Same Gay Hmergency Fare llow (2)

NHS England

Overall description of intervention:

- In this example, the combined assessment unit (CAU), which supports both medical/ surgical, is adjacent to the Hmergency Gepartment (ED). The unit provides the ability for patients with an emergency/ urgent need to be seen within an SDEC service and allowing ED to concentrate on the critically ill patients.
- Figure 1 (slide 5) highlights the initial front door pathway for both self-presenting “walk-in” patients (green line) and ambulance arrivals (red/ yellow line). Both pathways have the ability for the patient to be seen within an SDEC service.
- There is a senior nurse at the front door, who undertakes the streaming to the right service (see figure 2, slide 5).
- Continuous review and subsequent improvement of SDEC services is crucial in supporting flow

Benefits

- Improved patient flow, preventing crowding of departments.
- Provides an admission alterative to patients, to enable capacity and flow within the acute care system.
- Improved patient experience
- Improved ambulance handover delays

Lessons learned and advice to those who want to implement:

- Early identification of SDEC suitable patients is key to ensuring that the patient is directed to the right place first time and improves the experience of care for the patient.
- Staff engagement is crucial in the development of the pathway, gaining momentum and achieving a sustainable model.
- Relationships with the wider UEC system is important in maintaining conversations to support real improvements.
- Clinical and executive leadership is crucial in starting, developing and improve the SDEC offer
- 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.
- Consider the use of combined SDEC services to support knowledge exchange and combined workforce models

Enablers
ED, SDEC and patient flow all sits within one clinical division unit, meaning everyone has a part to play in the overall patient journey from the front door.
Executive and clinical leadership and oversight
Staff engagement across specialties.
Project management team resource including key support services such as business informatics

Barriers	Cause	How the barrier was addressed
Logistical challenge managing large number of referrals	Increased demand	Well-resourced administrative team is critical in supporting clinical decision makers
Impact on waiting times for patients	Workforce capacity	Minimise unnecessary waits – input from senior clinical leaders and swift discharge.
Bedding of SDEC estate	Use of SDEC estate as additional inpatient capacity	Review of site escalation plan, action card and benefit evidence on the impact of not bedding SDEC.

Supporting documents used / developed by Trust:

- Standard Rperating Srocedure (SOP) for the service, with an exclusion criteria
- Combined system UEC action plan
- Site level project plan and/or organogram which includes a risk register
- Business informatic dashboard to track improvements.
- Qualitative information from Patient, Advice and Liaison Service (PALS), Datix, Complements, Friends and Family Test feedback and complaints reports

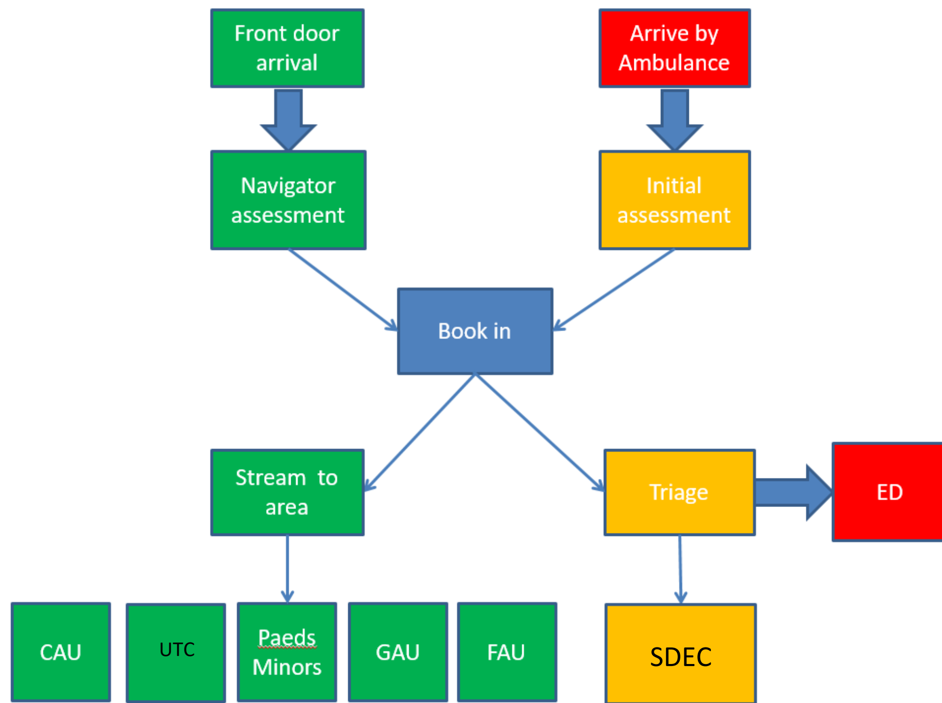
Links to guidance and best practice:

SDEC Collaboration Platform - FutureNHS Collaboration Platform

Same day emergency care flow (3)

NHS
England

Figure 1. Initial front door pathway



Abbreviation Key

CAU – Combined assessment unit for medical/ surgical SDEC

GAU – Gynae assessment unit

FAU – Frailty assessment unit

Figure 2. ED streaming tool

Navigation/Triage

M

F

CONSIDER GAU CRITERIA

0-18

19- 65

65 +

CONSIDER FAU CRITERIA

USE PAEDIATRIC ALGORITHM

CHILD FLOPPY OR DROWSY?

CHILD DEMONSTRATES EVIDENCE OF RESPIRATORY DISTRESS?

ALTERED COLOUR OR EVIDENCE OF MOTTLING

NOT PASSED URINE IN LAST 12 HRS?

RIGORS? OR UNCONTROLABLE FEVER

USE FEVER PROTCOL

PURPURIC RASH OR MENINGISM

SEEN BY H/CARE IN 72HRS.

NO

PRIMARY CARE

ILLNESS / MSK PAIN

SEEN BY H/CARE IN 72HRS.
ACTIVLEY BLEEDING.
HIGH MECHANISM .
PAIN SCORE >5.
UNABLE TO PASS URINE
PERSISTANT VOMITING
INTOXICATED
SUICIDAL INTENT
DEVIATION FROM NORMAL BASELINE – inc. non weight bearing

YES

ED

NO

ED / SDEC / CAU

HEAD INJURY
FEVER
CHEST PAIN
ABDO PAIN
MSK PAIN

CONSIDER

INJURY

UNCONTROLLED HAEMORRAGE
OPEN FRACTURE
HIGH MECHANISM INJURY
ANTICOAGULANTS
GROSS DEFORMITY
PAIN SCORE>8
DEVIATION FROM NORMAL BASELINE

YES

ED

NO

MINORS INJURY

Same day emergency care flow (4)

NHS England

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 to review)	
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
	Time in department in SDEC
	No of patients referred for direct access by pathway
	Conversion rate to admission via SDEC

Same day emergency care flow (5)

NHS England

Critical implementation path in reviewing same day emergency care service :

	Critical action	Timeframe	Lead
Process	Review of existing service provision. This should include representatives from the wider UEC forum, such as community, ICB colleagues, social care. Guidance materials are available on the NHS SDEC Futures platform. Guidance - SDEC Collaboration Platform - FutureNHS Collaboration Platform	Week 1 - 2	Divisional director, Ops team and clinical leaders.
	Develop a joint improvement plan which spans across the wider UEC and includes key actions such as the review of services standard operating procedure, workforce and demand and capacity planning. Weekly meetings should be set to ensure pace is gathered and traction gained.	Week 2 +	PMO Lead / SROs
Workforce	Review workforce model within the service. The review should include • Review tasks performed within SDEC compared to the skill set available. This can then support articulate gaps or where staff with specific skill sets can provide support. • The review should also include demand vs activity linked to staffing. Tools available on the SDEC NHS Futures platform can assist with all of the above: Supporting Workforce Planning - SDEC Collaboration Platform - FutureNHS Collaboration Platform	Week 3+	Ops team/ clinical leaders
Activity volumes	A review across the system should take place around activity volumes and include colleagues within the ICB. The purpose of which is to ensure that there is a clear understanding of the current activity through the service and any further potential to increase. This could be ascertained through a missed opportunity audit conducted jointly across the system in reviewing retrospective patients who attended ED and may have been best placed being seen elsewhere.	Week 3-4	SRO's/ Ops team/ clinical leaders/ system partners
SOP	Collaboratively create a SOP and metrics to be monitored. The SOP should include how patients will be identified for SDEC, how to access the service, diagnostics available and timings, procedures, roles and responsibility of staff in the service.	Week 3 - 5	PMO Lead / SROs / Ops and clinical leaders
	Staff engagement in developing the SOP including wider system partners such as ICB, ambulance, Primary Care, NHS 111 provider. Involving staff within the service early on will support model delivery and sustainability.	Week 2-5	PMO Lead / SROs / Ops and clinical leaders
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

Same day emergency care flow (6)

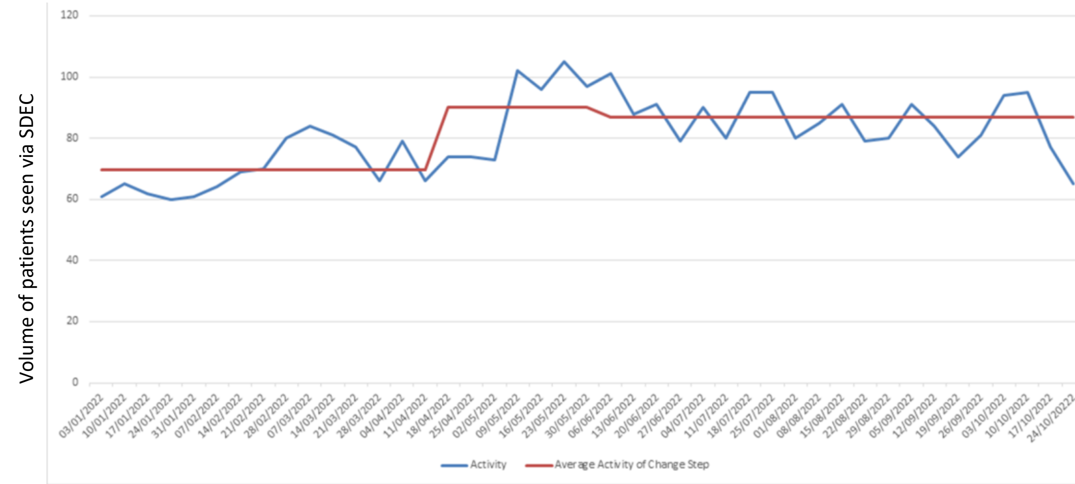
NHS England

Activity within SDEC

As part of the example used within this UEC Improvement guide, 26.8% of the urgent and emergency care attendances were seen via SDEC following the review of the model.

Activity	%
Surgical	5.3%
Children's	2.7%
Medical	11.0%
Frailty	6.7%
Gynae	1.1%
Total	26.8%

Impact on non bedding of SDEC estate



An example of not bedding SDEC

Through commitment to not use the SDEC estate space as additional inpatient capacity, improved SDEC throughput by approximately 20% compared to baseline.

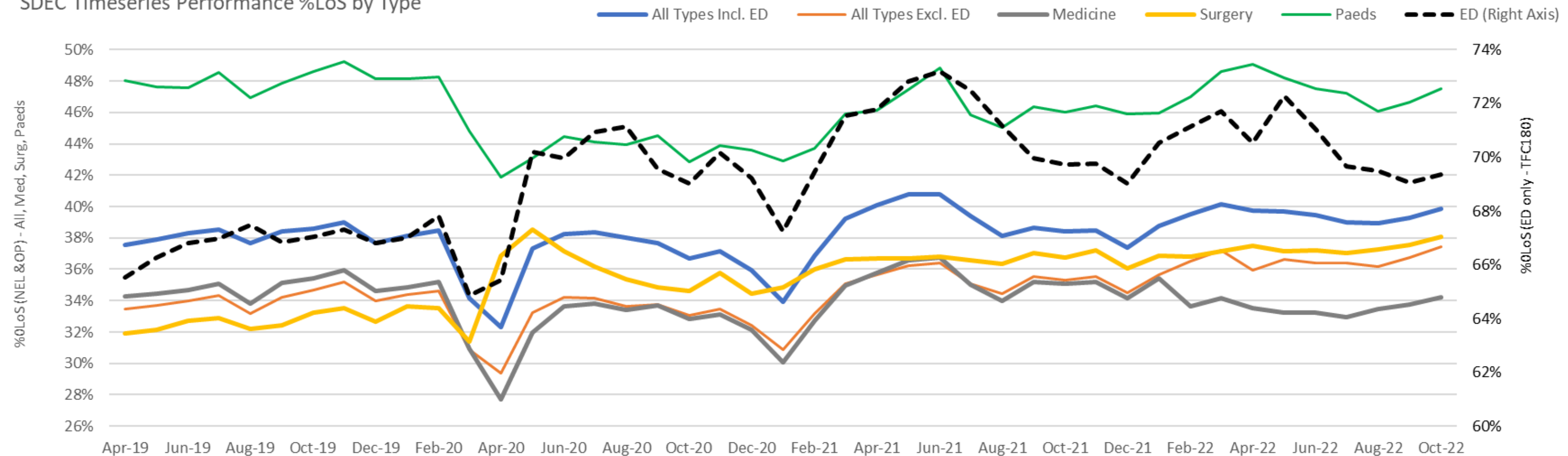
National SDEC Activity 0LOS (Proxy Measure)

The national position for SDEC activity based on a 0 d Length of Stay (LoS) position.

The information highlights the recovery of SDEC servi post pandemic and the increased use of SDEC across specialities.

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

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



Supporting roles and responsibilities: national, regional and system

NHS England

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	Guidance on improving clinician to clinician confidence, effective steaming from front door, avoid patients sitting in ED before moving to SDEC, development of surgical SDEC, avoidance of bedding SDEC	National UEC team to reiterate and share good SDEC practice.
Regional	Ensure all have a clinical SDEC lead and regional working group	Identify regional, system and trust SDEC leads who are requested to attend a monthly SDEC focused forum.
System	Improve and standardise SDEC referrals from GPs/ ambulances/ HCPs	System to appoint a project lead to audit SDEC referral prevalence, work with system and acute clinical leaders to create an improvement action plan that results in improved direct SDEC referrals from the community/ambulances.
Local	Ensure clinical ownership of SDEC	Ensure there is an SDEC triumvirate leadership group (Clinical Lead/Lead Nurse/manager) in place to ensure consistency and leadership of service. This team should ensure that that is a full SDEC oversight governance in place, SDEC has a performance dashboard, and there is an improvement action plan for the development of appropriate SDEC activity.
	To maximise capacity by ensuring SDEC services are not bedded	Executive commitment to never bed SDEC and to source alternative solutions to flow challenges.
	Actively pull SDEC patients out of ED	SDEC triumvirate to ensure open access criteria is in place to encourage referrals and also a culture of pulling patients from ED is empowered within SDEC daily working.
	Review 0 day length of stay in assessment units to identify alternative treatment options	SDEC triumvirate group to perform monthly audit on 0 length of stay in order to establish missed opportunity for SDEC activity growth. The results of this should feed the SDEC improvement plan.

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	Number of patients referred for medical / surgical SDEC over the number of patients accepted to medical / surgical SDEC	Collected through ambulance daily collection – trusts may require ambulance service to share	Ambulance service	Outcome
In ED	Type 1 patients streamed to medical / surgical SDEC within 60m	Collected on UEC daily SitRep	Trust, region	Balancing
	Number of patients referred to medical / surgical SDEC out of hours	Locally collected	Trust	Balancing
In hospital	Average time in department prior to discharge from medical / surgical SDEC	Locally collected	Trust	Process
	Number of patients admitted to hospital from SDEC (admission rate expected)	Locally collected	Trust	Process
	Number of return patients seen in SDEC within 72 hours	Locally collected	Trust	Balancing

Flow Area	Possible Metric	Locally collected / already reported	Level of visibility	Type of measure
Ambulance	Ambulance arrivals direct to SDEC	Locally collected	Trust	Process
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
	Reattendance rate	Locally collected	Trust	Balancing
	Mean time in ED by chief complaint / age	ECDS	Trust	Balancing
	comprehensive geriatric assessment (CGA) within 30 mins of arrival			
In Hospital	1+ Day LoS	SUS/HES	Trust	Balancing
	Activity by hour	Locally collected	Trust	Process
	Number of direct referrals to SDEC from 111/999	Locally collected	Trust	Process