Access to & from Emergency Departments

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Disclaimer

• Speaking in a personal capacity
  – not on behalf of Sligo University Hospital or the Saolta UHG
  – not on behalf of the Irish Association for Emergency Medicine

• ... but I suspect no one in EM would dispute what I’m saying!
Objectives

• To explain why the current difficulties exist
• To point out the implications of the current difficulties
• To explode some myths about ‘solutions’.
The Current Situation

• Demand ever increasing
  – Increasing number of very elderly
  – Medical successes
  – Greater treatment possibilities
  – Many more time-critical interventions possible

• Capacity hasn't kept pace with need
  – Insufficient before austerity anyway
  – Became populist to claim we had more than sufficient beds in early-2000s
  – Savagely cut during austerity
  – Painfully slow & limited restoration since the end of austerity

• Severe difficulty accessing critical care and many time-critical tertiary services.
Failure to plan

Rep. of Ireland - Projected rise by age group
2006 - 2041
Hospital Beds (OECD)
Triple whammy

• Insufficient beds for Emergency Admissions
• Insufficient beds for elective activity
• Resulting inefficiencies in turn increase demand ....
The Current Reality

The warehousing of ever-increasing numbers of patients in EDs with knock-on delays
Ambulance Offload Delays........
Myths about Causation

• ‘A&E’ problem
• ‘Winter’ problem
• ‘Inappropriate’ attenders
• ‘Drunks’
• Adult ED only problem

Its ‘capacity, capacity, capacity, stupid!’.
Implications for patients

• Die unnecessarily as a result
• Have poorer outcomes
  – adverse effects for individual patients
  – increased costs
• Have longer lengths of stay
• Are less likely to return to previous functional level
• Negatively experience acute healthcare.
Implications for those who staff EDs

- Drop-outs from training in EM
- Inability to recruit Consultants in EM
- Haemorrhage of experienced ED nurses
- Emigration of much EM/nursing talent.
Myths about ‘solutions’

• All the solutions lie in enhanced Primary Care
• Its all about ‘flow’
• Just provide alternative routes into the hospital.
Acute Care Continuum

Least Acute

Primary Care

Secondary (Emergency) Care

Tertiary / Quaternary Care

Most Acute
Primary Care

• **Absolutely needs** investment in its own right
• Prevention / wellness is important
• More chronic disease management can transition to primary care

but, I don't see it having a major impact on those I see on trolleys every day.
Flow Optimisation

• Inherently good
• Little further scope for improvement in many hospitals
• Current dysfunctionality incredibly destructive of flow.
Alternative routes into the hospital

Adding doors
What could good look like?

National Strategy for EM
Limited implementation
Notwithstanding all this...

- We do a really good job
- Good EM is really good
- Outcomes improving in spite of the constraints
- Due to teamwork and commitment ..... which need recognition and appreciation!
Summary

• The current situation is genuinely difficult
• It needs acknowledgement not inertia and needs proper investment in appropriate solutions
• Things would be even worse for patients but for the enormous commitment and efforts of ED staff.