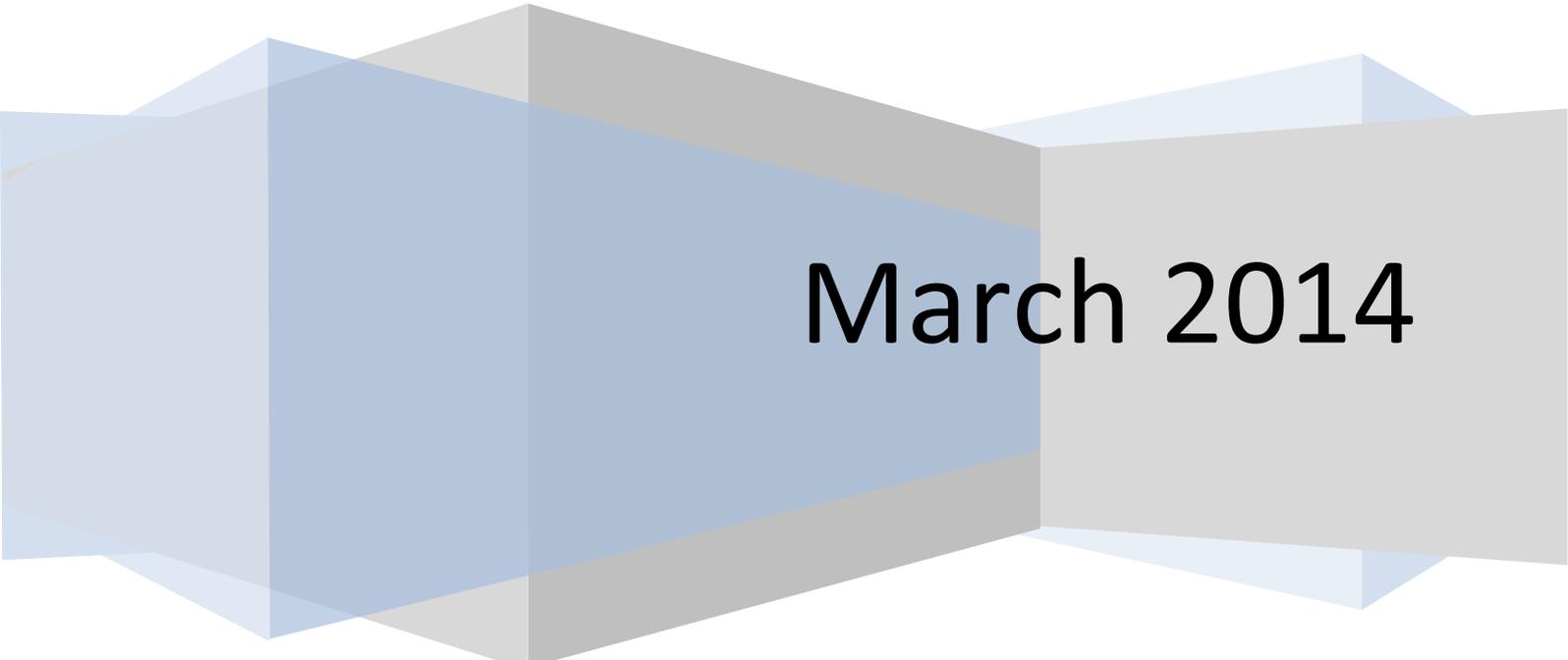


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What do we know about Emergency Department pressures and challenges?

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How have targets impacted on demand in emergency care?

Original intention

Despite universal coverage, a strong network of GP's, and a variety of sites for unscheduled care, such as walk-in centres and after hour GP clinics., demands on emergency departments in England continue to rise. Attendances increased from 14.2 million in 1998-9 to 16.5 million in 2008-09¹. Until recently, EDs were infamous for their "corridors of shame": patients lying on trolleys for 12 or more hours, waiting for admission to hospital and reception areas filled with patients waiting 6 to 8 hours to see a physician. In 2000, the Labour government promised to change this. "By 2004, no-one should be waiting more than four hours in accident and emergency from arrival to admission, transfer or discharge."². Though the UK was the first to set a throughput target for ED visits, New Zealand, and parts of Australia and Canada are also trialling a similar target for their ED patients.³⁻⁵. Ambulance services have also had time targets set for their performance over a number of years. Whilst patients receive their ambulance more quickly, there is no evidence that outcomes are improved⁶.

What really happened in EDs

Four-hour target performance was reported publicly on the Department of Health website and the NHS established an "Emergency Services Collaborative" which brought representatives of hospitals together to discuss and encourage process changes to improve flow within the ED and the hospital, but EDs were free to determine how to change their processes to meet the target. Initiatives that were introduced included⁷:

- Streaming: separation of major and minor patients
- "see and treat": eliminating formal triage
- Clinical Decision Units: where patients requiring more than four hour evaluation, but not admission, could be watched prior to discharge
- Senior doctor front door assessment: Patient had a brief initial assessment by an ED consultant and investigations and treatments were started earlier
- Rest of the hospital had to find ways to create beds, including improving its admission planning and discharge processes

There was concern as to how the target was being reached by some hospital trusts and evidence shows that⁸⁻¹¹:

- The sickest and oldest patients were still spending the longest in the ED waiting for admission to a hospital bed
- some degree of cheating was be going on, perhaps with back-timing discharges and admissions by a few (or more) minutes, to register the discharges within four hours.ⁱ
- Studies have failed to identify harms from the introduction of the target, with no change in mortality outcomes, unplanned return visits and number of investigations undertaken.
- Concerns still exist about whether patients were rushed out of the ED to find themselves on an available, but inappropriate, ward or to then undergo a long wait for evaluation by an inpatient team, delaying care that could have been received sooner had they remained in the ED.

The future of targets

Despite lack of definitive evidence of the target's benefit or harm (and more likely a mixture), the target was abolished in April of 2011, and incorporated into a new set of Quality Indicators which it was believed would begin to measure quality and safety of care as well as timeliness¹². However, to date, these indicators have proven cumbersome to collect given the lack of efficient IT systems in most EDs, and also lack a strong evidence base to convince clinicians of their value. There is no doubt that some form of quality assurance of emergency departments and emergency care systems are required. The challenge is in developing measurable and meaningful metrics to achieve this. The complexity and heterogeneity of the system needs to be taken into account, but makes this incredibly challenging and research is needed to develop the most appropriate methods for successfully surveying the system in a sustainable fashion that does not paradoxically lead to increased demand on it. Whilst patients prefer waiting for less, they often do not mind spending time in the ED if that is perceived as being productive and if they understand the process they are undergoing. Likewise if we are to signpost patients from the ED, there needs to be alternative services to access. Measure of performance and quality need to distinguish between measuring the process of care or the outcomes of care provided in the ED. Whilst process of care is relatively easy to measure in the emergency care system, attributing the outcomes of care to certain parts of that system are difficult. Current quality measures do not also take into account the heterogeneity of the system – for example, adjusting for casemix, which would provide a more realistic picture of the performance of a system.

GP contract and access:

Given that we know there is rising demand for emergency care, we have to ask ourselves why this has happened? There appear to be several factors that are driving this, but these have been split into two broad categories below:

Policy Initiatives

In recent years, a number of major policy initiatives have driven the behaviour of the general public in how and why they access healthcare. Several reports can be cited including the NHS Plan which first talked about the need to reduce ED waiting times²; Reforming Emergency Care¹² which introduced the concept of the 4-hour target, promised improved access and new ways of working for healthcare professionals; Transforming NHS Ambulance Services¹³ which discussed developing a mobile health resource taking healthcare to patient and reducing ED attendances; the NHS Next stage review¹⁴ which advocated care nearer patient, improving quality and changing expectations. This coupled with directives that impacted hugely on the way healthcare professionals worked and were available to see patients, such as the European Working Time Directive and the changes to the GP contract.

User behaviour

The increased demand has been shown to have led to services users inappropriately access in a higher level of care than they need. This is also evidenced by the high proportion ED patients arriving by ambulance are discharged without referral¹⁵⁻¹⁹. More recent studies have shown that patients report they need to access the ED because²⁰:

- perceptions of GP availability, or that ED facilities are required, such as xray.
- being directed to the ED from other service providers (e.g. NHS 111)
- feeling confident with ED system and happy to access it again
- increasing social mobility and more family separation, less support in the community

- increased reliance on and demand for professionalised healthcare
- ageing population who are proportionately more frequent and heavier users of ambulance services and emergency departments.
- Increased numbers of patients with mental health and alcohol problems
- Immigrant populations with no previous experience of UK primary care services
- clinical presentations are becoming more complex as healthcare improves and patients live longer with multiple co-morbidities and the health service can deliver more time-sensitive care
- risk-averse behaviour from clinicians

These problems are clearly multi-factorial, and some amenable to change, whilst others are not, but merely reflect society today. Once again, the evidence base for changing behaviour in an acceptable and safe way is limited and it is clear that this is an area of work that requires further development.

Capacity, staffing and seven day working

Capacity

One of the key factors that impacts directly on the performance of an ED is exit block, that is the inability to get a patient out of the department due to lack of access to a hospital bed or suitable community services to discharge patients to. Declining acute trust bed capacity and the inability of hospitals to discharge patients for lack of social support at home is a key factor in creating crowded emergency departments leading to shortage of space and staff to provide care for patients²¹. There is growing evidence that overcrowding of EDs can lead to adverse clinical outcome for patients²²⁻²⁸. In the NHS, the number of acute hospital beds has decreased by a third in the last 25 years whilst bed occupancy rates have increase from around 80% in 1997 to nearly 88% in 2012. The Australasian College of Emergency Medicine in 2004²⁹ stated 7 key objectives for reducing access block and these are very similar for the UK, highlighting hospital bed capacity as being a key factor and calling for bed occupancy to fall to below 85%. They also rightly highlight that solutions to overcrowding lie within different parts of the emergency care system, with only marginal gains being made to reducing the primary care patients accessing emergency departments due to their low complexity.

Staffing

There are three main models of urgent care facility as described by the UK College of Emergency Medicine³⁰:

1. EDs and EM-trained staff treat only those patients with serious acute conditions. There are other facilities (which may or may not be co-located) available around-the-clock for less serious problems. (This is the current system in the UK that, for reasons detailed above, is failing.)
2. A combined urgent and emergency care centre caters for all attendees. Patients are streamed to different parts of the centre on arrival. No condition is deemed inappropriate for treatment, advice or re-direction. (This is the model that is being widely proposed; it is dependent on adequate staffing and facilities.)
3. EM staff disappear into history as a failed experiment of the English-speaking nations. Patients are triaged on arrival at the hospital into specialty groups (earache to ENT, chest pain to medicine, red eye to ophthalmology etc.). (This is the current system in many European countries; for many of them it seems to work well.)

There are currently around 249 type I (major) Emergency Departments in the UK, staffed by 1400 consultants, 1000 staff and associate specialist doctors and 1200 trainees in emergency medicine.

However, over the last three years, there has been a vacancy rate in applications to EM specialist training posts of over 50%. Surveys suggest that the majority of trainees enjoy their training time in the ED but that reducing numbers of them want to pursue a career in the specialty. Amongst other things, they cite poor working conditions, a harsh work-life balance, a target-driven culture and the lack of 24-hour support for the ED as barriers to a long-term career choice in EM.

24-hour working

Whatever model is adopted, there is widespread agreement that the urgent care system needs to be standardised across the UK. The public are generally confused about who does what out-of-hours and are often forced into making the wrong choice by unnecessary complexity and disorganisation. Even the nomenclature of urgent care facilities needs to be agreed.

There is also general agreement about the need for more investment in 24/7 services. Much more of the UK's healthcare workforce needs to be readily available during so-called "unsocial" hours. This includes diagnostic staff, social care staff and managers. The NHS will have to develop contractual arrangements that ensure the availability of higher numbers of staff when needed and a more equal sharing of the burden of healthcare around the clock. It has been suggested that all commissioning decisions in the future should consider their impact on unscheduled care in the same way as they are currently considered for other possible implications.

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