WP 06
Ymchwiliad i barodrwydd ar gyfer y gaeaf 2016
Inquiry into winter preparedness 2016/17
Ymateb gan: Coleg Brenhinol y Meddygon (Cymru)
Response from: Royal College of Physicians (Wales)

Royal College of Physicians | Coleg Brenhinol y Meddygon (Cymru)

Inquiry into winter preparedness 2016/17

RCP Wales response

Key points

- The challenges facing health boards as they prepare for winter are complex. They reflect wider pressures on the NHS and social care.
- Health boards are operating in an under-funded, under-doctored and overstretched context. This is resulting in an increasing demand on hospitals.
- Recent RCP research shows that 40% of advertised consultant physician vacancies in Wales were unfilled last year; in the majority of cases, this is because there are simply no applicants. This is having a significant impact on the ability of doctors to deliver high quality care for patients.
- A stretched social care system, staffing shortages, and lack of hospital beds all contribute to delayed transfers of care.
- The RCP, through its Future Hospital Programme and our work with hospitals in Wales, is exploring new and innovative ways of delivering care.
- This includes better coordination of care and treatment of patients to prevent unnecessary hospital admission and to help them leave hospital as soon as possible. We are also developing telehealth projects in north Wales and encouraging partnership working between hospital and community services.

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Inquiry into winter preparedness 2016/17

1. Thank you for the opportunity to respond to your consultation on the National Assembly for Wales committee inquiry into winter preparedness 2016/17. Our response is based on the experiences of our fellows and members, and all quotations unless otherwise referenced, are taken from evidence submissions we received from RCP fellows and members.

2. The Royal College of Physicians (RCP) aims to improve patient care and reduce illness, in the UK and across the globe. We are patient centred and clinically led. Our 33,000 members worldwide, including 1,100 in Wales, work in hospitals and the community across 30 different medical specialties, diagnosing and treating millions of patients with a huge range of medical conditions.

3. There are a number of barriers preventing hospitals from dealing effectively with unscheduled care winter pressures. The barriers include delayed transfers of care leading to ineffective management of patient flows. Studies from England suggest that as many as 40% of patients who die in hospital do not have the medical needs that require them to be there[1]. Furthermore, at least 25% of hospital beds are occupied by people with dementia, many of whom are likely to stay more than twice as long in hospital than other patients aged over 65[2]. This is often because of a lack of community based care. The situation is compounded by the challenging financial circumstances in which the NHS operates.

4. Managing the patient flow between the emergency department, the acute medical unit and specialty wards depends on effective transfers of care and timely discharge of patients. Underfunding of social care, a lack of beds and issues with recruitment and retention of doctors mean that hospitals often struggle to effectively transfer patients while maintaining a high level of care.

> *I do not think there is any serious planning. An increase in capacity is what is needed. This is the lesson that needs to be learned and it has not been.*
> [Consultant physician in Wales]

[1] Royal College of Physicians 2014. National care of the dying audit for hospitals, England: May 2014
[2] Alzheimer's Society. *Fix Dementia Care in Hospitals*. 2016

5. Our members and fellows are working in an, under-funded, under-doctored and overstretched health service. Patient demand matched with significant workforce gaps are making it difficult to care for patients. In 2014-2015, 21% of UK consultant physicians reported 'significant gaps in the trainees rotas such that patient care is compromised'[3]. These figures are concerning because the specialties most closely associated with alleviating winter pressure on unscheduled care are seeing the highest staffing gaps, with geriatric and acute medicine reporting the greatest number of cancelled and failed consultant appointments.

A growing workforce crisis

6. This staffing crisis is having a major impact on physicians' ability to swiftly assess patients after they present at emergency departments, to tailor their care plans and to achieve safe and timely transfers of care. This can negatively impact on patient experience and leaves wards unable to alleviate pressures on emergency departments. Targets are difficult to achieve unless there are enough staff to treat patients or transfer them into social care in a timely manner.

7. There is currently no real national strategic approach to medical workforce planning in Wales. Over the years, this has contributed to recruitment and retention challenges in the medical workforce, especially among trainee doctors. **We strongly support the development of a clinically led national medical workforce and training strategy for Wales.** Wales has a real opportunity to develop an innovative model, and we urge that clinical leadership be placed at the very centre of that process.

8. It is also crucial that Wales makes a more concerted effort to attract its own students to medical school in Cardiff and Swansea. These students may be more likely to stay in Wales for their postgraduate training, and if they do leave, they are more likely to return home afterwards. Only 30% of students in Welsh medical schools are Welsh domiciled. This compares to 55% in Scotland, 80% in England and 85% in Northern Ireland.[4] **Medical schools must offer more undergraduate places to Welsh domiciled students in order to grow and retain a home-grown workforce**, and they should invest in outreach programmes which encourage applications from rural, remote and Welsh speaking communities.

Bed shortages and a lack of capacity

9. Hospital bed shortages also compound problems with patient flow. The UK has the second lowest number of hospital beds per 1,000 of the population among 23 European countries . Our members and fellows often cite that moving patients from acute medical units to general or specialty wards can be problematic because there are no beds available. These are older patient who are deemed well enough to receive care in the community but cannot be transferred due to a lack of services in community settings.

10. There is clear evidence that well run acute medical units (AMU) help reduce mortality, length of stay and readmissions[5]. AMUs staffed by multidisciplinary teams and led by acute medicine physicians have the potential to improve the quality and the safety of care of a significant proportion of acutely ill patients. We would urge health boards to invest in their general medical

[3] Federation of the Royal College of Physicians of the UK. *Census of consultant physicians and higher specialty trainees in the UK 2014-15.* London: Royal College of Physicians, 2016.
[4] NHS Education for Scotland. *Domicile of UK undergraduate medical students*. March 2013
[5] Scott, I; Vaughan, L; Bell, D. Effectiveness of acute medical units in hospitals: a systematic review. *International Journal for Quality in Health Care,* 2009; Volume 21, Number 6: pp. 397 –407.

workforce and AMUs to enable hospitals to respond more effectively and safely to the increasingly complex demands placed on the hospital with regard to acute medical care.

Redesigning the ambulatory care system

11. Some clinical teams, including those in Abertawe Bro Morgannwg University Health Board and Cwm Taf University Health Board have recognised that a new approach is needed to deal with the considerable pressures faced by emergency departments, and have successfully redesigned their systems to implement ambulatory emergency care (AEC) as part of the solution[6]. Ambulatory care is clinical care which may include diagnosis, observation, treatment and rehabilitation, not provided within the traditional hospital bed base or within the traditional outpatient services[7].

12. Implementing AEC ensures that where appropriate, emergency patients presenting to hospital for admission are rapidly assessed and streamed to AEC, to be diagnosed and treated on the same day with ongoing clinical care. Processes are streamlined, including review by a consultant, timely access to diagnostics and treatments all being delivered within one working day. This has improved both clinical outcomes and patient experience, while reducing costs. Clinical teams using this approach report managing significant numbers of emergency patients quickly, without the need for full admission, converting at least 20–30% of emergency admissions to AEC[8].

13. AEC can be particularly valuable in the assessment and management of frail, older patients being managed with pathways supported by a multidisciplinary team with good links to services in primary care, the community and local authorities. These links can offer rapid assessment and interventions for older people, which can avoid an inpatient stay. For older people, access to these services is important to live safely at home and avoid unnecessary readmission.

> *In my health board, the real positive aspects [of] winter planning have been quality improvement training for care home staff (and resultant anticipatory care planning), emphasis on proactive care planning for people with co-morbidities or those with frailty, and integrated working with the council and third sector.*
>
> [Trainee physician in Wales]

Developing new models of care to prevent hospital admission

14. The RCP is also working with local clinical teams through our flagship Future Hospital Programme (FHP) to develop innovative models of care to help meet patient need using current resources[9]. One Future Hospital site is based in north Wales, and has piloted the use of telehealth patient consultations over video link between hospital specialists and community healthcare teams.[10] However, two RCP Future Hospital sites in England are specifically working

[6] Royal College of Physicians. Acute Care Toolkit 10. Ambulatory Emergency Care. October 2014
[7] Royal College of Physicians. *Acute medical care: The right person, in the right setting – first time. Report of the Acute Medical Task Force.* London: RCP, 2007: p xxi. Endorsed by The College of Emergency Medicine, 2012.
[8] Blunt I. *Focus on preventable admissions: Trends in emergency admissions for ambulatory care sensitive conditions, 2001 to 2013.* London: The Health Foundation and the Nuffield Trust, 2013.
[9] RCP Future Hospital Programme
[10] RCP Future Hospital development site: Betsi Cadwaladr University Health Board

to reduce the admission of patients to hospital and ensure that they receive care in the community: Mid Yorkshire NHS Hospital Trust and East Lancashire Hospitals Trust.

15. Mid Yorkshire NHS Hospitals Trust has established a Rapid Elderly Assessment Care Team (REACT) within the acute admissions unit at Pinderfields Hospital in Wakefield. REACT are a multidisciplinary team made up of geriatric consultants, specialist nurses and therapists who work together to assess patients aged 80 and over, or those aged 65 and older who are care home residents, within 24 hours of their arrival at hospital. The team meet daily to coordinate the care and treatment of patients to help them leave hospital as soon as possible and prevent unnecessary hospital admission. The multidisciplinary nature of the team means that they are able to offer person centred care because they provide people both the health and therapeutic services they need.

16. Since the REACT team was established in 2014, Pinderfields Hospital has seen significant improvements in the number of patients receiving care in the community rather than being admitted to hospital. Comparing data from 2014 to 2015, there has been a 24% increase in the number of people with frailty being transferred to community care rather than moving onto a ward in hospital. The total number of hospital ward admissions for patients aged over 80 also decreased by 14% during the same period in 2014 to 2015. This quick assessment by a multidisciplinary team at the front door of the hospital ensures that patients are able to access the care most suitable to their individual needs and relieved some of the pressures faced by staff in the rest of the hospital.

17. The REACT team in Pinderfields Hospital has also been working closely with third sector providers to improve the transfer of care from the hospital to the community. Age UK regularly come into the acute assessment unit at the hospital to provide safe transfers of care into the community[11]; they offer transport and a grocery shopping service so that vulnerable older people are not discharged without adequate support. Working collaboratively with health and social care professionals outside of the hospital building has enabled frail older people to receive personalised care, which has helped them to maintain their independence and prevent readmission.

18. Another FHP development site at East Lancashire Hospitals Trust aims to identify frail older patients who are available for discharge the same day they present at hospital. The medical assessment unit (MAU) nurse monitors the acute intake of frail older people in order to identify patients suitable for rapid discharge, arranges their comprehensive geriatric assessment and liaises with secondary and social care professionals to plan for safe same-day discharge.

19. Preliminary data from the East Lancashire Hospitals Trust project suggests that 59% of admissions were avoided using this care model since the project started in 2014[12]. If admission can be avoided by streamlining the patient journey from the MAU through to social care, frail older people can be supported to leave hospital quickly and to live independently in the community.

20. In both these case studies, partnership working between hospital and community services has reduced delayed discharge. Integrated secondary and social care for older people can achieve

[11] Age UK. *Frailty in secondary care*.
[12] Temple, M; Dytham, L; Bristow, H. *Action learning at the Future Hospital development sites.* Future Hospital Journal 2016 Vol 3, No 1: 13–5

lower rates of bed use and the Kings Fund has found that hospitals operating in an integrated way also tend to have lower admission rates which provide a better patient experience.[13]

21. The problems facing emergency departments particularly during winter are complex and cannot be solved using a single solution. Reducing the volume of delayed transfers of care will go some way to alleviating pressures on emergency departments. The impact of an underfunded social care system is adding to the pressures being experienced in hospitals, with patients staying longer in hospital than necessary due to lack of services in the community. Furthermore, there is an ever-pressing need to find a national solution to problems with recruitment and retention of doctors. Without enough doctors on the ground, patient care will be compromised.

22. As the FHP project teams show, effective multidisciplinary working and the integration of healthcare services achieve better patient outcomes and experiences, thus alleviating winter pressures. This is why the RCP believes that we need to move away from a model of care in which we invest in either primary or secondary care, and towards integrated team working, where hospital specialists hold more of their clinics in the community, and GPs spend part of their time working with colleagues at the front door of the hospital.

A new integrated model of healthcare is needed

23. We would welcome a mature conversation about the future of service design in Wales, and the vision needed at a national level to develop a new way of working. It is important that future investment into the health service does not go towards propping up the old, broken system. The Welsh Government must promote innovative models of integration and introduce shared budgets that establish shared outcomes across the local health and care sector. Spending money on the existing system will not change anything in the long term; health boards must invest in prevention and treatment of chronic conditions and allow clinicians to innovate.

24. Those living in rural and remote areas must not be forgotten either; it is these areas where the crisis in primary care is hitting hardest, and where a new ambitious model of care has the most potential. All of this will need a drastic change in mind-set, stronger clinical leadership and engagement, and more joined-up thinking between primary, secondary, community and social care teams.

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With best wishes,

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[13] Imison C, Poteliakhoff E, Thompson J. *Older people and emergency bed use. Exploring variation*. London: The King's Fund, 2012.