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
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?

- Inputs: Money & Time, Blind Faith
- Activities: Buy Lots of Flip Charts & Sticky Notes, Hold Lots of Meetings & Workshops, Ignore Basic Principles of Causation
- Outputs: Lots of Logic Models, Simplistic View of Reality
- Outcomes: No Money Left, No Improvement in Outcomes, No Understanding of WTF Happened

Next 'Transformational' Initiative
Figure 5: Proportion of total bed days for emergency admissions and elective admissions


† 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
- **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
National tasks

Signal
Count
Pay
SDEC

≠ ZLoS

≠ A Place/Site Code/Ward

= Diagnosis +/- lX +/- Rx recorded via SDECDS
one two three
<table>
<thead>
<tr>
<th>ECDS_Description</th>
<th>AEC Description</th>
<th>Scenario</th>
<th>SNOME</th>
<th>ICD1</th>
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</thead>
<tbody>
<tr>
<td>Complication of gastrostomy (PEG tube)</td>
<td>Attention to gastrostomy</td>
<td>PEG related complications</td>
<td>509773000</td>
<td>Y833</td>
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<tr>
<td>Upper gastrointestinal hemorrhage</td>
<td>Gastrointestinal haemorrhage, unspecified</td>
<td>Upper gastro-intestinal haemorrhage</td>
<td>37372002</td>
<td>K920</td>
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<tr>
<td>Lower gastrointestinal hemorrhage</td>
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<td>Lower gastro-intestinal haemorrhage</td>
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<td>Inflammatory Bowel Disease</td>
<td>Inflammatory Bowel Disease</td>
<td>340000006</td>
<td>K509</td>
</tr>
<tr>
<td>Ulcerative colitis</td>
<td>Inflammatory Bowel Disease</td>
<td>Inflammatory Bowel Disease</td>
<td>64766004</td>
<td>K519</td>
</tr>
<tr>
<td>Oesophageal stricture</td>
<td></td>
<td></td>
<td>63305008</td>
<td>K222</td>
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<td>Migraine</td>
<td>Migraine, unspecified</td>
<td>Acute headache</td>
<td>57796009</td>
<td>G439</td>
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<tr>
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<td>Acute headache</td>
<td>19303109</td>
<td>G440</td>
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<td>Stroke</td>
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<td>230690007</td>
<td>K64</td>
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<tr>
<td>Transient ischaemic attack</td>
<td>Transient cerebral ischaemic attack, unspecified</td>
<td>Transient ischaemic attack</td>
<td>266257000</td>
<td>G459</td>
</tr>
<tr>
<td>Epilepsy : generalised</td>
<td>Epilepsy, unspecified</td>
<td>Seizure in known epileptic</td>
<td>352818000</td>
<td>G403</td>
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<tr>
<td>Status epileptic</td>
<td>we have different types of epilepsy but not by these names</td>
<td></td>
<td>230456007</td>
<td>G419</td>
</tr>
<tr>
<td>Epilepsy : absence</td>
<td>we have different types of epilepsy but not by these names</td>
<td></td>
<td>9631006</td>
<td>G403</td>
</tr>
<tr>
<td>Epilepsy : focal</td>
<td>we have different types of epilepsy but not by these names</td>
<td></td>
<td>29753000</td>
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<tr>
<td>Asthma</td>
<td>Asthma, unspecified</td>
<td>Asthma</td>
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<tr>
<td>Chronic obstructive pulmonary disease</td>
<td>Chronic obstructive pulmonary disease, unspecified</td>
<td>Chronic obstructive pulmonary disease (COPD)</td>
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<td>J449</td>
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<td>Pulmonary embolism</td>
<td>Pulmonary embolism with mention of acute cor pulmonale</td>
<td>Pulmonary embolism</td>
<td>59282003</td>
<td>I269</td>
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<td>Spontaneous pneumothorax</td>
<td>Spontaneous tension pneumothorax; Other spontaneous pneumothorax</td>
<td>Pneumothorax</td>
<td>80423007</td>
<td>J931</td>
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<td>Pleural effusion</td>
<td>Pleural effusion, not elsewhere classified</td>
<td>Pleural effusions</td>
<td>60046008</td>
<td>J90</td>
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<td>Anaemia</td>
<td>Anaemia, unspecified</td>
<td>Anaemia</td>
<td>271737000</td>
<td>D649</td>
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</table>
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

<table>
<thead>
<tr>
<th>The Royal Free</th>
</tr>
</thead>
<tbody>
<tr>
<td>Northwick Park</td>
</tr>
<tr>
<td>Wexham Park</td>
</tr>
<tr>
<td>Warrington and Halton</td>
</tr>
<tr>
<td>Epsom &amp; Helier</td>
</tr>
<tr>
<td>Leeds Teaching Hospital</td>
</tr>
<tr>
<td>Northampton</td>
</tr>
<tr>
<td>Norfolk &amp; Norwich</td>
</tr>
<tr>
<td>City Hospitals Sunderland</td>
</tr>
<tr>
<td>Western Sussex Hospitals</td>
</tr>
</tbody>
</table>
Incentives

3 CQUINS ≈ £500k per trust pa

New revenue from blended payment

Pneumonia
Pulmonary Embolus
Atrial Fibrillation
Fiscally prudent

For most SDEC conditions Tariff $\leq$ 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"
FUNCTION

Usual trajectory (no hospital admissions)

Hospital admission trajectory

TIME

+ve influence
-ve influence

Access to early diagnosis
Advanced care planning
Socioeconomics
Pathophysiology
Frailty
Disease expression

Acute admissions
Inflammatory insult, Delirium
Poor recovery, iatrogenic insult

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

Source: Joint Activity Report Report M11 – continuous timeseries graphs
Bed Days at M11

Non Elective Bed Days

Source: Joint Activity Report at M11 – continuous timeseries graph
We are responsible for reforming hospitals emergency care delivering a step-change in Same Day Emergency Care this year

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

National SDEC CQUINs published for 2019/20
- pulmonary embolus
- community acquired pneumonia
- atrial fibrillation with tachycardia
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**

<table>
<thead>
<tr>
<th>5 Scenarios:</th>
<th>No. of 1+ LOS admissions shifted to 0 LOS</th>
<th>Estimated cost reductions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Per year</td>
<td>Per day</td>
</tr>
<tr>
<td>A: Increase to AEC Network minimum estimate per condition ^</td>
<td>2,440</td>
<td>7</td>
</tr>
<tr>
<td>B: Increase to AEC Network mid point estimate per condition ^</td>
<td>4,154</td>
<td>11</td>
</tr>
<tr>
<td>C: Increase to AEC Network maximum estimate per condition ^</td>
<td>6,178</td>
<td>17</td>
</tr>
<tr>
<td>D: Shift all 1 day LOS admissions to 0 day LOS</td>
<td>3,562</td>
<td>10</td>
</tr>
<tr>
<td>E: Shift all SDEC amenable admissions to 0 day LOS</td>
<td>11,924</td>
<td>33</td>
</tr>
</tbody>
</table>

* 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.

Average wait for admitted patients *not receiving SDEC*

*Patients with an amenable condition, arriving during core AEC unit operating hours*
What is SDEC?

Jay Banerjee
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.....

“It is not enough to do your best; you must know what to do, and then do your best”

- W. Edwards Deming
## Challenge

<table>
<thead>
<tr>
<th>TECHNICAL</th>
<th>ADAPTIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>➢ Problem is well defined</td>
<td>➢ Challenge is complex</td>
</tr>
<tr>
<td>➢ Solution is known/ can be found</td>
<td>➢ To solve requires transforming long-standing habits and deeply held assumptions and values</td>
</tr>
<tr>
<td>➢ Implementation is clear</td>
<td>➢ Involves feelings of loss, sacrifice (sometimes betrayal to values)</td>
</tr>
<tr>
<td></td>
<td>➢ Solution requires learning and a new way of thinking, new relationships</td>
</tr>
</tbody>
</table>
Small steps lead to big changes

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

**Model for Improvement**
- What are we trying to accomplish?
- How will we know that a change is an improvement?
- What change can we make that will result in improvement?

**Aims**
**Measures**
**Changes**

**Test the Changes (PDSA Cycles)**

**Building Knowledge with PDSA Tests**
- Evidence and Data
- Theories and Best Practices
- Very small scale
- Follow up test
- Test under new condition
- Wide scale tests of change

Source: Langley et al. (1996), The Improvement Guide, Jossey-Bass: San Francisco
Right patient, right place

ED/OPD/GP
Activity

Opinion
Referral

Management
Referral

Definite
Admission

ED/OPD/GP
Management

AEC

Admit to
Assess

Admit
UPDATE - Directory of 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?
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

- 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”
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?

<table>
<thead>
<tr>
<th>Managed in AEC</th>
<th>Not managed in AEC</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Conversion</strong></td>
<td></td>
</tr>
<tr>
<td>Box 1: Success</td>
<td>Box 2: Missed opportunity</td>
</tr>
</tbody>
</table>
  % conversion from AEC service to admission  
  Clinical outcomes/experience  
| Box 3a: Wasted capacity | Box 4: Appropriate |
  Some HRGs may indicate Low conversion rates  
  Casefile review  
| Box 3b: Potential clinical risk  
  Patients NEWs score  
  High conversion rates  
  Casefile review | Emergency inpatient/outpatient care |
Maximising potential

**Suitable for AEC**

- **Clear aim**
- **Objectives criteria**
- **Gatekeeping**
- **Early identification**
- **Early streaming**
- **Appropriate measures**

**Unsuitable for AEC**

- Risk (Pt too sick/complex at time of selection – Review thresholds)
- Waste (Pt could be managed in other outpatient service – Review flow map and thresholds)

**Seen in AEC**

- Success (expect about 10% conversion rate)
- Missed Opportunity (Do ICD10 short LOS search and post take reviews)

**Not Seen in AEC**

- Success (appropriate alternative care)
Heart Failure Pathway
Define who can go home & Define who needs specialist care
Inclusion/exclusion criteria

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

- Aim to reduce unhelpful variation 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*

<table>
<thead>
<tr>
<th>Variable</th>
<th>Points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>1 point per decade</td>
</tr>
<tr>
<td>NEWS</td>
<td>1 point per NEWS</td>
</tr>
<tr>
<td>Triage Category</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>5 points</td>
</tr>
<tr>
<td>2 (or 3+)</td>
<td>10 points</td>
</tr>
<tr>
<td>1</td>
<td>20 points</td>
</tr>
<tr>
<td>Referred by GP</td>
<td>10 points</td>
</tr>
<tr>
<td>Arrived by Ambulance</td>
<td>5 points</td>
</tr>
<tr>
<td>Admitted &lt;1 year ago</td>
<td>5 points</td>
</tr>
</tbody>
</table>


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
Block Tariff
PbR Tariff (HRGs = DRGs)
Blended payment

![Diagram showing the relationship between activity and income. The graph indicates a linear increase in income as activity increases from 80% to 100%.]
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
Where is SDEC hiding?

Non-elective (Long), £14.0bn

Non-elective (Short), £3.9bn

Outpatients, £7.5bn

A&E, £3.2bn
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
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
AEC in Emergency Care
Dr Tara Sood

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network
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)
Drivers For Change
Other Drivers

• Patient expectation
• Patient satisfaction
• Delivering quality in a culture of increasing demand
• Workforce issues

NHS LONG TERM PLAN

The Royal College of Emergency Medicine
Key Ingredients

Same day emergency care can be successfully achieved by:

• Early senior decision making
• Streamlining access to diagnostic services
• Collaborative working
• Providing an environment that supports same day emergency care
Who Does This?

Emergency Physicians
Acute Physicians
Acute Surgeons
Frailty Teams
Specialist teams e.g. renal, O&G
Principles of Delivering AEC from the ED

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

The Royal College of Emergency Medicine
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

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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

Low Risk Chest Pain

First Seizure

DVT

Ureteric Colic

SVT

Asthma

Frailty

Pneumothorax

Low risk GI bleed

Urinary Retention

Low risk PE

TIA

Low risk PE

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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

## 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

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The Royal College of Emergency Medicine
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

Delivered by
NHS England, NHS Improvement and the Ambulatory Emergency Care Network
Putting SDEC in policy context
What’s the national approach?

FROM THIS

‘The frail Elderly’

Late Crisis presentation
Fall, delirium, immobility

Hospital-based episodic care
Disruptive & disjointed

TO THIS

‘An Older Person living with frailty’
A long-term condition

Timely identification preventive, proactive care supported self management & personalised care planning

Community based person centred & coordinated
Health + Social +Voluntary+ Mental Health + Community assets

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


<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Weight loss</td>
<td>Self-reported weight loss of more than 4.5 kg or recorded weight loss of &quot;5% per year</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>Self-reported exhaustion on US Center for Epidemiological Studies depression scale73 (3–4 days per week or most of the time)</td>
</tr>
<tr>
<td>Low energy expenditure</td>
<td>Energy expenditure &lt;383 kcal/week (men) or &lt;270 kcal/week (women)</td>
</tr>
<tr>
<td>Slow gait speed</td>
<td>Standardised cut-off times to walk 4.57 m, stratified by sex and height</td>
</tr>
<tr>
<td>Weak grip strength</td>
<td>Grip strength, stratified by sex and body-mass index</td>
</tr>
</tbody>
</table>
## Categories

<table>
<thead>
<tr>
<th>Number of factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Not frail</td>
</tr>
<tr>
<td>1-2</td>
<td>Pre-frail</td>
</tr>
<tr>
<td>3-5</td>
<td>Frail</td>
</tr>
</tbody>
</table>
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

Reducing proportion alive

Fit
Mild frailty
Moderate frailty
Severe frailty

43%
37%
16%
4%
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.

Clinical Frailty Scale: mortality prediction

Community dwelling people

Rockwood CMAJ 2005
How common is frailty?
Who are the frail people?

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

% of frail patients by age band

- National average (all ages 16+)

<table>
<thead>
<tr>
<th>Age Band</th>
<th>% of Frail Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-34</td>
<td>1.8%</td>
</tr>
<tr>
<td>35-54</td>
<td>2.9%</td>
</tr>
<tr>
<td>55-74</td>
<td>3.3%</td>
</tr>
<tr>
<td>75+</td>
<td>7.6%</td>
</tr>
</tbody>
</table>

...more likely to live in deprived areas

% of frail patients by deprivation

- National average (all areas)

<table>
<thead>
<tr>
<th>Deprivation Level</th>
<th>% of Frail Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most deprived areas</td>
<td>4.6%</td>
</tr>
<tr>
<td>Moderately deprived areas</td>
<td>2.9%</td>
</tr>
<tr>
<td>Least deprived areas</td>
<td>2.1%</td>
</tr>
</tbody>
</table>
Distribution of Frailty in old age (eFI)

NHS England analysis - KID 2017-18
Older people, frailty, hospital use and outcomes
<table>
<thead>
<tr>
<th>Healthcare Activity</th>
<th>Percentage of in England aged 75+</th>
</tr>
</thead>
<tbody>
<tr>
<td>No hospital activity</td>
<td>25.8%</td>
</tr>
<tr>
<td>Outpatient activity only</td>
<td>30.9%</td>
</tr>
<tr>
<td>A&amp;E activity, no admissions</td>
<td>6.8%</td>
</tr>
<tr>
<td>Only planned admissions</td>
<td>13.7%</td>
</tr>
<tr>
<td>Single emergency admission</td>
<td>14.6%</td>
</tr>
<tr>
<td>Two emergency admissions</td>
<td>4.9%</td>
</tr>
<tr>
<td>3+ emergency admissions</td>
<td>3.4%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Activity type (frail older people)</th>
<th>England</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of total admissions</td>
<td>57%</td>
</tr>
<tr>
<td>Percentage of total bed days</td>
<td>87%</td>
</tr>
<tr>
<td>Percentage of emergency readmissions within 90 days</td>
<td>84%</td>
</tr>
<tr>
<td>Percentage of deaths within 90 days of admission</td>
<td>84%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Intervention group n=91</th>
<th>Control group n=85</th>
<th>Significance of difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Length of hospital stay (days)</td>
<td>3.3</td>
<td>5.5</td>
<td>P&lt;0.001</td>
</tr>
<tr>
<td>Post operative delirium</td>
<td>9 (11%)</td>
<td>22 (24%)</td>
<td>P&lt;0.05</td>
</tr>
<tr>
<td>All complications</td>
<td>7%</td>
<td>4.2%</td>
<td>P&lt;0.05</td>
</tr>
</tbody>
</table>

Partridge J et al, 2016; Br J Surg
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

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**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.acutefrailtypnetwork.org.uk](http://www.acutefrailtypnetwork.org.uk)

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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

SAU Cases

- 61% Gl Surgery
- 20% 101 - Urology
- 12% 107 - Vascular Surgery
- 3% 160 - Plastic Surgery
- 1% 361 - Nephrology
- 0% 103 - Breast Surgery
- 0% Medicine
- 0% 161 - Burns Care
- 0% Womens
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)
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

<table>
<thead>
<tr>
<th>Year</th>
<th>Month Start</th>
<th>SAU Measures</th>
<th>SDAU Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SAU Cases</td>
<td>SDAU Cases</td>
</tr>
<tr>
<td></td>
<td></td>
<td>SAU AvLoS</td>
<td>SDAU Av Ed Wait hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% SAU Discharge</td>
<td>SDAU Dept hrs</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% SAU 14hr Discharge</td>
<td>SDAU Conversions</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% SDAU Conversions</td>
<td>SDAU Avg time</td>
</tr>
<tr>
<td></td>
<td></td>
<td>% SDAU 14hr Discharge</td>
<td></td>
</tr>
<tr>
<td>2017 Total</td>
<td></td>
<td>4900</td>
<td>3777</td>
</tr>
<tr>
<td></td>
<td></td>
<td>39.7</td>
<td>6.1</td>
</tr>
<tr>
<td>2018 Total</td>
<td></td>
<td>6106</td>
<td>3983</td>
</tr>
<tr>
<td></td>
<td></td>
<td>31.7</td>
<td>6.3</td>
</tr>
</tbody>
</table>

- 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

<table>
<thead>
<tr>
<th>Year</th>
<th>Month Start</th>
<th>SAU/SDAU Combined Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>GP Adm Saved</td>
</tr>
<tr>
<td>2017 Total</td>
<td></td>
<td>2005</td>
</tr>
<tr>
<td>2018 Total</td>
<td></td>
<td>2360</td>
</tr>
</tbody>
</table>
WINTER 17/18 VS 18/19

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

<table>
<thead>
<tr>
<th>Week Start</th>
<th>SAU Cases</th>
<th>SAU AvLoS</th>
<th>SAU &lt;14hr</th>
<th>% SAU</th>
<th>SAU &lt;14hr Cases</th>
<th>% SAU Conversions</th>
<th>SDAU Cases</th>
<th>SDAU Conversions</th>
<th>SDAU % SDAU</th>
<th>SDAU Avg time 1st Scan</th>
<th>SDAU Avg % GP Adm Saved</th>
<th>% GP Adm Saved</th>
<th>SDAU Avg Wait hrs</th>
<th>SDAU Avg Wait mins</th>
<th>SDAU/SDAU Combined Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1731</td>
<td>32.1</td>
<td>354</td>
<td>20.5%</td>
<td>1343</td>
<td>321</td>
<td>23.9%</td>
<td>2.0</td>
<td>603</td>
<td>42.1%</td>
<td>4.1</td>
<td>102.2</td>
<td>32.6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Change</td>
<td>12.0%</td>
<td></td>
<td></td>
<td></td>
<td>21.1%</td>
<td>-5.5%</td>
<td>-20.3%</td>
<td>-1.3%</td>
<td>-3.0%</td>
<td>-8.9%</td>
<td>-39.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Average Ward LoS (hrs)
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)

<table>
<thead>
<tr>
<th>Immediate</th>
<th>Emergency</th>
<th>Urgent</th>
<th>Scheduled</th>
</tr>
</thead>
<tbody>
<tr>
<td>% In Target</td>
<td>% In Target</td>
<td>% In Target</td>
<td>% In Target</td>
</tr>
<tr>
<td>FirstD-1 Total</td>
<td>FirstD-1 Total</td>
<td>FirstD-1 Total</td>
<td>FirstD-1 Total</td>
</tr>
<tr>
<td>Nov-17</td>
<td>79.4%</td>
<td>Nov-17</td>
<td>78.7%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>77.6%</td>
<td>Dec-17</td>
<td>81.0%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>76.9%</td>
<td>Jan-18</td>
<td>88.5%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>77.6%</td>
<td>Feb-18</td>
<td>83.6%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>70.6%</td>
<td>Mar-18</td>
<td>85.9%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>68.6%</td>
<td>Apr-18</td>
<td>86.7%</td>
</tr>
<tr>
<td>May-18</td>
<td>78.4%</td>
<td>May-18</td>
<td>87.4%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>80.0%</td>
<td>Jun-18</td>
<td>89.6%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>78.8%</td>
<td>Jul-18</td>
<td>84.7%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>80.4%</td>
<td>Aug-18</td>
<td>84.4%</td>
</tr>
<tr>
<td>Sep-18</td>
<td>76.0%</td>
<td>Sep-18</td>
<td>80.2%</td>
</tr>
<tr>
<td>Oct-18</td>
<td>67.4%</td>
<td>Oct-18</td>
<td>83.5%</td>
</tr>
<tr>
<td>Total</td>
<td>75.9%</td>
<td>Total</td>
<td>84.6%</td>
</tr>
<tr>
<td></td>
<td>72.8%</td>
<td></td>
<td>89.2%</td>
</tr>
</tbody>
</table>

**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
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

- September 2015: 63
- October 2015: 538
- November 2015: 504
- December 2015: 138
- January 2016: 300
- February 2016: 504
- March 2016: 504
- April 2016: 504
- May 2016: 504
- June 2016: 504
- July 2016: 504
- August 2016: 504
- September 2016: 504
- October 2016: 504
- November 2016: 504
- December 2016: 504
- January 2017: 504
- February 2017: 504
- March 2017: 504
- April 2017: 504
- May 2017: 504
- June 2017: 504
- July 2017: 504
- August 2017: 504
- September 2017: 504
- October 2017: 504
- November 2017: 504
- December 2017: 504
- January 2018: 504
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?

- 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
- Suspected CVA or acute ICH
- Non-ambulatory patients
- Confused patients/mental health patients
- Those with oxygen requirements
- Those needing isolation
  - i.e. D&V, Flu, Meningitis, TB or Neutropenic infection
- ED
- ED
- Acute Medical Unit
- Acute Medical Unit
- Acute Medical Unit
- Acute Medical Unit
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 Attendences to AEC per month (including admitted) Total Patients

- September 2015: 63
- October 2015: 538
- November 2015: 138
- December 2015: 191
- January 2016: 504

The graph shows a significant increase in attendances in October 2015, followed by a decrease in December 2015. There is a noticeable spike in attendances in January 2016.
Emergency & Acute Care Flow
October 2016

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).

Our Values
Service Teamwork Ambition Respect

*Please note that the Urgent Care Centre were using SystmOne until June 2017, therefore not all data is available.
Where did they come from.

Admitted Patients

- 51% Swast
- 24% ED
- 12% GP
- 7% Clinic
- 3% OOH
- 3% Returning
- 0% LAMU
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
<table>
<thead>
<tr>
<th>3</th>
<th><strong>Three</strong> things I am going to make sure happen, to embed or further develop our same day emergency care service</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td><strong>Two</strong> people I need to speak to about supporting development of our same day emergency care service (when?)</td>
</tr>
<tr>
<td>1</td>
<td><strong>One</strong> thing I am going to take forward, following today, to maximise same day emergency care in our organisation</td>
</tr>
</tbody>
</table>
Developing a dashboard for AEC

Mike Holmes
Measurement Lead – AEC Network
NHS Elect

MikehatAEC@nhselect.org.uk
What do you picture when someone says “Dashboard”?
Almost every dashboard was heavily skewed to financial data. Almost every image of a dashboard was “just too much”!

That is doing my head in!

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.

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

Reference: Langley et al 1996
Good measurement doesn’t happen by magic

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

1. Decide Aim
2. Choose Measures
3. Define Measures
4. Collect Data
5. Analyse & Present
6. Repeat Measures

Steps 4-6

Repeat steps 4-6
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
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:

1. Decide Aim
2. Choose Measures
3. Define Measures
4. Collect Data
5. Analyse & Present
6. Review Measures
7. Repeat steps 4-6
Measuring change in a system context

**Input**

Staff time and resources used by your service

**Process**

The care plans, protocols and policies which staff use to care for patients

**Outcome**

The effect on the patient of how you use the inputs and follow the process

*Source: “Evaluating the Quality of Medical Care”, Donabedian A, 1966*
So you need three types of measures:

- **Process measure**: Process measures show how well we do what we say we do.
- **Outcome measure**: Outcome measures show the impact of what we do on patients/our aim.
- **Balancing measure**: Balancing measures show any unintended consequences of a change.
Three recommended measures

**Process 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.”
Number of emergency surgical bed days used each week

- Reduction in bed days used from around 229 per week to around 199 per week
- Each extra patient per week appears to have saved just over two bed days per week
The percentage of GP patients going home same day has risen from 22% to 40% for surgical patients since SACU opened.
The average waiting time between arrival at ED and procedure being carried out has reduced by 0.6 days with a marked reduction in variation since the commencement of the abscess pathway.
During the pilot, the average number of patients admitted for at least one night’s stay fell from 10 to 7 per day. It rose again to 8 when the pilot finished. There was also a reduction in variation during the pilot - the pilot made the number of admissions more stable/predictable. The highest number of admissions during the pilot was less than the pre-pilot average.
More help is available

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 Places of Analysis
- Measurement and Baseline
Measuring your process

Ambulatory emergency care guide
Same day emergency care: clinical definition, patient selection and metrics

Published by NHS Improvement and the Ambulatory Emergency Care Network
June 2018
High level Driver Diagram from AEC Network

For all eligible emergency patients to be treated in AEC, reducing the need for admission to a hospital bed

- Rapid identification and streaming of appropriate patients to AEC
  - Senior clinical input at point of referral to stream suitable patients to AEC
  - Care is delivered by senior decision-makers
- Staffing and resources organised to provide rapid assessment, diagnosis and same day treatment
  - Clear time standards in AEC that reflect those used in ED e.g. time to first assess
  - Diagnostic capacity built for AEC that matches ED priority
- Collaborative commissioning of AEC services to agree recording, reporting and funding
  - AEC area not used for inpatient bedded capacity
- All stakeholders to work together to develop an effective AEC service
  - Develop education, training and comms to keep all stakeholders engaged

Key drivers:

- %NELA who complete care via AEC
- %NELA offered AEC
- Time to senior decision-maker
- Time to diagnostics
- Time in department
- % of AEC patients going on to require admission
- Reduction in occupied bed days for those conditions treated in AEC
- % patients reporting good or outstanding care
- % patients returning to ED within 48hrs for same condition
- Increase in non-elective expenditure beyond predicted growth (excluding setup period)
- Medical Outliers
- ED Performance
- % of patients with 1-2 day LOS
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?
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
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 #NHSSSDEC to spread the conversation a little wider
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