Emergency Department Task Force Report

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Terminology

In December 2000, the Medical Council of Ireland accepted the advice of the Irish Surgical Postgraduate Training Committee (the recognised training body for the specialty) that the title of the specialty of Accident & Emergency Medicine' in Ireland be changed to 'Emergency Medicine'.

The term 'Emergency Medicine' is used in the United States, Canada, Australia and in a number of other countries. Emergency Medicine is also recognised as a separate specialty in Ireland, the UK and in a number of other EU states.

Subsequently Comhairle na nOspidéal changed the title of consultant posts in the specialty to 'Consultant in Emergency Medicine'.

In recognition of this and for consistency purposes, the terms 'Emergency Medicine' and 'Emergency Department (instead of Accident & Emergency Department) are used where possible throughout this document. The term 'Emergency Department' is often abbreviated to 'ED'.

The document is entitled 'Emergency Department Task Force – Report' in this context.

The term 'HSE A&E Framework' was determined prior to the Task Force's establishment and remains unchanged.

Summary of Key Findings and Recommendations

Background and Context

- In late March 2006, the HSE established a dedicated Task Force to facilitate the implementation of the HSE's Framework for addressing problems manifesting in Emergency Department Services and to work closely with hospitals experiencing difficulty supporting their EDs.

- The Task Force membership includes Consultants in Emergency Medicine, a Consultant Geriatrician, a Consultant Respiratory Physician, a General Practitioner, a Specialist in Public Health Medicine, a Director of Nursing, the CEO of an Academic Teaching Hospital and senior staff from the Primary Community and Continuing Care and National Hospitals Office Directorates of the HSE.

- The Task Force focused on those hospitals that have persistent challenges in Emergency Departments (EDs) and emphasised three goals to these hospitals: reducing the numbers waiting in EDs; reducing the length of time that patients wait and improving the overall patient experience.

- The Task Force concluded that it would best meet its stated terms of reference by identifying on a site-by-site basis specific initiatives that would have a potentially high impact on those sets of variables that affect ED performance.

- To guide individual hospitals in their approach to change, the Task Force issued a document 'ED Task Force – Supporting Local Action' based on the HSE's A&E Framework. It set out ten key areas within which hospitals were asked to propose actions. In addition, the Task Force examined processes within EDs and internal management control and measurement processes and the hospital and community interface.

- At the inaugural meeting of the Task Force, it was confirmed that an Acute Bed Capacity review was to be initiated. On that basis the Task Force did not undertake to assess specific bed requirements on a hospital or geographic basis. It focused in the first instance on optimising existing capacity in line with international best practice. The Task Force considered international evidence on the requirements for optimal capacity as well as the risks associated with over crowding. The report comments on a site-specific basis on issues relating to capacity. It suggests short term measures to optimise existing capacity including the provision of long term beds, the development of enhanced diagnostic and treatment capability on site and shifting care to more effective settings. Alongside recommendations regarding capability and control processes, the Report proposes enhanced capacity solutions to improve overall patient flow.

Summary of Findings - The Core Problem

At the current time, hospitals routinely do not have beds available to meet patient need. This results in those patients who require admission to hospital spending significant periods in the Emergency Department (ED). Such patients are sometimes referred to as 'boarded inpatients'.

Variation is a key cause of delay

The key cause of delays for patients in ED are variations in the hospitals and community's capacity and capability and control processes. These variations include:

- Variation in bed capacity
- Variation in the level and availability of clinical decision-making
- Variation in the availability of diagnostics, senior in-house specialty assessment and other ED supports
- Variation in internal control processes
- Variation in community and continuing care capacity and processes.

Such variations result in admitted patients being accommodated inappropriately with in the ED while awaiting transfer to an inpatient bed.

International evidence

At the current time, a significant number of hospitals examined by the Task Force are operating at close to 100% capacity against a well-established international evidence base that states that the optimum level is approximately 85% occupancy[i].

- Recently published studies from Australia, Spain, the USA and other countries show an association between overcrowding in hospitals and Emergency Departments and increased mortality and morbidity;

- International evidence suggests that reducing variations in capacity can be achieved by moving away from ring-fencing of beds, smoothing elective activity, redesigning internal processing to reduce complexity and the number of steps needed to manage the patient effectively;

- The international evidence from Australia, UK and USA indicates that the key change requirement for effective chronic disease management is a move from existing predominantly hospital focus to a more pro-active, integrated, population-focussed model incorporating the hospital, community and GP services.

Summary of Overall Findings

The Task Force's key findings are summarised below under the headings of capacity, capability and control processes.

Capacity

- At least 7 of the Emergency Departments are unfit for purpose. This militates against effective management of patient volumes and wait times within Emergency Departments.

- A number of other hospitals are less than optimal in terms of space and overall design which does not enable effective streaming of patient cohorts. This points to the need for a national ED planning framework within the overall capital planning process that ensures there is adequate space provision within new builds to enable effective streaming and fast-tracking and / or diversion of attendees.

- The supporting infrastructure within EDs to address the resuscitation needs of patients and dignity and privacy requirements of specific groups such as paediatric and obstetric patients is inadequate on a number of sites.

- A number of the hospitals examined by the Task Force are operating at close to 100% capacity and the majority at 95%. This results in sub-optimal management of elective and emergency workloads.

- It is vital that hospitals have full access to their existing beds. For the Dublin hospitals, issues relating to delayed discharges have meant that up to 20% of their current bed capacity is not available to each hospital. There is insufficient access to long-term beds and an ad hoc approach to the allocation of such beds. A similar trend is emerging in Cork, Galway, Drogheda, Cavan and Limerick.

- In Dublin, there is an ongoing requirement for 46 long-stay beds per week to meet the needs of post-acute patients. The HSE has estimated that, nationally, there is a requirement for 2,472 long stay places over the next 12 months, with similar numbers recurring in future years.

- In terms of optimising existing capacity, issues have also been identified in relation to lack of consistent availability of diagnostics and reporting availability – in real time – in response to emergency and inpatient needs.

- The development and impact of community responses to address patient requirements at both primary and continuing care levels has been very variable. Specifically, the availability of and impact of out-of-hours services on ED volumes is variable.

- The development of appropriate home care supports outside of Dublin has been limited. As a result, their impact on addressing the continuing care needs of patients has been sub-optimal.

- There is a need for standardisation of processes to optimise the use of home care as an alternative to long-term care.

Capability

Appropriate ED avoidance

- Initiatives aimed at linking GP and PCCC services with acute hospitals have not been sufficiently targeted at supporting improvements in the volumes, or wait times of patients presenting in ED.

- There are no formal structures providing ongoing links between GP's, hospitals and community and continuing care services.

- In relation to the impact of out of hours and GP cooperatives on ED services, the following should be noted:
    - The period of highest demand and self-referrals to Emergency Departments is between 8 am and 8 pm, largely times when GP's are available in their surgeries.
    - While the development of GP out of hour cooperatives will provide more accessible and structured primary care services out of hours, such services do not act to reduce the number of patients inappropriately accommodated in EDs after a decision to admit to an inpatient bed. Instead, if utilised correctly by patients and properly supported by diagnostic capability, they will provide alternative rapid access for patients who have non-lifethreatening illness or injury, and who currently use the ED for these services.

Effective Management of Patients within ED

- The Task Force identified a number of initiatives as having the potential to improve patient processing and overall management within the ED. These include streaming, "See and Treat", Clinical Decision Units (CDUs) and fast-track specialist consultant clinics. Key issues identified are as follows:
    - There is a need to ensure that attempts to optimise the efficient management of high volumes of less urgent patients does not compromise the care of the more acutely or seriously ill patients.
    - In a number of the hospitals visited, the existing space and design would not enable such processes to be implemented efficiently.
    - Evidence of the efficacy of the CDU and Fast-Track Specialist Consultant Clinics is growing, if they are provided by Senior Clinical Decision Makers and adequately supported.
    - Accordingly, the success of each of the initiatives is dependent on there being sufficient availability of senior clinical decision-makers and adequate support from diagnostic services.

Rapid Access to appropriate inpatient care

- The Task Force acknowledged that the international evidence on the impact of initiatives aimed at enabling rapid access to inpatient care is robust. However, site visits and analysis highlighted the following:
    - The effect of fast- track and other initiatives aimed at improving patient flow on the volumes and wait times in ED have been variable.

- In some cases such initiatives have resulted in adverse effects through competition in resource terms with other services aimed at addressing problems in ED (e.g. Senior Clinical Decision-making, diagnostics).
- The development of chronic disease management programmes has not been cohesive**.** While most hospitals have taken some steps in this regard, it has been on a relatively small scale with limited resources.
- Hospitals can improve existing inpatient bed capacity usage through specific non elective 'medical' patient orientated capability initiatives, particularly the creation of Acute Medical Admission Units. The creation of short stay (less than 5 days), high intensity capacity (with rapid access to diagnostics) can result in the following benefits:
  - Reduced ED 'trolley' waits / prompt admission
  - 'Pull' to accommodation within appropriate ward
  - Focused condition specific protocol, rather than individualistic approach
  - Shorter average length of stay (approximately 2 day reduction)
  - Prompt effective discharge – with no increased readmission

<u>Senior Decision making.</u>

- The site visits identified the following issues:
  - In a number of hospitals there were insufficient decision-makers within the ED (both in Emergency Medicine and the admitting Specialty) to enable effective management of patients prior to decision to admit.
  - There was inadequate access to senior decision-makers within the admitting teams, which contributed significantly to delays in ED.
  - In a number of hospitals, issues were identified in terms of duplication of effort between the emergency teams and the admitting teams which pointed to the need for joint management of emergency attendances
  - In a number of sites where initiatives aimed at appropriately diverting or fast-tracking patients were introduced, their impact was diluted by inadequate access to senior decision-making.

- Taking the above into account, there is a clear requirement for an increased Consultant workforce. There is also an imperative to introduce an extended working day within a national IR framework.

<u>Access to Diagnostics</u>

- In terms of optimising existing physical capacity and bed utilisation, the lack of consistent availability to diagnostics - in real time - is a significant challenge for hospitals.

- The issues in diagnostics manifest themselves at three levels – GP access, access to diagnostics within the Emergency Department and inpatient diagnostic requirement.

- Such delays cause result in inappropriate referrals to the ED, inappropriate admissions and sub-optional bed utilisation.

Formal structure required between hospitals, PCCC and GP services

- There are no formal structures to support appropriate links between hospitals, PCCC and GP services.

- A number of initiatives undertaken to date would have benefited from improved dialogue and focus on the high impact changes required.

- There is an opportunity to use the recently established area meetings and local implementation teams as vehicles for articulating the critical priorities in tackling the ED issue and developing a common strategy and framework for action.

Effective Management of Specific Patient Cohorts

Older people - The international evidence on effective management of older people in hospitals highlights two key issues:

  - Most patients requiring long-stay or extended care have a defined underlying medical condition that necessitates full investigation and treatment.
  - A minority of older people (5%-20%) could be managed in a community hospital setting.

- The above evidence underlines the need for development of clear care pathways that enable effective streaming of patients to one of the following;
  - Early assessment in ED
  - Admission to a geriatric facility
  - Admission to an acute hospital
  - Referral to a Geriatric rapid access clinic, community intervention team or a day hospital for the elderly.

- The potential for developing appropriate alternatives to acute admission was identified by the Task Force. In this context the development of specialist complex discharge teams to facilitate the management of older patients requiring recuperation, re-enablement or transitional care. There would be obvious benefits in terms of patient out comes and bed utilisation.

- The further development and creation of primary care inter-disciplinary teams, together with better organisation of out of hours care provision, has the potential to positively impact on numbers attending the ED, reduce hospital admissions, lengths of stay, and facilitate the timely discharge of patients.

Management of Chronic disease - International and recent Irish evidence supports the development of integrated, population based chronic disease management programmes on the basis of the outcomes for patients, the significant improvements in overall bed utilisation and the reduction presentations to the ED

Patients with Mental Health Difficulties - In most hospitals, issues were raised in relation to the management of patients requiring Mental Health services. Key challenges included;

- Delays and inadequate access to psychiatrists to admit patients,
- Insufficient access to psychiatric beds and
- Inadequate facilities to safely treat and manage psychiatric patients within the ED.

These challenges result in patients spending significant time in the ED (often in excess of 24 hours), with sub-optimal arrangements to manage risks for patients and staff

Effective Discharge of Patients

- In some hospitals, measures are in place to support effective discharge planning – including identifying a projected discharge date on patient admission. These measures must be expanded to each hospital to facilitate appropriate engagement with PCCC services and support whole-system care pathways for patients.

Control

Acute Hospitals

- A significant number of hospitals have challenges in terms of the internal control processes in place to tackle emergency admission issues manifesting in ED on a whole hospital basis. This impacts their capacity to respond promptly and adequately to increasing delays or volume of patients presenting in the ED.

- Inadequate controls are typically demonstrated in areas such as the use of an escalation policy, management of elective/emergency split and involvement of Senior Clinical Decision makers on a whole hospital basis in tackling emergency admission issues manifesting in ED.

- In a number of hospitals, information on ED activity is not routinely used by management or by clinicians outside the ED.

- Information on the extent to which PCCC services are available to support the delivery of ED services is not always readily available.

- IT within Emergency Department is poor nationally.

- In some hospitals, measures are in place to support effective discharge planning – including identifying a projected discharge date on patient admission. These measures must be expanded to each hospital to facilitate appropriate engagement with PCCC services and support whole-system care pathways for patients.

PCCC Control Issues

- The Task Force suggests that within PCCC the existing control structures and processes are limited for purpose, as a result of the following:
    - Insufficient extended / long term care placements to meet hospital and community ongoing requirement – particularly within Dublin region.
    - The absence of a systematic and proactive approach to the provision of extended placement beds.
    - The lack of agreed hospital specific annual and monthly public community bed provision values.
    - The existence of public bed provision parallel with subvented bed provision
    - Delays in securing home subvention

Recommendations

The Task Force has identified a number of potential patient centred high-impact changes to the delivery of Emergency Department services as follows:

a) Capacity

- Ensure access to existing capacity using targeted initiatives in relation to issues such as diagnostics and long term care. The development of improved care pathways for specific groups such as chronic disease, paediatrics, geriatrics and mental health patients should also be considered as a matter of priority.

- Manage capacity according to prioritised need – Ensuring that capacity freed by initiatives such as the movement of patients to long-term care or improved diagnostics is appropriately balanced between emergency and elective admissions.

- Introduce or enhancing management control processes to ensure capacity freed by reductions in delayed discharges is used in line with emergency need is only one part of the solution. Hospitals must re-examine and re-configure their approach to overall bed capacity management in all settings if change is to be effective.

- Implement effective additional capacity initiatives to allow timely admission

- Identify the capacity requirement associated with emergency and elective admissions.

- Reduce variation in the level of elective activity.

- Implement appropriate escalation measures in response to rising emergency admission demand.

- Develop sustained solutions to meet the long- term care requirements of those patients who no longer require acute hospital beds (see section Meeting Future Long-Term Care Requirements).

- Ensure capacity released by the discharge of patients to long-term care is used to appropriately balance emergency and elective activity requirements;

- Create new capacity through initiatives aimed at diverting or fast tracking patients for example, AMAUs and rapid access clinics.

- Develop specific solutions to meet the continuing care requirements of Young Chronic Sick patients.

- Develop alternative community solutions to presentation to ED particularly for older patients, (see section Elderly patients in the ED)

b) Capability

- *Appropriate ED avoidance*

    - Create additional and alternative access routes to urgent care thereby obviating the need for Emergency Department attendance
    - Ensure that all initiatives aimed at supporting rapid access to Consultant opinion are underpinned by dedicated up skilled teams, supported by adequate diagnostic capability and robust clinical protocols
    - The availability of additional community professionals, especially Community nursing, on a seven day basis to match changed hospital service provision and discharge policies should be immediately pursued

- *Effective Management of Patients within the ED:*

    - Increase the level of senior clinical decision making in ED
    - The Task Force recommends that the role of each on-call admitting Consultant in the hospital includes a specific commitment to respond to ED activity. This includes:
        - Daily specialist Consultant ward rounds in the acute specialties.
        - Daily handover of admitted patients to the relevant Consultant or specialty in that hospital.
        - Participation of the on call admitting team in escalation measures.
        - The availability of specialist Consultants to admit, discharge, or refer patients to fast-track clinics.

      The workforce implications of these measures will need to be quantified.

- *Rapid Access to inpatient care*

    - Fast track Clinics: The Taskforce endorses such clinics as likely to be effective in reducing the volumes and wait times in EDs, provided they are delivered and overseen by senior decision makers and underpinned by robust clinical protocols.
    - Hospitals can improve existing inpatient bed capacity usage through specific non-elective ‘medical’ patient orientated capability initiatives, particularly the creation of Acute Medical Admission Units. The creation of short stay (less than 5 days), high intensity capacity can result in the following benefits:

- Reduced ED 'trolley' waits / prompt admission
- 'Pull' to accommodation within appropriate ward
- Focused condition specific protocols, rather than individualistic approach
- Shorter average length of stay (approximately 2 day reduction)
- Prompt effective discharge – with no adverse increased readmission

- *Senior Decision Making*

    - There is a need for additional consultant workforce levels in the admitting specialties and in Emergency Medicine and the introduction of an extended working day within a National IR framework to facilitate such changes to ensure the 2007 target of Emergency Department Registration to Disposition of 6 hours is achieved and maintained.
        - There is an imperative to ensure that those attending Emergency Departments for admission are assessed by a senior clinician in the admitting team as soon as possible after arrival.
        - Supporting improved access to early Senior Clinical Decision making by admitting consultants – in relation to inpatients and patients within ED – including those patients who do not require admission from ED (including diversion by specialists to Rapid Access / OPD / Clinics / Diagnostics or Social Worker – depending on circumstance).

- *Access to Diagnostics*

    - Develop rapid routine diagnostic reporting on an extended 12 hour, 7 day basis – linking diagnostic reporting capacity to ED attendance patterns and patient need over the 24 hour period.
    - In the short term, the option of out-sourcing diagnostics should be considered particularly for GP workloads in order to improve overall bed utilisation and patient flow. Also, the potential for delivering an extended day through the use of overtime should be supported. It is vital that safeguards are in place to ensure quality assurance, shared access to results, and avoidance of test duplication should the patient require hospital attendance.
    - Any short-term initiatives should be carefully selected and evaluated in terms of overall impact on volumes and wait times in ED and control.
    - In this context, work practice issues must be addressed urgently in relation to diagnostic and support services within the context of a national IR environment.

- *Chronic Disease Management*

    - Expand and mainstream chronic disease management programmes with the development of shared care models and integrated care pathways.
    - Exploit the opportunities offered by a national system for developing common protocols and care pathways to facilitate chronic disease management in line with the established evidence base (see sections under international evidence and recommendations)

- *Effective Discharge of patients*

    - Patients placed directly under the care of the appropriate specialist will have a streamlined investigation process; early diagnosis and treatment and earlier discharge (see section 4.2.4)

c) Control

- *Acute Hospitals*

    - Ensure that the Hospital Manager is accountable and responsible for overall operational management of hospital including target settings and effecting changes in work practices.
    - Develop an overall pan-hospital control structure that recognises the need to accommodate emergency, urgent elective and less urgent patient groups within the bed base.
    - Hospitals should set specific volume targets relating to the patient groups on a day- to- day basis on the premise that. ED and Elective generated bed base volume requirements are largely predictable; this should be done on a daily, weekly, and monthly basis
    - Establish a single bed management control function within hospitals to manage the requirements of all patient cohorts efficiently.
    - Strengthen discharge management functions as an immediate priority. incorporating two key elements- (Planned) date of discharge to be identified on admission and individual patient information to be used at a macro hospital level to predict overall ongoing bed availability / capacity.
    - Support hospitals to develop solutions tailored to specific local needs. Robust clinical and business processes and mechanisms to assess the impact on overall patient flow should underpin such solutions.
    - Develop Clinical Treatment / Care pathways, whereby predetermined optimal pathways are developed for specific illnesses and used to effect control of work practises and enable achievement of desired performance metrics. Apply control mechanisms to the totality of the patient care pathway.

- *PCCC Controls*

    - Ensure that Community bed volume, other community service provisions and wait times for assessment and access to community and continuing service should form an integral part of the PCCC annual service plan agreement.
    - Targets linked to service volumes and wait times should be developed with immediate effect for PCCC
    - Provide placements and services on a proactive assessment of overall hospital need, rather than a delayed reactive response to demand based on actual inappropriate acute bed occupancy.
    - Design Control structures within PCCC to enable and support discharge in a timely manner – avoiding duplication of assessment and in securing services.

- *Hospital / PCCC Control Interface*

    - Each Hospital and local PCCC area should jointly develop and effect discharge and community maintenance requirements, supported by joint performance metrics.

- *Measurement*

    - Introduce system wide definitions that apply to all Hospitals and Emergency Departments, to allow for better comparative analysis of performance. (including paediatric beds/ paediatric hospitals)
    - Develop dedicated IT systems to measure agreed variables. There is a requirement for enhanced National and Local IT and information availability.
    - Develop National Frameworks to establish norms on issues such as Triage, supporting Infrastructure, Staffing levels, Transport and Treatment;
    - Measure wait time for all patients from time of arrival at Emergency Department or AMAU. This will require significant effort and resources but will build a more accurate picture of clinical need and demand volumes.
    - Agree on the targets to be applied for the balance of 2006 and for 2007. At a very minimum there is a need to introduce a maximum target waiting time of 12 hours with immediate effect, with a six hour total maximum target wait time to be set by the HSE.

  The above innovations must be implemented in an integrated manner to maximise the impact on the volumes and wait times in ED

- *The Role of Incentivisation*

    - The Task Force acknowledges the effect of the introduction by the HSE of ED targets linked to financial allocation in providing a whole hospital focus in tackling the problems that manifest themselves in the Emergency Department.
    - The Task Force observations in relation to the role of incentivisation can be summarised as follows;
        - There is a need for positive incentives aimed at rewarding performance and/or enabling whole system focus on the emergency admission issues manifesting in ED.
        - Targets also need to be set for hospital avoidance measures at community level.
        - There is a need to balance the merits of incentivisation against the requirement to enable improved performance in those hospitals that have infrastructural deficits.

Summary of recommendations regarding implementation

Zero-tolerance for trolley waits

As emphasised throughout the report, the Task Force has identified its key objective as ensuring that the health system adopts a culture of 'zero-tolerance' for trolley waits. Achieving this objective requires that hospitals measure wait time for all patients from time of arrival at the Emergency Department.

While there has been significant, sustained improvements in ED performance over the past year, the Task Force takes the view that it is not acceptable, in any context, for patients to wait for 24 hours in ED for admission to a bed. In the current system, such 24 hour waits (and those of less than 24, less than 12, or less than 6 hours) are measured only from the decision to admit.

The HSE's clear responsibility is to ensure that the Irish health system provides care in Emergency Departments of a standard and quality comparable to that delivered internationally. In this context and in light of its findings regarding operational and infrastructural constraints on ED performance across the health system, the Task Force believes that a 6-hour total wait time from arrival to discharge/admission represents a realistic, medium-term operational target for the HSE and hospitals.

As an interim step, the Task Force is of the view that there should be an immediate requirement for hospitals to meet a target of 12-hours from decision to admit.

Targets for Primary Community and Continuing Care (PCCC)

In light of the evidence of the affect of delayed discharges from acute hospitals on ED volumes and wait times, the Taskforce recommends the introduction of targets for the delivery of continuing care (community or institutionally based) by the HSE PCCC Directorate. Such targets are intended to be a realistic and deliverable mechanism to positively affect the flow of patients through the acute hospital setting and minimise wait-time in the ED.

As a first step for patients requiring continuing care services, the Taskforce recommends that a target of 2 weeks should be set with immediate effect upon completion of the management of their acute care episode. While similar targets should be set in 2007 for those patients who require continuing community or institutional-based care, the Taskforce accepts that - having regard to the infrastructural and other programmes for securing additional longstay capacity - this target will not be fully realised in the immediate term. It is critical, however, that these targets are set during 2007.

Meeting targets – constraints on delivery across the health system

Arising from the Task Force's site visits and related analysis, three broad groups of hospitals emerged from within the 18 hospitals;

i) A small number of hospitals that are capable, with support, of moving beyond a 12 hour target to a 6-hour target wait time from decision to admit.
ii) A group of approximately 10 hospitals that have - for the most part - delivered on the 24-hour target. The Task Force is confident that these hospitals will achieve the target of 12 hours from decision to admit if targeted initiatives are implemented and supported by robust management controls.
iii) A group, (originally comprised of 6-7 hospitals but now of 2-5 hospitals) that have failed to deliver on the 24-hours target. These hospitals require sustained focus and support if an intermediate target of 12 hours is to be achieved.

The Task Force identified three broad issues that militate against effective delivery on immediate and ultimate waiting time targets.

i) Adequacy of physical infrastructure within ED
ii) Availability on a consistent basis of long stay facilities, particularly in Dublin
iii) Adequacy of internal management controls

Issues relating to other hospitals

The Task Force emphasised three goals to the 18 hospitals which formed its remit: reducing the numbers waiting in EDs; reducing the length of time that patients wait and improving the overall patient experience. The Task Force is aware that these goals equally apply to those hospitals with Emergency Departments which were not the subject of study. The Task Force urges the HSE to address issues particular to these other hospitals, including; the extent to which the data recorded at hospital level accurately captures and reflects ED performance; and how hospitals currently displaying a high level of performance are best supported and enabled to continue achieving targets by the HSE.

Achieving a target of 12 hours or less wait time from decision to admit

The Task Force is of the view that initiatives for those hospitals having difficulty meeting the interim 24-hour target wait time - after decision to admit - should be targeted at achieving a 12-hour target wait time from decision to admit. It is accepted that physical infrastructural deficits in Our Lady of Lourdes Hospital Drogheda; and serious long-stay capacity issues relating to Beaumont's catchment area in North Dublin militate against early delivery on a 12-hour target.

The Task Force recommends that by 1st January 2007 the HSE introduce the target of 12-hours or less wait time after decision to admit. It will be necessary for the HSE to detail the measures to be undertaken to enable each hospital to meet this target at that time.

Achieving a target of 6-hours or less wait time from decision to admit

At the end of 2006, the Task Force has identified three hospitals as capable of delivering – during 2007 - on a target of 6-hours or less patient wait time after decision to admit: St James's, Sligo, Galway. A further group of hospitals namely: CUH, Limerick, Connolly, Wexford and St Columcille's could with structural supports and strengthened internal management controls deliver on the target of 6 hour less wait time from decision to admit. The remaining hospitals mainly Mater, St Vincent's, AMiNCH Tallaght, Naas, Mercy, Letterkenny and Cavan will require targeted initiatives in line with the recommendations with this report if the target of 6 hours or less wait time from decision to admit is to be achieved. The four key factors in this context are:

- *Enhanced Senior Decision-Making within the ED and within admitting teams to enable faster decision-making.* This is vital in the Mater, Vincent's Hospital, AMNCH, the Mercy and Cavan hospitals. It is also an imperative for St. James's and Connolly hospitals in the first group above.

- *Availability of Appropriate Long-Stay Facilities* - The HSE programme of the development of additional long-stay facilities will yield additional beds for the greater Dublin area and will come on stream from September 2007 onwards. Outside of Dublin, the capacity will be delivered during the second half of the year. Hospitals impeded by such capacity requirements include St. James's, St. Vincent's, the Mater, Beaumont, Tallaght and Connolly, Hospitals and Cork University Hospital and University College Hospital, Galway.

- *The physical capacity requirements of the emergency departments* in the hospitals have been well articulated in this report. The development of new emergency departments on the sites of our Lady of Lourdes, Letterkenny, the Mercy, Wexford General Hospital and the Mater hospital will yield significant improvements in the physical environment. More importantly, they will enable more effective streaming and management of patients. However, with the exception of the Mercy Hospital the earliest completion date for any of these departments is early 2008 and accordingly the hospitals concerned will be seriously impeded in delivery on a target of 6-hours or less wait time after decision to admit.

- *Control requirements* - The Task Force report highlights the imperative of putting in place robust management controls to ensure that the freed-up capacity is appropriately targeted at emergency patients. The delivery of the 6 hour target is contingent upon the importance of full implementation of its recommendations alongside the hospital specific initiatives to ensure that the available capacity is fully optimised.

The Task Force recommends that by 1st February 2007, the HSE announces the date from which hospitals will meet the target of 6-hours or less wait time after decision to admit. The HSE should detail the measures to be undertaken to enable each hospital to meet this target.

Achieving a target of 6-hours total wait time – from arrival to discharge/admission

In summary, the Task Force recommends that:

a. The HSE moves immediately to a target of 12 hours or less wait time from decision to admit;

b. The HSE sets a date by the 1st February 2007 from which hospitals will meet a target of 6-hours or less wait time after decision to admit; and in this context takes account of the timeframe for implementation of infrastructural and other measures identified above:

c. The HSE sets a date by 1st February 2007, to have determined the timeframe from which a total maximum wait time of 6 hours from arrival at the Emergency Department to admission or discharge will apply and have detailed the measures to be undertaken to enable each hospital to meet this target.

Chapter 1 - The Work of the Task Force

1.1 Context

Emergency Departments in Ireland have experienced significant pressures over the last 20 years – a source of increasing public and professional disquiet. There has been particular pressure on Emergency Department services across the country over the past 5 years. In the first few months of 2006, numbers waiting in ED for admission to a hospital bed were higher than those in the equivalent period in 2005 and previous years. This was exacerbated by an increase in attendances to Emergency Departments (ED), a rise in admissions from Emergency Departments to hospital beds, an expansion of Delayed Discharges and the recurrence of infectious illnesses such as NoroVirus.

1.2 HSE A&E Framework

In response to the issues highlighted above, the HSE, National Hospitals Office identified the delivery of sustainable improvements in Emergency Department services as its key priority for 2006. To ensure this, the HSE developed a Framework in February 2006, *(The HSE A&E Framework)* for the operation of ED services across the hospital system

The Framework is underpinned by three key strands:

- Reducing and diverting Emergency Department attendances and admissions;
- Reducing delayed discharges; and
- Improving efficiency and throughput across the whole hospital – not just in Emergency Departments.

The HSE moved to implement the Framework by:

- Developing hospital specific time based targets in relation to Emergency Departments and Delayed Discharges;
- The development of financial incentives linked to performance in these areas;
- Introduction of targeted initiatives aimed at delivering immediate and sustained impact in the areas set out above.

1.3 Emergency Department Task Force

In late March 2006, the HSE established a dedicated Task Force to facilitate the implementation of the HSE's Framework and work closely with hospitals experiencing problems in Emergency Departments.

Terms of reference

The Terms of Reference of the Task Force emphasised the need to:

- Drive the implementation, on an individual hospital basis, of targeted solutions aimed at reducing the numbers of patients waiting for emergency admission and the length of time that patients wait.

- Ensure that immediate steps are taken at individual hospital level to improve individual patient comfort, privacy and the overall experience of patients.

- Identify and implement a range of short and medium term solutions for those patients that require continuing care following discharge from hospital.

- Work with hospitals to develop their internal management structures and processes to improve overall patient flow.

The Task Force membership was as follows:

- Ms Angela Fitzgerald, Hospital Network Manager, National Hospitals Office, (Chair),
- Dr Gerard McCarthy, Consultant in Emergency Medicine, Cork University Hospital,
- Dr. Gerard Lane, Consultant in Emergency Medicine, Letterkenny General Hospital,
- Dr Conor Burke, Consultant Respiratory Physician, Connolly Hospital, Blanchardstown,
- Dr. Dermot Power, Consultant Geriatrician, Mater Misericordiae Hospital,
- Ms Mary McHugh, Director of Nursing, Galway Regional Hospitals,
- Dr Emer Feely, Specialist in Public Health Medicine, Population Health Directorate, HSE;
- Dr Richard Brennan, General Practitioner;
- Mr Jim Breslin, Assistant National Director, PCCC;
- Mr Ian Carter, Chief Executive Officer, St James's Hospital;

Andrew Condon, Jennifer Feighan, Robert Kidd and Louise Dodrill of the National Hospitals Office provided support to the Task Force.

The Task Force wishes to acknowledge the support provided by and data management and analysis undertaken by the National Hospitals Performance Management Unit and Ms Carol Hickey, Chief Executive's Office, St James's Hospital.

1.4 Methodology

The Task Force focused on those hospitals that had been experiencing persistent challenges in dealing with emergency admission issues manifesting in Emergency Departments as follows:

- Wexford General Hospital,
- Cork University Hospital,
- Mercy University Hospital,
- Cavan General Hospital,
- Our Lady of Lourdes Hospital, Drogheda,
- Letterkenny General Hospital,
- Sligo General Hospital,
- Galway Regional Hospitals,
- Mayo General Hospital, Castlebar,
- Mid-Western Regional Hospital, Limerick,
- St Vincent's University Hospital,

- Adelaide & Meath Hospital incorporating the National Childrens' Hospital Tallaght,
- St James's Hospital,
- Naas General Hospital,
- Beaumont Hospital,
- Connolly Hospital Blanchardstown,
- St Columcille's Hospital, Loughlinstown,
- Mater Misericordiae University Hospital.

Three key areas of focus were emphasised to these hospitals:

- Reducing the numbers waiting in Emergency Departments;
- Reducing the length of time that patients wait to get to a formal hospital bed; and
- Improving the overall patient experience.

At the first meeting, the Task Force identified the key objective as ensuring that the health system adopted a culture of "zero tolerance for trolley waits." Alongside this the Task Force set out to work with hospitals to identify the areas of focus above, and to ensure that while awaiting admission to a ward, patients are guaranteed privacy and dignity.

The Task Force concluded that the terms of reference would be best met by identifying on a site-by-site basis those issues that were impeding effective operation of the ED in terms of capacity, capability and control. The Task Force would then identify a series of site specific initiatives that would have a significant positive effect on emergency admission issues manifesting in ED; and improve the delivery of patient care.

1.5 Targets

As an immediate priority, the Task Force undertook to work with hospitals to identify actions required to ensure that no person is required to wait from after decision to admit, on a trolley, in an Emergency Department, for more than 24 hours and that such patients are accommodated in a comfortable and dignified setting. This standard was determined by the HSE's National Hospitals Office (The decision to admit is counted by the HSE as when the ED team refers the patient to the admitting team for admission).

In this context and in light of its findings regarding operational and infrastructural constraints on ED performance across the health system, the Task Force believes that a 6-hour total wait time from arrival to discharge/admission represents a realistic, medium-term operational target for the HSE and hospitals.

As an interim step, the Task Force is of the view that there should be an immediate requirement for hospitals to meet a target of 12-hours from decision to admit.

The introduction of ED targets linked to financial allocations by the HSE in 2006 has been fundamental to creating a hospital-wide focus on emergency admission issues manifesting in ED. Alongside the introduction of daily and weekly reporting it has provided a useful framework for comparative analysis of performance across

hospitals. During the period May to December 2006 there has been a significant overall reduction in ED waiting times and volume.

For example, the proportion of patients recorded as waiting for admission for more than 24 hours decreased by 3% between May and October, from 9% in May to 6% for October, with those waiting 12-24 hours falling 4% from 30% of the total in May to 26% in October. The numbers waiting 6-12 hours were 24% in October while the proportion of those waiting 0-6 hours increased from 38% in May to 43% in October.

Overall this meant that 39% of patients waited over 12 hours in May, compared to 33% in October.

Taking this into account, the Task Force wishes to emphasise the limitations of not counting waiting time from time of arrival. These have been articulated repeatedly during the Task Force's work and are re-iterated below for the following reasons:

- The true waiting time for patients is not measured;
- The potential delays in processing patients up to point of referral by the admitting team are not highlighted;
- Experience from other jurisdictions point to the potential for 'gaming' in relation to meeting targets for waiting times

At its first meeting, the Task Force took the decision, in agreement with the HSE and the Tanaiste and Minister for Health and Children, Mary Harney, to focus on those patients in ED that require admission to the hospital (boarded inpatients). Targets in relation to numbers of patients on trolleys and waiting times reflected this focus.

The Task Force emphasised the requirement to set targets in relation to total waiting times and that these targets should be applied to all patients. The obvious advantage is that the target then reflects the total patient experience in ED.

Within this report, the primary focus for action is on supporting the achievement of targets in relation to total wait times for those patients that require admission. However, the Task Force wishes to emphasise the critical importance of providing appropriate supports to those hospitals that are already delivering on the basic targets and are now moving to the advanced targets to enable them to achieve and sustain substantial improvements in the total ED experience. A small number of hospitals within the group examined by the Task Force fall within this category. The options for providing such supports without disadvantaging other hospitals are discussed in the overall recommendations section.

1.6 Site by site assessment by the Task Force

The Task Force established three teams for the purposes of working with hospitals and undertook a series of site visits and assessments with each of the hospitals under its remit.

Prior to consultation and site visits, the Task Force reviewed data relating the management of ED attendances, emergency and elective admissions, bed capacity and discharges from each hospital. This data was of varying quality and maturity. Further information was sought during site visits with the aim of:

- Effecting process improvement to optimise the use of internal capacity.

- Identifying actions that would improve the overall patient processing with specific regard to Emergency Departments.
- Delivering improvements in the co-ordination and management of discharge planning from the Acute Hospitals
- Achieving improved and timelier access to continuing care services in the public and private sector.

To facilitate a joint hospital, primary care and community approach to the issue, the Task Force requested that meetings between the Task Force and representatives of individual hospitals be attended by the relevant Hospital Network Manager, Assistant Director, HSE Primary, Community and Continuing Care Directorate (PCCC) and other PCCC officials as required.

1.7 Local accountability

During its work the Task Force was emphatic that change should be owned, managed and driven locally by the Hospital CEO / General Manager. Accountability for action rests with the Hospital CEO / General Manager and subsequently with the Hospital Network Manager. Similarly ownership of and accountability arrangements for change in the PCCC setting rests with Local Health Office Managers, relevant PCCC officials and subsequently with the relevant Assistant Director, PCCC.

1.8 Guidance issued by Task Force

To guide individual hospitals in their approach to change, the Task Force issued a document 'ED Task Force – Supporting Local Action' based on the HSE's ED Framework (attached at Appendix A). It set out key areas within which hospitals were asked to propose actions:

- To ensure that systems were in place to support rapid access to urgent inpatient wards.
- Development of and implementation of a Full Capacity Protocol as required
- Availability of timely Senior Clinical Decision making in the admitting team,
- The establishment of links with General Practitioners and other PCCC services
- To ensure the ready availability of diagnostics, imaging and tests.
- Management of elective activity in response to Emergency Department demand and emergency admission demand,
- Mechanisms to support the appropriate and efficient discharge of patients,
- Best use of existing capacity,
- Internal management control and audit processes

Hospitals were advised that all initiatives would be supported by performance measures which would allow regular audit and review of progress by a team led by the Hospital CEO / Manager and including lead consultants and other clinicians. Similar arrangements would apply in the PCCC setting.

The Task Force's overall findings and recommendations are set out in Chapter's 2 and 3. Chapter 4 sets out the findings and recommendations on a hospital specific basis. The recommendations aim to address those issues that are adversely affecting overall responsiveness for patients requiring admission. The rationale behind this approach is to enable measured and sustainable improvements in performance to be secured and maintained.

Chapter 2 - Task Force findings

2.1 Introduction and Context

2.1.1 The Core Problem

The core problems facing those hospitals experiencing problems in ED are related to variations in local capacity, capability and control.

One effect of such variation is that hospitals frequently do not have beds available to meet patient need. This results in those patients who require admission to hospital spending significant periods in the Emergency Department (ED).

Delays can result in deterioration in patients' clinical condition and contribute – as patient volumes in the ED rise to reductions in the quality of the patient environment.

A key cause of delays for patients in ED are variations in the hospitals and community's capacity and capability and control processes. These variations include:

- Variation in bed capacity
- Variation in the availability of diagnostics, senior in-house specialty assessment and other ED supports
- Variation in internal control processes
- Variation in the level and availability of clinical decision-making
- Variation in community and continuing care capacity and processes.

Such variations result in admitted patients being accommodated inappropriately within the ED while awaiting transfer to an inpatient bed. (Boarded Inpatients)

2.1.2 Variation and Optimal Capacity

A significant number of hospitals examined by the Task Force are operating between 95% and 100% capacity against a well- established international evidence base that states that the optimum level is approximately 85% occupancy.

International evidence suggests that variation in demand or variation in capacity will result in queues and consequent delay in the assessment, treatment and discharge of patients.

Key drivers of variability include:

- The organisational mismatch of hospital services to support ED being routinely available over the Monday to Friday period while patients attend ED over the full seven day week;
- The organisational mismatch of elective activity – which results in peaks in the number of patients waiting in ED particularly on Mondays and Tuesdays;
- Elective and emergency workloads are not appropriately balanced with available beds;
- Inability to increase numbers of patients treated on a day case basis.
- Mismatch between the supply and capacity from the acute and community sector of continuing care services and the needs for such services.

Recent international evidence suggests that reducing variations in capacity can be achieved by moving away from ring-fencing of beds, smoothing elective activity, redesigning internal processing to reduce complexity and the number of steps needed to manage the patient effectively.

The analysis of activity trends by the Task Force in the targeted hospitals highlights a direct correlation in a number of hospitals between the organisation of elective activity and the volumes and wait times in ED.

2.1.3 Increasing delays increase mortality and morbidity

Recently published studies from Australia, Spain, the USA and other countries show an association between overcrowding in hospitals and Emergency Departments and increased mortality and morbidity. Sprivulis et al's study of ED overcrowding in three tertiary EDs in Perth Australia showed that hospital and ED overcrowding was associated with a 30% relative increase in mortality by Day 2 and Day 7 for patients requiring admission via the ED to an inpatient bed. This increase in mortality appears to be independent of patient age, season, diagnosis or urgency.

2.1.4 Development of Chronic Disease Management Programmes

International evidence from Australia and the USA suggests that the key change requirement for effective chronic disease management is a move from existing predominantly hospital centred, singular, reactive, episodic, short term response to acute need, to a more proactive, integrated, population focussed model incorporating PCCC (equivalent) and hospital delivery systems. This enables effective provision of the 7 core elements of chronic disease management: early detection, assessment, MDT planning, clinical management, 'self' support, rehabilitation and monitoring.

Health delivery systems that have refocused in this manner have demonstrated specific (and relevant to Task Force purpose) benefits for this patient group these benefits include:

- Increased ability of patient to remain at home / non acute environment
- Reduced occurrence of ED attendance
- Reduced occurrence of unplanned readmission
- Shorter ALOS
- Higher compliance with care pathway / improved individual + population health status.

Patients with Chronic Diseases in Ireland such as Respiratory disease use 300% more beds in winter than summer; their demand is predictable and they have the potential to be managed outside the Hospital setting. Recent evidence from Irish hospitals shows that chronic disease management programmes can reduce average length of stay of some of these patients from 10.5 to 1.8 days, which in one hospital represented a saving of 2,300 bed days over two years and a reduction in ED respiratory admissions by 30% for patients on such programmes. The key elements include;

- When Consultant outpatient appointments are available within twenty-four hours, 20% of respiratory patients on trolleys in the ED can be discharged to such clinics.

- Use of fast track clinics for prompt Consultant review following discharge has reduced length of stay from 10 to 6 days for chronic respiratory patients in one Dublin hospital over the past six months.
- Fast track Consultant clinics or similar facilities can divert a significant proportion of referrals of patients with chronic disease to ED (at least a 20% reduction).

2.2 Overall Findings

The key findings from the Task Force are summarised below under the headings of capacity, capability and control processes across the continuum of hospital and community services. The areas of focus identified by the Task Force are used as a framework for reference within this construct.

2.2.1 Capacity

Physical Infrastructure

A key finding from the Taskforce visits was the inadequacy of most of the Emergency Departments in terms of their physical infrastructure. At least seven of the hospitals visited were unfit for purpose in terms of their physical infrastructure, which militated against effective management and processing of patients.

- In a number of other departments, even the more modern ones - while modifications and/or realignments may have been undertaken in recent years - the overall space and design did not enable effective streaming of patient cohorts, notably the treatment of minor injury patients and has contributed to overcrowding in a number of cases.

- In most EDs, the resuscitation areas were insufficient, both in terms of overall space and capacity to treat the volume of patients presenting. For those hospitals that treat children and adults, the spaces allocated for the appropriate management of paediatric patients was inadequate in some instances.

- Most of these hospitals had mechanisms for fast-tracking specific complex paediatric patients to the ward areas. However, there were still circumstances in which children were receiving urgent and necessary treatment alongside adults.

- Similarly, for patients with obstetric or gynaecological needs, in a number of hospitals, there were insufficient facilities for appropriate examination and assessment of emergency cases. Again, most hospitals had appropriate arrangements in place to direct and fast-track obstetric / gynaecological patients to the wards, but there is a need to review the facilities to ensure that the dignity and privacy needs of patients are met.

Optimising Capacity

The majority of hospitals examined by the Task Force are operating at close to 95% occupancy, which by definition negates the capacity to adequately address daily emergency admissions.

The development of primary and community care responses aimed at avoiding ED presentations and their impact on the numbers waiting in ED has been limited overall.

Specifically, the availability of and impact of out-of hours services on ED attendances is variable and this is consistent with the international evidence in this regard.

The key issues identified for acute hospitals were;

- Hospitals can reduce variability and reduce delays by creating a steady flow of patients through the system at a steady rate. To do this, hospitals must address patterns in variation over time – many of which are predictable - and make provision for intermittent, sudden variation.

- In terms of capacity, it is vital that hospitals have full access to their existing beds. For the Dublin hospitals the issues in relation to the delayed discharges have meant that up to 20% of capacity is not available to the hospitals. The recent private beds initiatives have shown a positive correlation between reducing delayed discharges and reducing the numbers on trolleys. The reduction by 30% in the number of delayed discharges is a major contributory factor to a reduction of almost 50% in the numbers waiting in ED in the Dublin hospitals compared with the equivalent period last year. The analysis of the impact of the recent private long-stay initiatives demonstrates this correlation. In addition, it points up the following key issues.

- There is a need to ensure that there is consistent access to home care supports and long-stay capacity given the rate of replacement of the numbers of delayed discharges.

- The unlocking of acute capacity using discharge initiatives must be matched by the development of robust internal management control processes to ensure that this capacity is appropriately balanced between emergency and elective workloads. The sustained reduction in the numbers in ED in the Dublin hospitals over the period April-September 2006 could not have been achieved without the implementation of strengthened local controls.

- For a number of hospitals, inadequate access to diagnostic services and senior in house decision-making has resulted in extended length of stay for a significant number of patients with adverse implications for overall bed utilisation. These issues are explored further under the section on capability.

In relation to continuing care services, the issues can be summarised as follows:

- The site visits highlighted insufficient access to long-term beds and an ad hoc approach to the allocation to such beds. In Dublin, there is an ongoing

requirement for 46 long-stay beds per week recurring to meet the needs of post acute patients. Similar problems were identified in Cork, Galway, Mayo, Drogheda and Cavan. The HSE has estimated that nationally there is a requirement for 2,472 long stay places over the next 12 months. (See section 3.7.1)

- Other challenges in relation to long stay beds include the following; -
    - Geographic access to beds
    - Dependency level of patients (most private sector nursing homes prefer to take lower dependency patients)
    - Insufficient support services e.g. rehabilitation to ensure that existing levels of function are maintained
    - Unplanned and sustained closures of public long stay facilities
    - Need to up skill community facilities to deal with catheterisations, IV therapy, antibiotics
    - Opportunities for synergy between the acute hospital system and the public and private nursing home sectors not fully exploited

- The trends experienced in Dublin in relation to reduced uptake of subvention are now being observed in other areas notably Cork, Waterford, Limerick, Galway, and Drogheda**.** It would appear that most areas outside of Dublin are not offering enhanced subvention to post-acute patients.

- In relation to home supports, the development of such services outside of Dublin appear to be variable often being unplanned and patient specific**.** Specifically, the development of comprehensive packages of care and the use of home care as an alternative to residential long-stay is very limited. Weekend services and out of hours services are minimal.

- There is an absence of standardisation in relation to assessment and the allocation of home support services**.** Variation has also been observed in access to timely and consistent support services such as aids and appliances. In a number of cases, patient discharge was significantly prolonged due to unavailability of essential equipment.

2.2.2 Capability within ED and the overall Hospital.

When looking at capability the Task Force used a 'patient pathway' approach – examining key issues in terms of the patient's experience prior to hospital presentation, the management of patients within the Emergency Department and the management of patients within the overall hospital and subsequent discharge / transfer to PCCC.

Appropriate ED avoidance - Building Structures with GPs and other PCCC services

Whilst most hospitals have developed links with GP's and PCCC services, the site visits would indicate that for the most part initiatives have not been sufficiently targeted at supporting reductions in the volumes, or wait times of patients presenting in ED. There are no formal structures linking GP's, hospitals and community services.

Direct access by GPs to Rapid Access Consultant Clinics with Consultant opinion and other alternate pathways is to be recommended as an effective way to reduce Emergency Department attendance

On the issue of the impact of out of hours and GP cooperatives on ED services, the following should be noted:

- The period of highest demand and self referrals to Emergency Departments is between 8 am and 8 pm, largely times when GP's are available in their surgeries.

- While the development of GP out of hour cooperatives will provide more accessible and structured primary care services out of hours, such services do not act to reduce the number of patients inappropriately accommodated in EDs after a decision to admit to an inpatient bed. Instead, if utilised correctly by patients, they will provide alternative rapid access for patients who have non-lifethreatening illness or injury, and who currently use the ED for these services.

Access to Diagnostics

In terms of optimising existing physical capacity and bed utilisation, the lack of consistent access to diagnostic imaging, laboratory diagnostics and reporting availability - in real time is a significant challenge for hospitals. These challenges arise in 3 specific contexts:

1. There is the issue of GP access to diagnostics. Across many of the hospitals studied, restricted GP access to timely appropriate investigations was identified as an issue contributing to attendances at ED. General Practitioner access to results and reports is also problematic. Access to laboratory and diagnostic imaging, early in a patient's illness, and prior to attendance at any hospital setting, facilitates the subsequent choice of care pathway for the patient.

   Improved access for general practitioners will support options to manage the patient in the community, to divert patients, with non urgent needs from ED, or to refer to the appropriate specialty Consultant or rapid access clinic if necessary.

   The requirement to enhance diagnostic capacity, availability and improve process efficiency within our hospitals must also recognise the wider community needs, and reduce competition for the resource.

2. Within ED, most hospitals identified problems with real time access to diagnostics and reporting resulting in delays in relation to decisions to admit and overall waiting time. In most cases the limitations in diagnostics are linked to the fact that core diagnostic services are only available on a 9 to 5 basis and not routinely available at weekends. In a number of cases the issues in diagnostics also related to inadequate capacity in terms of facilities and core senior staff.

3. In relation to inpatients, there were significant challenges identified in a number of sites in relation to key diagnostic tests resulting in extended length of stay for those patients. A related issue raised on the visits is that delays in outpatient diagnostic tests can also result in patients being kept in hospital for follow-up tests resulting in sub-optimal use of beds.

Senior Clinical Decision Making

It is acknowledged that patients need access to senior clinicians who have the capability to make informed decisions about their care. The Task Force visits and analysis highlighted a number of issues in this regard.

- In a number of hospitals, there were insufficient decision-makers within the ED to enable effective management of patients prior to decision to admit.
- There was inadequate access to senior decision-makers within the admitting teams which contributed significantly to delays in ED.
- In a number of hospitals, issues were identified in terms of duplication of effort between the emergency physicians and the admitting teams which pointed to the need for joint ownership of emergency attendances.
- In a number of sites where initiatives aimed at appropriately diverting or fast-tracking patients were introduced, their impact was diluted by inadequate access to senior decision-making

Effective management of patients within ED

The Task Force examined a number of initiatives aimed at improving patient flow in the ED. The benefits and challenges associated with these initiatives are set out below.

There is a need to ensure that efforts within ED to optimise the efficient management of high volumes of less urgent patients do not disadvantage seriously ill patients.

- ***Streaming –*** Streaming is a practice whereby agreed protocols are followed to allow patients whose needs are apparently simple or circumscribed to be removed from the general queue of patients waiting to be seen and dealt with in a separate and expeditious manner.
  At its simplest, streaming involves a qualified practitioner being assigned to concentrate on ambulatory patients whose problem is deemed simple or non-urgent, leaving patients with more serious or complex conditions to be seen by other colleagues. This practice has been proven to be effective in reducing waiting times for this group of patients, but has no effect on the numbers of Boarded Inpatients
  The success of this practice is dependent on there being sufficient numbers and type of staff on duty (e.g. Advanced Emergency Nurse Practitioners) and an appropriate working area of the department free to be effective. The reduction of the numbers awaiting admission in EDs will free space and staff and facilitate the development of streaming in Ireland. Change is required to allow Nurse prescribing of limited list materials and to allow Nurse ordered and interpreted Radiology.

- ***Trolley Streaming*** (*or Fast-Tracking to a bed*) of other more urgent patient groups within the Emergency Department has also been described e.g. elderly patients with broken hips or elderly males with urinary retention known to be due to a benign cause. This has been shown to be effective[2] when there are inpatient beds into which these patients may be moved expeditiously.

- ***Process Streaming*****:** Streaming of processes (e.g. the application of splints by Technicians, suturing by dedicated staff, procedures requiring sedation), with consequent reduction in "down-time" for staff and patients in the department is also used.

Streaming has clear benefits for the timely management of patients. When planning for its introduction, it is important not to compromise patient welfare or dignity. Most Emergency Departments in Ireland visited have overwhelming space limitations and design flaws that preclude the rapid introduction of streaming.

- ***See and Treat* -** See and Treat is a practice introduced in many Emergency Departments in the United Kingdom in recent years, as part of an effort to reduce the length of time spent in EDs by all patients attending. The primary objective is to empower the first healthcare professional that sees the patient to make diagnostic and treatment decisions so that less urgent patients do not have to wait for considerable periods to be seen and treated. Research into a "see and treat" type system in Hong Kong found a beneficial effect on waiting times but noted the demanding nature of the role and this has implications for the sustainability of focus and productivity. The other challenge is to balance the benefits of treating large numbers of non urgent patients in a short time against the need to prioritise acutely ill patients.

- ***Clinical Decision Units (CDU)*** - These are appropriately staffed and resourced ward areas, within or immediately adjacent to, the Emergency Department, offering additional functionality in parallel to ED Core Care. The patients typically admitted here are:

    - *Those who require a period of observation* (e.g. certain head injuries, electrical burns, patients recovering from a convulsion, procedural sedation or intoxication).
    - *Those who require a set of time defined investigations* (e.g. serial ECGs and cardiac enzymes to out rule myocardial infarction, lumbar puncture after CT to out rule subarachnoid haemorrhage)
    - *Those who require specific therapies that may allow short rather than longer term hospitalisation* (e.g. nebulisers for acute severe asthma, antibiotics for soft tissue infection).

    Experience from the United States suggests that staff in the Emergency Department, given adequate resources, can appropriately manage a range of conditions on CDU, avoiding admission to a formal hospital bed.

    A CDU can have a significant impact in minimizing clinical risk occult life-threatening conditions. This increases the efficiency and effectiveness of the Emergency Department in better gate-keeping of the inpatient bed base. There is also evidence that CDUs can improve the delivery of treatment to certain groups of patients, who were previously accommodated in in-hospital facilities.

- ***Fast-track Specialist Clinics*** - Fast-track Specialist Clinics provide urgent specialist assessment of pre-defined groups of patients who can await such an assessment. Patients with recent (as opposed to current) chest pain, worsening respiratory problems, recurrent falls or TIA (mini-stroke) are examples of conditions for whom the availability of Fast-track clinics can lead to avoidance of an Emergency Department visit at all.

The critical success factors for such clinics the establishment of a pathway of referral from the Emergency Department as well as the GP. This will reduce numbers of patients requiring admission and the length of time Emergency Department staff need to spend seeking a safe discharge option for these patients. The Taskforce endorses such clinics as being effective in reducing the volumes and wait times in EDs, provided they are delivered and overseen by senior decision makers and underpinned by robust clinical protocols.

Rapid Access to appropriate inpatient care

The Task Force observed a number of initiatives aimed at improving patient flow on the volumes and wait times in the ED**.**

- ***Acute Medical Assessment Unit –*** Many hospitals have either put local initiatives in place aimed at improving patient flow or are developing proposals in this regard. However, the impact of such initiatives has been variable**.** In some cases such initiatives have resulted in adverse effects through competition in resource terms with other services aimed at addressing problems in the ED (e.g. Senior Clinical Decision-making, diagnostics). There is a need to support hospitals to develop solutions tailored to specific local needs. Robust clinical and business processes and mechanisms to assess the impact on overall patient flow should underpin such solutions.
- ***Acute Medical Admission Units -*** Hospitals can improve existing inpatient bed capacity usage through specific non elective 'medical' patient orientated capability initiatives, particularly the creation of Acute Medical Admission Units. The creation of short stay (less than 5 days), high intensity capacity can result in the following benefits:
    - Reduced ED 'trolley' waits / prompt admission
    - 'Pull' to accommodation within appropriate ward
    - Focused condition specific protocols, rather than individualistic approach
    - Shorter average length of stay (approximately 2 day reduction)
    - Prompt effective discharge – with no adverse increased readmissions

- ***Chronic Disease management -*** A number of hospitals visited by the Task Force proposed the development of chronic illness management as part of long term initiatives to reduce the number of hospital admissions and average length of stay - including chronic lung disease, heart failure and diabetes.

  The purpose of Chronic Disease Management Programmes is to provide integrated care for patients with defined chronic diseases. The target is to prevent ED attendance with all the associated difficulties for the patient and to reduce length of stay for such patients. These management programmes must be community based but equally must be supported by the hospital at senior decision-making level (i.e. Consultant). General Practitioners are an essential component of these management plans.

  The major difficulty in implementation of such plans lies in the integration of various disciplines within the hospital and within the community (doctors, nurses, physiotherapists, social workers, IT support) and most importantly the integration of community and hospital care. Such integration represents a significant challenge, which requires a "whole system" solution.

The development of chronic disease management programmes has been variable. While most hospitals have taken some steps in this regard, it has been on a relatively small scale with limited resources. The opportunities offered by a national system for developing common protocols and care pathways to facilitate chronic disease management in line with the established evidence base should be exploited.

Effective Discharge of Inpatients

In some hospitals, measures are in place to support effective discharge planning – including identifying a projected discharge date on patient admission. These measures must be expanded to each hospital to enable an effective engagement with PCCC services and support whole-system care pathways for patients.

In some sites, centralised discharge management processes are in place – including identifying a projected discharge date on patient admission. Nevertheless, discharge planning is fragmented, often specialty specific and often constrained by poor integration between admitting clinicians, discharge planners and staff in the primary community and continuing care setting.

Patient transportation

In most hospitals issues were raised in relation to delays arising from insufficient access or ad-hoc arrangements for patient transportation**.** This results in significant delays in discharging patients and in some sites up to 7 patients per day are delayed due to transportation issues.

2.2.3 Control

Hospital Controls

A significant number of hospitals have inadequate internal control processes in place to tackle hospital and ED overcrowding on a whole hospital basis. This impedes their capacity to respond promptly and adequately to increasing delays or volume of patients presenting in the ED. Force found the following:

- Typically, poor internal controls were demonstrated in areas such as the use and scope of escalation policy, management of elective/emergency split, involvement of Senior Clinical Decision makers on a whole hospital basis in tackling hospital emergency admission problems manifesting in ED.

- In some hospitals, measures are in place to support effective discharge planning – including identifying a projected discharge date on patient admission. These measures must be expanded to each hospital to facilitate appropriate engagement with PCCC services and support whole-system care pathways for patients.

- In a number of hospitals, information on Emergency Department activity is not routinely used by management or clinicians outside the ED**.** Information on the extent to which PCCC services are available to support the delivery of Emergency Department services is not always readily available. The Task Force's efforts were hampered by the absence of a robust national ED IT system and the Task Force recommend its provision urgently.

- Variation in management capacity and competency across the hospitals was noted which impeded the implementation of critical control processes**.** Taking this into account, the Task Force recommends that admitting teams set a discharge date for patients which is subsequently audited against the actual date of discharge.

PCCC Controls

The Task Force suggests that the existing control structures and processes within PCCC are limited for purpose, as a result of:

- Insufficient extended or long term care placements to meet hospital and community ongoing requirement – particularly within Dublin region**.**

- The absence of a systematic, proactive approach to the provision of extended placement beds.

- The lack of agreed hospital specific annual and monthly public community bed provision values.

- The existence of public bed provision in parallel with subvention bed provision

- The delays in a number of areas in securing home subvention due to lack of standardisation of processes**.**

Chapter 3 - Key Recommendations

The findings from the site visits point to the need for action on the nine target areas. These are summarised below. This section also makes recommendations in relation to the optimising the use of existing capacity and developing improved measurement systems.

The Task Force areas of focus as previously outlined are:

- To ensure that systems are in place to support rapid access to inpatient beds.
- Development of and implementation of a Full Escalation Protocol as required.
- Availability of timely Senior Clinical Decision making in the admitting team.
- The establishment of links with General Practitioners and other PCCC services
- To ensure the ready access to diagnostics, imaging and reporting on an extended day and 7 day basis.
- Management of elective activity in response to emergency admission demand.
- Mechanisms to support the appropriate and efficient discharge of patients.
- Optimising existing capacity- creating new capacity.
- Internal management control and audit processes.

3.1. Optimising capacity/ Building new capacity

At the inaugural meeting of the Task Force, it was confirmed that an Acute Bed Capacity review was to be initiated. On that basis the Task Force did not undertake to assess specific bed requirements on a hospital or geographic basis. It focused in the first instance on optimising existing capacity in line with international best practice. The report provides international evidence on the requirements for optimal capacity as well as the risks associated with over crowding. The report comments on a site-specific basis on issues relating to capacity. It suggests short term measures to optimise existing capacity including the provision of long term beds, the development of enhanced diagnostic and treatment capability on site and shifting care to more effective settings. It also identifies capacity solutions, for example: AMAUs are proposed with associated supporting beds to improve patient flow and overall capacity

Prior to site visits, hospitals were asked to propose initiatives related to the best use of existing capacity as follows;

- Maximising existing capacity
- Identifying means by which acute capacity could be enhanced in the short term
- Working between hospitals and PCCC to identify where capacity could be developed in the non-acute, community and rehabilitation settings.

The site visits identified a number of issues in relation to optimising existing capacity that require specific action. These are summarised below:

- Identifying the capacity requirement associated with emergency and elective admissions.
- Reducing variation in the level of elective activity.
- Implementation of appropriate escalation measures in response to rising emergency admission demand.
- Working with individual specialties and sub-specialties to identify the capacity needed to support emergency activity and ensuring such capacity is available when a Consultant from that specialty / sub-specialty goes ‘on-take’.

- Development of sustained solutions to meet the long term care requirements of those patients who no longer require acute hospital beds, (*see section on Meeting Future Long-Term Care Requirements).*
- Ensuring capacity released by the discharge of patients to long-term care is appropriately used to balance emergency and elective activity requirements;
- Creation of new capacity through initiatives aimed at diverting or fast tracking patients for example, AMAUs and rapid access clinics.
- Development of specific solutions to meet the continuing care requirements of Young Chronic Sick patients.
- Development of alternative community solutions to presentation to ED particularly for older patients, (*see section on Elderly Patients in the ED).*

The site visits and follows up highlighted the challenges associated with operating at close to full capacity. In this context, recent published international evidence demonstrates the association between over crowding and increased mortality and morbidity. The Task Force is confident that the full implementation of the recommendations will unlock existing capacity; however it would urge that the Bed Capacity Review be completed at the earliest possible time and that appropriate solutions be developed to meet the national requirements for long stay care.

3.2 Capability

3.2.1 Appropriate ED Avoidance Measures

The unrestricted access and the easy availability of medical expertise, diagnostic and treatment facilities means that some other conditions that may not be serious emergencies but, nonetheless, require rapid access to a hospital environment, for example injuries of moderate severity, have historically tended to be referred to emergency departments to allow initial assessment and management in a safe environment.

The Task Force site visits identified a paucity of comprehensive ED avoidance measures. In practice most GPs have a single access portal for ill patients via Emergency Department only. Accordingly from a GP perspective, the following are priority actions;

- The development of formal structures to support early access to consultant opinion
- The development of formal structures at community level between GPs and hospitals to enable patients to remain safely at home. The proposed Community Intervention Teams and hospital at home initiatives may go some way towards meeting these requirements.
- The establishment of Rapid Access Consultant clinics underpinned by adequate diagnostic capability whereby patients are seen at the request of the GP within 2 working days.
- The expansion and mainstreaming of Chronic Disease Management programmes with appropriate links between hospitals, GPs and the community

In addition to optimising existing beds and reducing the volume of presentations to ED, the above initiatives should also facilitate a reduction of duplication of activity between GPs, Emergency Department and admitting teams.

3.2.2 Availability of Senior Clinical Decision making

The principle of Senior Clinical Decision making at the front door is to ensure that those attending Emergency Departments for admission are assessed by a senior clinician in the admitting team as soon as possible after arrival. Taking this into account, there is a clear requirement for an increased Consultant workforce. There is also an imperative to introduce an extended working day within a national IR framework context.

In the short term, the principle of the team approach within the ED is recommended whereby the first senior healthcare professional to meet the patient can usefully expedite their journey, e.g. the ability to initiate essential investigations or treatment according to protocol,
In relation to senior decision making among admitting teams, the Task Force recommends that the role of each on-call admitting Consultant in the hospital includes a specific commitment to respond to ED activity. This should include their being freed from other scheduled commitments to allow:

- the presence of the relevant on-call admitting specialist Consultant within the ED as part of an escalating response towards full capacity;
- the availability of on-call admitting specialist Consultants to discharge, refer to fast-track clinics or decide to admit patients;
- the availability of on-call admitting specialist on-call Consultants to monitor, supervise and quality assure the actions of the admitting team during the patient's admission phase;
- Daily specialist Consultant ward rounds in the acute specialties; and
- Daily handover of admitted patients to care of the relevant Consultant or specialty in that hospital
- National IR issues need to be addressed in delivering and supporting senior decision making on a daily basis including weekends and public holidays

The workforce implications of the above must be addressed urgently.

3.2.3 Building links with General Practitioners and other PCCC Services

The Task Force recognises that a wider health systems approach, with closer collaboration between individual hospitals, General Practitioners and PCCC services will be required to meet both the increasing demands on ED and hospital specialist services, whilst achieving the ambitious targets for maximum waiting times in ED (6 hours), which has been recommended.

The further development and creation of primary care inter-disciplinary teams, together with better organisation of out of hours care provision, has the potential to positively impact on numbers attending the ED, reduce hospital admissions, lengths of stay, and facilitate the timely discharge of patients.

The development of GP out of hour cooperatives will provide more accessible and structured primary care services out of hours. If utilised correctly by patients, they will provide alternative rapid access for patients who have non-lifethreatening illness or injury, and who currently use the ED for these services. Their role should be viewed as complementary to the ED in meeting the ever increasing demand for medical care out of hours.

It should be noted that there is little international or national evidence to date, regarding the specific effect of Cooperatives on the problems being experienced by Emergency Departments.

The availability of additional community professionals, especially Community nursing, on a seven day basis to match changed hospital service provision and discharge policies should be immediately pursued.

A more integrated and collaborative approach between general practice and hospitals is required to:

- Provide treatment at the appropriate level of complexity – either in General practice or Hospital
- Provide alternative pathways to urgent assessment or diagnostics, other than ED
- Improve communications, remove barriers, and avoid duplication at the interface between hospital and General practitioners, facilitating both admission and discharge of patients.
- Develop models of best care for chronic disease, and for care of the elderly
- Develop care protocols which reduce unnecessary return attendances at OPD and increase capacity for new attendees
- Develop targeted patient education initiatives on access and appropriate utilisation of health care services.
- Be part of a wider system response to hospital emergency admission problems manifesting in ED.

3.2.4 Supporting effective inpatient care

Acute Medical Admission Units

Hospitals can improve existing inpatient bed capacity usage through specific non elective 'medical' patient orientated capability initiatives, particularly the creation of Acute Medical Admission Units. The creation of short stay (less than 5 days), high intensity capacity can result in the following benefits:

- reduced ED 'trolley' waits / prompt admission
- 'pull' to accommodation within appropriate ward
- focused condition specific protocols, rather than individualistic approach
- shorter average length of stay (approximately 2 day reduction)
- prompt effective discharge – with no adverse increased readmissions

The Task Force findings would recommend the provision of a dedicated up-skilled team supported by rapid diagnostic assess, protocol driven assessment and well developed overall patient pathways to ensure effective functioning of an AMAU.

Balancing elective and emergency workloads

Hospitals can reduce variability and reduce delays by creating a flow of patients through the system at a steady rate. To do this, hospitals must address patterns in variation over time – many of which are predictable - and make provision for intermittent, sudden variation.

Variation can be reduced by moving away from ring-fencing, smoothing elective activity, redesigning internal processing to reduce complexity and the number of steps needed to manage the patient effectively.

A core element of this is the acknowledgement at individual hospital level that patterns of elective activity – as currently undertaken – are more variable than emergency demand. Elective activity affects the management and effective processing of emergency activity. In this context, reducing variation in elective activity will enable better processing of emergency demand. Hospitals must act to address variation prior to any assessment of capacity requirements. The section on Control in this chapter sets out proposals for pan hospital control structures that recognise the need to accommodate emergency, urgent elective and non-urgent patients within the acute bed base. It also sets out the requirements for a centralised bed management control function within each hospital.

Responding to increasing Emergency Admission demands

The Task Force found that most hospitals have deficiencies in terms of internal control which impeded their capacity to respond adequately to delays or volume of patients presenting in the ED. Consideration should be given as to whether each hospital should – if such is not in place already - institute an Escalation Protocol that sets out the response by each specialty in the hospital to increases in emergency admission activity. This should include: strengthening early Senior Clinical Decision making by the admitting team; reductions in elective activity; and prioritisation of diagnostic and other resources for the ED. This issue is addressed in more detail in the section on Control.

3.2.4 Access to Diagnostics

The overriding priority is for a routine diagnostic service, 12 hours a day, 7 days a week for GPs, Emergency Departments and Admitting teams. This will need to be negotiated within a National IR context.

In the short term the option of procuring diagnostic services from private providers for general practice and hospitals should be exploited. Also, the potential for providing an extended day through the use of over-time should also be supported Any short-term initiatives involving should be carefully targeted and evaluated in terms of impact and control on the volumes and wait times in ED.

It is vital that safeguards are in place to ensure quality assurance, shared access to results, and avoidance of test duplication should the patient require hospital attendance.

3.2.5 Measures to support effective discharge of inpatients

In terms of discharge planning, ongoing evaluation of the available community bed base, identification of discharge needs, mapping of the patient journey from admission to discharge and related steps to facilitate rapid availability of a bed in the community setting are required. Forward planning is essential.

This will entail enhancing –and in some cases building – links between each hospital, local PCCC management (Local Health Office Managers for example), General Practitioners (who can flag potential long-stay patients prior to admission) and individual agencies or services providing long-stay / intermediate care beds.

In this context, specific initiatives include:

- Hospital-wide discharge process managed centrally with appropriate authority to integrate relevant components of process;
- Identification of a discharge date on admission where possible and immediate action in the community to prepare for discharge;
- Routine assessment by the hospital and the community of the level of access for each cohort of patients to community care settings / services and action by PCCC as required on the findings of such audit to maintain patient flow;
- Routine and Documented assessment by PCCC of long-stay, step-down and intermediate care capacity and in line with assessed hospital need;
- Performance targets linked to financial allocation for the hospitals and PCCC aimed at improving the speed with which patients are assessed and discharged to long-stay / intermediate care;
- Establishment of discharge lounges to deal with short-term delay.

Alongside these initiatives provision must be made for suitable transport for patients from the acute to the long stay or community setting.

3.2.6 Transportation

The Task Force's findings reiterate the extent to which variations in the availability and type of transport affect the delivery of services. At the current time, the ambulance service provides emergency services, routine patient transfer services and outpatient services. These services are delivered using several modes of transport and care; emergency ambulance vehicles; patient transport vehicles, outsourced private ambulance services and private hire operators. The Task Force notes that:

- In order to ensure a quality service to all patients, non-emergency workload must be removed from emergency ambulance vehicles to increase the availability required to significantly improve performance standards.

- Patient transport service must be developed and coordinated in line with patient need and this should be developed in conjunction with national hospital services, primary, community and continuing care services, and other key stakeholders.

- The development and delivery of patient transport must be able to be measured against agreed performance indicators and agreed based on the clinical / medical condition of patients.

- In order to develop new initiatives, policies and procedures in this area, a comprehensive review of patient transport services is required urgently in 2006.

In the immediate term, hospitals and the ambulance service should:

- Initiate a review of daily transport needs in order to scope and identify demand and predictable variation
- Identifying transport needs as a core initial step in the discharge process

3.2.7 Requirements for Continuing Care

The Task Force analysis reinforces the clear, ongoing requirement for additional long-stay / intermediate care beds. In the past, action to address this requirement was initiated on an annual basis. Recently however, the HSE moved to address this need and source capacity on a number of occasions throughout the year. This is to be welcomed as it facilitates stabilisation in the level of need and facilitate better planning.

Nevertheless - if the HSE is to continue to successfully source appropriate beds or care placements – such action must be supported by a comprehensive assessment of long-stay / intermediate care capacity and access to home and other community supports across the country.

Similarly, in relation to home care support services, there is a need to review as a matter of urgency the arrangements for the development and delivery of such services. The key priorities here are to:

- Address variations in assessment processes within and across geographic areas,
- Reduce duplication of processes between hospital and community and
- Look to develop home care packages as a mainstream service and an alternative to long-stay care.

In parallel, there is a need for standardisation of discharge processing; planning and links between GP, hospital and a range of primary, community and continuing care services. Such standardisation should form a key performance indicator in service level agreements and related business plans for both NHO and PCCC funded agencies. The Task Force advises;

- A requirement for a national strategy for rehabilitation services.
- As a priority a national needs assessment and capacity plan should be completed in respect of those under 65 whose chronic conditions require management in post-acute settings in order to facilitate their discharge from acute hospitals
- Acute hospitals should not be the only access point to rehabilitative care and, much less, long term care. There is a need to ensure that there are pathways to appropriate care for older people with non-acute conditions which, where appropriate, do not entail attendance or waiting in Emergency Departments. (Geriatric diversion to Day Hospitals, Rapid Access OPD and Day Hospital) There are notable examples of rapid access to multi disciplinary care for older people that have been successful in meetings the needs of large numbers of older people and avoiding acute admissions. There is scope for much greater development of partnerships between acute and non-acute providers to support the needs of older people in appropriate

settings and avoid admissions to hospitals or long term care. This is particularly appropriate to larger units.

- Targets and performance measures must apply in to both NHO and PCCC agencies relating to;
    - The bed management function in both acute and non-acute settings
    - Ensuring that acute adult and paediatric hospitals audit rather than simply observe performance

Extended Care – Defining and planning for the Overall Requirement

The most reliable historical information on the requirement for extended care and home placements is available from St. James's, AMNCH, St.Vincent's, Beaumont and the Mater hospitals. (Dublin Academic Teaching Hospitals – DATHS*)* Although delayed discharges are at their greatest in these hospitals, working through this data will assist in illustrating the overall problem and the measures needed to address it.

Over the months May to July 2006 an average of 46 patients per week were classified by these hospitals as a delayed discharge on the basis that they were awaiting long-term care or home care. On average per week 8.6 patients previously listed for long term care become acutely ill or die. Therefore, the net requirement is 36.5 placements from these five hospitals each week.

Extrapolating these figures some 1,950 long term care or home care package placements would be needed annually to satisfy demand in these hospitals. (This does not allow for placements from the community, which, if not managed in a timely fashion, are likely to contribute to care crises and acute admissions.)

The proportion of those inappropriately occupying acute beds in these hospitals breaks down as follows:

- 66% - Over 65 & Requiring Long Term Care in Public or Private Nursing Home
- 22% - Over 65 and Requiring Home Care/Community Support
- 12% - Under 65 and awaiting placement in a more appropriate setting (e.g. rehabilitation, nursing or home care)

It can be acknowledged that the requirement of those currently delayed in hospital (and perhaps by inference hardest to place) may not be a fully predicative indicator of the needs of all of those requiring placements from acute hospitals. However notwithstanding this and the need for more refined work at local level, extrapolation from those current delayed would suggest that the projected requirement over the next year might break down as follows:

- 1,287 placements of those over 65s in Nursing Homes (Public and Private)
- 429 placements of those over 65s at home via home care packages & other supports
- 234 placements of those under 65s in rehabilitation, nursing or home settings

In addition provision needs to be made as a priority for the 310 patients already in the DATHS requiring placement in other settings. Adding these to projected future requirements would produce the following target placements from these hospitals for the next 12 months.

Fig 1, Projected Placements from DATHs Required Over Next 12 Months:

Category of Placement	Number (Current & Annual Projected)
65+ Requiring Nursing Home Care	1,493
65+ Requiring Home Care	496
<65 Requiring Alternative Care	271
Total	2,260

Estimating the Requirement Nationally

The National Hospitals Office has commenced collecting delayed discharge information similar to that already collected in the DATHs across all hospitals. The following is the position as reflected in this data:

Fig 2, National Delayed Discharges

Hospital	Number Delayed
Five DATHs	310
All Other Adult General Hospitals	204
Total Nationally	514

Again for the purposes of national level estimation it might be assumed that the:

- Ratio between those currently delayed and monthly additional requirements in the DATHs applies to other hospitals
- Breakdown in the overall requirement in the DATHs between nursing home placements, home care and young chronically sick is also representative of that found in other hospitals.

On this basis the placements across the country for the next 12 months from acute hospitals required to meet those currently delayed and future projected demand would be as follows:

Fig 3, Projected Placements Nationally Required Over Next 12 Months

Category of Placement	Number Required
65+ Requiring Nursing Home Care	2,472
65+ Requiring Home Care	829
<65 Requiring Alternative Care	447
Total	**3,748**

Note: Recurrent requirements will emerge in future years

Supplying the Necessary Placements

While inevitably the above projections cannot be completely exact they do emphasise that an ongoing stream of alternative care provision is required to continue to allow hospitals to have access to their total bed provision.

The above requirement of 3,748 placements will need to be met through vacancies occurring in existing facilities and home care capacity plus the introduction of

additional capacity. The Task Force does not have available to it sufficient historic information to determine the vacancies occurring in existing capacity on a steady state basis. This is crucial information on which to plan care pathways for discharge into locally based facilities and, where relevant, to determine the need for and type of additional provision required. .

3.2.8 Effective Management of Specific Patient Cohorts

The three groups that present most challenges to EDs are the elderly, the mentally ill and patients with chronic disease.

Elderly patients and the Emergency Department

The management of elderly patients within the acute hospital sector presents many challenges both within the Emergency Department and the wards of our acute hospitals. A key issue for the treatment of elderly or geriatric patients (patients above the age of 65) in the Emergency Department is the extent to which such patients present with non-specific symptoms and are popularly perceived as having been 'dumped' in the ED or requiring only a 'social' admission. Audits however, suggest that most patients awaiting long-term or extended care in the acute hospital sector had a definite underlying medical problem which justifiably required their admission, needed full investigation and treatment (such as an infection, cardiac failure, or a myocardial infarction) and may itself have precipitated a requirement for long-term care.

However, observations from the UK and elsewhere suggest a minority of older people presenting as emergencies (At least 5% and possibly up to 20%) could be managed in a community hospital setting. Indeed more recent evidence suggests they may be better managed in this setting.

Taking both these observations into account, the Task Force wishes to emphasise the need for hospitals to develop clear care pathways for all categories of elderly patients arriving at the ED specifically streaming into one of a range of pathways including:

- Early assessment (<2 hours) of referred elderly patients in Emergency Departments by a Specialist Nurse Practitioner supported by on-call Consultant Geriatrician or SpR .
- Admission to a specialist geriatric facility (off site or on-site) where ongoing specialist assessment, investigation, re-ablement and rehabilitation are priorities
- Admission to acute hospital where the nature of the pathology requires the services of an acute hospital
- Referral to a Geriatric Rapid Access Medical Clinic
- Referral to a community intervention service where available
- Referral to a Day Hospital for further assessment

A role may exist for off-site specialist geriatric facilities in providing alternatives to acute hospital admission. While the development of such facilities requires further planning and will need substantial resources; an important benefit accruing from the admission avoidance role of a specialist geriatric service would be early access (via PHN or GP) to assessment and crisis support for vulnerable community-dwelling elderly. This could be supported by:

- Rapid response community intervention teams who are able to access appropriate support for home care, urgent respite, hospital at home, palliative care or day hospital attendance.
- GP and ED accessible Specialist Geriatric Rapid Access Clinic for specified medical conditions and Rapid Access Day Hospital for multidisciplinary assessment and intervention
- Assessment for and provision of “emergency” long term care

The main visible gains of enhanced specialist geriatric services, in terms of bed days in the acute sector, would be both from admission avoidance and supporting earlier discharges from acute beds for:

- Patients requiring recuperation,
- Patients requiring re-enablement (frequently after a period of specialist inpatient rehabilitation in the acute general hospital) and
- Most especially those patients requiring transitional care/complex discharge planning.

This latter group of patients represent some of the most challenging for the acute hospital and occupy a disproportionate number of bed days - often remaining within the acute sector for periods of up to one year or more.

If this group of patients were placed together in a group , the staff of a specialist complex discharge facility could build on existing knowledge and develop greater expertise in the design of tailored community care packages and locating appropriate and acceptable nursing home placements.

To ensure appropriate care in the community setting the Task Force recommends consideration should be given to the appointment of a cohort of community based geriatricians (ideally with a substantial number of hospital based sessions in addition). Such a consultant resource would provide supervision, domiciliary assessment ambulatory care planning and educational support to patients and carers.

Management of Patients with Mental Health Difficulties

The timely assessment, management and discharge of patients presenting to ED with mental health difficulties or psychiatric illness was identified as a significant problem during the Task Force's site visits.

The Task Force identified a number of issues related to the effective management of such patients as follows:

- The presence or on-site availability of 24/7 psychiatric cover and the extent and speed of response once a request was made for psychiatric assessment.
- The limited access to on-site psychiatric beds and delays in access to off-site psychiatric beds (including wait for transport) results in long waiting times in the ED.
- Child and adolescent psychiatric services have no designated beds for young people between the ages of 16 – 18 years.
- The supports available to ensure the safe and secure management of certain patients - including isolation facilities;

- The overly-rigid use of catchment areas as a determinant of where a particular patient may be treated; this is a particular issue for homeless people who have mental health problems particularly if not registered with a GP and arranging follow up care.
- The limited availability of community alternatives for addressing non acute psychiatric services and for out of hours primary health access

Where a patient with a psychiatric illness as a primary presenting condition presents at the Emergency Department the most appropriate place for that patient is a Psychiatric ward with medical and surgical intervention available if necessary.

The Task Force recommends the following:

- The provision of on-site or immediately accessible appropriate inpatient capacity.
- Provision of consultant led multi -disciplinary teams.
- The development of appropriate community services and links between the ED and community services
- Introduction of safety and risk management measures including:
    - Training for all Emergency Department staff in managing the risk.
    - The management of aggression and breakaway techniques
    - Safe Visible assessment areas in Emergency Departments for people with acute mental health problems who are waiting for an assessment.

An effective short-term measure to improve access to acute psychiatric beds would be the use of private bed initiatives in certain areas. This should be implemented immediately in order to reduce the unacceptable waiting times for these patients

Effective Management of Chronic Diseases

The principles of Chronic Disease Management are well established and have been validated by numerous international and Irish pilot studies, the ultimate "systems approach" would be the institution of similar programmes in all acute hospitals ideally in the country or at least in contiguous geographical areas.

Various approaches to Chronic Disease Management have emphasised different aspects of such programmes including:

- Hospital at home initiatives
- ED management plans for designated patients who meet designated criteria
- Fast discharge tracks from ED or hospitals for patients with well defined diseases who meet well defined criteria;
- Provision of "fast track" Consultant out-patient appointments for suitable patients from family doctors to avoid ED referral,
- Crisis intervention during working hours (most patients with these diseases who present to ED Departments during the night require admission);
- Patient education and self management plans; drop in services for patients to avoid ED
- Community or hospital based rehabilitation programmes which have been shown to reduce re-admission rates and improve quality of life

- Smoking cessation programmes and similar initiatives.

It is important that any such initiatives are developed in conjunction with General Practitioners and relevant hospital Consultants. While Hospital specific initiatives are welcome and should be developed - studies demonstrate that shared care provides the best outcomes for patients. Ultimately, national programmes for shared care of chronic disease should be the targets.

The Task Force is aware that the HSE has established a Working Group on Chronic Disease Management and that the group has been tasked with providing the HSE with recommendations on progressing a Chronic Disease Management approach within the HSE. It is understood that the group will also outline proposals for funding that reflect HSE priorities as part of the 2007 estimates process. Alongside this group the HSE is developing the hospital at home initiative, a significant number of hospitals have identified initiatives aimed at improving management of chronic diseases. It is critical that there is cohesion in the development and implementation of these initiatives so that resources and outcomes for patients are optimised.

3.3 Control, Structure and Process.

3.3.1 Acute Hospital Recommendations

The Task Force recommends the following control structure as being necessary to effect timely placement and to optimise overall patient pathway flow within acute hospitals.

- Development of an overall pan-hospital control structure that recognises the need to accommodate three broad patient groups within the acute bed base:
    - ***Category 1:*** Emergency Department or Outpatient Department patients requiring emergency admission
    - ***Category 2:*** extremely urgent elective patients for example; cancer patients requiring chemotherapy or surgery
    - ***Category 3:*** patients who are waiting for less urgent inpatient treatment
- Establishment of a single bed management control function **-** whilst access routes can and should be multiple, it is essential that there is a single control function in terms of accessing the bed base. This must be evident on a hospital-wide basis and undertaken by staff with appropriate authority and ability
- Ensure that the Hospital Manager is accountable and responsible for overall operational management of hospital including:
    - Setting of performance targets
    - Establishment of work practices that will achieve desired performance values
    - Provision of necessary feedback in terms actual performance values being achieved

  - Introduction of change to raise performance / quickly address and respond to problems causing poor performance

- Establishment of Hospital Working Group with responsibility to pragmatically review actual practice versus agreed practise. Where appropriate, this should involve developing and promoting necessary amendments and change to further optimise bed utilisation. – This group should be interdisciplinary and clearly engage all stakeholders

- Adopt a "pull" rather than "push" practice in developing and affecting an overall control focus – whereby control design:

  - Assures consistent work efforts to enable and maintain capacity, rather than simply reacting to demand
  - Ensures patient is 'pulled' through appropriate investigation, diagnosis, placement, treatment and discharge pathways.

- Develop Clinical Treatment / Care pathways, whereby predetermined optimal pathways are developed for specific illnesses and used to effect control of work practises and enable achievement of desired performance metrics.

- Apply control mechanisms to the totality of the patient care pathway.

- Set measurable performance metrics set for all work practices**.** Subsequent work practices and capacity / capability must be structured to effect the desired performance metric.

- Establish mechanisms for providing feedback on actual performance versus desired performance in terms of a necessary control loop. Feedback must be real time and in a clear, accurate and concise format that enables effective control.

  - Feed forward control measurement should be designed to capture and identify problems before they occur for example; there should be an appropriate skill mix to match patient need.
  - Concurrent control measurement designed to ensure that the necessary facilities, services and staff are available.
  - Feedback control measurement designed to ensure desired outcomes are being achieved, e.g. target wait time 6 hours from registration to exit.

- Deviation from set performance metrics should automatically trigger pre-agreed best practise actions designed to restore necessary performance value**.** An example of this would be the activation of an escalation policy in response to a set number of patients waiting for admission in ED.

- Set (within the pan-hospital control structure), specific volume targets relating to Category 1, 2, 3 patients on the premise that. ED and Elective generated bed base volume requirements are largely predictable; this should be done on a daily, weekly, and monthly basis. The Task Force recognises that this control process will significantly impact on elective access volume and is not sustainable long term, without advancement of hospital specific initiatives identified in Chapter 4.

- Strengthen discharge management functions as an immediate priority**.** Working within (current) 100% full occupancy paradigm, there is obviously a requirement to discharge to effect admission; it is therefore recommended that necessary pan-hospital control structure enable:

- (Planned) date of discharge to be identified on admission by the admitting team. This should be audited against the actual Discharge date with variance analysis
- (This) individual patient information to be used at a macro hospital level to predict overall ongoing bed availability / capacity.

The Task Force recognise this control ability is limited, particularly within the Dublin area as a result of insufficient community long term care provisions.

- Measure wait time for all patients from time of arrival. This will require significant effort and resources but will build a more accurate picture of clinical need and demand volumes.

3.3.2 PCCC Control Recommendations

Effective Hospital to Home transfers currently requires PCCC validation and agreement to support requirements identified as necessary by hospital – in certain instances this repeat assessment and evaluation leads to transfer delays.

Accordingly the Task Force makes the following recommendations:

- Community bed volume, other community service provisions and / access to service times should form an integral part of the PCCC annual service plan/ agreement.

- Placements / services should be provided on a proactive assessment of overall hospital need, rather than a delayed reactive response to demand based on actual inappropriate acute bed occupancy.

- Control structures within PCCC should be designed to enable and support discharge in a timely manner – avoiding duplication of assessment / delays in securing services.

3.3.4 Hospital / PCCC Control Interface Recommendations

The Task Force recommends that:

- Each Hospital and local PCCC area should jointly develop and effect discharge and community maintenance requirements.

- Each Hospital and local PCCC should develop and effect joint performance metrics.

3.3.5 The Role of Incentivisation

The HSE has concluded that there is a case for appropriate incentives within the hospital system aimed at rewarding existing good practice as well as promoting improved engagement by in-house consultants in tackling the issues in ED on a consistent basis. Key issues here are timely decision-making from admitting consultants freeing up of capacity.

In January 2006, as an initial step, the HSE introduced targets in relation to volumes and wait times in ED, which were linked to financial allocations. The rationale for this initiative was to promote whole hospital engagement in the management of issues in ED.

The Task Force visits and analysis have underlined the need for a whole-system approach to the management of issues in ED and the introduction of financial incentives needs to reflect this approach

a) A Whole System Focus

A core issue in the development of whole- system approaches to the management of hospital emergency admission problems manifesting in ED. is the extent to which progress in this area can be measured and hospitals and PCCC are incentivised to create whole-system discharge-focused patient pathways. The incentives should promote focus on the entire patient pathway– from contact with General Practitioners prior to admission to treatment to contact with staff in agencies providing long-stay or intermediate care post admission.
Specifically, the incentives need to support the development of whole system responses to the management of issues that manifest themselves in the ED.

b) Targets and Measurement

Targets linked to financial allocations need to be also set for hospital avoidance initiatives at community level (e.g. the impact of rapid access clinics, out-of-hours GP services on the numbers presenting to ED's)s as well as specific targets for volumes and wait times for discharge initiatives to in order to promote measurable improvements in this area. Targets should, in the first instance, relate to those aspects of care that can be altered by the staff and institutions whose performance is being measured. This has particular relevance to the various hospitals surveyed by the Task Force.

c) Enabling Improved Performance

The Task Force role and focus has been to identify challenges in relation to local capacity, capability and control issues on a site-by-site basis. Its analysis has highlighted a number of infrastructural and internal capability challenges that are outside the direct control of the hospitals but have militated against effective performance in relation to the management of issues in ED. It is vital that in parallel to the incentives schemes there are targeted initiatives aimed at enabling improved performance

3.3.6 Setting Targets

The Task force at its inaugural meeting agreed that the ultimate target for all Emergency Department attendances was six hours from registration to exit. This was subsequently reinforced by the HSE in its publication ***100+.***

The need to set further targets in relation to waiting time for 2006 and 2007 is strongly endorsed by the Task Force. Specifically, there is a need to move to a 12 hour ED target in the current year (last quarter – 2006) and a 6 hour target in 2007. In setting such an ED target, regard must be had for the need to measure total wait

time in ED so as to reflect the overall patient experience. The imperative of moving to measure total wait time is emphasised by the Task Force.

The decision to move to more challenging targets will have significant implications for hospitals in terms of bed days used and will require targeted initiatives aimed at increasing capacity and capability. The elimination of delayed discharges would enable the achievements of ED targets in a number of hospitals. For those hospitals where delayed discharges are not a significant issue, it may require in the short-term, a reduction in elective activity if the development of additional capacity is not an option. The use of other initiatives to unlock capacity such as out-sourcing diagnostics or enhancing in-house availability of diagnostics would have an effect but would need to be carefully targeted to ensure that inpatient bed-days are unlocked

The Task Force wishes to emphasise the need for targets and performance measures to apply to PCCC delivered services. An example might be that a patient who is deemed to require a Home Care Package of long-term institutional care will be placed appropriately within one week of the decision being made.