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 37

Ymateb gan: | Response from: Y Coleg Brenhinol Meddygaeth Frys | Royal College of Emergency Medicine

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Hospital discharge and its impact on patient flow through hospitals

The Royal College of Emergency Medicine is The Royal College of Emergency Medicine (RCEM) is the single authoritative body for Emergency Medicine in the UK. Emergency Medicine is the medical specialty which provides doctors and consultants to A&E departments in the NHS in the UK and other healthcare systems across the world. The Royal College, representing over 10,000 members, works to ensure high quality care by setting and monitoring standards of care and providing expert guidance and advice on policy to relevant bodies on matters relating to Emergency Medicine.

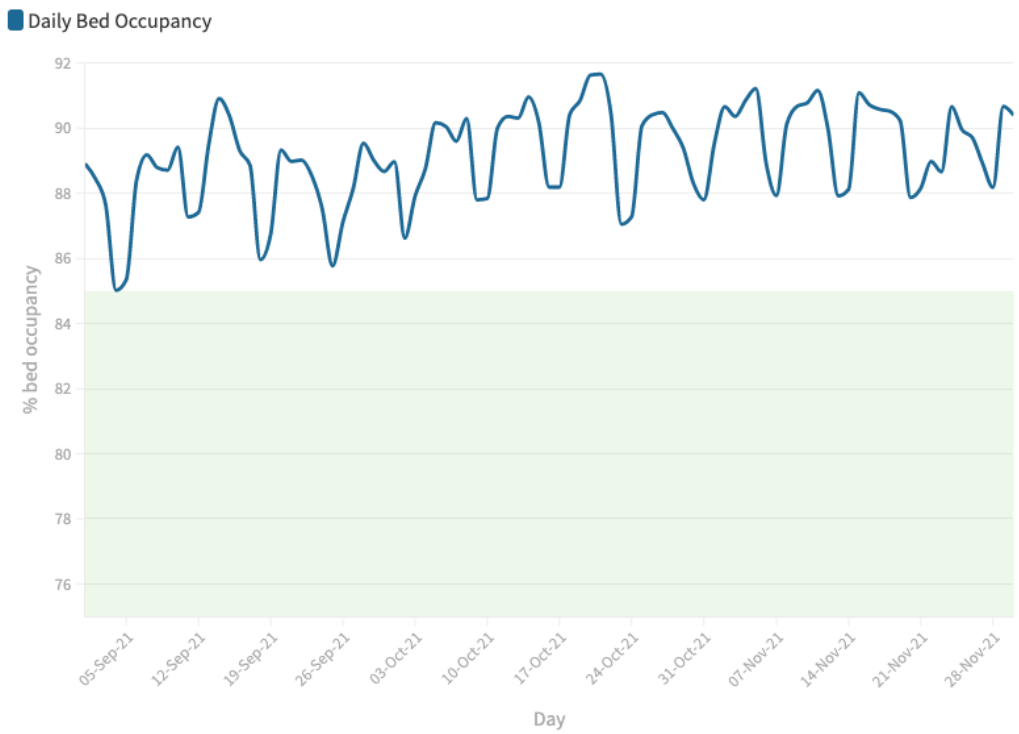
Delayed Discharges

Delayed discharges have long been increasing in prevalence across Emergency Departments in Wales. A delayed discharge occurs when a patient, clinically ready for discharge, cannot leave hospital because the other necessary care, support or accommodation for them is not readily accessible and/or funding is not available. Not only is being delayed in this way stressful and sometimes harmful to the patient waiting to be discharged, but it subsequently causes delays and crowding upstream, which are in turn, dangerous for the patients waiting to be admitted.

The true scale of the problem is difficult to measure as, since the pandemic, the Welsh Government suspended delayed transfers of care (DTOC) reporting requirements. Anecdotally, we know from our members who are working on the ground that delayed discharges have worsened in recent times. In England, recent data show that 59.1% (or almost 6 in 10) of patients who are ready to be discharged remain in hospital. There is reason to believe that Emergency Departments in Wales are under comparable strain.

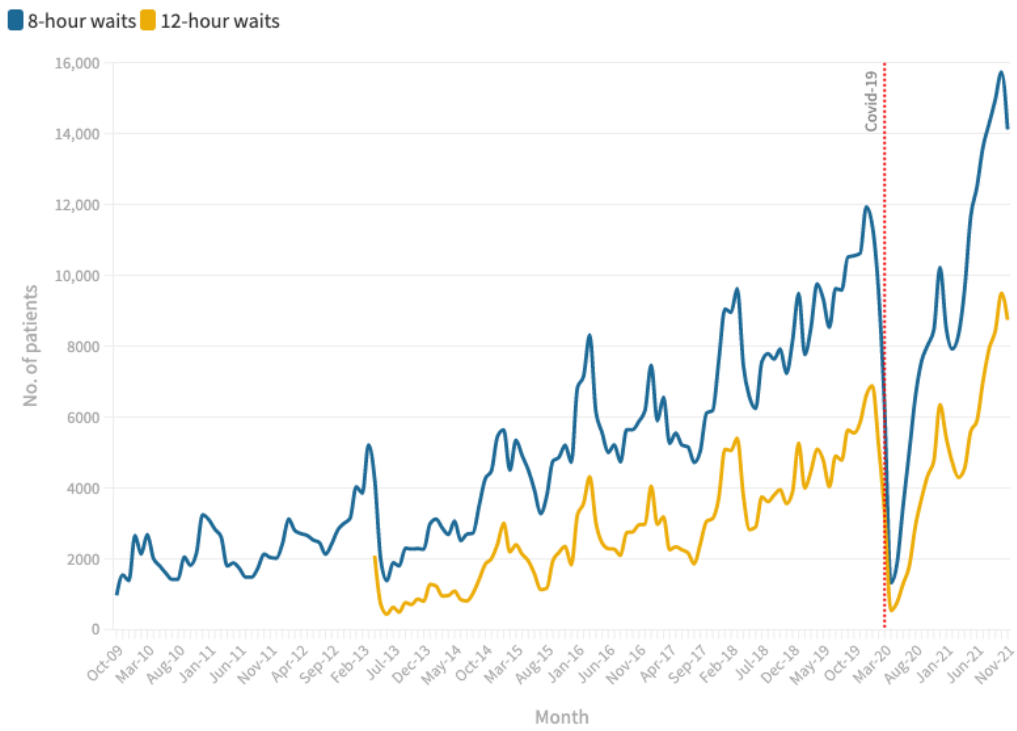
Furthermore, there are alternative measures we can look at that indicate the extremely poor patient flow in Emergency Departments across Wales. These help to paint a picture of what may be happening with delayed discharges in spite of no DTOC data.

Graph 1. Daily bed occupancy for September, October and November 2021



Graph 1 above shows the daily bed occupancy for September, October and November 2021 in Wales. The green area indicates safe bed occupancy of 85% and below. As demonstrated by the graph, bed occupancy during this time never reached safe levels. This would indicate that admission rates were really high despite no significant spike in attendances, or that patients occupying a bed were unable to be discharged into the hospital or home. When departments are operating under these conditions, it is extremely difficult to maintain good patient flow and, as a result, long waits ensue.

Graph 2. 8- and 12-hour waits in major departments since records began



Graph 2 demonstrates eight- and 12-hour performance since records began. While there was a temporary dip in long waits during the start of the pandemic, recent months have seen the highest delays on record with one in four patients waiting eight hours or more in October 2021. This trend has been in the making for some time, and while the pandemic has certainly made delivering healthcare more complicated, it cannot totally explain the current poor performance.

Impact on Patients

The link between long waits and patient harm is well-accepted but quantifying this harm has been near impossible until now. The Emergency Medicine Getting It Right First Time Programme National Specialty Report by Chris Moulton and Cliff Mann report explored the relationship between delays to timely admission and patient harm. The model controlled for all confounding variables such as: age and gender; deprivation; Elixhauser comorbidity index; month/year/hour of day; number of emergency admissions in the previous 12 months; number of ED attendances in the previous 12 months; trust/site; and ED crowding (as measured by performance against the NHS four-hour operational standard). The analysis concluded that beyond around the 5-hour mark, the standardised mortality rate (SMR) goes up and continues to go up the longer a patient is delayed in an emergency department.

Hours in the ED	SMR	Percentage change in the SMR	95% lower confidence limit for the SMR	95% upper confidence limit for the SMR	Adjusted absolute mortality rate	Number needed to harm (30-day mortality)
Up to 4 hours	0.94	-6%	0.92	0.95	8.5%	-175
4 - 6 hours	1.06	6%	1.04	1.08	9.5%	192
6 - 8 hours	1.14	14%	1.11	1.18	10.3%	77
8 - 12 hours	1.16	16%	1.12	1.21	10.4%	67

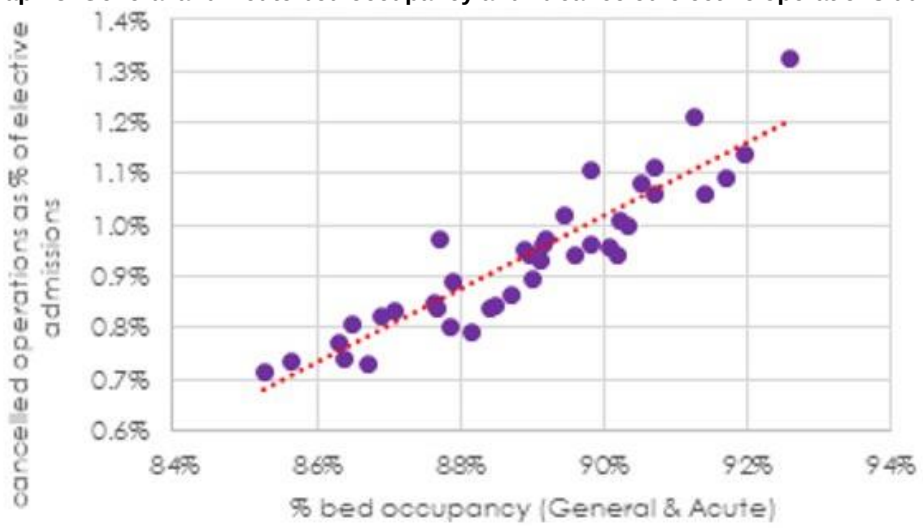
Data source: HES and ONS 2016 - 2018[18]

The report found that beyond around the five-hour mark, the SMR goes up and continues to go up the longer a patient is delayed in an emergency department. Applying this model to Welsh data for 2021 (January to November) of those that waited between eight and 12 hours, this would translate as 877 excess deaths. For those that waited eight hours and beyond, the figure more than doubles to 1,946 excess deaths. This is unconscionable and would be preventable if sufficient resources were available.

Impact on Recovery

When unscheduled care is unable to cope with the demand placed on it, other parts of the system are inevitably disrupted to allow for temporary expansion of capacity. Graph 3 uses data from England to show that when general and acute bed occupancy increases, so does the percentage of canceled operations due to non-clinical reasons I.e., capacity or hospital issues.

Graph 3. General and Acute bed occupancy and % canceled elective operations due to non-clinical reasons.



This is not exclusive to the pandemic and regularly occurs during the winter period when unscheduled care sees a spike in demand. However, at a time when the backlog is the worst it's ever been, it's crucial that unscheduled care is firmly embedded in any plans to tackle the waiting lists. This means ensuring that there is capacity to deal with variations in demand and crowding. Addressing delayed discharges would go some way in alleviating the need for the cancelation of elective surgery in order to provide temporary capacity expansion.

Impact on Staff

It goes without saying that working under these conditions inevitably has an impact on the staff that give their all and bridge the gap between an under sourced system and what is required of them. Our workforce survey found that three quarters of respondents (74%) expressed that they have considered changing their working patterns, with half (50%) indicating they are planning on reducing their working hours in the next two years. This poses significant challenges for the functioning of our NHS – a challenge that needs to be tackled urgently by policymakers. Across Welsh emergency departments, based on current annual demand, there would need to be an additional 100 emergency medicine consultants to achieve safe staffing levels. With ever increasing rates of burnout and a rise in the number of staff working less than full time, this figure is likely to grow. Action needs to be taken now to ensure the future workforce.

Recommendations:

1. The Welsh Government must immediately prepare and manage adequate capacity in order to minimise the harm to patients and staff caused by ED crowding and exit block. This will reduce the risk of emergency demand derailing the elective recovery and improve the working conditions of staff in EDs. This must include but is not limited to:
    a. Making funding available to local health systems to maintain or expand discharge to assess services so they are available all year round.
    b. Expanding clinical validation of Phone First services to ensure patients receive care in the best setting based on their needs. These services are only effective if there are adequate levels of clinical involvement.

2. The Welsh Government must act now to achieve safe staffing levels in EDs. At present, there is a shortfall of 100 Whole Time Equivalent consultants in Wales. Expansion of the workforce is needed to ensure patients are treated by staff who are trained in Emergency Medicine.