

# A lay perspective and commentary on the association between delays to patient admission from the emergency department and all-cause 30-day mortality

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A&E is a brand; it is among the best known brands in the UK and is trusted and loved by the UK public. Why? Because they know when all else fails, when other agencies just don't or won't respond, their local A&E department will be there for them 24/7, 365 days a year.

Confirmation of this is available daily in every emergency department in the UK, with patient attendances at the highest since the inception of the National Health Service (NHS).

Yet, as the paper by Moulton and colleagues reports,<sup>1</sup> this trust and indeed the dedicated service of the clinicians is being undermined by a killer and one that for far too long the government, NHS leadership, trust boards and their chief executives have chosen to ignore or simply blame patients for having the temerity to turn up.

For at least the last 12 years and more, we have seen cuts after cuts to the budget of the NHS, leading to reduced bed numbers and staffing. This is bad enough in itself but has been further compounded by repeated large reductions in central government financial support to local authorities, with a devastating impact on social care. The result has been fewer beds in hospitals and a grave lack of social care provision for those patients ready for discharge, or as it is called, exit block and delayed timely admission. Thanks to this report, we now have confirmation that such delay kills patients.

UK patients and the population as a whole love their NHS, they know only too well that it is not perfect, and they are prepared to be forgiving when things go wrong, perhaps too forgiving. Most people, for instance, wait patiently for hours to be seen in A&E. However, patients have an absolute right to be informed when their trust in a service has serious consequences

for their wellbeing and also, possibly, their life. As ever, it is the elderly/frail and those living in deprived communities who are most likely to be affected.

From the perspective of the patient, and certainly from those of us who have the privilege to represent patient interest, one statement and one fact stand out. Within the Conclusions it states:

'The NHS 4-hour operational standard thus appears to have succeeded in preventing avoidable delay-related patient harm in hospitals where it has been achieved while also reducing additional morbidity and poor patient experiences.'<sup>1</sup>

and in what is already known on this subject:

'Counterfactual modelling has shown reduced patient mortality as a result of the NHS 4-hour operational target.'<sup>1</sup>

Little wonder therefore that some of us have such contempt for those in government and the NHS leadership who have done so much to try to undermine and remove this key target.

The authors defined the rise in mortality as starting at 5 hours and so a 4-hour threshold seems both justifiable and sensible. It is interesting to note that

while the 4-hour target initially seemed to be an arbitrary figure, the paper's graph plotting mortality rate against time in the emergency department clearly shows a steady rise after 4 hours.

Let nobody be in doubt any longer, the NHS 4-hour operational target is, as many of us have always known, of key importance to patient safety. Patients are, and will continue to be, grateful for it and for the publication of this paper.

However there are some difficult truths to be faced when discussing this target and some from sources that are uncomfortable to identify.

The only practical concern with the target is when chief executives fail to see its achievement (or lack thereof) as a hospital-wide issue and, it has to be said, too often there is a lack of support from other specialties. To this, can of course be added the lack of beds, lack of staff and chronic underfunding of the NHS and social care. Get these right and the target is achievable, as the majority of NHS trusts proved during the decade between the introduction of the target in 2004 and the winter of 2014–2015. This graph from the King's Fund shows the change from 2010 (when the target was changed from 98% to 95%) and the current situation [figure 1](#)<sup>2</sup>.

But, and here is the really uncomfortable issue, too many within the emergency medicine specialty have also sought to undermine this 4-hour target. Could there be better measures? Possibly, but until there are, and crucially, ones that have the support and trust of patients, the 4-hour target or one very close to this, must remain the gold standard. Those in doubt need look no further than the evidence provided by this excellent paper.

Percentage of attendances admitted, discharged or transferred within four hours

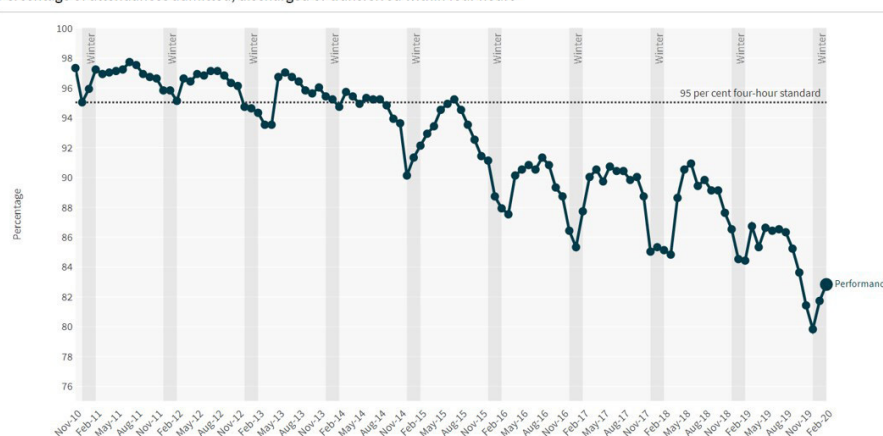


Figure 1 Performance against the A&E waiting time standard has steadily declined.

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