Irish Association For Emergency Medicine

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IAEM expresses concerns about proposed private facilities co-located with public hospitals.

The Irish Association for Emergency Medicine (IAEM) has significant reservations about the recent DoHC/HSE proposals to develop private hospital facilities on public hospital sites. This so-called *Co-located* model of care has significant implications for patients who attend an Emergency Department (ED) and require emergency admission to hospital. Under this proposed model early access to an inpatient bed will be determined by ability to pay rather than clinical need. (See our press release of 9th March 2007.) While this is the Association's greatest concern there are many other aspects of this proposal that also concern us.

The briefing document tabled by the DoHC/HSE at the Consultant Contract talks being held at the HSE EA encourages the private partners to develop Urgent Care and Admission Units. They state that *the Private Facility will accept direct admission to wards or to medical/ surgical units from primary care centres and general practitioners on a 24 /7 basis*. It is also anticipated that these facilities will accept admissions from the single (public) ED on site. However there is no obvious thought given to how these units will be staffed, or how patients will be safely transferred (with Enterprise Liability Cover) from the public ED to these hospitals.

We are further concerned that there is a fundamental lack of understanding of the differences between an Urgent Care Centre and an Admission Unit within a hospital setting. Urgent Care Centres (UCCs) are largely aimed at mobile patients with conditions that do not require hospital admission. Admission Units, on the other hand, deal with patients at the opposite end of the spectrum, most of whom require hospital admission. Both types of unit however need to have full resuscitation facilities and immediate onsite access to staff experienced in resuscitation. The IAEM has published standards based upon international evidence, which determine that this is an absolute requirement.

The HSE and DoHC have displayed a worrying lack of understanding of how the acute public hospital sector manages acutely ill patients with multiple co-morbidities (eg. an elderly patient with confusion, myocardial infarction and a fractured hip). Such patients require the timely intervention of Consultants from

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multiple specialties and multi-disciplinary teams of other healthcare professionals – there is no description of how these services are to be provided or co-ordinated in the co-located model. Will every co-located facility have its own coronary care unit, intensive care unit and delivery suite? If so, who is going to staff these units? Presently there are not enough specialised staff to work in the units we already have. These units will need to have 24 hour access to advanced diagnostics such as CT and ultrasound. How will this be achieved with the current national shortage of radiographers? Will non-medical staff be allowed to work unhindered across both sites?

It is very clear that no thought has been given to the practical aspects of whether these new facilities can safely manage emergency medical admissions on a 24/7 basis. If, as envisaged by the DoHC/HSE, most Consultants are on a Type A contract, there will neither be the number of Consultants nor an appropriate range of specialties necessary to run a safe 24/7 acute admission service. It is clear that no discussions have taken place with staff who routinely manage emergency admissions and to date there have been none with IAEM.

The IAEM is concerned that after these co-located facilities have opened it will become self evident that they cannot provide a safe 24/7 service for emergency admissions and they will therefore revert to the traditional model of care provided by private hospitals i.e. admitting high volume low acuity patients. This “development” will thus have no impact on the number of impatient boarders waiting on trolleys in EDs. Moreover, we fear that the overall quality of care provided to patients with emergency problems will suffer as a result of the inadequate planning, fragmentation of services and inequity of patient access inherent in the proposed co-location model.