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Labour

TACKLING THE CRISIS

AN AGREED
AGENDA ON A&E





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FINE GAEL AND THE LABOUR PARTY

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INTRODUCTION

“Next time I go to A&E, I’d rather not be breathing.”

- An A&E patient

A Government of Failure

The FF/PD Government has failed miserably to deliver the ‘world class’ health service that it promised the Irish people.

The crisis in A&E departments is the most visible manifestation of the problems in the Irish health service. To a considerable degree, A&Es are simply a weather-vane for the problems in the health service as a whole – problems which our health plan is intended to address.

Conditions in our A&E units continue to be a disgrace in an economically prosperous country. Overcrowding, poor hygiene, long delays, indignity and discomfort for patients, many of them elderly, staff working heroically in impossible circumstances – the problems are well known. There are too many people attending A&E, and being forced to spend too much time in A&E, thereby adding to the general over-crowding and discomfort of those who must attend, their family members as well as those who work there.

Among the problems within very many of the existing A&E units are:

- Inadequate physical space to see and treat patients in a safe, dignified and private or confidential manner
- Inadequate ancillary facilities such as washing and toilet facilities; space for relatives to wait or grieve in private or to be interviewed in private by staff
- Inadequate cleaning of facilities, particularly toilets and showers
- Intrusion by noisy and intoxicated patients and those accompanying them
- Buildings and facilities that are simply not designed for people staying for more than a few hours at a maximum
- Delays in getting test results, sometimes, for example, as a result of the scheduled hours that labs function
- The requirement for a person who has been seen by their GP to queue in A&E to see a hospital doctor, who is often far less experienced than their GP
- No adequate systems for clearing minor cases so that they do not add to the congestion
- Inappropriate attendances because of the absence of realistic alternatives for those who are ill or in need of advice or reassurance
- Only one new consultant in emergency medicine appointed since 2003

“It’s the thought of going to hospital that really scares me.”

- an elderly person

Among the problems within the broader health system which underlie the A&E crisis are:

- Inadequate numbers of beds in acute hospitals, leading to people queuing on a trolley in an A&E unit while they await admission to a hospital bed which the A&E team consider they need
- Delays in discharging patients from acute hospital beds until they have been seen by a consultant
- Lack of step-down beds, leading to hospital beds being occupied by patients whose real requirement is for a step-down bed
- Lack of effective bed-management to ensure appropriate allocation of available resources
- Non-availability of staff at weekends and out-of-hours (including social workers and other professionals) to see patients who could otherwise be discharged
- Inadequate provision of primary care, including out-of-hours GP services, which could treat patients who would otherwise go to an A&E
- Limited access for GPs to diagnostics, thus resulting in patients being sent to A&E departments as a means of accessing essential diagnostic services
- Absence of agreed protocols between hospitals and their local GPs regarding priority access to consultant led clinics for urgent cases

“It’s worse here than Baghdad in the 1980s.”

- a consultant in an Irish hospital

THE FINE GAEL / LABOUR PLAN FOR A&Es

Short term immediate measures to relieve A&Es:

- Rigorous enforcement of strict cleaning regimes in A&Es, so that they do not become the source of infection or illness and allocation of clear responsibility for such cleaning regimes.
- Emergency Helpline and GP location service: A 24 hour telephone emergency helpline that would be staffed by properly trained personnel with a good knowledge of triage, clinical advisory and counselling skills. Staff will assess the situation with the caller, and advise what patients should do next. The helpline service can explain how the person can be looked after at home, or advise the patient where to access their nearest GP out-of-hours service or other appropriate assistance.
- Information Online: An online web based health information system with a 24 hour response capability.
- Changing Behaviour: A Public Information Campaign on what constitutes an 'emergency' and information on the alternatives to attendance at an A&E department.
- 'Wet rooms' where those found to be simply drunk, following a medical assessment, can sleep it off under supervision. These rooms would have security staff and be medically supervised.
- Increased security in A&Es, especially at the weekend, targeted at keeping out drunken hangers-on who cause disruption and mayhem. Increased training for staff in the management of aggressive behaviour so common in A&Es.
- Improved linkages with local Gardai including protocols for speedy Garda availability if their assistance is required to deal with disruption or disorder, particularly at weekends.
- Expand offence of assaulting medical staff to include hospital security and admission staff and paramedic and ambulance staff.

Urgent Care Centres

We will provide Urgent Care Centres, staffed by GPs, Nurses and backup staff. They will be open out of hours. They will provide an alternative to A&Es for treating relatively minor medical and surgical problems. These centres will provide: suturing, cleansing and dressing of wounds; urgent support in the management of short term medical crises in chronic diseases such as asthma and diabetes. They will be equipped with essential diagnostic facilities and would have a small number of beds for observing patients for up to 12 hours. Up to 15 centres will be provided countrywide, with three in Dublin the priority.

Provision of out-of-hours GP services

Too many patients are presenting at A&E units who could be treated by their GP, were a GP service available. GPs are entitled to decent working conditions, but are generally willing to provide out-of-hours services on a rostered basis. This can occur within a single group practice, or through a co-operative of several practices. What is required is for the HSE to play a co-ordinating role, and provide backup services, which are often relatively inexpensive.

Provision of out-of-hours (24 hour) Pharmacy services

In tandem with the further development of out-of-hours GP services, an out-of-hours pharmacy service will be instituted with the necessary on-call arrangements being put in place to ensure that all necessary community pharmacy facilities are available to those requiring urgent prescribed medication.

Additional Consultants in Emergency Medicine

HSE figures released recently show that just ONE new Consultant in Emergency Medicine post has been approved for the entire country since 2003. Fifty two new consultant posts have been given the green light so far this year – but none of them are for our stricken A&E departments. There were no new posts approved last year and just one approved in 2004. Report after report has shown that we simply don't have enough Emergency Medicine consultants, and there are some suggestions that the numbers need to be doubled. Labour and Fine Gael in Government will prioritise the delivery of an effective, well resourced healthcare system and planning for and appointment of more consultants in Emergency Medicine for our A&E service will form part of that delivery.

Provision of Medical Assessment Units (MAUs)

Provision of Medical Assessment Units (MAUs) within hospitals to cater for patients who have been referred either by their GP or by the A&E department. MAUs will be designed to provide an appropriate and comfortable environment for patients to be fully assessed, diagnosed, treated where possible or to be admitted to a hospital bed. They will be assessment units for medical, rather than surgical, patients. It simply makes no sense that a patient, who has been deemed by an experienced GP to require urgent assessment by a Consultant, or to require admission to hospital, should have to sit in an A&E for hours, waiting to see a less experienced doctor, so they can be assessed by the appropriate team. Protocols will be drawn up and agreed whereby referrals from GPs are seen within a specified time by a Consultant. The decision to admit must remain a matter for the hospital medical staff. As part of this process, GPs should be afforded improved access to diagnostic facilities including prompt results of diagnostic tests.

Separate streams for minor injuries

This system is widely used in the UK. The key principle of the 'See and Treat' system in the UK is to assess and treat patients with minor complaints as soon as they arrive. It involves a dedicated team of skilled clinicians including Emergency Nurse Practitioners, who keep working on minor cases while other staff deal with the more serious traumas and the acute patients. People with minor injuries are seen, treated and sent home, rather than being sent to the back of the queue.

Greater out-of-hours cover for diagnostics within hospitals

All too often, patients wait for long periods on trolleys, awaiting test results before decisions can be made to admit or discharge them. There are too many examples of diagnostics within hospitals operating limited out-of-hours cover. There is an urgent need to address this problem. This may include the prioritisation of diagnostic tests which are immediately needed so as to ensure that patients are not kept waiting merely for simple test results.

Tackle delays in discharging patients

Bed availability contributes to the A&E crisis. It is important to make optimal use of the available stock of beds. Equally, it is in the best interests of patients that they be enabled to leave hospital as soon as they are fit to do so. Inappropriate delays in patient discharge should be tackled. There is a need for better discharge planning involving the development of a Patient Discharge Plan which starts with admission and improved links with primary and community care services.

Additional Aid for elderly patients

In a great many cases patients access the Acute Hospitals or are referred by their GPs simply because they cannot get the type of community support that is available only during normal weekly working hours. We propose improved out-of-hours support for elderly patients – including home help where appropriate. Many older people can manage at home with the assistance of minor aids such as stair rail fittings, walk-in showers, wheelchairs, etc. The waiting lists for such adaptations is long and often prolongs hospital stays. We propose a fast-track system of approval for such works for elderly patients or people with disabilities who could be treated at home more appropriately.

Investment in step-down facilities to free up acute beds

As described above, people are waiting on trolleys to access an acute bed. An ongoing problem in the hospital system is the occupation of beds, often by elderly patients or patients with a more enduring illness who no longer need acute care, but for whom 'step down' places are not available. A step down bed is a non-acute hospital bed which can either be a convalescent bed for short duration stays, a rehabilitation bed for intensive rehabilitation to improve the patient's quality of life or a long-term continuous care bed. We are committed, therefore to putting in place at least 1500 step down beds with at least 600 in Dublin immediately. The emphasis will be on rehabilitation and convalescence, with a proportion of these beds being long-term care beds.

Investment in acute bed capacity with associated staff complements

A large number of patients in trolley queues, particularly those on trolleys for prolonged periods are made up of people who are waiting for an acute bed to become available for them. Part of the solution to this problem is to provide more beds. We believe that ultimately there will be a need for significant investment in acute bed capacity, with associated staff complements. We address this issue in more detail elsewhere in our health plan. We also propose greater and more timely investment in equipment and facilities in existing hospitals and services. Where an urgent and compelling need for additional acute beds arises in a particular hospital, causing acute problems in A&E, they will be made available immediately.

Research and evaluation

There is a need to examine how effectively hospitals operate as integrated entities. In a pressurised situation there are many potential areas of conflict within multi-disciplinary teams and between inter-disciplinary teams resulting in teams working to less than optimum standards and capacity. It is important that these potential tensions and conflicts are recognised and addressed and the root causes eliminated. Practitioners in A&E departments will be asked to submit research proposals with a view to identifying common problems and resolving them in a non-adversarial manner.

THE COST OF OUR PROPOSALS

We estimate that the proposals outlined above have a current cost of €180 million a year and capital costs of up to €575 million, the most significant tranche of which will be the provision of 1,500 step-down beds which will cost €375 million.

