Australasian College
for Emergency Medicine

Position Statement

Time-based targets

ACEM considers clinically relevant national benchmarks with peer-performance comparisons across all jurisdictions as a valuable policy tool, and strongly supports the retention of such targets. Time-based targets are an important part of a suite of tools to promote and monitor better health systems that provide timely, high-quality care for all Australians and New Zealanders.

ACEM welcomed the acknowledgement by governments of the serious consequences to patients when access to emergency medical care is delayed due to lack of hospital capacity, implicit in the adoption of emergency department (ED) length-of-stay targets from 2009 in New Zealand (1) and 2012 in Australia (2). ACEM acknowledges the ongoing efforts to improve emergency access to care since then.

It is imperative that jurisdictions in Australia and New Zealand continue to support the use of time-based targets as an important part of a range of strategies to address access block and overcrowding. ACEM believes an equal emphasis on access to inpatient beds must be explicit in access improvement strategies, and has recently reviewed its recommended time based measures to reflect the need for specific targets for inpatient care access. (3)

Patients require access to timely and consistent emergency medical care whenever and wherever required. ACEM aims to achieve this as a partnership, emphasising quality care for patients, as determined by the patient's treating clinician and supported by national standards and guidelines.

Hospital overcrowding, and the access block it causes, constitute the greatest threat to quality acute medical care, adversely impacting on hospital performance and efficiency, as well as patient safety. It is associated with excess deaths, clinical errors, delayed time-critical care, and increased morbidity. Inadequate hospital bed capacity, or lack of an available bed when it is needed, results in delayed transfer of admitted patients from the ED to an appropriate in-hospital bed, further contributing to hospital access block and longer hospital stays (4-6). In large EDs, almost 40% of staff time is spent caring for patients who are waiting for a bed, rather than looking after new emergency patients (7). ACEM research has demonstrated that patients with behavioural and mental health concerns experience extended delays for access to inpatient care (8).

Document Review

Timeframe for review:	Every three years, or earlier if required.
Document authorisation:	Council of Advocacy, Practice and Partnerships
Document implementation:	Standards and Endorsement Committee
Document maintenance:	Department of Policy, Research and Partnerships

Revision History

Version	Date	Pages revised / Brief Explanation of Revision
V1	Jul-10	Approved by Council
V2	Jul-16	Title of Statement changed from 'Statement on National Time-Based Emergency Access Targets in Australia and New Zealand.' The introduction has been modified in order to acknowledge that time-based targets have come to an end at the national level but that ACEM supports their ongoing implementation at the State and Territory level. Under 'position', the subheadings have all been modified to better reflect the content of the paragraphs. • Now relates to continuing time-based targets • Included discussion of the way in which time-based targets can be utilised to drive change. This section now includes a discussion of the way in which time-based targets should be coupled with other quality measures and improvements in hospital functions. • Incorporated updated statistics on ED presentations. • Included reference to the outcomes of the targets implemented from 2009 and 2012.
V3	Mar-21	The introduction has been modified to acknowledge ongoing efforts to improve emergency access to care, and that equal emphasis on access to inpatient beds must be explicit in access improvement strategies. • Incorporated the extended delays for access to inpatient care experienced by mental health patients. • Acknowledged how the exclusive focus on increasing the performance of the discharge patient stream to meet access targets can lead to a lack of reduction of morbidity and mortality of the sickest and most complex patients who require inpatient care. • Included updated data. • Incorporated new research on time-based targets and access block, and updated data on access block. • References have been updated.

1. Time-based targets – a tool to drive change

Time-based targets are a useful tool to drive systematic changes in care delivery and improve patient journeys throughout hospitals (9-11). However, time-based targets are not an end in themselves. They must be clinically meaningful and coupled with appropriate accountability. Measures of patient care quality, through the use of associated quality standards or indicators, should be used to facilitate continuous quality improvement, avoid unintended poor outcomes and complement time-based performance measures (12).

There is evidence that ED length-of-stay targets drive important changes in work practices, hospital and system processes, and discharge planning. This results in more efficient use of resources, therefore reducing ED overcrowding and improving overall hospital function and patient outcomes (9, 11, 12). However, evidence also demonstrates that emphasis on time alone, rather than quality of patient care, can adversely affect patient safety and staff morale (12). Similarly, exclusive focus on increasing the performance of the discharge patient stream to meet access targets can lead to a lack of reduction of morbidity and mortality of the sickest and most complex patients who require inpatient care (13). Quality standards, and explicit inpatient targets, encouraging a focus on quality and safety, are therefore integral in reducing ED overcrowding and maintaining quality patient care. Such standards provide defined processes and indicators for continuous review and improvement and, in conjunction with all length of stay targets, assist in avoiding the unintended consequences of such targets. Any time-based measure relating to EDs (or any other site of care) should therefore be one of a suite of indicators measuring aspects of the whole patient care process, to identify and quantify areas for further improvement.

As public hospital capacity is not keeping pace with the growth in population and growing clinical care demands, time-based targets for EDs can only work if access to appropriate care and resources during a patient's hospital journey and into post-discharge care is improved. These targets are intended to drive change throughout hospitals and into the community, not just the ED. The onus is therefore on hospital administrators to ensure that appropriate bed capacity and staffing support is available for ED patients when clinically indicated, through improvements in hospital function.

Time-based targets should therefore not be considered as a substitute for appropriate capacity planning. There is a strong need for both clinical and executive leadership, to ensure that a whole of hospital approach is taken, and EDs and in-patient units are supported in their work to reach relevant targets whilst maintaining quality care. This must be a visible priority of senior management, as without such support from across the hospital, there is likely to be limited long-term improvements in hospital-wide efficiencies. Continued investment in improving hospital infrastructure and adequate bed capacity must be a part of demand management.

2. Additional resources are required to achieve improvements

Additional resources will be required to initiate and maintain redesigning of current processes, improving access to diagnostic and other support services and making effective use of hospital infrastructure over extended hours seven days a week. In particular, appropriate and improved staffing of EDs, in-patient units and diagnostic and support services will be necessary to ensure prompt, timely and safe care for patients, 24 hours per day, every day.

Resources must support the continued ability of the ED, hospital and community providers to fulfil clinical education, training and supervisory obligations in accordance with national professional guidelines and standards.

3. Increasing system capacity

Ongoing growth in emergency department presentations requires the sustained attention of health policymakers and hospital executives, to ensure the hospital system capacity is resilient enough to meet current and future demand for acute medical care.

Access targets and other quality and performance measures have an important role in monitoring and informing system improvements. System redesign and efficiency improvements have contributed to health systems dealing more effectively with the long term growth in ED presentations (14% increase from 2011-12 to 2018-19, averaging 1.9% annually) and increased demand for acute hospital beds (31% of presentations in 2018-19 compared to 28% in 2011-12) (14, 15). However this cannot be the only solution, with increased bed capacity forming an essential part of ongoing demand management.(13, 16, 17)

Out of hospital demand management strategies and improved community support are also vital. In particular, the demand associated with aged care and mental health must be addressed as a matter of urgency so that sufficient resources are available for these patients to be treated in the community. This would include access to respite and ongoing Residential Aged Care Facility beds.

4. Monitoring and evaluation of national access targets

Evidence to date suggests that national time-based targets implemented across Australia and New Zealand have been catalysts for significant clinical process redesign and improvement, with compliance against targets trending positively (9-12). While data also showed decreased levels of hospital access block, with improvements in patient outcomes following the implementation of time-based targets (9, 10); however, levels of access block have been ~20% across Australia from 2014-2019 (18). Given recent findings showing new patients presenting to an ED have a 10% greater chance of dying when more than 10% of patients waiting for admission are access blocked (19), ongoing vigilance is required.

Continued evaluation, audit and transparent dissemination of results are essential to allow flexible changes in response to outcomes at the local level, and across systems. Consideration of hospitals' differing circumstances, for example, local populations and disease severity, availability of specialised resources or staffing models, must guide local implementation and potentially modify targets.

Rigorous and independent monitoring at the national level must be mandatory to safeguard quality clinical care, and to ensure optimal use of health system resources. Access to data should also be made available to researchers and the public in order to enable independent evaluation and informed improvements.

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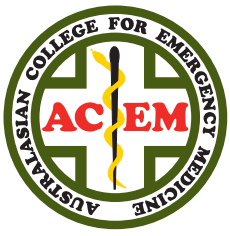

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