



## STATEMENT ON NATIONAL TIME-BASED ACUTE HOSPITAL ACCESS TARGETS IN AUSTRALIA AND NEW ZEALAND

### 1. INTRODUCTION

The Australasian College for Emergency Medicine (ACEM) welcomes 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 and 2012 in Australia.<sup>(1, 2)</sup>

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.<sup>i</sup>

### 2. POSITION

#### 2.1 Continuation of time-based targets

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.

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.

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.<sup>(3)</sup> In large EDs, 40% or more of staff time is spent caring for patients who are waiting for a bed, rather than looking after new emergency patients.<sup>(4)</sup>

#### 2.2 Time-based targets are a tool to drive change and not an end in themselves

Time-based targets are a useful tool to drive systematic changes in care delivery and improve patient journeys throughout hospitals.<sup>(5)</sup> 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.<sup>(6)</sup>

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

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<sup>i</sup> The ACEM [P02 Policy on Standard Terminology](#) describes access block as the situation where patients who have been admitted and need a hospital bed are delayed from leaving the ED due to lack of *inpatient* bed capacity.

overcrowding and improving overall hospital function and patient outcomes.(7, 8) However, evidence also demonstrates that emphasis on time alone, rather than quality of patient care, can adversely affect patient safety and staff morale.(9) Quality standards, 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 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.

### **2.3 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, 7 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.

### **2.4 Increasing system capacity**

Ongoing growth in ED presentations requires the sustained attention of health policy-makers 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 (3.4% on average between 2010-11 and 2014-15) and increased demand for acute hospital beds.(10) However this cannot be the only solution, with increased bed capacity forming an essential part of ongoing demand management.(11)

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.

### **2.5 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.(12) Publicly available data also shows decreased levels of hospital access block, with improvements in patient outcomes.(8, 12)

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.

### 3. REFERENCES

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## 4. DOCUMENT REVIEW

Timeframe for review: every five (5) years, or earlier if required.

### 4.1 Responsibilities

Document authorisation: Council of Advocacy Practice and Partnerships  
 Document implementation: Hospital Overcrowding Subcommittee  
 Document maintenance: Policy and Research Department

### 4.2 Revision History

Version	Date of Version	Pages revised / Brief Explanation of Revision
V1	Jul-10	Approved by Council
V2	Jul-16	<p>Title of Statement changed from 'Statement on National Time-Based Emergency Access Targets in Australia and New Zealand.'</p> <p>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.</p> <p>Under 'position', the subheadings have all been modified to better reflect the content of the paragraphs.</p> <ul style="list-style-type: none"> <li>• 2.1 now relates to continuing time-based targets</li> <li>• 2.2 (previously 2.3) is a 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.</li> <li>• 2.4 (previously 2.5) has been edited to incorporate updated statistics on ED presentations.</li> <li>• 2.5 (previously 2.6) has been edited to include reference to the outcomes of the targets implemented from 2009 and 2012.</li> </ul>

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