



Unscheduled Emergency Care Programme – Opportunities for Integration

*Dr. Michael O' Connor, National Clinical Advisor and Group
Lead, Acute Operations*

29th November 2023



Overview



Healthcare demand



The problems and Harm



Reform



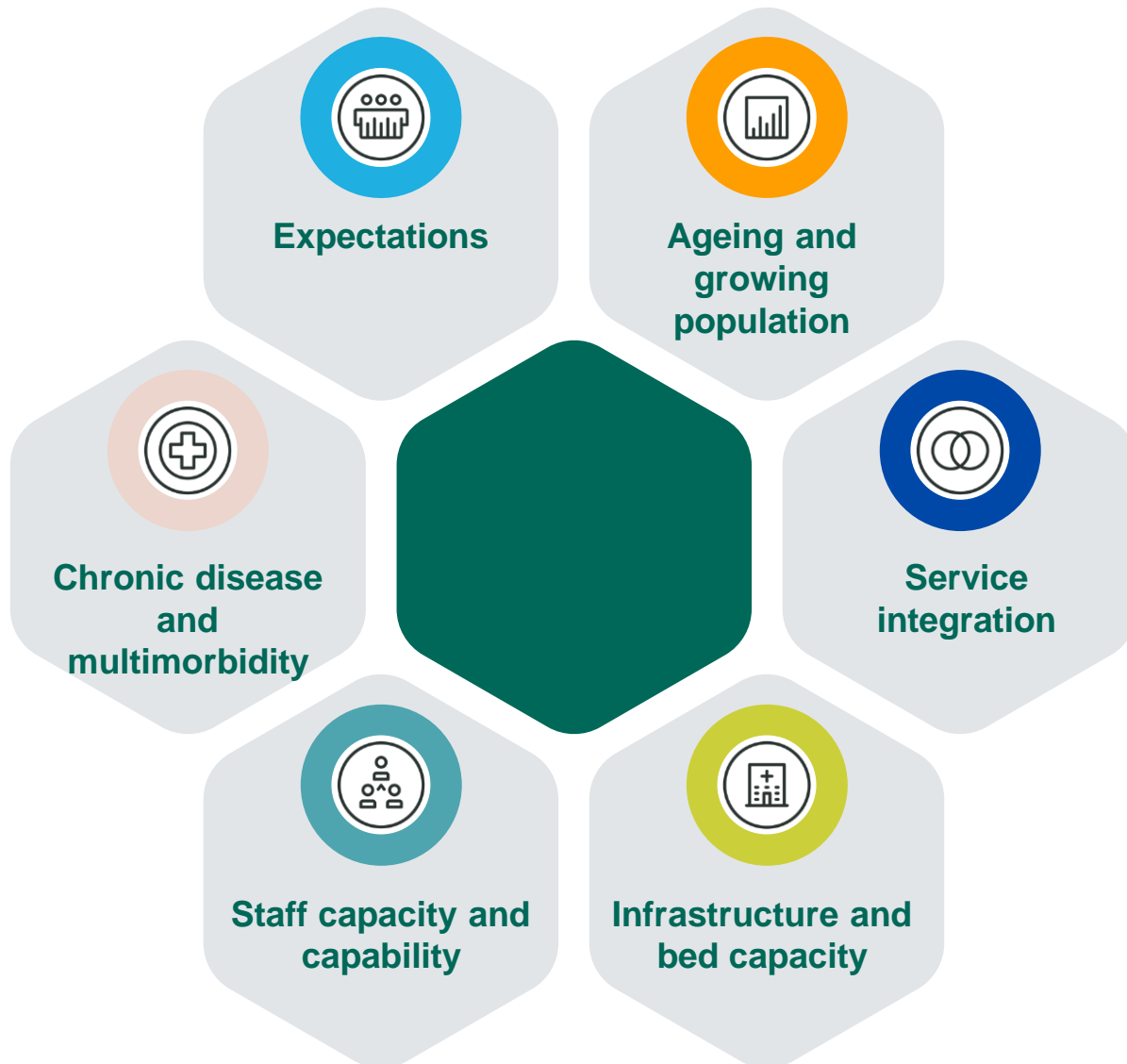
One Patient group Focus



Who owns these challenges?



Healthcare demand and delivery in Ireland

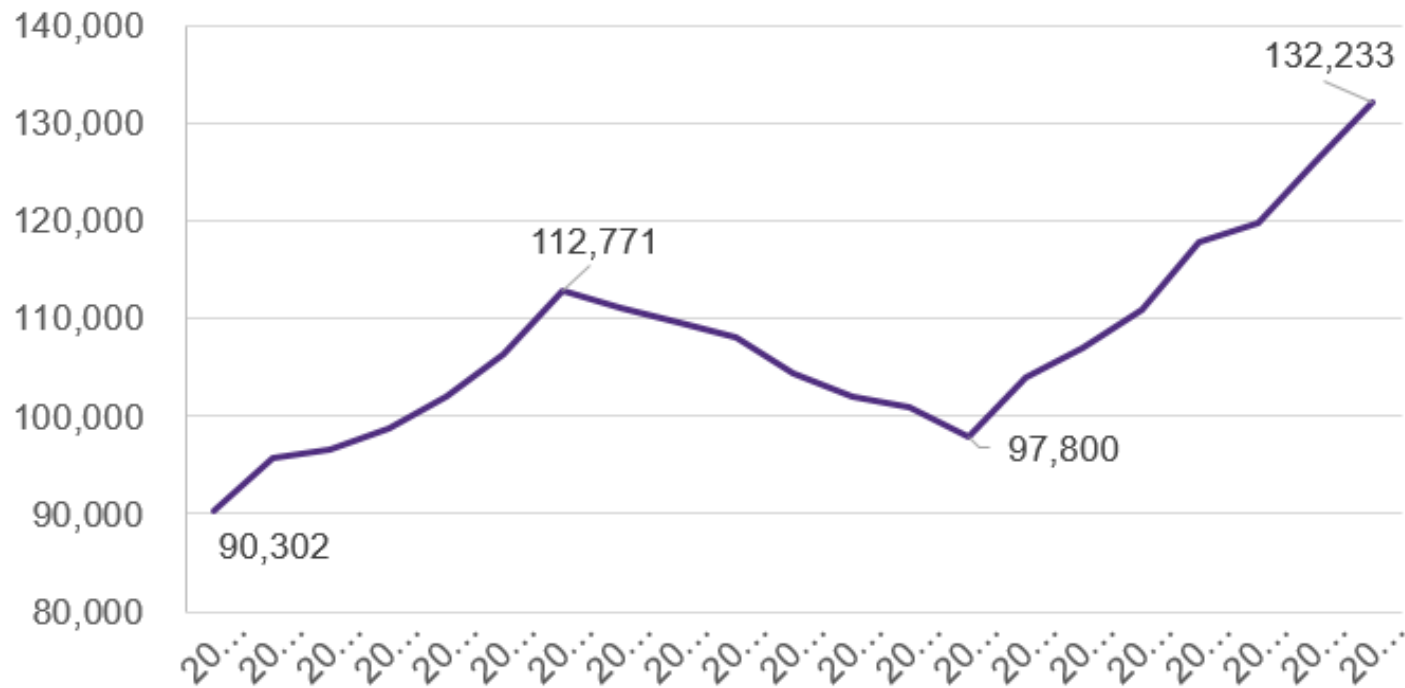


Reform programmes and plans guided by the Sláintecare vision:

- Regional Health Areas
- National Urgent and Emergency Care Plan
- Enhanced Community Care
- Waiting List Action Plan
- Modernised Care Pathways
- Trauma Programme
- Workforce Plan



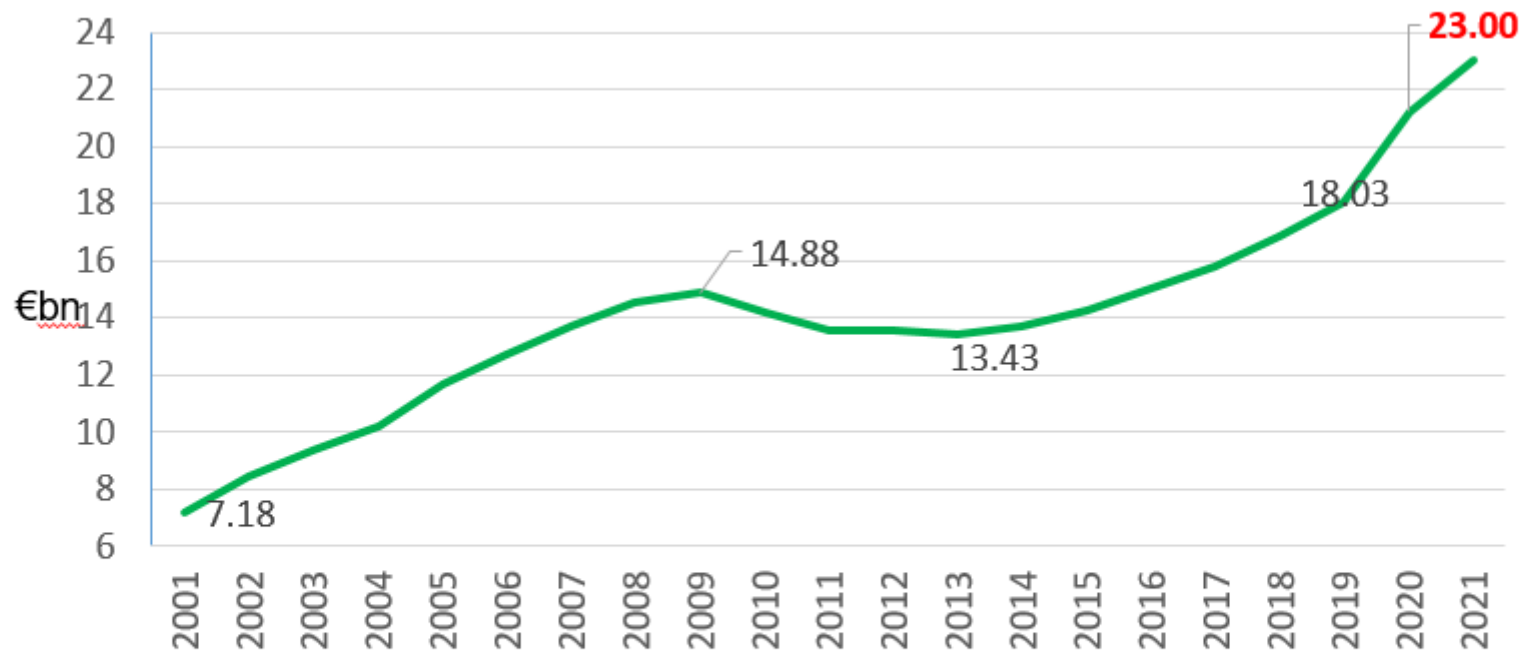
HSE Staff Numbers



Source: Department of Health. Health In Ireland: Key Trends 2022. Available at <https://www.gov.ie/en/publication/fdc2a-health-in-ireland-key-trends-2022/> Accessed 10.1.23



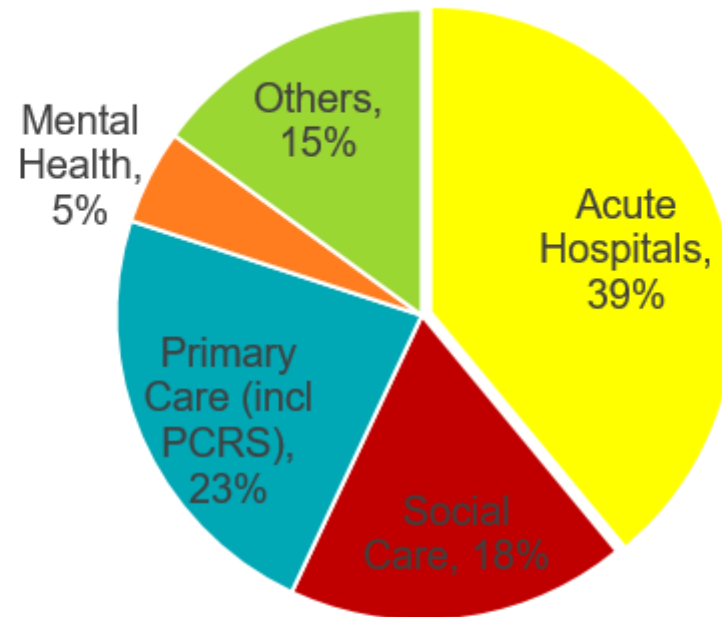
HSE Spending



Source: Department of Health. Health In Ireland: Key Trends 2022. Available at <https://www.gov.ie/en/publication/fdc2a-health-in-ireland-key-trends-2022/> Accessed 7.1323



HSE Spending....where?



Source: Department of Health. Health In Ireland: Key Trends 2022. Available at <https://www.gov.ie/en/publication/fdc2a-health-in-ireland-key-trends-2022/> Accessed 10.1.23



Healthcare demand and delivery in Ireland

Urgent and Emergency Care Demand Compared to 2022:

29 million

GP Consultations

1 million

Out of Hours GP

140,000

Local Injury Units

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



Healthcare demand and delivery in Ireland

Urgent and Emergency Care Demand

Compared to 2022:

+0.3% | ED attendances

+4.9% | ED attendances patients ≥75 years

+3.8% | ED admissions

+4.2% | ED admissions patients ≥75 years

Compared to 2019:

+7.7% | ED attendances

+21.7% | ED attendances patients ≥75 years

+7.9% | ED admissions

+16.4% | ED admissions patients ≥75 years



Problem Statements



Delay in Response Time to 999



Delay in Ambulance Handover



Delay in Triage



Delay in time to be seen by Manchester Triage Category



Delay in Patient Experience after being seen



Delay in Admission to Bed



Lost Beds due to Non Valued Added Care



Delays in accessing Community Services



Communication Inadequacies





TROLLEY CRISIS

October trolley watch stats show 'almost' double numbers this year than same period in 2020

INMO figures show that there are five times as many children on trolleys compared to October 2020.

↗ 17.2k 💬 26 Oct 31st 2021, 4:34 PM



CRISIS

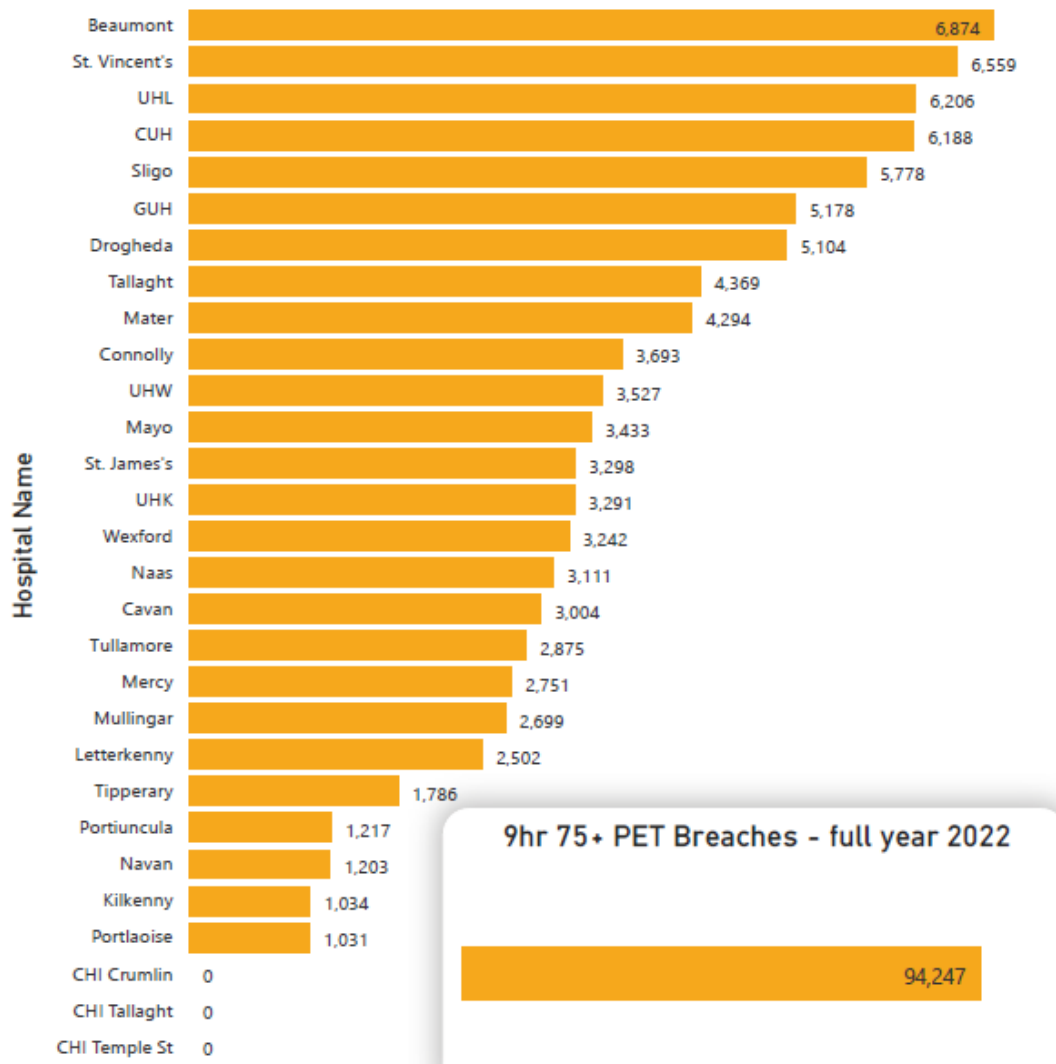
Waiting list figures on the rise as more than 550,000 patients waiting for an appointment

The IHCA criticised the latest figures and said the Government had failed to meet its own 2019 targets.



Harm and poor experience

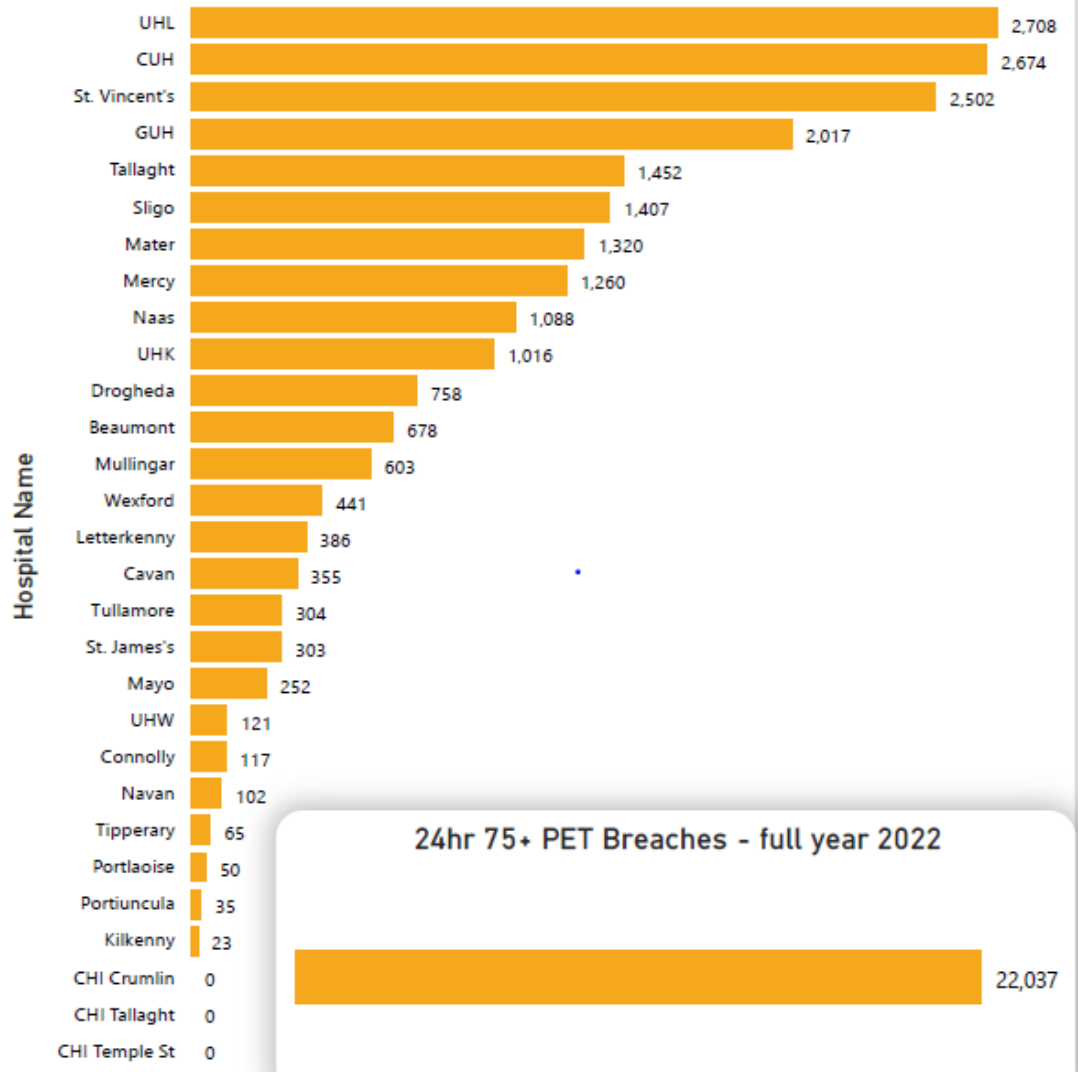
9hr 75+ PET Breaches - full year 2022



9hr 75+ PET Breaches - full year 2022



24hr 75+ PET Breaches - full year 2022



24hr 75+ PET Breaches - full year 2022





Effect of hours awaiting admission on and ED Trolley on SMR

- Cross-sectional, retrospective observational study
- Every ED in England April 2016 to March 2018. The primary outcome was death from all causes within 30 days of admission
- 7,472,480 patients admitted relating to 5,249,891 patients
- Statistically significant linear increase in mortality from 5 hours after time of arrival at the ED up to 12 hours (when accurate data collection ceased) ($p < 0.001$)
- 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



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

¹Department of Population Health, New York University School of Medicine, New York, New York, USA
²Methods Analytics, London, UK
³The "Getting It Right First Time" programme, NHS Improvement, London, UK
⁴Emergency Department, Royal Bolton Hospital, Bolton, UK
⁵Index Unit, University of Exeter Business School, Exeter, UK
⁶Black Box Data Science Ltd, Biggleswade, UK
⁷Emergency Department, Musgrave Park Hospital, Taunton, UK

Correspondence to Dr Chris Moulton, Emergency Department, Royal Bolton Hospital, Bolton, UK; Chris.Moulton@boltontr.nhs.uk

Clifford Mann deceased

Received 30 April 2021
 Accepted 15 November 2021
 Published Online First 18 January 2022



<http://dx.doi.org/10.1136/emered-2021-212106>



© Author(s) (or their employer(s)) 2022. Re-use permitted under CC BY-NC. No commercial re-use. See rights and permissions. Published by BMJ.

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.

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.^{1–4} (The 4-hour

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.

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'.⁵

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

168



Jones S, et al. *Emerg Med J* 2022;**39**:168–173. doi:10.1136/emered-2021-212106

BMJ



November 6, 2023


Overnight Stay in the Emergency Department and Mortality in Older Patients

Melanie Roussel, MD¹; Dorian Teissandier, MD²; Youri Yordanov, MD, PhD^{3,4}; [et al](#)

» [Author Affiliations](#)

JAMA Intern Med. Published online November 6, 2023. doi:10.1001/jamainternmed.2023.5961

 [Editorial Comment](#)

 [Interviews](#)

Key Points

Question Is spending a night in the emergency department (ED) associated with increased in-hospital mortality and morbidity among older patients?

Findings This French cohort study of 1598 patients 75 years and older, those who spent a night in the ED showed a higher in-hospital mortality rate and increased risk of adverse events compared with patients admitted to a ward before midnight. This finding was particularly notable among patients with limited autonomy.

Meaning These findings suggest that older patients, particularly those with limited autonomy, who spend the night in the ED awaiting hospital admission may have a higher risk of in-hospital mortality and morbidity; they

Findings from the National In-patient Experience Survey 2022

Although older adults value, trust and believe in the healthcare system, their experience is poor



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



"The A&E was like a battlefield"



"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"



"Being moved was disturbing & hard to cope with"



"There was no curtain around my bed"



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 felt overwhelmed"



"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"



The reform journey

Where we are



Standardising of care through clinical leadership



Sláintecare as a template for future care



Patient expectations and empowerment



Pandemic response and aftermath

Clinical Reform



National healthcare strategies and programmes



Community programmes development



Precision medicine



Public Health Reform



Moulding and leading a workforce; supporting reform

Path Ahead



Regionalisation



Increased digital enablement



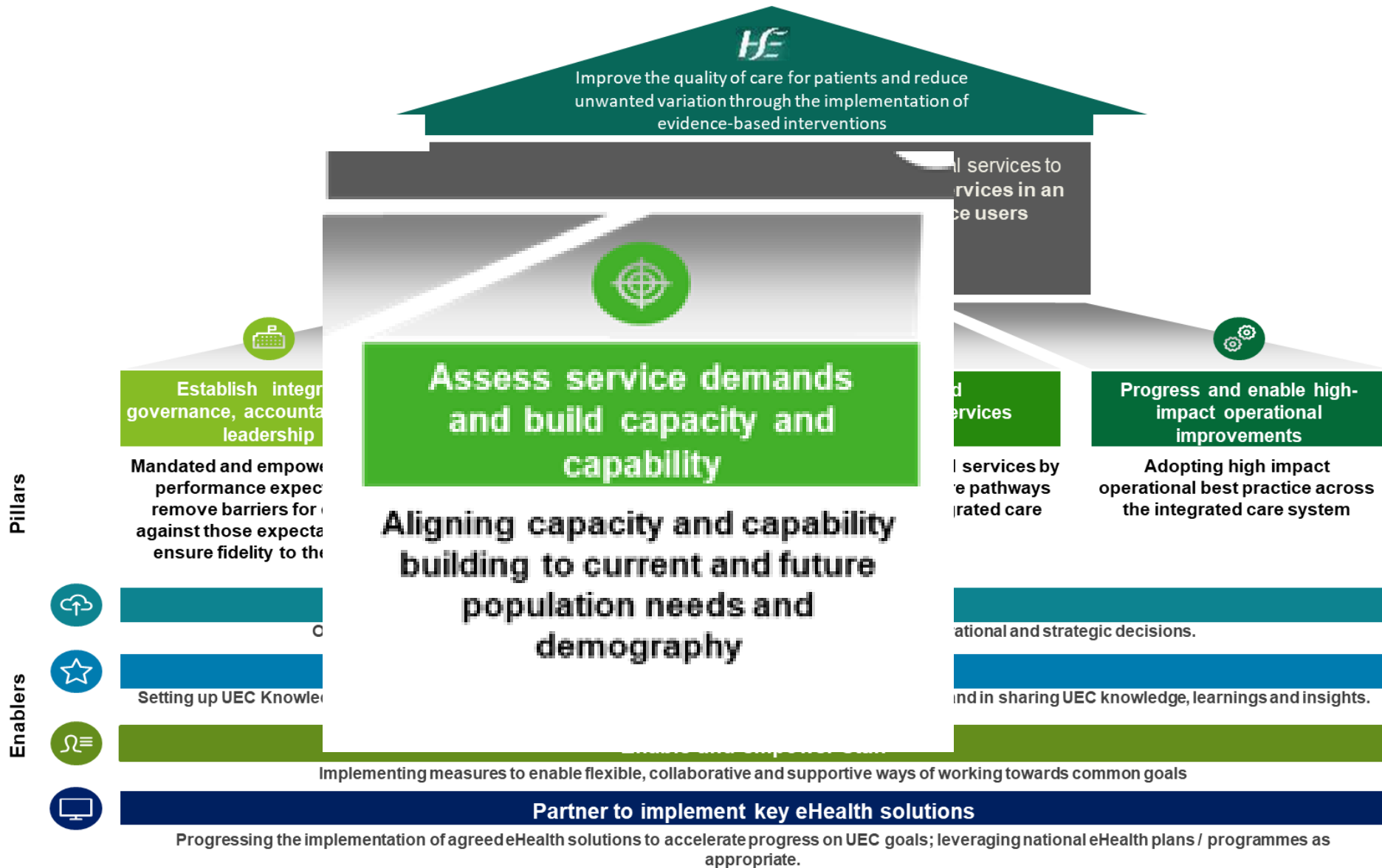
Patient involvement and participation



Defining correct capacity for healthcare needs



3 Year Framework UEC



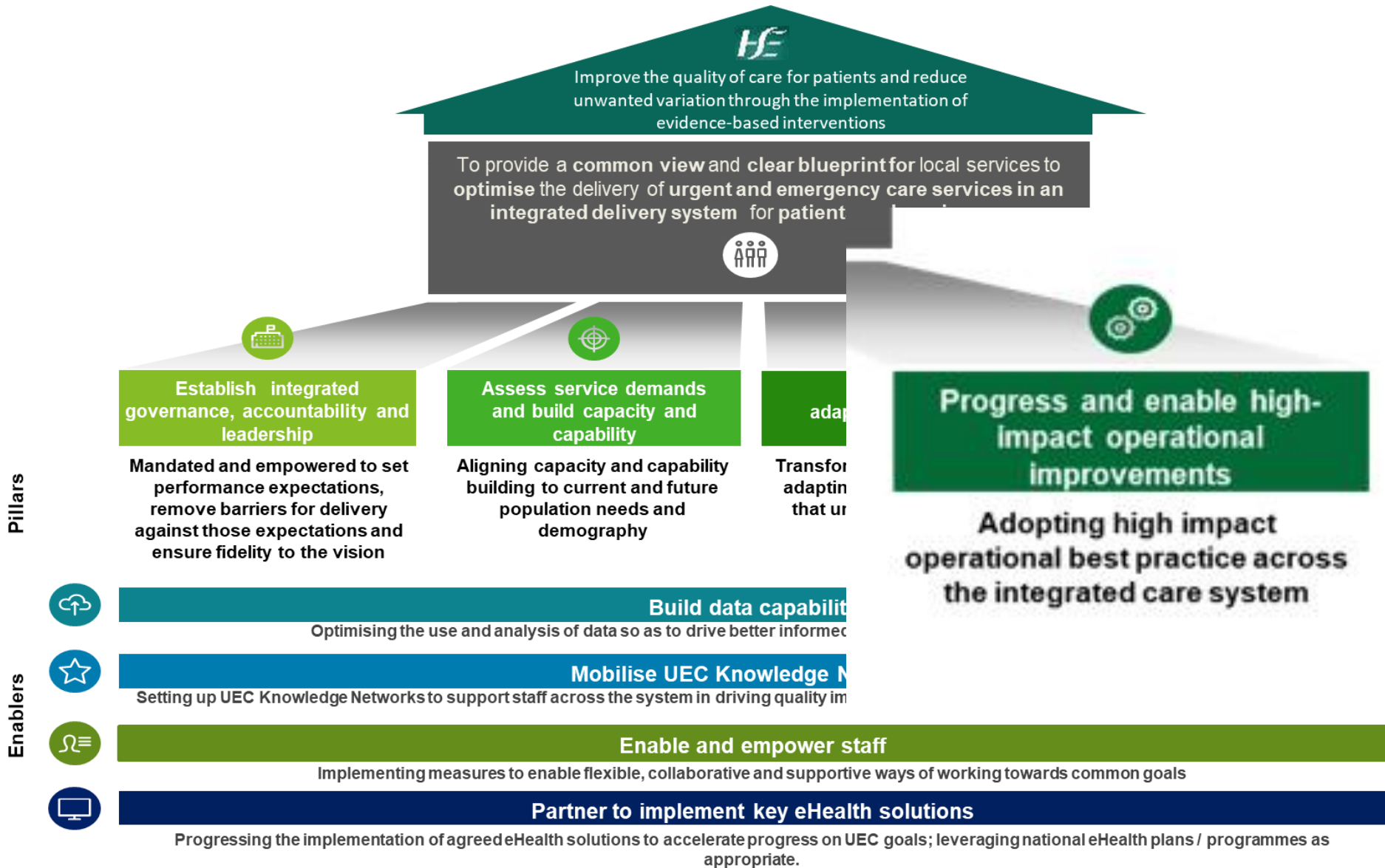
UEC Integrated Capacity Plan

Proposal for additional acute inpatient beds and community-based beds

24 July 2023



3 Year Framework UEC





In Year Plan

Hospital Avoidance

Emergency Department (ED) Operations

In Hospital Operations

Discharge Operations

Abstract citation ID: afad156.274

15 HOSPITAL AT HOME—A POTENTIAL ALTERNATIVE OPTION TO ACUTE HOSPITAL ADMISSION FOR OLDER ADULTS

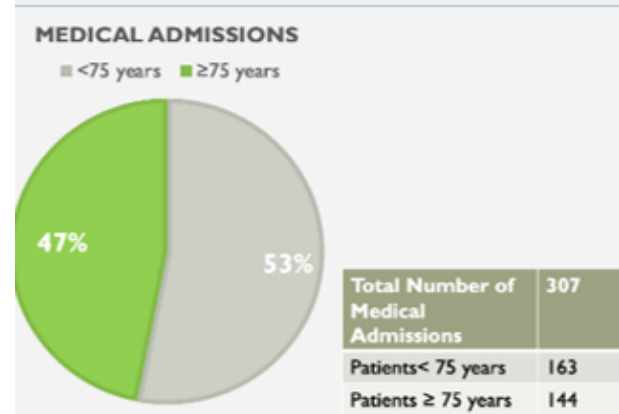
C. Conlon, R. Murphy, C. Small
University Hospital Galway, Galway, Ireland

Background: Novel ways to respond to the acute care needs of older adults are needed. Hospital at Home (H@H) could be a viable alternative to emergency hospitalisation. We developed inclusion and exclusion criteria for selected medical conditions that could theoretically be treated in a hospital at home setting if supported by a geriatric medicine multidisciplinary team with a consultant, Advanced Nurse Practitioner (ANP), Physiotherapist (PT) and Occupational Therapist (OT).

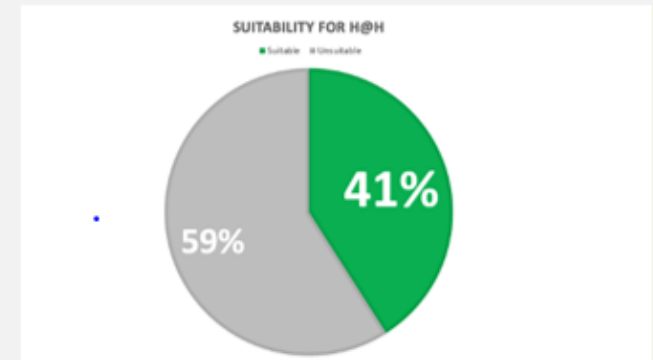
Methods: We completed a retrospective cohort study of unselected medical admissions over a two week period in a level four hospital. We developed illness specific criteria for stable patients that if met could allow a patient to be treated in a hospital at home environment. These conditions included community acquired pneumonia, congestive cardiac failure, COPD exacerbation and urinary tract infection.

Results: There were 307 medical admissions over the study period, with 144 over the age of 75 (47%). Mean age 83.2. 59 patients met our inclusion criteria for a potential H@H service (41%). All patients were clinically stable based on admission vital signs. The mean length of stay was shorter for patients eligible for H@H than patients who did not meet the criteria (9 days vs 14 days, $p = 0.01$), and patients meeting the H@H criteria were more likely to be discharged home directly. They were less likely to have needed occupational therapy (32% vs 52%, $p = 0.02$) or medical social worker input (22% vs 42%). There was no difference in frailty category or readmission rates by whether or not a patient met the H@H criteria.

Conclusion: Over 40% of unselected medical take patients were of a low acuity that could have theoretically met our inclusion criteria for a supported hospital at home model. Strategies are needed to support expansion of this model of care.



Pie-chart 1. Medical Admissions over two week period

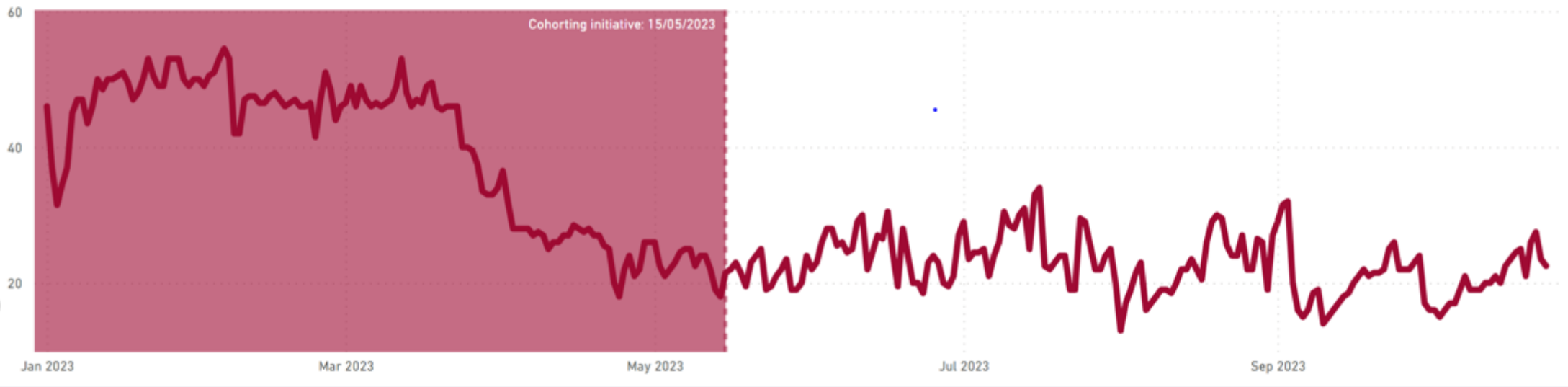


Pie-chart 2. Suitability for Hospital at Home



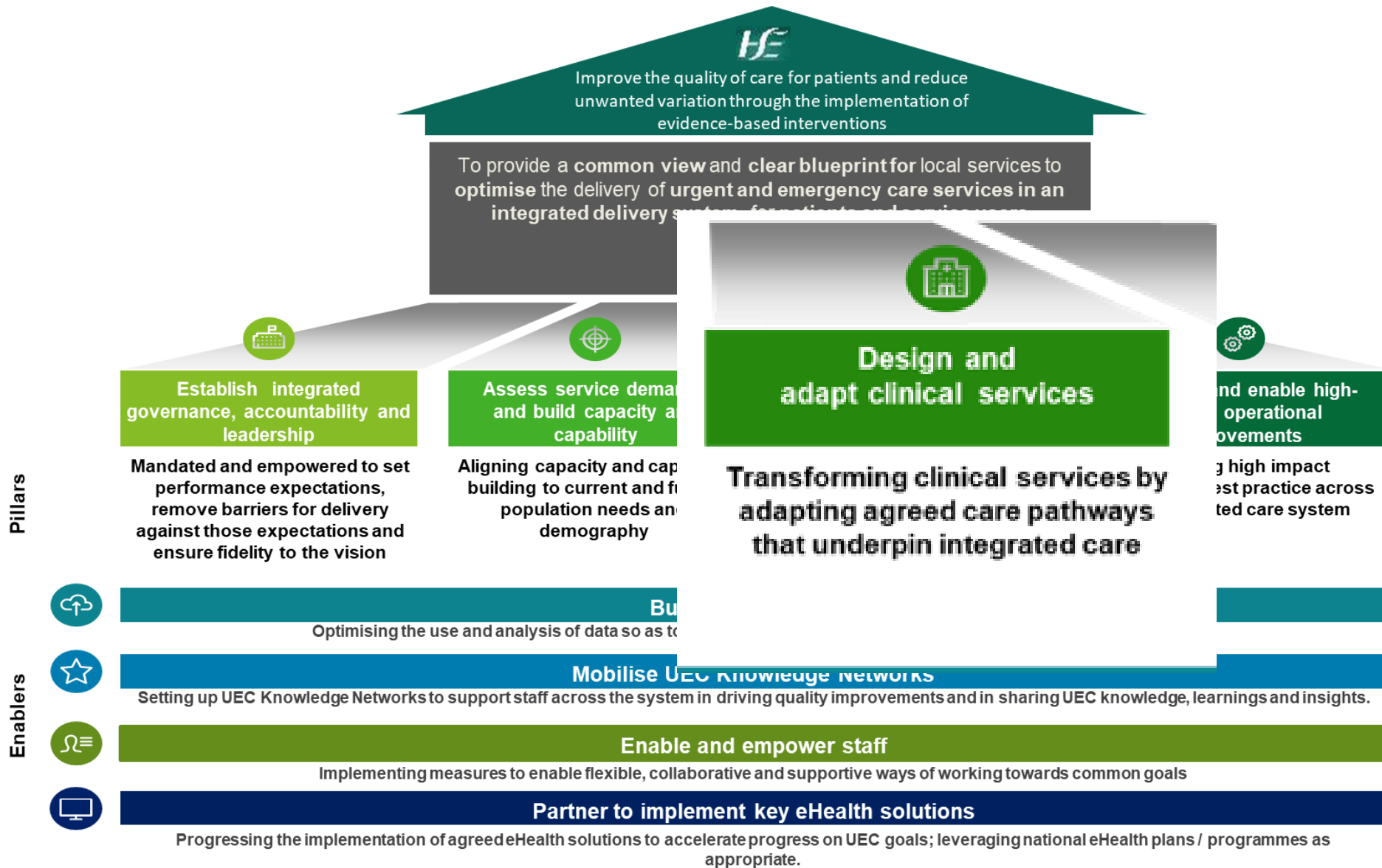
Re-design-return to the Old



Geriatric Medicine Median LOS



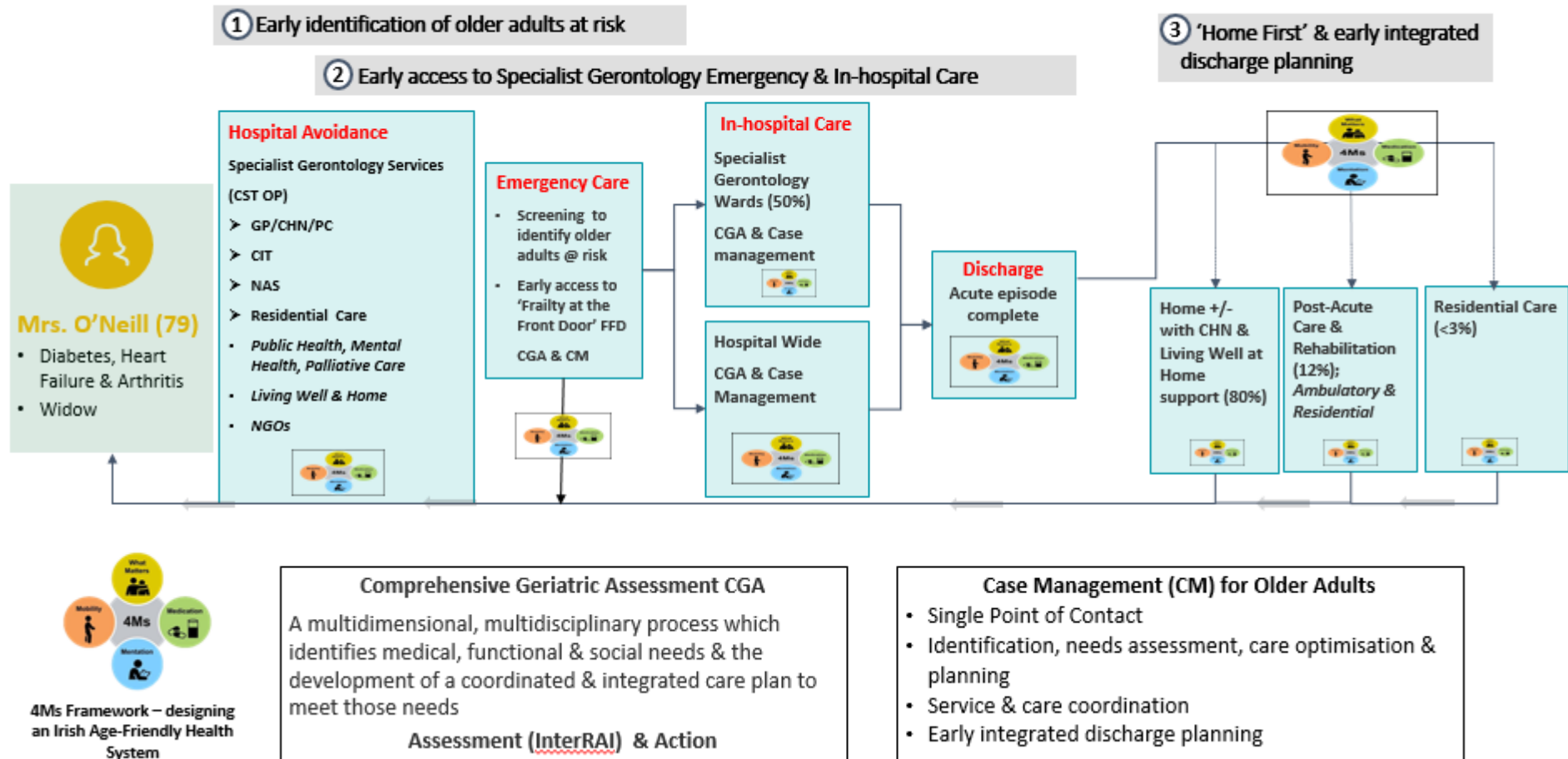


3 Year Framework UEC

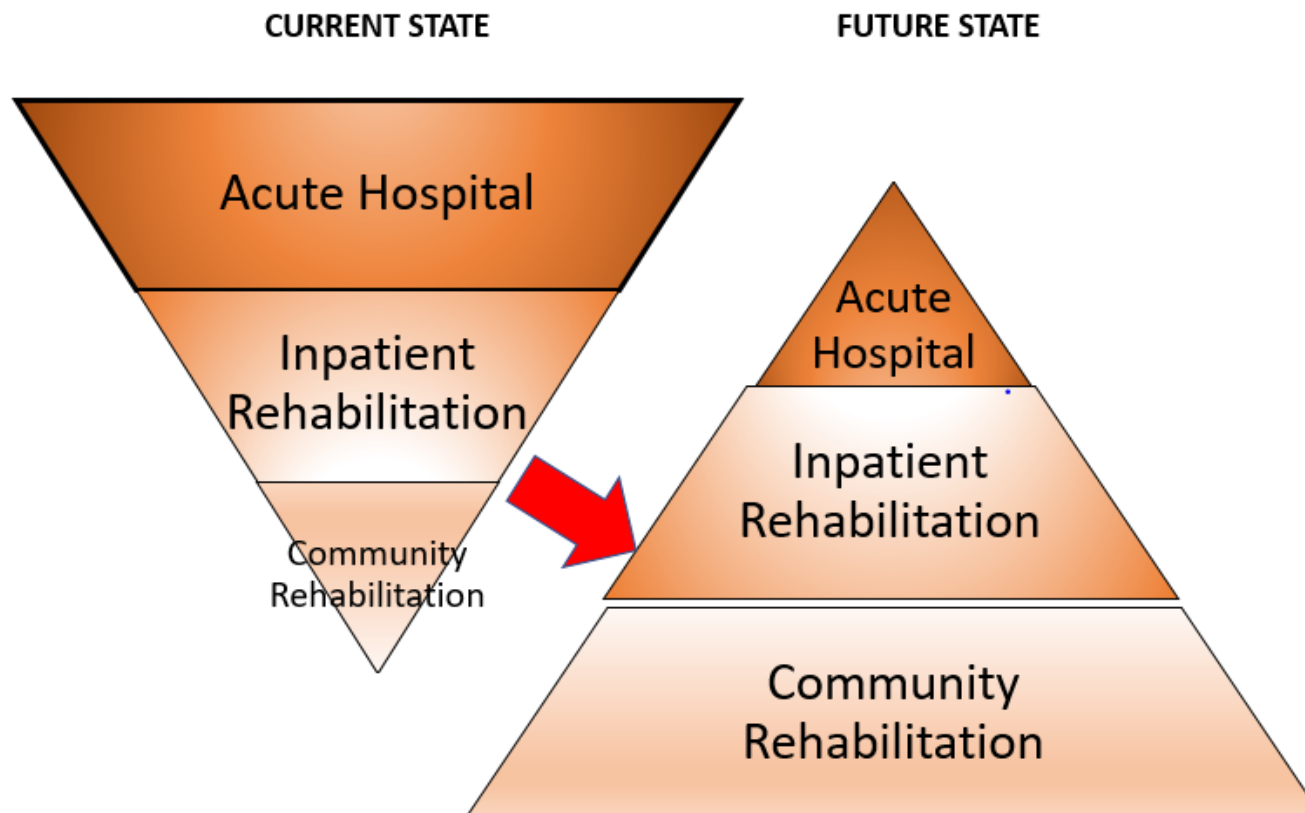


 <p>NATIONAL AMBULANCE SERVICE IRELAND</p>	<p>National Ambulance Service (NAS)</p>
 <p>ACUTE MEDICINE</p>	<p>National Acute Medicine Programme (NAMMP)</p>
 <p>EMERGENCY MEDICINE</p>	<p>National Emergency Medicine Programme (NEMP)</p>
 <p>NCPS</p>	<p>National Clinical Programme for Surgery (NCPS)</p>
	<p>National Office for Trauma Services (NOTS)</p>
 <p>NCPOP National Clinical Programme for Older People</p>	<p>National Clinical Programme for Older People (NCPOP)</p>

Urgent & Emergency Care for Older Adults



Shifting healthcare delivery to what matters most to patients



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



WICOP service

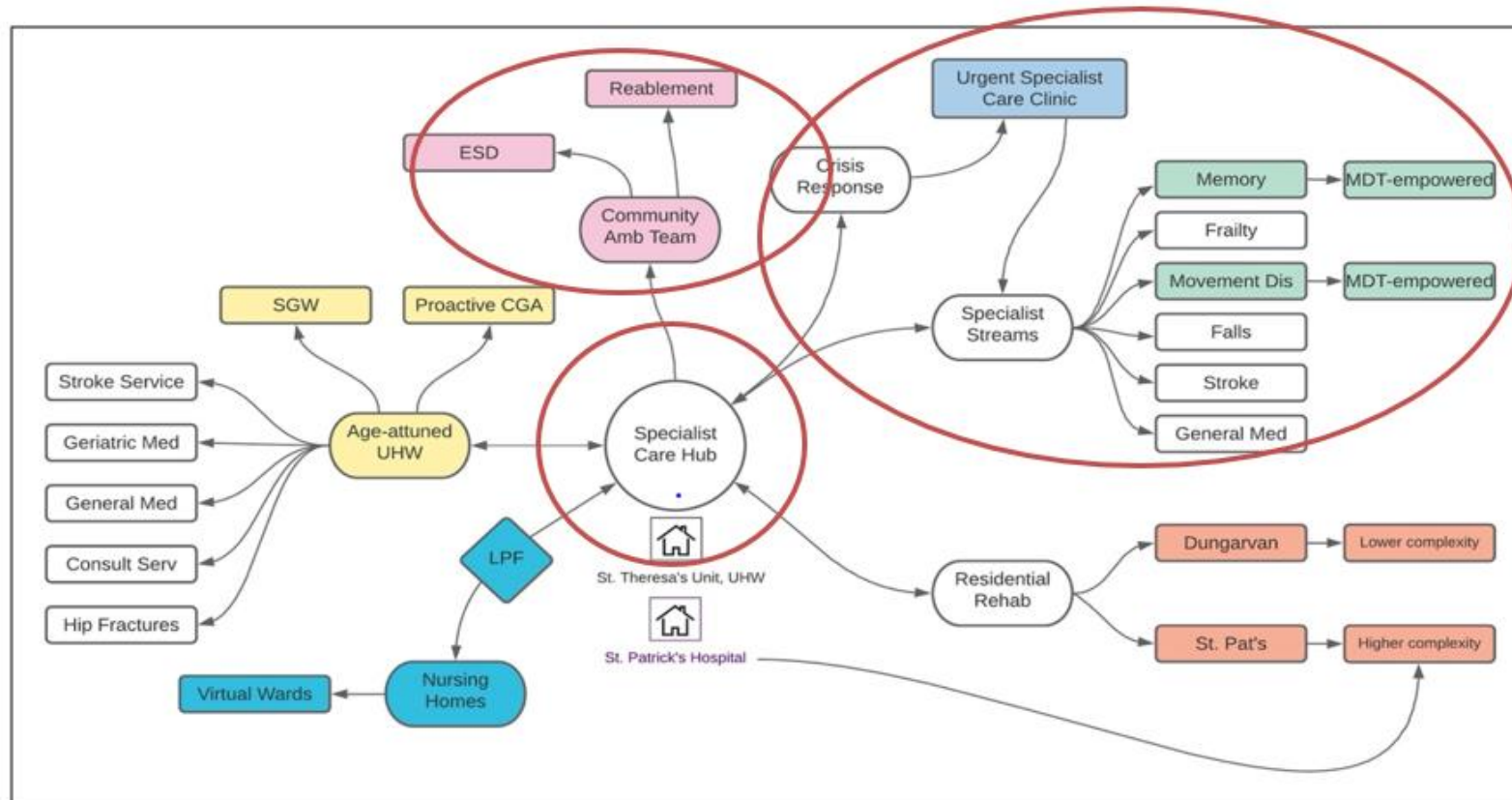


Figure 3. Map of six new Regional Health Areas

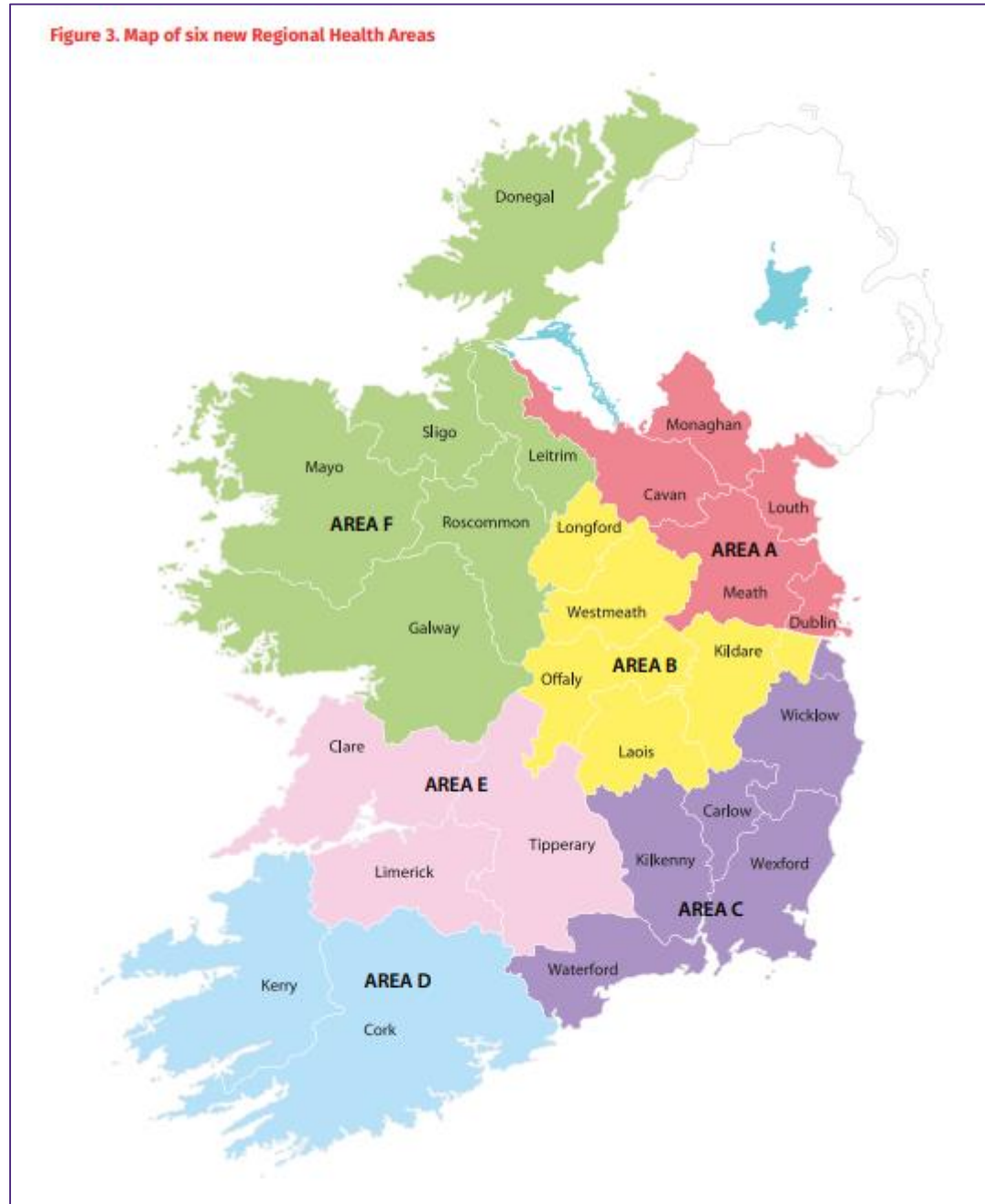


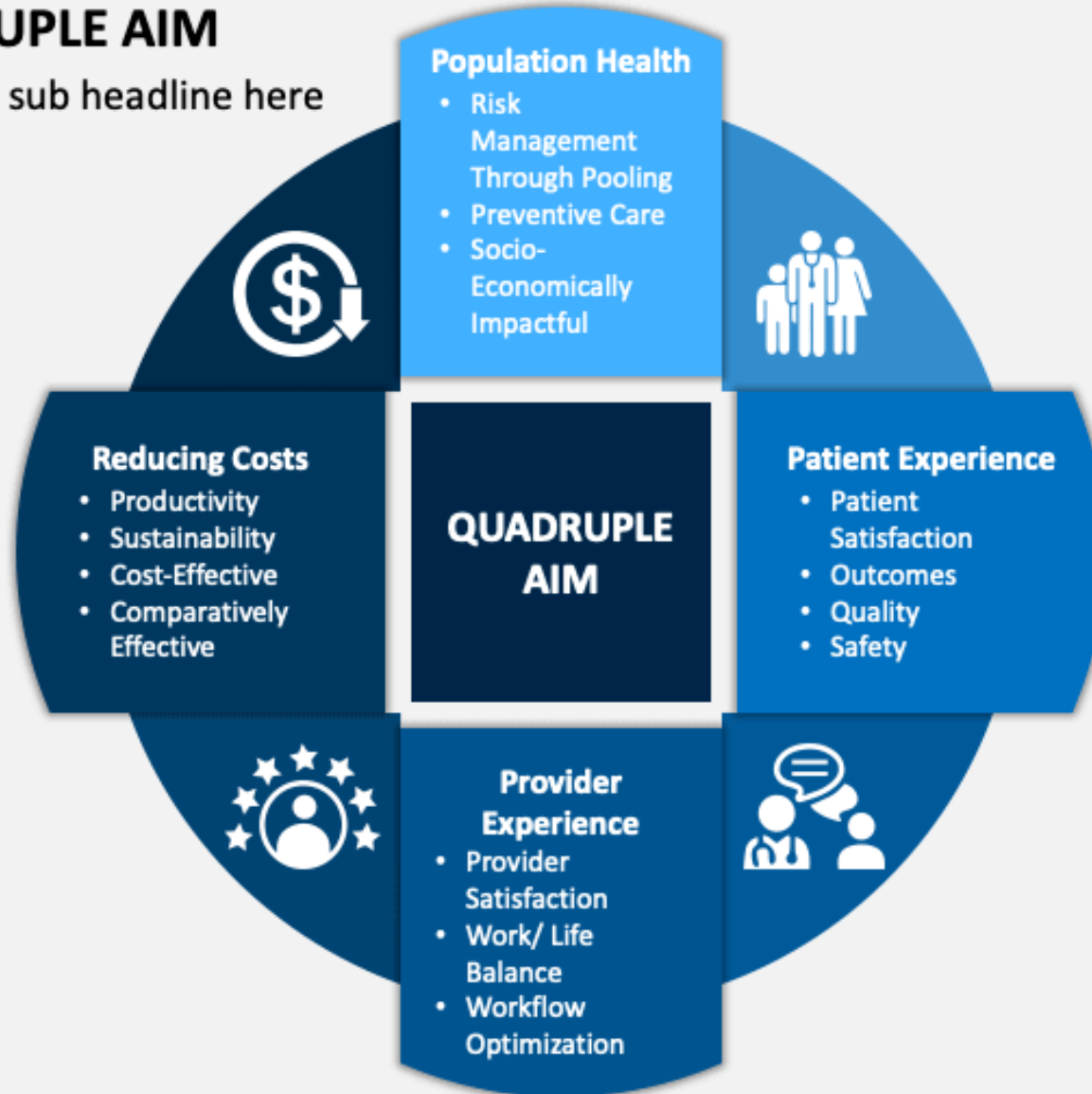


Figure 5. Sláintecare Model of Care principles²⁰



QUADRUPLE AIM

Enter your sub headline here



1 Continuously Learning, Well-informed, and Insightful: Understanding the current environment with an eye toward the future change trajectory.

2 “Change-Forward” with Bold, Inspiring Vision: Not satisfied with incremental change, but desirous of “breakthrough, transformative change;” not just “change ready,” but embracing change management as a competitive advantage.

3 Agile and Adaptable: Setting a course and planning a transformation that is flexible and effectively prioritizes.

4 Actionable Information-Oriented: Translating data into data analytics, into information, into transparent, actionable-information and ultimately, into “predictive analytics.”

5 Financially Disciplined: Financial Discipline is palpable throughout high-performing organizations.

6 Respectful and Optimized Staffing: Always respectful to one another, seeking diversity of thought and “collective wisdom” of the team while prioritizing professional development and talent management.

7 Accountable and Execution-Focused: Accountable toward their community and expectations of their employees with laser focus on execution and activation.

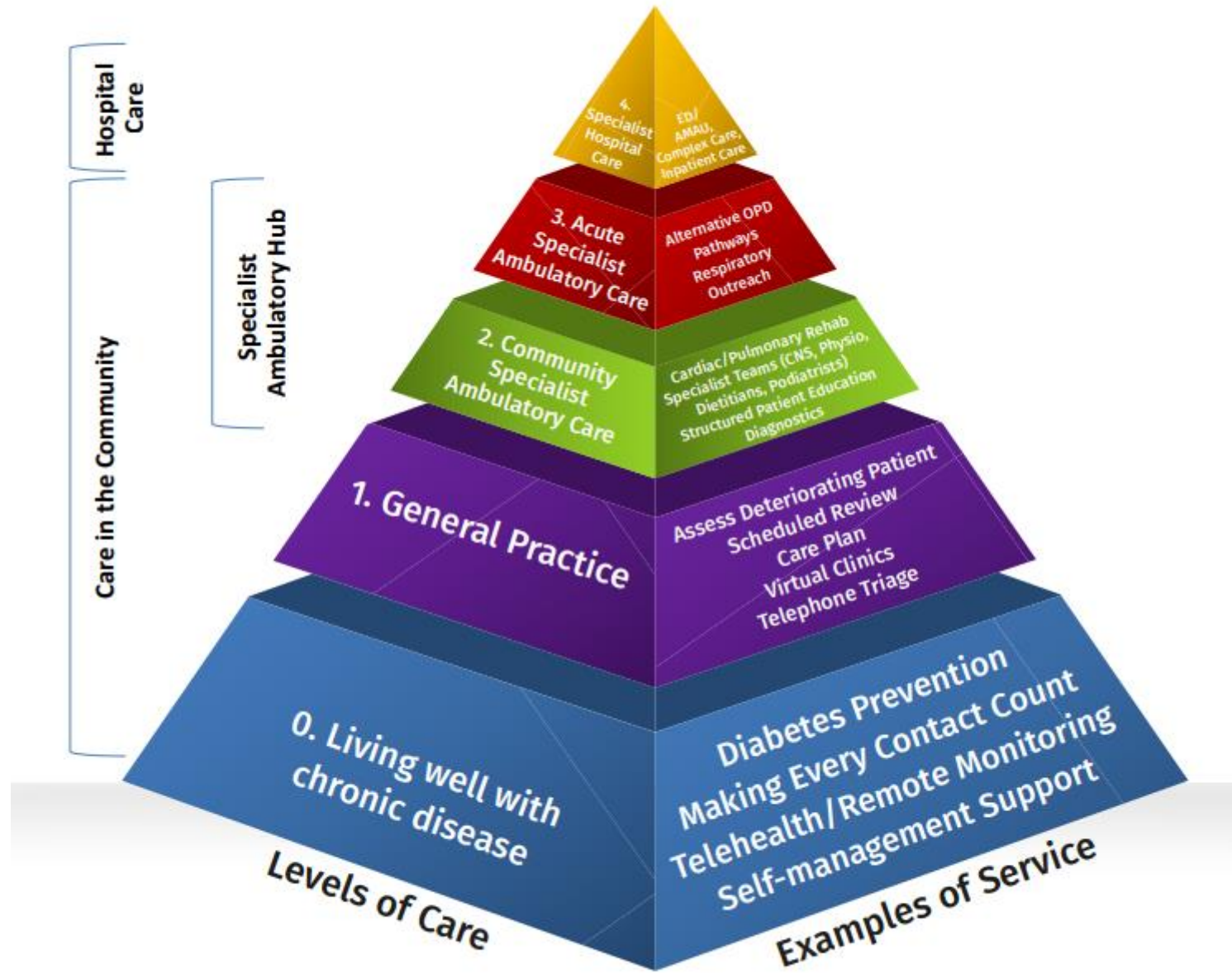
8 Patient-Centric and Operationally Proficient: Standardizing care processes, embracing clinical protocols, and effecting seamless, patient access.

9 Creative Collaborators: Partnerships and joint ventures with other providers, payers, employers, clinical technology companies, and other key stakeholders, all intended to create and increase value for patients and communities.

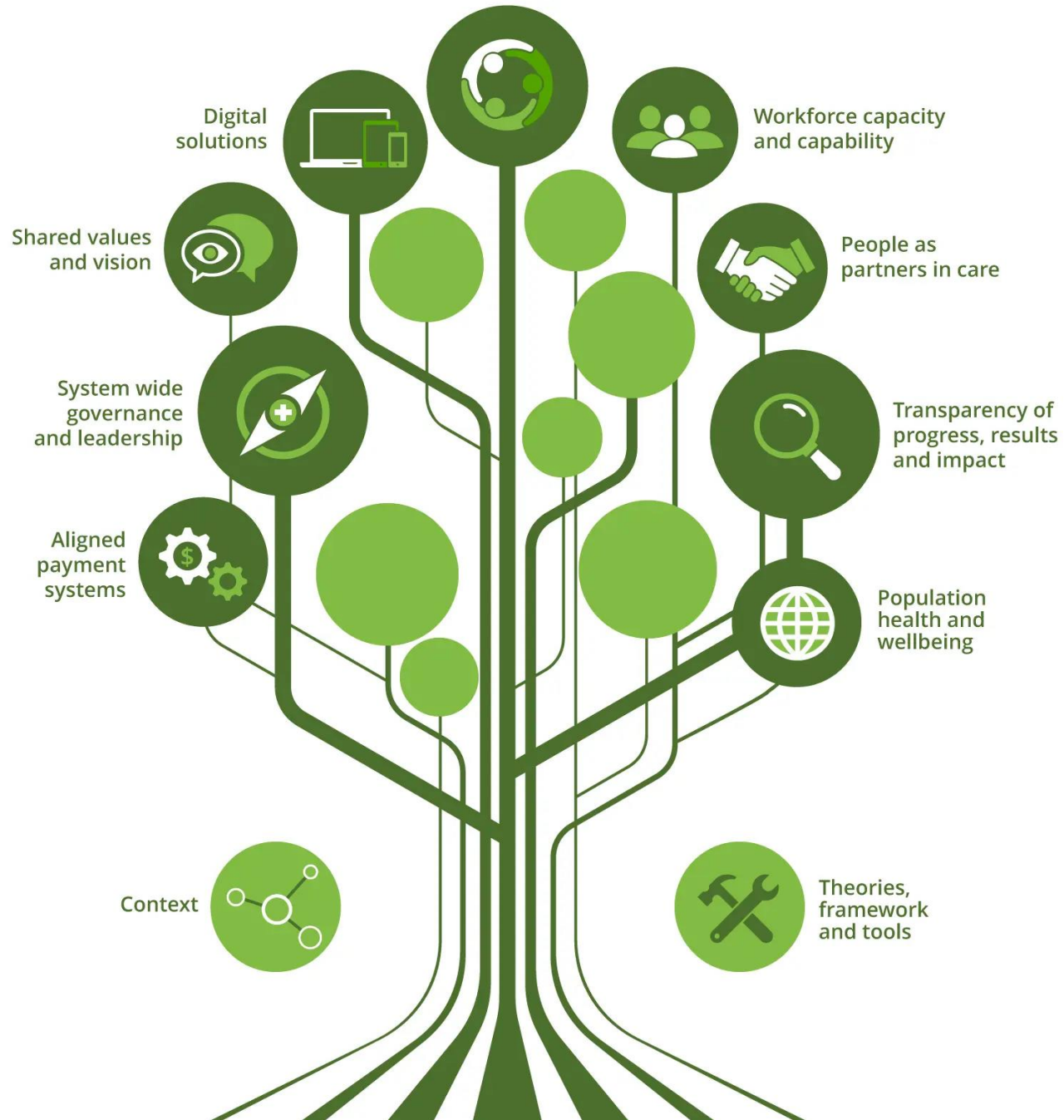
10 Realizing the Value of System Integration: Creating value through economies of scale and scope with system integration and optimizing synergies.

Top 10 Characteristics of High-performing Healthcare Organizations

By Darryl Greene, MS, Vice President, GE Healthcare Camden Group, and Robert Green, MBA, FACHE, CHFP, Senior Vice President, GE Healthcare Camden Group



Resilient Communities
& New Alliances



Seirbhís Sláinte
Níos Fearr
á Forbairt

Building a
Better Health
Service



Reflect

Short term...next crisis

Its always been this way

....the bloody HSE

I'm up to my tonsils.....

My department want this....

**The bloody community.....the bloody
Hospitals**

Clearly articulated Reproducible Vision

What we stand for and don't stand for

**Accountable Leadership at all levels with
front line ownership**

Different ways of working

Same goals across all of Healthcare

Integration



We have tremendous assets











You don't get excellence from pieces, you get excellence from connections





Thank you for listening and your precious time