Emergency Medicine Programme

Models of Care

Consultant Staffing

Measures

Guidelines

Strategy

Programme objectives:

Quality:

- Maximise access to consultant provided care - decreased mortality and morbidity
- Development and attainment of quality targets (HIQA compliant)

Access:

- Patients admitted or discharged within 6 hrs
- Triage within target time
- Patients with high-risk conditions to be assessed by a consultant/registrar.
- Decreased number of patients leaving without completion of treatment (LWOCT)

Cost:

- Reduction in number of admissions
- Decrease LOS for in-patients referred from ED

Key Solution Areas

Develop Model of care:

- Staffing, work practices, role & responsibilities, workforce models/skill mix
- Define **governance**& clinical audit system requirements
- Pre-Hospital care – develop interface, with medical support, training opportunities for paramedics
- Paediatric Emergency Medicine

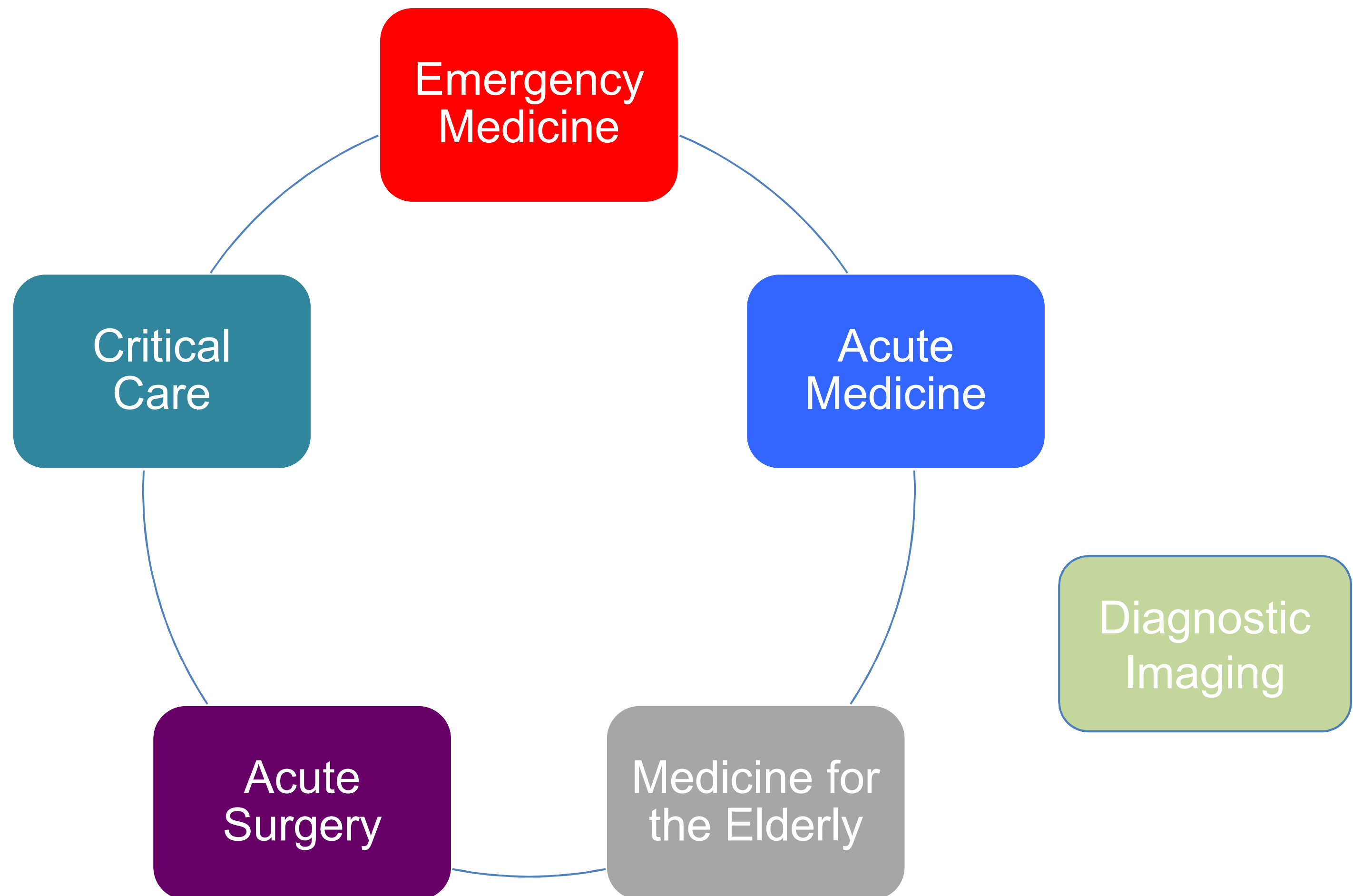
Performance Improvement:

- Implement national **clinical guidelines** top 20 EM conditions & other DQCC programme's guidelines
- Suite of **KPIs for process efficiency** and **quality** of clinical care
- Develop data definitions around measures
- Enhance Clinical Decision Unit work
- International benchmarking
- Case-mix, coding, clinical acuity measures
- Best Practice Project – survey, consultation, feedback, gap analysis

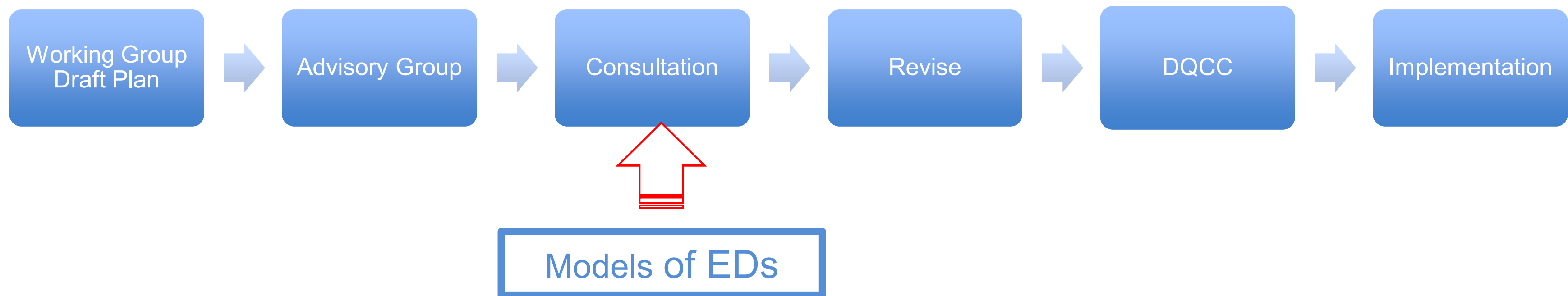
Sustaining Improvement:

- Strategic plan for EM
- Inter-programme implementation across acute hospital system and regions
- Change management and embed continuous improvement

Acute Access Programmes



Time Line



Multidisciplinary Team Staffing

Governance Structures

KPIs and Measures

Emergency Medicine Programme

National Emergency Care System

Emergency Care Networks

A National Emergency Care System

- Equitable access to high quality care, irrespective of geography
- Standardised care, clinical guidelines
- National KPIs and defined process measures
- Governance framework
- National stragegy and workforce planning
- Comprised of Emergency Care Network as “functional units” within regions
- Integration with National Ambulance Service

Emergency Care Networks

- All EDs in a network would be part of the **same system** of care
- Shared governance structure for EM issues
- All patients have appropriate access to high complexity high acuity care through retrieval service and **access protocols**.
- More than 1 network within a HSE region.
- A network may have more than one ED.
- Coordination of training and staffing across the network
- Other contributors: Primary Care, voluntary groups, first responders, supporting specialties and services.
- ICT requirements to support networks

examples:
CUH, KGH, Mercy, Mallow, Bantry, South Inf.
Midwest Limerick, Ennis, Nenagh, St John's
Drogheda, Cavan, Navan, Louth, Monaghan

Emergency Care Networks

Benefits for the system:

- Standardised Care, safe and convenient
- Training and governance
- Other specialties will be network based
- Trauma networks and regionalised care
- Provides a role for smaller hospitals
- More equitable distribution of resources
- Collaborative practice

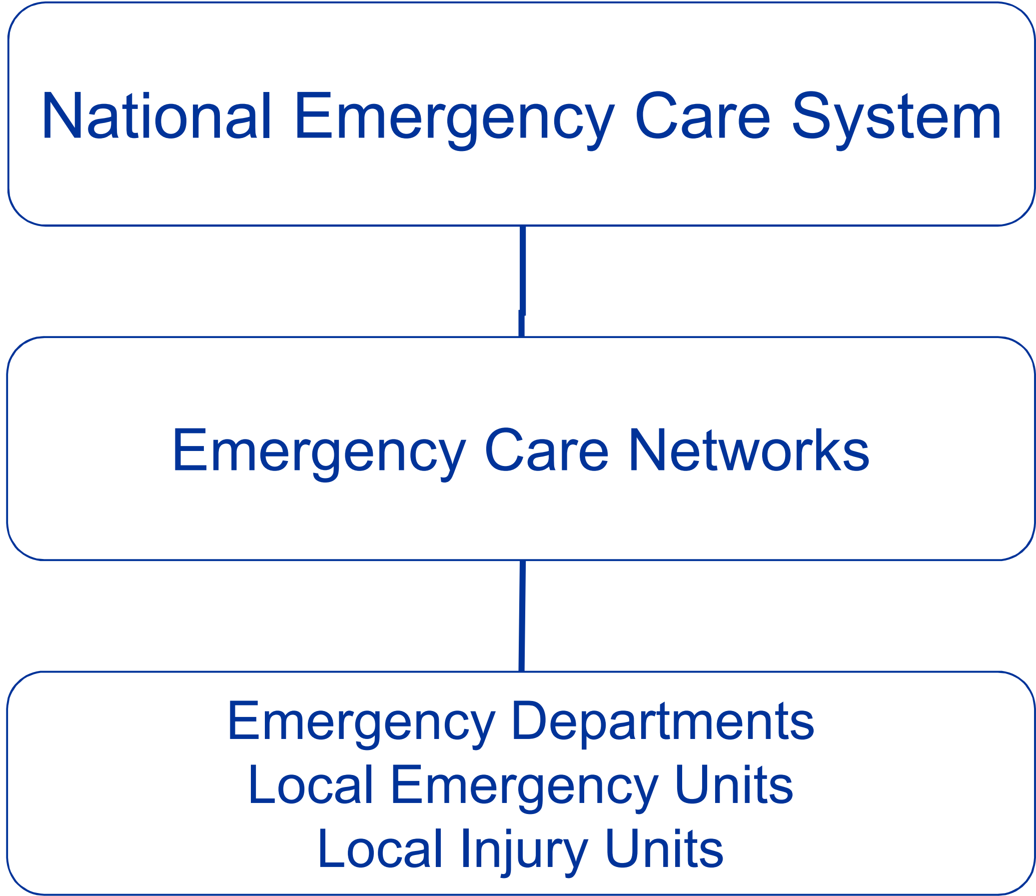
Benefits for the specialty:

- Strength in providing essential emergency services to populations
- United interface for negotiation with other services
- Peer support
- Mutual growth with NAS

Emergency Care Networks

- Fewer larger Emergency Departments providing 24/7 EM
- Defined roles for other units within Networks:

  Local Injury Unit = "Minor" injury unit
- Is there a need for limited hours / daytime unit – a Local Emergency Unit ?
  Risks vs benefits?
  Cost effective?
  Interim measure?
- Lead ED, linked EDs and Local Injury Units
  May have one Local Emergency Unit.



Emergency Medicine Programme

Midwestern Emergency Care Network

Emergency Department

Midwestern Emergency Care Network

Local Injury Unit

08:00 – xx:00
every day

Models of Hospitals and Emergency Units

Generic Hospital Model	Criteria	Hours of Access
4	Emergency Department	24/7
3	Emergency Department	24/7
3	Local Emergency Unit ?	Daytime
2	Local Injury Unit	Daytime

Models of Emergency Departments and Local Units within an Emergency Care Network

Type	Criteria	Hours of Access	Appropriate DQCC Generic Hospital Model
A1	**Emergency Department** All supporting specialties on site	24/7	4
A2	**Emergency Department** Majority of supporting specialties on site	24/7	3 or 4
A3	**Emergency Department** Geographical need; core specialties on site	24/7	3
B	**Local Emergency Unit** Limited access hours	Daytime	3
C	**Local Injury Unit** Limited hours access for patients with non-life or limb threatening injuries	Daytime	2

Questions on Networks and Nomenclature?

Senior Staffing

65 Consultants in EM, including 6 in PEM

- Comparing consultant staffing levels to:
  - Australia - 180 consultants in total for Irish population
  - State of Victoria – 240 consultants
  - US model 24/7 – 286 consultants (Hanly, PKP & AG)
- PEM in General EDs

Funding for 14 posts in EM secured in service plan for 2011 – General and PEM

- Economic factors
- Availability of Consultants
- Risk of getting nothing

Long-term plan

- Identify consultant post applications that are in progress and ensure they are compatible with the EMP framework. Identify current Consultant in EM staffing levels across all EDs.
- Step 2: Create new posts to support Emergency Care Networks (ECNs) focussing first on centres destined to become Type A units. All new appointments should be made on a **regional basis** to allow for network development. All job descriptions should include a commitment to **providing support to future networked units**.
- Step 3: Establish the structure of future networks and map requirements for future posts accordingly. Continue recruitment to Consultant in EM posts.
- Step 4: **Expand BSTEM and HSTEM training** in a phased manner in anticipation of future staffing needs.
- Step 5: Engage in **ongoing workforce planning** to support the development of ECNs.
- Step 6: Support adequately staffed and mature ECNs, with new Consultant work-practices

Reality

- Hospitals had to be named for Team Briefing
- Posts will require agreement with RDOs, CEOs
- Posts will need support of EMP and QCCD
- Posts to be activated in Q3
- Reconfiguration will be a factor
- Not being allocated a post in 2011 does not imply no future for hospital!
- Lots of risk, no guarantees
- Will cause unhappiness
- Respect difficulty of task

Questions on Consultant Posts?

Clinical Guidelines & Quality Indicators

Guidelines and Pathways:

- Top 20 EM Conditions
- Guidelines from other programmes – academic committee
- Common and high risk conditions
- Pre-hospital, PEM and ED-based guidelines
- Consistency of guidelines
- Integrated Care Pathways vs undifferentiated presentations

Indicators & Measures:

- Limitations of ICT
- Diagnostic and referral coding at end of ED episode

Emergency Medicine Programme

Early Deliverables:

- Quality improvement in clinical care - guidelines, best practice
- Standardised definitions & measures
- Governance
- New roles
- Workforce survey and planning
- Increased Consultant provided care
- Collaboration with Ambulance Service

Concerns:

- Managing expectations
- Sustainability
- Data quality
- Management of change
- Culture of competition vs collaboration
- Need for sustained development
- Overcrowding
- Management Legacy Issues

Programme Interfaces

- Acute Medicine Programme
- Emergency Medicine Programme
- First tranche of Consultant posts
- EM nurse reference group
- Major Incident Planning
- GP roles, training, interface
- Reconfiguration
- ICT
- Measures – HIQA, DOHC
- Future funding of EM
- Clinical Guidelines
- Overcrowding positioned in the hospital system

Strategic Future of EM – everyone has a part to play

Thinking beyond and outside the programme

Summary

- Does IAEM support the concept of networks?
- Can anyone propose a better system of nomenclature for units within networks?
- Is there understanding around the allocation of consultant posts?
- Do IAEM members appreciate that there will be changes in practice in EDs?