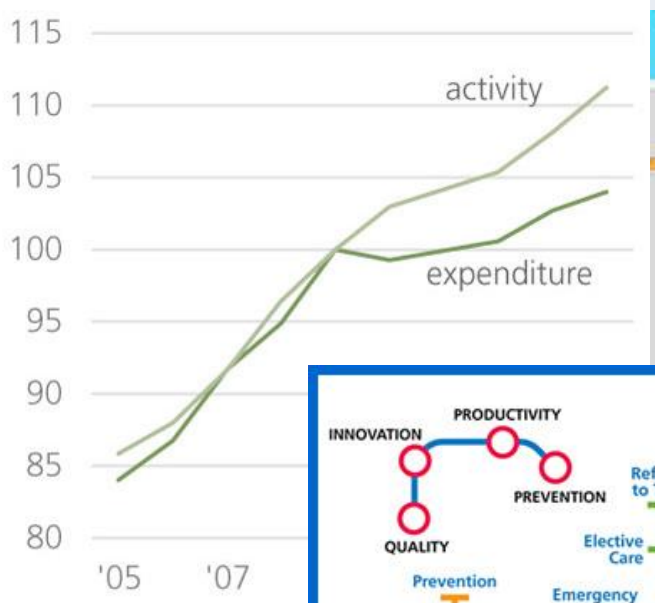
What is SDEC?

Jay Banerjee

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



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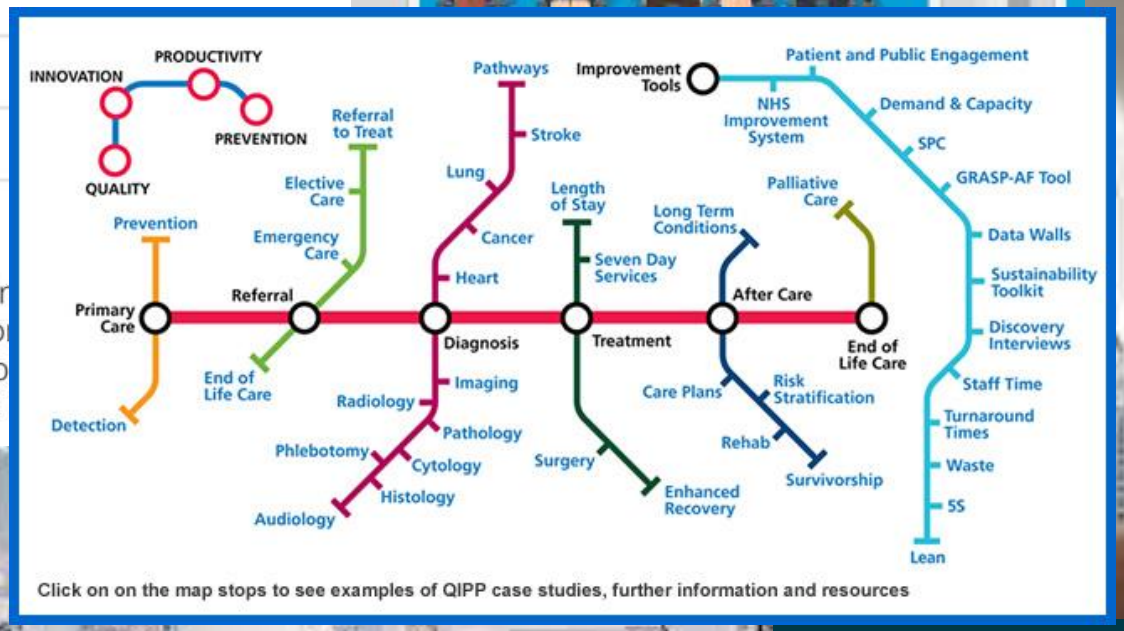

The NHS needs to be more productive – or is it more efficient?

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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

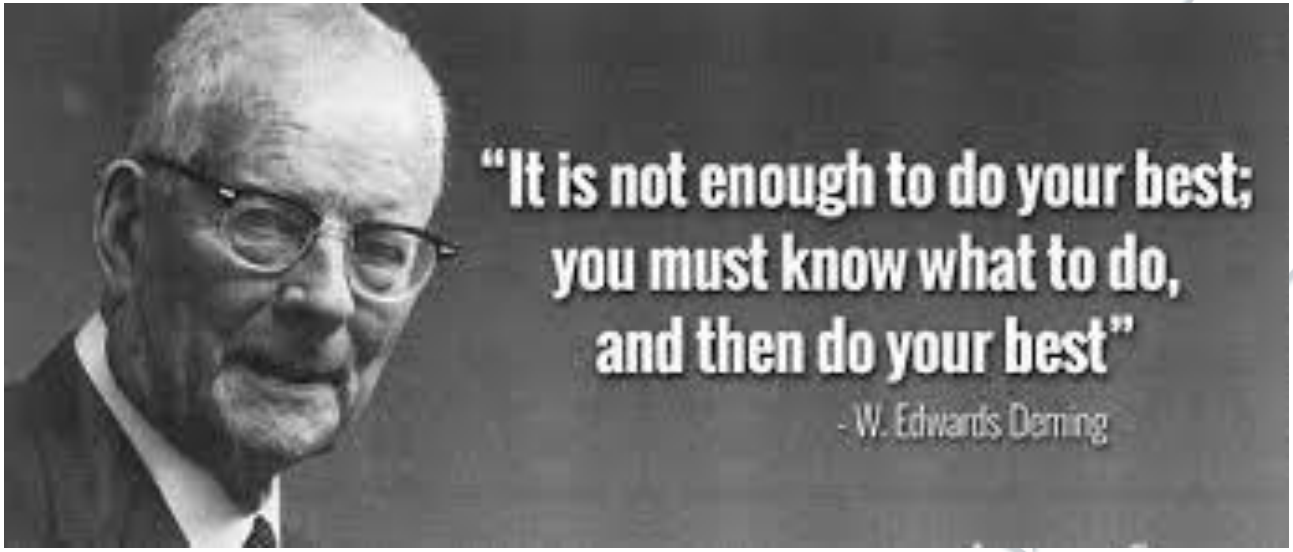
- Admission…..
- Morbidity….
- Satisfaction?
- Carer burden?
- Autonomy?
- Mood?
- PPC/PPD?

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

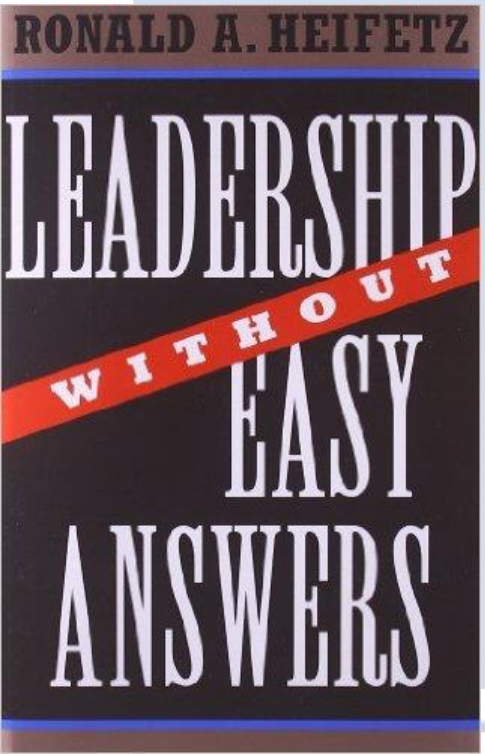
Other influencers

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



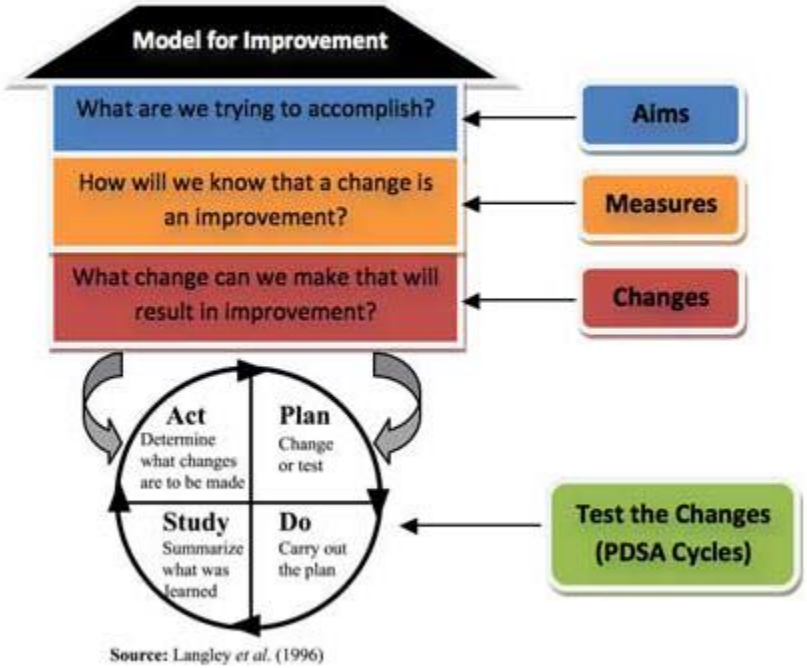
Challenge

TECHNICAL	ADAPTIVE
➢Problem is well defined ➢ Solution is known/ can be found ➢ Implementation is clear	➢ 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



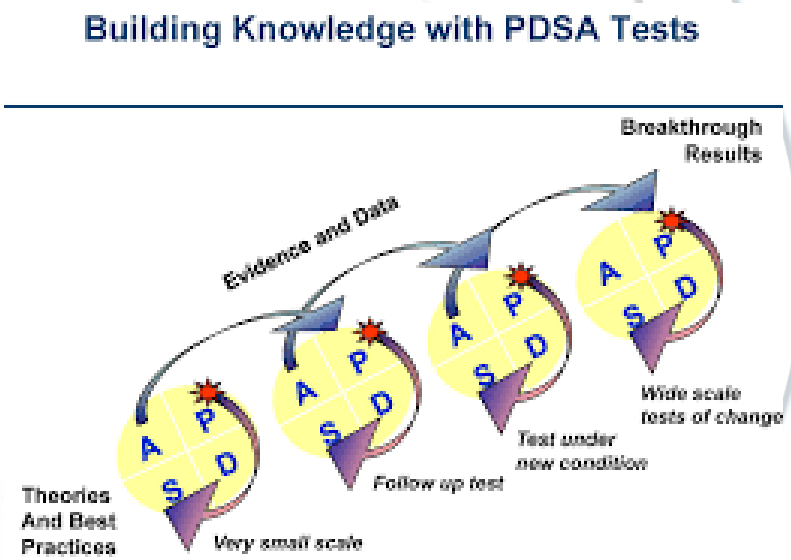
Small steps lead to big changes

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

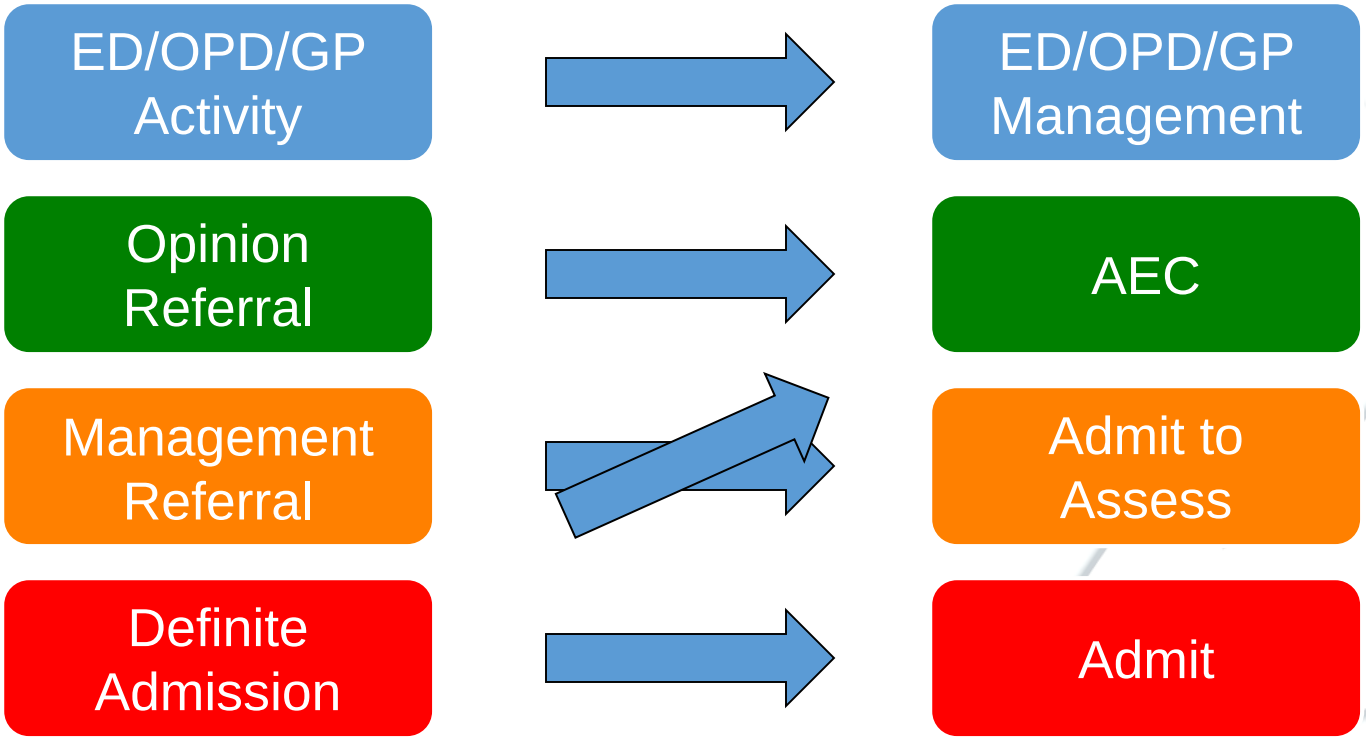


Source: Langley *et al.* (1996)

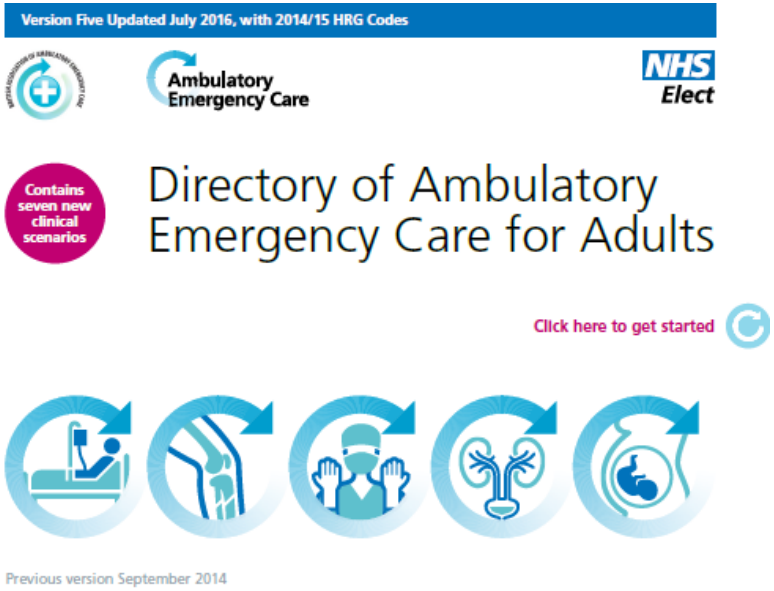
Langley et al. (1996). The Improvement Guide, Jossey-Bass: San Francisco

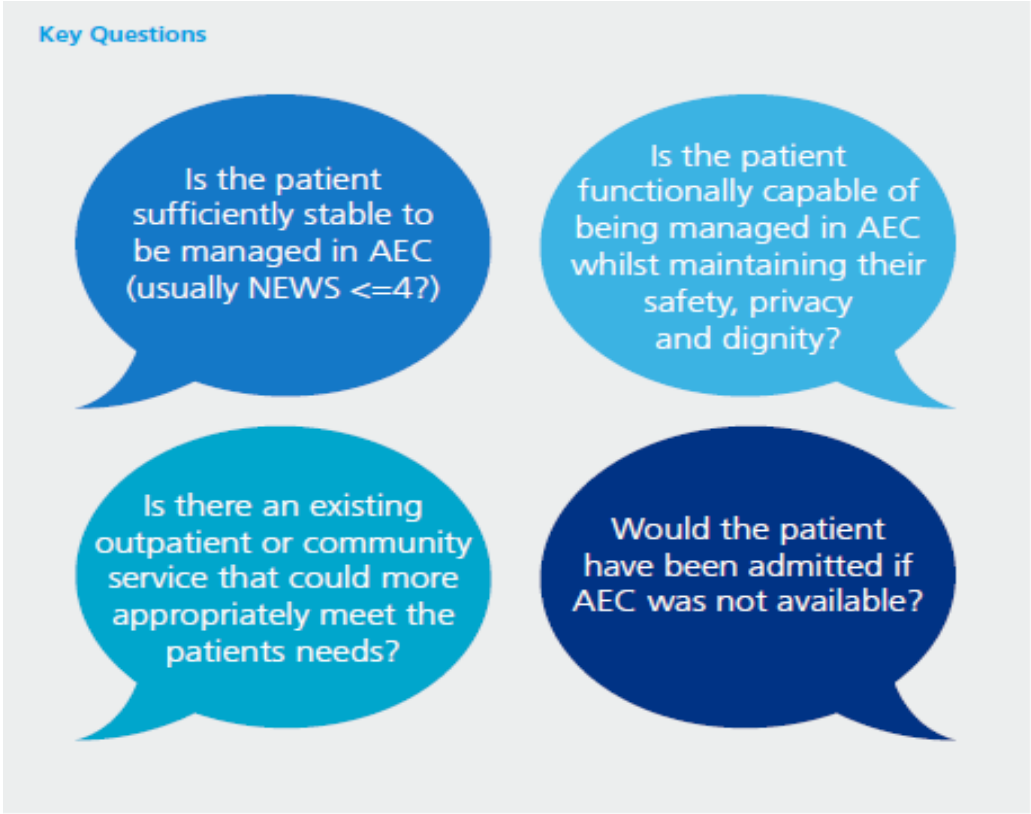


Right patient, right place



UPDATE - Directory of AEC

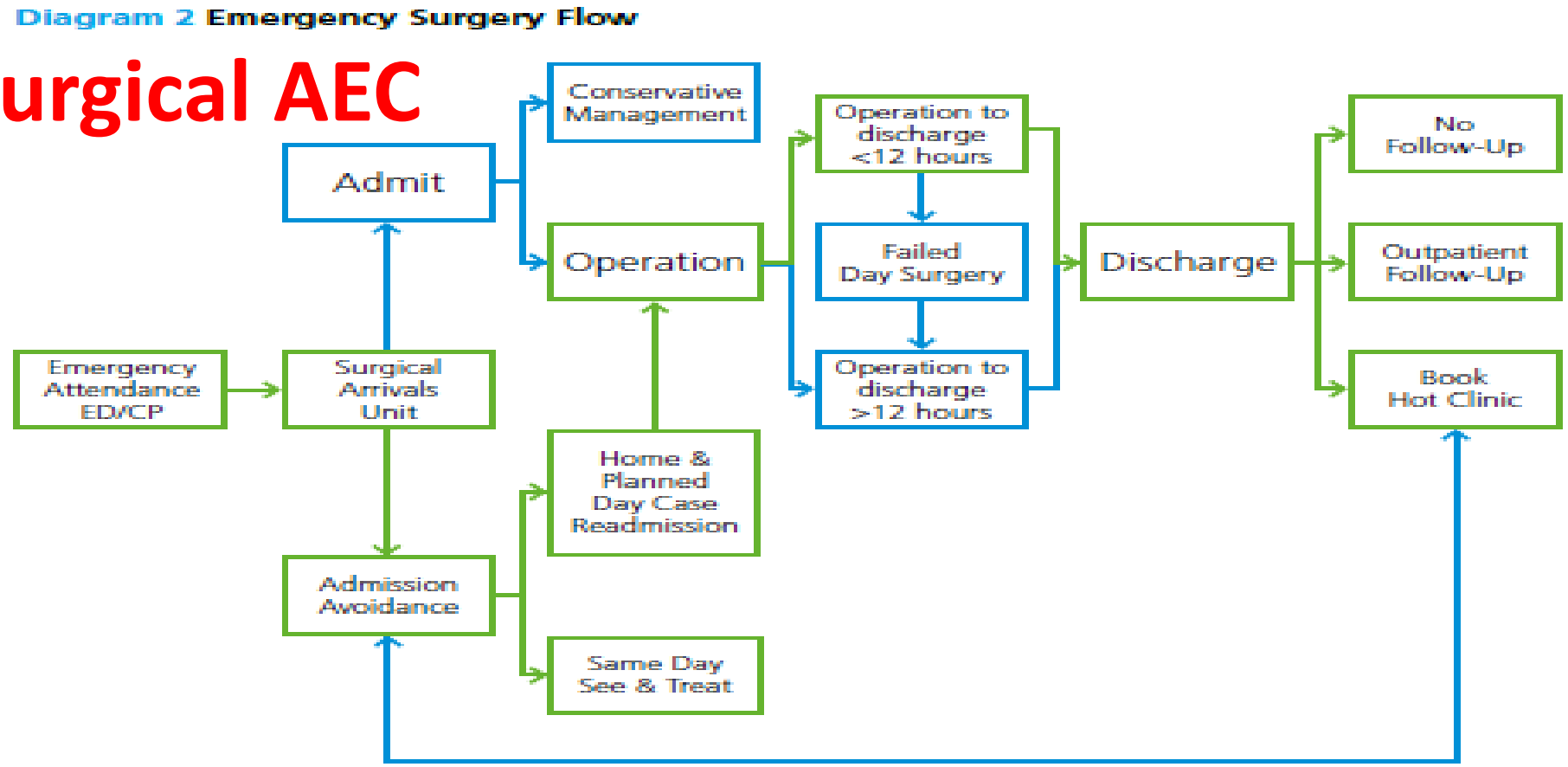




The 4Ps Model of AEC

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

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

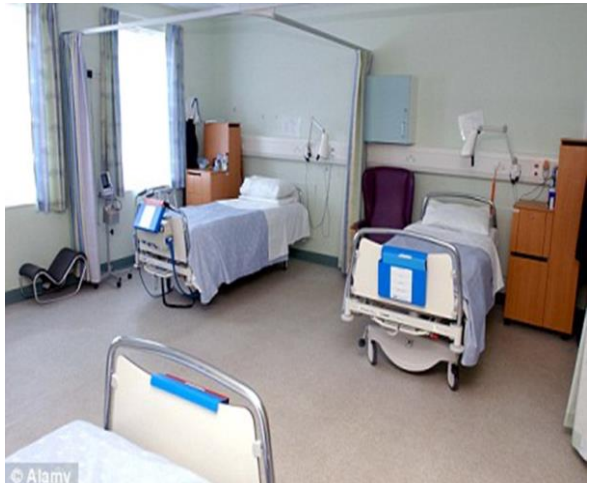
Tendon repair

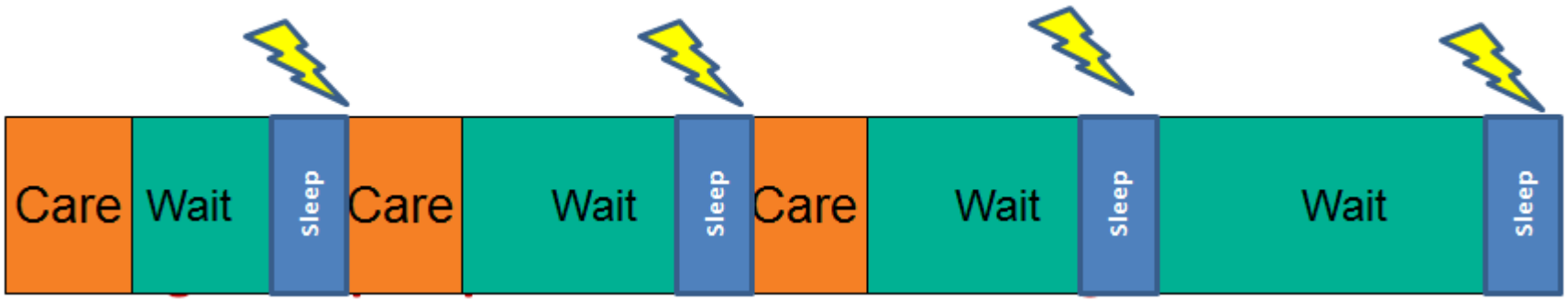
Maximising front door care

- 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





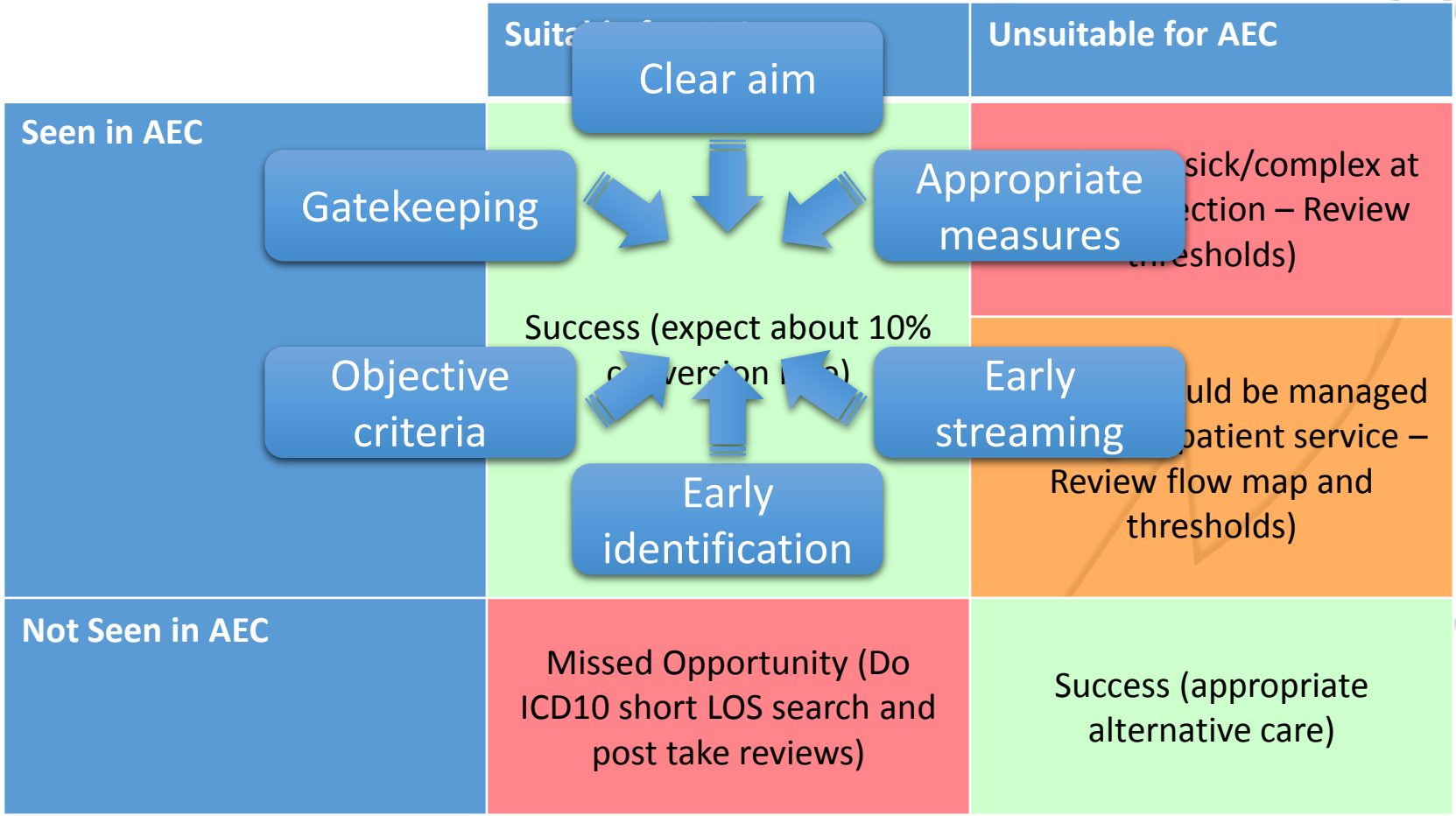
What is SDEC?

- 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
- ☐ SOBoE
- ☐ Night cough
- ☐ Ankle oedema
- ☐ HR 120+ bpm
- ☐ Hepatomegaly
- ☐ Pleural effusion

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

BNP

< 100 pg/mL → Consider alternative diagnosis CCF unlikely

> 400 pg/mL → Known Heart failure
- Watch list
- Previous echo with ↓ LV

100-400 pg/mL → Consider other causes of SOB
AF, Cor pulmonale, PE, Ca lung, Diastolic dysfunction

Yes → Symptomatic Rx

NYHA IV
> 3 admissions in 12/12 CCF
RR> 40 or 02 saturation <90%
SBP <110 mmHg >220
HR >130
2 + kg above dry weight
Creatinine > 300 umol/L
Multiple comorbidities

Yes / No → Screening Echo* → Normal

Abnormal → **Other abnormality** *(Consider cardiology*

Abnormal → Systolic dysfunction

No to all → Ambulatory care pathway (see over)

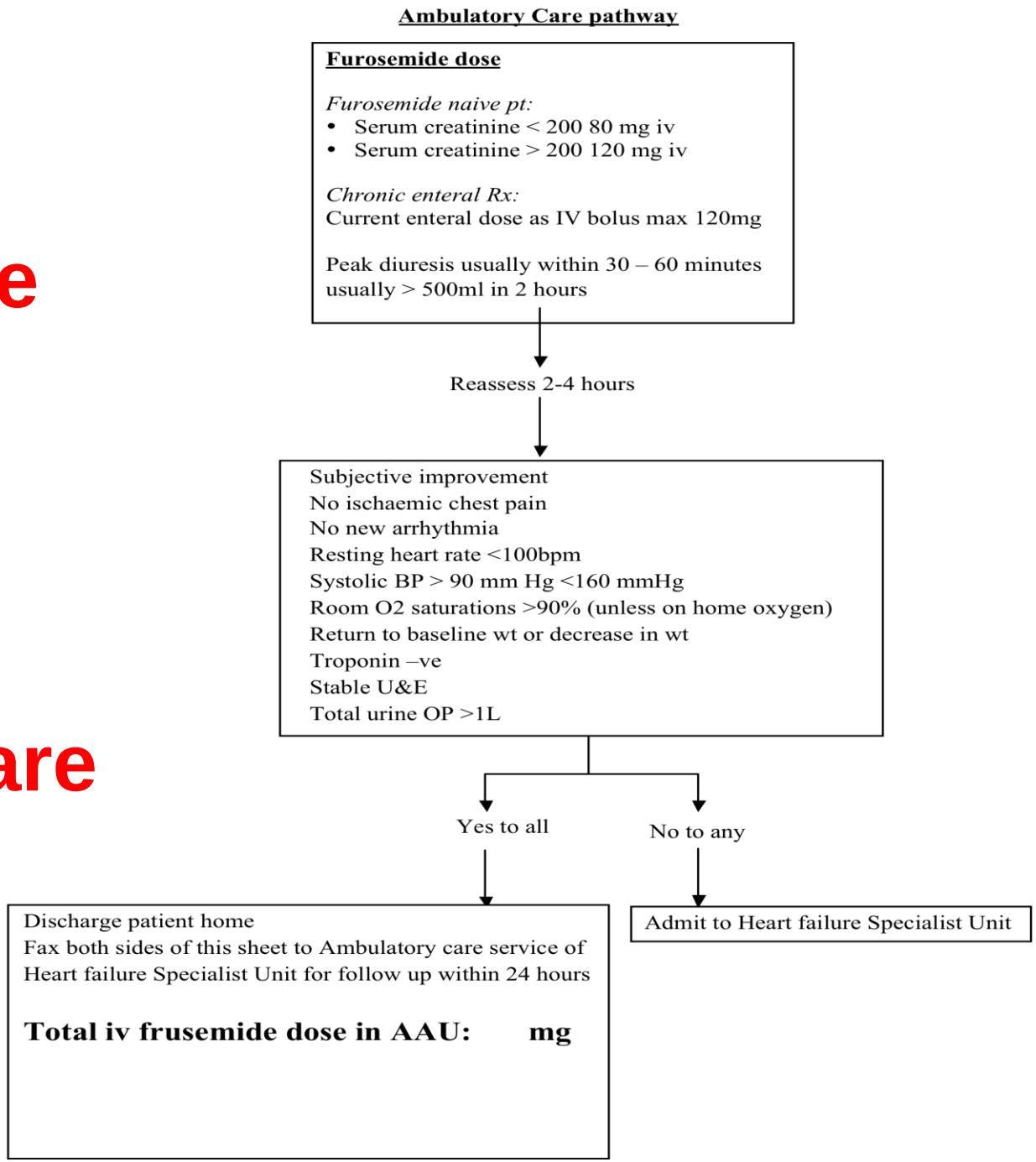
Yes to any → Admit to Heart failure Specialist Unit

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 be 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
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

*Cameron A, et al (2014) A simple tool to predict admission at the time of triage. *Emerg Med J (online)* doi: 10.1136/emermed-2013-203200.

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.