NHS Rotherham Clinical Commissioning Group

Operational Executive – 13th September, 2019

Strategic Clinical Executive – 18th September 2019

GP Members Committee (GPMC) – 30th October 2019

Clinical Commissioning Group Governing Body – 4 March 2020

Same Day Emergency Care (General Medicine)

(aka ambulatory care)

Lead Executive:	Ian Atkinson, Deputy Chief Officer
Lead Officer:	Becci Chadburn
Lead GP:	Dr David Clitherow

Purpose:

This paper summarises a proposal to fully embed a same day emergency care (SDEC) model (aka ambulatory emergency care) in The Rotherham NHS Foundation Trust (TRFT) in line with expectations in the NHS Long Term Plan.

Background:

The NHS Long Term Plan sates that every acute hospital with a type 1 A&E department will move to a comprehensive model of same day emergency care, thereby increasing the proportion of acute admissions discharged on the day of attendance from a fifth to a third. The SDEC model should be embedded in every hospital during 2019/20 and be available for a minimum of 12 hours per day, seven days per week.[1]

TRFT established a nurse-led ambulatory care centre (ACC) in December 2017. A review by TRFT of the first six months of the ACC noted that 75-80% of ACC patients (acute and returners) were clerked/reviewed by an acute medicine advanced nurse practitioner (ANP), and nearly 60% of these patients were discharged independently by an ANP. The same report states that TRFT manages 35-40% of its acute medicine activity through the ambulatory care service. GP/primary care referrals account for the majority (80%) of patients seen in the ACC, with referrals from urgent and emergency care centre (UECC) accounting for most of the rest. TRFT acknowledges, however, that these data have been collected by hand and, therefore, the accuracy is questionable.

Analysis of TRFT activity by the CCG suggests that there remains a significant opportunity to improve the proportion of patients that receive same day emergency care. Maximising this opportunity will improve patient experience and quality of care, and reduce the need for hospital admission.

It is, therefore, proposed that the CCG works with TRFT to embed a more robust model of same day emergency care (SDEC) by 1st April 2020. A draft service specification has been prepared by the CCG and provided to the Trust.

[1] NHS Long Term Plan, NHS England, 2019, p. 22

The overarching principle of same day emergency care is that patients should be assessed for admission, rather than being admitted for an assessment. All emergency patients should be considered ambulatory until proven otherwise.

The key requirements of the service include:

- Open a minimum of 12 hours per day, seven days per week;
- Senior clinical input is needed at the point of referral to redirect suitable patients to ambulatory care. A senior decision maker should be available during all operational hours. This would usually be a consultant-level doctor but can be experienced middle grade doctors or ANPs, provided they are empowered to complete the patient episode in a similarly efficient manner;
- Clear exclusion criteria based on the NHS early warning score (NEWS) should be developed to maximise patient flow to ambulatory care;
- The ambulatory emergency care service should be closely located to the UECC;
- Staffing and resources should be organised to provide rapid assessment, diagnosis and treatment on the same day;
- A member of the community respiratory team will be based in the SDEC area each day, with the aim to reduce the number of admissions onto the respiratory unit. Patients who arrive into the UECC, when stable will be transported to the SDEC team for further treatment/review. The community respiratory nurse (CRN), will work with the acute team to determine if the patient can be discharged with home support (by the community nursing team) within 12, 24, 48 or 72 hours and also follow-up for patents who have had prolonged stay in the acute setting;
- The time standards in SDEC should match the Clinical Quality Indicators for A&E i.e. time to initial assessment: 15 minutes, time to medical assessment; 60 minutes and completion within four hours;
- Patients should be informed early in their journey (ideally in A&E or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight to manage their expectations and those of their family;
- Secondary and primary care services should be geared around patient needs and work together to provide on-going care outside of hospital to avoid a full admission;
- Staff training is needed across the local healthcare system to ensure appropriate patients are streamed to ambulatory care;
- Comprehensive records must be kept and discharge summaries sent to primary care within 24 hours.

In addition to this, TRFT have already significantly changed their surgical assessment unit which is impacting on the number of assessments and non-elective attendances and RCCG wishes to work collectively with TRFT on this area of work along with how this could work in gynaecology.

Analysis of key issues and of risks

The key objectives of the proposed SDEC model are to:

- Prevent crowding in emergency departments and improve patient outcomes and experience;
- Get patients into the right ward first time, reducing mortality, harm and length of stay;
- Ensure that patients on the urgent and emergency care pathway are seen by a senior clinical decision maker as soon as possible. This will improve outcomes and reduce length of stay, hospitalisation rates and cost;

- Ensure that frail and vulnerable patients, including those with disabilities and mental health problems of all ages, are managed assertively but holistically (to cover medical, psychological, social and functional domains) and that their care is transferred back into the community as soon as they are medically fit, to avoid them losing their ability to self-care.

The key risks are:

- The CCG and TFRT may disagree on the best approach to fully implement SDEC
- Leadership issues within the current area, there are no substantive consultants within the AMU area where the ACC is located and the TRFT have not been able to identify a lead clinician from another area to implement the specification
- The CCG and TRFT may disagree on the size of opportunity to reduce admissions through the implementation of SDEC, which may create difficulties in agreeing and monitoring the contract
- Trust staffing and vacancy levels may hamper delivery
- It is essential that the Trust supports RCCG working into TRFT to support delivery

Patient, Public and Stakeholder Involvement:

Key stakeholders are:

- Patients
- TRFT (both acute and care co-ordination centre)
- GPs
- A&E Delivery Board

Preliminary discussions have already taken place with TRFT and a working group has now been established as this is a national as well as local requirement.

Patent engagement will be an important aspect of implementing the service. Patients should be informed early in their journey (ideally in A&E or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight to manage their expectations and those of their family

Equality Impact:

An equality impact assessment has been completed. This identified a positive impact for the protected characteristic of age.

This is because the scheme will ensure that a greater number of patients receive rapid assessment and treatment and avoid hospital admissions. Hospital admissions for frail and vulnerable patients can lead to them losing independence, adversely impacting upon their ability to self-care. Frail patients are more likely to be elderly and therefore this will be a positive impact for older people.

Financial Implications:

Savings would arise from managing a greater proportion of acute general medical patients on the day that they present, in an ambulatory setting, avoiding a hospital admission.

Activity and financial modelling has been informed by best practice provided by the Ambulatory Emergency Care Network.

Current savings assumption is £866k in 2020/21.

Human Resource Implications:
TRFT will need to consider the operational logistics of fully implementing the SDEC model, including any changes if required to its workforce. There may be an opportunity to secure a GP clinical fellow to work within the trust for up to four sessions per week to establish and work in the SDEC unit. The clinical fellow would work alongside ED and general medical consultant colleagues, GPs, ANPs and other clinicians to develop ambulatory care pathways. Once established, GPs or GP clinical fellows could continue to work within the SDEC unit on a sessional basis alongside their primary care roles. It is proposed that project management resource is also assigned to support this project particularly given the significant opportunity for improving patient flow and efficiency
Procurement Advice:
Implementing Same Day Emergency Care involves changing the way existing services operate at a pathway level. There is no requirement to consider procurement.
Data Protection Impact Assessment:
DPIA screening tool completed. Full DPIA not indicated at this stage.
Approval history:
OE – 13 September 2019 SCE – 18 September 2019 GP Members committee – 30 October 2019
Recommendations:
Governing body are asked to approve that this scheme is supported to proceed.
Paper is for Approval

2020/21 Transformation Scheme Profile

Scheme Number	Scheme Name
	Same Day Emergency Care (General Medicine) (aka Ambulatory Care)

Section 1: Scheme Overview

Brief Description of Scheme	
To fully embed a same day emergency care (SDEC) model (aka ambulatory emergency care) in The Rotherham NHS Foundation Trust (TRFT) in line with expectations in the NHS Long Term Plan.	
Lead GP:	**Lead Officer:**
Dr David Clitherow	Jon Hayes / Becci Chadburn

Please identify what level of documentation this scheme needs for approval		
Standard Report Template	**High Level (brief) Business Case**	**Full Business Case**
Yes		

Section 2: Impact Assessments *(see enclosures)*

Impact Assessments	Yes	No	Has this triggered the need for further assessment?
Has a Quality Impact Assessment been carried out?	**Yes**		**No**
Has an Equality and Engagement Impact Assessment been carried out?	**Yes**		Comms plan required.
Has a Data Protection Impact Assessment been carried out?	**Yes**		**No**

Section 3: High Level Value

What is the value of your Transformation Scheme		
£866k		
Have you provided further financial information for your scheme *(completion of enclosure 1)*	**Yes**	**No**
	Y	

Section 4: Approval

Recommendation	
Reviewed by (OE Exec)	13 September 2019
Date approved at OE	13 September 2019
Date approved at SCE	18 September 2019
Date approved at CCG Governing Body	
Proposed frequency of review	

Enclosures	
Enclosure 1	*Financial Information*
Enclosure 2	*Quality Impact Assessment*
Enclosure 3	*Equality and Engagement Impact Assessment*
Enclosure 4	*Data Protection Impact Assessment*

Appendices	
Appendix 1	*Risk Scoring*
Appendix 2	*Engagement Assessment*

Financial Information

Brief Description of where savings arise from

Savings arise from managing a greater proportion of acute general medical patients on the day that they present, in an ambulatory setting, avoiding a hospital admission.

Activity and financial modelling has been informed by best practice provided by the Ambulatory Emergency Care Network.

Current savings assumption is £866k in 2020/21.

Profile of savings *(enter by month when the savings will be realised)*

	£		£
Apr- 20	72,160	Oct-20	72,160
May-20	72,160	Nov-20	72,160
Jun-20	72,160	Dec-20	72,160
Jul-20	72,160	Jan-21	72,160
Aug-20	72,160	Feb-21	72,160
Sep-20	72,160	Mar-21	72,160
		Total	**866,000**

Please provide further appropriate financial information for your scheme:

AEC_1920_Analysis %20FINAL.xlsx

Quality Impact Assessment Screening Tool

Area of Quality Could the proposal impact *positive* ***(P)***, *negative* ***(N)***, *or neutral* ***(N/A)*** on any of the following:		P/N or N/A	Risk score (if N) *See app 1*	**Comments:** include reason for identifying impact as positive, negative or neutral
1	**Duty of Quality** *Consider: Compliance with NHS Constitution, Impact on partner organisations, Impact on organisations duty to safeguard children and vulnerable adults, Impact on other services within the organisation*	P		Will help to prevent crowding in the emergency department, and support the achievement of NHS constitutional standards for A&E (i.e. 4 hour wait)
2	**Clinical effectiveness** *Consider: Impact on provision of NICE compliant treatment, Impact on the implementation of evidence based practice, Impact on clinical outcomes, Impact on clinical leadership, Impact on the promotion of self-care, Impact on clinical engagement, mortality rates, readmission rates, safeguarding, partnership working*	P		Will ensure that a greater number of patients receive rapid assessment and treatment and avoid hospital admissions. Hospital admissions for frail and vulnerable patients can lead to them losing independence, adversely impacting upon their ability to self-care.
3	**Patient Safety** *Consider: Impact on patient safety, Impact on avoidable harm, Impact on reliability of safety systems and processes, Impact on clinical workforce levels, competencies and experience, Impact on treatment times and procedures, Impact on safeguarding, Impact on systems and processes for ensuring that the risk of HCAIs is reduced, Impact upon clean and safe environments*	P		Will get patients into the right ward first time, reducing mortality, harm and length of stay. Will ensure that patients on the urgent and emergency care pathway are seen by a senior clinical decision maker as soon as possible. This will improve outcomes and reduce length of stay, hospitalisation rates and cost.
4	**Patient Experience** *Consider: Impact on patient informed choice and autonomy, Impact on patient access, Impact on dignity, respect and compassion, Impact on patients self-reported satisfaction on national/local surveys/ FFT, Impact on patients self-reported experience through the complaints process/PALS contacts, Impact on patient waiting times, Impact on the provision of individualised care, length of stay, privacy and dignity, discharge planning, collaborative working*	P		More patients will receive same day emergency care and be able to return to their normal place of residence without the need for a hospital admission. Patients who are not suitable for same day emergency care will also benefit from improved flow through the emergency department.
For any scoring 12 and above, please consider whether this should be included in the CCGs risk register				

Assessment Completed by:	Jon Hayes
Date of Assessment:	13/08/19

Equality Impact and Engagement Assessment Form

Please retain one copy, and pass one copy to both the Equalities and Engagement leads

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Section 1: Equality Impact Assessment

1.1 **Gathering of Information:** *This is the core of the analysis; how might the project or work impact on protected groups, with consideration of the General Equality Duty.*
Please add any general information here.

1.2 **Screening**

Please complete each area	**What key impact have you identified?**			**Information Source**
	Positive Impact *will actively promote or improve equality of opportunity*	**Neutral Impact** *where there are no notable consequences for any group.*	**Negative Impact** *negative or adverse impact causes disadvantage or exclusion* *If such an impact is identified, the EIA should ensure, that as far as possible, it is either justified, eliminated, minimised or counter balanced by other measures*	**What action,** *if any, is needed to address these issues and what difference will this make?* *For example: at this point no action is required. Further EIA screenings will be developed in future once there are recommendations to assess*
Human Rights		Y		
Age	Y			Will ensure that a greater number of patients receive rapid assessment and treatment and avoid hospital admissions. Hospital admissions for frail and vulnerable patients can lead to them losing independence, adversely impacting upon their ability to self-care. Frail patients are more likely to be elderly and therefore this will be a positive impact for older people.
Carers		Y		
Disability		Y		
Sex		Y		
Race		Y		
Religion or belief		Y		
Sexual Orientation		Y		
Gender reassignment		Y		
Pregnancy and maternity		Y		
Marriage/civil partnership (only eliminating discrimination)		Y		
Other relevant groups		Y		

Section 2: Engagement Impact Assessment

2.1 What is the level of service change?

Refer to appendix 2 to assess the size of the change and tick the appropriate box

Level 1	Y	Level 2		Level 3		Level 4	

Add additional information and rationale for this scoring below

Implementing Same Day Emergency Care involves changing the way existing services operate at a pathway level.

2.2 Who are your stakeholders?

Consider using a mapping tool to identify stakeholders (resources can be found in the Project Management Checklist) - who is the change going to affect and how?
Complete below or attach or link to a mapping document

Key stakeholders are:

- Patients
- TRFT (both acute and care co-ordination centre)
- GPs
- A&E Delivery Board

Preliminary discussions have already taken place with TRFT.

Patent engagement will be an important aspect of implementing the service. Patients should be informed early in their journey (ideally in A&E or by the GP) that they are likely to receive treatment that day and are unlikely to be admitted overnight to manage their expectations and those of their family

2.3 What do we already know?

What do you already know about peoples' access, experience, health inequalities and health outcomes? Use intelligence from existing local, regional or national research, data, deliberative events or engagements.

Include any existing arrangements to involve patients and the public which are relevant to this plan/activity and/or provide relevant sources of patient and public insight?

Describe how the existing or proposed engagement will be 'fair and proportionate', in relation to the activity?

Building on the EIA, how will you reach out to any community identified as having an impact by the scheme, are additional arrangements required?

Need to check what insights are already available

2.4 Next Steps

As a result of this screening has further actions been identified	Yes	No
	Yes	

	Further discussions with Engagement Lead	Completion of Full Engagement Plan	Other
If yes, please describe actions	Patient and GP comms will be required to ensure that patients are informed early in their journey that they are likely to receive treatment on the same day and are unlikely to be admitted, to manage their expectations.		

Assessment Completed by:	Jon Hayes
Date of Assessment:	13/08/19

Enclosure 4

Data Protection Impact Assessment

The below screening questions should be used inform whether a DPIA is necessary. This is not an exhaustive list therefore in the event of uncertainty, completion of a DPIA is recommended.

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Answering yes to any of these questions is an indication that a DPIA is required:

	Screening Questions	Yes	No
1	Will the project involve the collection of new identifiable or potentially identifiable data about individuals?		N
2	Will the project compel individuals to provide data about themselves? i.e. where they will have little awareness or choice.		N
3	Will identifiable data about individuals be shared with other organisations or people who have not previously had routine access to the data?		N
4	Are you using data about individuals for a purpose it is not currently used for or in a new way? i.e. using data collected to provide care for an evaluation of service development.		N
5	Where data about individuals is being used, would this be likely to raise privacy concerns or expectations? i.e. will it include health records, criminal records or other information that people may consider to be sensitive and private and may cause them concern or distress.		N
6	Will the project require you to contact individuals in ways which they may find intrusive? i.e. telephoning or emailing them without their prior consent.		N
7	Will the project result in you making decisions in ways which can have a significant impact on individuals? i.e. will it affect the care a person receives?		N
8	Does the project involve you using new technology which might be perceived as being privacy intrusive? i.e. using biometrics, facial recognition or automated decision making.		N
9	Is a service being transferred to a new supplier (or recontracted) and the end of an existing contract		N
10	Is processing of identifiable/potentially identifiable data being moved to a new organisation (but with same staff and processes)		N

Assessment Completed by:	Jon Hayes
Date of Assessment:	13/08/19

For further information or if a DPIA is required please contact Jonathan Mayes@ mayes.jonathan@nhs.net

Please retain a copy of this questionnaire within your project/system documentation.
Please note that once completed the following sections (1 to 4) should be extracted from the rest of this document prior to being included within the Publication Scheme.