



Jim Mackey, Northumbria Healthcare

National picture of AEC



Northumbria Healthcare
NHS Foundation Trust

Maximising AEC – Annual Conference 2018

31 October 2018

Jim Mackey, Chief Executive

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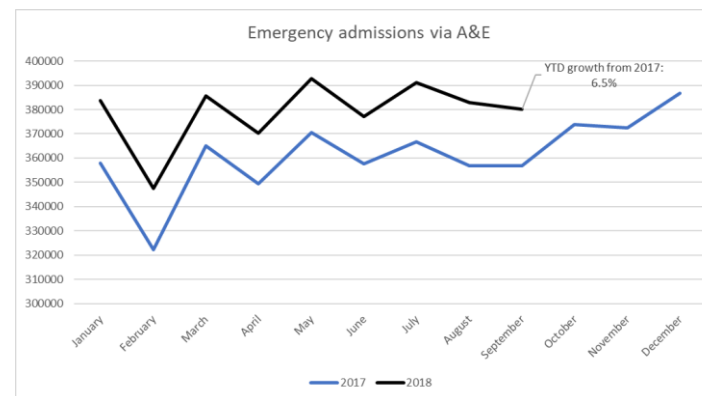
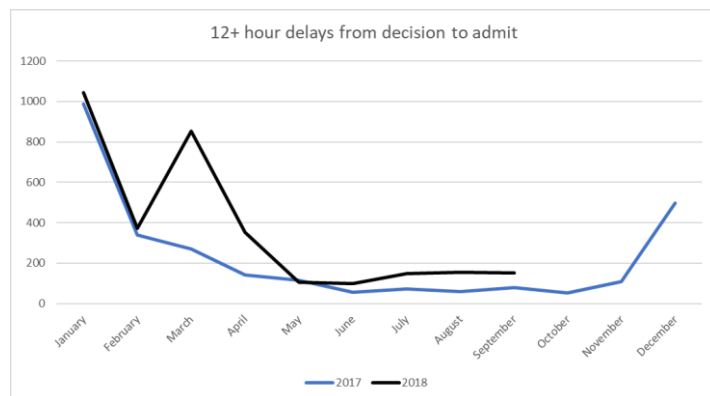
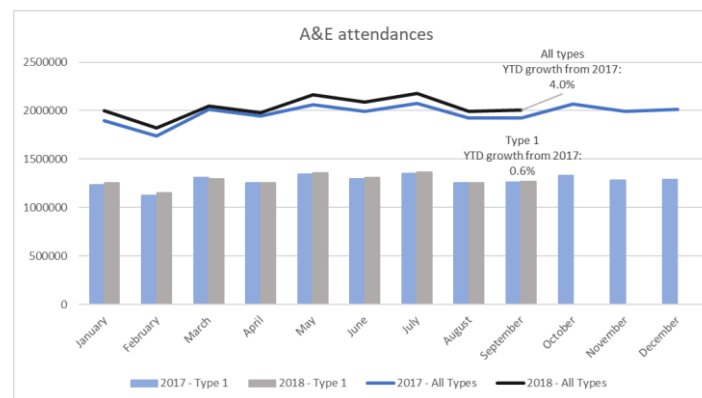
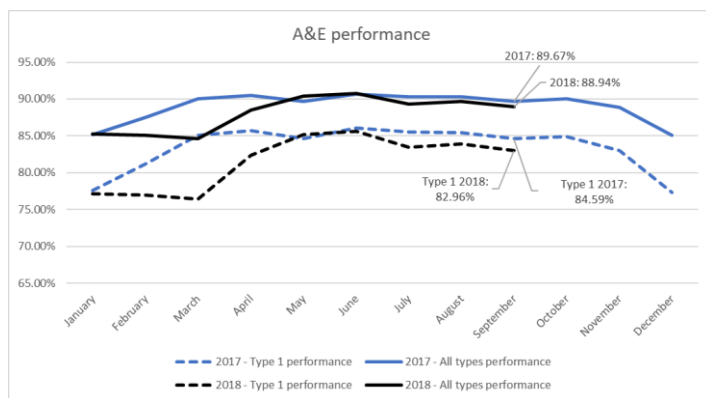


Maximising AEC

National picture of AEC

- Intro....
- Reminder of what we mean by Ambulatory Emergency Care
- Some trends and progress over last few years
- What would happen without it..
- Some loose ends and tensions.....
- Close and discussion

ED Performance - National



Growth in Non- Elective (Zero Day) (National)

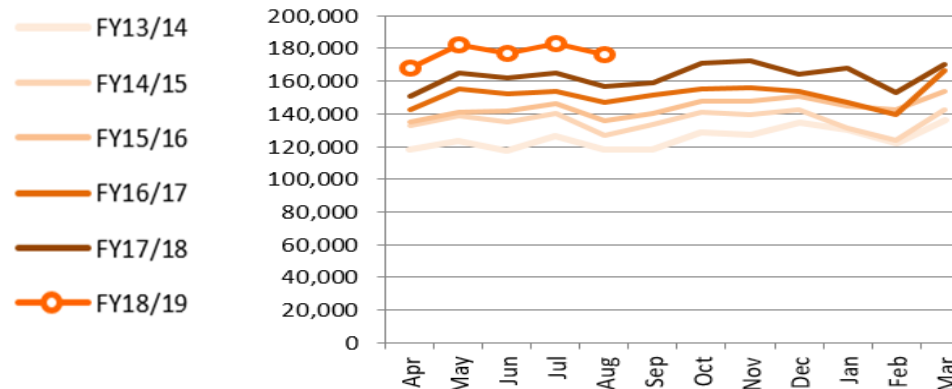
Over recent years, the NHS have seen a large increase in the SUS recorded zero-day non-elective admissions. In 17/18 growth was at 7.8%, year to date growth as at July 2018 is at 10.5% in comparison to the same period last year.

Non-elective spells - M04

England (CCG + Spec Com + DCS
Activity + Other; Acute NHS Providers)

Zero length of stay spells

YTD Actual Activity	YTD Growth (Adj.)	YTD % Growth (Adj.)
709,663	67,656	10.5%



Growth in Non- Elective (Zero Day) – Cont... (National)

Nine Providers, from each of the five regions within England were asked to populate a template-

- Seven Providers with the largest percentage increase in zero-day non-electives based on a 12-month rolling average to month 4, 2018/9; and
- Two Providers with the largest decrease in zero-day non-electives based on a 12-month rolling average to month 4, 2018/9

Region	Point of Delivery	Growth	Vol change due to new /additional capacity	Vol change due to new service model	Vol change due to coding / classification changes	Vol change due to underlying growth	% change due to new /additional capacity	% change due to new service model	% change due to coding / classification changes	% change due to underlying growth
Total	Urgent 1st OP Appt	18,397	7,179	-5,973	1,489	15,702	39.0%	-32.5%	8.1%	85.3%
	0 LoS NE Adm	72,921	17,515	28,148	8,733	18,525	24.0%	38.6%	12.0%	25.4%
	>=1 LoS NE Adm	28,512	2,362	7,709	-3,836	22,277	8.3%	27.0%	-13.5%	78.1%

This shows

- A significant proportion of the zero length of stay non-elective activity could be non-recurrent in nature of which **AEC would be included**,
- Of this 50.6% consisting of 38.6% new service model and 12.0% coding/classification changes
- 25.4% of the growth is 'true' underlying (demographic) growth and 24.0% growth in new / additional capacity.
- When rebasing this to a total national picture with the counting and coding changes this would suggest a total non-elective growth rate of 3.1%.

Summary:

What drives A&E performance

The problem

Many trusts did not meet the A&E four-hour maximum waiting time standard in winter 2017/18. To help improve next winter, we wanted to understand what was behind this.

Our analysis

We have undertaken detailed analysis of what drives A&E performance using daily data from winters 2016/17-17/18. We have used econometric analysis which allows us bring together all the factors and isolate the effect of each on A&E performance. We grouped the factors into the A&E department and patient flow.

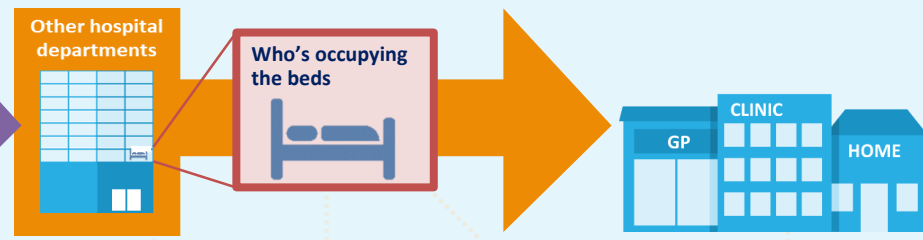
The A&E department

The capacity of A&E departments to respond to higher numbers of patients in winter affects performance.



Patient flow

Maintaining good patient flow ensures hospitals have capacity to admit new patients from the emergency department, avoiding bottlenecks.



Key factors

Workforce

Senior doctors make quicker decisions so patients wait for less time

Resilience to pressures

How well providers **respond** to and **recover** from pressure affects performance

Admissions

High **daily** and **uneven hourly** admissions decrease performance

Bed occupancy

Rising occupancy reduces performance, with accelerating effects above **92%**

Flu

1/3rd of the growth in emergency admissions came from flu in winter 17/18

Long-stay patients

Long-stay patients can decrease performance by reducing bed flexibility

Discharges

Discharges **on the day** and **previous day** improve performance

Preparation for winter 2018/19...

Factors that indicate potentially better performance and patient care compared to last winter	Factors that indicate potentially worse performance and patient care compared to last winter
Second year of better national level planning	Increased level and complexity of demand, currently significantly outstripping planning estimates
Further impact of general improvement initiatives and new care models	Worse A&E performance so far this year compared to last
Impact of £145m extra capital funding	Pressure across all other hospital activity restricting ability to prioritise urgent care
Impact of £240m extra social care funding	Greater pressure across mental health, community and ambulance services
Benefits of extra focus on reducing delayed transfers of care and length of stay	More fragile social care and less total real terms investment, even accounting for extra £240m
Potential for a less virulent and prevalent flu strain	More fragile primary care
	Continuing financial pressure with 2018/19 NHS frontline budget increases less than the increase in cost and demand
	Loss of last year's dedicated £337m winter funding, now subsumed into general commissioning budgets
	Higher level of staff vacancies
	More tired and pressured workforce making it more difficult than last year to secure extra shifts

Comparative Performance

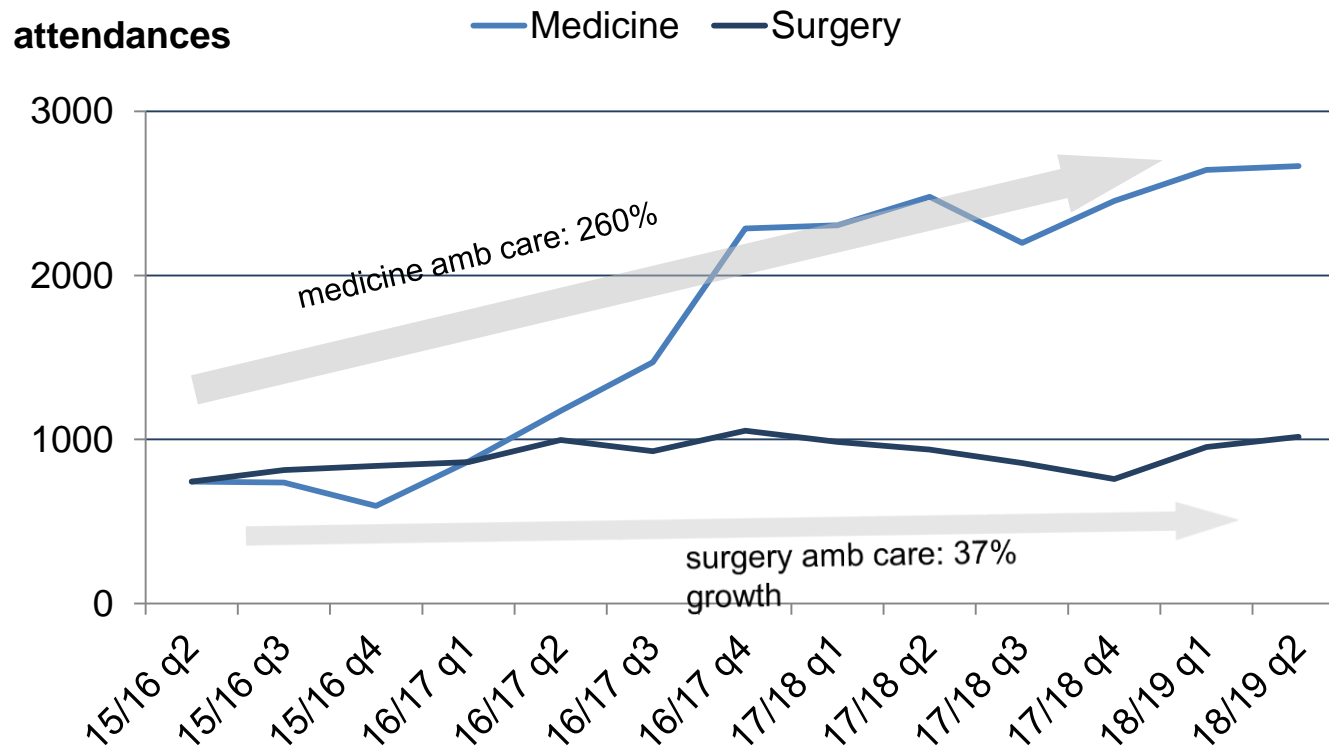
	Q1+Q2 17/18	Q1+Q2 18/19
NSECH ED attends	48287	52837
Total A&E attends	101076	107080
Blue Zone *	15146	19633
ED performance	94.3%	97.5%
Non Elec Admissions (excl short stay, ambl care)	18862	18515
Ambl care and short stay	8684	10179
Surgical ambl care (1 st appt)	2187	2230
Stranded patients 7+ days	358	336
Stranded patients 21+ days	150	129
Occupied beds midnight NSECH **	45183	43379
Occupied beds midnight Trust wide**	148540	139282
Qualified Nurse OBD***	0.088	0.094

- * Proxy = walk in and no admission type / short stay
- ** Including elective beds, maternity, escalation
- *** mean worked (not contracted)

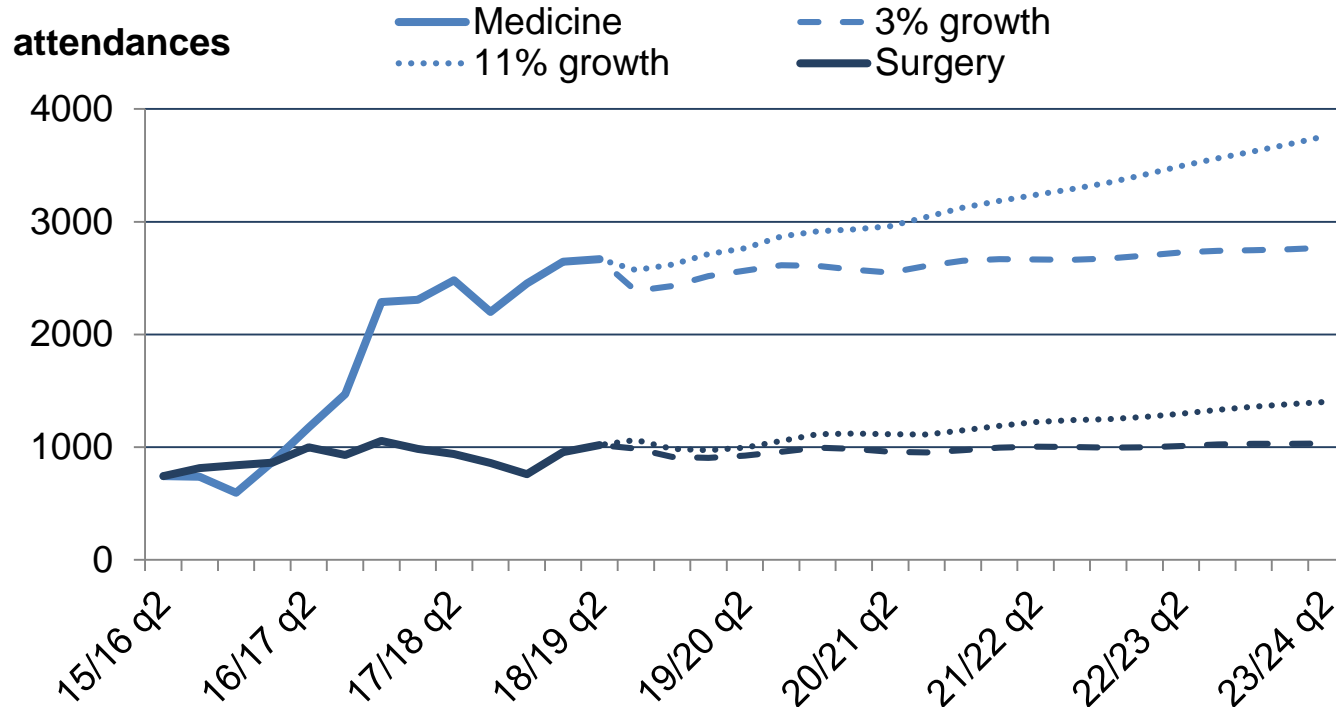
Winter Prep- comparison to last year

- Very thorough plan-started earlier and much broader engagement
- Limited signs of flu in the Antipodes (but note vaccine supply problems)
- Greater “system” fragility is evident
- Learning and action re infection/outbreak management
- Big volume/demand growth, but using fewer beds because of ED Re-set and ambulatory care
- Marginally more qualified nursing staff than last year

Ambulatory care: activity growth



Ambulatory care: activity growth over the next 5 years



Ambulatory care

Co-located medicine and surgery ambulatory care service

- 78% of referrals result in only 1 attendance
- 16% of referrals result in 2 attendances
- 6% of referrals result in 3 or more attendances

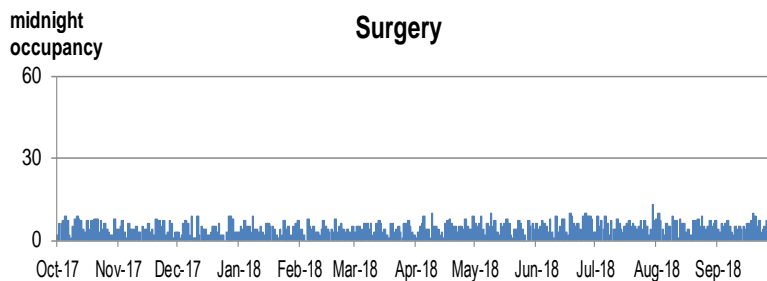
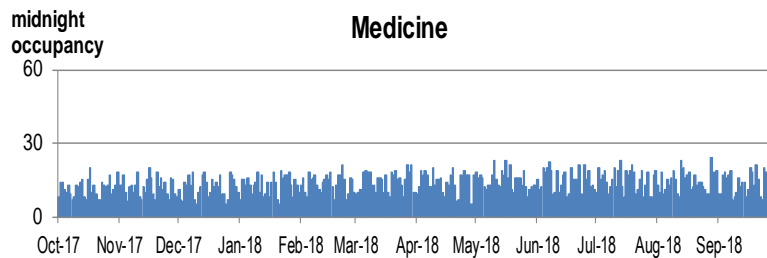
(very similar breakdown for both medicine and surgery)

Ambulatory care

Assume ambulatory care attends admitted to standard ward:

- Scenario 1 – 50% of attendances do not result in an overnight stay; 50% result in 24 hour stay
- Scenario 2 – all attendances result in a 1 day stay
- Scenario 3 – all attendances result in a 48 hour stay
- Scenario 4 – 50% of attendances result in 24 hour stay; 50% result in a 48 hour stay

Ambulatory care - If 50% of attends were admitted for 24 hours....



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

23
medicine beds

10
surgery beds

30
co-located
beds



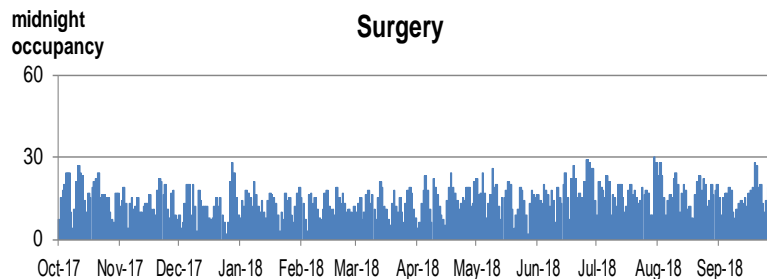
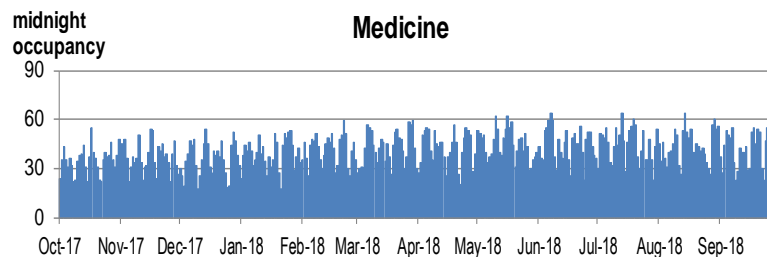
36 wte nurses



£2m ward costs

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



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

63
medicine beds

85
co-located
beds

27
surgery beds



108 wte nurses



£6m ward costs

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Applying growth to the combined “50% no overnight stay/50% 24 hour” model...

year-on-year growth model applied	Year 1			Year 5			Year 10		
	beds	nurses	ward costs	beds	nurses	ward costs	beds	nurses	ward costs
no growth	30	36	£2m	30	36	£2m	30	36	£2m
3% growth	32	72	£4m	36	72	£4m	42	72	£4m
11% growth	34	72	£4m	52	72	£4m	87	108	£6m
med 11%; surg 3%	33	72	£4m	46	72	£4m	72	108	£6m

Assumptions:

- ward = 30 beds
- Nurses per 30 bed ward = 36 wte
- Cost per 30 bed ward = £2m

Applying growth to the combined 24/48 hour model...

year-on-year growth model applied	Year 1			Year 5			Year 10		
	beds	nurses	ward costs	beds	nurses	ward costs	beds	nurses	ward costs
no growth	85	108	£6m	85	108	£6m	85	108	£6m
3% growth	88	108	£6m	102	144	£8m	118	144	£8m
11% growth	94	144	£8m	144	180	£10m	162	216	£12m
med 11%; surg 3%	93	144	£8m	135	180	£10m	160	216	£12m

Assumptions:

- ward = 30 beds
- Nurses per 30 bed ward = 36 wte
- Cost per 30 bed ward = £2m

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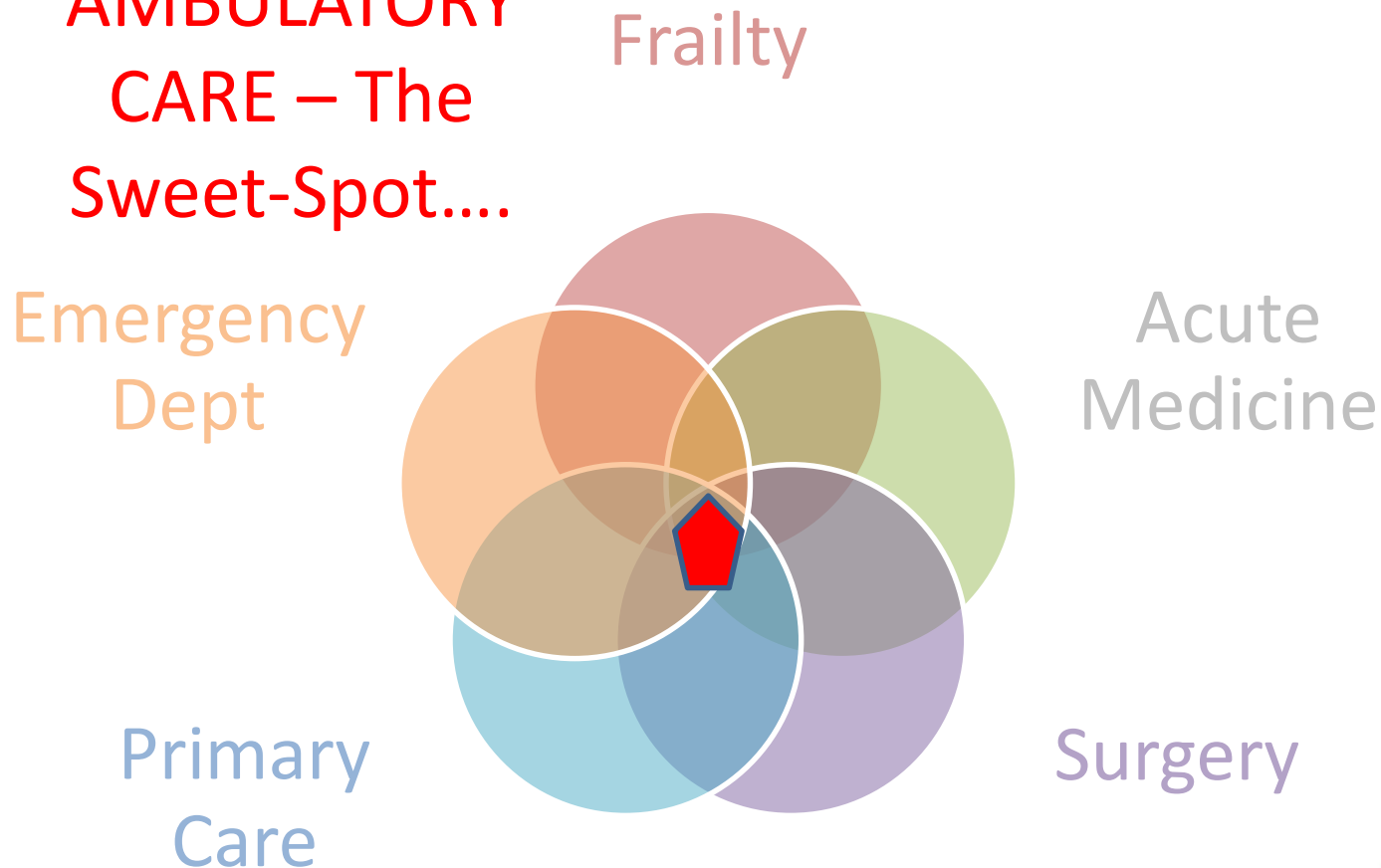
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Some loose ends and tensions

- Definitions....let's not get hung up on this
- Data & counting – need a national response to aid consistency
- Environment – let's think about the people we are looking after
- Workforce – must be a shared endeavour
- Link with other services – diagnostics, urgent OP/hot clinics, integrated care
- Billing and contractual stuff – let's not be silly
- Ownership & control – think of the patients and, it's a shared endeavour....

AMBULATORY CARE – The Sweet-Spot....



Wrapping up

- Ambulatory care is a good thing for patients and the NHS.
- Utilisation and effectiveness is very variable across the NHS
- Without it, we would have sunk
- Without further development and spread, we will sink
- Let's not get hung up or distracted by the noise around data, billing and turf wars etc
- Further shifts ahead, moving closer to people's homes (working between primary and secondary care) ?
- For those of you directly involved, well done, go back with enthusiasm and do more....
- Most importantly, do it well....