Cyflwynwyd yr ymateb i ymgynghoriad y Pwyllgor Iechyd a Gofal Cymdeithasol ar rhyddhau cleifion o ysbytai ac effaith hynny ar y llif cleifion drwy ysbytai

This response was submitted to the Health and Social Care Committee consultation on Hospital discharge and its impact on patient flow through hospitals

HD 21
Ymateb gan: | Response from: Coleg Brenhinol Llawfeddygon Caeredin | Royal College of Surgeons of Edinburgh

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Submission of evidence to the Welsh Senedd consultation on hospital discharge and its impact on patient flow through hospitals from the Royal College of Surgeons of Edinburgh.

Introduction.

1. The Royal College of Surgeons of Edinburgh is the oldest and one of the largest of the medical Royal Colleges. We support a significant percentage of the surgical, dental surgical and perioperative capacity in Wales.

2. There are frequently patients in hospital awaiting transfer elsewhere (so-called 'bed-blocking') and that this has been made worse by the pandemic. The College will not dwell on individual numbers as these are very volatile and can change rapidly. Rather it will comment on factors which can cause numbers to increase and what can be done about it.

3. The impact on patients of delays in hospital discharge is considerable. The most significant impact is the delay to treatment of others when a bed is being blocked. Delays to surgery or other treatment leave patients in pain and with reduced capacity to go about their everyday lives. In some cases, it may even be life threatening.

4. However, there are also impacts on the patient unable to go home. They frequently express feelings of guilt, are uncomfortable and wish to return home and there is an increased risk of nosocomial infection. This is particularly the case presently with as virulent an infection as the Omicron variant of Covid-19 rampant but is also true in 'normal' times.

5. It is however worth dividing this response into two, those factors which are perennial and those factors which are Covid-specific.

Common issues.

6. The most frequent reason for 'bed-blocking' is a lack of suitable care or care plans for the patient once discharged. This may be that the patient requires a place in a care facility, and there is no place available or there are delays in securing a place, or it may be that there are delays in putting in place a plan for follow-up care in the patients own home.

7. These issues require more joined up working and communication between hospitals and social care. This discussion is well-rehearsed, and it is a topic which the College does not have expertise in, so we will not go into it in depth on the topic here other than to acknowledge it as a major issue.

8. A second reason for a patient remaining in a bed longer than strictly necessary may be a simple lack of transport to their place of residence if this cannot be provided by friends or family. Patients may not be physically able to drive and, if they have arrived by ambulance, their vehicle will not be at the hospital. They may not be in a fit state to take public transport, particularly in rural areas where public transport may be unreliable and/or infrequent and taxis expensive. Particularly over the winter months ambulances are in limited supply and unlikely to be available to return them to their homes or care facility.

9. The provision of a minibus and driver, potentially staffed by volunteers, can be invaluable for preventing this transport issue preventing patient discharge. Some, but not all, hospitals already have this provision.

10. A further reason can be a lingering concern for the patient in terms of whether they are yet ready to go home, particularly if they live alone. There may be an indicator, for example blood sugar levels, which their clinician has concerns about and may consider requires monitoring, but which does not require actual treatment.

11. In these instances, the advent of technology and 'virtual wards' to monitor the indicator worried about at home has the potential to make a real difference. These are however in their infancy and need to be examined thoroughly before being rolled out en masse, with patient safety and clinical judgement foremost in the minds of all involved.

12. A tangential but related issue with patient flow can be a spike in emergency admissions, resulting in beds no longer being available and therefore cancellation or delay of elective operations or treatments. The College has been championing a model of ending the colocation of acute and elective care. The transfer of routine elective operations, such as hernia removal, to 'community hubs' which do not have an accident and emergency department would allow elective treatments to continue in cases where emergency admissions are spiking. Countries which use this model – such as New Zealand, Australia and the United States – are seeing considerably smaller backlogs as they were able to make these elective hubs 'Covid Green sites' to continue treatments during the pandemic. Diagnostic hubs, as recommended by the Richards Review, are another aspect of this which is being rolled out in NHS England.

Covid-specific issues.

13. The first point to note about the impact of Covid is that it has exacerbated each of the common issues. Patients who were Covid positive could not be released to care homes. Nor could they be transported in volunteer hospital transports or get taxis or public transport. This has caused further delays and prolonged bed occupancy.

14. The biggest impact in terms of patient flow however has been that one Covid case can 'block' the beds of an entire ward. In particular with the Omicron variant many patients who are in hospital for other issues are testing positive, and often two or three days after arrival. That means that the ward they are on then becomes an infection red site, meaning only Covid positive patients can be admitted to it. This means every bed in that ward is now 'blocked' to Covid negative patients. There is little that can be done about this, other than to continue with the vaccine program and wait for the pandemic to take its course.