

Queensland Emergency Medical System

AIM

Optimum emergency patient-care through
safe, cost-effective services.



DISCUSSION PURPOSES ONLY

QEMS

FUTURE DIRECTIONS FORUM
26th OCTOBER 2001



Queensland Government
Queensland Health
Department of Emergency Services



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CONTENTS

Introduction.....	4
Overview Of Qems.....	6
Queensland Emergency Medical System Model.....	8
Implementation and Coordination.....	12
QEMS Consultation.....	15
Guidelines, Submission of Papers to Qemsac.....	214
QEMS Submission Cover Sheet.....	23
QEMS Meeting Calendar.....	25
Key Contact Officers, QEMS Network.....	Annexure



Introduction

Emergency responses have been provided in one form or another for more than a hundred years, but the development of a systematic approach to the delivery of these services has only evolved since the late 1960's with mature and effective systems operating in a number of parts of the world. Queensland has adopted an emergency medical system (EMS) approach through the implementation of QEMS and is the first Australian State to establish a formal EMS.

The lack of a fully integrated and coordinated structure of emergency health care makes it difficult for Government to gain a statewide perspective of the needs of the community and for Government to plan to meet those needs appropriately.

Because of findings by a Parliamentary Select Committee in 1991, the Emergency Health Services Coordination Advisory Committee (EHSCAC) was established as an inter-departmental committee between Queensland Health and the Bureau of Emergency Services. EHSCAC remained active until December 1997. EHSCAC supervised the implementation of joint initiatives aimed at improving the provision EMS.

It was identified by EHSCAC that for the system to function effectively; integration, coordination and cooperation needed to be expanded to incorporate all components of EMS.

Consequently, the Queensland Government established the Queensland Emergency Medical System Advisory Committee (QEMSAC) on 28 January 1997. (Refer to page 8 for further information on QEMSAC.)

The Queensland Emergency Medical System (QEMS) aims to improve collaboration, integration, and coordination between all emergency medical service providers.

The system is designed to avoid duplication between services, creating a seamless, integrated model of patient care.

QEMS is not a new organisation, but is a collaborative model designed to help communities coordinate and manage their own EMS efficiently and effectively.



The elements listed below are seen as being common to an effective EMS:

- System organisation
- Operational Policies
- Data Collection and Evaluation
- Transportation
- Facilities
- Public Information and Education
- Communications
- Training
- Mass Casualty Planning

The system's goal is to improve EMS response and patient care. This care should be a seamless process through first responder, pre-hospital, and hospital stages of care.

The key focus areas for QEMS stakeholder consultation and policy development are:

- ◆ Community Engagement;
- ◆ Pre-hospital care; and
- ◆ Definitive Medical Care.

QEMS embraces an integration model which considers the community, health care providers (first aid, pre-hospital, medical), and government as equal partners in a safe, comprehensive and cost effective system, able to deliver optimum emergency patient care.

The aim of this booklet is to provide guidance to QEMS stakeholders on processes to be adopted for consultation on EMS issues and when submitting policy recommendations and other documents to QEMSAC.

QEMS STAKEHOLDERS

- People within each community;
- Community Health Care providers (ambulance, doctors, nurses, paramedics, allied health professionals, RFDS, Queensland Rescue, Community Helicopter Services);
- Public and Private Hospitals;
- State and Local Government agencies.
- Allied emergency services agencies.



OVERVIEW OF QEMS

Aim

The aim of QEMS is to provide optimum emergency patient care through safe, cost-effective services.

Mission

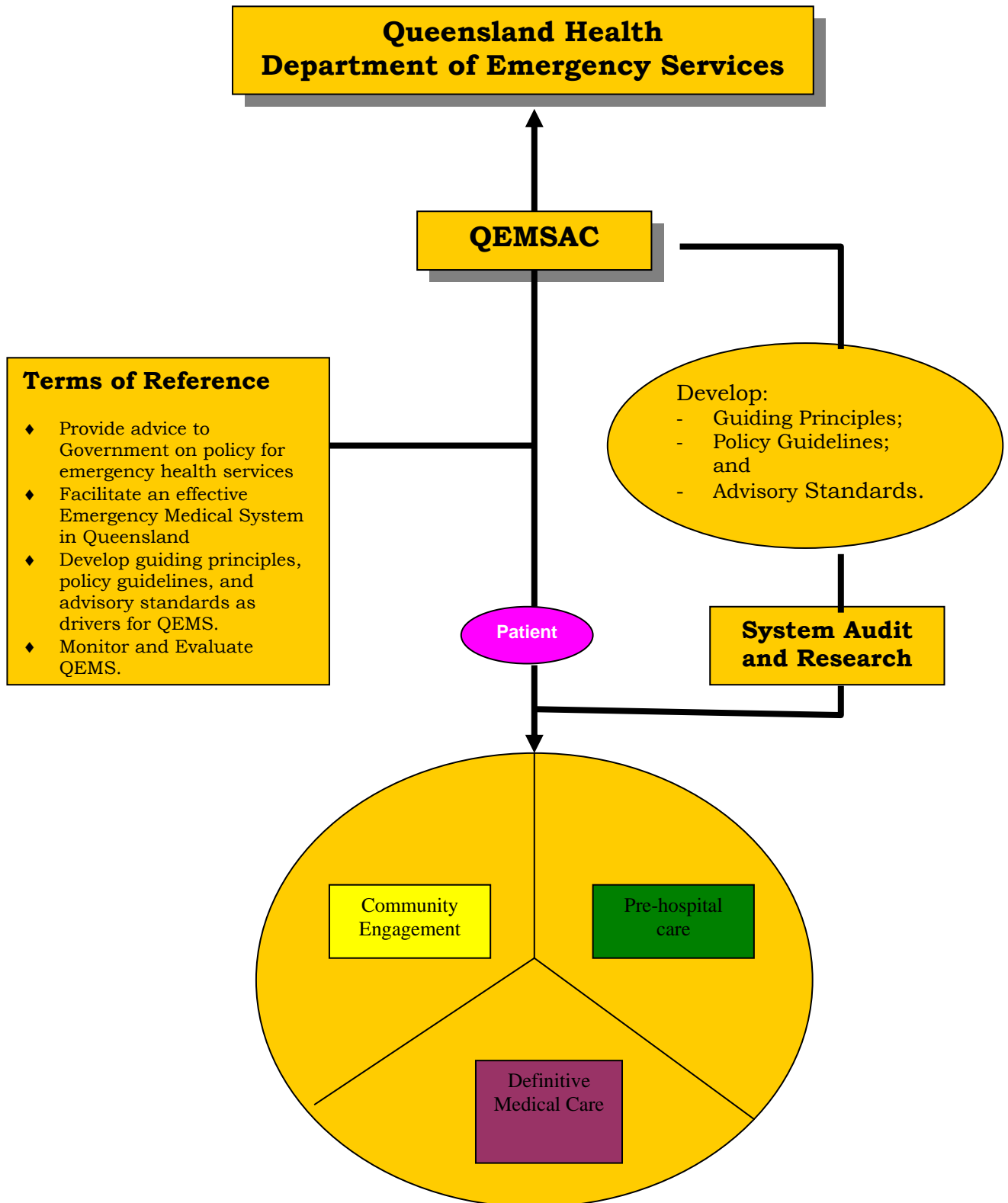
The QEMS mission is to improve health outcomes through integrated emergency health care by providing timely and effective response to community needs.

Goals

The goals of QEMS are to:

- ◆ Prepare the community to recognise and respond to sudden illness and injury.
- ◆ Improve pre-hospital services so there is a high standard of integrated care.
- ◆ Further develop hospital emergency medical services.
- ◆ Improve the coordination and integration of aeromedical services with other emergency medical services.
- ◆ Prepare emergency health services for multi-casualty incidents and disasters.

To achieve these goals QEMSAC developed an EMS implementation model. The model is shown on pages 7 and 11. The current QEMS committees are shown in the Annexure at the end of this guide.





EMERGENCY MEDICAL SYSTEM MODEL

An Emergency Medical System (EMS) is a series of interrelated processes involving bystander care, pre-hospital patient care, and definitive emergency medical services. EMS includes an implementation framework, feedback mechanisms, and a system for monitoring, reduction in duplication, integration, and effectiveness

The key outcomes for QEMS are:

- The development of the framework for implementation;
- Defined linkages and feedback mechanisms between government, service providers and the patient;
- Ongoing systems for monitoring and adjustment;
- Reduction of duplicity of service;
- Identification of areas in need of strengthening; and ultimately
- An integrated system which functions effectively.

The QEMS focus is concentrated in three key component areas:

- Community Engagement;
- Pre-hospital patient Care; and
- Definitive Medical Care.

QEMSAC is the driving force for EMS in Queensland. QEMSAC has overall responsibility for the development and monitoring of EMS policy and standards.

The terms of reference of QEMSAC are:

- Provide advice to Government on policy for emergency health services;
- Facilitate an effective EMS in Queensland;
- Develop guiding principles, policy guidelines and advisory standards; and
- Monitor and evaluate QEMS.

Each of the specialist component advisory committees has responsibility for consultation processes, which lead to the development of guiding principles, policy guidelines or advisory standards. These documents establish the foundation upon which the EMS will function.



The diagram on the next page (QEMS and Trauma System Interface diagram) attempts to describe in a simple format what is a complex set of potential patient care interactions, organizational arrangements, and progress through the system.

Queensland does not have a formal Trauma System. However, trauma services are provided in a coordinated way through Queensland's tertiary hospitals and major public and private hospitals. There is an overlap (merging) between EMS and Trauma services dependent on the particular needs of the patient.

Effective community safety and prevention strategies may limit or eliminate the need for health care intervention. But, in the event of sudden illness or injury, the 'system' is expected to respond in a seamless and coordinated way. The patient response will be in accordance with the clinical needs of the patients. This may be a minor injury managed within a local EMS arrangement or require system wide coordination, response, and retrieval.

QEMS SECRETARIAT

Supporting QEMSAC and the Advisory Committees is a Secretariat, located in the Emergency Services complex, Brisbane.

The role of the Secretariat is to manage the business of QEMSAC. QEMSAC is an interdepartmental committee responsible for the establishment and effectiveness of QEMS. Queensland Ambulance Service funds the Secretariat with assistance from Queensland Health. The Secretariat comprises two people, an Executive Officer, and Administration Officer.

The Secretariat is responsible for:

- Facilitating the work of QEMSAC;
- Facilitating the work of QEMSAC sub-committees;
- Support the establishment and function of District EMS Committees and Local EMS Groups
- Liaise with and support Zonal EMS Committees.

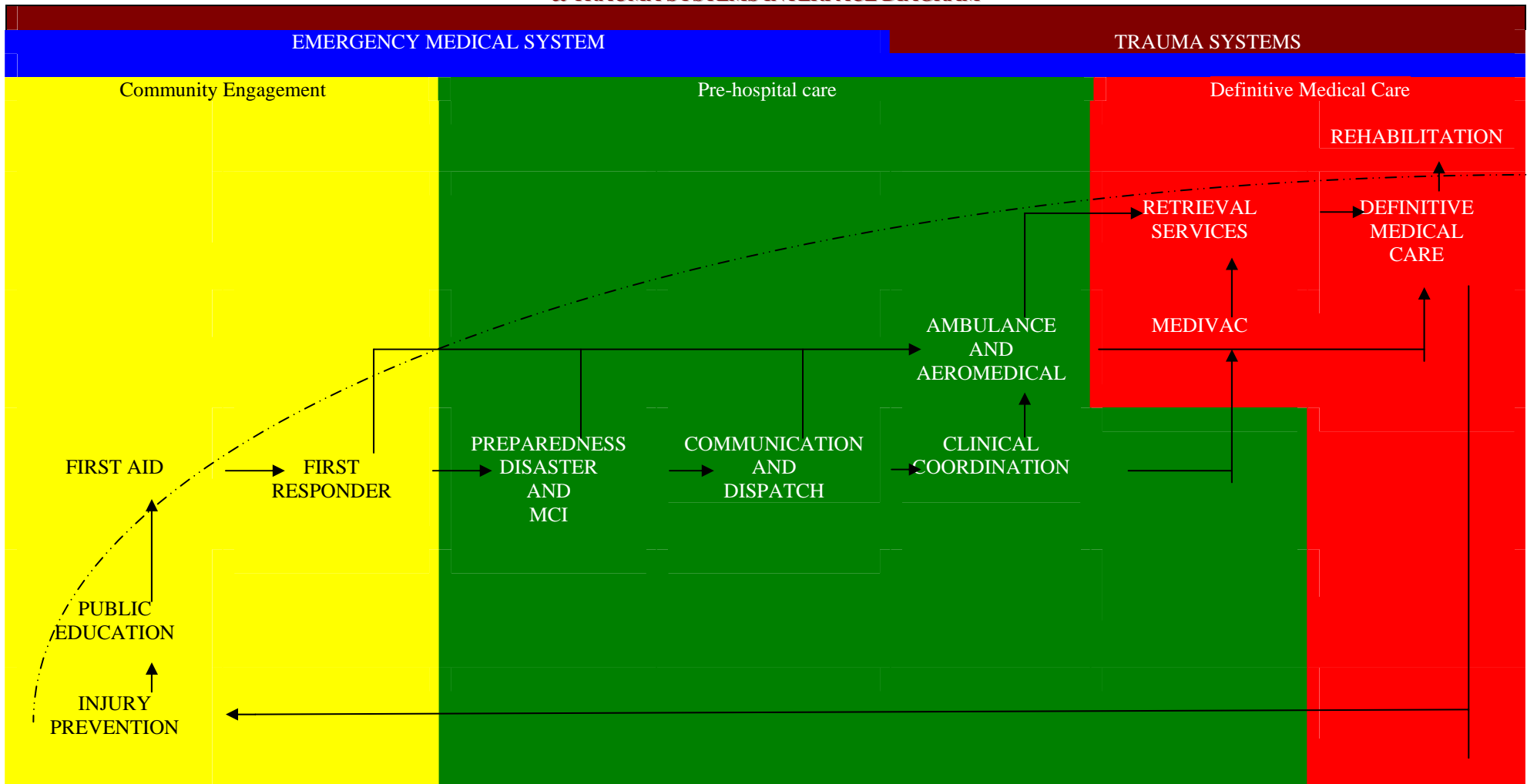
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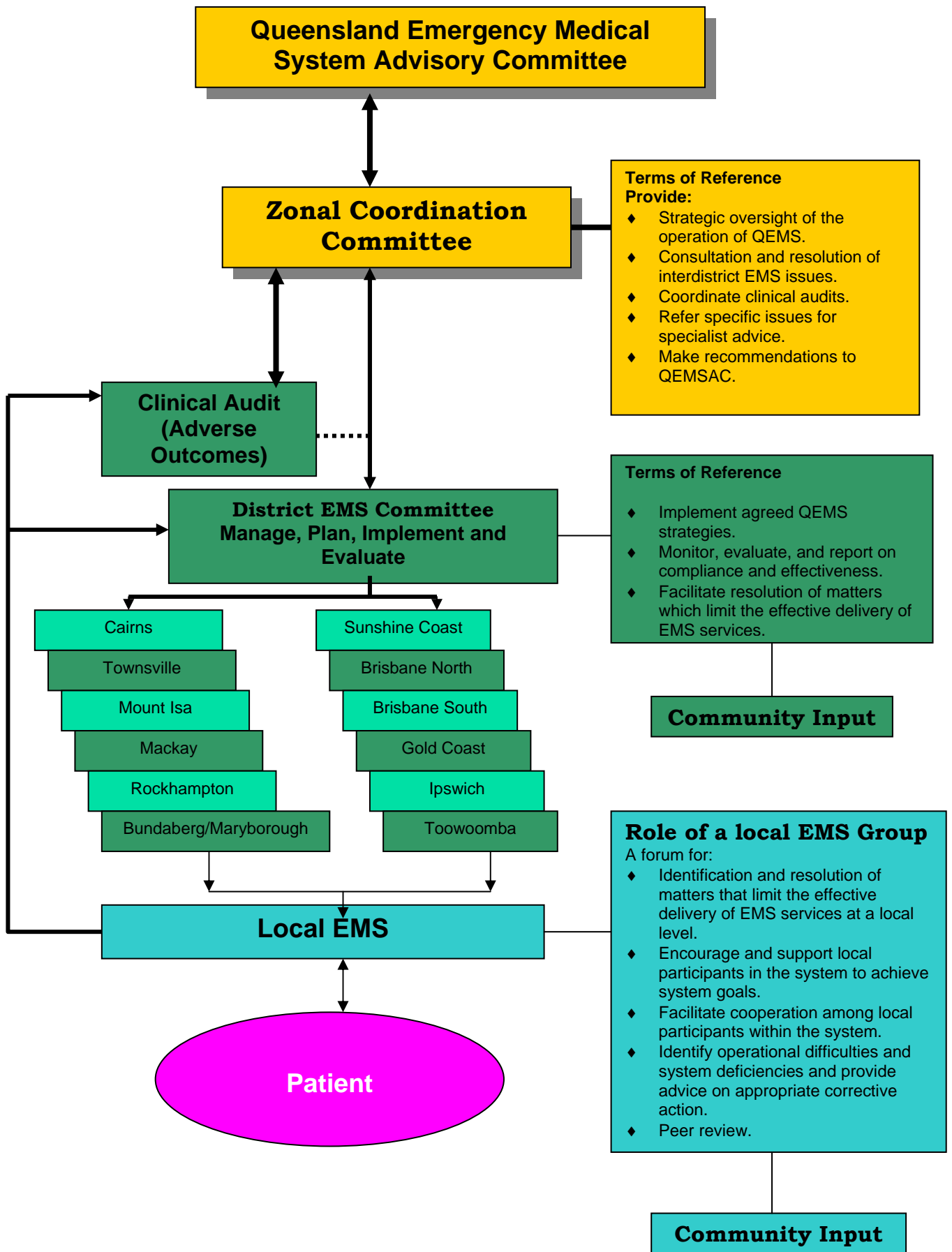
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QUEENSLAND EMERGENCY MEDICAL SYSTEM (EMS)
& TRAUMA SYSTEMS INTERFACE DIAGRAM







IMPLEMENTATION AND COORDINATION

Three Zonal committees are responsible for the strategic operation of QEMS. District EMS Committees are responsible for implementing EMS strategies, and Local EMS Groups meet as a peer group to consider and resolve local EMS issues.

The structure of these committees and their terms of reference are shown on the preceding page.

Zonal QEMS

Three zonal QEMS committees have been established in line with Queensland Health's zonal system. Members of the zonal committee are drawn from executive officers of EMS service providers. Their role is to:

- Liaise with District QEMS Committees;
- Develop policy recommendations;
- Coordinate the Implementation of QEMS; and
- Evaluate of the system.

The terms of reference of the Zonal Committees are to:

- Provide recommendations to QEMSAC on operational policy and standards.
- Refer issues for specialist advice to sub-committees of QEMSAC.
- Provide strategic oversight of the implementation of QEMS.
- Facilitate consultation for the resolution of inter-district EMS issues.
- Coordinate and supervise audit and research processes.
- Meet quarterly as a minimum.

District EMS

Queensland Health's Zones and the Department of Emergency Services' regions are sub-divided into smaller Districts. For EMS purposes these districts each have a EMS Committee with responsibility for implementation of agreed EMS strategies. District Committees are established around the:

- **Northern Zone** Cairns, Townsville, Mount Isa, Mackay.
- **Central Zone** Rockhampton, Bundaberg/Maryborough, Sunshine Coast and Brisbane North.
- **Southern Zone** Brisbane South/Logan, Gold Coast, Ipswich and Toowoomba.

It is expected that the majority of EMS issues will be resolved at the district level. However, unresolved issues and adverse outcomes are to be referred to the zonal committee for resolution, and where necessary the development of policy recommendations for QEMSAC.



District EMS committees manage processes to implement QEMS strategies, monitor compliance and effectiveness of EMS within the district.

Local QEMS

There is another important part of the QEMS network, which recognizes local EMS areas. An EMS can refer to a single doctor and nurse in a small remote hospital or to the entire statewide system.

QEMS recognizes that local communities, particularly in rural and remote areas, operate their EMS with a high level of self-sufficiency. These systems function quite autonomously until a patient needs to be moved to a larger facility or a retrieval of a critical patient is required.

Local QEMS Groups are informal systems that reflect local community networks. People within these systems operate very much at the sharp end of emergency patient care provision.

Local EMS groups are not mandated within the system. However, local EMS committees are encouraged as a means to:

- Inform local practitioners about QEMS;
- Establish the communication channels so that QEMS strategies and principles will be implemented; and to
- Ensure that local practitioners have access to key decision makers at district level to resolve problems.

Local issues should be able to be resolved locally. But if they can't they are referred to the District committee. Isolation will be the driver for the establishment of local EMS committees. Encouraging local EMS practitioners to meet will encourage inter-agency professional and clinical support, provide a mechanism for local feedback, and support self-sufficiency.

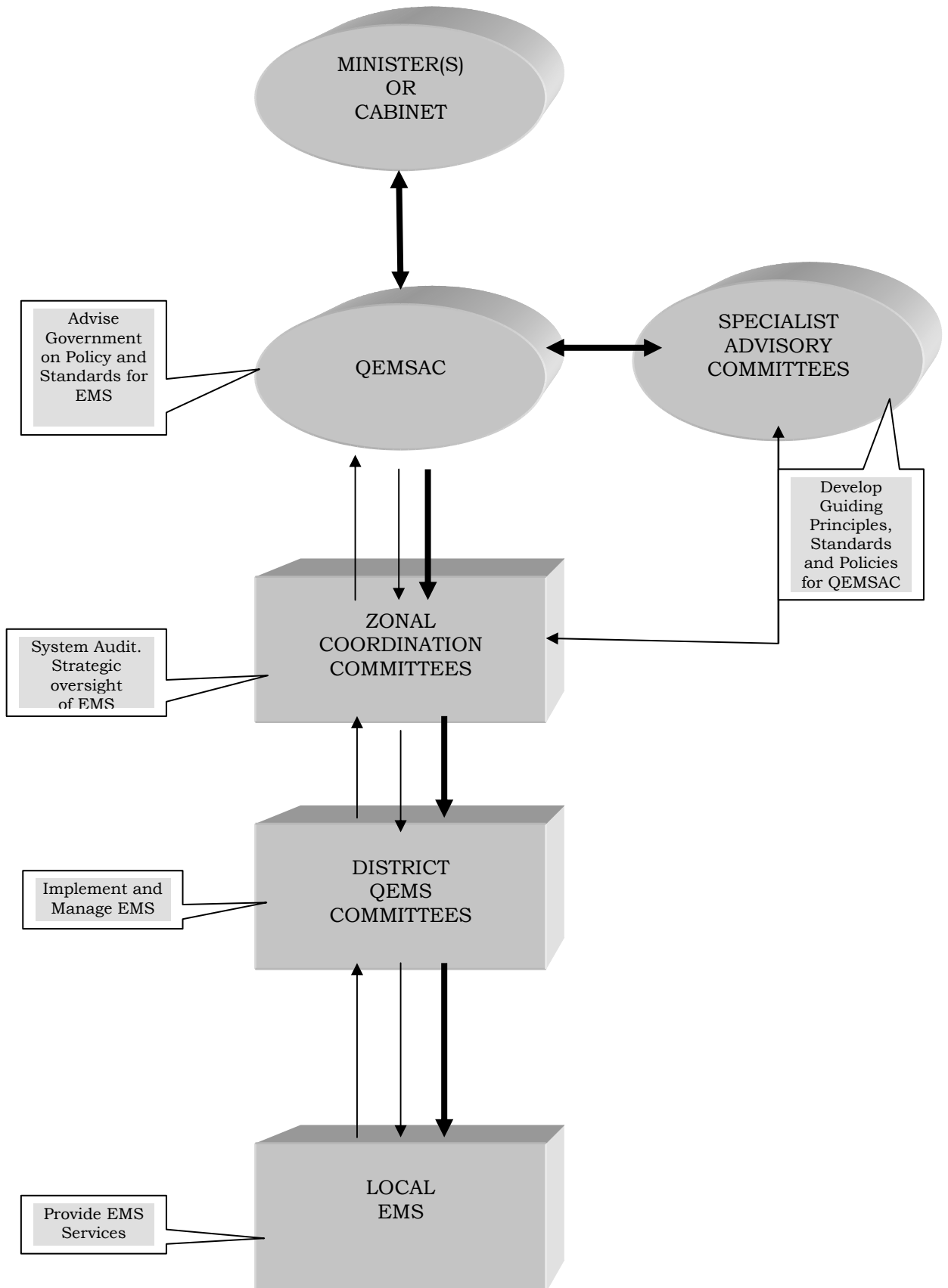
QEMS is a tiered structure at State, Zonal, District, and Local levels.

On face value QEMS structure may appear complex. But, it reflects the system very much as it is, particularly with respect to patient flow patterns.

The purpose of QEMS is to put a framework over this existing structure so that channels of communication are available to identify and resolve problems, develop standards for future services and, as much as possible, ensure consistency across the system.

Achievement of these goals will deliver improvements to out-of-hospital patient care through greater integration of services and coordination between providers of services.

QUEENSLAND EMERGENCY MEDICAL SYSTEM CONSULTATION PROCESS





QEMS CONSULTATION

The QEMS framework is structured across state, zone, district and local EMS committees. QEMSAC has responsibility to advise Queensland Health and the Department of Emergency Services on guiding principles and standards that shape the way emergency patient care services are provided. Additionally, with respect to matters with cross-portfolio implications, QEMSAC will consider and endorse specific strategic policies. QEMSAC is also responsible for providing advice to relevant ministers and Queensland government on EMS matters.

Assisting QEMSAC in these processes are specialist advisory panels or ad hoc working parties:

These committees' develop component specific guiding principles and standards, review strategic policies as required and lead strategic consultation processes.

Each zonal coordination committee has responsibility for compliance with QEMS guiding principles and strategic coordination and implementation of QEMS standards.

District QEMS committees are constituted of personnel with responsibility for management and provision of emergency patient care services. Accordingly, these committees monitor EMS services and provide the focal point through which QEMS guiding principles and standards are implemented.

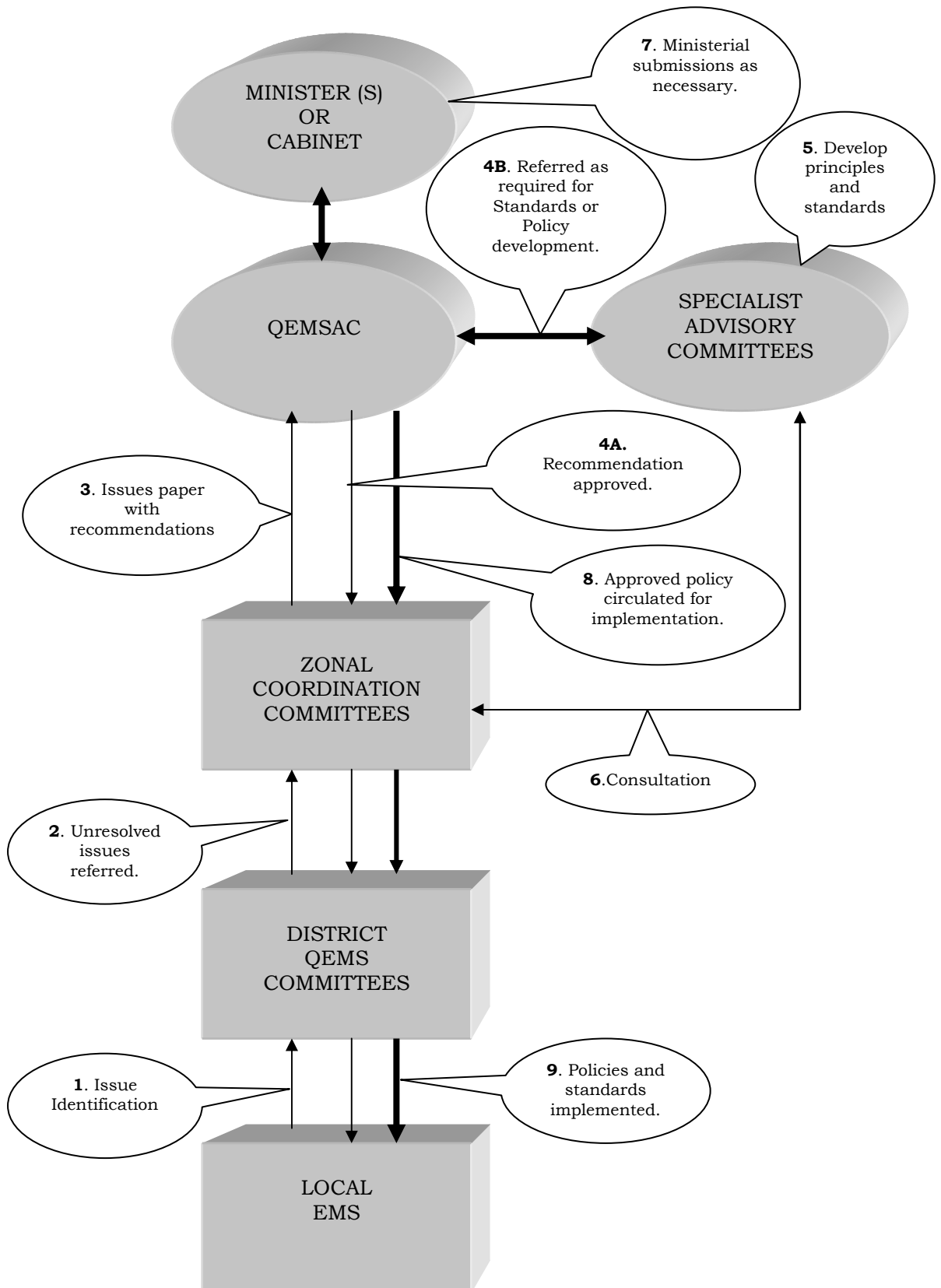
QEMS recognizes that practitioners at the local level provide emergency patient care services. The establishment of local EMS committees provides the opportunity for these personnel to meet, discuss, and resolve local EMS issues.

The QEMS structure enables non-resolved issues to be referred directly to decision-makers at a district, zone, or state level as necessary.

A recommended consultation process is outlined on page 14.



QEMS CONSULTATION PROCESS





As mentioned earlier in this document it is anticipated that many EMS issues will be resolved at the local or district levels. The consultation process outlined in the diagram on page 14 provides guidance to practitioners within QEMS when issues cannot be resolved and committees require inter-agency policy direction or proposed changes will impact strategically on budgets, operational and business plans.

Policy development is the primary responsibility of individual agencies. However, it may be necessary for agencies to modify their policy or procedures as a result of a Government policy directive, revised guiding principles or standards (Top-down driven change) or as a result of operation needs. (Bottom-up driven change)

The following example of how the consultation process may be applied should be read in conjunction with the diagram at left.

Issue Identification

(Note: Numbers in the following paragraphs refer to the diagram.)

Issues identified by local EMS committee.

1. Resolved issues managed locally with outcome communicated to the district EMS committee.
2. Unresolved issue referred to the district EMS committee.

As a general principle all issues should be resolved as close as possible to the locality in which the issue arises with due regard to individual delegations and the capacity to reach a local agreement. It is anticipated therefore that the majority of issues will be resolved at either the local or district level. However, some matters may be of a significantly complex nature that it necessitates referral to the zonal QEMS committee.

Should the impact of the recommended resolution impact across agencies and/or portfolios it will be necessary to seek the advice/endorsement of QEMSAC. A standard format for making submissions to QEMSAC is shown in the next section of this guide.

Issues Paper

3. It is requested that submissions to QEMSAC be in a consistent format. This will aid administration and contribute to timely processing of QEMSAC business. Procedural guidelines for submissions to QEMSAC are provided in the next section.

Recommendations

Senior executive officers of Queensland Health and the Department of Emergency Services, along with the Chairs of the component advisory



committees, constitute the membership of QEMSAC. The QEMSAC will either endorse submission recommendations or refer the issue to a component advisory committee for further investigation and advice.

4. **A.** Endorsed submissions will be returned to the zonal QEMS committee for implementation.
4. **B.** Submissions requiring further investigation or specialist advice will be referred to the relevant component advisory committee.

Guiding Principles and Advisory Standards

Component advisory committees are responsible for the development of guiding principles and advisory standards for the delivery of emergency patient care services. QEMSAC directives will be the triggers for these tasks. These processes will involve detailed research and stakeholder consultation. QEMSAC decisions will be published in appropriate departmental or agency policy documents manuals and other professional or public advisory documents.

5. The development of QEMS guiding principles and standards remain the responsibly of the relevant component advisory committee. The advisory committee refers all recommendations to QEMSAC for approval.
6. When carrying out its tasks, component advisory committees should ensure that the zonal QEMS committees and other stakeholders are consulted.

Advising Government

QEMSAC is required to report to the relevant Ministers on a quarterly basis to advise on progress toward the establishment of QEMS. Additionally, recommendations, which may impact on government policy or portfolio strategic planning, will be referred to the relevant Departmental Head and Minister for approval.

7. QEMSAC will refer matters as necessary to Departmental Heads and to relevant Ministers for approval.



Implementation of Decisions

District QEMS committees are responsible to work with local EMS personnel and service providers to implement policies that reflect QEMS advisory standards.

All QEMSAC determinations will be communicated directly to the Chair of the zonal QEMS committees for dissemination to the QEMS network. Matters of a strategic nature which effect the integration and coordination of emergency patient care services should not be implemented without the endorsement of QEMSAC.

8. QEMSAC is responsible for strategic determinations effecting emergency patient care services. These determinations will be communicated to the Chair of the zonal QEMS committees.



GUIDELINES SUBMISSION OF PAPERS TO QEMSAC

Submission Timing

Submissions and other documents for consideration by QEMSAC are to be lodged with the Secretariat not less than fourteen (14) days prior to QEMSAC meetings so that they may be circulated to Members. Meetings of QEMSAC are scheduled at three monthly intervals on the first Monday in February, May, August and November.

Documents that are lodged after this fourteen-day interval may not be tabled until the following Advisory Committee meeting. Late submissions not tabled at the meeting of the Advisory Committee will be placed on a review list for the agenda of the next meeting.

Submission Format and Content

Because of the significant workload and pressures borne by Advisory Committee Members and their staff, it is essential that all Advisory Committee submissions:

- Focus on only one issue (for information or decision).
- Be presented in a familiar format that facilitates understanding and enables Members to focus on particular issues.
- Be concise, logical and clearly focus on the essential issues for consideration.
- Indicate policy options and their implications.
- Provide clear recommendations for the guidance of the Advisory Committee.
- Provide an executive summary.

The content of a submission is to be concise and emphasise essential matters under a series of headings. Care should be taken to minimise the use of technical terms, acronyms and jargon.

The executive summary for the submission should not exceed two (2) A4 pages and the total submission should not, as a general rule exceed twelve (12) A4 pages. Attachments may be added to a submission as necessary. However, lengthy attachments should be avoided.

Submissions or documents to be considered by the Advisory Committee may directly or indirectly relate to patient care matters on contractual arrangements between Queensland Health and/or the Department of Emergency Services and service providers. Therefore, all matters coming before QEMSAC will be considered **confidential**.

Submission Checklist

- Submissions are to be typed on white A4 size paper.



- A QEMSAC Submissions **cover sheet** (Sample attached) must be attached to the front of the submission.
- Draft submissions must be clearly marked *Draft*.
- It is preferred that type size be 12 pitch, but no smaller than 10 pitch with single line spacing;
- A 3-cm left margin is to be provided in all submissions and attachments to facilitate filing.
- The Executive summary pages shall incorporate a 6-cm **Minute** right margin.
- Header/Footers should contain the page numbering, version number or date and title of submission;
- Any cross-referencing in the body of a submission to an attachment must clearly identify the attachment, its page number, paragraph number, table or schedule number.

Submission Structure

A submission normally addresses one issue, and is used as a decision making tool. Therefore, it is critical that a submission demonstrates evidence of research, and provides an analysis of the information obtained.

The suggested structure below is provided as a guide. As necessary, depending on the complexity of the submission, the structure of the submission should be separated and sequenced into the following divisions:

- Submission cover sheet
- Table of Contents
- Executive Summary
- Introduction
- Background
- Description of consultation process.
- Body of Submission
- Current Issues defined.
- Future directions outlined.
- Conclusion(s)
- Benefits to the community.
- Ramification of implementing the policy.
- Recommendations
- Bibliography
- Appendix (as required)
- Glossary (if appropriate)



QUEENSLAND EMERGENCY MEDICAL SYSTEM SUBMISSION COVER SHEET

TO: Chair, QEMSAC

FROM: (Insert the name of the Chair of the Committee)

SUBJECT: (Insert Title of Submission)

EXECUTIVE SUMMARY:

RECOMMENDATION:

It is recommended that the Advisory Committee:

.....
Chair

Date: / /

QEMS Secretariat use only:

Submission NO:

SUBMISSION ATTACHED:

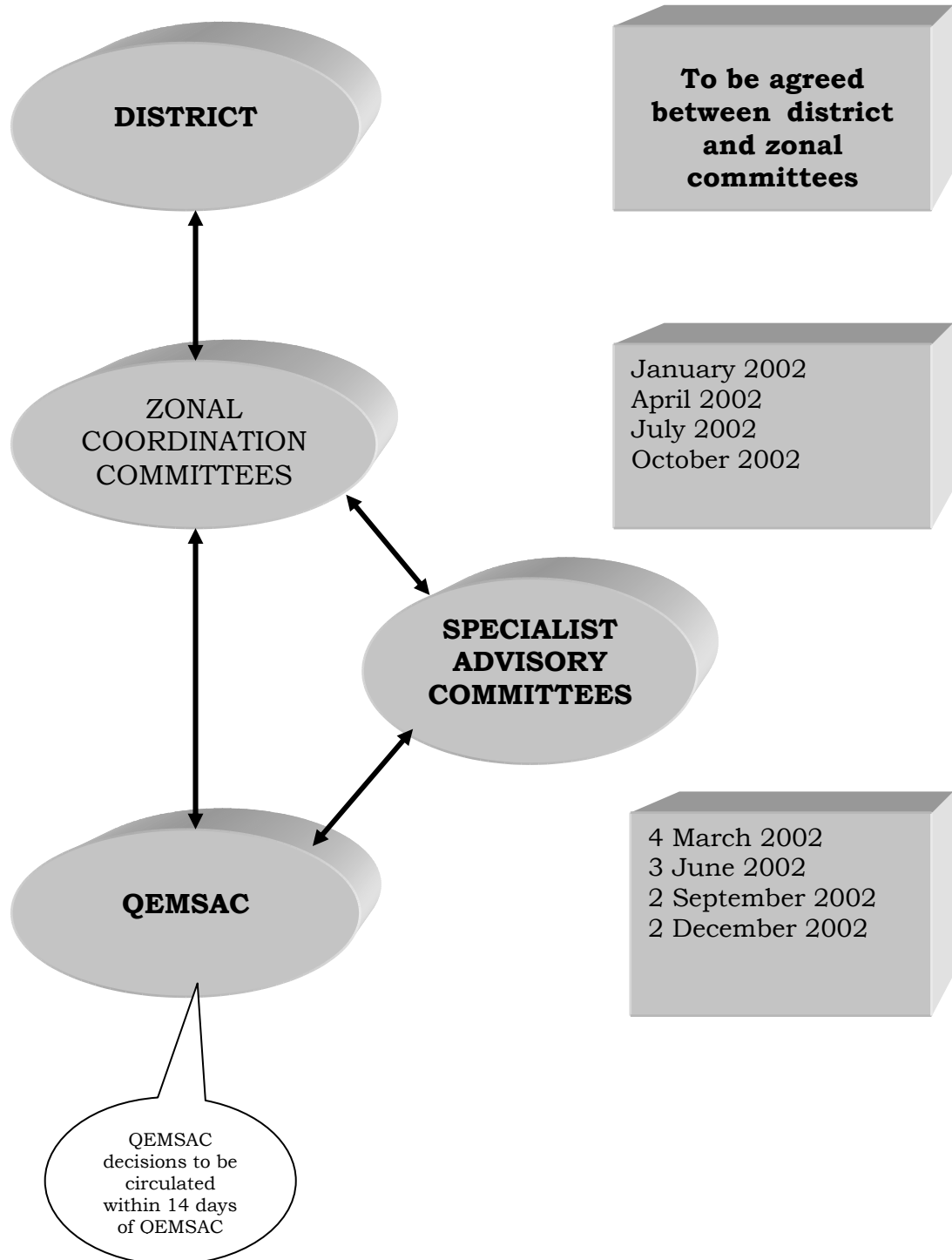
Contact Officer:

Telephone No:

The suggested submission structure below is provided as a guide.

- | | |
|---|--|
| <ol style="list-style-type: none">1. Submission cover sheet2. Table of Contents3. Executive Summary4. Introduction<ul style="list-style-type: none">▪ Background▪ Description of consultation process.5. Body of Submission<ul style="list-style-type: none">▪ Current Issues defined.▪ Future directions outlined. | <ol style="list-style-type: none">6. Conclusion(s)<ul style="list-style-type: none">▪ Benefits to the community.▪ Ramification of implementing the policy.7. Recommendations8. Bibliography9. Appendix (as required)10. Glossary (if appropriate) |
|---|--|

CLOSING DATES FOR SUBMISSIONS AND REPORTS TO QEMSAC 2000





QEMSAC Meeting Calender for Year 2000

Whenever possible, local EMS issues are resolved locally, that is either at the local, district, or zonal level. Development of guiding principles, policy guidelines and advisory standards will be coordinated through, and ultimately approved by, QEMSAC for recommendation to relevant Minister's or departmental CEOs as the case may be.

To ensure a smooth progression of consultation processes, and finally submission to QEMSAC, an annual timetable of QEMSAC's meetings is provided in the diagram opposite. A recommended structure for consultation is shown on page 16.

**CONTACT DETAILS FOR THE QEMS NETWORK TO BE ADDED
HERE.**