A Call to Action

Dr Colm Henry
Chief Clinical Officer
HSE Patient Flow Conference
13th of November 2024

Overview

1. Current context and problem statements
2. Focus on the older person
3. Critical success factors
4. A call to action

Current Context and Problem Statements

Urgent and Emergency Care Demand

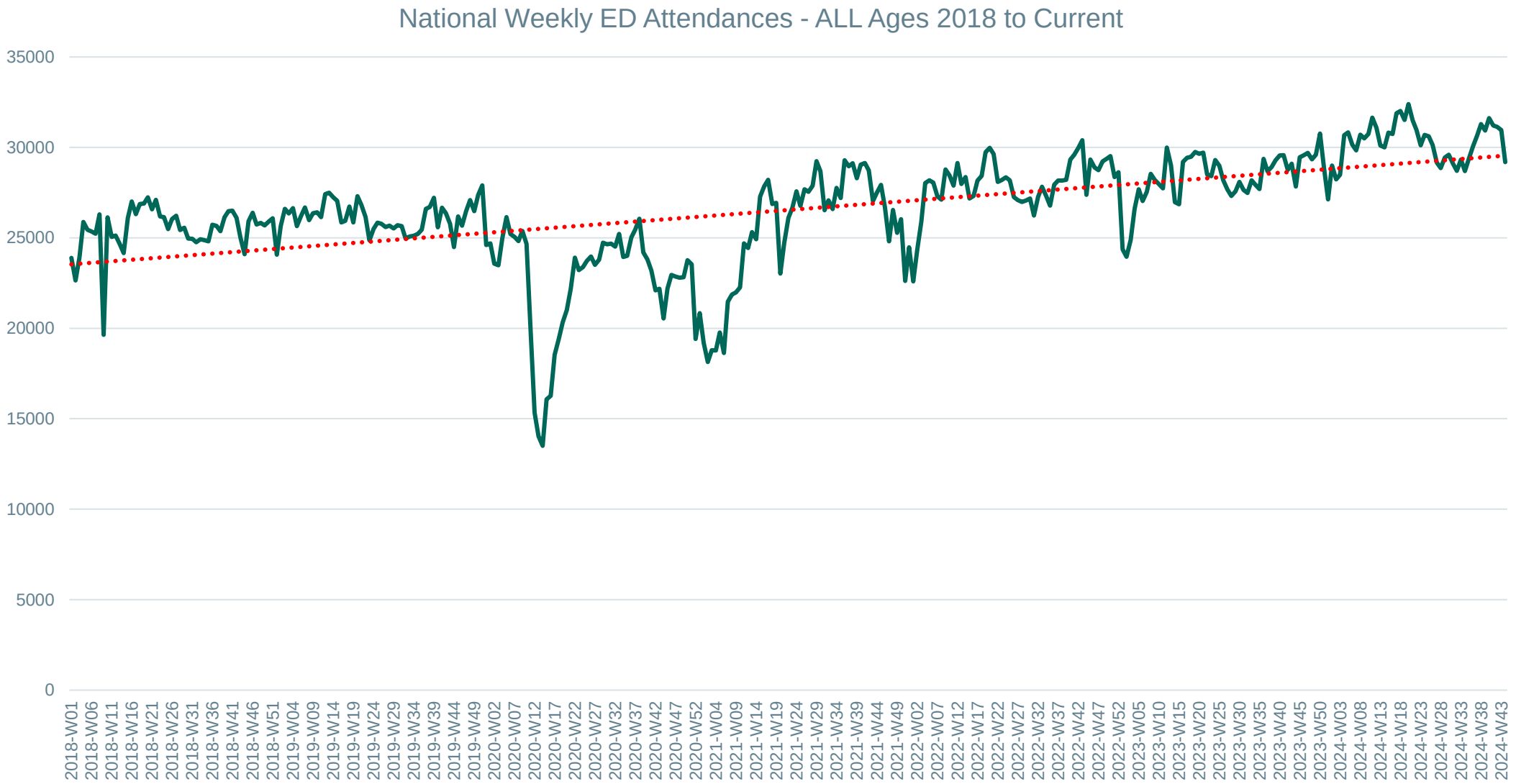
Healthcare demand and delivery in Ireland

29 million	GP Consultations	1 million	Out of Hours GP
110,000	Local Injury Units	100,000	Medical Assessment Unit
100,000	Medical Assessment Unit		
1.4 million	ED attendances	365,000	ED admissions

Also Scheduled Care

1.1 million Day Cases
3.6 million Outpatients

National Weekly ED Attendances - ALL Ages (2018 to current)



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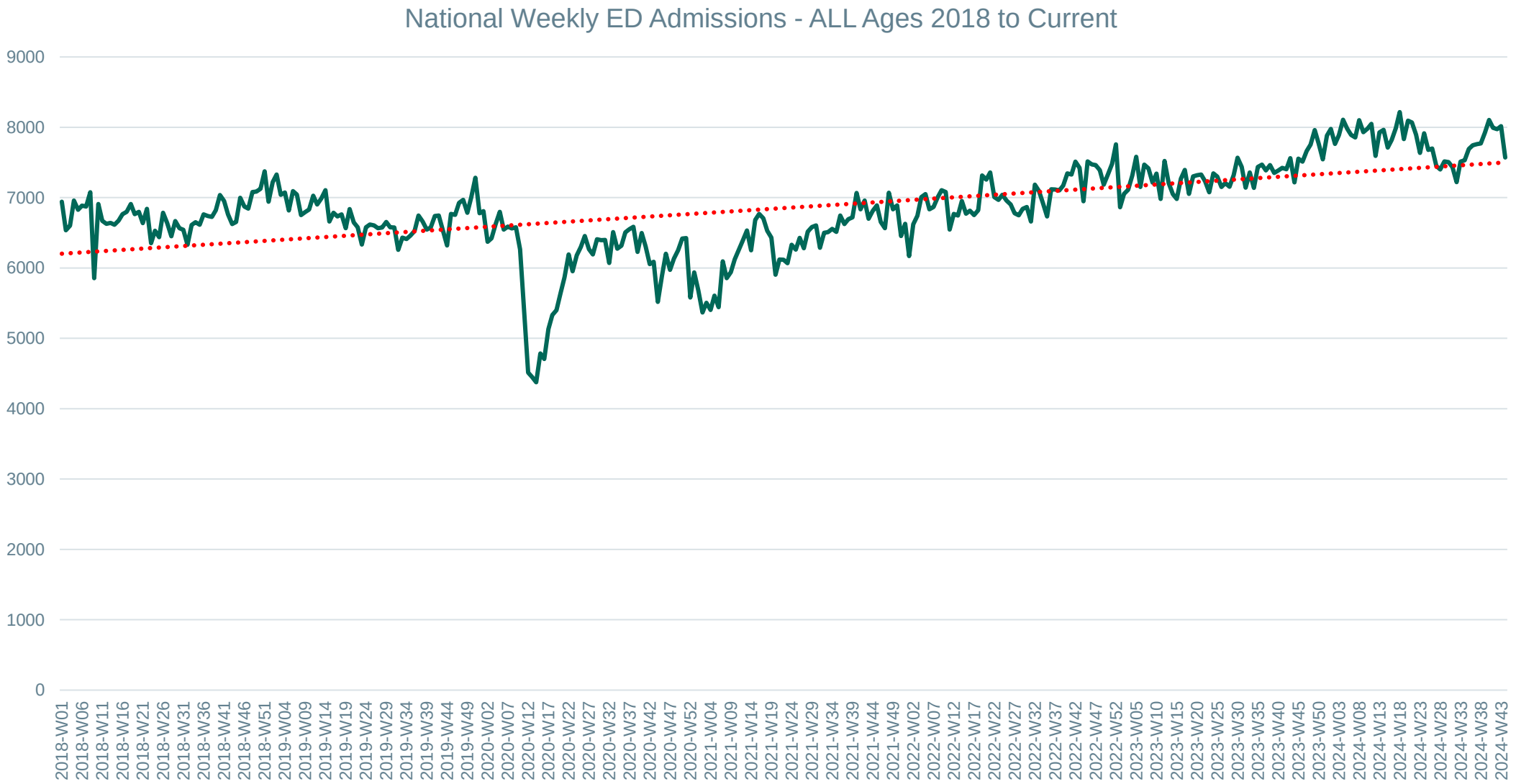
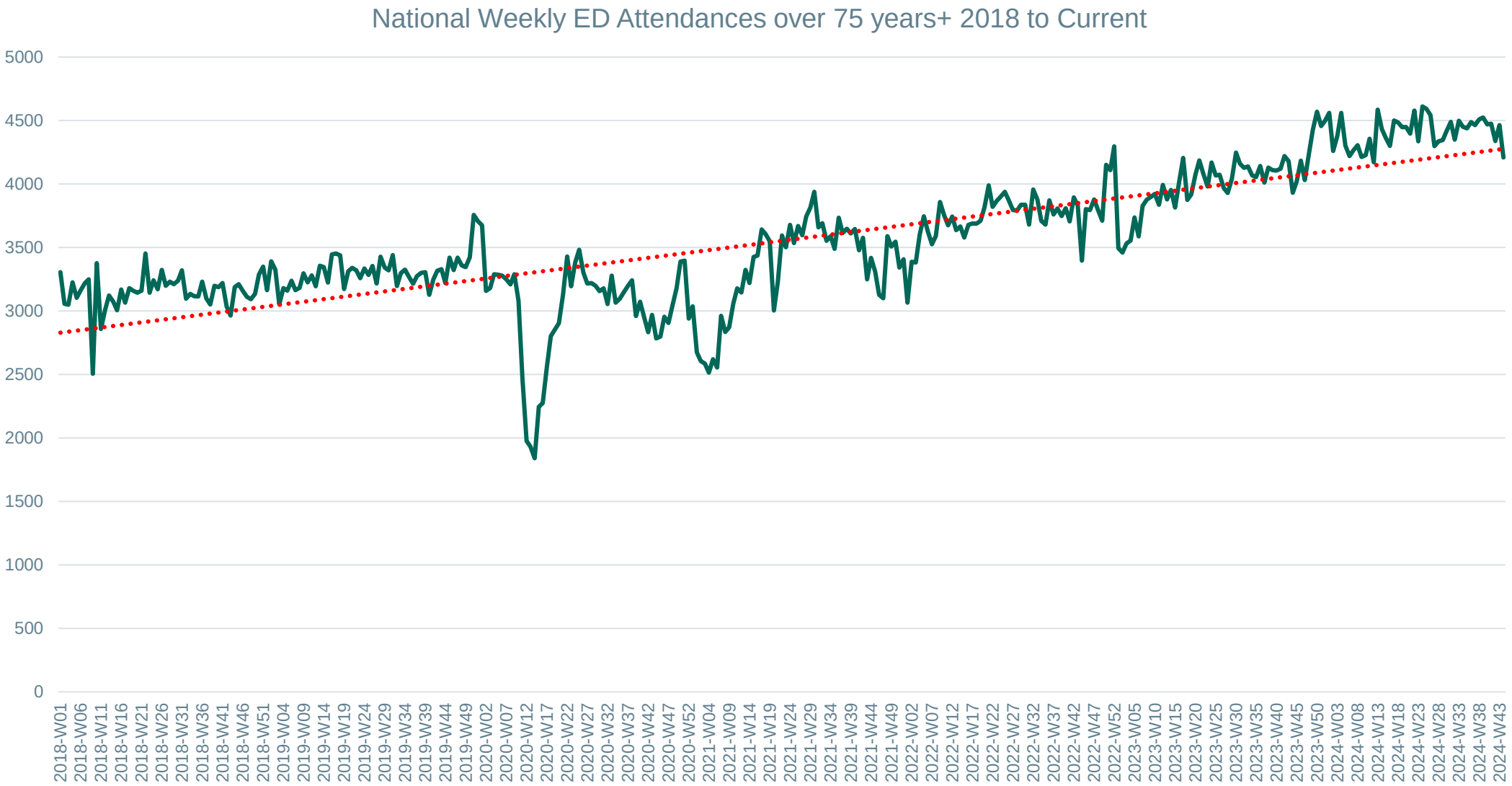
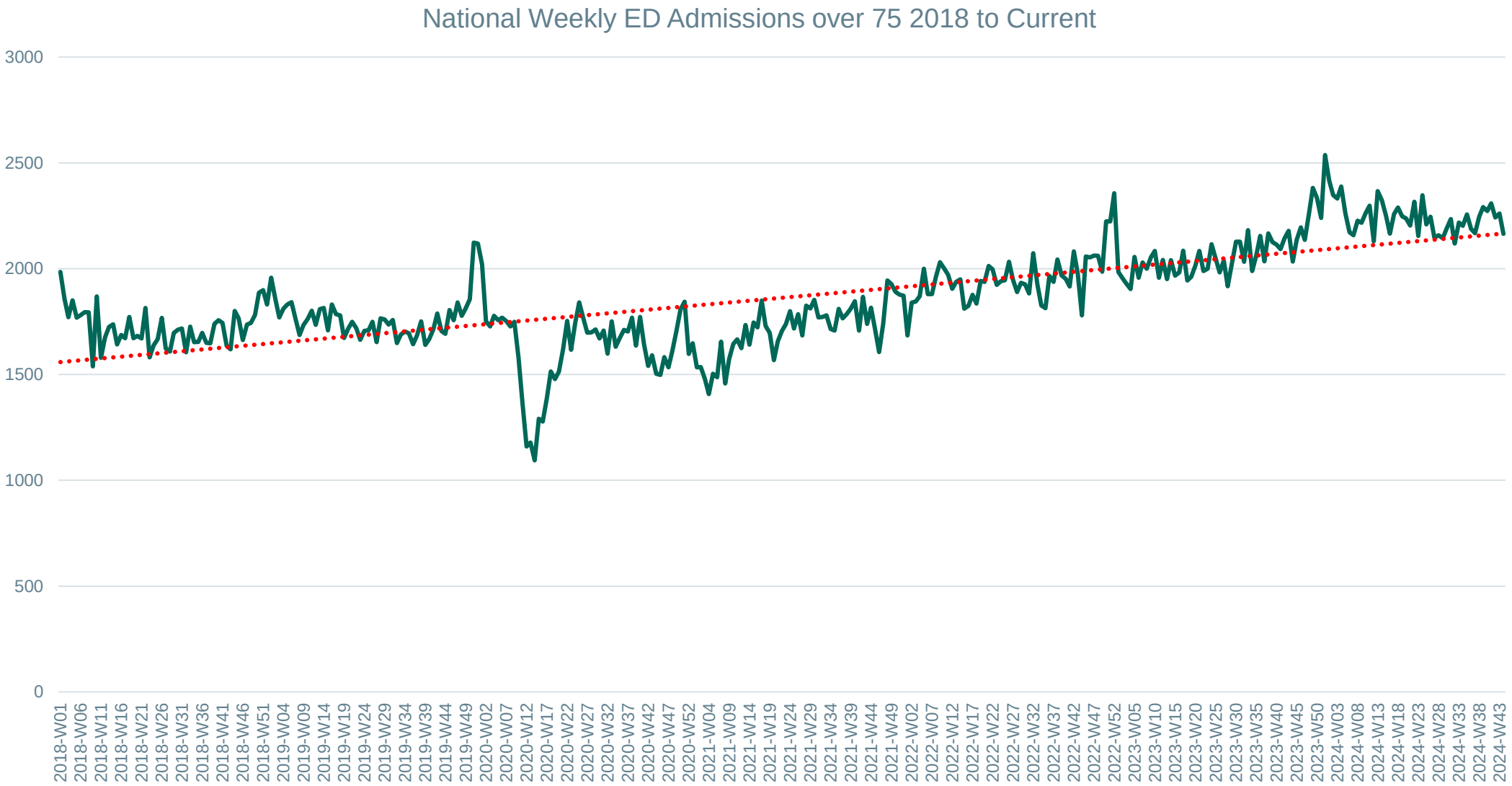


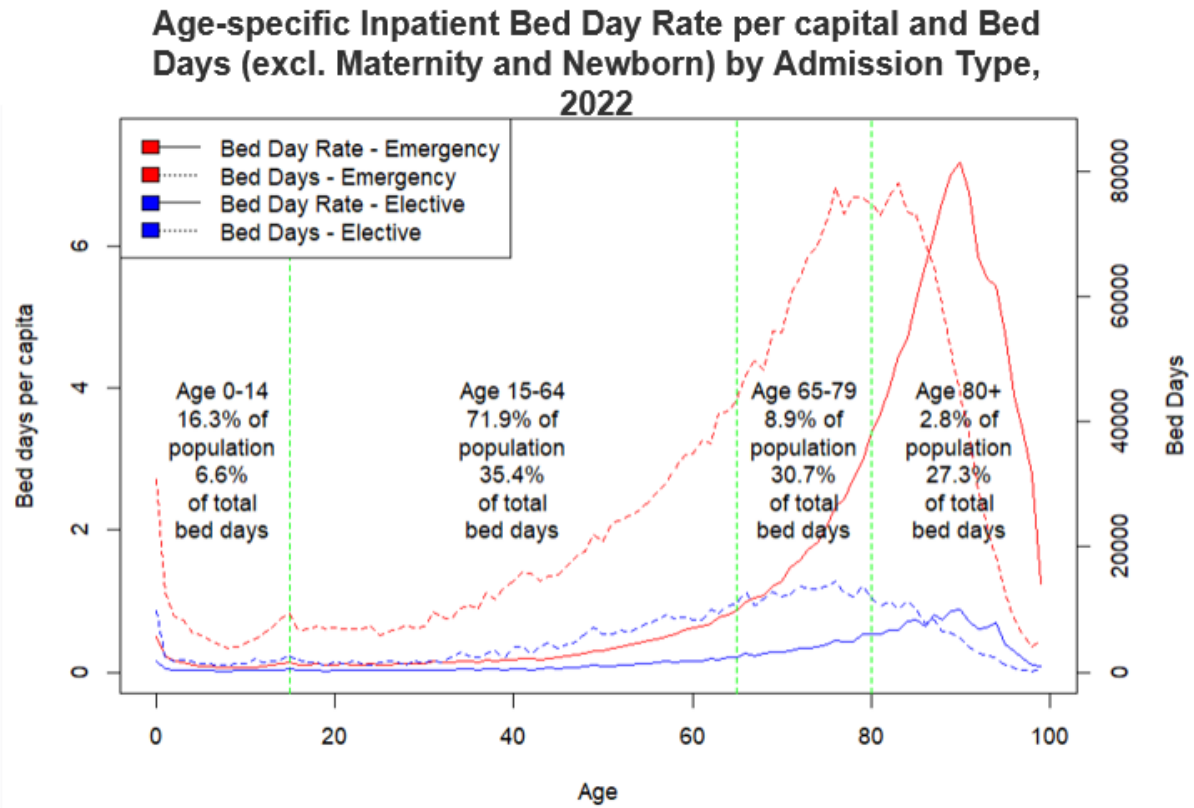
National Weekly ED Attendances - Over 75 years+ (2018 to current)



National Weekly ED Admissions - Over 75 years+ (2018 to current)



Healthcare Reform: Age as a Driver for Change



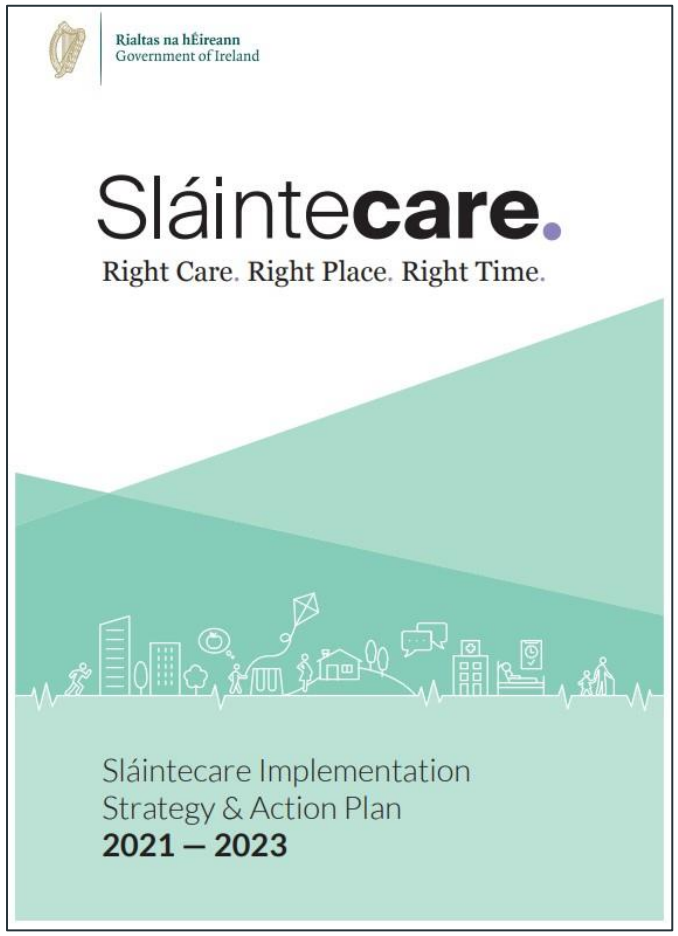
Older Person Intensive Case Management (OPICM)

- Proactive identification, assessment and care planning
- Service and Care coordination
- Integrated, early supported discharge

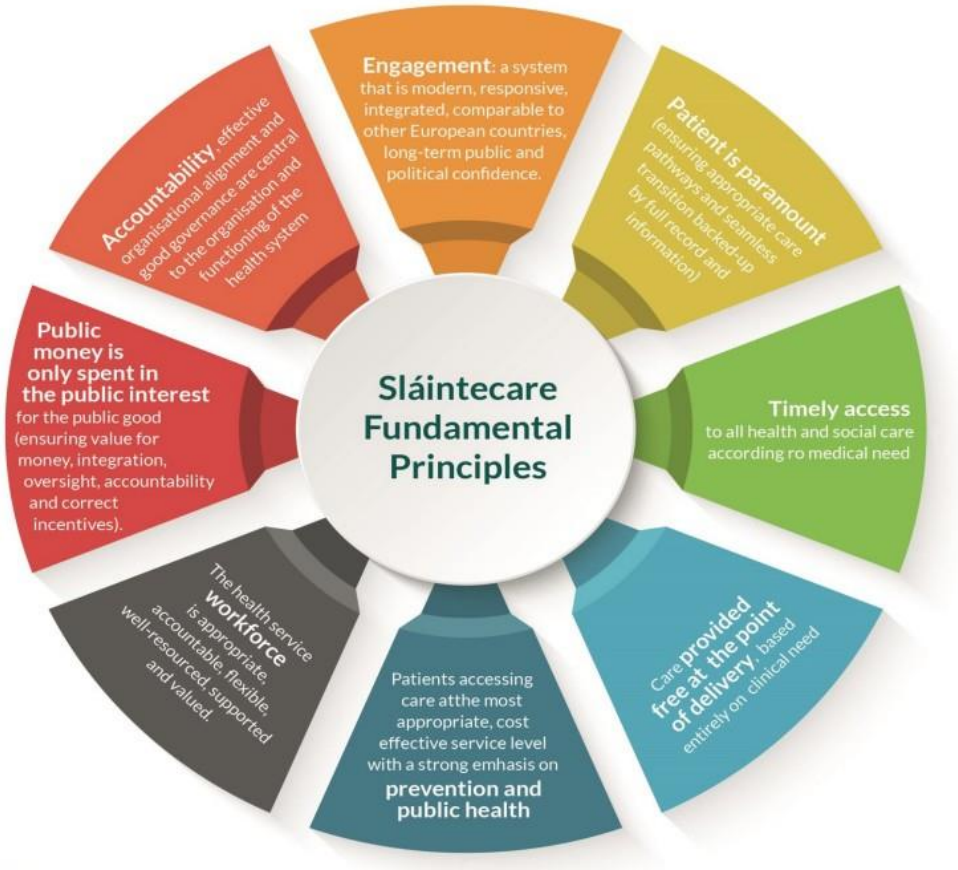
Source: HIPE (2022 discharges)

- 55% of the bed days in public acute hospitals are used by those are 65 years and above.
- Demand per capita for healthcare increases sharply with increasing age.
- As our population ages we need to plan for the impact on future demand by service area.
- **Because demand per capita increases steeply in older age group, small increases in the numbers of older people lead to large increases in demand for care.**

Sláintecare is Setting the Standards and Principles of Future Healthcare Practices in Ireland



Sláintecare – agreed framework of healthcare reform



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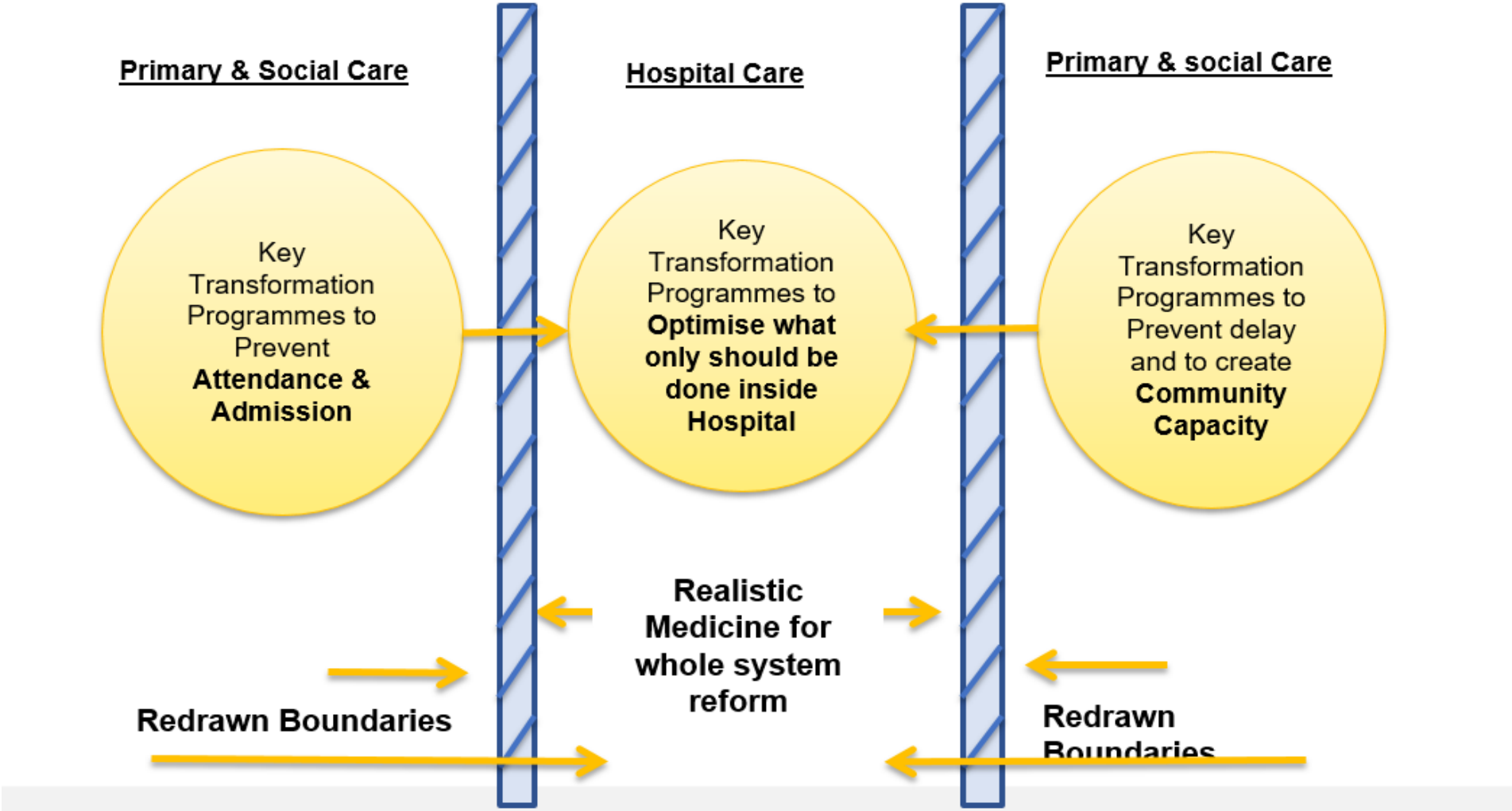
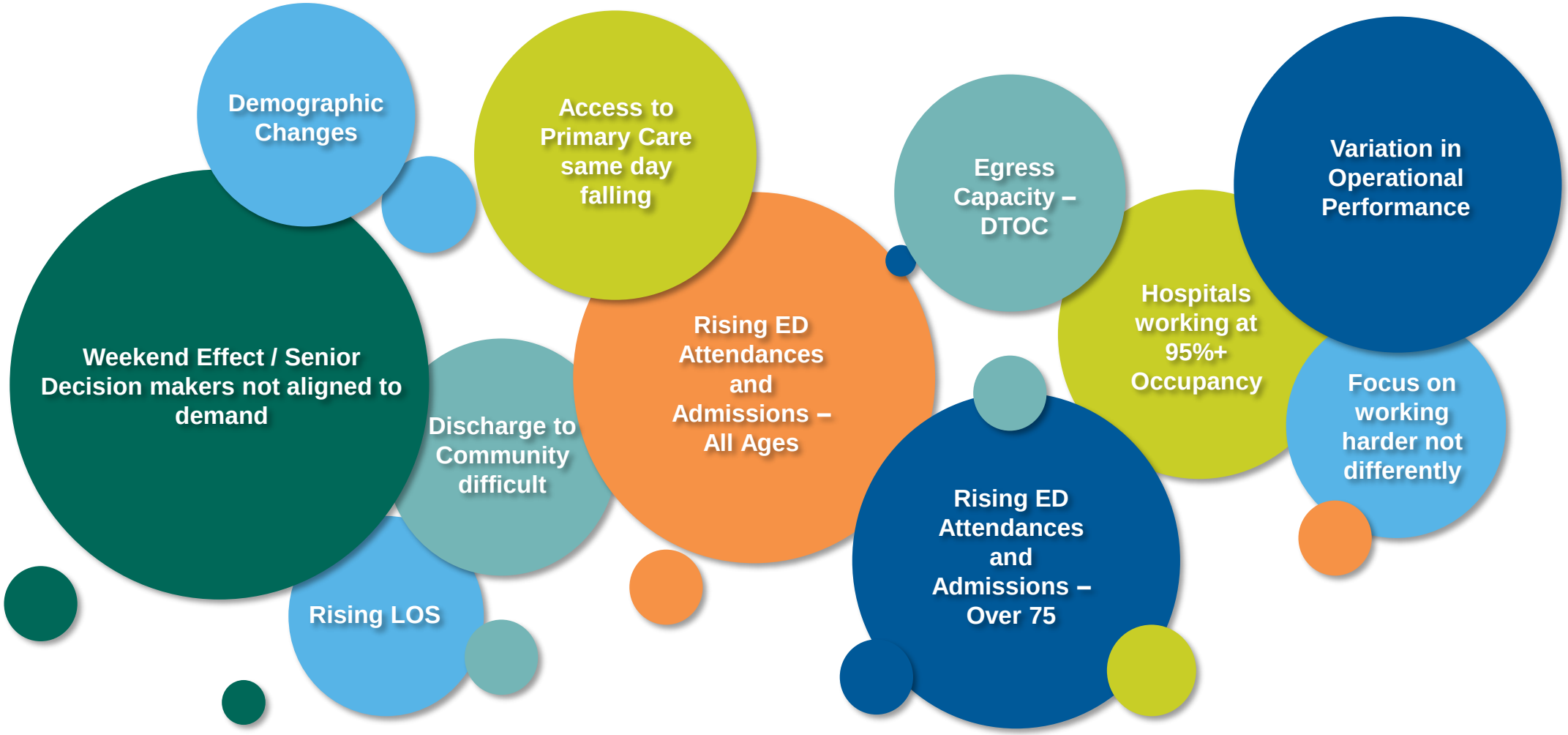
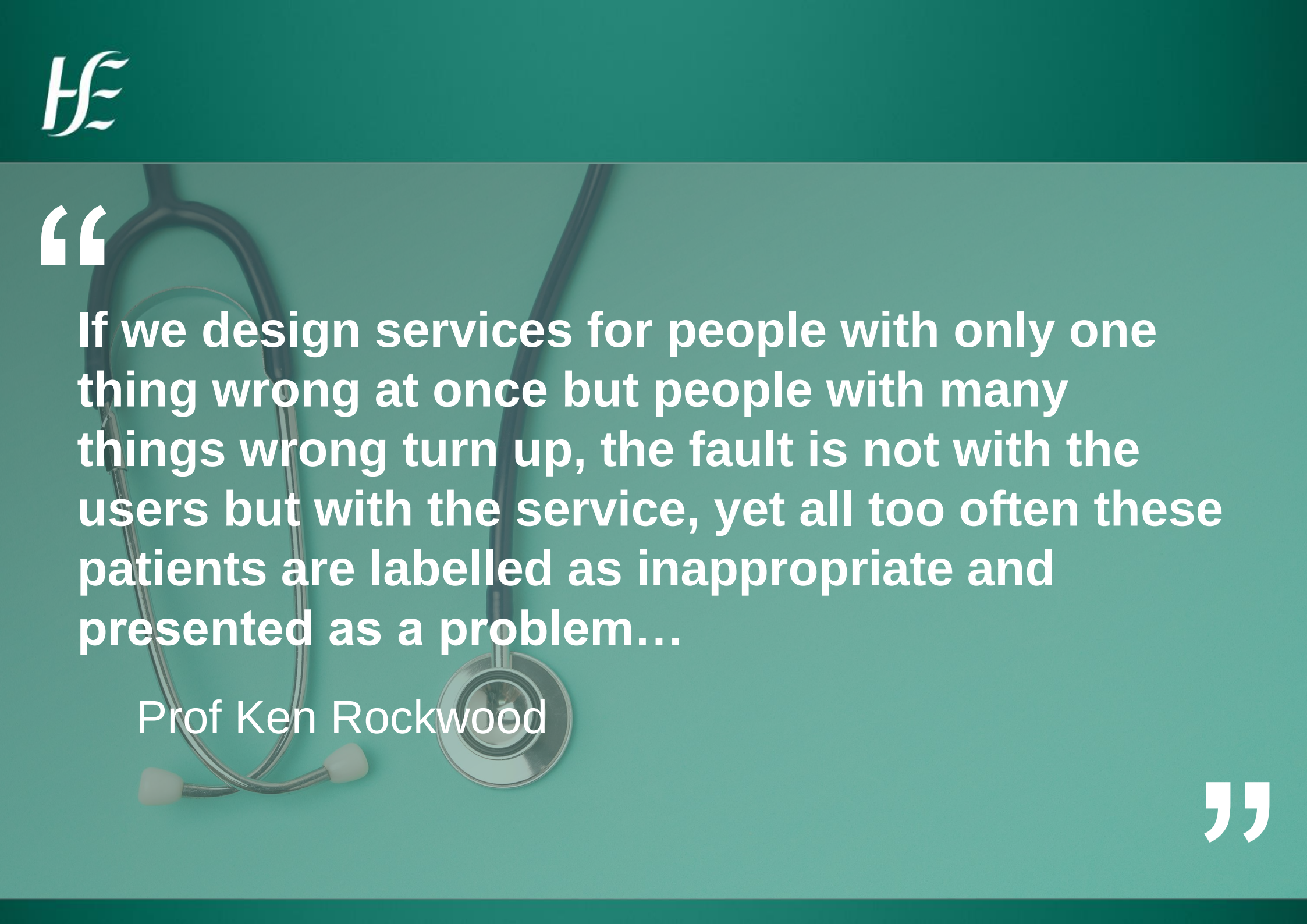
We Need to Focus on the Entire Healthcare System…..



Problem Statements





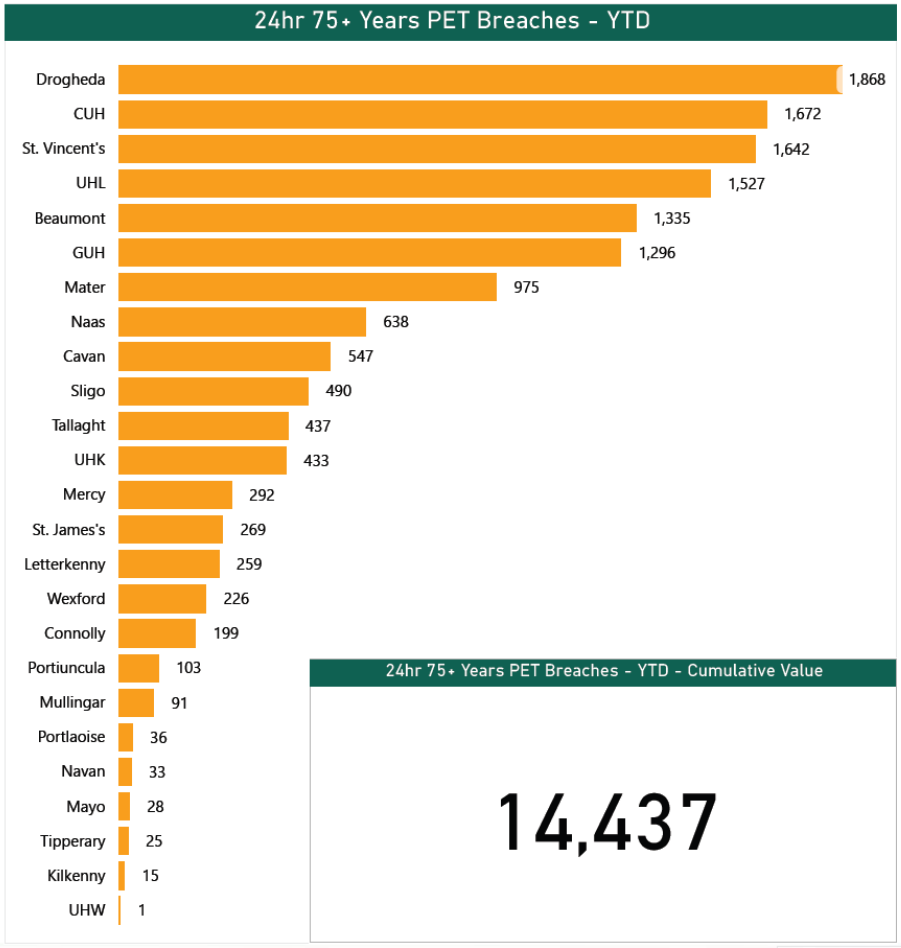
If we design services for people with only one thing wrong at once but people with many things wrong turn up, the fault is not with the users but with the service, yet all too often these patients are labelled as inappropriate and presented as a problem…

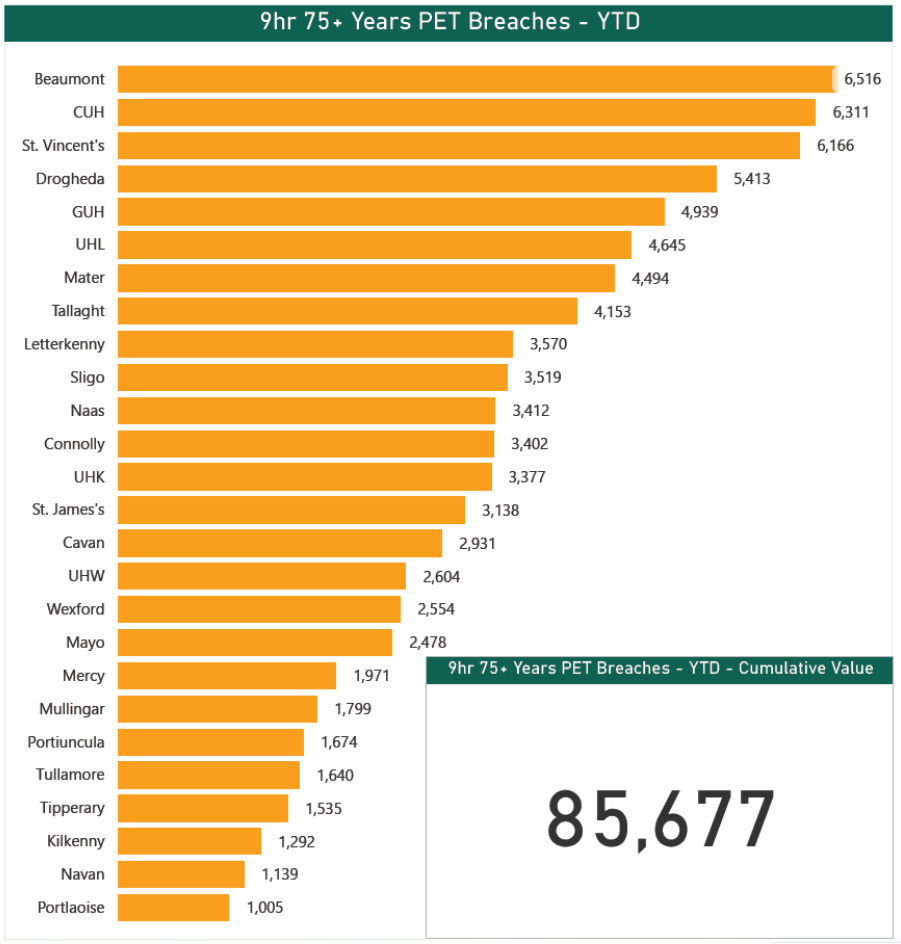
Prof Ken Rockwood

Focus on the Older Person

The Need for Change: Acute Hospital Demand

As we age our need for health and social care services increases and our health services need to change to be 'Age Ready'





- ED Attendances 75+ Years Old have increased by 11.4% V 2023 (YTD 2024).
- ED Admissions 75+ Years Old have increased by 10.4% V 2023 (YTD 2024).

The Impact of Delays: Evidence-Based Findings

Research

JAMA Internal Medicine | Original Investigation

Overnight Stay in the Emergency Department and Mortality in Older Patients

Melanie Roussel, MD; Dorian Teissandier, MD; Youri Yordanov, MD, PhD; Frederic Balen, MD; Marc Noizet, MD; Karim Tazarourte, MD, PhD; Ben Bloom, MD, PhD; Pierre Catoire, MD; Laurence Berard, MD; Marine Cachanado, MSc; Tabassome Simon, MD, PhD; Said Laribi, MD, PhD; Yonathan Freund, MD, PhD; for the FHU IMPEC–IRU SFMU Collaborators

IMPORTANCE Patients in the en
admission on a wheeled cot ma
among older patients who sper
are unknown.

OBJECTIVE To assess whether c
to a hospital ward are at increas

DESIGN, SETTINGS, AND PARTICI
(≥75 years) who visited the ED
2022, at 97 EDs across France.
the ED from midnight until 8:0
before midnight (ward group).

MAIN OUTCOMES AND MEASURI
at 30 days. Secondary outcome
bleeding, myocardial infarction
length of stay. A generalized lin
between groups.

RESULTS The total sample comp
880 [55%] female and 718 [45
the ward group. Patients who s
of 15.7% vs 11.1% (adjusted risk
of adverse events compared wi
median length of stay (9 vs 8 d
subgroup analysis of patients w
spending the night in the ED wa
(aRR, 1.81; 95% CI, 1.25-2.61).

OPEN ACCESS

Association between delays to patient admission from the emergency department and all-cause 30-day mortality

Simon Jones [1,2], Chris Moulton [3,4], Simon Swift [2,5], Paul Molyneux [2], Steve Black [6], Neil Mason [2], Richard Oakley [2], Clifford Mann [3,7]

Handling editor Simon Carley

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Clifford Mann deceased

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Linked

► http://dx.doi.org/10.1136/emermed-2021-212106

Check for updates

To cite: Jones S, Moulton C, Swift S, *et al*. *Emerg Med J* 2022;**39**:168–173.

ABSTRACT

Background Delays to timely admission from emergency departments (EDs) are known to harm patients.

Objective To assess and quantify the increased risk of death resulting from delays to inpatient admission from EDs, using Hospital Episode Statistics and Office of National Statistics data in England.

Methods A cross-sectional, retrospective observational study was carried out of patients admitted from every type 1 (major) ED in England between April 2016 and March 2018. The primary outcome was death from all causes within 30 days of admission. Observed mortality was compared with expected mortality, as calculated using a logistic regression model to adjust for sex, age, deprivation, comorbidities, hour of day, month, previous ED attendances/emergency admissions and crowding in the department at the time of the attendance.

Results Between April 2016 and March 2018, 26 738 514 people attended an ED, with 7 472 480 patients admitted relating to 5 249 891 individual patients, who constituted the study's dataset. A total of 433 962 deaths occurred within 30 days. The overall crude 30-day mortality rate was 8.71% (95% CI 8.69% to 8.74%). A statistically significant linear increase in mortality was found from 5 hours after time of arrival at the ED up to 12 hours (when accurate data collection ceased) ($p<0.001$). The greatest change in the 30-day standardised mortality ratio was an 8% increase, occurring in the patient cohort that waited in the ED for more than 6 to 8 hours from the time of arrival.

Conclusions Delays to hospital inpatient admission for patients in excess of 5 hours from time of arrival at the ED are associated with an increase in all-cause 30-day mortality. Between 5 and 12 hours, delays cause a predictable dose–response effect. For every 82 admitted patients whose time to inpatient bed transfer is delayed beyond 6 to 8 hours from time of arrival at the ED, there is one extra death.

Key messages

What is already known on this subject
→ Small studies from Canada and Australia have indicated that there is an increased mortality rate among patients who experience delays in admission to an inpatient bed from the emergency department (ED).
→ Counterfactual modelling has shown reduced patient mortality as a result of the NHS 4-hour operational standard. The NHS Benchmarking Network found a coefficient of determination (R^2 value) of 0.07 between time greater than 4 hours in the ED and a hospital's Summary Hospital-level Mortality Indicator.

What this study adds
→ This study of over five million NHS patients shows an increase in all-cause 30-day mortality that is independently associated with delays to hospital admission from the ED rather than with crowding alone.
→ The standardised mortality rate starts to rise from 5 hours after the patient's time of arrival at the ED.
→ The increasing effect of long stays in the ED before inpatient admission can be measured and represented as a number needed to harm metric: after 6–8 hours, there is one extra death for every 82 patients delayed.

INTRODUCTION

In England, by the end of the 20th century, demographic changes and reduced numbers of acute hospital beds had resulted in crowded emergency departments (EDs) and long delays for patients. In consequence, the NHS 4-hour operational standard was introduced in 2004 and shortly thereafter, the other nations of the UK and several other countries, such as Canada and Australia, introduced similar standards for ED waiting times.[1–5] (The 4-hour standard is a binary time threshold for discharge, admission or transfer; it starts when the patient arrives at the ED, and time in the ED beyond 4 hours is a 'breach' of the 'target'.)

For more than a decade, the 4-hour standard served both patients and the NHS well but, during the past few years, further increases in the demand for urgent and emergency care have exacerbated long waits for hospital admission.[6] By 2019–2020, over 3.2% of all ED patients waited in the ED for more than 12 hours from their time of arrival.[7] Long ED delays are most often caused by 'exit block' due to a lack of available inpatient beds. This was demonstrated using data collected from all English EDs over a 90-day period by an NHS economics team. They showed that higher inpatient bed occupancy was correlated with longer ED waiting times, but with a non-linear association.[8]

- Delays in patient flow are associated with increased mortality
- For every 82 admitted patients whose transfer to an inpatient bed is delayed beyond 6-8 hours, there is 1 additional death
- Patients who spent the night in the ED had a higher in-hospital mortality rate of 15.7% vs 11.1%
- Patients who spent the night in the ED had a higher median length of stay of 9 versus 8 days

The Need for Change: Here Is What You Told Us (National Inpatient Experience Survey 2022)

Although older adults value, trust and believe in the healthcare system and its services, there are many poor experiences older adults continue to face:

Emergency Department

72% of patients were given enough privacy when being examined or treated in the ED

57% of patients got answers they could understand from doctors and nurses in the ED

30% of patients waited over 12 hours for admission to a ward

"Very frightening place"

"I was left on my own from 9am to 9pm not knowing whether I was going to be discharged or not"

Stay on the wards

30% of patients could find someone to talk about their worries and fears

47% of patients got help from staff in time to get to the bathroom or toilet

62% of patients had enough time to discuss their care or treatment with a doctor

"Noise levels were very bad and the food was awful"

"More privacy is needed. I did not like sharing a ward with men"

Discharge

60% of patients felt they were involved in decisions about their discharge

37% of patients got information about medication side effects going home

36% of families got all the information needed to help care for patients at home

"I was waiting all day to be told if I was going home"

"Sent me to respite and had to re-admit me a day later"

https://www.hse.ie/eng/about/who/acute-hospitals-division/national-patient-experience-survey/

The Need for Change: Older Adults (Inpatients) with Frailty – Prevalence in Model 4 Acute Hospitals

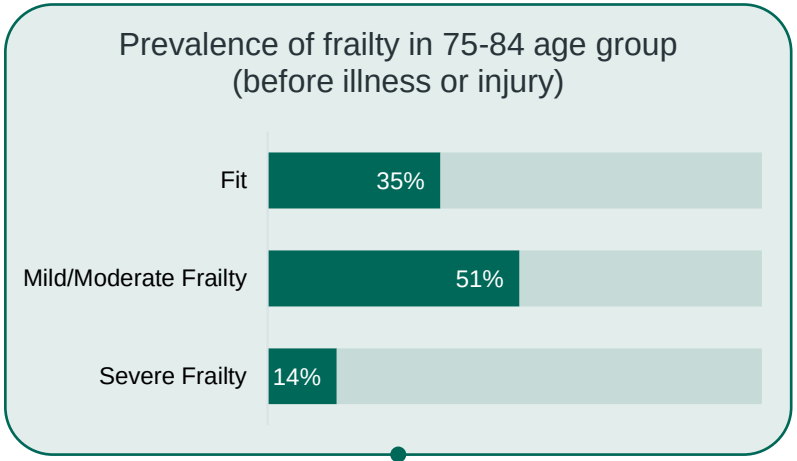
Frailty is common in older patients on admission to acute hospitals and remains predictive of mortality, LOS and discharge home with more severe frailty associated with greater risk

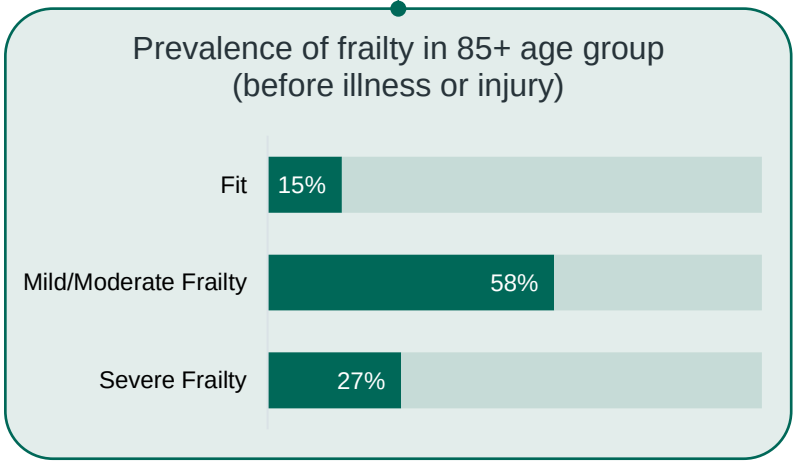
- After admission, 30% of older adults get sicker rather than better in hospital (HAD, Hospital Acquired Disability)
- Most of the patients **waiting** in our Acute Hospitals for discharge are older adults (DTOC)
- Acute Hospitals are a source of 40% of all NHSS applications who, on average, wait a month in hospital

Older Adult Intensive Care Management (OAICM) is needed

- Proactive identification, assessment, optimisation & care planning (Comprehensive Geriatric Assessment)
- Single point of contact for service and care co-ordination
- Integrated early supported discharge

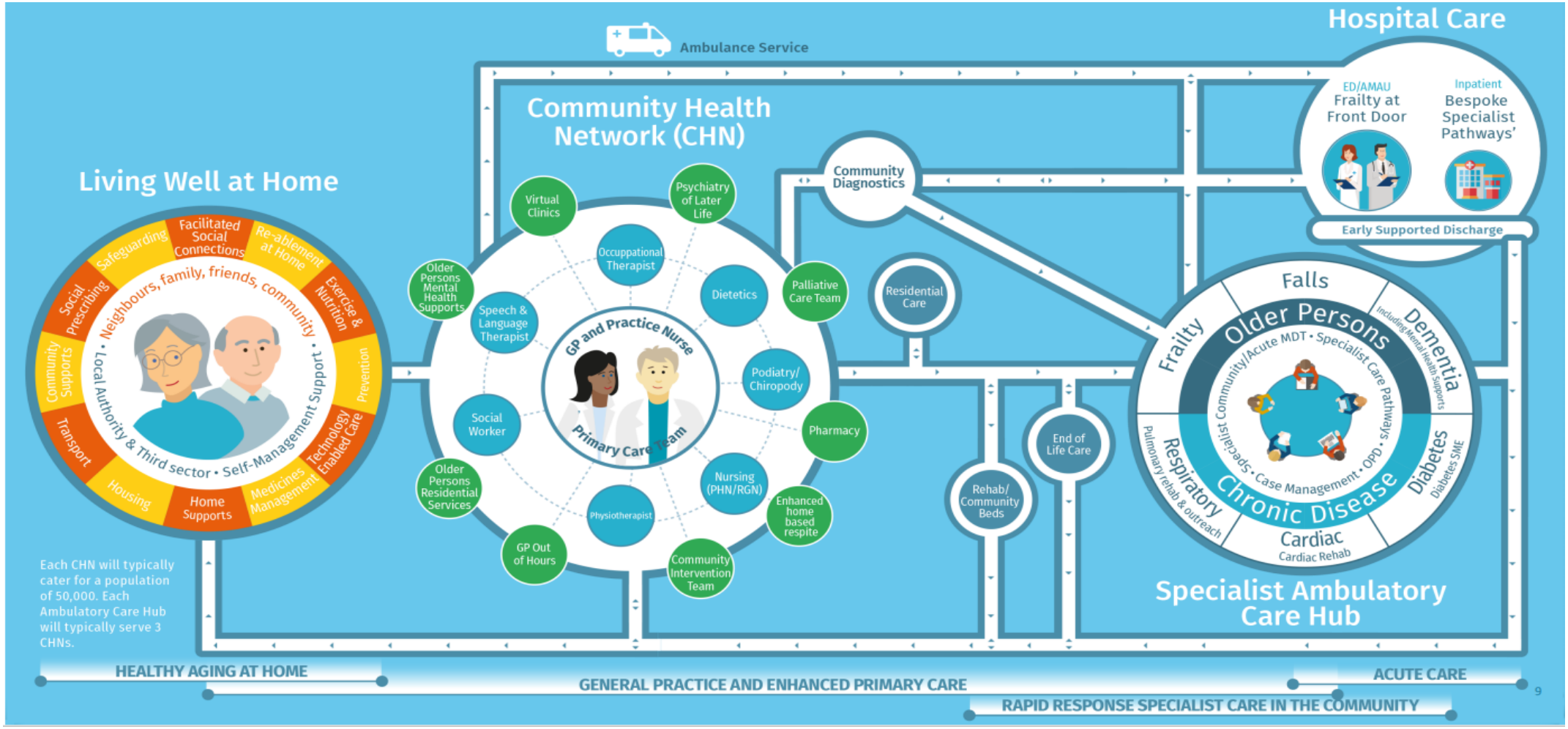
4M's Framework – designing an Irish Age-Friendly Health System





Sláintecare & ECC Older Adults Integrated Health & Social Care Delivery System

What Matters | Medication | Mobility | Mentation



Critical Success Factors

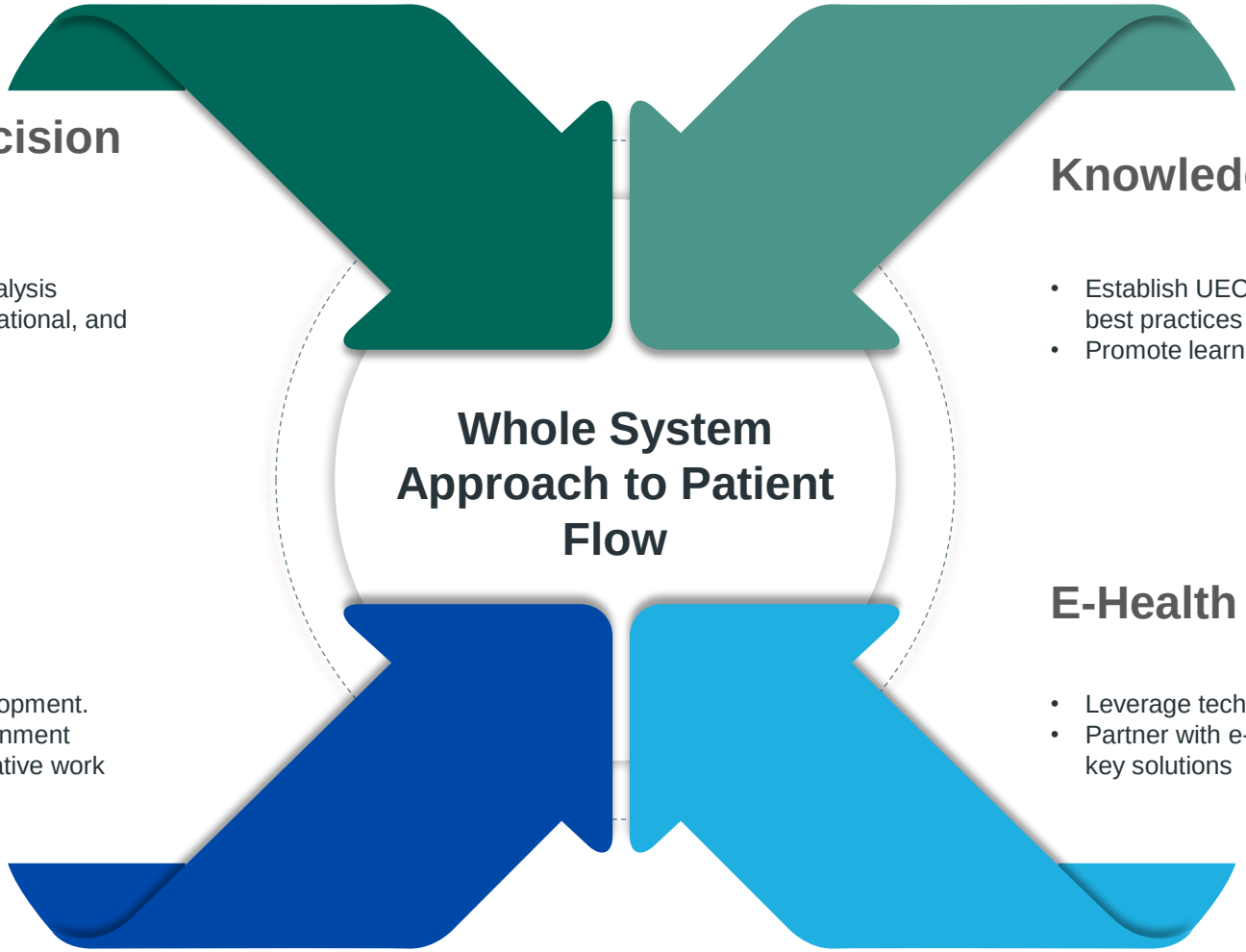
Critical Enablers for Success

Data-Informed Decision Making

- Optimise data collection and analysis
- Use data to inform clinical, operational, and strategic decisions

Knowledge Networks

- Establish UEC knowledge networks to share best practices
- Promote learning and innovation



Empowered Staff

- Invest in staff training and development.
- Create a supportive work environment
- Implement flexible and collaborative work arrangements

E-Health Solutions

- Leverage technology to improve patient flow
- Partner with e-health providers to implement key solutions

Progress to Date

The National Virtual Ward (VW) Programme was launched in two partner hospitals, with an increasing BDU usage over the trial period

The VW Programme has been in operation since the 1st of July 2024, with progress as follows:

Two virtual wards have been set up in our partner hospitals:

ST. VINCENT'S UNIVERSITY HOSPITAL
Elm Park

Ospidéil OL
UL Hospitals

For which the following KPIs were recorded between Jul - Oct

2,029

Virtual BDU

6.1 days

Av. Length of Stay

325

Patients seen

8

Clinical pathways (across cardiology & respiratory)

Data as of 03/11/2024

A Call to Action

A Call to Action: Partnering for Improvement

" You can't be a great change agent on your own. If you want to challenge the status quo – find your crew. Together you can make change happen"

Helen Bevan, NHS

Mile Buiochas