NHS England

Winter improvement collaborative

Urgent and emergency care improvement guide to direct access

NHS IMPACT
Improving Patient Care Together

Introduction

A series of ‘Urgent and emergency care improvement guides’ have been designed for providers and systems to consider embedding as good practice to reduce ambulance handover delays.

The contents have been drawn from the Winter Improvement Collaborative which was set up to identify solutions to the problems facing the system over the winter period. Members of the collaborative were asked to co-design a series of plans and potential improvement measures, to be adapted and trialled at local level.

Throughout the process there were opportunities to understand what is working and what is proving challenging, and to iterate the approach to ensure it has maximum benefit.

The learnings from the programme cover a range of areas including the flow of patients within hospitals from emergency services to wards, streaming patients into the most appropriate services, and standardising operational processes to be as efficient as possible.

The example trust used in this document has been anonymised.

Each trust is different and will need its own bespoke approach; examples are provided to inform local decision-making and action.

Key principles of direct access to SDEC

Over the last decade same day emergency care (SDEC) has become a widely used and accepted model of care for the management of acutely unwell patients: creating improved patient flow from referral to arrival, supporting early senior clinical decision-making and maximising the opportunity to complete patient care within the same day. A patient may need to return to hospital for additional treatment and monitoring and should be facilitated where this is clinically appropriate.

The standard definition of SDEC is same day emergency care. It allows specialists, where possible, to care for patients within the same day of arrival as an alternative to hospital admission, removing delays for patients requiring further investigation and/or treatment.

In December 2020 direct access to SDEC was launched nationally, specifically activating direct referral from NHS 111 and 999 services, supported by the direct referral pathway in the directory of services (DOS) using code DX022.

In the first instance, acute providers should establish same day emergency care / hot clinics direct referral options for NHS 111 and 999 to refer patients directly via clinician to clinician referral.

The main aim of direct access, is to enhance and develop the access routes from the first point of contact a patient has with a healthcare professional in order to improve access to secondary care. Enabling direct referral to secondary care is part of the overall Long Term Plan supporting appropriate pathways that reduce the impact on emergency departments.

Same day emergency care – direct access

Overall description of intervention:
Providing direct access into same day emergency care (SDEC) is crucial in supporting flow across the wider urgent and emergency care (UEC) system, improving patient experience and avoiding delays within the pathway. Senior clinical decision makers (SCDMs) play a vital within the SDEC service and are the first point of contact for direct referral. SCDMs are not defined by their professional group, instead should be autonomous in their decision making. SCDMs accept referrals from all healthcare professionals instead of using fixed and potentially conservative inclusion criteria. A clinician-to-clinician discussion is required to determine whether the patient is suitable for the service and will be accepted on a case-by-case basis. Calls should be accepted from NHS 111 (and profiled on the directory of service), ambulance, primary care and emergency care as a minimum. Systems can also develop and implement a contact hub approach where all calls are fed into one single point of contact, however with this model a clinician-to-clinician discussion should still take place as to whether the patient is suitable for SDEC. Appendix 1 also provides an overview on the exclusions which apply to SDEC.

Benefits
- Patient behaviour of 'fit to sit' minimised/removed delays in the patient pathway
- Allowing services to care for urgent/emergency patients on the same day
- Reduced length of stay (LoS)
- Reduced waiting times for patients
- Patients referred the right service first time
- Opportunity to build system maturity
- Winder understanding of SDEC services across 111/999 services
- Relationship building with wider healthcare community
- Reduction of patients attending SDEC who could be seen elsewhere e.g.: community/primary care

Lessons learned and advice to those who want to implement:
- Clinical and operational leadership is an imperative to support transformation and maintain long term delivery
- Staff engagement is critical for all staff to understand and adopt the transformational principles of direct access.
- Relationship building between specialty areas and referrers is crucial in developing direct access pathways. Referring clinicians need to understand what the specialty can offer in order for referrals to be received.
- Staff engagement is crucial for direct access, explaining the benefits and how it will work will gain momentum and achieve a sustainable model.
- Ensure that capacity has been mapped to support flow within the service from emergency department, NHS 111 and ambulance referrals.
- The lack of inpatient bed capacity can mean that the SDEC estate can be used to support additional bed space, a clear procedure should be in place should the estate need to be used and only invoked by the executive team.

Enablers
Designating senior clinicians as first point of contact answering referral phone calls
Having frictionless contact between both parties to communicate at ease
Parallel working of the whole multi disciplinary team (MDT)
Close collaboration with the Hospital at Home (HAH) team

Barriers	Cause	How the barrier was addressed
Changing consultant behaviour to accept referrals	Lack of understanding of why it is important to open up direct access	Further training and education of the senior clinical decision makers should be provided and they should be supported by their SRO.
Ability to navigate legal complications of making a decision when the doctor is not face to face with the patient	Many hospitals are uncomfortable with arms – length decision making, where mistakes could result in death	Set up a new governance process, to enable patient case review of suitable and non suitable patients. Also explore local patient records (such as within NHS 111 or ambulance to capture the discussion.
Interdisciplinary friction	The change requires multidisciplinary collaboration	The SDEC service and specifically the wider clinical team need to own the risk and ensuring patients are discharged on same day

Supporting tools/ protocols/ policies developed:
- A standardised recording system for all referral routes/dashboard
- Dedicated SDEC access to CT, ultrasound and MRI diagnostic tests
- A system for patients discharged within 72 hours to return directly to SDEC should they need to
- Standard Operating Procedure (SOP) for the service including an exclusion criteria
- Site level project plan and/or organogram which includes a risk register
- Qualitative information from
- Patient Advice and Liaison Service (PALS), Datix, Complements, Friends and Family Test feedback and complaints reports

Links to guidance and good practice:
System wide access to SDEC - SDEC Collaboration Platform - FutureNHS Collaboration Platform

Same day emergency care – direct access

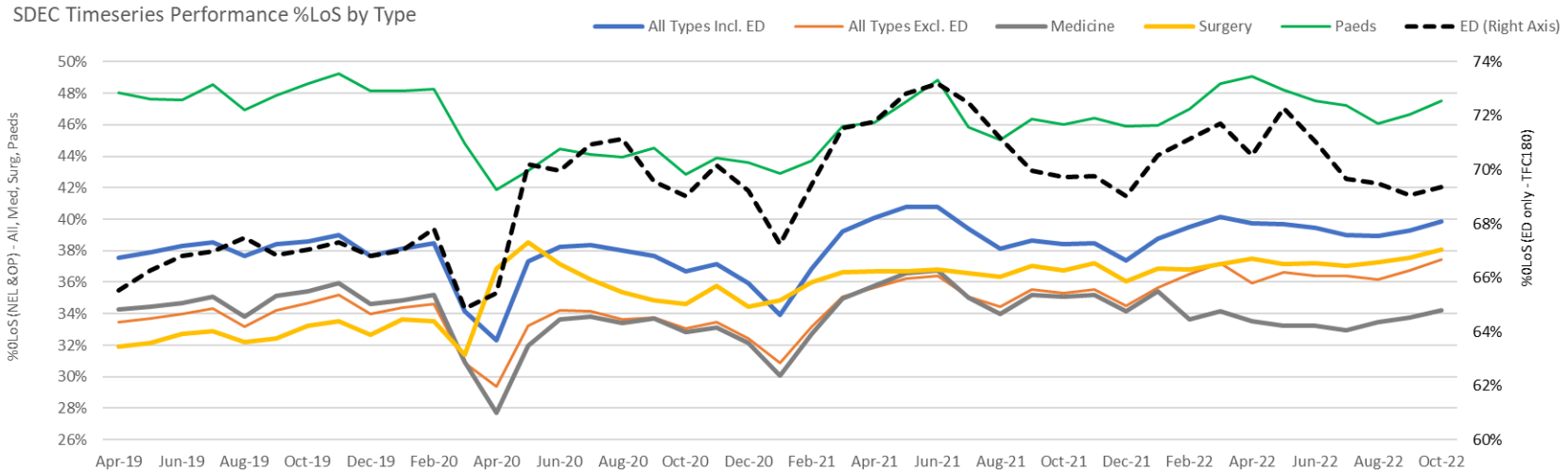
National SDEC activity 0LOS (proxy measure)

The national position for same day emergency care (SDEC) activity based on a 0 day length of stay (LoS) position.

The information highlights the recovery of SDEC services post pandemic and the increased use of SDEC across specialties.

A third of the total non elective activity should be seen via SDEC services with an increase year on year.

The 0 day LoS position can be used at site level to track improvements.

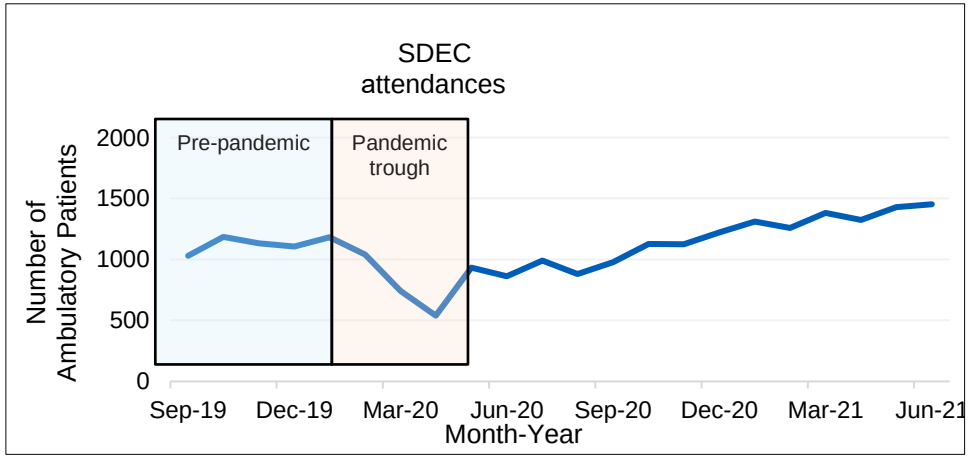


Direct access referrals

The number of referrals which are referred direct to SDEC is tracked on a month by month basis.

The graph highlights the recovery of referrals into SDEC post pandemic and the continued increase.

This information is available for sites to use and track improvements at: [SDEC Referral Data - SDEC Collaboration Platform - FutureNHS Collaboration Platform]



Same day emergency care – direct access (2)

Roles and responsibilities that enabled intervention delivery:

Role	Responsibility
COO	Operational oversight of the service and general management team and the transformation/ PMO team. Also responsible for communications and business informatic support.
Medical director	Clinical and risk oversight of the service. Lead for signing off clinical risk and oversight factors
Chief nurse	Clinical and risk oversight of the service. Lead for signing off governance including workforce and patient experience risk (physical risk assessment lead).
Roles critical in implementation	Divisional Director – providing clinical oversight of the service, PMO/ transformation team – Tracking delivery and review of impact, Ops team – Operational delivery and performance, Service clinical leaders – liaison with staff and implementation, communication team - staff engagement and Business informatics – review of performance

Metrics (top 6):	
Ambulance	Ambulance referrals directed to SDEC / ambulance referrals accepted
In ED	Type 1 patients seen by senior decision maker within 60m
In hospital	111 Referrals directed to SDEC / 111 referrals accepted
In hospital	Time in Department in SDEC
In hospital	No of patients referred for direct access by pathway
In hospital	Conversion rate to admission via SDEC

Same Day Emergency Care – Direct Access (3)

Critical implementation path:

	Critical action	Timeframe	Lead
Process	Review existing barriers for direct referrals into SDEC. This should include representatives from the wider UEC forum, such as community, ICB colleagues, ambulance, NHS 111 etc. Guidance materials are available on the NHS SDEC Futures platform. Referral guidance - SDEC Collaboration Platform - FutureNHS Collaboration Platform	Week 1	Ops team and clinical leaders.
	Develop a joint improvement plan which spans the wider UEC pathway and includes key actions such as the review of the directory of services (health system wide) and demand and capacity planning. Weekly meetings should be set to ensure pace is gathered and traction gained.	Week 2	SRO/ Ops team and clinical leaders.
	Review the SOP in place for the service, ensuring that the SDEC team and referrers have been engaged in its development.	Week 2 - 3	PMO Lead / SROs / Ops and clinical leaders
DoS Review	Liaise with the DoS team to review and amend profiles, testing with referrers to ensure that they are clear.	Week 3-4	SROs / Ops / Wider UEC system team
	Design exclusion criteria and governance profile	Week 3-4	SROs / Ops / Wider UEC system team
Governance	Review governance change requirements to support staff in being comfortable and confident in arms length decision making processes. This should be fully supported by the executive team.	Week 2-4	CEO / SROs
	A method for recording all referrals should be provided. Suppliers who provide an advice/ guidance telephony option can be considered where calls are logged, recorded and outcomes can be added onto an electronic system.	Week 3	SROs / Ops / Wider UEC system team
Comms	Communications plan drafted and initiated, this should include active engagement with NHS 111, ambulance, community providers and Primary Care.	Week 4 +	PMO Lead / ops team/ Comms
	Weekly service improvement meeting to track delivery, comms approaches and to address risks/ issues.	Weekly	PMO Lead / SROs / Comms
Data/ BI	Key metrics to track improvements set and agreed	Week 2-4	Ops and clinical leaders
	Daily and weekly metric monitoring and reporting	Daily/ weekly	Business informatic team

Supporting roles and responsibilities: national, regional and system

The following table represents a list of 'responsibilities' that were shared by members of the collaborative on subjects that were barriers/ enablers to implementing this intervention. These have been allocated against suggested roles that could provide support on these items. The collaborative has worked with subject matter experts in the national UEC team who have developed suggested actions that regulatory /national / regional / system / local teams may wish to consider in supporting solutions to those asks and, ultimately, would be at their discretion

Role	Responsibility	What action could be taken?
National	Create standard metrics and KPIs for SDEC and monitor these (to include at a minimum patients accessing each of the direct access pathways)	National UEC team to work with winter collaborative in approving monitoring metrics for SDEC use. National UEC team to work with winter collaborative on the sharing of best practice documents, advice and case studies
Regional	Support embedding of standard metrics and KPIs	Identify regional, system and trust direct access leads who are requested to attend a monthly direct access pathways focused forum.
System	Encourage strong communication between primary care and accepting pathways	Appoint project lead to audit pathway usage. Project lead to create an improvement action plan that encourages collaboration from across the system to grow direct referrals into alternative pathways.
	Provide robust definitions/governance/guidance around inclusion/exclusion criteria for all alternative pathways	System clinical leaders to work collaboratively on the creation of open access criteria for alternative pathways as opposed to inclusion/exclusion criteria so as to encourage clinician to clinician conversations and adherence to the CQC people first guidance.
	Review alignment of ambulance categories of patients and proposed alignment to specific pathways	Systems should not automate ambulance categories to specific pathways. Instead it is good practice for a system leader/project lead to audit alternative pathway usage by the ambulance service and produce an improvement action plan with both the ambulance service and the trust to increase appropriate activity.
Local	Ensure rapid access to hot clinics within specialities	Medical director to work with each divisional clinical lead to ensure hot clinics are available and are being used (audit).
	Access to diagnostics in line with ED turnaround times	Trust executive triumvirate to ensure there is equitable access to diagnostics across the whole emergency floor (SDEC/ED/Assessment Units) with only resus taking priority
	Monitor patient feedback for all direct access pathways	All alternative pathway management leads to ensure patient feedback/complaints reviews are included in their services quality governance reporting

Metrics

The level of data availability, completeness, quality and ability to extract these items varies significantly from organisation to organisation and therefore the final decision about the most useful indicators of success sits at a trust level

Top 6 metrics: Flow Area	Possible metric	Locally collected / already reported	Level of visibility	Type of measure
Ambulance	Ambulance referrals directed to SDEC / ambulance referrals accepted	Collected through Ambulance Daily Collection – trusts may require ambulance service to share	Ambulance service	Outcome
In ED	Type 1 patients seen by senior decision maker within 60m	Locally collected	Trust	Balancing
In hospital	111 Referrals directed to SDEC / 111 referrals accepted	Locally collected	111 Provider	Process
	Time in Department in SDEC	Locally collected	Trust	Process
	No of patients referred for direct access by pathway	Locally collected	Trust	Process
	Conversion rate to admission via SDEC	Locally collected	Trust	Process

Flow area	Possible metric	Locally collected / already reported	Level of visibility	Type of measure
Ambulance	Ambulance arrivals direct to SDEC	Locally collected	Trust	Process
	Total 999 referrals to SDEC of which were directly transferred/referred			
In ED	No. of patients in ED by hour	Locally collected	Trust	Process
	Type 1 patients seen within 60m	Collected on UEC Daily SitRep	Trust	Process
	Type 1 patients seen by senior decision maker within 60m	Locally collected	Trust	Process
	4h A&E Performance	Collected on UEC Daily SitRep	Trust, region	Process
	12h waits from decision to admit	Collected on UEC Daily SitRep	Trust, region	Balancing
	12h waits from arrival to ED	Collected on UEC Daily SitRep	Trust, region	Balancing
	Clinically ready to proceed	Should be collected on ECDS – data quality may be poor	Trust, region	Balancing
	Mean time in ED by chief complaint / age	ECDS	Trust	Balancing
	Comprehensive geriatric assessment (CGA) within 30 mins of arrival			
In hospital	Total 111 referrals to SDEC of which were directly transferred/referred			

Appendix 1 - Exclusions for same day emergency care

The importance of a clinician-to-clinician discussion

- The senior clinical decision makers (SCDMs) rely on a clinician-to-clinician conversation to advise on a case-by-case basis whether to accept a direct referral.

Immediate exclusions

- hyper-acute patients
- where there is clear trauma
- where patients are in need of resuscitation
- when they are experiencing a heart attack or stroke (further exclusions below).

Inclusions for SDEC

- All clinically appropriate patients with an urgent and emergency care need requiring a hospital attendance that could be managed on the same day should be referred directly to SDEC.
- An initial assessment must be carried out on each patient to rule out whether they can be treated by primary or community care before being referred to hospital.
- If patients are >65 years of age a frailty pathway should be considered first.

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