Winter improvement collaborative

Urgent and emergency care improvement guide to same day emergency care pathways

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.

Example of one trust's approach: SDEC pathways (surgical SDEC model)

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 (SDEC) 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.

Teams across England continue to develop and improve their SDEC service appreciating its vital role to rapidly assess, treat and discharge home will support patient flow across urgent and emergency care.

The hospital in this guide opened a standalone surgical SDEC unit in June 2021. The surgical SDEC unit is on the same level as the emergency department (ED), with the medical SDEC unit, alongside the radiology department.

The surgical SDEC unit consists of 2 bays (male and female) each containing 7 chairs and 3 trolleys, with 2 consultation rooms, to manage patients. The unit is open 7 days a week, from 7.30am to 8pm, with the last referral being accepted at 6pm.

The unit has a dedicated surgical SDEC clinical lead (consultant surgeon) and surgical SDEC lead nurse. They are supported by advanced nurse practitioners (ANP) and a bespoke nursing team. Daily there is an identified junior doctor and surgical registrar on the unit with in-reach from surgical specialties such as ENT and Orthopaedics as needed. The on call surgical teams also provide back up to the team on the unit when needed.

The SDEC units accept referrals from primary care, the ambulance service and from ED either direct from triage or following review. The SDEC team monitor the ED activity and actively pull appropriate patients to the surgical SDEC unit.

SDEC pathways (surgical SDEC model)

Overall description of intervention:

- This UEC improvement guide is based on a trust who previously had a surgical admissions unit (SAU) where 25% of patients were discharged the same day. However, the clinical team felt that there were more patients that could be managed and discharge the same day following a review of patient cases seen on the surgical assessment unit (SAU).
- SAU was a ward based service that accepted all emergency surgical cases, therefore it was felt that focussing on same day care within the same space was a challenge and sicker patients quite rightly took priority meaning those patients that could be seen, managed and discharged the same day were not targeted. The trust decided that a dedicated surgical SDEC unit was needed with its own staff to focus on seeing and managing surgical patients discharging them the same day. The trust already had a dedicated medical SDEC.
- A dedicated surgical SDEC clinical lead was identified for the unit who became the name consultant for any patients that attended the SDEC and was responsible for managing and following up patients as needed.

Benefits (the trust reported)

- Patients were directed to SDEC reducing attendances at ED
- Patients awaiting laparoscopic cholecystectomy for gallstones are told to contact SDEC if they have a flare up and are managed by SDEC service and so don't attend ED
- Using patient initiated follow-up (PIFU), patients seek support from SDEC directly rather than attending ED
- Supporting elective recovery
- Co-location of surgical and medical SDECs to develop relationships
- Improved patient experience through reduced delay

Lessons learned and advice to those who want to implement:

- Staff engagement is key to ensure that people understand what the Surgical SDEC does and the patients that it can see and manage so that appropriate patients are identified and streamed to SDEC
- Having a named clinical lead based on the unit enabled continuity of service provision, facilitated consultant to consultant discussions, helped build relationships with ED and other teams across the hospital plus having dedicated time to develop clinical guidance, audit and review activity within the SDEC, as well as providing SDEC patients with a named consultant who is responsible for their care and subsequent review of scans and follow up if needed.
- Identify a lead nurse who works with the clinical lead to review if there has been any missed opportunities for patients to have be seen via the SDEC rather than elsewhere in the system, provide training to staff, monitor and review their data and implement changes with the wider change as and when needed.
- Having a dedicated space and bespoke unit provides a home for the service to be delivered from and allows the team to own the space and how it is used.

Enablers
Having dedicated clinical space for SDEC service
Identified clinical lead and lead nurse for the unit
Significant staff engagement exercises to promote surgical SDED model
Executive agreement that the SDEC doesn't get bedded

Barriers	Cause	How the barrier was addressed
No identified named consultant for patients	Multiple specialities utilise SDEC	Clinical lead appointment for SDEC unit and all patients allocated to them. So named consultant responsible for their care, review of diagnostics and follow up
Unit not open 24/7 (open 7.30am to 8pm)	Workforce capacity	Outside of opening hours, ED can refer appropriate patients to SDEC service. SDEC team will follow up patient next day. Meaning that patients can be discharge from ED and not have to wait overnight.

Supporting documents used / developed by Trust:

- Standard operating procedure (SOP)
- Risk log / register
- Inclusive / exclusion criteria
- Patient Advice and Liaison Service (PALS), Datix, Freedom to Speak & Complaints reports
- Training packs

Links to guidance and best practice:

Surgical SDEC - SDEC Collaboration Platform - FutureNHS Collaboration Platform

SDEC pathways (surgical SDEC model) (2)

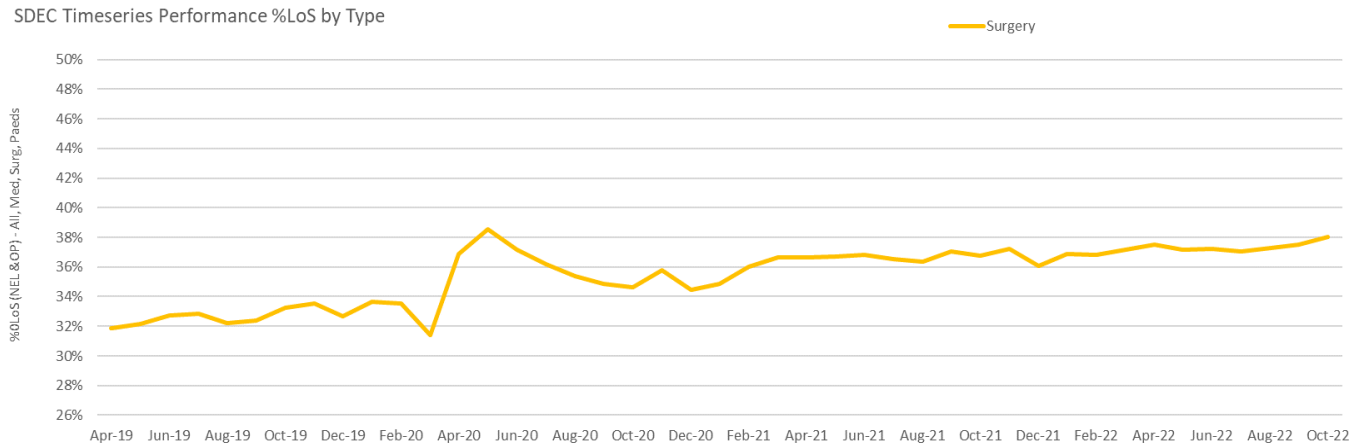
National SDEC Activity 0LOS (Proxy Measure) for Surgery

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

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

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.



Activity within SDEC

As part of the example used within this UEC improvement guide, this table outlines the number of referrals that the SAU received and how many of these patients were discharged the same day in comparison to how many patients where discharged the same day when managed via the new surgical SDEC service.

At this trust, before the surgical SDEC was opened, 25% of patients were discharged on the same day, following the surgical SDEC being opened, 71% of patients were discharged on the same day

	January to September 2019 SAU	January to September 2022 Surgical SDEC
Number of patients referrals into service	2573	2576
% Of these patients discharges the same day	25%	71%

SDEC pathways (surgical SDEC model) (3)

Roles and responsibilities that enabled intervention delivery:

Role	Responsibility
COO	SRO maintains oversight – Operational. Empowered reactive decision making to ensure traction and delivery of model. Liaison with Trust Board and CEO.
Surgical SDEC Clinical Lead (CL)	Named consultant for SDEC service. Audit and reviewing activity on unit. Develop clinical guidance. Undertake opportunities audits to identify any patients that went to SAU that could have been managed on SDEC. Reviewing diagnostic and following up patients.
Surgical SDEC Lead Nurse (LN)	Maintain quality and standards of care on unit. Ongoing management and development of staff. Develop clinical guidance. Undertake opportunities audits to identify any patients that went to SAU that could have been managed on SDEC.
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	Number of patients referred for surgical SDEC over the number of patients accepted to surgical SDEC
In ED	Type 1 patients streamed to surgical SDEC within 60m
	Number of patients referred to surgical SDEC out of hours
In SDEC	Average time in department prior to discharge from surgical SDEC
	Number of patients admitted to hospital from SDEC (expected admission rate)
	Number of return patients seen in SDEC within 72 hours

SDEC pathways (surgical SDEC model) (4)

Critical implementation path:

	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
	Identify space for surgical SDEC unit if identified as a constraint	Week 1	COO/CL/LN
	Role allocation and risk assessment.	Week 1	CL/LN
	Review of current risk mitigations and improvements. Safe staffing assessment.	Week 1 – 3	COO/CL/LN
Policy	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

Roles and responsibilities
SDEC pathways (surgical SDEC Model)

Role	Responsibility	What action could be taken?
National	SDEC definition, opening hours, criteria, principles, standards, streaming targets and best practice which looks at both medical SDEC and other specialities such as Frailty models	National UEC team to work with Winter Collaborative on the sharing of best practice documents, advice and case studies
Regional	Ensure standard SDEC opening times and criteria	Identify regional, system and trust SDEC leads who are requested to attend a monthly SDEC focused forum. Regional SDEC lead to perform a gap analysis and regional improvement plan
System	Whole system to approach SDEC in the same way to ensure no confusion for referring parties (e.g. Ambulance know who is SDEC appropriate regardless of Trust)	Identify a system SDEC clinical leader to influence a standardised SDEC offer for whole system/reducing unwarranted variance. This includes working with both ambulance and acute trusts to reduce patient care inequity
Local	Senior clinician first point of contact	Trust SDEC triumvirate to ensure a clinical single point of access exists so as to provide advice and accept referrals from other HCPs
	Agreement to not bed SDEC overnight unless this is the absolute last resort	Executive commitment to never bed SDEC and to source alternative solutions to flow challenges

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 surgical SDEC over the number of patients accepted to surgical SDEC	Collected through Ambulance Daily Collection – trusts may require ambulance service to share	Ambulance service	Outcome
In ED	Type 1 patients streamed to surgical SDEC within 60m	Collected on UEC Daily SitRep	Trust, region	Balancing
	Number of patients referred to surgical SDEC out of hours	Locally collected	Trust	Balancing
In Hospital	Average time in department prior to discharge from 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
	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	1+ Day LoS	SUS/HES?	Trust	Process
	Bed occupancy	Collected on UEC Daily SitRep	Trust	Balancing
	Number of red (red 2 green) patients	Locally collected	Trust	Process
	Discharges pre 10am/12pm	Locally collected	Trust	Process
	Discharge lounge occupancy	Locally collected	Trust	Process
	Total 111 referrals to SDEC of which were directly transferred/referred			