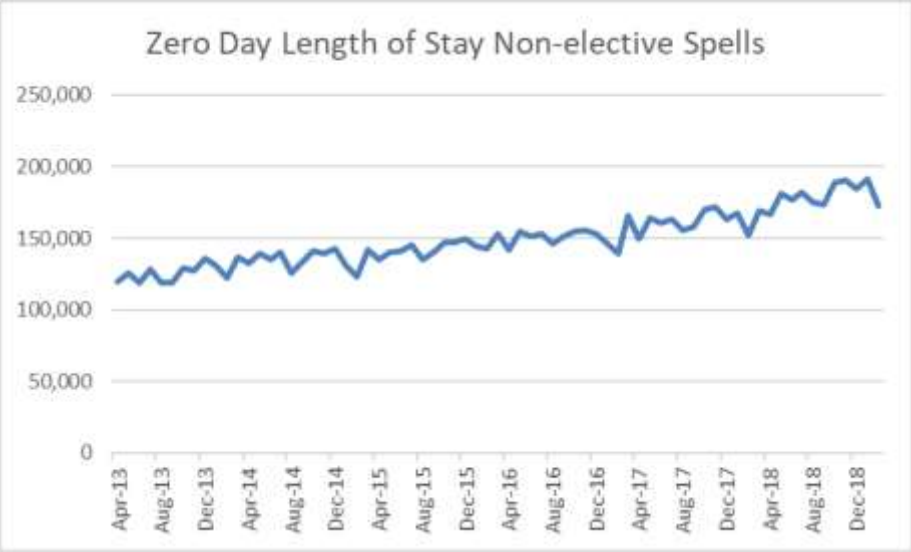
SDEC Workshop

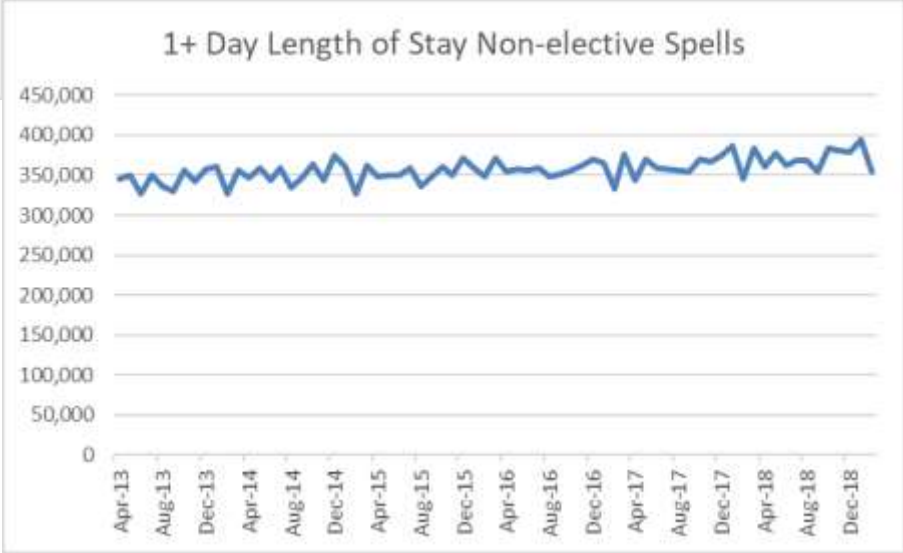
Wednesday 17th April 2019

Mark England – Deputy National Director of Emergency and Elective Care NHSI/E

NHS England and NHS Improvement

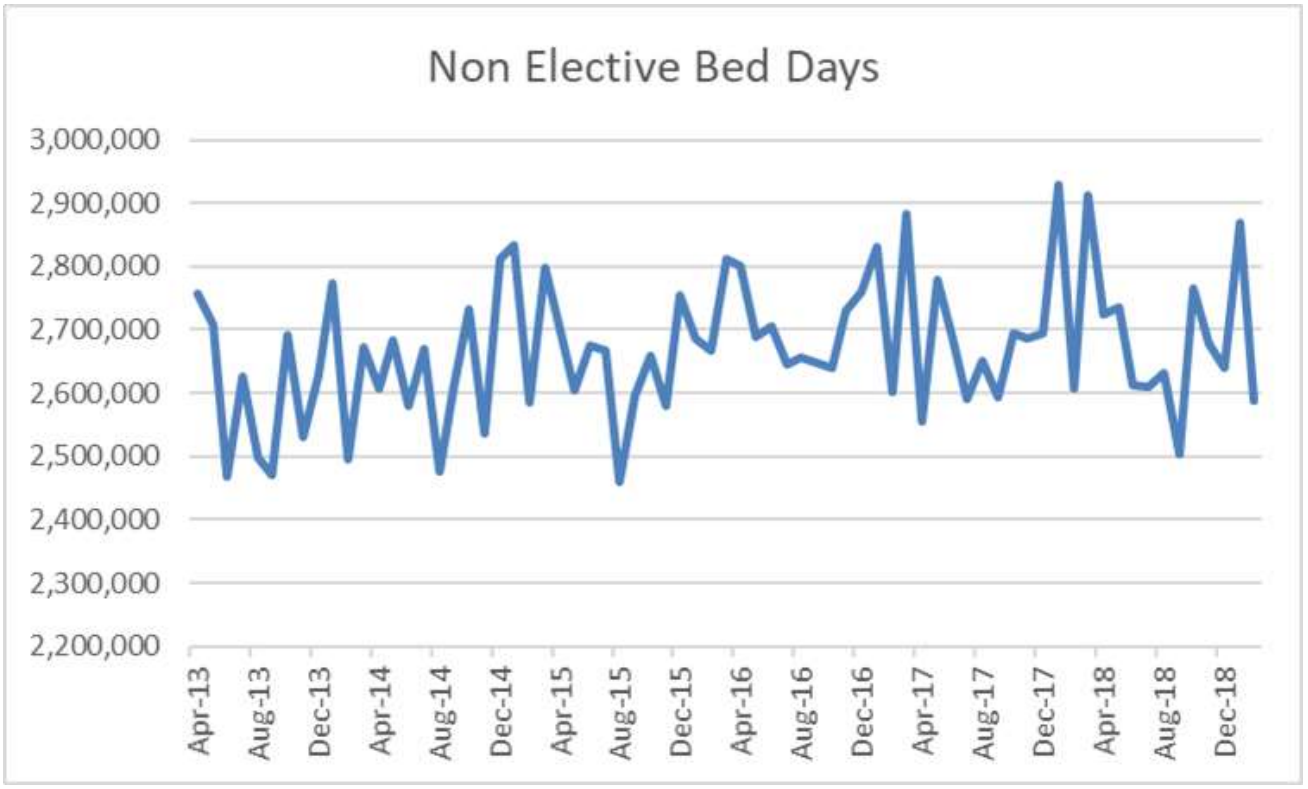
Non-elective spells at M11





 Source: Joint Activity Report Report M11 – continuous timeseries graphs

Bed Days at M11



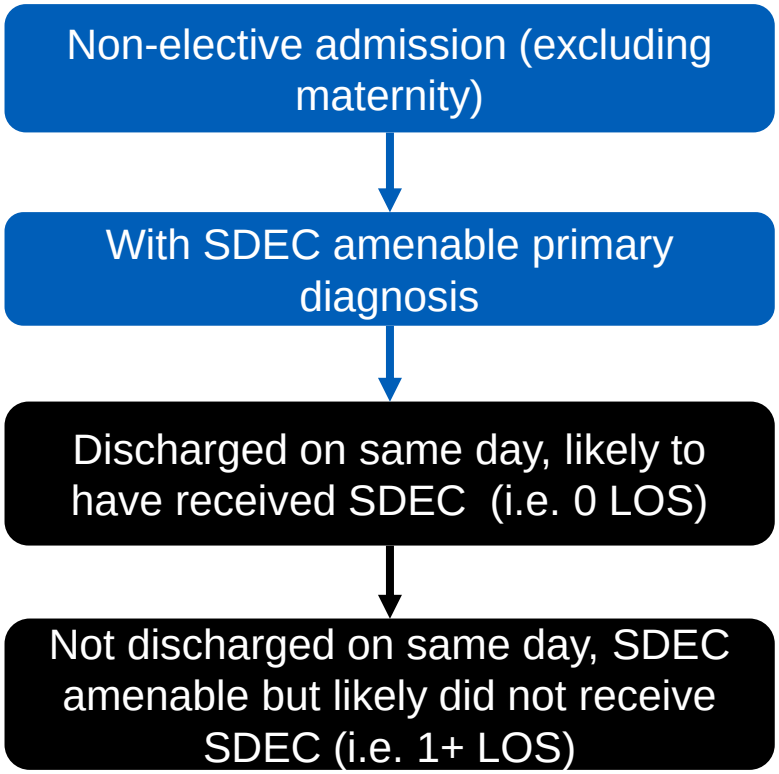
 Source: Joint Activity Report at M11 – continuous timeseries graph

SDEC – Patient Level Information Cost System (PLICS) Analysis

April 2019

NHS England and NHS Improvement

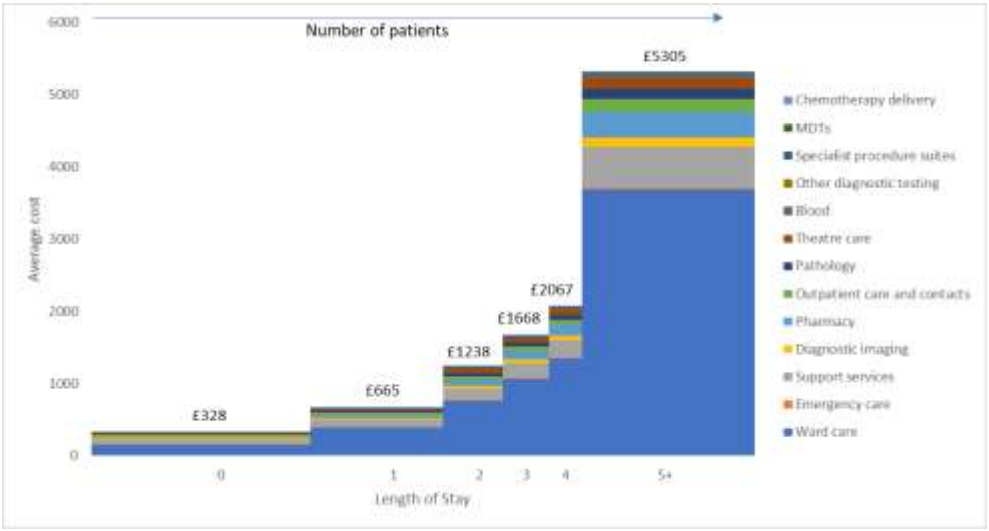
The approach used to identify SDEC amenable patients

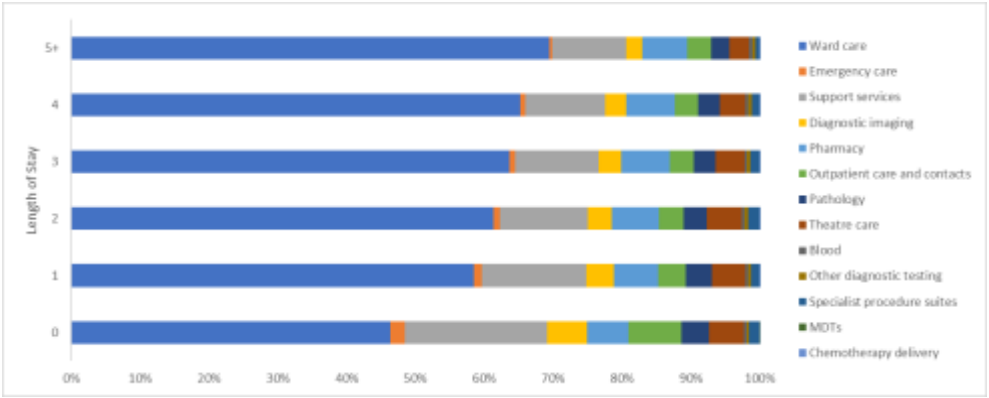


- We identify SDEC and potential SDEC spells in 2017/18 PLICS data. This covers 69 acute trusts.
- This approach was applied as a way to analyse historic data and thus applies contemporaneous information on diagnoses amenable to SDEC treatment from the Directory of Ambulatory Emergency Care for Adults (version 6).
- Thus, while similar, the identification method does not reflect developments by the SDEC Data Group to reach a definition for future coding of SDEC.
- This includes all non elective routes to SDEC treatment.

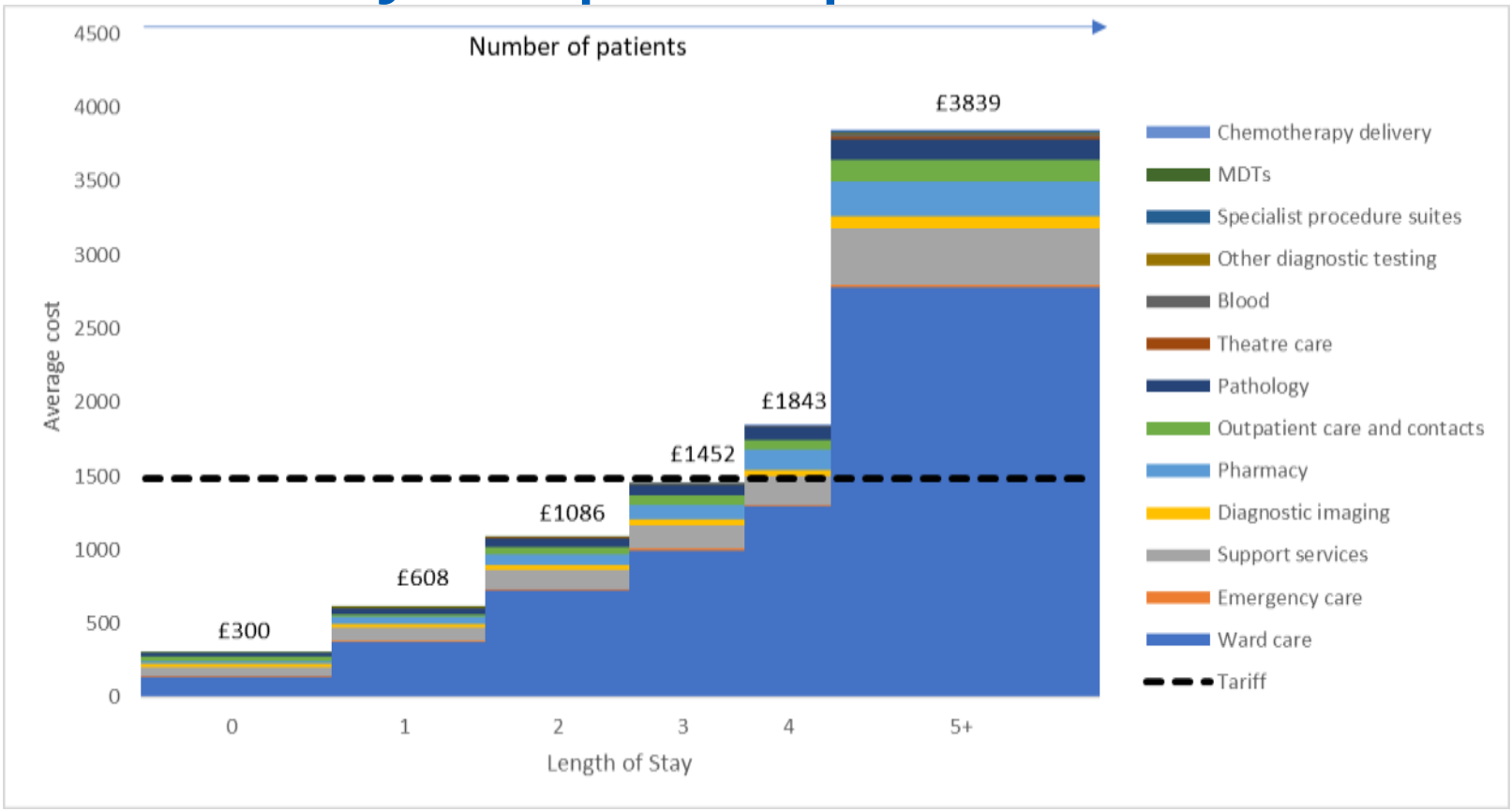
There are large differences in cost per patient as length of stay increases

- Cost per patient increases as length of stay increases (top).
- Support services make up a larger proportion of costs as LoS decreases and ward care makes up a larger proportion of costs as LoS increases (bottom).
- Costs are MFF-adjusted.
- This top right analysis is reproduced for the top three largest conditions by their largest HRG on the slides which follow.
- Tariffs on the following slides are calculated using the first episode HRG, and do not adjust for the marginal rate, nor do they incorporate locally agreed arrangements. In 17/18 (the time of the data) the marginal rate reduced tariff by 30% for activity above the threshold.
- Further, the tariff is applied to all emergency admissions without excluding 30-day readmissions.



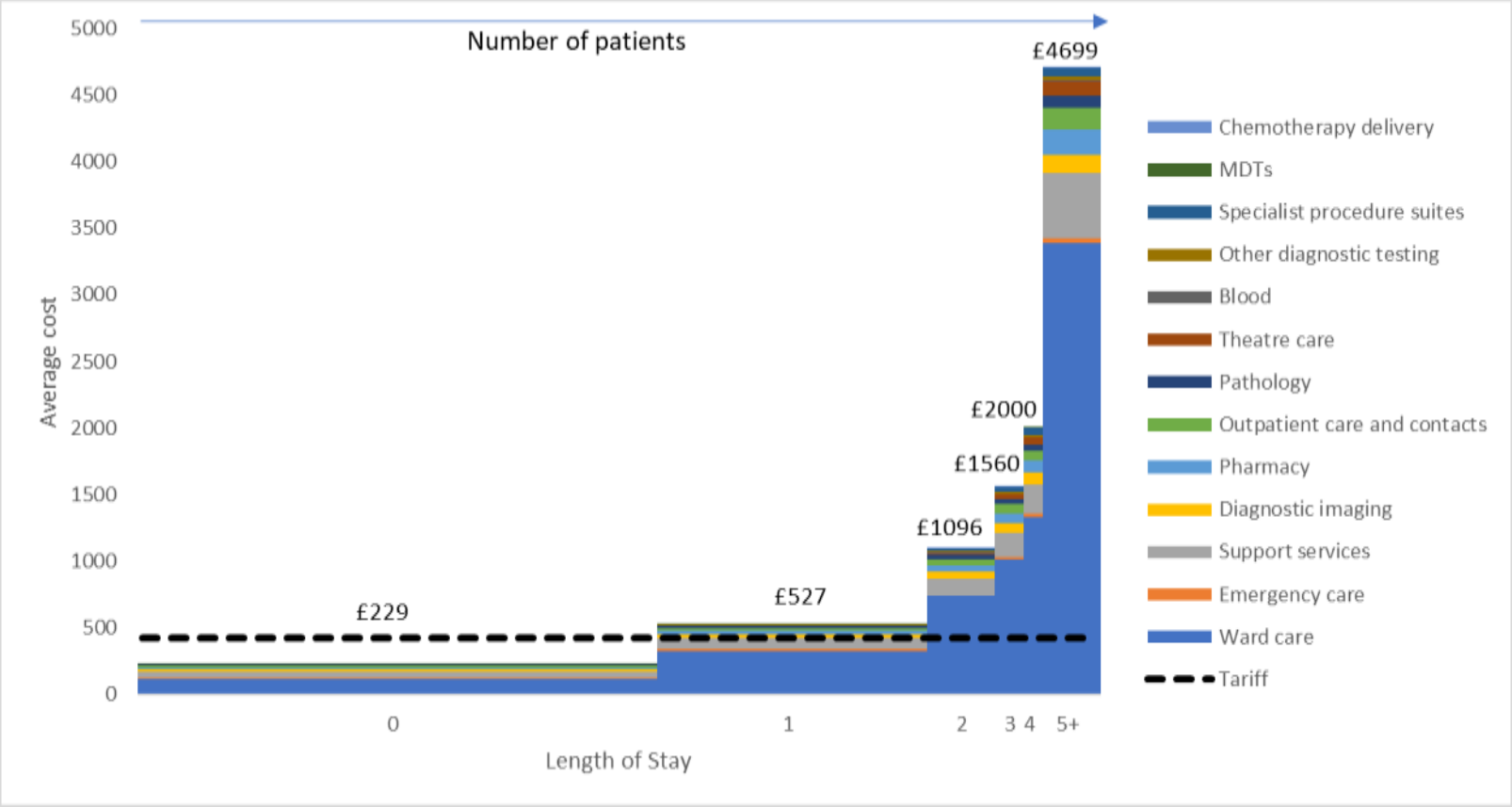


Community-acquired pneumonia



HRG: Lobar, Atypical or Viral Pneumonia, without Interventions, with CC Score 0-3 (DZ11V)

Falls including syncope or collapse



HRG: Syncope or Collapse, with CC Score 0-3 (EB08E)

Cost reductions from additional SDEC amenable patients treated same day

The average trust* in the PLICS dataset had 99 NEL admissions per day in FY2017/18, of which 35 were SDEC amenable. Of these 35 SDEC amenable admissions, seven had a 0 day LOS and an average cost of admission half of that of the eleven who had a 1 day LOS. Shifting more admissions to same day would thus reduced total costs for the trust.

Table 1: Estimated cost reductions per trust* based on 5 scenarios of treating increased volumes of 1+ day LOS SDEC amenable admissions same day

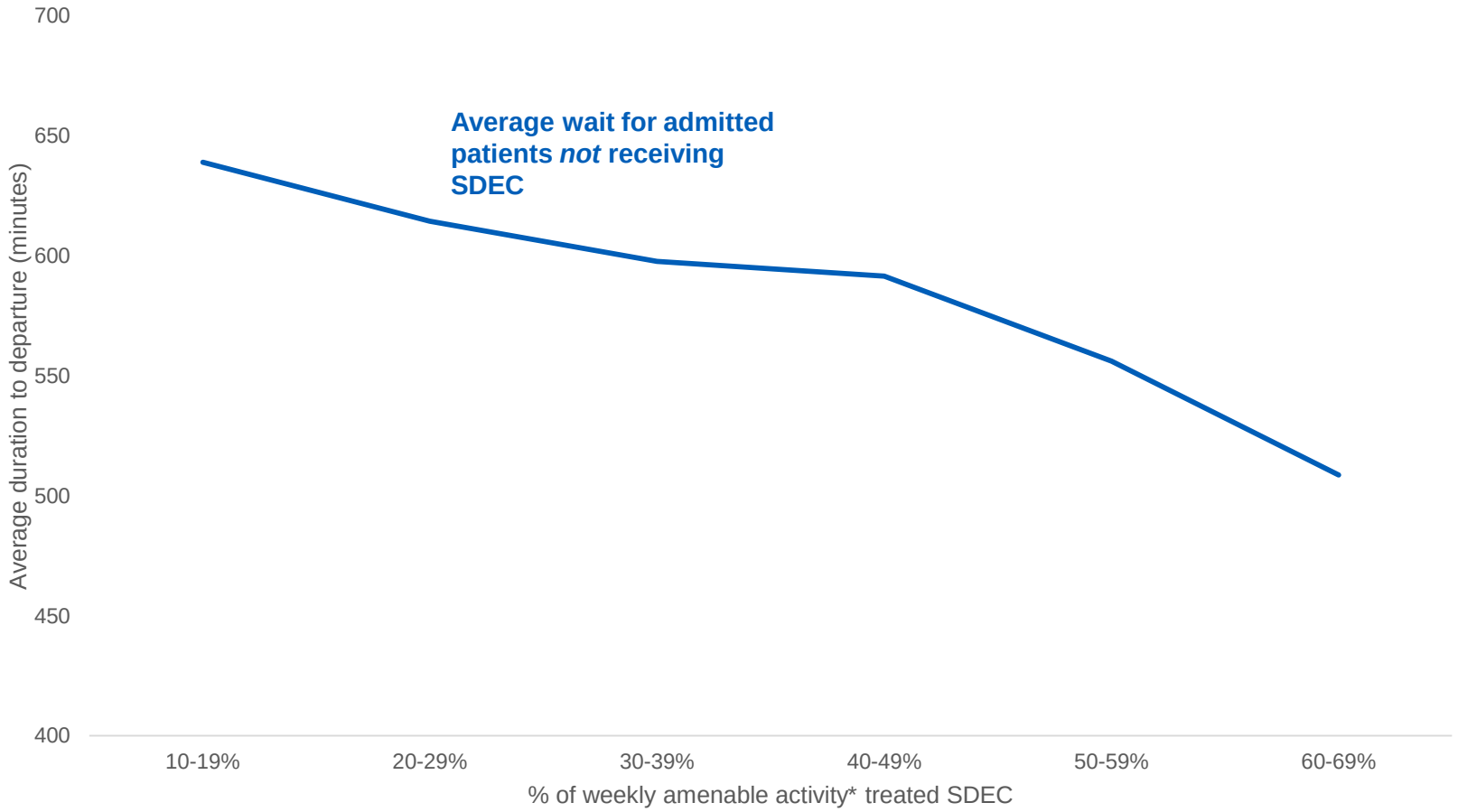
5 Scenarios:	No. of 1+ LOS admissions shifted to 0 LOS		Estimated cost reductions	
	Per year	Per day	Per admission	Per year
A: Increase to AEC Network minimum estimate per condition ^	2,440	7	£715	£1.7m
B: Increase to AEC Network mid point estimate per condition ^	4,154	11	£939	£3.9m
C: Increase to AEC Network maximum estimate per condition ^	6,178	17	£1,333	£8.2m
D: Shift all 1 day LOS admissions to 0 day LOS	3,562	10	£363	£1.3m
E: Shift all SDEC amenable admissions to 0 day LOS	11,924	33	£2,596	£31m

* The average trust is based on the 69 trusts in the PLICS dataset with substantial NEL activity in FY2017/18.

^ The method applied to these scenarios was to shift the lowest LOS patients to 0 day LOS necessary to meet the AEC Network threshold.

Knock-on effect of SDEC for patients admitted from Type 1 A&E

This graph illustrates how increasing SDEC activity affects average time spent in A&E for admitted non-SDEC patients.



*Patients with an amenable condition, arriving during core AEC unit operating hours