Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

A&E Departments

Background Briefing | May 2006

Introduction

Many of Ireland's A&E Departments operate very effectively. Every day, staff provide thousands of patients with outstanding services* delivered with care and compassion.

The Health Service Executive (HSE) recognises that difficulties are being experienced in some A&E Departments. These difficulties can cause distress for patients, their families and staff and the associated waiting times and poor conditions are unacceptable. Addressing these difficulties with sustainable solutions is the organisation's priority.

A&E Departments are a critical part of a complex healthcare system; they are not stand alone services. Their ability to function effectively depends on the efficiency of the wider health system particularly in relation to the local availability of the appropriate type and amount of beds, how these beds and hospital facilities are used, and the availability of services that minimise A&E attendances and admissions.

This document points out how the structures and processes in the wider health system can have a major impact on A&E Departments and outlines the types of system wide changes that are needed.

The HSE is focused on transforming the health system to ensure that the right care is consistently delivered in the right place by the right people at the right time.

* *In a recent survey 93% of patients said they were satisfied with the service they received during their hospital stay. (Irish Society for Quality and Safety in Healthcare) More than 80% said they had been seen by a doctor in A&E within three hours of registering, with 3 out of every 4 saying that they had been admitted to a ward within 6 hours of the decision to admit.*

INCREASING EFFICIENCY AND CONVENIENCE FOR PATIENTS WITHOUT COMPROMISING CLINICAL CARE

Avoiding Hospital Admissions

Examples of community based services that enable patients to be treated more efficiently outside hospitals.

> Enhanced Out of Hours GP services;
> More GP Access to Diagnostics;
> Rapid Access Clinics;
> Community Intervention Teams;
> Primary Care Teams;
> Chronic Illness Management Programmes;
> Home Care Packages.

Reducing Hospital Stays

Types of initiatives that can impact on the length of time patients need to stay in hospitals.

> Access to the correct amount and appropriate use of all capacity (beds & facilities);
> Proactive Admission & Discharge Planning;
> Diagnostics available over extended working day;
> Consultant provided daily ward rounds for every patient as standard;
> More Consultants and more working in teams;
> Hospital Out Reach services.

Background

Ireland has 53 acute hospitals, which vary greatly in size, type, number of specialties and activity levels. They provide the full range of quality services including complex and advanced treatments to the highest internationally comparable standards.

During 2005, they handled more than 3.5 million inpatient and outpatient visits.

Of the 53 acute hospitals in Ireland, 35 have A&E Departments which, during 2005, had more than 1.2 million attendances.

The majority of A&E Departments function well. Each day in the region of 3300 patients attend these 35 A&E Departments. On average 75%, or 2500, of these patients are treated there and then, and discharged without the need for admission to a ward. Approximately 800 patients each day require admission to a ward and the vast majority of these patients are admitted without undue delay.

However, in some A&E Departments there can be delays between the time the clinical decision to admit a patient is made and the time they are transferred to a ward. These difficulties are not unique to Ireland and are being experienced by many modern health services in other parts of the world such as Sweden, Canada, USA and United Kingdom.

The HSE is focused on addressing the difficulties that can arise from these delays and the fundamental issues that are causing them in the first place.

Number of attendances at A&E Departments during 2005

Monaghan General Hospital	11,791	Mercy Hospital, Cork	23,547	Tralee General Hospital	34,859
Roscommon General Hospital	12,410	South Infirmary Victoria Hospital	23,617	St. Vincents University Hospital	36,577
St. Joseph's Hospital, Clonmel	12,689	Naas General Hospital	24,461	Our Lady of Lourdes, Drogheda	38,456
Nenagh General Hospital	13,329	St. Columcille's Hospital	24,529	Mater Misericordiae Hospital	41,000
Portiuncula Hospital	18,237	Midland Regional Hospital, Tullamore	27,065	St. James's Hospital	43,086
Our Lady's General Hospital, Navan	18,620	Mayo General Hospital	28,223	Beaumont Hospital	47,941
St. John's Hospital, Limerick	19,795	Sligo Regional Hospital	29,412	Regional Hospital, Dooradoyle, Limerick	52,617
Cavan General Hospital	20,019	St. Luke's Hospital, Kilkenny	29,967	University College Hospital, Galway	56,041
Louth County Hospital	20,104	Wexford General Hospital	31,063	Waterford Regional Hospital	57,957
Ennis General Hospital	21,345	Connolly Hospital, Blanchardstown	31,434	Cork University Hospital	59,733
Our Lady's Hospital, Cashel	20,592	Midland Regional Hospital, Mullingar	31,383	Tallaght Hospital*	75,392
Midland Regional Hospital, Portlaoise	23,123	Letterkenny General Hospital	31,599		

** (includes Adult and Paediatric A&E)*

Objectives

The two main issues concerning patients and their families is the length of time patients sometimes have to wait in A&E Departments for admission and the conditions in which they wait. As an immediate measure to address these issues, the HSE has set the following near term targets:

- No patient is to wait for more than 24 hours in an A&E Department for admission, from the time they have been referred by the A&E team for admission;
- No A&E Department is to have more than 10 patients waiting for admission, from the time they have been referred by the A&E team for admission; and
- While awaiting admission, patients will be guaranteed privacy and dignity.

The HSE's longer term target for 2007 is to ensure, consistent with international standards, that no patient should have to wait in an A&E Department for more than 6 hours for admission, from the time they have been referred by the A&E team for admission.

There are hospitals which regularly reach this target and the challenge is to support these hospitals to maintain their effectiveness and bring all hospitals up to this level of performance.

Waiting Time Vs Number waiting

In relation to daily records, what is important is how long patients have to wait in A&E Departments to be admitted and the quality of the facilities available; not just how many patients are waiting. For example, while it is unsatisfactory to have two people waiting for 36 hours for admission, it is relatively understandable for six people to wait in appropriate conditions for a maximum of six hours.

The HSE displays waiting times, attendances and activity in all 35 A&E Departments on the HSE website, www.hse.ie.

A&E Task Force

This Task Force, established in March 2006, is reviewing, on an individual basis, the 10-15 hospitals that have A&E Departments which regularly face difficulties and, in conjunction with them, identifying and advancing practical solutions.

The team includes A&E Consultants, a GP, a Geriatrician, a Respiratory Physician, Director of Nursing, Hospital Chief Executive and senior full-time representatives from the National Hospitals Office, Primary, Community and Continuing Care Services and Population Health.

Immediate Measures

The HSE is introducing a series of immediate measures to meet its near term targets and make progress towards its longer term target.

- Free up acute hospital beds by making more appropriate facilities available for delayed discharge patients.

In Dublin's acute hospitals there are regularly around 400 patients whose discharge has been delayed. These patients no longer need acute hospital beds, but for a variety of reasons, are not in a position to return home.

Each week approximately 50 additional patients are deemed to have completed the acute phase of their treatment and require care in a setting other than an acute hospital. There is therefore an ongoing need to provide a range of care options, encompassing home care, rehabilitation and long term care.

Home care supports and long term care facilities are being made available to free up acute beds and the HSE is proactively pursuing all opportunities to develop and expand its existing non acute long stay facilities to be able to accommodate more patients.

As the acute hospital beds become available as a result of these initiatives, they will be ring-fenced for use only by patients waiting in A&E Departments for admission.

- Fast track the introduction of Admission Lounges.

Admission Lounges are designated areas adjacent to A&E Departments which have beds along with appropriate nursing staff and facilities.

Their purpose is two fold:

Firstly, they allow patients to wait for admission to hospital wards in comfortable surroundings ensuring their privacy and dignity.

Secondly, they enable the work performed in A&E Departments to flow more freely and therefore operate more effectively.

While patients transferred to Admission Lounges have been admitted to the hospital and come under the care of the admitting physician, these lounges are not hospital wards. In addition, their management will feature a strong focus on quickly transferring patients to their ultimate destination within the hospital. Plans are underway to introduce Admission Lounges to a number of hospitals during the next 4-6 months.

These two initiatives are designed to provide immediate support to specific A&E Departments. However it is essential that they are supported in the medium term with significant changes within the wider health system in relation to the use of capacity, practices, processes and non-acute hospital services.

Long Term Measures

There are many structural and process factors within the health system which can influence the functioning of hospitals, in particular, how they access and use their acute beds and facilities. These factors in turn can have a significant impact on the functioning of A&E Departments.

The HSE's approach to delivering long term and sustainable solutions to the difficulties facing A&E Departments is focused on three key areas:

1. Beds and appropriate use of acute beds;
2. Practices and processes;
3. Development of Primary, Community and Continuing Care services.

Success in these three areas will enable A&E Departments to concentrate on their primary purpose, which is to deal with accidents and emergencies.

1. Beds and appropriate use of acute beds

To function effectively, hospitals must have local access to the appropriate number and type of beds and be able to maximise the use of all of their acute beds for acute patients.

To ensure the existing volume and type of beds are correct, and in the context of the country's growing and ageing population, the HSE is undertaking a study of the country's acute bed requirement up to the year 2020. This study will take into account the potential impact of (1) all existing capacity (beds and facilities) being used fully and appropriately, (2) hospital practices and processes functioning for maximum impact, (3) all the necessary non hospital supports being in place and (4) the increasing number of private acute hospital beds being developed. Allied to this, is a study being undertaken by the HSE to establish the long term requirement for community based beds such as step down facilities and long stay beds.

The HSE's immediate priority with respect to maximising the use of existing beds is to ensure that nobody is inappropriately placed in an acute hospital bed longer than is medically necessary.

Currently there are many patients occupying acute hospital beds who have finished the acute phase of their treatment and should be either accommodated in more appropriate facilities such as long stay units, rehabilitation facilities or discharged home with their care managed through hospital out-reach or community based services.

In the major Dublin hospitals there are regularly around 400 patients occupying acute hospital beds who should be more appropriately accommodated in alternative settings. Annually, this equates to almost 150,000 bed days.

2. Practices and Processes

There are many practices and processes which can influence how efficiently hospitals use their beds and facilities and ultimately how quickly patients enter, pass through and are discharged from the hospital system. Collectively they can impact on the ability of A&E Departments to function effectively.

2.1 Admission & Discharge Planning:

For patients and their families spending time in hospital can create significant upset and inconvenience. The HSE therefore believes that attention should at all times be given to ensuring that hospital stays are kept to a minimum, without compromising clinical care, and is examining the range of opportunities available to achieve this.

For example, with proactive admission and discharge planning, when a patient is admitted to a ward, their daily treatment and discharge schedule can be prepared and arrangements made to ensure that all of the services they need while in hospital, such as tests and consultations, are co-ordinated in a way that minimises the length of their stay and maximises their convenience.

In addition, with the support of multidisciplinary teams working in co-operation with community service providers, preparations can be made to ensure that post-hospital supports are available within the community when patients are ready for discharge. This enables patients to either return home or transfer to other non acute facilities without delay.

Rigorous admission/discharge planning processes enable hospital managers and clinicians to identify the specific hospital processes and/or service shortfalls that can cause discharge delays. This can in turn facilitate more effective resources and facilities planning.

It can also help to pin point and address why patients, with the same conditions, need to stay in hospital longer in different parts of the country. At the moment this can occur for a variety of reasons such as patient profile, hospital processes and limited access to non acute facilities.

2.2 Diagnostics:

The availability of diagnostic facilities (x-ray, ultrasound scans, CT scans, MRI scans, etc.) outside normal working hours can increase the opportunities for patients to pass through to the next stage of their treatments more quickly. This applies to both inpatients and outpatients.

For example, if facilities operate for twelve hours a day as opposed to the normal 8 hour working day, access to diagnostics will increase by 50%. As a result, inpatients and outpatients will receive their tests and subsequent diagnosis and treatment sooner.

The knock-on effect of having greater access is that patients can spend less time in hospital. This is an example of where a hospital's access to its existing bed capacity can be improved when processes and practices operate at their optimum for patient convenience.

Recently radiographers and radiation therapists extended the length of time they would be available by agreeing to be rostered to work between 8am and 6pm. This is welcome and there is a need to build on this development.

In the USA for example, it is standard practice for operating theatres and the necessary support facilities to be used on Saturdays as if it is a normal working day.

Extending the availability of diagnostics in hospitals and within the community can also benefit patients who attend their GPs and require a diagnostic test (see 3.2 below). If capacity is available at the time it is needed, patients can avoid A&E Departments and instead be referred by GPs directly to diagnostic services.

During the coming months, the HSE will be examining opportunities to extend the working day and working week for its hospital facilities such as operating theatres and diagnostic facilities.

Discussions are also underway with the private sector in relation to immediate initiatives aimed at

(a) offering improved and faster GP access to key diagnostic services and

(b) reducing inpatient bed days used by improving access to diagnostics.

2.3 Access to A&E Departments & acute medical care:

In relation to A&E Departments, there are processes and practices in place that can be cumbersome and alternatives need to be explored with a view to increasing the convenience and comfort for patients.

For example, when a patient first arrives at an A&E Department they can see a triage nurse who then refers him or her on to a doctor who may refer the patient to a more senior doctor and maybe a consultant. If the A&E Department's clinicians decide that it is appropriate for the patient to be admitted, the 'in house' team will be called. The patient will then be assessed by a member of this hospital's 'in-house' team who will decide whether he or she should be admitted. Before this decision is made, the 'in-house' doctor may order more tests and involve a consultation with a more senior 'in-house' doctor.

There have been a number of developments in recent years to enable patients to more conveniently access acute medical care and there are opportunities to build on this success. Essentially this approach involves reducing the dependence on the A&E Department as the only access point for acute care and providing patients with alternative access to care specific to their particular needs.

Initiatives that have proved successful include Acute Medical Units (AMUs) which are designed to provide rapid assessment, diagnosis and treatment of acute medically ill patients referred from GPs, the A&E Department, and the hospital's Outpatient Department. Similarly, Chest Pain

Units and Respiratory Clinics provide a short stay area for rapid assessment, diagnosis, observation and early treatment of patients presenting with chest pain or respiratory (breathing) difficulties. These facilities allow A&E Departments to function more effectively and, when required, fast-track the admission process.

For example if a patient is experiencing respiratory difficulty and the GP knows there will be a Respiratory Clinic in the hospital the following day, he or she may view this as a more appropriate option than referring the patient to the A&E.

The HSE proposes to extend the use of rapid access and fast-track services and the Task Force is working with the hospitals and community services to identify appropriate initiatives in these areas and support their early implementation

2.4 Consultant Delivered Service:

Consultants play a pivotal role in ensuring that patients are admitted, treated and discharged without delay. They are the senior decision makers and their importance in hastening a patient's treatment schedule cannot be overstated.

For example, admission rates from A&E Departments (the number of people admitted as a % of the number of people attending the A&E) are likely to be lower when decisions are made by senior clinicians.

- There needs to be far more consultants and senior clinical decision makers available at the frontline, both in A&E Departments and within the hospitals themselves. There is currently an over reliance on Non Consultant Hospital Doctors (NCHDs). The ratio between the number of consultants (currently approx 2,000) and the number of NCHDs (currently approx 4,000) needs to be reversed.

- Consultant ward rounds performed early in the day, every day, can have a significant impact on moving patients to the next stage in their treatment schedule which can subsequently impact on freeing up acute beds. This needs to become a standard practice across the system.

- Senior clinical decision makers, mainly consultants, working in teams can have a very positive impact on hospital processes. This can involve clinicians being rostered to work in specific areas for set periods and at the same time be freed up from other clinical duties. In relation to A&E Departments this team approach would see consultants responsible for accepting patients from A&Es being freed up from other clinical duties to concentrate solely on emergency patients. Team working would also enable patients to be discharged by a consultant's colleague when he or she is not available.

3. Primary and Community Care Services

The availability of primary and community care services can contribute significantly to easing the difficulties facing some A&E Departments and the demand for acute hospital beds. Community and primary care providers can in fact remove the need for patients to attend A&E Departments, reduce their likelihood of admission and speed up their discharge.

Internationally, the focus of reform of healthcare systems is on improving primary and community care. The HSE sees this as the foundation upon which the reformed health service will be built and plans to reorient the health service towards the provision of care within the community so that patients only need to attend hospital for specialist services not available in their community.

At the cornerstone of primary care are GPs who carry out approximately 15 million consultations each year in Ireland. The number of GPs practicing in some geographical areas needs to be increased, as does the range of services they provide such as chronic illness management, minor injury units, etc. where these services are currently not available.

3.1 Out of Hours GP services:

It is essential that patients have access to GP services for urgent problems outside normal surgery opening hours. Where such services are not available, patients often have to attend A&E Departments for problems which would be more appropriately managed in the community. If after seeing a GP outside surgery opening hours, a patient still requires hospital admission this can be organised in a more appropriate manner.

In many areas throughout the country, there are very well developed, high quality, out of hours GP services, provided through GP co-operatives which are funded by the HSE. These services provide patients with easy access through a single lo-call telephone number and in most instances advice from a triage nurse is available as well as access to a GP.

The HSE is progressing with the development of these services throughout all areas of the country and for example in North Dublin it is expected that a local service will be operational later this year, serving a population of over 500,000 people.

3.2 GP access to diagnostics:

In many parts of the country, GPs do not have access to basic diagnostics such as plain x-ray and ultrasound scans. This often results in patients having to be referred to A&E Departments or outpatient departments. These services could be provided locally in public acute hospitals, county hospitals or by the private sector in community diagnostic centres.

The HSE is prioritising this area for development and funding has been allocated to commence the roll out of these services.

3.3 Rapid Access Clinics:

At community level, in some areas Rapid Access Clinics have been developed to ensure that older people who may not be well enough to wait for a regular out patient appointment can be seen promptly without having to present to A&E Departments. For example, in 2005 one such clinic in Dublin treated 500 patients who otherwise would have had to attend A&E Departments.

3.4 Community Intervention Teams:

Admission to hospitals can be avoided where flexible care supports are available on a timely basis to people experiencing a care crisis or a relatively routine ailment. An example of this would be where an elderly person, living independently in their own home develops an acute chest infection and as a result is unable to make their meals and is too weak to move around their house safely. While their medical illness can be managed satisfactorily by their GP, unless social, personal or nursing care supports are put in place urgently this patient may have to be admitted to hospital.

The HSE is establishing Community Intervention Teams which will provide a rapid response to ensure these social and personal supports are provided in a matter of hours and hospital admission can be avoided. The teams will cover four areas initially, serving a population of 850,000. They will commence in Cork City in May 2006 and then roll out to Dublin West, Dublin North and Limerick.

3.5 Primary Health Care Teams:

Primary health care is usually the first point of access for most patients to the healthcare system. Most patients who encounter medical problems will consult initially with a GP. A patient's GP, in conjunction with a Primary Health Care Team consisting of other healthcare, personal and social care professionals such as nurses, physiotherapists, occupational therapists, social workers, personal care attendants, home helps and many more, should be able to manage at least 95% of a community's health problems.

Where primary health care services have been enhanced, for example in the HSE's 10 Primary Health Care Team projects, patients can receive care locally from health professionals in a team approach ensuring easier access to care for patients much of which would traditionally have been provided in hospitals.

A priority for these teams is to ensure that close working relationships are developed between all of the healthcare professionals in the community who are dealing with individual patients and there is a focus on providing enhanced services, which may not have been available in the past, within the community.

All General Practitioners have recently been invited to become involved with the HSE in the further development of 100 Primary Health Care Teams in 2006 and the continuing development of such teams in the future. There has been a very positive response to this invitation with over 1000 GPs expressing interest and the roll out of these teams is being actively pursued

Primary Health Care Teams will also work closely with the hospital healthcare professionals to ensure that when a patient needs to access hospital services it is organised in an efficient manner, avoiding the need to attend an A&E Department. Similarly, when a patient is being discharged from hospital the event will be planned and co-ordinated with the Primary Health Care Team to ensure that patients do not have to spend any longer in hospital than is medically necessary.

3.6 Chronic Illness Management:

It is estimated that internationally, a significant number of acute hospital admissions result from an exacerbation of a chronic illness. Evidence indicates that many of these admissions could be avoided, and if required shortened, with high quality chronic disease management programmes provided through GPs, Primary Health Care Teams or in other non-acute settings.

Currently, people with chronic illnesses like diabetes, heart disease, etc., regularly attend hospital outpatient departments for the management of their ongoing condition. This care could be provided to the same or better standard in a structured care programme in the community by the GP and other members of the Primary Health Care Teams. The current GP contract negotiation has, as a central plank, the provision of structured chronic disease management programmes.

3.7 Home Care:

The HSE is currently investing heavily in Home Care packages and this year expects to provide more than 2000, which will provide people with a wide range of services to enhance their ability to continue living in their own homes and reduce their need to access acute hospital services. The HSE is committed to ensuring greater access to tailored packages of home care, addressing any process delays that arise in some areas in accessing this care and ensuring that assessment processes across the country are standardised.

Commitment

Driving change and delivering improvements for patients in A&E Departments and the wider health system is a priority for the HSE.

Difficulties experienced by some A&E Departments are a consequence of a number of factors which will require both local and system wide solutions.

High performing hospitals must be commended, rewarded and supported, and lessons shared with the hospitals who are having difficulty coping with their particular challenges.

The HSE is committed to providing care as efficiently as possible, to the highest quality standard and in a manner that promotes the greatest convenience for patients and their families. This involves, where possible, reducing the need for patients to be admitted to hospital and, if hospitalisation is required, to ensure that this does not extend beyond what is clinically required.

All existing capacity (beds and facilities), hospital practices and processes must be directed towards achieving this and supported with comprehensive primary and community care services.

Achieving this will require the full participation and support from clinicians, staff, managers and all who are in a position to effect these crucial changes.