



THE 12th INTERNATIONAL SCIENTIFIC CONFERENCE
THE SOCIETY FOR ACUTE MEDICINE

**Bournemouth International Centre
20 – 21 September 2018**

**SAMBA18 data – where do the new NICE
guidelines fit in?**

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Conflict of Interest

- Member of the NICE 094 Guideline Committee
- Advisory group to Dr Foster Ethics Committee – Uses and Abuses of Performance Data in Healthcare Report

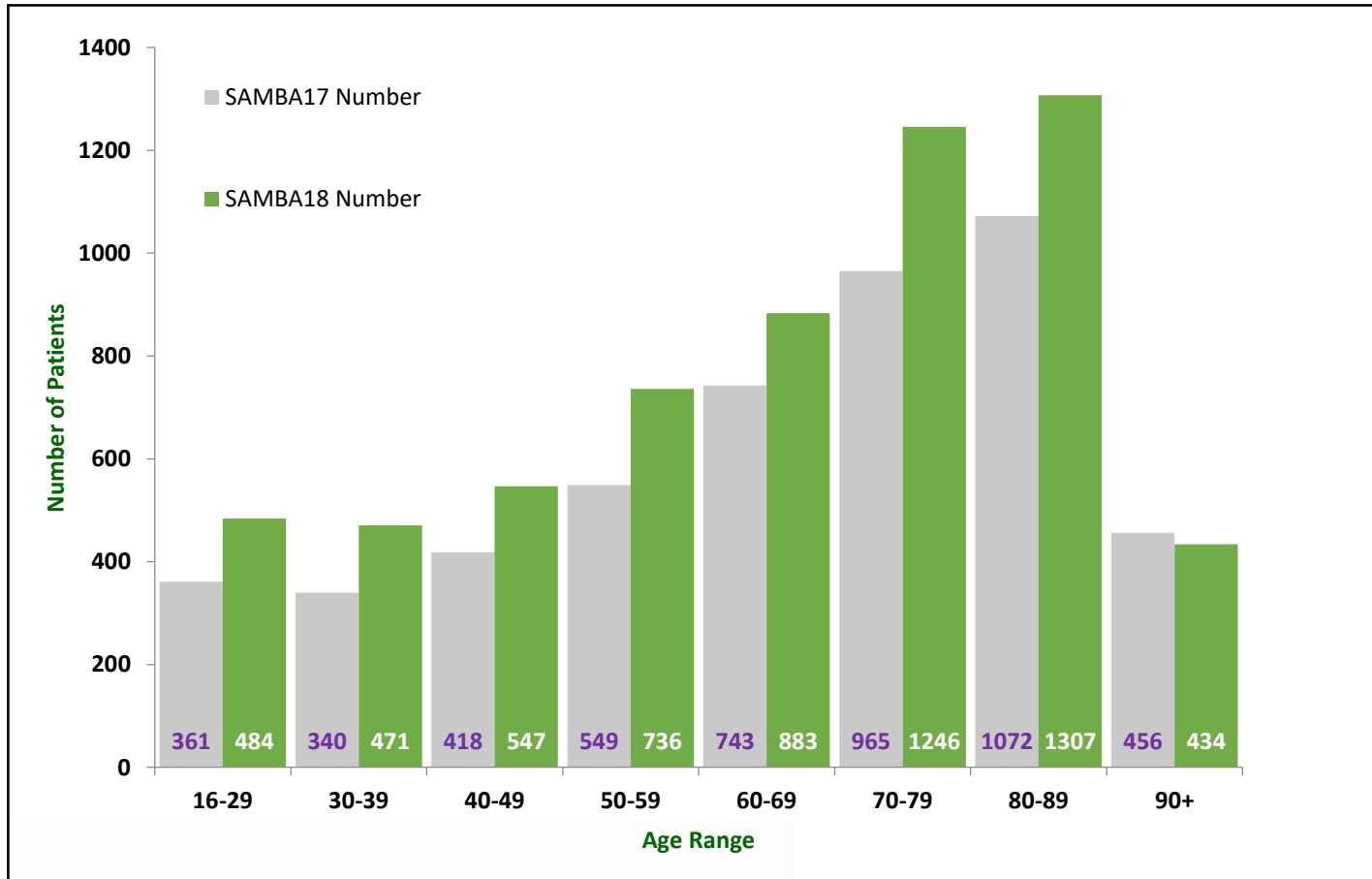
Society for Acute Medicine Benchmarking Audit

- Annual data collection - 24 hours in June
- Site level - organisation and delivery of acute medical care
 - Numbers of staff/beds/critical care beds
 - Elderly care 'take', frailty units, surgical units
 - Access to point of care (POC) diagnostics
- Patient level
 - clinical quality indicators
 - national recommendations
 - demographic data needed to interpret performance

Society for Acute Medicine Benchmarking Audit

- All patients assessed by acute medical teams
 - Emergency Department (ED)
 - AMU
 - Ambulatory emergency care (AEC)
- Patients
- Process
- Pathway and outcomes

SAMBA 18 – The Patients



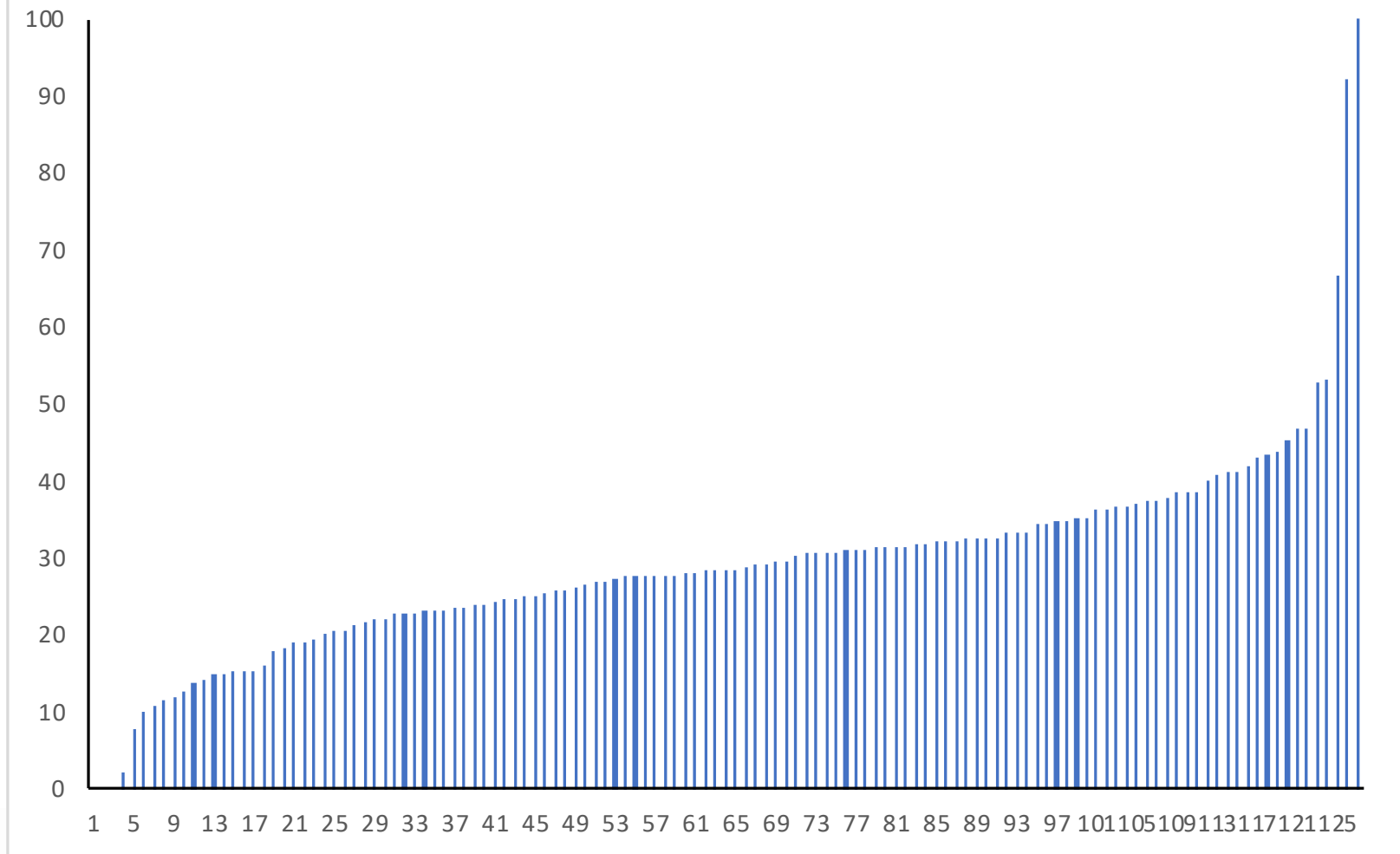
6114 patients

127 registered units

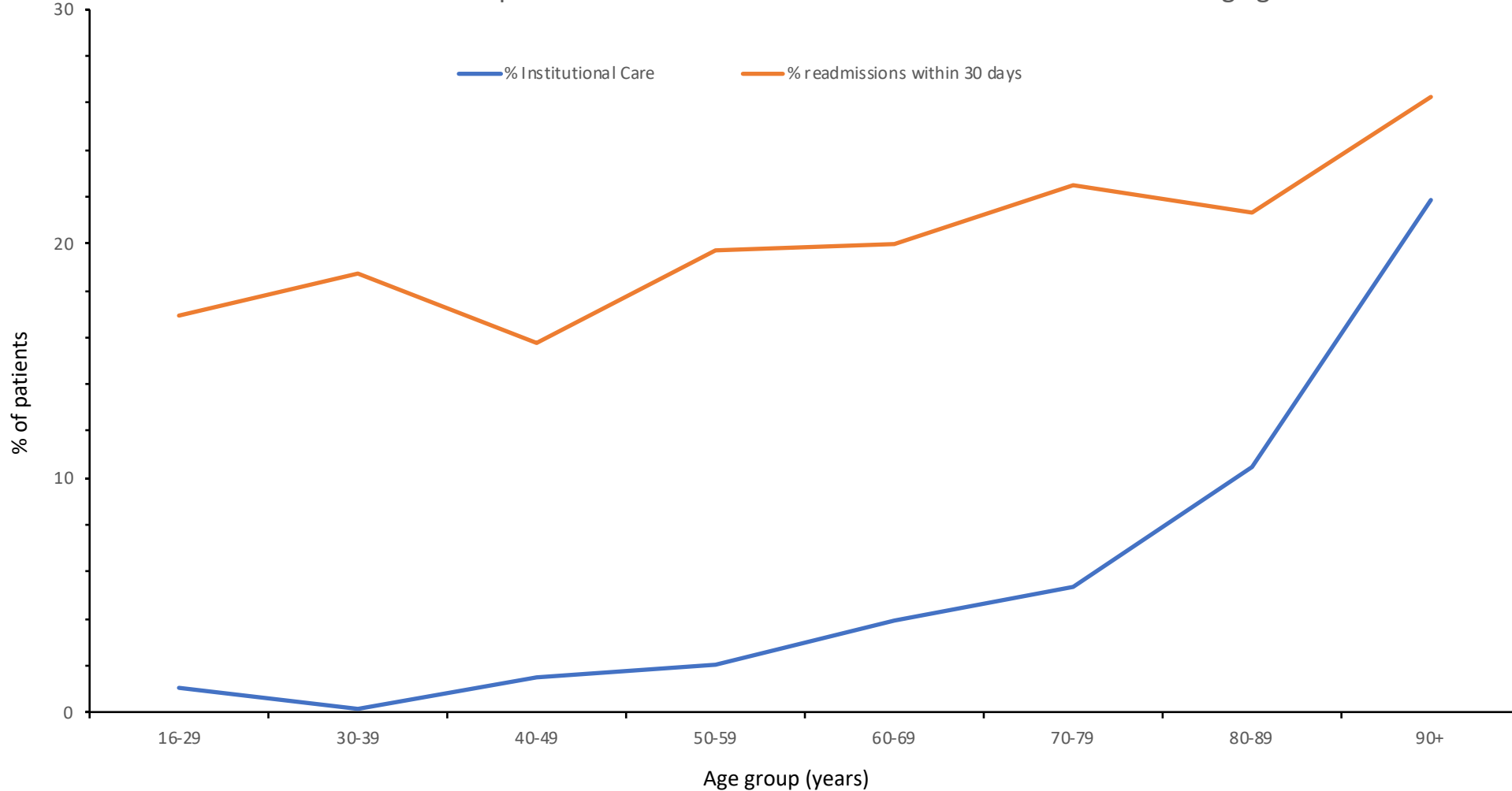
123 hospitals

104 acute trusts

Variation in % of patients >80 years old

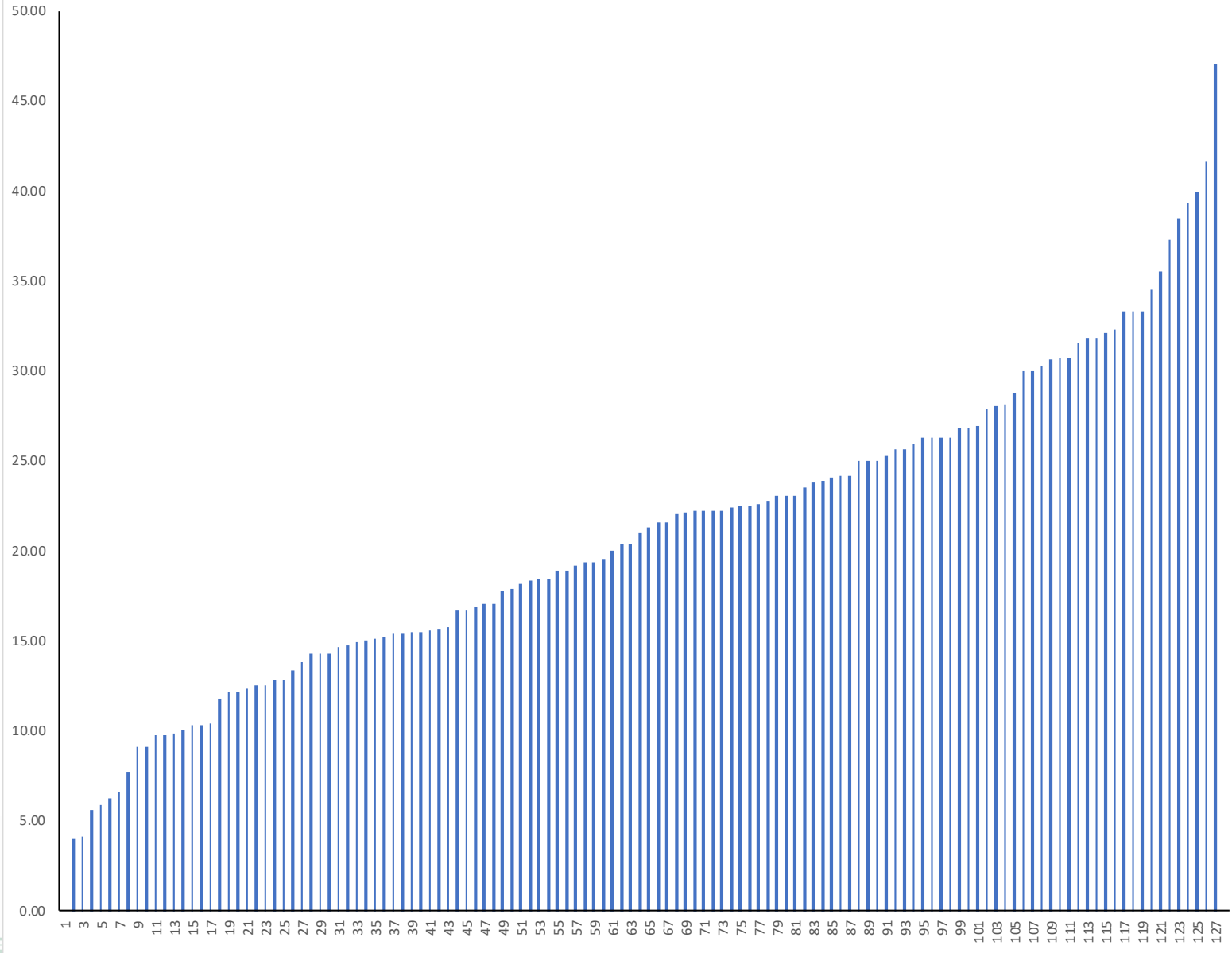


Increase in % of patients from care homes and % readmissions with increasing age



- **6.0% of patients from care homes**
- **20.4% of patients were in hospital in the previous 30 days**
- **SAMBA 17 – 12%**
SAMBA 16 – 13%

Unit variation in % of patients who are being readmitted within 30 days



Advanced Care Plans

NG 94 Chapter 15: Offer advance care planning to people in the community and in hospital who are approaching the end of life and are at risk of a medical emergency

NHS England “ACP is essential in supporting delivery of the Government’s six point commitment to end of life care to reduce variation and ensure end of life care is of high quality and personalised by 2020 ”

What proportion of patients have an advanced care plan available to the admitting team ?

AGE	Total % with ACP	Readmission < 30 days % with an ACP	% where admitting team thought ACP should be in place
16-29	0.83	2.47	0.84
30-39	1.28	0.00	0.86
40-49	1.48	2.38	1.69
50-59	2.88	3.57	5.08
60-69	2.96	5.14	11.49
70-79	4.86	7.97	20.51
80-89	8.55	10.91	36.03
90+	12.56	15.32	59.84

Care Quality Indicator 1 – Early Warning Score within 30 minutes of arrival

Variation in scores

NEWS	75.3% of hospitals
MEWS	10.8%
Hospital own	8.3%
NEWS2	2.5%
VEWS	1.7%
SEWS	0.8%

Care Quality Indicator 1 – Early Warning Score within 30 minutes of arrival

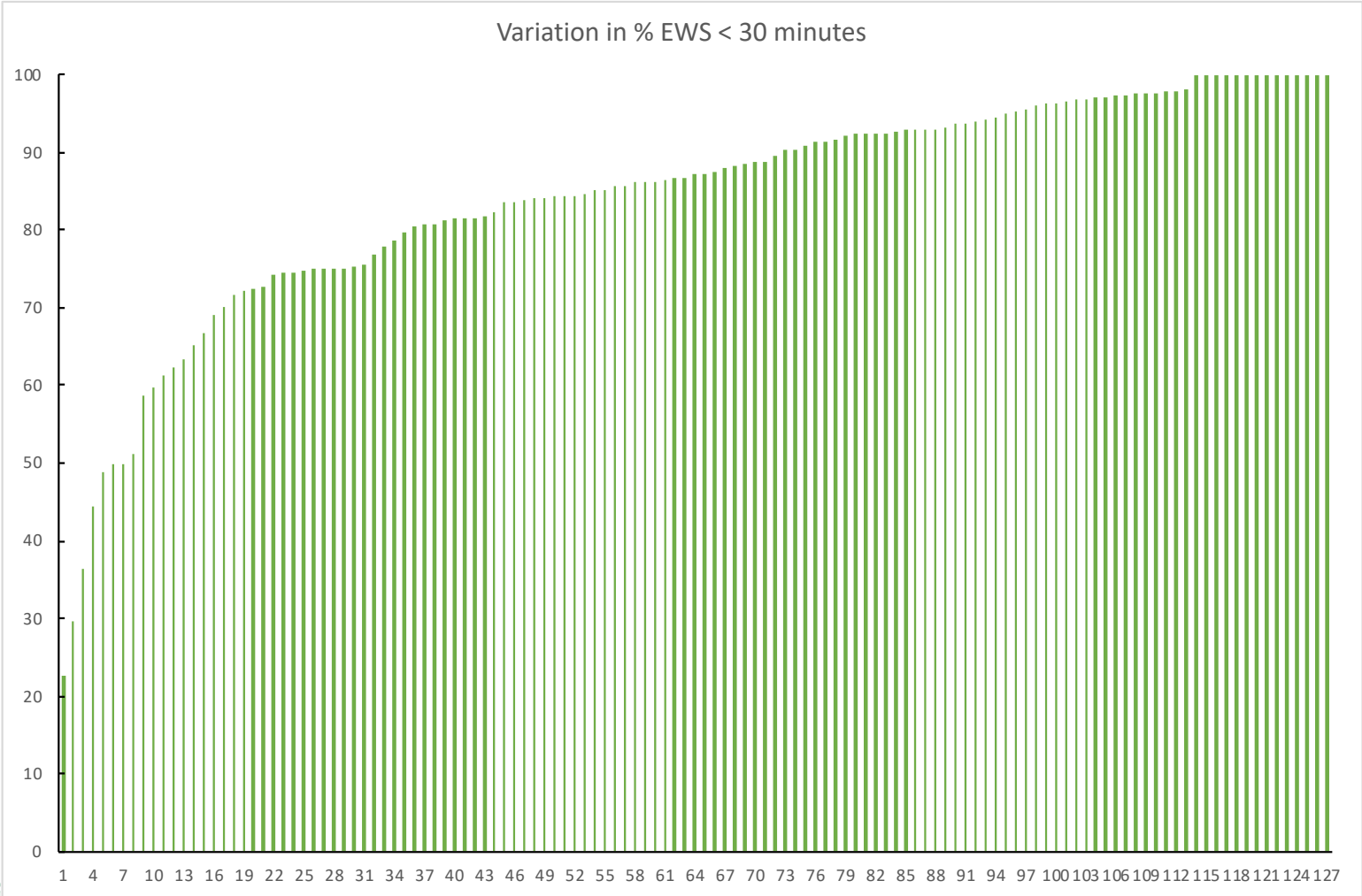
84.1% of patients had EWS < 30 minutes of arrival

AEC 82.2%

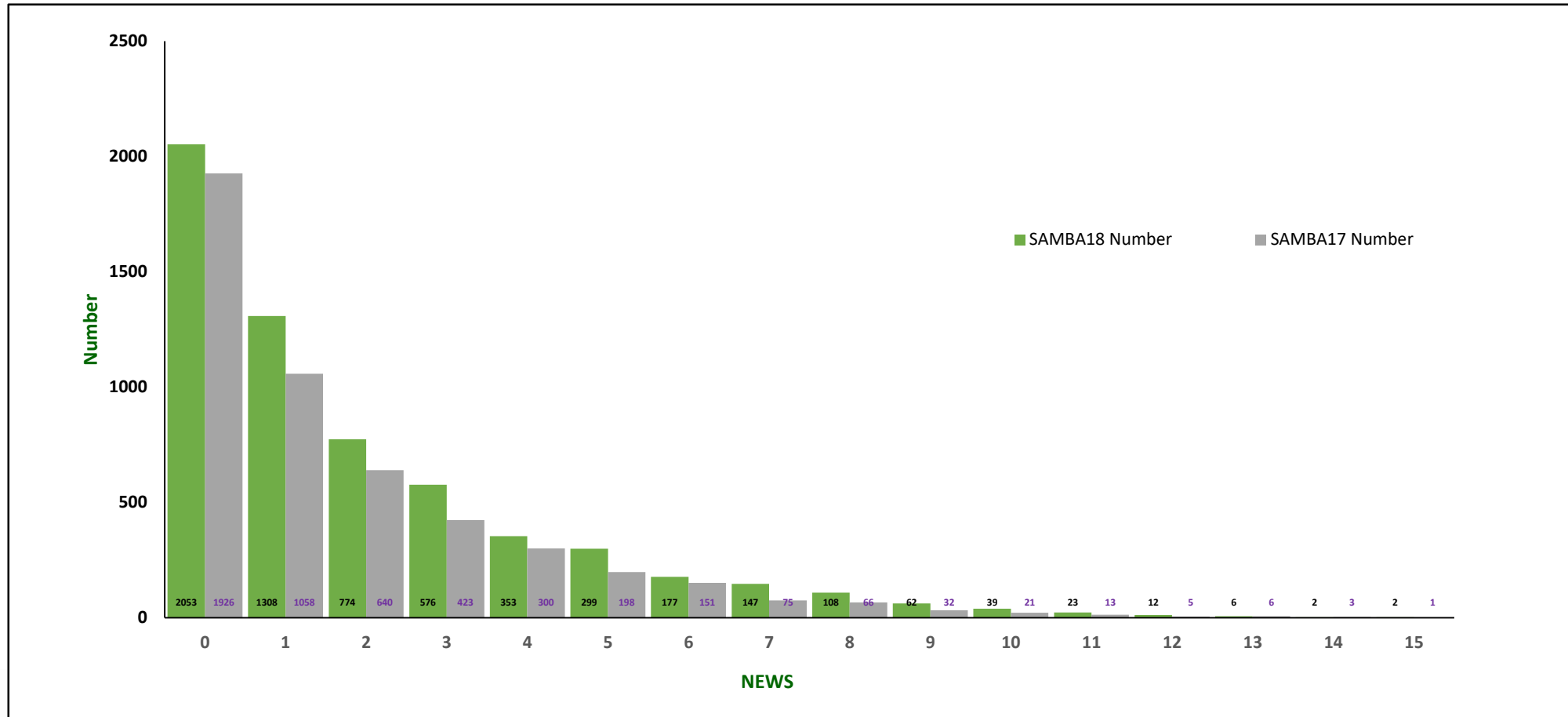
ED 85.4%

AMU 84.9%

Care Quality Indicator 1 – Early Warning Score within 30 minutes of arrival



Distribution of NEWS on arrival



Care Quality Indicator 2 – Review by a competent clinical decision maker < 4 hours

- Tier 1 competent decision makers – capable of making an initial assessment of a patient with acute illness
- Includes
 - FY1 and above
 - Advanced Care Practitioners
 - Physician Associates

Care Quality Indicator 2 – Review by a competent clinical decision maker < 4 hours

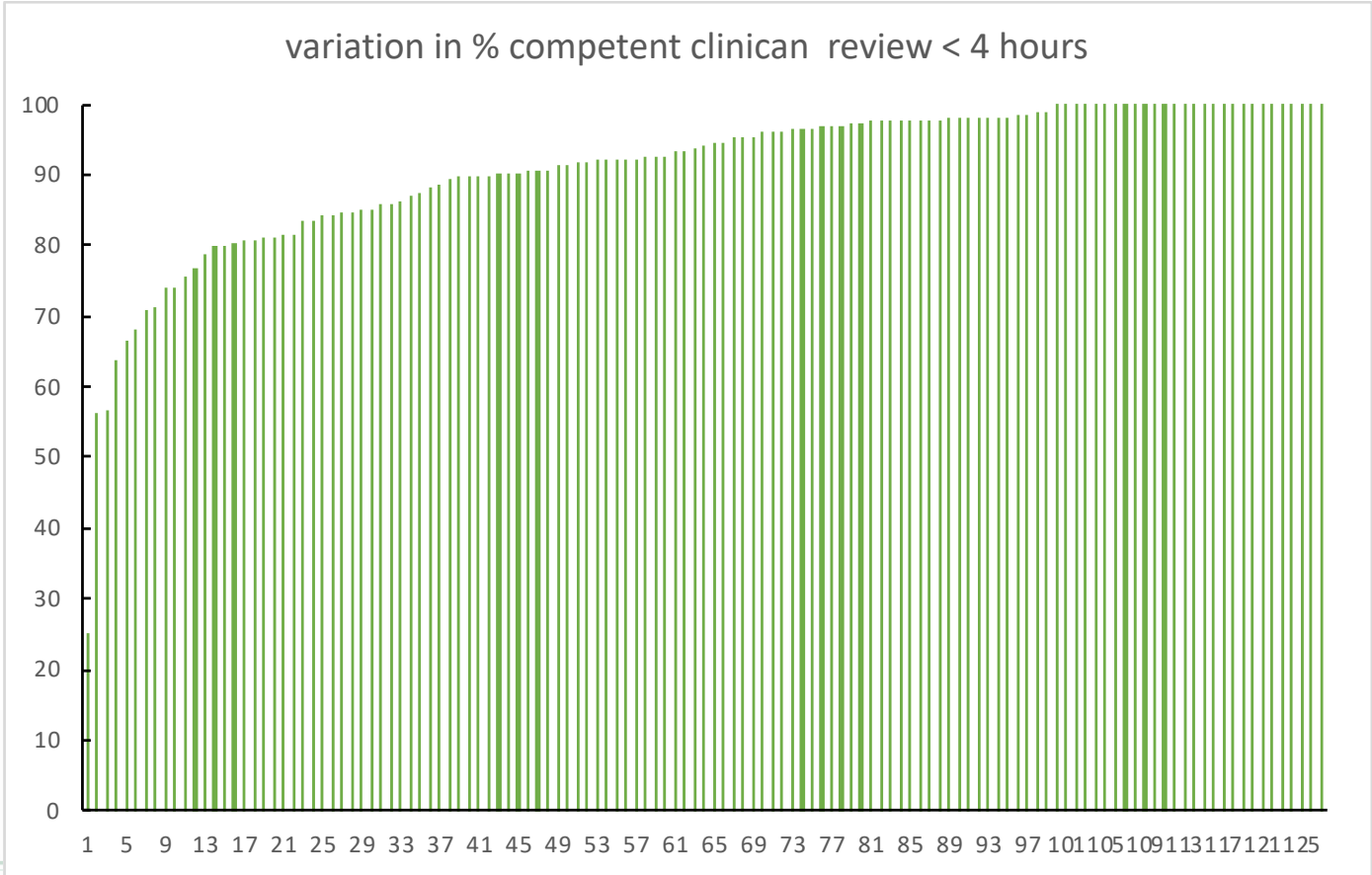
91.6% of patients reviewed < 4 hours

AEC 95.0%

AMU 88.9%

ED 91.4%

Care Quality Indicator 2 – Review by a competent clinical decision maker < 4 hours



Time to consultant review - NICE Guideline Committee discussion

- Department of Health asked NICE to examine consultant review within 12 hours
- No evidence for any time standard
- 'Pragmatic recommendations' from Societies were 'reasonable'. 12 hours for ICU (extrapolated to CCU/HASU)
- "the natural progression of the NHS in England is to deliver earlier and consistent consultant input into the patient journey"

Range of time targets

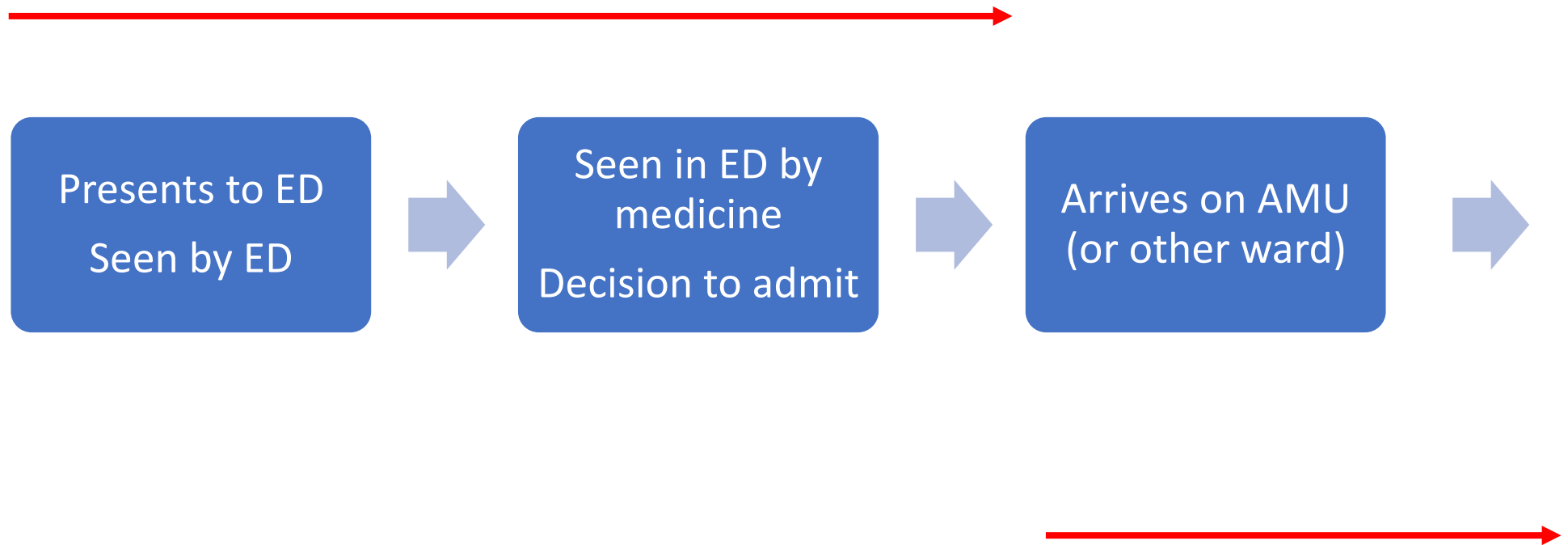
- SAM
 - 8 hours from admission if 08:00 – 20:00
 - 14 hours if admitted 20:00 – 08:00
- NICE Quality Standards
 - 6 hours from admission if 08:00 – 20:00
- NHS England (ECIST)
 - 3 hours daytime
 - 12 hours overnight
- NHS England (7 day clinical services standards)
 - 6 hours daytime
 - If predicted mortality 10% - consultant 'involvement' in 1 hour

NHS England

- This time standard should be determined locally, as part of the process of agreeing 'internal professional standards' (see section 4). ECIST recommends the earliest possible consultant review of all admissions - we suggest within 2-3 hours of admission between 8am and 8pm, and a maximum of 12 hours if the admission is 'out-of-hours', and much sooner if the patient is not responding

- <https://www.england.nhs.uk/wp-content/uploads/2013/08/prior-acute-hosp.pdf> to treatment as expected

When should the clock start?



Consultant review times from hospital arrival

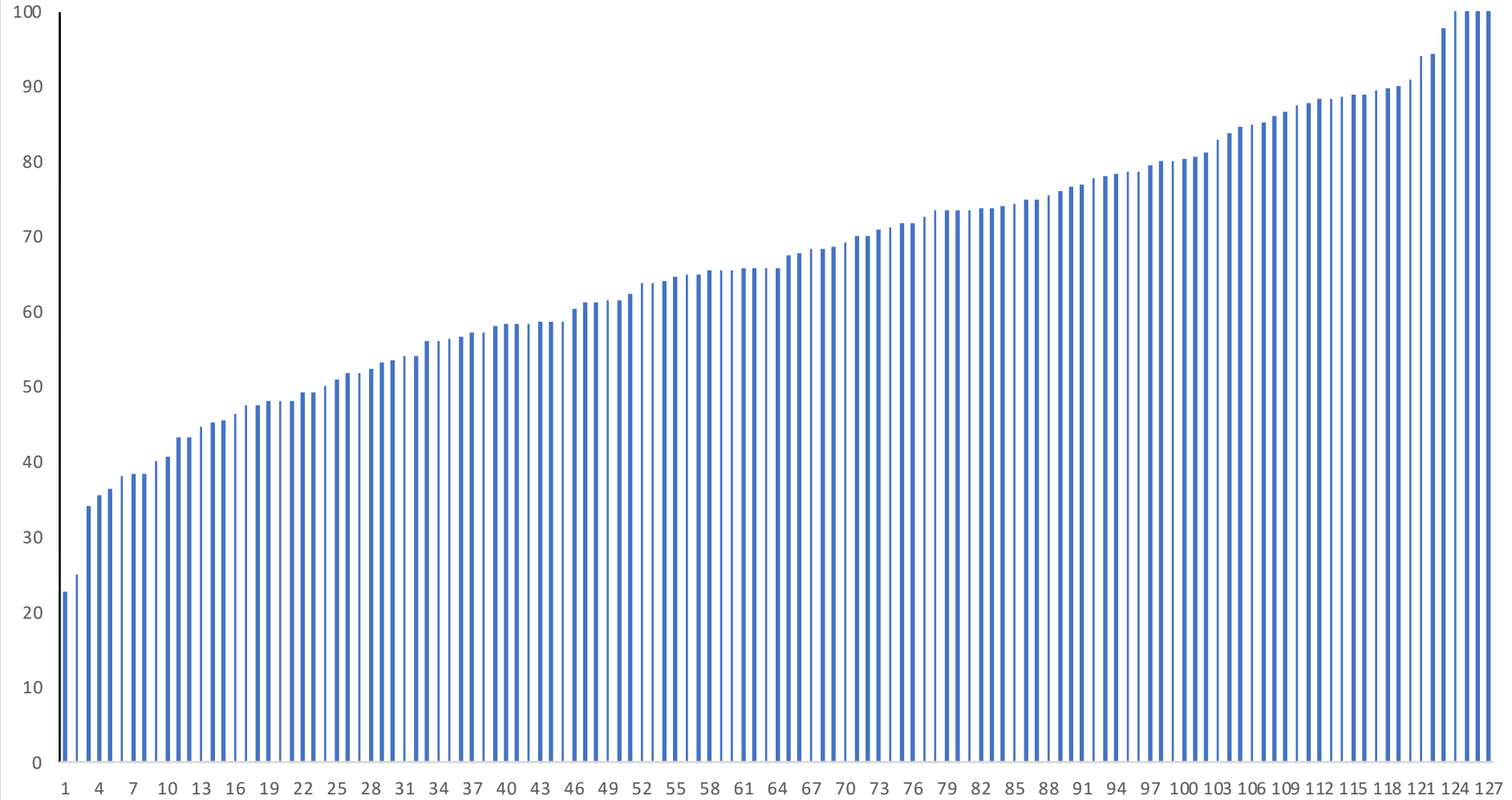
- Many patients spend a significant amount of their initial acute care journey in ED /waiting for a bed
- Capturing robust times for embedded process difficult to capture and validate (time referred to medicine, time seen by medicine, decision to admit) - time of arrival in hospital usually very well captured
- Makes sense from the perspective of the patient

Overall results for time to review

- 62.8 % of patients requiring consultant review were seen within 12 hours of arrival in hospital

- AEC 73.8%
- AMU 65.3%
- ED 59.0%

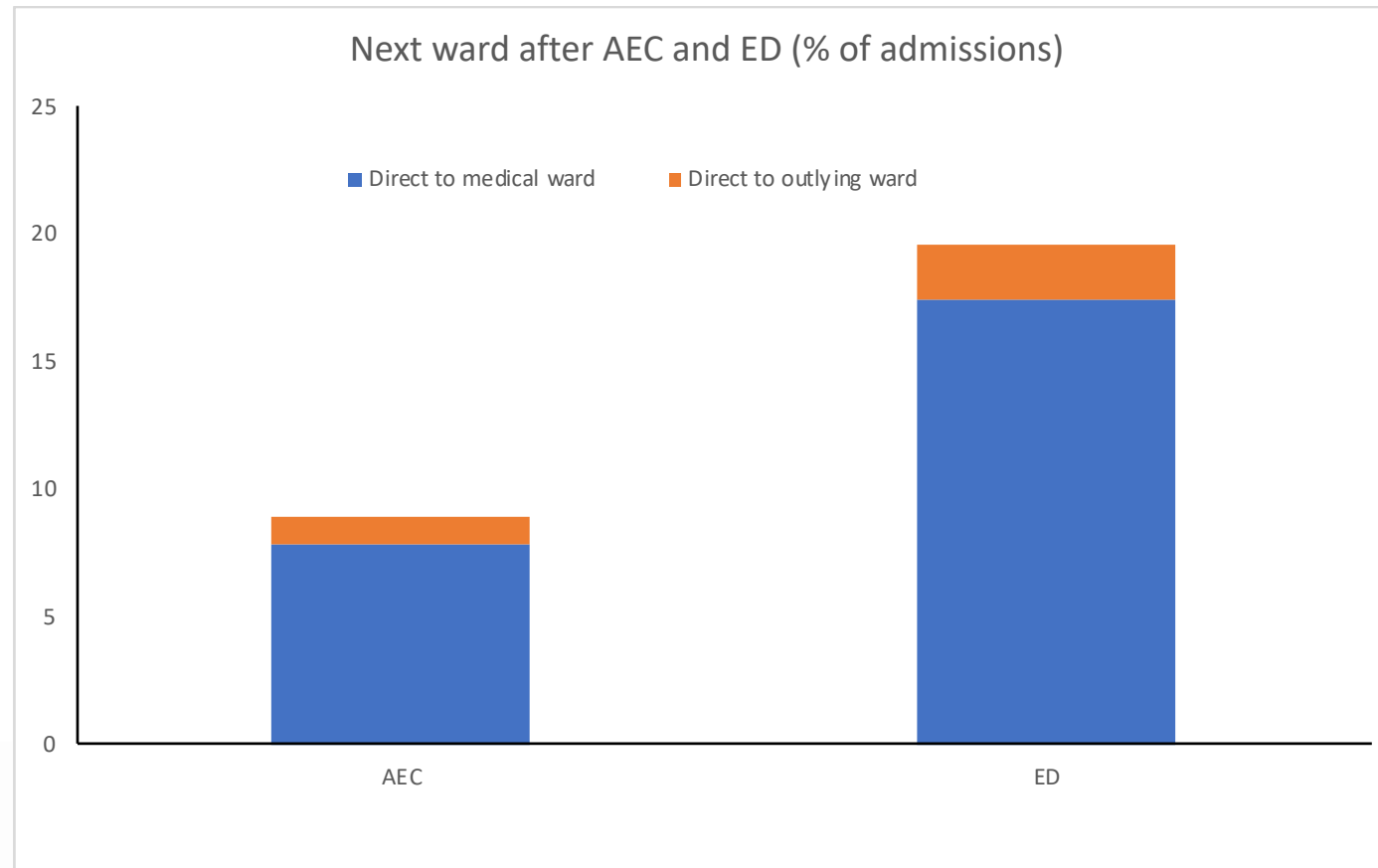
Variation in % of patients reviewed by consultant < 12 hours



Admission through AMU

- **NG 94 Recommendation**
- 1.2.2 Assess and treat people needing hospital admission with undifferentiated medical emergencies in an acute medical unit.

Bypassing the AMU – medical and outlying wards



Ambulatory Emergency Care (AEC)

NHS Improvement

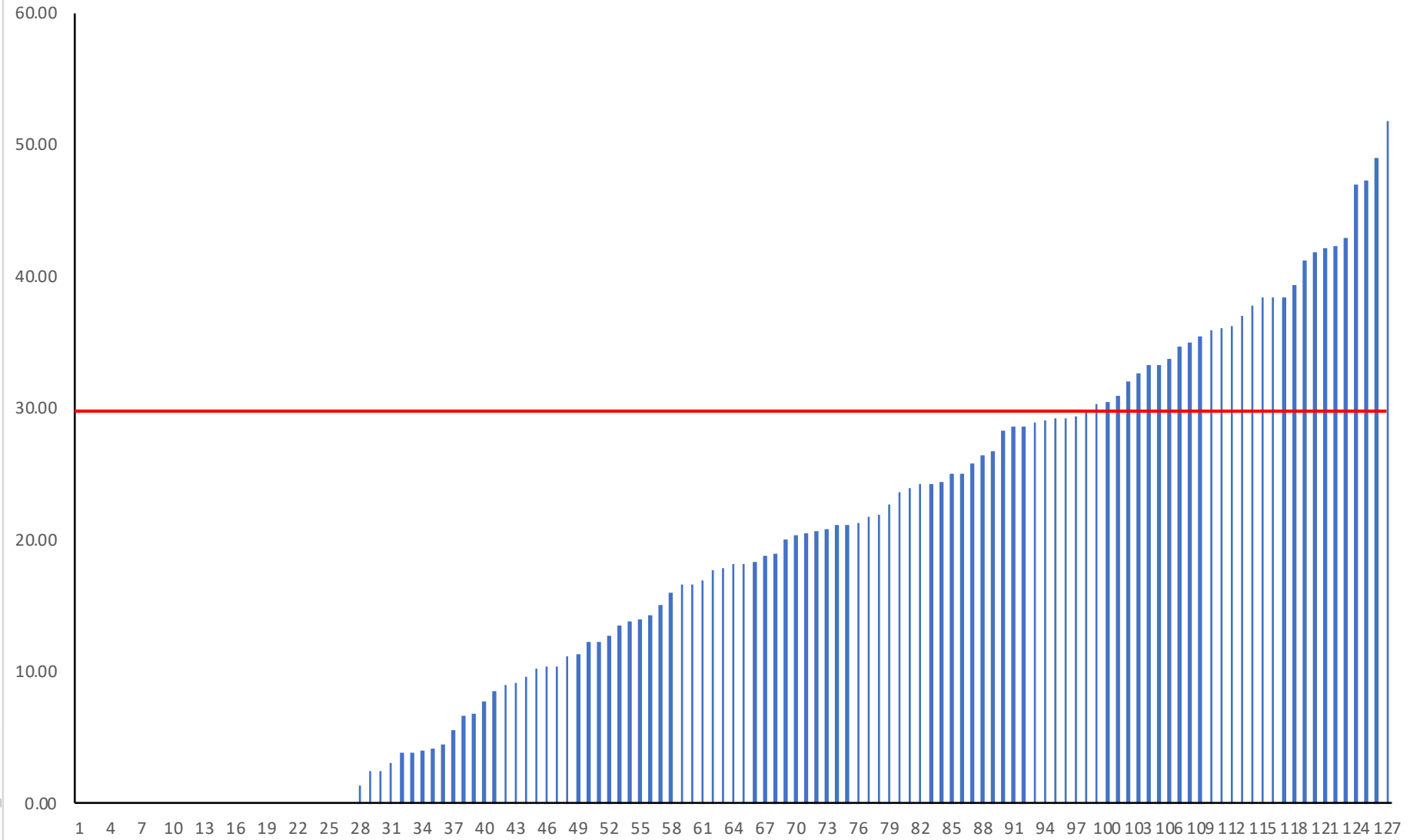
“We expect that hospitals introducing AEC could convert 30% of acute medical admissions to ambulatory care episodes”

https://improvement.nhs.uk/documents/2715/AEC_publications_index_intro.pdf

AEC

- 20.1% of patients had their first medical assessment in AEC
- 22% of units met the NHS Improvement expectation of 30% of first assessments being undertaken in AEC
- Of patients seen in AEC, 79.5% were sent home the same day

Variation in % of initial medical assessments undertaken in AEC



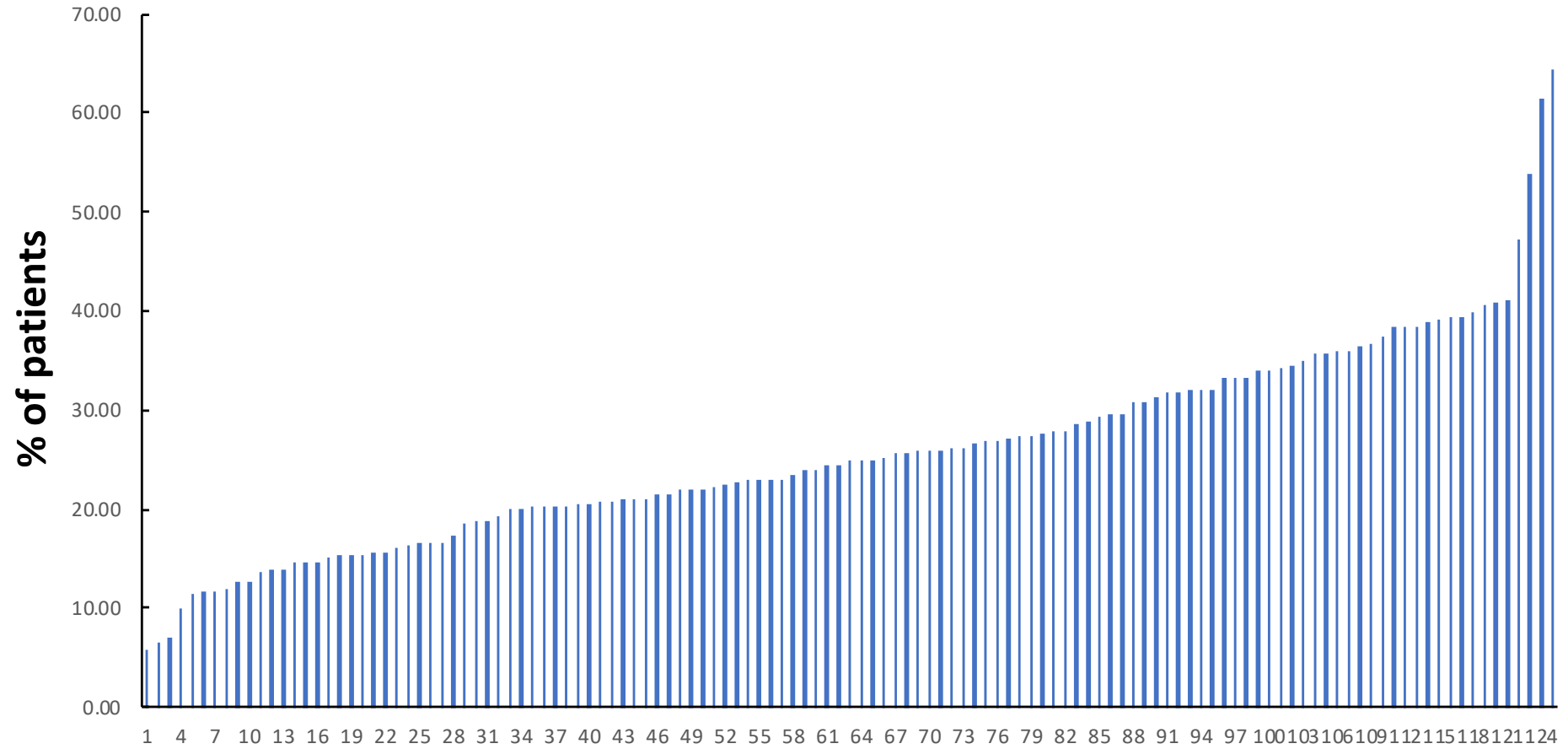
CQI 4

- All AMUs should collect the following data:
- Hospital mortality rates for all patients admitted via AMU

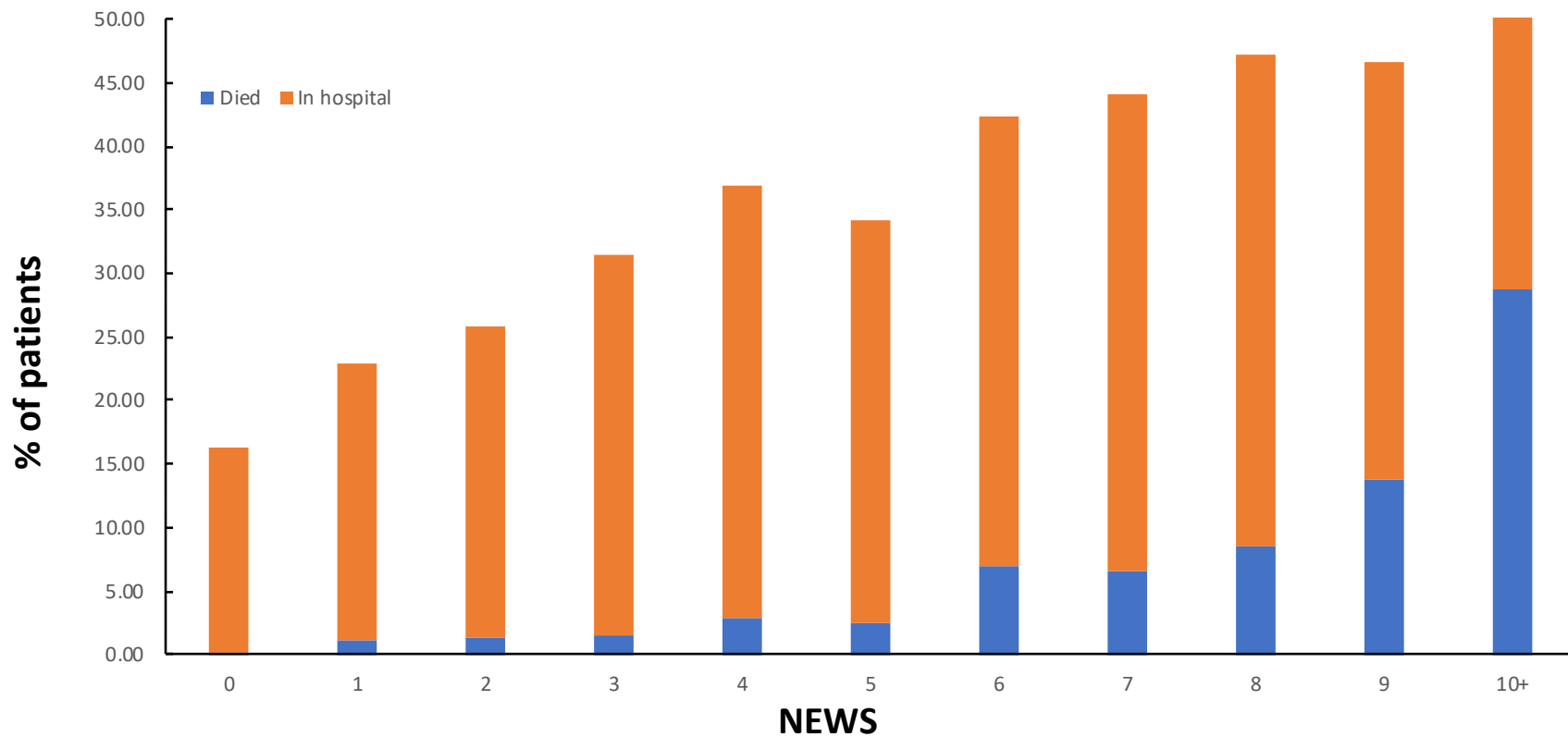
7 day outcomes in SAMBA

Outcome	% of all SAMBA patients
Died in hospital	2.01
In patient	23.18
Medically discharged	72.20
Self-discharged	1.31
Transferred	1.30

Variation in % of patients in hospital at 7 days

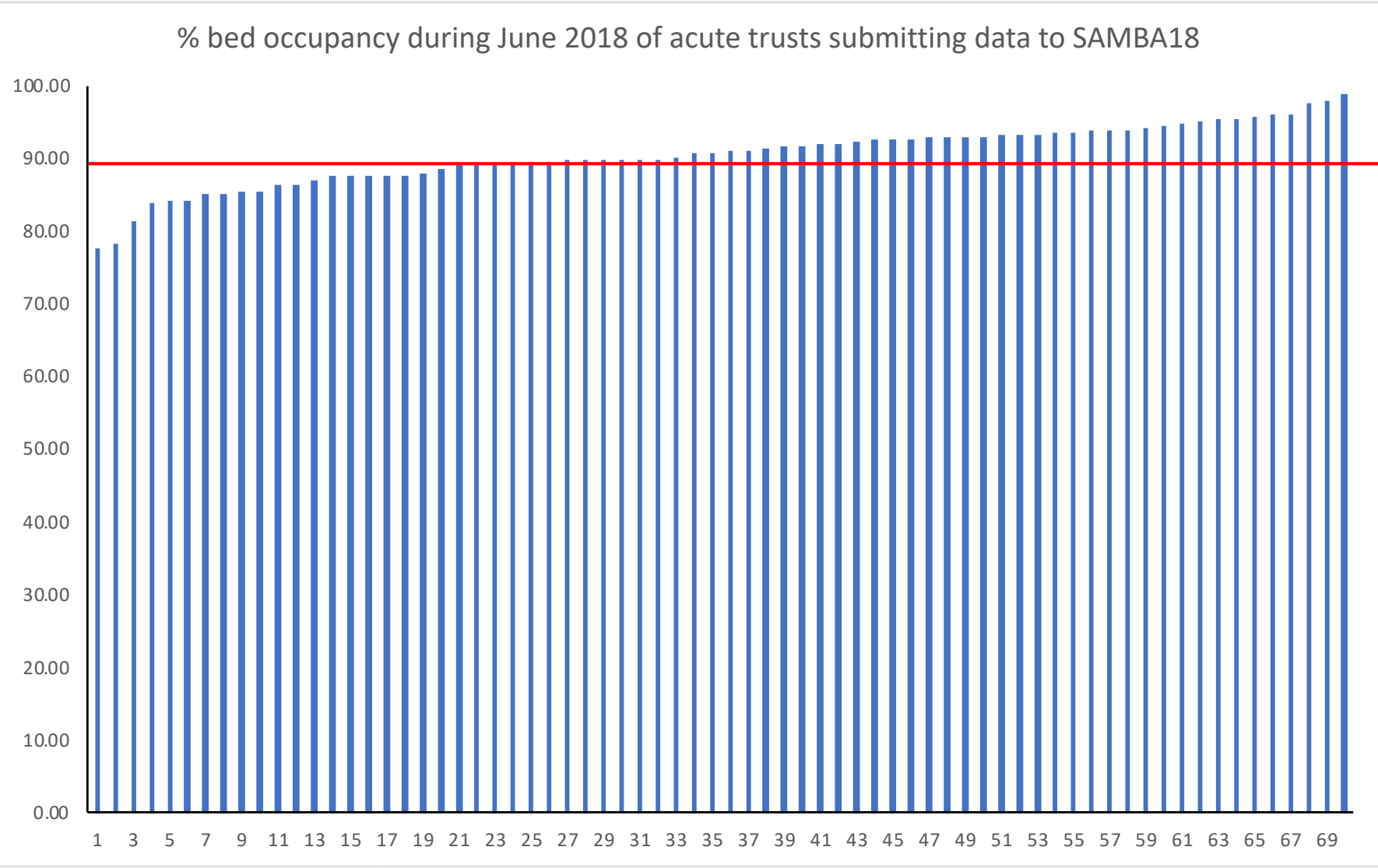


Mortality and in patient status at 7 days by NEWS (% of patients)



NG 94

- 1.3.1 Healthcare providers should:
 - monitor total acute hospital bed occupancy, capacity, ow and outcomes in real time, taking account of changes in a 24-hour period and the occupancy levels and needs of specific wards and units
 - plan capacity to minimise the risks associated with occupancy rates exceeding 90%.



SAMBA 18

- Almost doubling of % of patients who are admitted within 30 days of a prior admission
- Very few patients have Advanced Care Plans available to admitting teams, even if they have recently been in hospital and are >90 years old.
- Very high rates of EWS time targets and initial tier 1 review time targets
- Increase in AEC activity, and the right cohort is being selected for AEC (91.6% at home at 7 days, 4.7% in hospital, 0.2% died)

SAMBA 18

- Largest SAMBA to date
- Day of care survey – cautious about interpreting how a single unit functions
- Substantial variation across UK hospitals in process and outcomes – more work is needed to find out why, and how this affects patient outcomes
- Assessment over longer periods of time and during intense and sustained pressure over winter are needed



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