AMA

Time-based national access targets for public hospital emergency departments – 2010

Background

This position statement sets out the principles the AMA considers should underpin the national introduction of time-based targets for public hospital emergency departments (EDs) in order that patient safety and outcomes, quality of care and the training of doctors are not compromised.

It has been estimated that there is a 20-30% excess mortality rate every year attributable to access block and overcrowding in Australian hospitals. There is clear evidence that these problems are due to minimal increases in the capacity of the hospital system whilst ED presentations and emergency admissions have increased substantially.[i]

Position

The AMA cautiously supports, as part of a suite of measurements, having an aspirational time-based target of patient journey and outcomes. The AMA notes that there is no evidence to demonstrate that any specific time-based target is an appropriate benchmark. While early data from Western Australia and the United Kingdom show clear improvements in patient flow from EDs when whole-of-hospital changes are made, there is no peer-reviewed data yet available that show improvements in patient care or health outcomes as a result of setting time-based targets. UK government decisions to introduce and later remove a time-based target policy, were not based on any rigorous evaluation or evidence.

Delays in leaving the ED, particularly for hospital admission, are mainly due to capacity constraints elsewhere in the hospital. Delays are caused by lack of free hospital beds, lack of access to diagnostic procedures, and/or to senior or specialist doctors. The purpose of time-based targets should therefore be to drive improvements in whole-of-system service delivery and add resources to improve system capacity.

Measuring performance against aspirational targets may therefore provide an indication of whether there is sufficient capacity, and government investment, in our hospitals.

The importance of hospital capacity

Public hospitals have been increasingly asked to do more with less. The capacity of our public hospitals has been slashed, relative to demand, by 67 percent over the last twenty years[ii]. This has had a direct impact on the ability of EDs to treat or admit patients in a timely manner.

Improving ED waiting times can only occur with investment in whole-of-hospital, and community, capacity. Short-term efficiency gains for hospitals and EDs can be achieved by making immediate improvements to hospital systems, such as changes to discharge planning. However any long-term efficiency gains require increased, and ongoing, improvements in the capacity of our hospitals.[iii]

This means funding more beds to reduce average bed occupancy rates in hospitals to 85% and to provide an appropriate quality of care for all hospital patients[iv]. Patients must be admitted to wards that have the capacity, capability, facilities and staffing to provide treatment and supervision appropriate to their needs.

Increasing capacity also means providing access to timely imaging services, investigations and therapeutic options. Improving access to diagnostic services within the hospital has been shown to significantly reduce access block/overcrowding and improve patient satisfaction[v].

It is also essential that senior medical and nursing expertise is available in both ED and wards in order to protect patient safety. Increasing whole-of-hospital staff capacity has been reported to reduce ED length of stay[vi].

Finally, evidence shows that diverting GP-type patients from EDs to general practice, other primary care services and telephone services does not reduce ED overcrowding because the overcrowding is from admitted patients, not GP patients[vii].

Implementation framework

The AMA supports implementation of time-based access targets for emergency departments that are consistent with the following requirements.

- The definition must be nationally consistent where appropriate and clinically safe.

  Practising clinicians must be consulted in the implementation of the targets to ensure they are clinically appropriate.

- Patient safety is paramount and targets must not override the clinical judgement of treating doctors.

  Doctors have the ultimate responsibility for patient care and must be free to make decisions about appropriate treatment, admittance, or discharge without inappropriate intervention or pressure.

- Targets must be flexible to allow for circumstances when patients need to stay within EDs for longer than any time-based target.

  There will be good reasons for some patients needing to be assessed and treated in the ED for longer. For example, patients that have a psychiatric order may be more difficult to initially diagnose and treat safely, and some diagnostic strategies are best completed in the ED but require longer to complete.

- Target definitions and implementation must be consistent with clinical guidelines.

  The Australian College of Emergency Medicine is the recognised expert body in emergency medicine. The time-based targets must be implemented consistent with the College's definitions and guidelines. For admitted patients, ward based strategies must be implemented consistent with other colleges' and societies' guidelines.

- Sufficient resources must be made available to increase not only the capacity of the ED but also of the rest of the hospital to provide patients with safe and clinically appropriate treatment.

  There is no point imposing time-based targets if there are insufficient staff, beds, and other resources needed throughout the hospital, especially outside normal working hours, to respond appropriately to patient demand.

- No penalties should apply to hospitals or individual doctors if targets are not met.

  Targets should be used to drive system improvements and to identify hospitals needing further investment and resources. Penalties for hospitals and doctors will only lead to data manipulation and gaming and not lead to improvements in patient care and efficient hospital practices.

- A rigorous evaluation, overseen by an appropriate independent body and informed by hospital doctors, should be started at the same time as any national targets are implemented, and implementation of targets should be incremental and flexible in order to draw on evidence arising. A review considering whether to continue with time-based targets should occur within three years of implementation.

  The evaluation should include tracking of individual patient journeys through ED, hospital stay, and post-discharge using a range of performance and quality indicators. Base line data should be collected prior to implementation, against which the impacts of any new system on patients and doctors (including teaching, training and staff satisfaction) can be monitored and compared. This will ensure that patient treatment times and clinical outcomes are measured and any adverse or unintended consequences are identified. This evidence should be used to modify the approach, including the benchmark timeframe as necessary. Evidence from jurisdictions where time-based targets have already been implemented, should inform early national targets implementation.

  Independent research should be encouraged by specific funding so that we can learn as much as possible from current and future implementation of targets.

- Targets must not lead to a diminution of experience and training for junior doctors.

  An emphasis on targets and patient flow may negatively impact on junior doctors and students, both those in the ED and those admitting or reviewing patients. Junior doctors, supervised by senior doctors, may sometimes take longer to diagnose and treat patients. While it is understandable that patients wish to move through the ED as quickly as possible, minor delays resulting from training procedures that do not risk the patient are sometimes the only way that junior doctors can gain vital experience.

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[i] Forero R and Hillman K. *Access block and overcrowding: a literature review* – prepared for the Australasian College for Emergency Medicine. University of NSW and The Simpson Centre for health Services Research, 2008

[ii] *Public Hospital Report Card 2009: an AMA analysis of Australia's public hospital system*, www.ama.com.au

[iii] Op cit (based on AIHW and ABS data)

[iv] Forero R and Hillman K, et al

[v] Op cit

[vi] Op cit

[vii] Op cit