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





RCEM VISION 2020

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

Staffing

Workforce

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



Leadership

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



Training

Enhancing the training environment to attract and retain high quality staff



Sustainable Careers

Defining careers that are successful, satisfying and sustainable



Systems

Eliminate Exit Block

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



Integrate Emergency Department 'Front Door'

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



Reconfiguration & Integration

Reorganising services to provide better, faster care



#RCEMsolutions

Support

Quality Indicators

Improving measurement of performance, safety and evidence based clinical care



Safety & Best Practice

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



Data & Information

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



rcem.ac.uk/vision2020



Same Day Emergency Care & Acute Frailty

Regional Event, Taunton: April 29th 2019

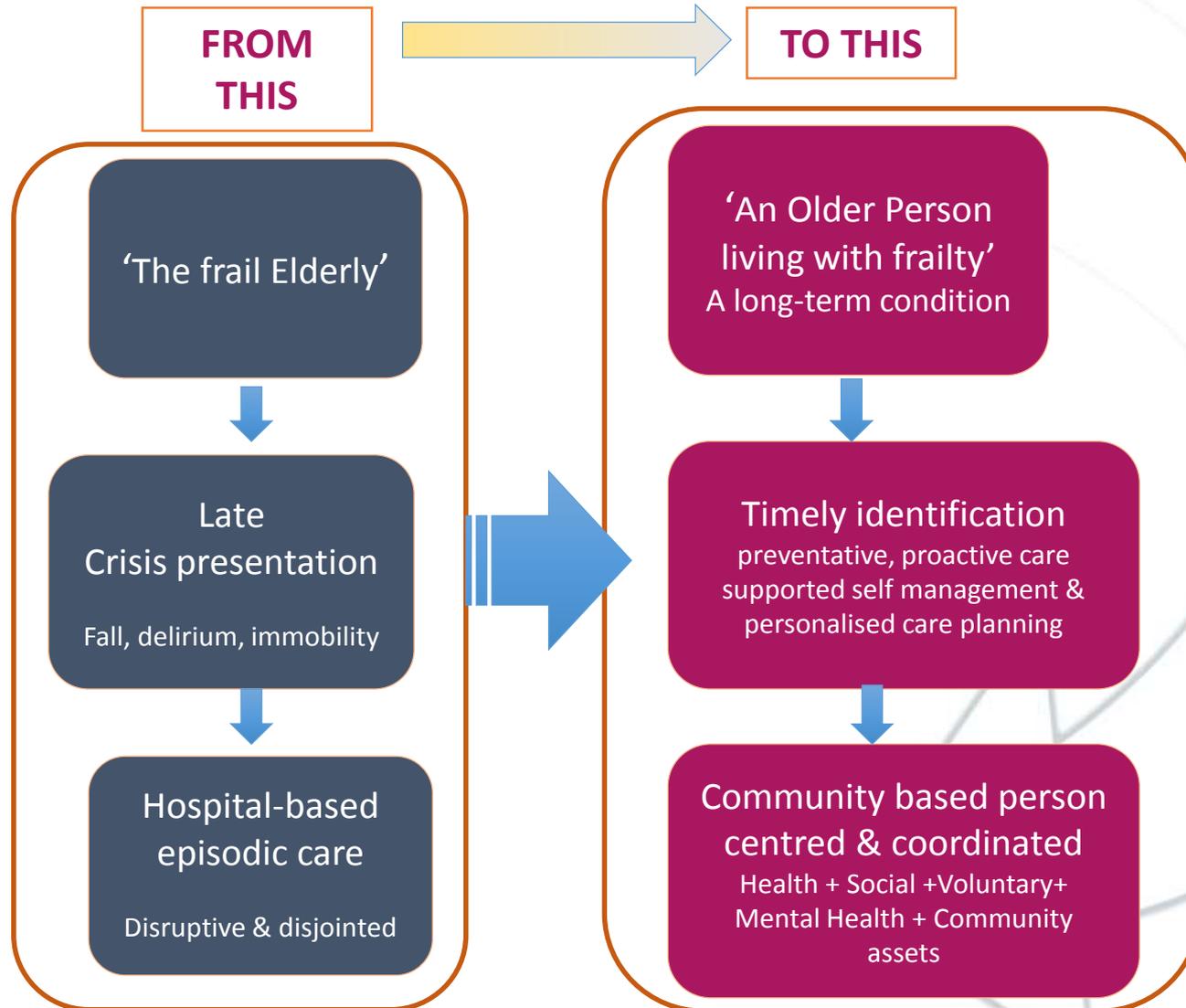
Finbarr C Martin
Emeritus Geriatrician and
Professor of Medical Gerontology

SDEC Frailty Sub-Group Lead

Putting SDEC in policy context



What's the national approach?



Slide courtesy of Martin Vernon and NHS England

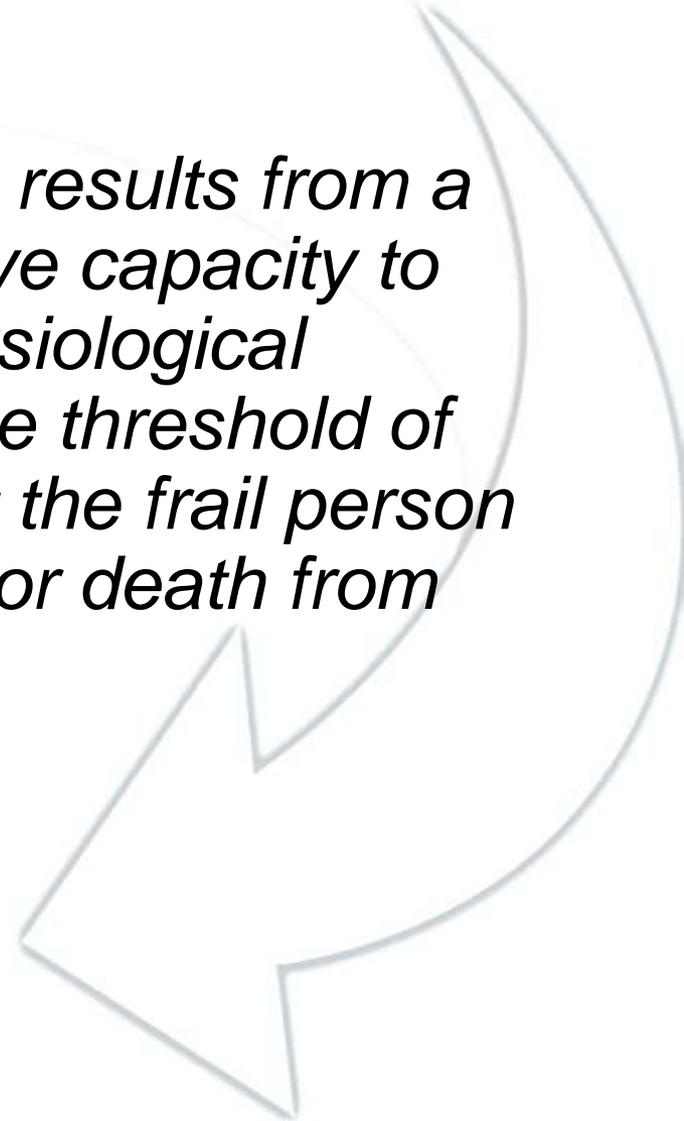
Frailty and How to Measure it



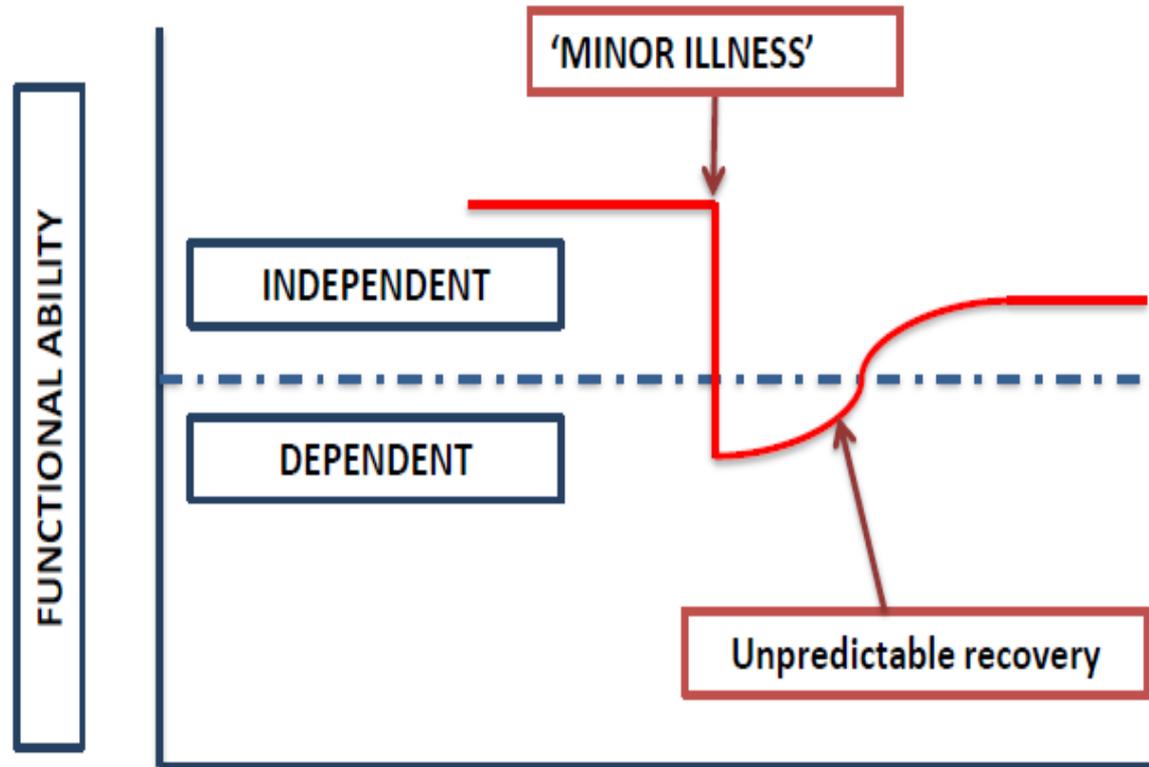
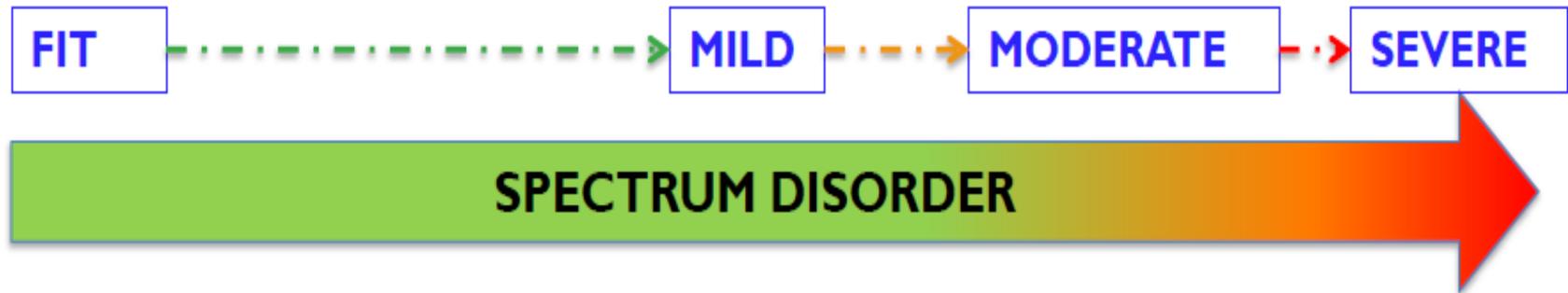
What is frailty?

- *“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"



Operationalising frailty

Phenotype

- specific measurable impairments
- distinct from co-morbidity

Deficit accumulation model

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



Fried's phenotype approach

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

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

Categories

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

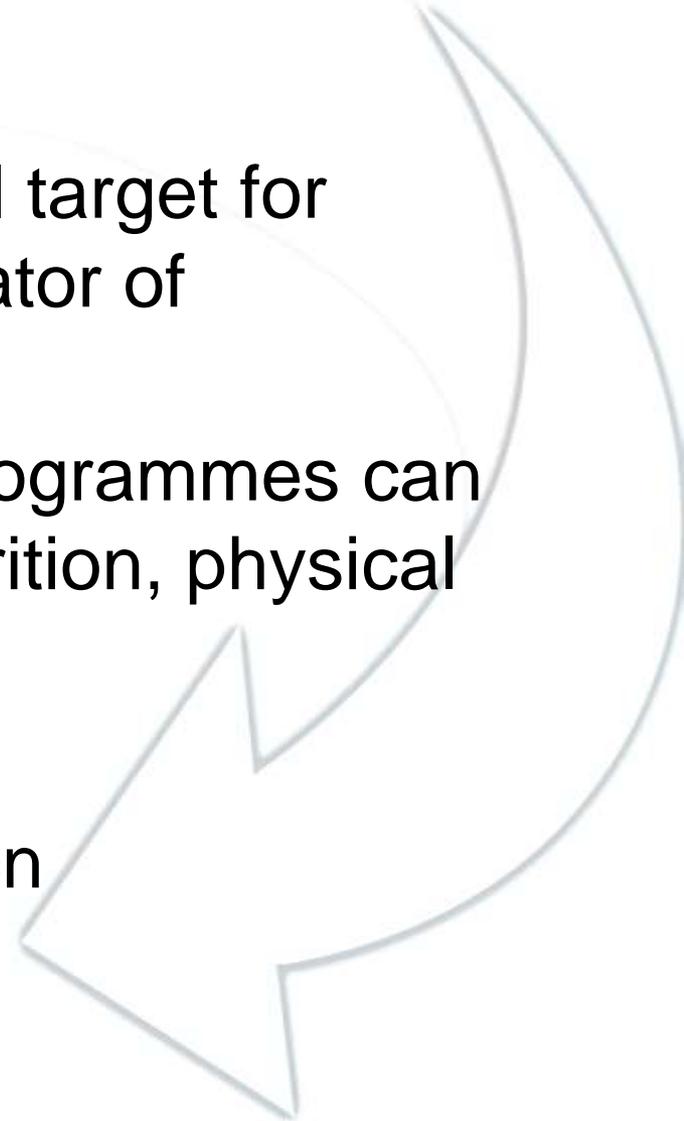


How does this help?

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

in addition to

- the current emphasis on function



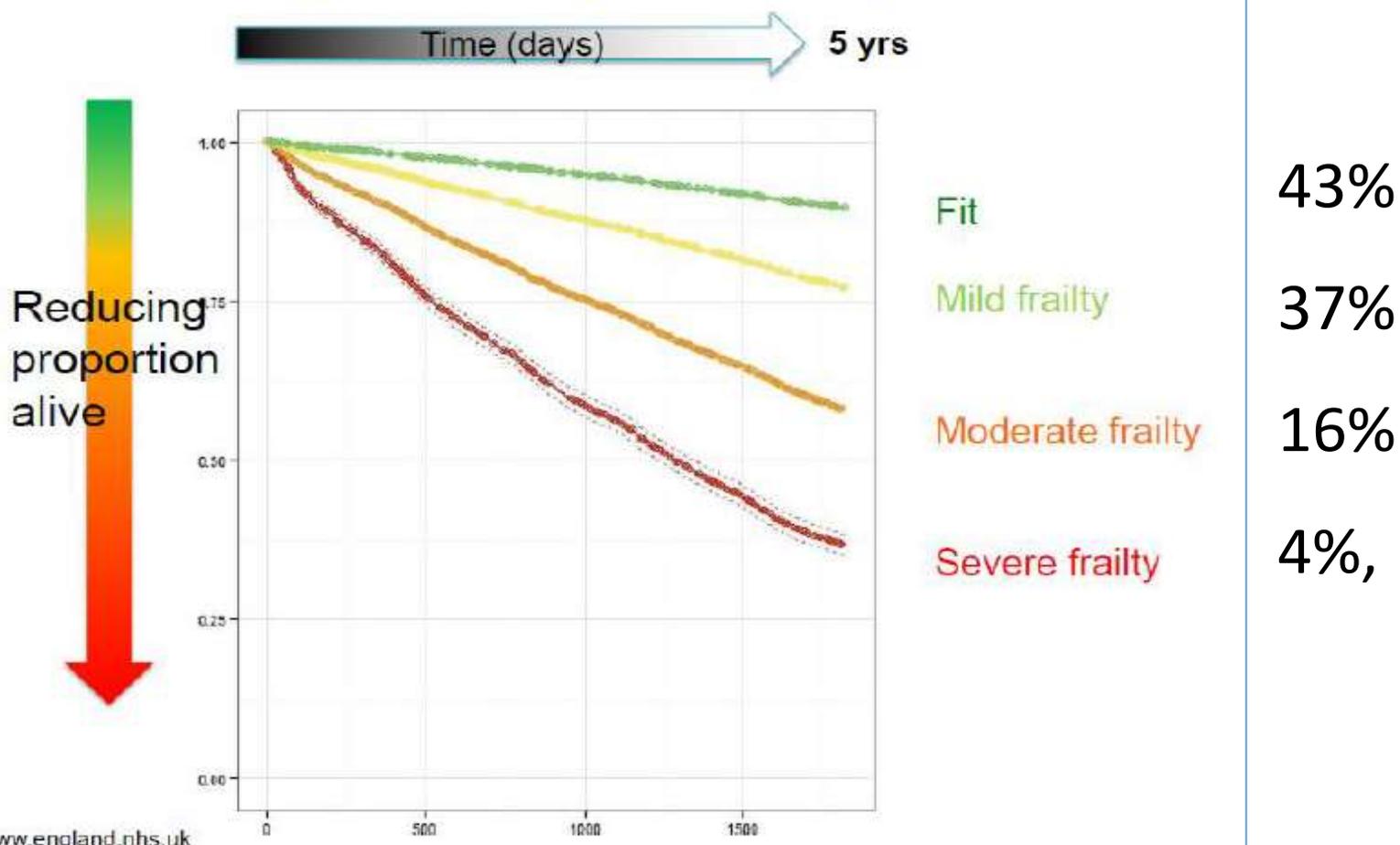
Deficit accumulation approach

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

Rockwood et al JAGS 2006; 54:975-979

eFI: the deficit approach from routine primary care data

Frailty is not good for you



How does this help?

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

(What matters to you)



Case finding – a simple tool

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

Clinical Frailty Scale*



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



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



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



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



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



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



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



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



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

Scoring frailty in people with dementia.

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

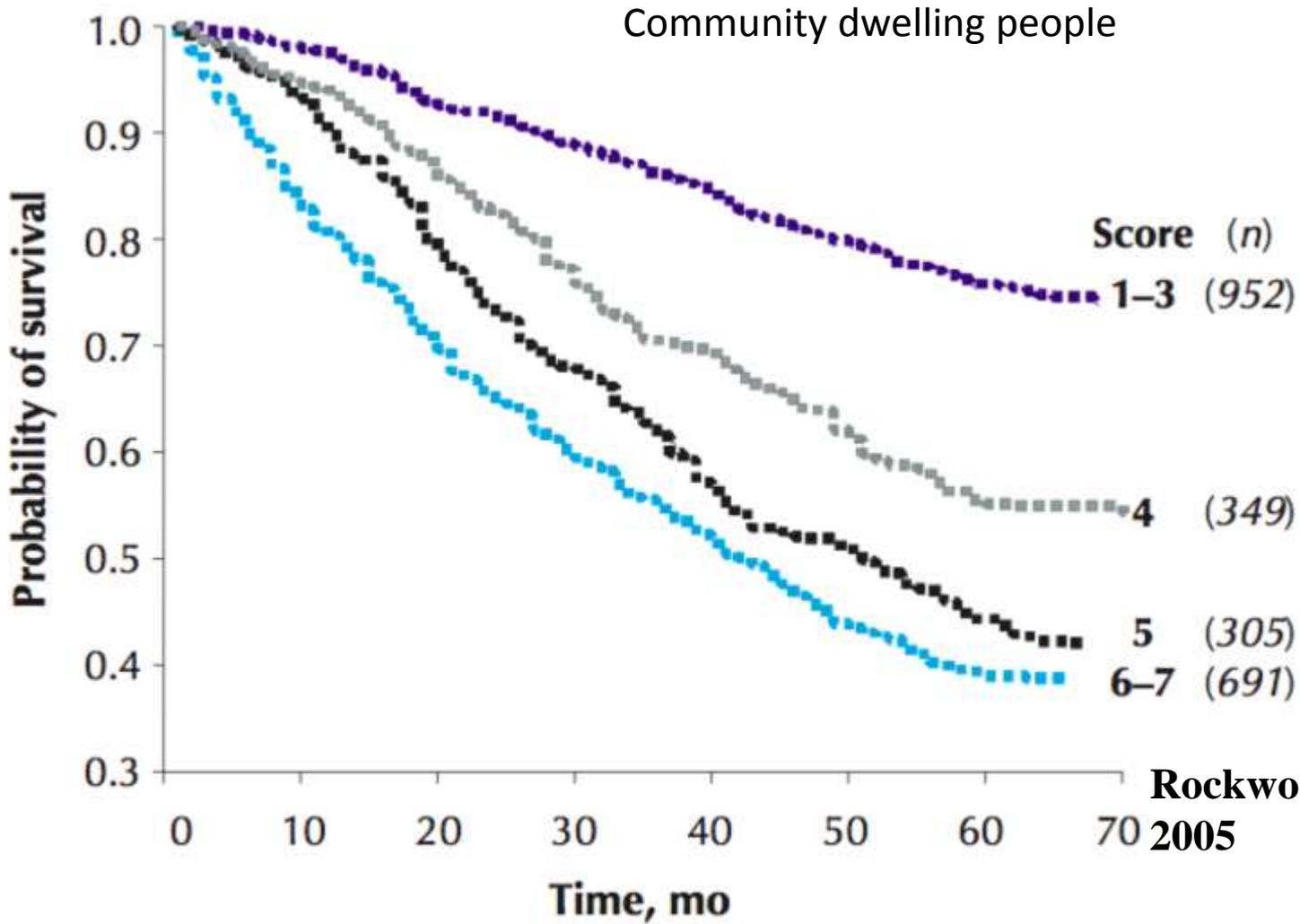
In **moderate dementia**, recent memory is very impaired, even though they seemingly can remember their past life events well. They can do personal care with prompting.

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

* 1. Canadian Study on Health & Aging, Revised 2008.

2. K. Rockwood et al. A global clinical measure of fitness and frailty in elderly people. CMAJ 2005;173:489-495.

Clinical Frailty Scale: mortality prediction



Rockwood CMAJ
2005

How common is frailty?



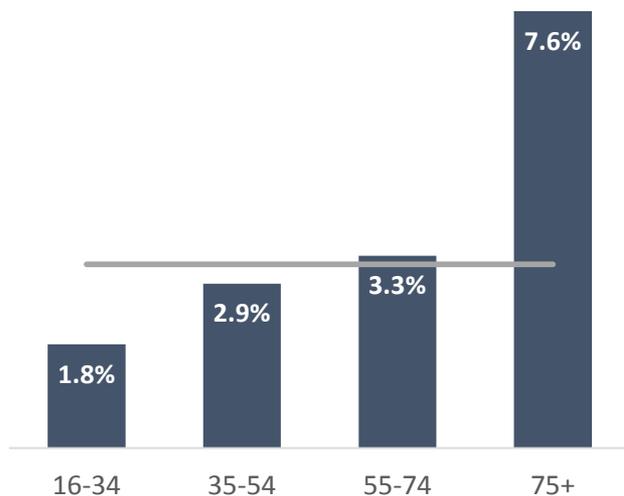
Who are the frail people?

...much older than average
(but a lot of 'frail' younger people too)

...more likely to live in
deprived areas

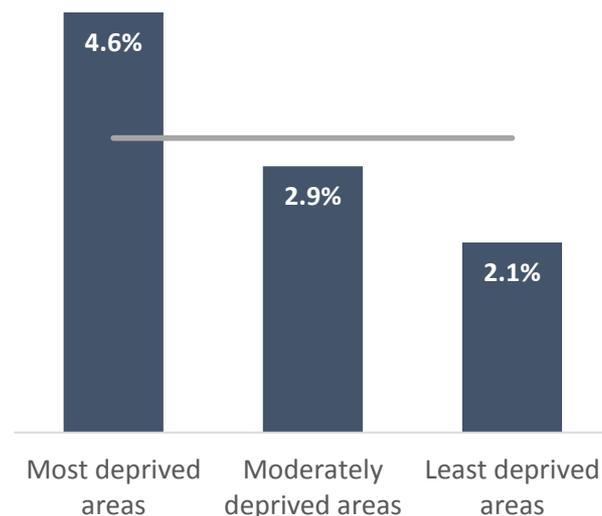
% of frail patients by age band

— National average (all ages 16+)

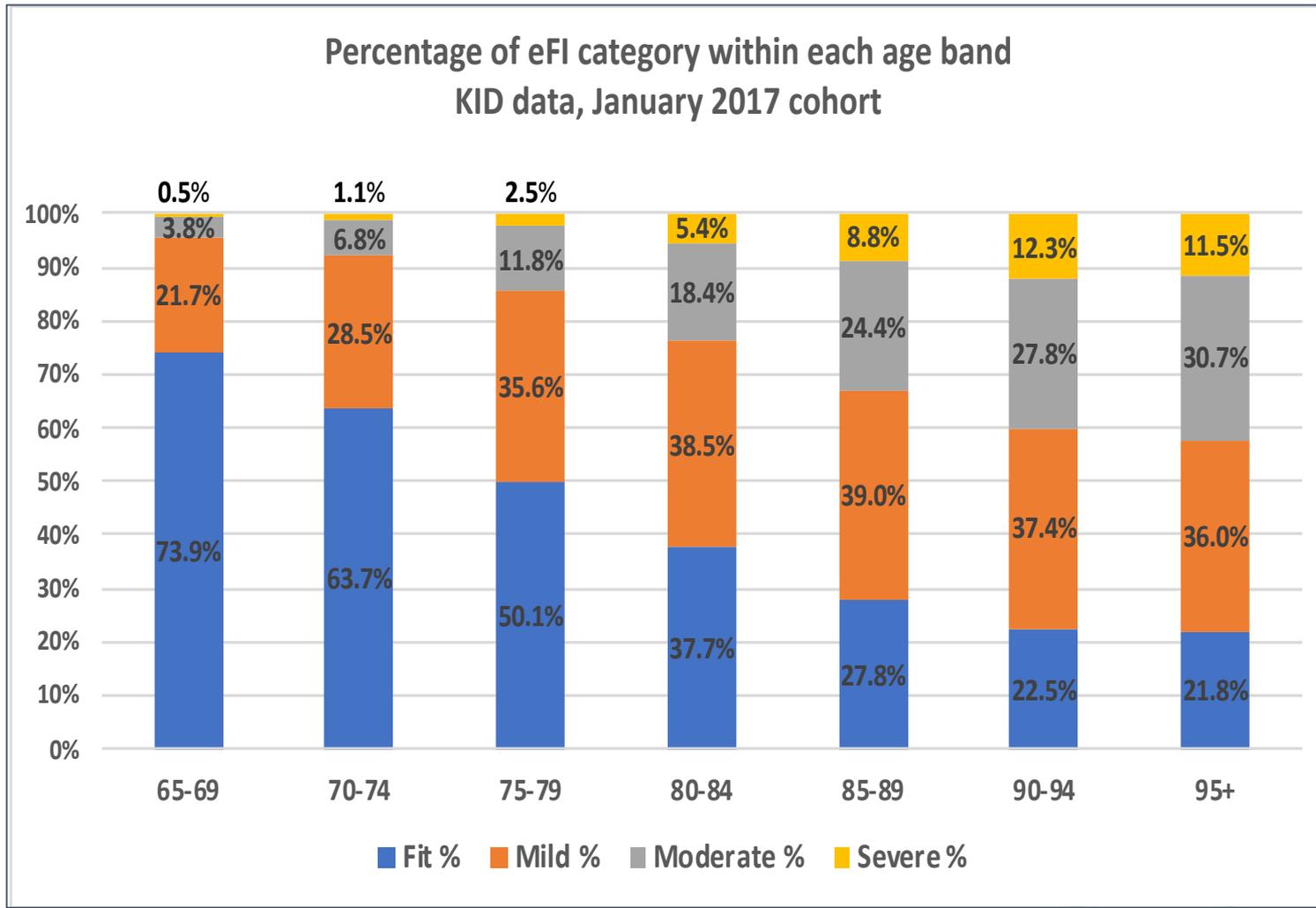


% of frail patients by deprivation

— National average (all areas)



Distribution of Frailty in old age (eFI)



Older people, frailty, hospital use and outcomes



Healthcare Activity	Percentage of in England aged 75+
No hospital activity	25.8%
Outpatient activity only	30.9%
A&E activity, no admissions	6.8%
Only planned admissions	13.7%
Single emergency admission	14.6%
Two emergency admissions	4.9%
3+ emergency admissions	3.4%

A minority are frequently admitted

Adapted slide, courtesy of the Acute Frailty Network

• Older People: HES codes to identify frailty:

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

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

Slide courtesy of the Acute Frailty Network

Their bed use and outcomes

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

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

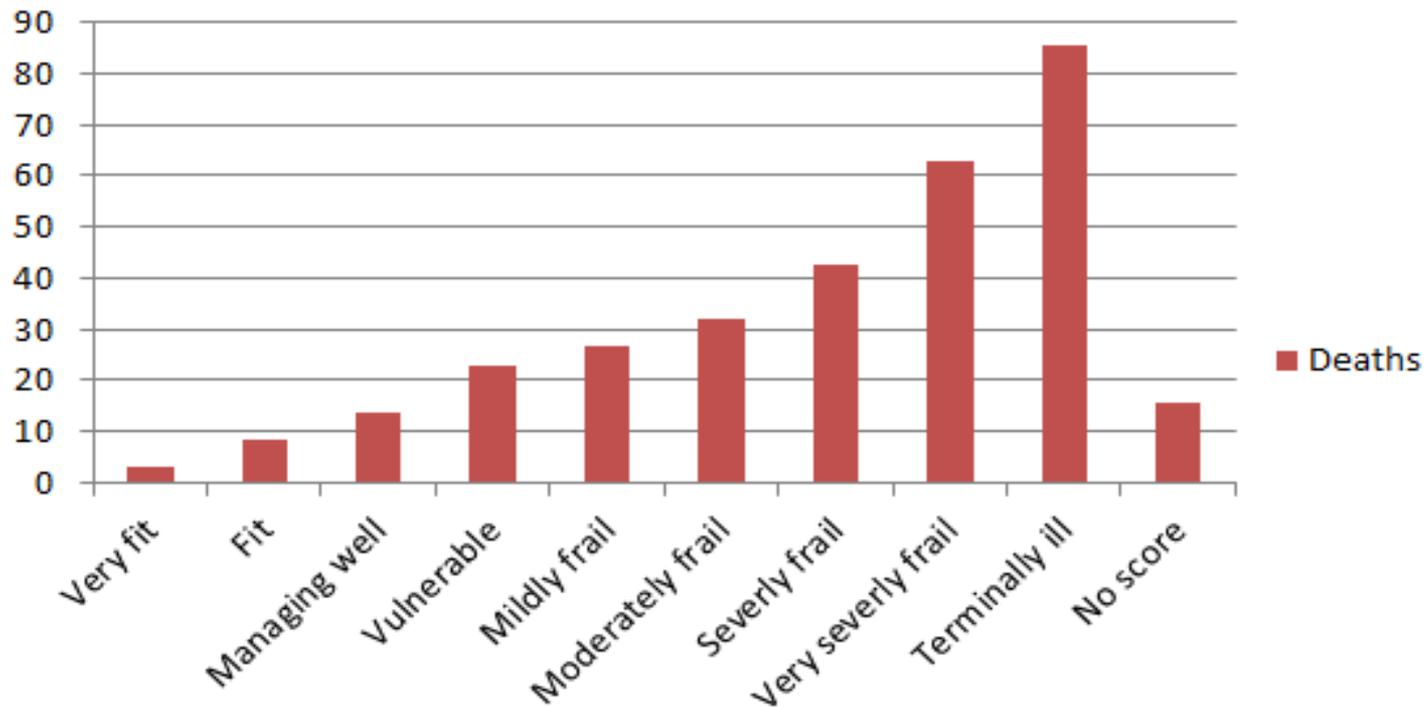
- Its not just about numbers
- Non-specific presentations can be underestimated
- It takes time to identify key issues

Three part challenge for all concerned

- Age attune in community to prevent deterioration if possible
- Provide alternatives
- Age attune the hospital to optimise the approach to the expected modern patient

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

(Admissions between April – Dec 2017)



Courtesy of David Hunt from
West Sussex Hospitals

Frailty and ED attendance



Why is identifying frailty useful?

- ***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)

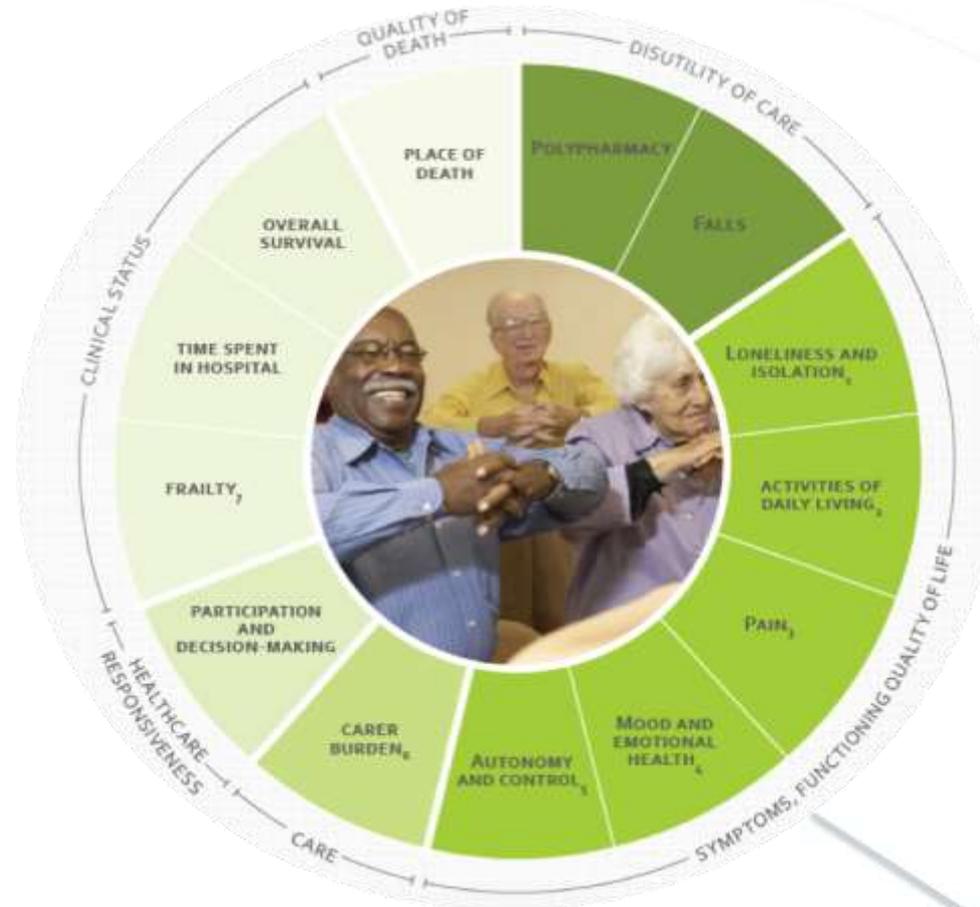
What we know what makes a
difference



Lessons from the Acute Frailty Network

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

Individualise the focus – What matters?



Domains:

- Symptoms, functioning, quality of life
- Disutility in care
- Care
- Healthcare responsiveness
- Clinical status
- Quality of death

<http://www.ichom.org/medical-conditions/older-person/>

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

Single site RCT of CGA before Vascular Surgery in London

	Intervention group n=91	Control group n=85	Significance of difference
Length of hospital stay (days)	3.3	5.5	P<0.001
Post operative delirium	9 (11%)	22 (24%)	P<0.05
All complications	7%	4.2%	P<0.05

Preventing future admissions

- Functional rehabilitation
- Building psycho-social resilience
- Adapt LTC programmes
- Medications modification
- Falls and fracture prevention
- Advanced care planning (especially care homes)





Summary points



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

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

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

Frailty

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

Frailism takes the place of ageism

Key actions

- Expect patients with frailty and identify this early
- Expect this in patients with medical or surgical issues
- Start a CGA approach to care from the start
- Develop clear reliable care pathways out of and into the hospital
- Develop shared governance systems

New Frontiers in Frailty conference

Book your place 27th June 2019

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

27th June 2019

9am – 4.30pm, Central London

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

Professor Simon Conroy
University Hospitals of Leicester

Early Bird Rate

Only £125 ~~£149~~

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

Only £149 ~~£189~~

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

Early bird available until 30th April 2019

Places are limited so please book soon:

www.acutefrailtynetwork.org.uk

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

Showcase Sites: North Bristol NHS Trust

SURGICAL EMERGENCY CARE

North Bristol NHS Trust

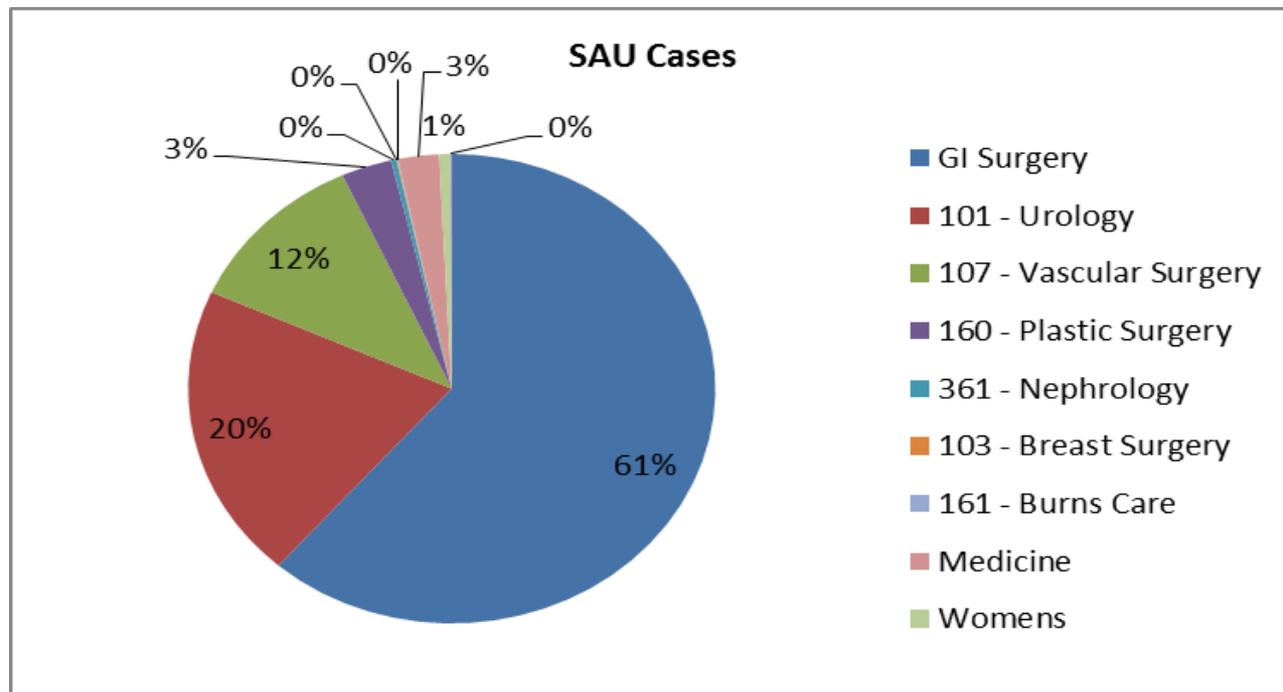


Surgical Assessment Unit

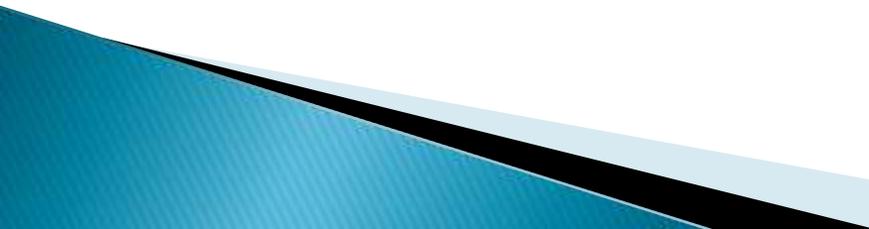
32 bedded unit, 1 'procedure' room

Nurse led, Multiple Consultant led WR

Input from: Hospital@Home, React, Geriatrician Registrar

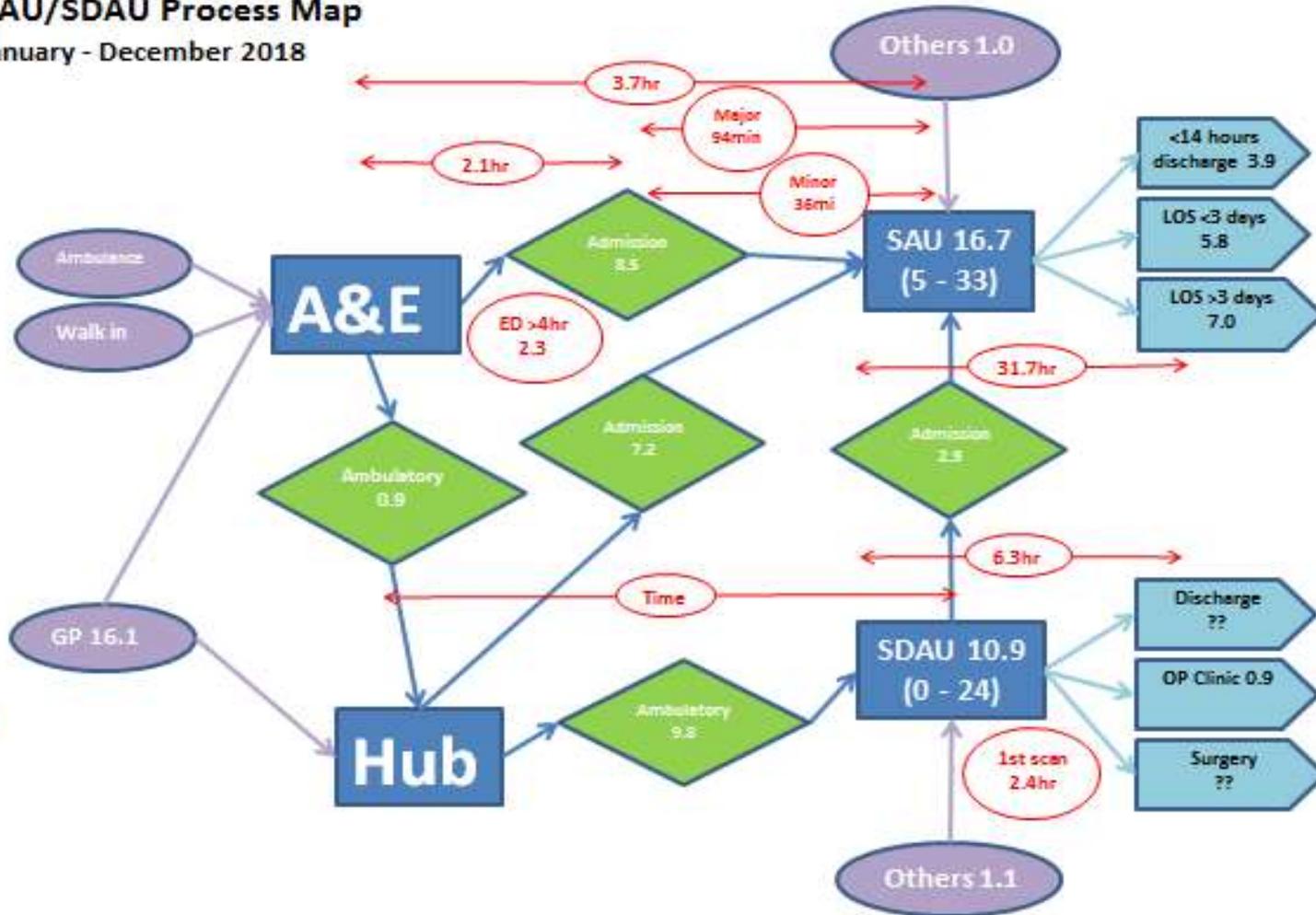


SURGICAL DAY ASSESSMENT UNIT

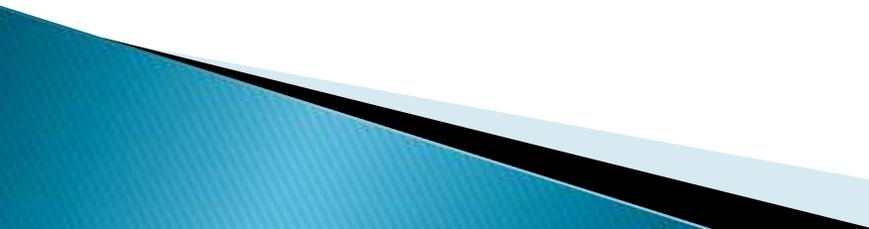
- ▶ Located in outpatient area using 4 clinic rooms
 - ▶ Close proximity to ED and Diagnostics (MRI, CT)
 - ▶ Staffed by 1 RN and 1 HCA from SAU workforce
 - ▶ Urology registrar (support by consultant)
 - ▶ GI Consultant, F2 and F1 (registrar on SAU)
- 

SAU/SDAU Process Map

January - December 2018



18/19 Service Re-design and Improvements

- Re-located SDAU to outpatient setting
 - Additional 400k worth of additional investment into kit, capital and workforce
 - Change in IT systems to introduce electronic FLOW system covering SDAU and SAU as separate entities
 - Improved data analysis and management to identify further opportunity
 - NO MORE AMBULATORY > fit to sit versus bed required
 - Increase in ring fenced 'hot' theatre capacity for urology and GI to allow for quicker access for emergency patients such as hot stones or laparoscopic cholecystectomy
 - Increased ring fenced ultra sound capacity for surgical emergency admissions.
 - Protocolised Pathways; Abscess/Biliary/UGI/LGI Pain/LGI bleed based on NEWS/Stability
- 

KEY OUTCOMES

		SAU Measures				SDAU Measures				
Year	Month	SAU Cases	SAU AvLoS	SAU <14hr Discharge	% SAU 14hr Dis	SDAU Cases	SDAU Avg Dept hrs	SDAU Conversions	% SDAU Conversions	SDAU Avg time 1st Scan
2017 Total		4900	39.7	814	16.6%	3777	6.1	1223	32.4%	3.1
2018 Total		6106	31.7	1430	23.4%	3983	6.3	1064	26.7%	2.4

- Reduction in transfer time from DTA within ED to SAU/SDAU: for Minors patients 21 minutes (avg. 54 minutes reduced to 33 minutes); and 10 minutes for majors patient
- Reduction in LoS on SAU ward from 38.5 hours to 32.1 hours.
- Increase of 6.8% admission avoidance with 76.09% of patients assessed via SDAU and discharged same day in winter 2018/19

		SAU/SDAU Combined Measures				
Year	Month	GP Adm Saved	% GP Adm Saved	Avg ED Wait hrs	Majors Avg DTA Wait mins	Minors Avg DTA Wait mins
2017 Total		2005	44.1%	3.8	111.2	51.7
2018 Total		2360	40.2%	3.7	94.5	36.0

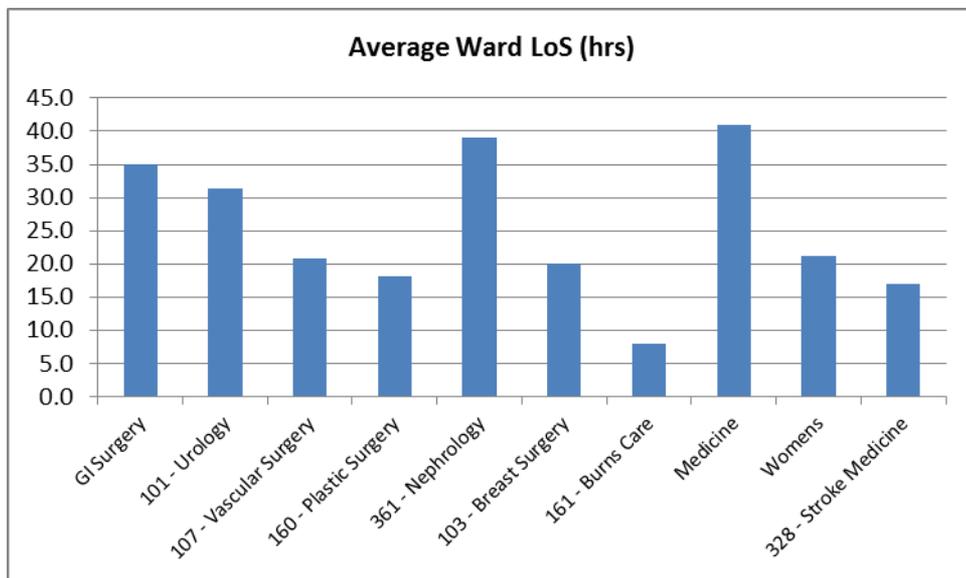
WINTER 17/18 VS 18/19

Week_Start	SAU Measures				SDAU Measures				SAU/SDAU Combined Measures				
	SAU Cases	SAU AvLoS	SAU <14hr Discharge	% SAU 14hr Dis	SDAU Cases	SDAU Conversions	% SDAU Conversions	SDAU Avg time 1st Scan	GP Adm Saved	% GP Adm Saved	Avg ED Wait hrs	Majors Avg DTA Wait mins	Minors Avg DTA Wait mins
Total	1731	32.1	354	20.5%	1343	321	23.9%	2.0	603	42.1%	4.1	102.2	32.6
Change	12.0%				21.1%	-5.6%		-20.3%	-1.3%		3.0%	-8.9%	-39.4%

0 complaints for March 2019

Average of 3-5 empty beds to start day each day on SAU

Improvement in LOS on SAU supporting better FLOW through ED



Emergency Theatre Provision

We monitor our emergency theatre based on the above KPIs. For GI surgery we perform as follows; (aiming for 85% as per NELA recommendations)

Immediate

% In Target	
FirstD	Total
Nov-17	79.4%
Dec-17	77.6%
Jan-18	76.9%
Feb-18	77.6%
Mar-18	70.6%
Apr-18	68.6%
May-18	78.4%
Jun-18	80.0%
Jul-18	78.8%
Aug-18	80.4%
Sep-18	76.0%
Oct-18	67.4%
Total	75.9%

Emergency

% In Target	
FirstD	Total
Nov-17	65.9%
Dec-17	68.0%
Jan-18	76.7%
Feb-18	75.0%
Mar-18	71.4%
Apr-18	76.3%
May-18	75.2%
Jun-18	81.5%
Jul-18	71.3%
Aug-18	73.7%
Sep-18	71.6%
Oct-18	67.9%
Total	72.8%

Urgent

% In Target	
FirstD	Total
Nov-17	78.7%
Dec-17	81.0%
Jan-18	88.5%
Feb-18	83.6%
Mar-18	85.9%
Apr-18	86.7%
May-18	87.4%
Jun-18	89.6%
Jul-18	84.7%
Aug-18	84.4%
Sep-18	80.2%
Oct-18	83.5%
Total	84.6%

Scheduled

% In Target	
FirstD	Total
Nov-17	79.6%
Dec-17	81.3%
Jan-18	87.1%
Feb-18	87.3%
Mar-18	87.0%
Apr-18	87.9%
May-18	87.9%
Jun-18	91.5%
Jul-18	94.0%
Aug-18	91.9%
Sep-18	91.6%
Oct-18	91.7%
Total	89.2%

Chole-Quic

Wait for Surgery 8 days < 30% to 100%

Waiting List 120 reduction to 20

NEXT STEPS

Expansion of nurse practitioner role

Triage: phone calls via ward nursing team to increase accuracy?

Safari Ward Rounds; delays to TTAs/pharmacy

Embedding nurse led discharge/enhanced recovery pathways
(emergency laparotomy etc)

Key focus on frailty patients

Further review of flow into emergency theatres/identification of
quick access

Showcase Sites: Great Western Hospitals

AEC- getting it right- slowly!!

Sarah Fallon ,Matron

Claire Adlam, Head Of Service

October 2018

History

- Started October 2011, Mon-Friday (initially 10am – 8pm)
- Process driven v Pathway driven
 - Based upon 49 ACU conditions Directory
 - “Are they well enough to sit in a chair?”, “Is there a single definitive test that would enable discharge?”
- Close links with the Emergency Department
 - Initially co-located
 - **Moved to 3rd floor Dec 2012**
 - Senior Decision Makers - Consultants
- Good access to radiology / investigations
 - ETT/ECHO bay – same day access

ACU High Volume Conditions

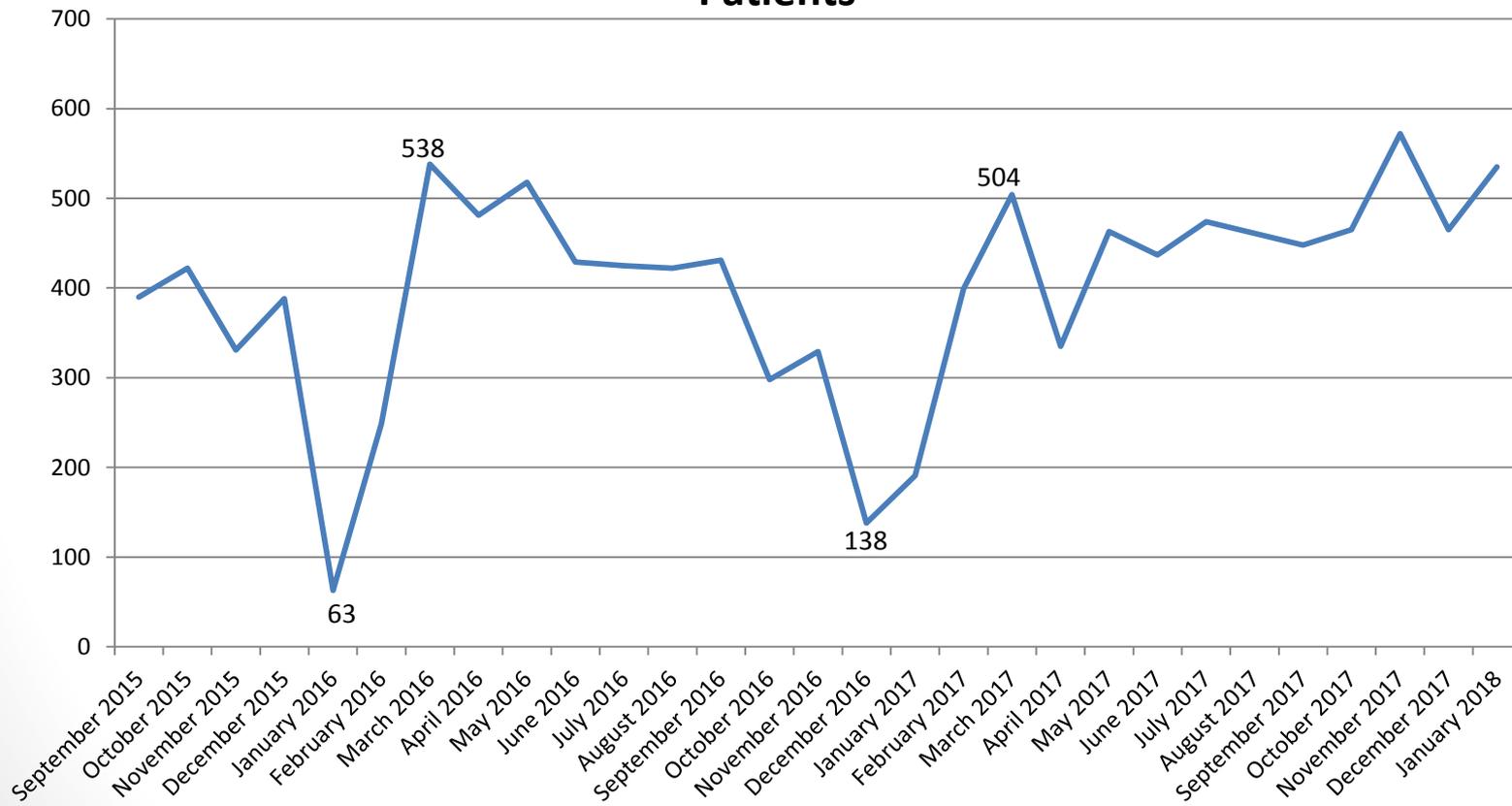
- Chest pain awaiting troponin/ETT
- Chest pain ?PE
- Cellulitis needing IVABx
- Headache ?SAH ?migraine ?temporal arteritis
- Severe Hypertension
- Heart Failure
- Mild CAP
- (Pseudo-)Hyperkalaemia
- Anaemia/low risk GI bleed
- SVT/AF
- Ascites/Pleural Effusions

What was wrong?

- The unit was incorporated on the 3rd floor alongside the AMU and SSU - distant from ED and diagnostics
- Previously a ward environment -provided space and ease to bed overnight at times of escalation- inpatients
- Review of data showed a zero length of stay of ~33% on AMU
- Frustration from clinical team
- Poor patient experience

What the data showed

Total Attendances to AEC per month (including admitted) Total Patients



So what did we do....

- Business case to move the AEC to location on the ground floor, close but not adjacent to the ED.
- We acknowledged loss 3 single side rooms/consulting rooms but gained a waiting room with 26 chairs, 4 trolleys/couches
- Assessment area for ECG, bloods obs
- Use of consulting rooms in the adjacent UCC if required.
- **Protected area that could not be bedded**
- Increased staffing model
- Buy in from execs
- Expectation to deliver on KPI's ~ improve standards for patients and internal professional standards.
- Deliver 30% of medical take daily through AEC = better flow and 4 hour performance

We did it....

- Business case successful and funding approved and build went ahead
- Opened in Jan 2017
- ANP team increased by 2 WTE
- GP Triage Phone calls taken by the whole team not just nursing team-consultants included
- Consultant Advice line established
- Opened an MEU on AMU to accept triaged GP calls from AEC to AMU if criteria met.
- We saw approximately 4% improvement in our 4 hour performance as a Trust-
- Daily Staffing on AEC now included –
 - 1 Consultant
 - 3 SHOs
 - Clinical Fellow, GP Trainee, Acute medicine SHO
 - 2 Advanced Nurse Practitioners
 - 1 RN Band 6
 - 1 Assistant Practitioner
 - 1 Patient Coordinator/Admin

Is the patient suitable for AEC?

Key Questions

Is the patient sufficiently stable to be managed in AEC (usually NEWS ≤ 4)?

Is the patient functionally capable of being managed in AEC whilst maintaining their safety, privacy and dignity?

Is there an existing outpatient or community service that could more appropriately meet the patients needs?

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

Unsuitable.. at present

Ambulatory Care: Unsuitable Referrals

- Suspected cardiac chest pain ➤ **ED**
- Suspected CVA or acute ICH ➤ **ED**
- Non-ambulatory patients ➤ **Acute Medical Unit**
- Confused patients/mental health patients ➤ **Acute Medical Unit**
- Those with oxygen requirements ➤ **Acute Medical Unit**
- Those needing isolation ➤ **Acute Medical Unit**
 - i.e. D&V, Flu, Meningitis, TB or Neutropenic infection

Ambulatory Care: Unsuitable Referrals

- Under 18-year olds
 - Suspected giant cell arteritis
 - Suspected idiopathic intracranial hypertension
 - Upper limb cellulitis
 - Facial/orbital cellulitis
 - Cholecystitis or appendicitis
- **Paediatrics**
 - **Rheumatology or Ophthalmology**
 - **Neurology**
 - **T&O**
 - **Maxillofacial**
 - **General Surgery**

Access to Hospital Outpatient Treatment: HOT Clinics

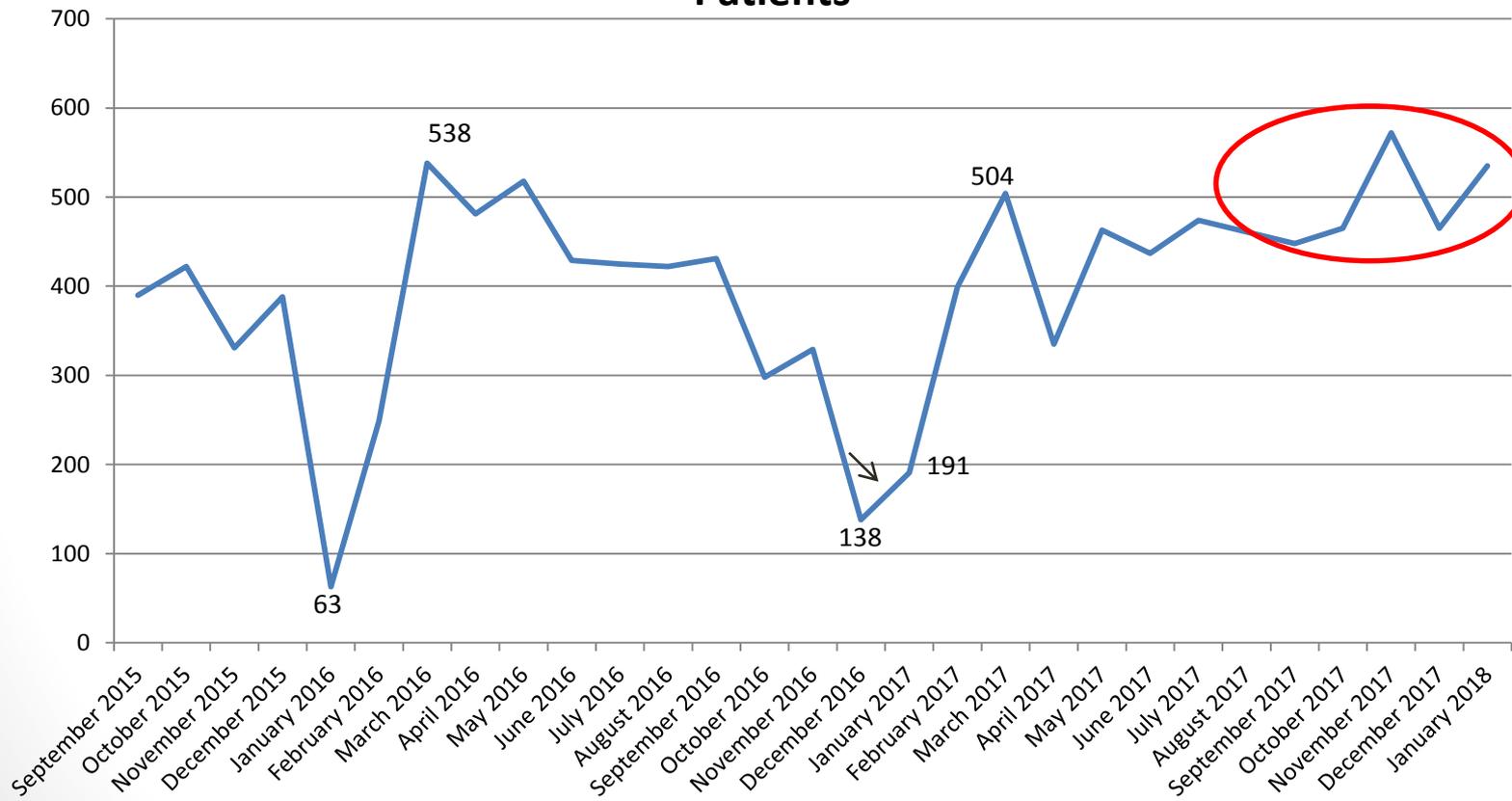
- **Neurology HOT Clinics**
 - 5 days per week
 - Not a TIA service
 - Screened through AMU/ACU first

- **Cardiology Chest Pain HOT Clinics**
 - 5 days per week
 - Referrals from AMU/ACU and ED

- Plans to expand to respiratory/pleural

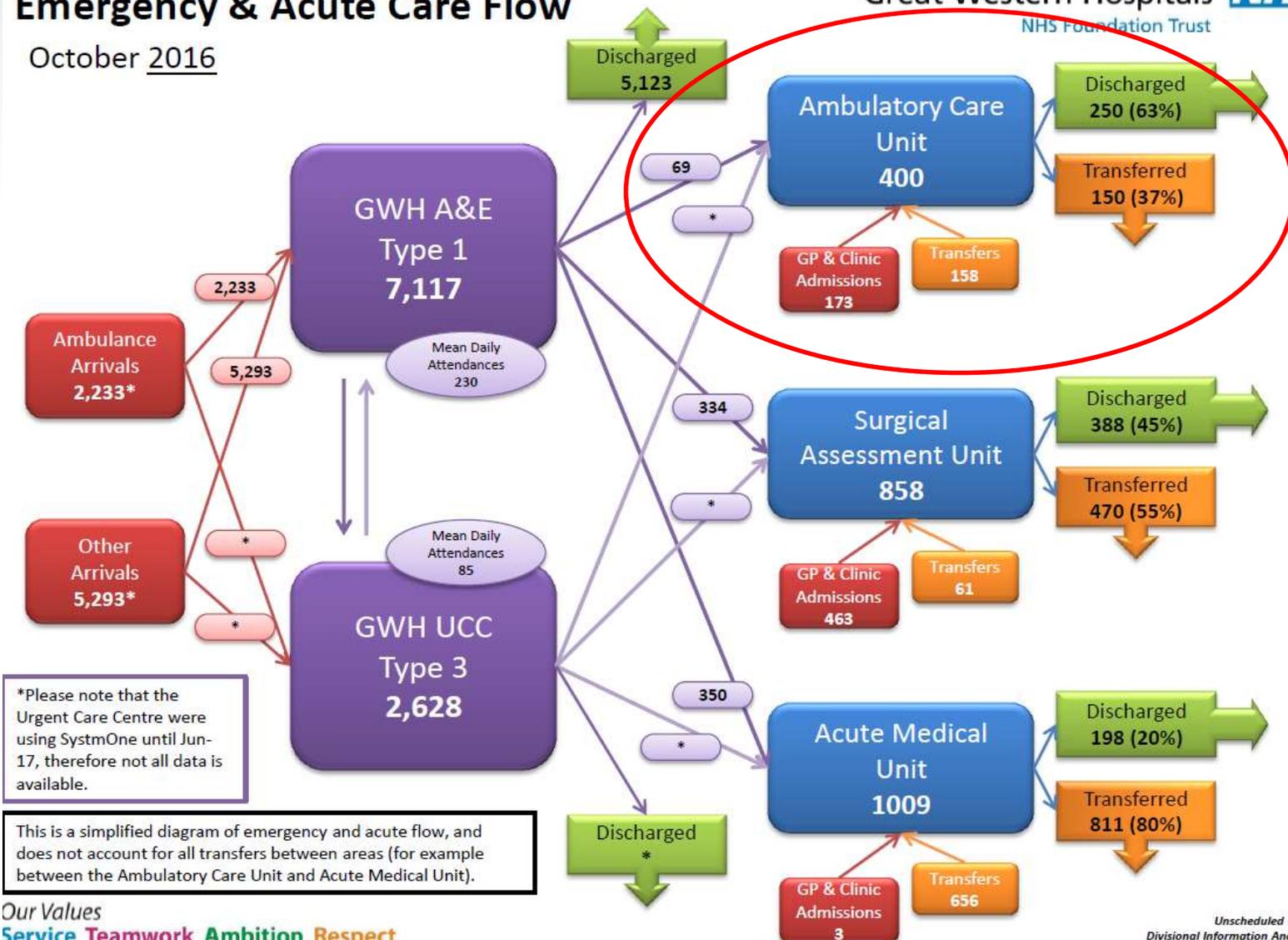
What the data showed

Total Attendances to AEC per month (including admitted) Total Patients



Emergency & Acute Care Flow

October 2016

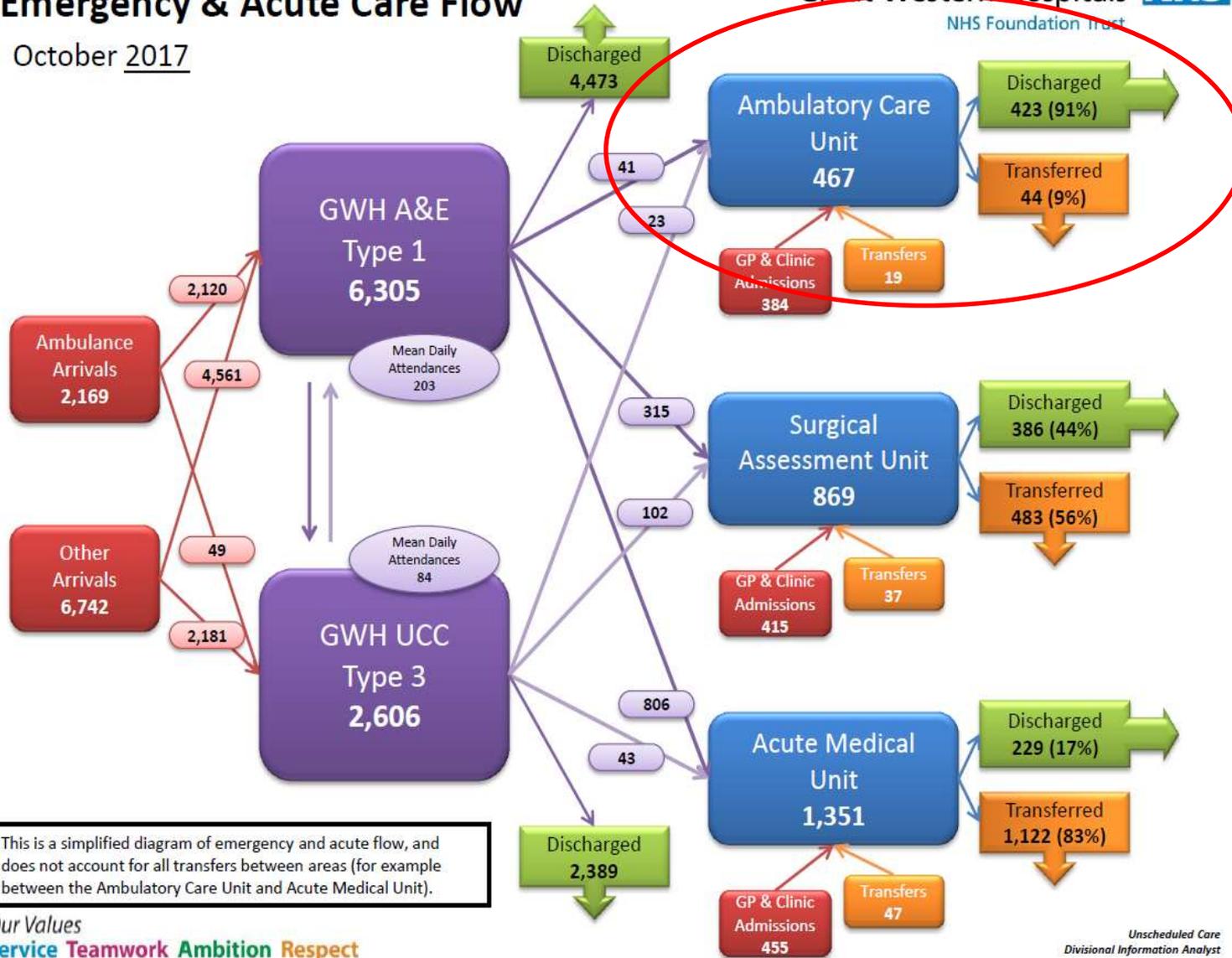


*Please note that the Urgent Care Centre were using SystemOne until Jun-17, therefore not all data is available.

This is a simplified diagram of emergency and acute flow, and does not account for all transfers between areas (for example between the Ambulatory Care Unit and Acute Medical Unit).

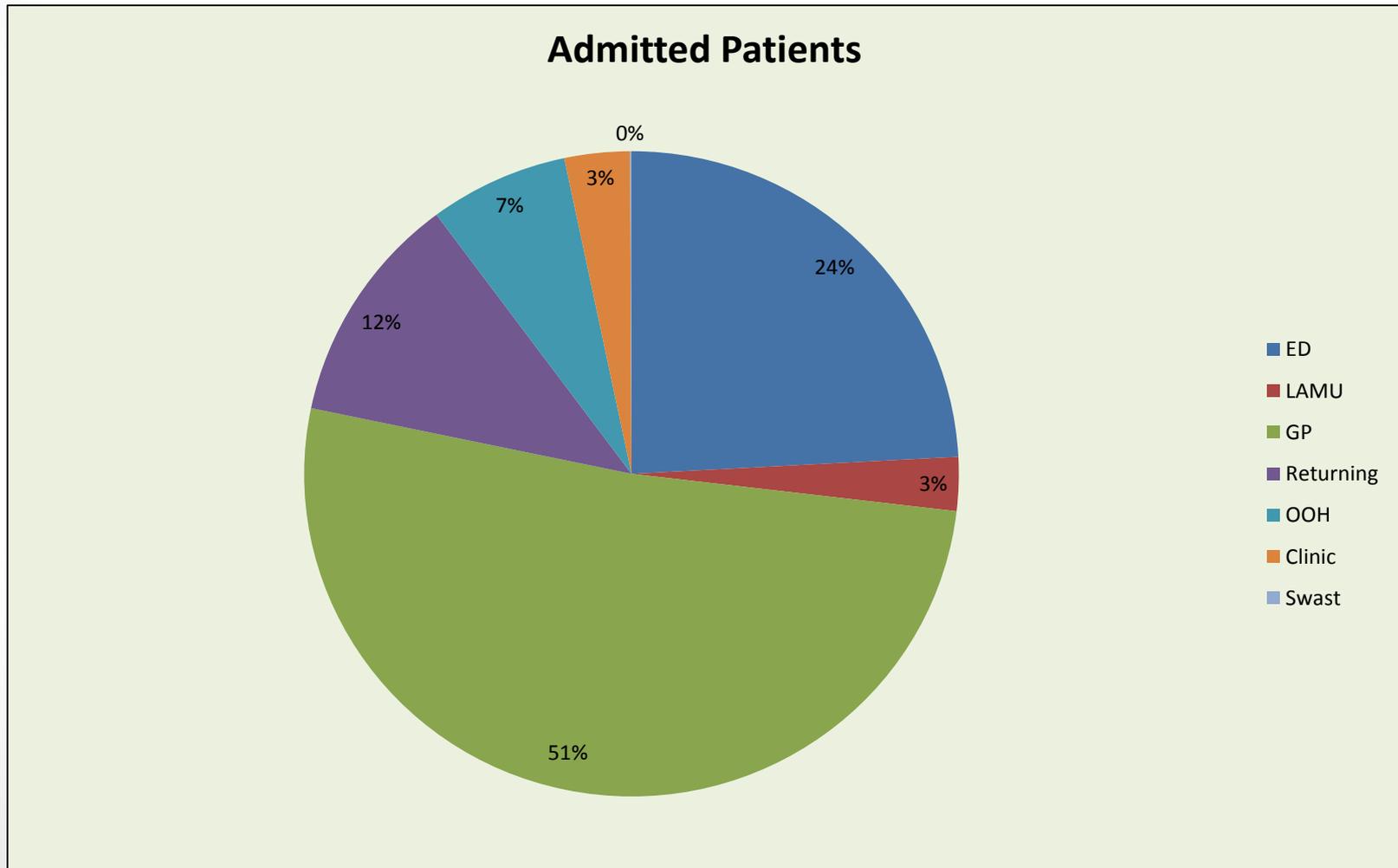
Emergency & Acute Care Flow

October 2017



This is a simplified diagram of emergency and acute flow, and does not account for all transfers between areas (for example between the Ambulatory Care Unit and Acute Medical Unit).

Where did they come from..



Challenges

- We had no isolations rooms
- Capacity for ECHO could match our demand at times
- DVT pathway in community collapsed and came into secondary care
- AEC was separate from the rest of Acute Medical team
- As confidence grew we began to take 'outpatient' pathways for other department that lacked capacity or own pathways.
- Team have to 'pull' from ED rather than active referral
- Inpatient referrals to support early discharge constant challenge.

Successes

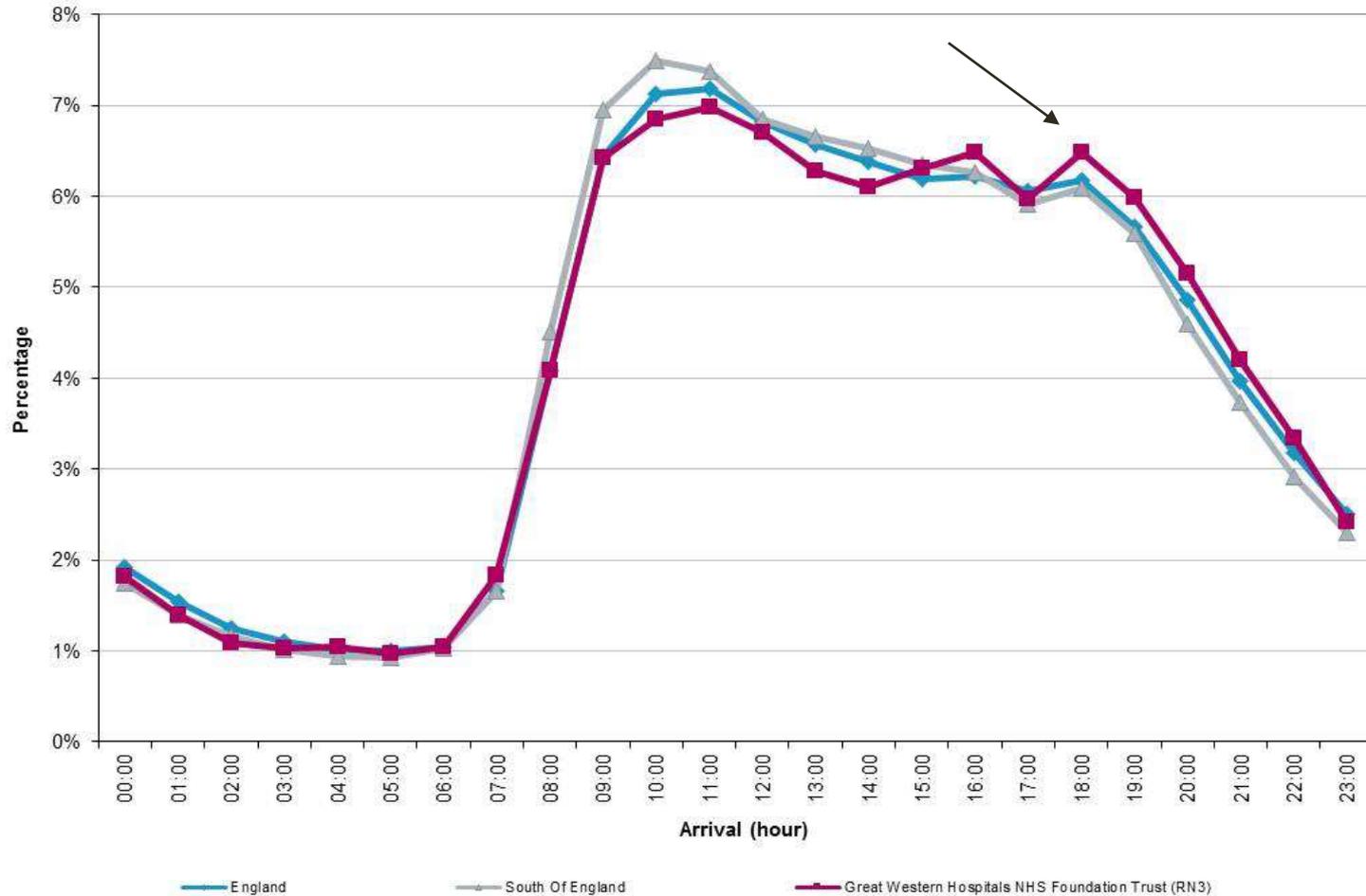
- We consistently see 25-35% of the daily medical take in AEC
- We have built a robust service that has reduced our zero length of stay on AMU
- Developed new pathways and continue to do so
- Introduced point of care testing for D-dimer – DVT

So what next

- We had our AEC review and rated 'Excellent standard'
- Currently building larger unit where ALL GP patients arrive and are RAT'ed ensuring optimisation of pathways into AEC
- 4 trolley bay, 7 consulting rooms and 2 monitored trollies waiting/treatment area of 26 chairs
- USS clinic room and discussion re training ACP to undertake USS of lower limb for ACP led DVT pathway
- Extended POCT
- Frailty pathways identified with DOME consultants and Older persons short stay unit
- Combining AEC and MEU means speciality consultants will provide more robust in-reach services.
- All patients sent to MEU will have been triages, blood radiology etc.
- Extended hours until 2200
- Improved advice and guidance

Extending Hours

To meet demand of take pressures



Future dreams....

- Co locate front door!!
- Work on active referral from ED
- Promote use of AEC for early discharge from Inpatient wards
- Have one combined unit
- Develop further ACP pathways with consultant oversight

Supporting Next Steps

Rachel Vokes

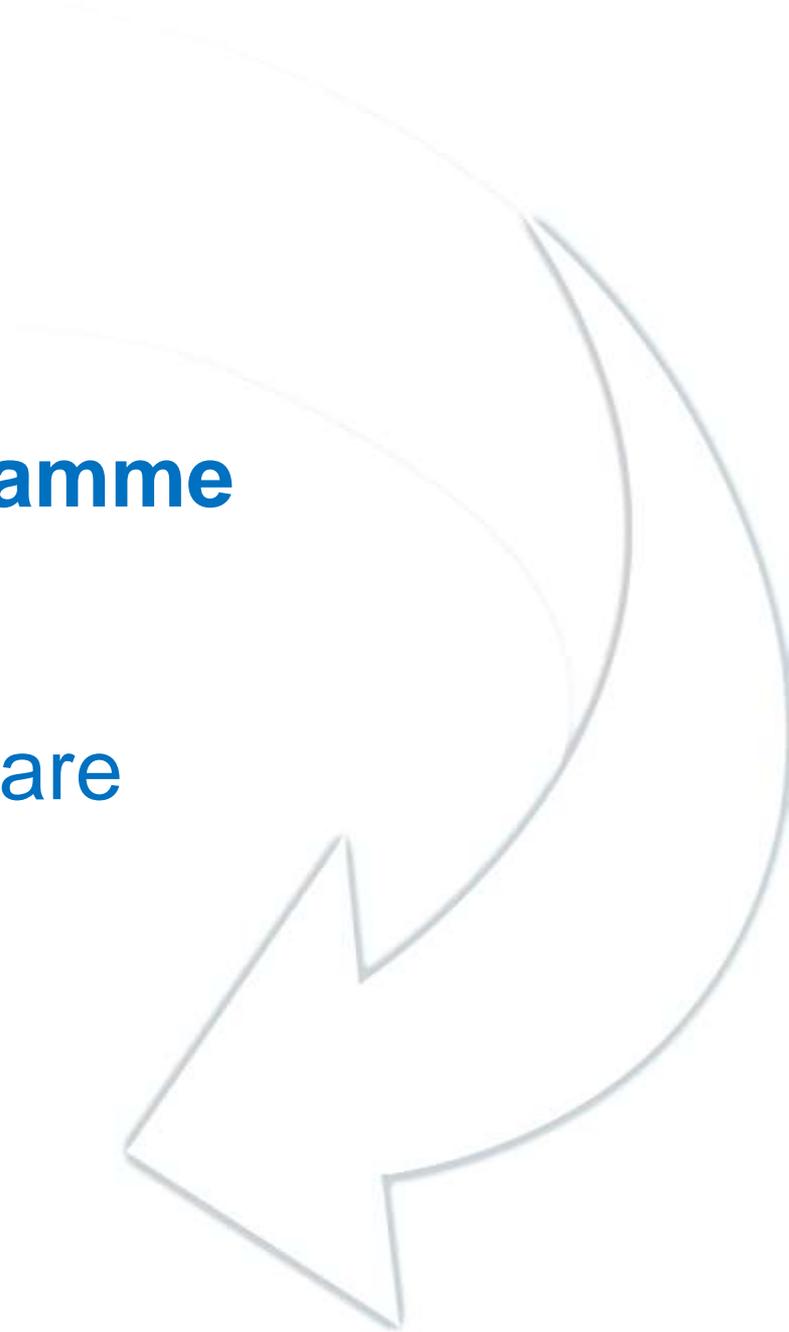
Introduction

Rachel Vokes

Head of Hospitals Programme

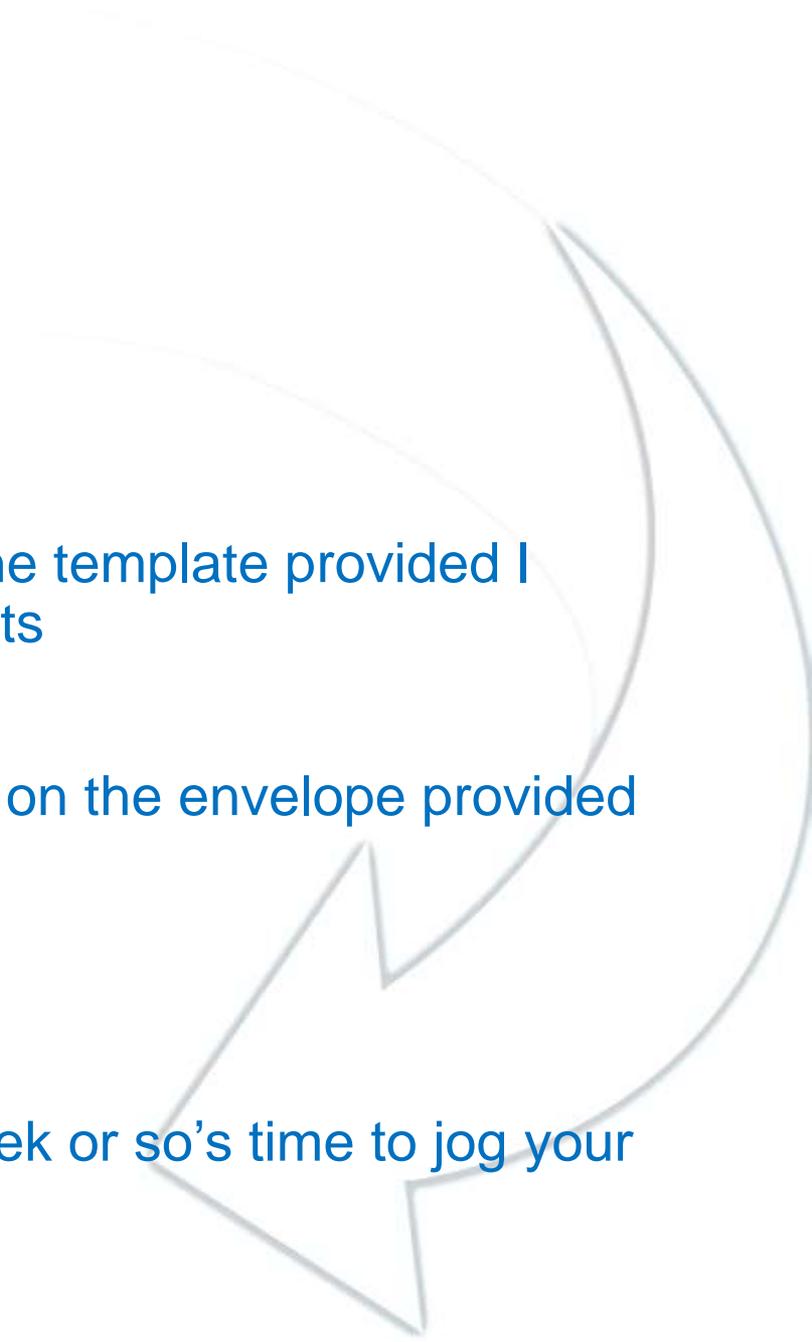
National UEC Team

- Same Day Emergency Care
- Acute Frailty
- SDEC Dataset
- CQUINs



Outline

Next session:

- With colleagues (or by yourself) on the template provided I would like you to make 3 commitments
 - Please write your name and address on the envelope provided
 - Post your template in the envelope
 - We will send this back to you in a week or so's time to jog your memory
- 

Session: 3, 2, 1



3	Three things I am going to make sure happen, to embed or further develop our same day emergency care service	
2	Two people I need to speak to about supporting development of our same day emergency care service (when?)	
1	One thing I am going to take forward, following today, to maximise same day emergency care in our organisation	

Developing a dashboard for AEC

Mike Holmes
Measurement Lead – AEC Network
NHS Elect

MikehatAEC@nhselect.org.uk

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



Almost every dashboard was heavily skewed to financial data

Almost every image of a dashboard was “just too much”!

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

We could not tell if things were changing over time

That is
doing my
head in!

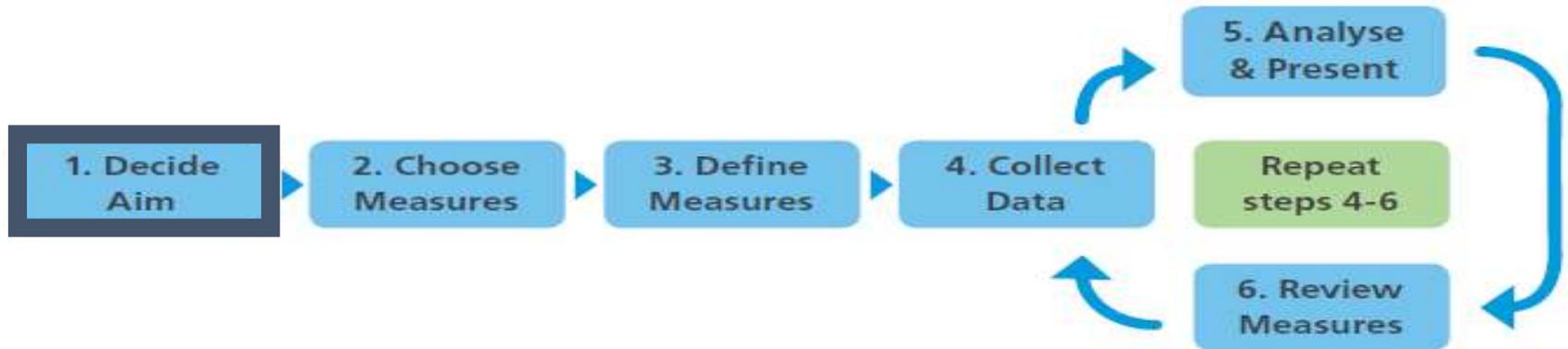
Measurement for improvement

MODEL FOR IMPROVEMENT

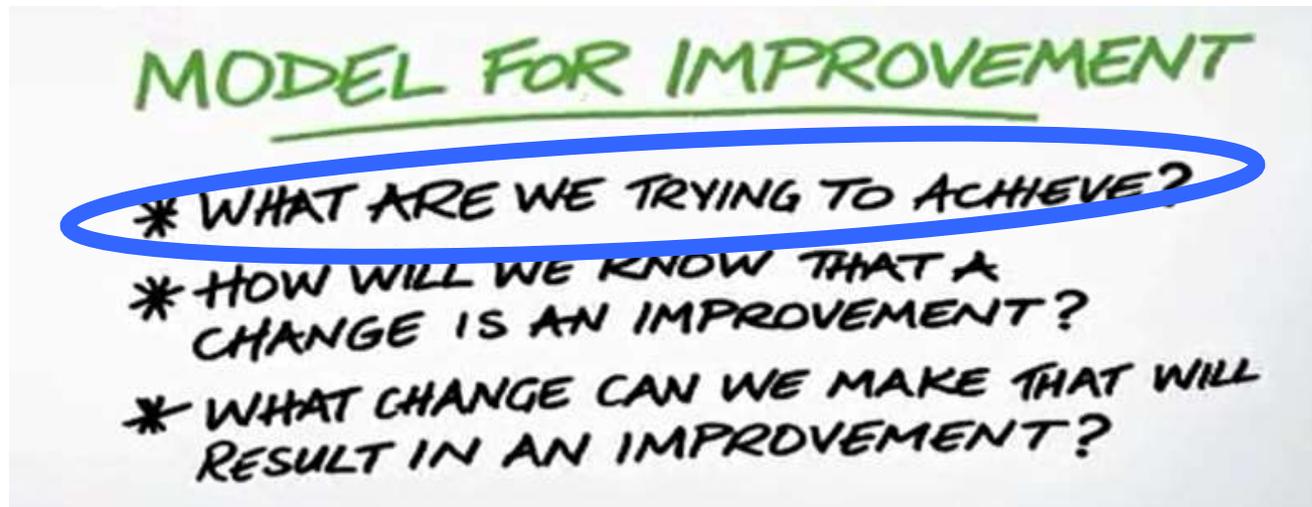
- * WHAT ARE WE TRYING TO ACHIEVE?
- * HOW WILL WE KNOW THAT A CHANGE IS AN IMPROVEMENT?
- * WHAT CHANGE CAN WE MAKE THAT WILL RESULT IN AN IMPROVEMENT?

Good measurement doesn't happen by magic

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



What are we aiming to achieve?



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

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

To reduce the number of emergency medical patients who are admitted to hospital for an overnight stay of at least one night

Signposting you to some help

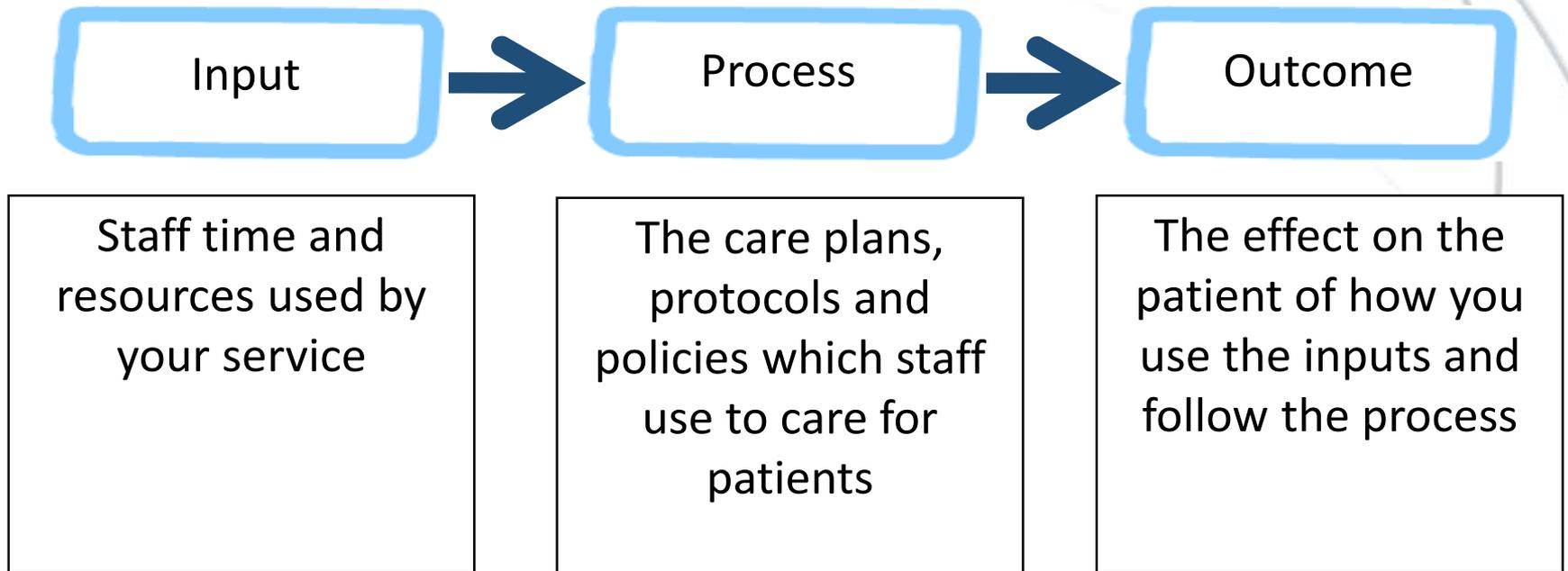
The screenshot shows the NHS Ambulatory Emergency Care Network website. The page title is "Measurement". The breadcrumb trail is "Home | Tools and Resources | Measurement". The main content area includes a date "Tuesday 27 February 2018" and a paragraph: "Robust measurement of the impact that your service is making and understanding the potential return on investment is critical to enable you to fully realise the potential of AEC." Below this is another paragraph: "We have worked with staff in Trusts and Commissioners to understand the challenges and skills required, and have produced guides and materials that will give you the tools to measure and quantify your improvement, and to estimate and measure your return on investment." This is followed by "For more please click below:" and a list of links: "The Measurement Team", "Measurement Guides", "Aim Statements", "Dashboards", "Driver Diagrams", "Flow Diagrams", "The Impact of AEC", "The Potential for AEC", "Measurement Fact Sheets", "Patient Experience", "Staff Experience", "Sample Pieces of Analysis", and "Measurement and Baseline". A left-hand navigation menu is visible, with "Measurement" highlighted. The page number "27" is in the bottom right corner.

Good measurement doesn't happen by magic

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



Measuring change in a system context



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

So you need three types of measures

**Process
measure**

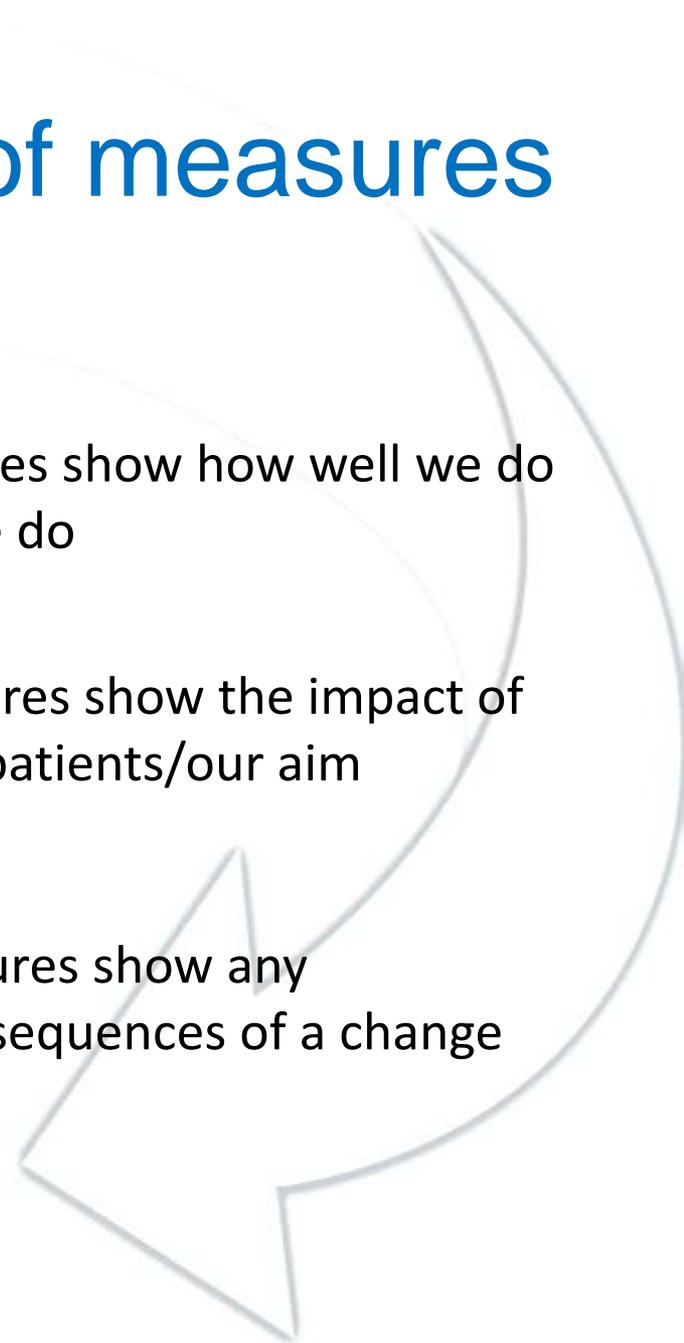
Process measures show how well we do what we say we do

**Outcome
measure**

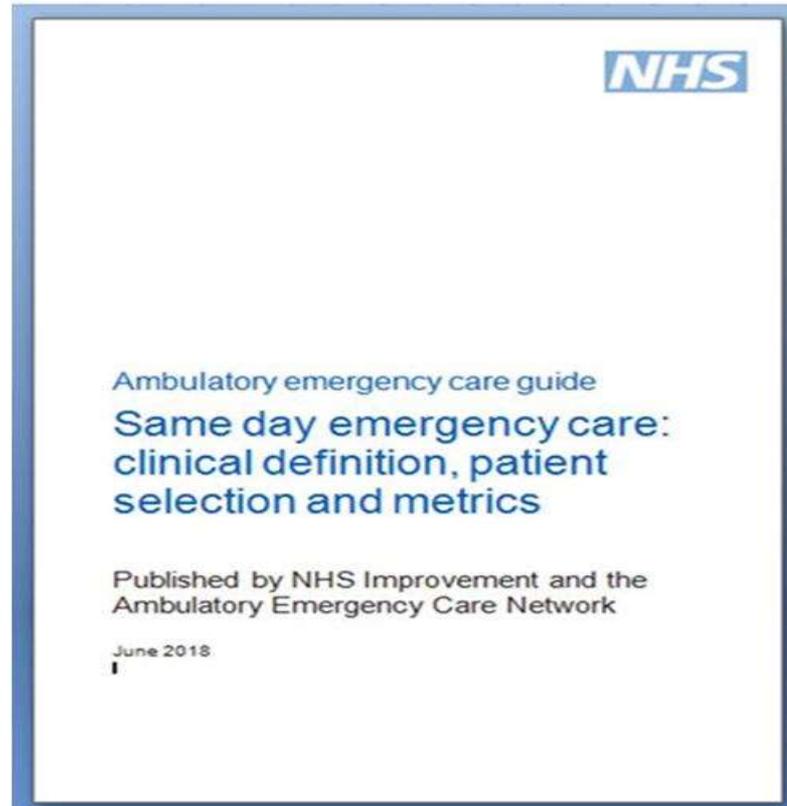
Outcome measures show the impact of what we do on patients/our aim

**Balancing
measure**

Balancing measures show any unintended consequences of a change



Three recommended measures



Process or activity measure

The number of new non-elective presentations seen and treated in AEC/SDEC

Impact measure

The number of new non-elective presentations who convert to an admission of at least one night

Balancing measure

The number of unplanned re-presentations of patients who had been managed by the AEC/SDEC unit within the previous 7 days

What presentation style to use

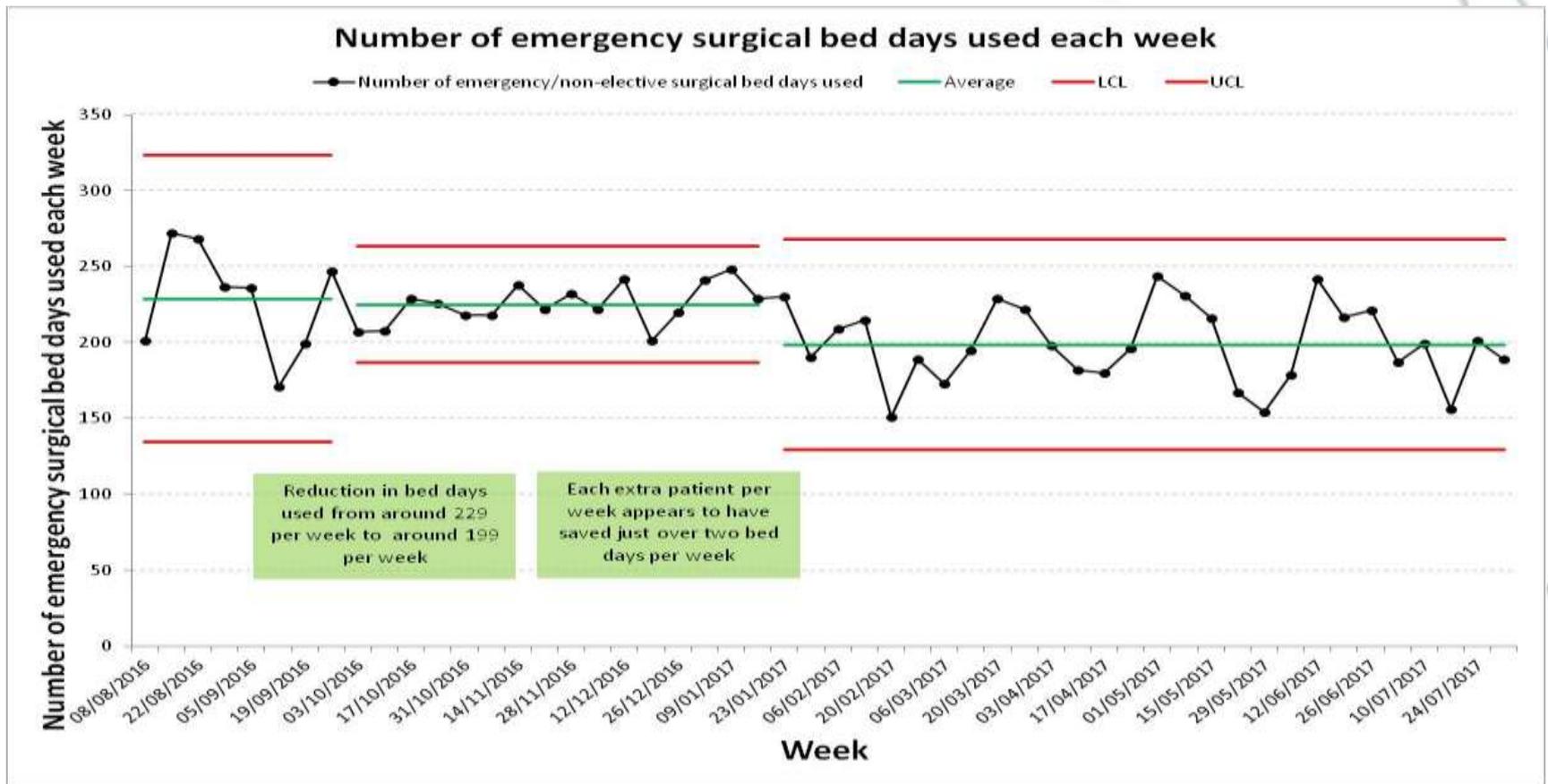
“We strongly recommend AEC/SDEC present these data items as daily run charts (or, better, **statistical process control charts**)

with appropriate explanation for special cause events

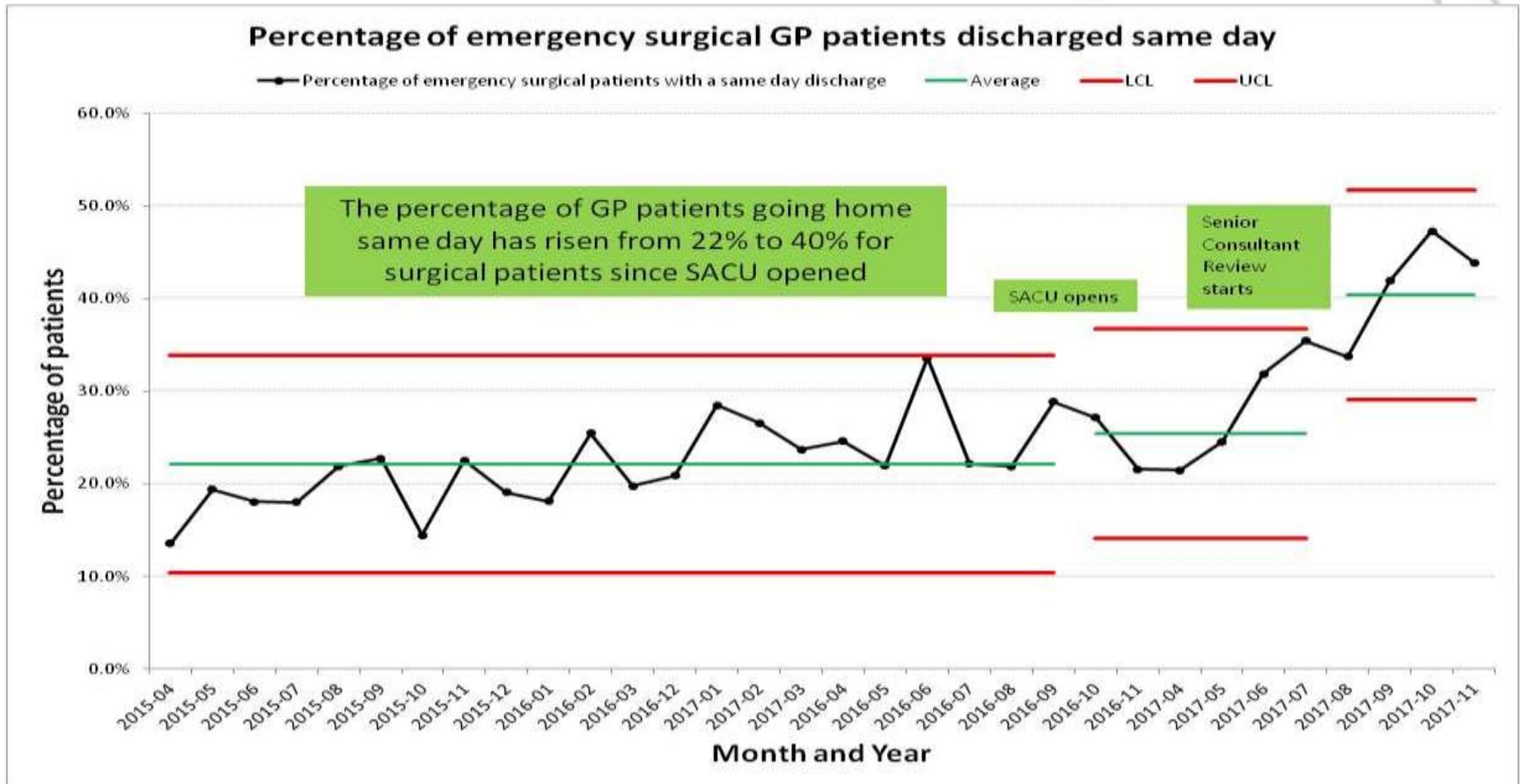
and **annotate the implementation of any changes** where there is an improvement in the data.”



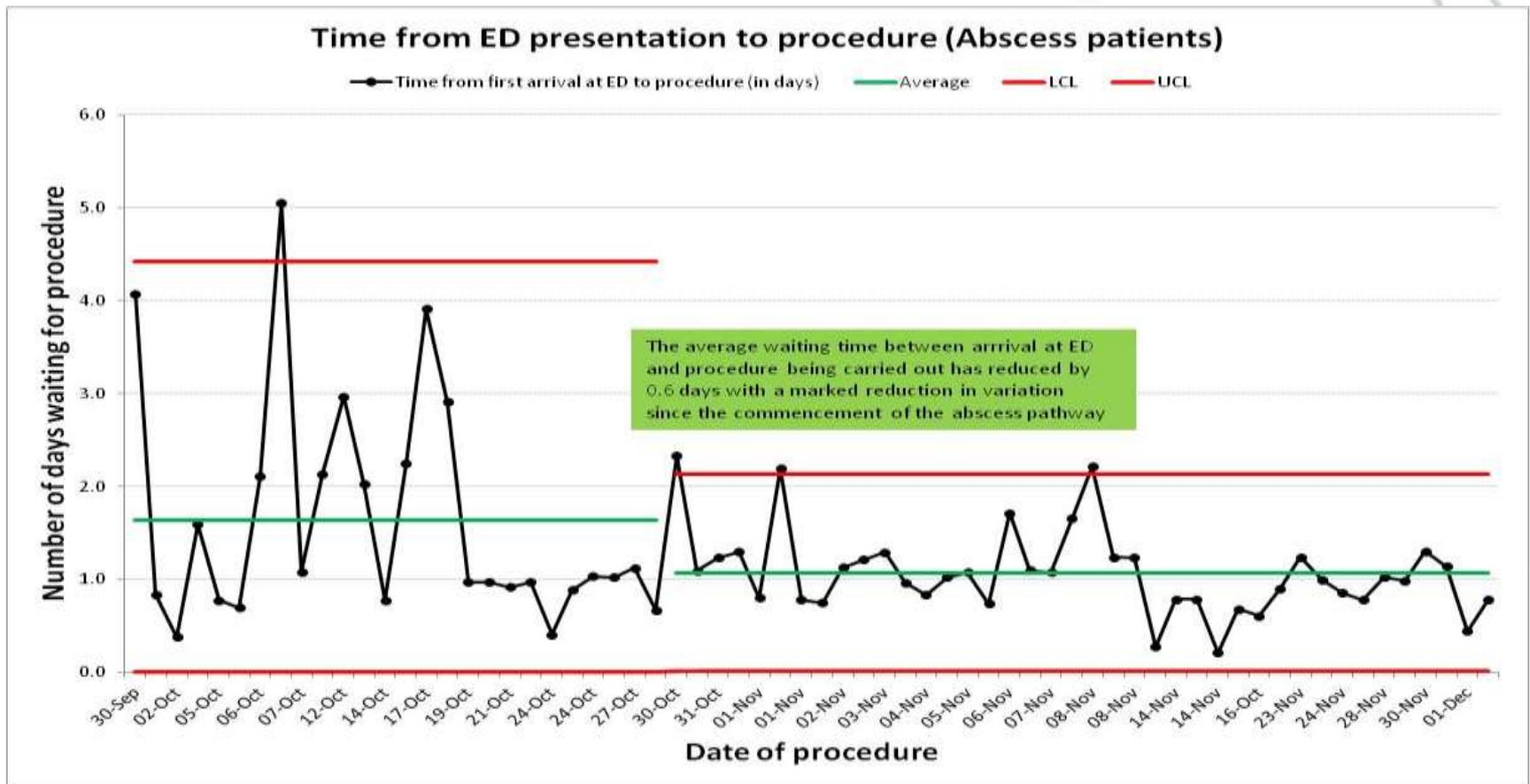
Wythenshawe Hospital Surgical AEC Network Cohort 1



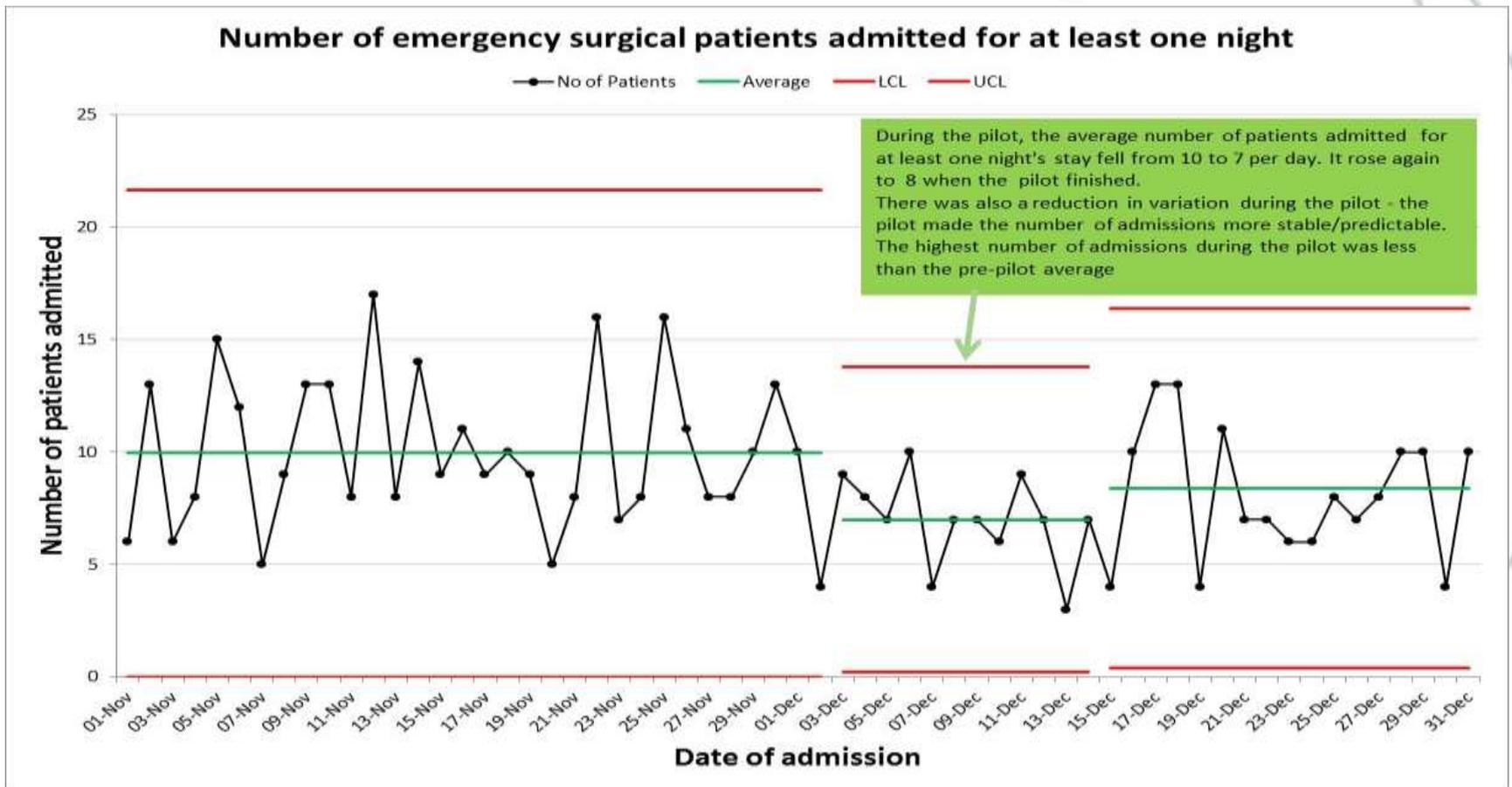
Leighton Hospital Surgical AEC Network Cohort 1



Royal London Surgical AEC Network Cohort 1



West Suffolk Hospital Surgical AEC Network Cohort 2



More help is available

The screenshot shows the NHS Ambulatory Emergency Care Network website. At the top right is the NHS logo and the text "Ambulatory Emergency Care Network". Below this is a search bar and a navigation menu with items: HOME, ABOUT, TOOLS AND RESOURCES (highlighted), EVENTS, NURSING, BAAEC, SAEC, AEC AP, and CONTACT US. Below the navigation is a breadcrumb trail: Home | Tools and Resources | Measurement. The main content area has a "Measurement" heading. To the left is a sidebar with a list of links: AEC Directory, Case Studies, Experience Based Design (EBD), EBD Films, Links to External Improvement Tools, and Measurement (expanded). The expanded "Measurement" menu includes: Measurement Team, Measurement Guides, Aim Statements, Dashboards, Driver Diagrams, Flow Diagrams, The Impact of AEC, The Potential for AEC, Measurement Fact Sheets, Patient Experience, Staff Experience, Sample Pieces of Analysis, and Measurement and Baseline. The main text area contains a paragraph about the importance of measurement and a list of links corresponding to the sidebar menu.

Search

NHS
Ambulatory Emergency Care Network

HOME ABOUT TOOLS AND RESOURCES EVENTS NURSING BAAEC SAEC AEC AP CONTACT US

Home | Tools and Resources | Measurement

Measurement

Tuesday 27 February 2018

- ▶ AEC Directory
- ▶ Case Studies
- ▶ Experience Based Design (EBD)
- ▶ EBD Films
- ▶ Links to External Improvement Tools
- ▼ Measurement
 - ▶ Measurement Team
 - ▶ Measurement Guides
 - ▶ Aim Statements
 - ▶ Dashboards
 - ▶ Driver Diagrams
 - ▶ Flow Diagrams
 - ▶ The Potential for AEC
 - ▶ Measurement

Robust measurement of the impact that your service is making and understanding the potential return on investment is critical to enable you to fully realise the potential of AEC.

We have worked with staff in Trusts and Commissioners to understand the challenges and skills required, and have produced guides and materials that will give you the tools to measure and quantify your improvement, and to estimate and measure your return on investment.

For more please click below:

- The Measurement Team
- Measurement Guides
- Aim Statements
- Dashboards
- Driver Diagrams
- Flow Diagrams
- The Impact of AEC
- The Potential for AEC
- Measurement Fact Sheets
- Patient Experience
- Staff Experience
- Sample Pieces of Analysis
- Measurement and Baseline

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

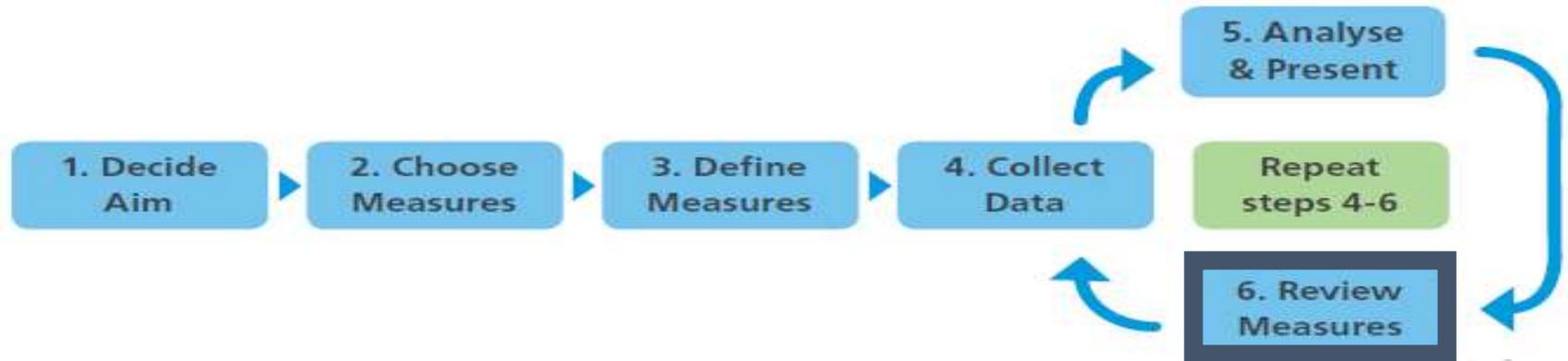
How, when and where you sit down as a team to look at your data and **use it to drive changes to your system**

is something you need to think through

MODEL FOR IMPROVEMENT

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

Reviewing and using your measures



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



Some practical things to take away

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

Close

Dr Cliff Mann

Useful Links

The SDEC programme website is:

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

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

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

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

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

Slido Event Evaluation

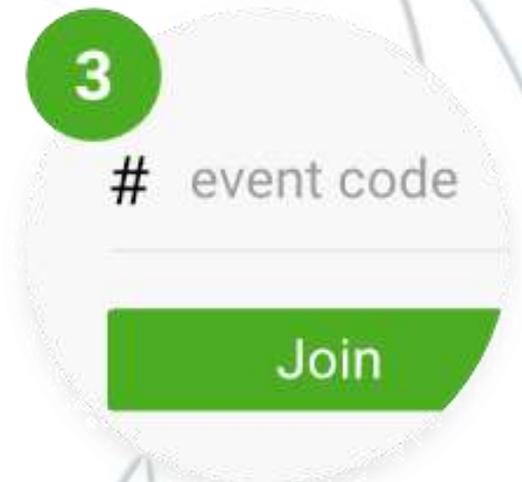
Access our event evaluation in 3 easy steps



1. Go to any web browser from any device



2. Go to slido.com



3. Type in the event code **#SDEC290419**