

Overview

The process of health reform, which has been under way since 2002, is founded on changes in the structures, funding, and delivery of health services in Ireland. Accident and Emergency Services form one of the most visible parts of the Health Service. Despite the reform processes, the experience of the patient at A&E has not improved.

International Experience

Across the world the pressure on A&E services has been increasing. In Australia 80% of patients waited for more than four hours at A&E in 2004, while in Canada 6% of patients wait 24 hours or more for admission in 2002. The Canadian Association of Emergency Physicians has described their overcrowding problem as a 'national epidemic'.

The NHS in England has tackled this problem in the last five years. In 2001 *Reforming Emergency Care* was published. It has six principles which are driving changes in A&E.

Six Principles of Reforming Emergency Care

- Services should be designed from the patients' point of view,
- Patients should receive a consistent response wherever, whenever, and however, they contact the service,
- Patients' needs should be met by the professional best able to deliver the service,
- Information obtained at each stage of the patient's journey should be shared with other professionals who become involved in their care,
- Assessment or treatment should not be delayed through the absence of diagnostic or specialist advice,
- Emergency care should be delivered to clear and measurable standards.

Prof. Sir George Alberti has reported in *Transforming Emergency Care in England* (2004) that 'the effect of Reforming Emergency Care was that, for the first time, emergency patients and staff were given the priority and focus that they deserved with strong support from professionals, patient groups and management.'

This is the fundamental driver for change in the NHS, the dedication of management effort and resources to the transformation of A&E.

Emergency Services Collaborative

The NHS allocated £30,000,000 to this programme which was targeted at frontline clinical teams. Every NHS trust with a 24 hour, consultant led, A&E department was involved. Multi-disciplinary teams and multi-professional teams were formed. 'Doctors, nurses, receptionists, and porters all worked together, using quality improvement techniques, to enhance the delivery of care for patients. Representatives from across the hospital across the primary and secondary care joined forces to tackle the different problems that they were facing.'

Five Point Plan

In January 2004, the Department of Health (UK), agreed a Five Point Plan.

FIVE POINT PLAN

- Clarified and refined the 4 hour target goal for treatment at A&E,
- Created incentives for superior performance by NHS trusts,
- Instituted an Intensive Support Team to help challenged A&E organisations,
- Focussed on improving the patient journey and developing solutions for key causes of delay,
- Identified and implemented the leadership and performance mechanisms associated with a radical programme of change.

Positive Approach

Ireland's problems are not insoluble. There are viable solutions to the A&E crisis. Two recent reports - on Accident and Emergency Services (February, 2002) and Acute Medical Units (October, 2004) both published by Comhairle na nOspidéal – offer clear recommendations which, when implemented, will have a significantly beneficial effect and should prompt appropriate and efficient management of emergency hospital referrals; 79% of these referred patients have medically related problems, and many of them are in the older age group.

The IMO welcomes the positive approach taken by the Tánaiste in her TEN ACTION POINTS. The 'whole system' approach and the underlying strategy of the Tánaiste is correct; to reduce demand and increase the efficient use of current facilities.

The IMO endorses the following actions:

- The provision of a second MRI at Beaumont Hospital.
- The establishment of Acute Medical Units at AMNCH, Tallaght, St. Vincent's, and Beaumont, to be led by consultant physicians with sessions dedicated to acute medicine.
- Dedicated cleaning services and security measures.

Reducing Demand

Primary Care, A New Direction, published by the Department of Health and Children, is designed to integrate the service delivered by the primary care sector more fully with the secondary care system.

The implementation of the Primary Care Strategy would address three of the Tánaiste's TEN ACTION POINTS for A&E:

- Provision of more out of hours GP services in order to keep people's need to attend Accident and Emergency to a minimum.
- The further expansion of palliative care facilities.
- Measures to enhance direct access for GPs to diagnostic services

€1.3 billion over ten years from 2001 were earmarked for the Primary Care Strategy. As of 15th June 2004 the Minister of Health and Children admitted on national radio that only €22million had been spent on the Primary Care Strategy.¹

Alcohol Policy

The A&E departments across the country experience a high volume of alcohol related cases. The IMO understands that the cost to the health system of Alcohol related illness is enormous.

Table 1. Health Costs of Alcohol Related Problems in 1999.²

Real Resource Costs	€millions
Health care costs	€433

Five Actions on Alcohol to reduce demand on A&E:

- Banning the advertisement of alcohol products, in particular to young people and children.
- Banning practices by publicans which encourage excessive drinking (e.g. happy hours; alcohol beverage promotion events),
- Banning the sponsorship of sporting events by alcohol suppliers;
- Enforcement of the law in relation to underage purchase of alcohol;
- Prevention of drink-driving including a reduction of the legal blood alcohol limit from 80mg/100mg to 50mg/100mg;

Acute Bed Capacity Crisis

Table 2.³

Year	Beds	% Change	Inpatients	ALOS	Day Cases	Outpatients
1980	17,665	100%	543,698	9.7	8,377	1,460,198
1986	16,878	95.54%	566,105	7.4	50,136	1,621,035
1990	13,753	77.85%	522,864	6.9	124,748	1,675,529
1995	11,953	67.66%	529,393	6.6	207,308	1,890,702
2000	11,832	66.97%	548,834	6.6	319,837	2,006,332

Taking 1980 as a baseline, a third (33.03%) of the acute bed capacity has been removed from the system while at the same time the health professionals have managed to increase efficiency and productivity. The Average Length of Stay is has dropped from 9.7 to 6.6 days.

Table 3.⁴

Age	0-14	15-44	45-64	65%
% of Inpatient bed days	16	39	18	27
% of general population	22			11

The 65+ age group uses a disproportionately high amount of inpatient bed days. The massive reduction in bed capacity coupled with the high use of bed capacity by the 65+ age group, indicate that one of the fundamental underlying causes of the A&E problem is chronic under-capacity in acute beds.

Efficient Use of Current Facilities

Comhairle na nOspidéal in its *Report of the Committee on Accident and Emergency Services*, (February, 2002) identifies six factors which, if remedied, will alleviate waiting times.

SIX FACTORS which impede the reduction of waiting times:

1. The absence or poor implementation of a triage process.
2. Restricted access to inpatient beds.
3. Restricted access to pathology and radiology services.
4. The treatment and management of large numbers of patients with minor injuries or illness who could ideally be treated in other settings.
5. Limited availability of senior clinical decision makers.
6. The design of, and resources available to, the Emergency Departments.

In its *Report on Acute Medical Units* (October, 2004)⁶ Comhairle recommends the development of AMUs in all acute general hospitals receiving acutely ill medical patients. Access should be based on clear patient driven protocols and guidelines which have been agreed by all relevant parties. Patient access to AMUs should be available via a referral process by general practitioners, by patients presenting to A&E Departments and by patients seen at hospital Out-Patient Departments.

The report identifies the following points as essential for successful AMUs:

- Clear and agreed protocols for access to and discharge from AMUs,
- Consultant leadership of AMUs,
- Consultant physicians appropriately trained to be dedicated to AMUs,
- All consultants in the hospital to be involved in service provision to AMUs as appropriate,
- Fast track access to the full range of diagnostic services,
- Evidence based protocols for management, diagnosis and treatment of AMU patients,
- Provision of high level of multi-disciplinary services in AMUs including specialist nurses, occupational therapy, physiotherapy and access to rehabilitation and community based services,
- Effective communication between AMUs and primary care providers, hospital bed managers, and OPD.

The IMO believes that the implementation of the recommendations mentioned above lie at the heart of the solution to the A&E crisis. In reality the crisis is an acute medical referral or admissions management crisis. The Comhairle report also recommended the increase in A&E Consultant numbers to 74 (there were 51 such posts at 1st January 2005) and an increase in support staff.⁷

The final paragraphs of the Comhairle report state that AMUs and the A&E crisis occur within a broader health service context:⁸

Comhairle na nOspidéal concurs with the views expressed during the consultation process that the development of acute medical units is only one element of the changes and reforms needed to facilitate the efficient and effective assessment, admission and discharge of medical patients in our acute hospital system.

Other elements which will contribute to the improvement of services provided to patients and the solving of the current difficulties being faced by hospitals include development of primary care, review of the role and operation of outpatient departments, development of elective medical day units and provision of an adequate infrastructure within the community to receive and support medical patients from general hospitals no longer in need of acute care.

Ring-fenced Resources

Experience in the UK, the conclusions of the reports written here in Ireland, and the Tanaiste's Ten Action Points all require the allocation of resources specifically for A&E. No success will be achieved without long term, ring-fenced resources for A&E.

Imo Recommendations:

■ DEMAND REDUCTION

Implementation of the Primary Care Strategy as the first step to reduce demand on A&E services.
Direct access for GPs to diagnostic services.
Provision of more out-of-hours GP services.
Increase home care packages for older people.
Transfer elderly patients from inappropriate acute beds to long stay nursing accommodation.

■ ALCOHOL POLICY

Measures to reduce the problem of alcohol related illness presenting to A&E services.
Ban on advertising.
Reduce overall consumption,
Employ Liaison Staff in A&E departments.

■ ACCIDENT & EMERGENCY

Implementation of the recommendations of the Report of the Committee on Accident and Emergency Services and Acute Medical Units to accelerate the expansion of appropriately staffed consultant physician led AMUs and additional A&E consultants.
Increasing the effectiveness of Triage.
Implementation of clear patient-driven protocols for access and discharge from AMUs.
Dedicated cleaning and security services for A&E.
Effective communication between A&E, AMUs, and Primary Care.

■ HOSPITAL SERVICE CHANGES

Increasing the numbers of Acute Beds in Hospitals.
Improving access to inpatient beds.
Negotiations to expand access to pathology and radiology services.
Increasing the number of High Dependency Unit beds.

■ RESOURCES

Ring-fenced resources including manpower and funding.
Develop and implement a long-term funding plan.

1. RTÉ, Morning Ireland, 0700-0900hrs, 15/7/04, Minister Micheál Martin, T.D. in conversation with Mr. Cathal MacCoille.
2. Source: Strategic Task force on Alcohol, DOH September, 2004.
3. *Acute Hospital Capacity – A National Review*, DOH, Dublin, 2002. Table 1.1 p.18. ALOS is Average Length of Stay.
4. *Acute Hospital Capacity – A National Review*, DOH, Dublin, 2002. Figure 4.7 p.46
5. Comhairle na nOspidéal, *Report of the Committee on Accident and Emergency Services*, February 2002, p. 66
6. Comhairle na nOspidéal, *Report on Acute Medical Units*, (October, 2004) pp.25-26
7. Comhairle na nOspidéal, *Report of the Committee on Accident and Emergency Services*, February 2002, pp.11, 32
8. Comhairle na nOspidéal, *Report on Acute Medical Units*, (October, 2004) p.34

