



QEMS FUTURE DIRECTIONS FORUM

REPORT

November 2001

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***“It is important to realise that an integrated trauma system is required in which the whole system is more important than any of the individual parts.”
(Driscoll PA, 1992)***

INTRODUCTION

An Emergency Medical System (EMS) can be defined as a comprehensive, coordinated and integrated arrangement of health and safety resources that serves to provide timely and effective care to victims of sudden illness and injury.

The benefits of the standardisation of trauma and disaster responses within Australia have been generally well accepted for some time now (Senate Standing Committee on Industry, Science, Technology, Transport, Communications and Infrastructure, 1994). Most Australian States and Territories have disaster, counter disaster, and other specific hazard plans in place for the management of multi-casualty events. However the implementation of an Emergency Medical System with the capacity to oversight and coordinate the management of both major disasters and traumatic events is critical to the efficient cross-portfolio deployment of resources and maximised patient outcomes.

Queensland was the first Australian State to adopt an integrated, statewide Emergency Medical System. In 1997, the Queensland government endorsed the concept of a comprehensive, integrated, accountable and cost-effective emergency medical system that was designed to be accessible statewide. That system is known as the Queensland Emergency Medicine System (QEMS).

In the four years since the implementation of QEMS, Queensland has sought to achieve improvements in five key result areas namely:

- community education and first aid
- the organization and funding of Ambulance services
- development of emergency medical services
- coordination of aero-medical services
- multi-casualty and disaster planning

1.0 PURPOSE OF THE WORKSHOP

In late October 2001, a planning forum was held to discuss and agree future directions for QEMS. The desired outcome was a strategic Action Plan that would take QEMS forward to 2005 (see Appendix 1).

1.1. Participants

Participants from all relevant sectors were invited to participate (see Appendix 2). Representatives of Queensland Health, Central Office, Zones, and District Health Services, and Queensland Ambulance Service participated. Representative of community organisations also attended including St John Ambulance, Surf Life Saving and Australian Resuscitation Council.

In total 47 participants attended.

2.0 APPROACH TO THE TASK

2.1 Introductory Comments

Workshop proceedings were begun with presentations to the plenary group from Dr Gerry Fitzgerald (Commissioner, QAS) and Dr John Youngman (General Manager, Queensland Health). The group was also later in the morning addressed by Mr. Michael Kinnane (Director- General, Department of Emergency Services). All three speakers stressed the ongoing significance and cross-portfolio support for QEMS and stressed the importance of improving strategies to maximise the evidence base of QEMS initiatives.

Dr Fitzgerald provided participants with a brief overview of the history of QEMS and the significance of initiatives applied to date. He stressed the importance of collaborative work arrangements and development of an evidence base against which to measure QEMS initiated improvements in the management of trauma and emergency medical care. Dr Fitzgerald also drew attention to the need for consistencies in professional standards and the staff education.

Dr Youngman drew the attention of participants to the need to consider whether there are better ways to do QEMS business. He also called for attention to issues of standardization of Emergency Department organization and the importance of staff being able to move between facilities without the need for re-education. The need for development of agreed definitions of roles within the system was also stressed. In particular, the roles and responsibilities of agencies providing emergency transport and transfers between facilities.

The capacity to measure the effectiveness of QEMS over time is clearly determined by the ability to collect appropriate data to monitor clinical/medical care outcomes. Dr Youngman asked participants to consider the importance of data collection and data utilization strategies to support outcomes based measurements. Associated with this are the importance of maximizing safety, high quality services and the ongoing development of mechanisms for measuring the impact of QEMS in a 'no blame' environment.

Mr. Michael Kinnane reinforced the ongoing going commitment of government to the aims and objectives of QEMS and encouraged participants to work diligently to maximize the impact of QEMS into the future.

2.2 Structure and process

Forum papers were circulated prior to the workshop to encourage pre-workshop discussion and analysis of QEMS (see Appendix 5). To maximize the input of participants, small working groups were formed. Participants were invited to self-select for one of three topic areas, namely:

- Community Engagement
- Pre-hospital Care
- Definitive Medical Care

Small groups worked with their facilitator to complete a “*SWOT*” analysis of their topic area. Strengths, weaknesses, opportunities, and threats were identified and this information utilized to set priority targets for action for QEMS over the coming 3 years. An Action Plan Proforma (see Appendix 3) was provided to the groups to assist in formulation of the desired action plan.

At the conclusion of each small group session, the outcome of group deliberations was reported to the plenary group by the small group facilitators. Comments and suggestions from the plenary group were incorporated into each working group’s material.

As the small groups worked and presented their information, the senior facilitator using the Action Plan proforma developed an overall plan of action. The resulting Action Plan was presented to participants in the final session of the day to provide a final opportunity to fine tune, as a plenary group, the tasks recommended by small groups for inclusion as priority actions for the future.

At the conclusion of the session participants were invited to assess the veracity of the draft plan for action and to endorse the basic structure for further development. Participants were canvassed to determine their interest in forming a small working party to assist in the further development of the Action Plan prior to presentation to Cabinet.

Following the workshop, facilitators provided their full set of notes to the secretariat for collation and application as background material to the Action Plan.

3.0 WORKSHOP OUTCOMES

Overall, participants stressed that the fundamental aims and objectives of QEMS continued to be endorsed. Consistent with this, the majority of participants reported their impression that QEMS “*wasn't broken*”, but could be improved with some targeted attention to:

- Improve data collection and accessibility to existing data for the purposes of development of an evidence base for policy decision making;
- Streamlining the committee structure of QEMS; and the
- Conduct of specific pieces of work included in the Draft Action Plan (see Appendix 4).

3.1 Community Engagement

There was an acknowledgement by the Community Engagement group that there is the need for development and acceptance of a clearer understanding of the purpose of community engagement in the QEMS context. The group identified the following in their SWOT analysis:

Strengths:

- Existing collaboration between agencies.
- Diverse range of community representation achieved through the engagement of agencies such as Surf Lifesavers, St Johns Ambulance, and the Red Cross.
- Demonstration those education initiatives in First Aid have been able to facilitate change in community attitudes and skills. Health Promotion strategies are believed to have heightened community awareness about safety.
- QEMS has assisted the sharing of knowledge and resources in local areas and there is significant goodwill with regard to QEMS.

Weaknesses:

Some frustrations are experienced as the result of perceived:

- Fragmentation, ‘red tape’, and the perceived impact of excluding community participation and engagement through the pursuit of rigorous accreditation.
- The focus to date of QEMS has rested with QLD Health and QAS and there is an acknowledged need to broaden the base of community participation.
- Some failure to pursue community driven initiatives in favor of more ‘commercial’ strategies.
- Some weakness in the QEMS structure resulting in the perception that QEMS is a framework rather than an active system.

Opportunities and Threats:

The group identified the need to:

- Raise the profile of Community Engagement on the QEMS agenda and capture commitment at the senior management level.
- Develop systems to measure outcomes for communities
- Develop long-term strategies to improve community capacity through enhanced community engagement and facilitate real feedback loops between community and government.
- Raise community awareness of injury prevention.
- Develop First Responder – ACE Program.
- Implement a QEMS Newsletter to facilitate improved information sharing. Alternatively, QEMS could link in with existing organisations’ media and thereby strengthen local networks.
- Continue to nurture goodwill.
- There is a need to stock take what is currently being achieved in local communities and determine how QEMS might target future strategies.

Threats were identified as those relating to an increasingly litigious society and the capacity for accreditation to hold back some first responder initiatives.

3.2 Pre Hospital Care

Strengths:

- Commitment to Quality of Care.
- Universality of Access.
- Infrastructure.
- Communication system.
- Readiness to respond and adapt.
- Respect:
 - For roles and responsibilities of others;
 - From the community.
- Goodwill.
- Data – audit analysis sharing.

Weaknesses:

- Intergovernmental and Interdepartmental hitches and friction:
 - cost – shifting;
 - dis-unity of planning;
 - lack of shared vision.
- Clinical coordination:
 - operational base;
 - skills level.
- Response.
- Retrieval.
- Resources.
- Data:
 - No general ownership;
 - Standardisation of zones / borders
- Roles

Opportunities and Threats:

- Explore alternatives for service provision.
- Map and scope resources.
- Workforce planning:
 - Definition;
 - Clarification;
- Improve evidence base:
 - Further development of data collection audit and analysis.
- Technology.
- Smooth inter-organisation and inter-department wrinkles.
- Enhance performance indicators.
- Further support existing staff.
- Challenge sacred cows.

Threats were identified as:

- Incomplete data or evidence.
- Political decision-making.
- Instability of workforce.
- Industrial situation.
- Private situation.
- Private retrieval.
- Increased demand on services (e.g. MP).
- International

3.3 Definitive Medical Care

Strengths:

- It's there.
- Appointment of E D physician.
- Training of nurses.
- PHTLS.
- Quality of indicators within ED's.
- Waiting times;
- Triage.
- Time to theatre etc.
- Transfer and well understood system of where to send the patient.
- Communication (AFCOM) – it's there.
- Clinical coordination – centralized system in place (can be built on).
- Centralized but Regional approach / flexibility.
- Medivac system (it's there).
- Effective decision making at macro level.
- Level of resources (including 24 hour access).
- Range / variety of resources.
- High level of commitment to Emergency Services surgical access teams.
- ↓ Bed block and access block than other States and Countries.
- Good relations ↑ degree of goodwill.
- Deal with local problems locally. Not a lot of bureaucracy.
- Commitment of Emergency Care Stake Holders.

Weaknesses:

- Lack of consistency (IHT) between Regions:
 - method of transport;
 - escort;
 - approval processes;
 - appropriate resource use;
 - lack of consistent guidelines / adherence to guidelines.
- Lack of facilities in some Regions.
- Mental health transfers.
- Obstetric transfers.
- Neonate transfers.
- Paediatric transfers and clinical coordination.
- Bypass policy – application of bypass can't get in the door.
- Problem resolution – need better mechanism for resolving problems.
- Balance between central v's periphery.
- Advanced warning to Regions of major events / major planning (ADF) – need to be better at major events planning.
- Lack of specific dedicated staff for retrievals (conflicting service requirements).
- Resources – making best use of resources in rural areas (ambulance taken out of town escorts etc.)

Weaknesses (continued)

- Lack of rural / remote perspective and issues in rural locations.
- Lack of metropolitan perspective – appreciation of different environments.
- Need for standardisation and improved education about the system.
- Time variation (24 hour access and levels of skills available).
- Planning among service providers (variation).
- Private / Public interface.
- Lack of agreed data sets.
- No forum for resolution of interagency issues – if can't be solved at zonal level – where does that go?
- Some secure cases held up along the way.
- Standardisation of equipment → training of staff.
- Lack of consistency with resources. Resources not adequate – inconsistent.

- Inconsistency of resources medical superintendents and right of private practice.
- Bureaucracy inconsistent – flow of information up and down.
- Workforce issues for some departments
 - ↓ Registered Nurses
 - ↓ ED Drs.
- Multi-agency system:
 - Strengths and weaknesses;
 - Taking agencies for granted.
- Weakness at Ambulance:
 - Non –ED admission – multiple reception points (don't go through admissions);
 - Handover;
 - interface unclear / undescribed.
- Zonal / District QEMS and lack of interface:
 - representation at the meetings;
 - composition of QEMS Committees;
 - coordination.

Opportunities and Threats:

- QEMS is a living example of cooperation / coordination, whole of govt. approach. (window of opportunity).
- Training / Models of education getting the QEMS message and goals across. Training at U/G level about system:
 - medical students;
 - registered nurses;
 - first aid in schools.
- Level of good will, understanding, and commitment → opportunity for being creative.
- Technology (understanding other environments).
- Opportunity to lead to action for QEMS.
- Opportunity for others to be involved (rescue services) especially in terms of data and other input.
- To showcase Emergency Services through QEMS – get the message to broader health community.
- Opportunity to work closely in health promotion, community health issues (rural / remote potential).
- Opportunity for standardisation – rules and procedures can be standardised.

Threats identified as:

- Inaction to address issues.
- Competition between agencies for resources and roles (role conflict / confusion).
- Victim of own success from other program areas.
- ↑ Community expectations and inability to meet these (communication support).
- Standards (LCD).

3.0 THE NEXT STEPS

The Workshop nominated three participants to assist with writing the QEMS Strategic Plan and QEMS Function Guide, these were:

Dr Mark Elcock
Mr Murray Excell
Ms Karen Roach.

With guidance of QEMSAC the Secretariat will translate the findings of the workshop into the **QEMS Strategic Plan 2002-2005** and **QEMS Function Guide** with relevant suggestions for enhanced communication strategies.

The Strategic Plan should be presented to departmental CEOs for endorsement and subsequently submitted for the approval of the relevant Ministers.