

Application: This policy guideline applies to all Departmental officers including:

- Public Service officers employed under the *Public Service Act 1996*;
- Health Service employees, employed under the *Health Services Act 1991*.
- Ambulance Service officers employed under the *Ambulance Service Act 1991*;
- Contractors or persons / agencies subject to agreements with by Queensland Health.
- Contractors or persons / agencies subject to agreements with Department of Emergency Services.

Purpose:

The purpose of policy guideline is to:

- Describe a framework for clinical quality improvement within QEMS; and to
- Identify the role of emergency services providers and committees within the quality framework.

Rationale:

Proactive quality initiatives such as standards, policies and procedures are the core role of QEMSAC. This policy guideline focuses on the clinical audit element within a comprehensive quality framework and is reliant upon an open and equal partnership between Queensland Health (QH) and the Department of Emergency Services (DES), including providers of clinical services.

Responsibilities:

The guideline identifies the responsibilities of officers and organisations under this policy, including:

- Directors-General Queensland Health and Department of Emergency Services;
- Chief Health Officer;
- Senior Executive Director Health Services, Zonal Managers and Health Service District Managers;
- Commissioner, Medical Director and Assistant Commissioners, Queensland Ambulance Services;
- Chief Executive Officers of service provider agencies to Queensland Health and Department of Emergency Services.
- Chairs of Zonal QEMS Committee;
- Chairs of District QEMS Committees; and
- Officers appointed to undertake audits and investigations.

Related Committees and Functions:

- Queensland Emergency Medical System Coordination Centre (QCC) Oversight Committee;
- QAS Medical Advisory Committee;
- QAS Clinical Governance Framework;
- Aeromedical Sub-Committee;
- Trauma Committee; and
- Zonal and District QEMS Committees

Policy:

1. Establishment and Function of the QEMS Quality Council

The QEMS Quality Council (Council) is established pursuant to *Section 31, Health Services Act 1991* as an approved quality assurance committee by the Chief Health Officer. Its function is to provide advice, and make recommendations to the Directors-General and Ministers for Health and Emergency Services, through the joint-Chairs of QEMSAC, on matters relating to statewide, and service-specific health morbidity and mortality. Specifically, the Council is required to review and evaluate health indicators using routinely collected data around the following key areas:

- **Measured quality**; the analysis of routinely collected data for quality purposes, including activity descriptions, outcome-based data, agreed benchmarks.
- **Sentinel events**; the death of a patient in transit or injury or accidental death to a patient or staff, major trauma cases, or complaints from external bodies such as the Minister, Coroner, service providers, Health Complaints Tribunal, or Medical Board.
- **Clinical audit**; such as:
 - Process; the interrelationships between services providers;
 - Impact; the short-term effect of the response and patient interventions; and
 - Outcome; the long-term survival and quality of life measures.

2. Terms of reference

In addressing measured quality, sentinel events and clinical audit, the following terms of reference apply to the Council

- a. Measured quality:
 - i. Identify sources of routinely collected data;
 - ii. Identify the information available from these data sources;
 - iii. Devise appropriate indicators, using data already available;
 - iv. Monitor data on clinical indicators.
 - v. Assess data, with respect to identification of trends or patterns, and clinical interpretation.
 - vi. Provide analysis in report, and provide recommendations for change to policy and/or practice.
 - vii. Conduct ongoing evaluation of changes to policy and/or practice.
- b. Sentinel events:
 - i. Monitor sentinel events;
 - ii. Assess data on sentinel events, with respect to identification of trends or patterns, and clinical interpretation;
 - iii. Receive reports from sub-committees or working party members;
 - iv. Provide recommendations for clinical audit in the relevant area(s) to the joint-Chairs of QEMSAC.

c. **Clinical audit:**

The Council is to act as an expert reference group for the conduct of clinical audits, and during the conduct of audits, ensure that:

- i. Clinical indicators are identified in conjunction with the Council;
- ii. Data are collected and analysed;
- iii. Interpretation of results is performed in light of available service capability documents and health care guidelines, etc; and
- iv. A report is forwarded to the Chief Health Officer, which includes recommendations to QEMSAC on service quality improvement.

3. Authorisation

The Council is established pursuant to *Section 31, Health Services Act 1991* as an approved quality assurance committee by the Chief Health Officer. The Council reports functionally to the Chief Health Officer. On matters relating to system improvement, the Council will refer reports and recommendations to the joint-Chairs of QEMSAC. The quality assurance provisions of the Health Services Act 1991 bind all activities and members of the Council. The confidentiality provisions of *Section 63 Health Services Act 1991*, which prohibits the disclosure of identifying information, bind all Council members.

4. Membership

Members will be appointed based on their individual expertise and not as representatives of any professional organisation. Membership will be drawn from the following key stakeholder groups:

- a. **Clinicians** from a range of disciplines, i.e. medical officer, nurses and paramedics, drawn from nominations by representative professional bodies, colleges, societies and similar.
- b. **Key government officials**, drawn from nominations from government areas responsible for policy and strategic planning, and/or service delivery.
- c. **Academics**, drawn from nominations from institutions involved in research and education in a relevant area.
- d. **Community stakeholders**, drawn from nominations from the community, district councils, rural health advisory councils, and similar.
- e. **Consumer stakeholders**, drawn from nominations from peak consumer groups, funding bodies, industrial bodies, and similar.

5. Chairperson

The Chief Health Officer will appoint a Council chairperson, for a period of three years. The chairperson may serve no more than two consecutive terms as chairperson of the Council. The Chief Health Officer will be guided by the following attributes when appointing the chairperson:

- a. A senior health administrator or academic;
- b. Independent of direct service provision, or the direct care of patients; and
- c. Capacity to adopt a broader, strategic view.

6. Responsibilities of the Chairperson

The chairperson is responsible for the following tasks:

- a. Chair meetings of the Council;
- b. Develop meeting agendas in consultation with the secretariat;
- c. Confirm accuracy of minutes prior to distribution;
- d. Develop annual work plan in consultation with the secretariat;
- e. Delegate and coordinate Council activity to meet the objectives of the work plan;
- f. Ensure the annual report is completed in a timely fashion; and
- g. Implement strategies to enable all members to actively participate.

7. Members of the Council

The Chief Health Officer will appoint members of the Council following consultation with the joint-Chairs of QEMSAC for a term of three years. Members may serve no more than three consecutive terms. In determining Council membership, the Chief Health Officer may consider individual expertise, geographical location, and ability to represent a variety of disciplines and/or issues. Ex-officio Council members may include the Chairpersons of other Quality Councils. Membership of Council may include casual vacancies, to be filled at the discretion of the Chief Health Officer.

Members who are public sector employees (including the Mater Misericordiae Public Hospital) are *not* able to receive remuneration or sitting fees for participation. Members who are not public sector employees may receive sitting fees for attendance, in accordance with the Department of Employment and Training and Industrial Relations schedule.

Members may be paid reasonable expenses incurred while travelling to attend meetings and on approved Council business.

A member may terminate Council membership at any time, in writing to the Chief Health Officer.

The Chief Health Officer may terminate a person's Council membership, if the member does not attend three consecutive meetings or actively participate in Council activity, or whose conduct is inconsistent with the best interests of the Council.

Members shall not misuse the information provided to them by virtue of their membership of the Council.

Members will be expected to take a strategic view of issues and not seek to take advantage of their membership of the Council to canvass personal or institutional issues.

Any member who has a real or perceived conflict of interest in any matter under discussion at the Council shall be expected to declare that conflict and exempt himself/herself from the discussion.

8. Sub-committees and working parties

The Council may establish sub-committees and working parties to investigate specific issues where appropriate.

Members of Zonal and District QEMS Committees will, in the first instance form the Council's sub-committees and working parties. Additional person may be appointed to sub-committees and working parties as directed by the council and/or Chief Health Officer.

A chairperson of a sub-committee or working party may be appointed by the Council chairperson or elected by Council members, and will, for the term of the sub-committee or working party, be Council member.

The quality assurance provisions of the *Health Services Act 1991* bind members of a sub-committee or working parties.

The responsibilities of the Council chairperson apply to the chairperson of sub-committees or working parties.

Each sub-committee or working party will maintain a record of its activity and provide a report to the Council.

Sub-committees and working parties are required to operate under terms of reference devised by the Council and approved by the chief Health Officer.

9. Responsibilities of members of Sub-committees and Working Parties

- a. Members are required to comply with the terms of reference of the sub-committee or working party;
- b. Know their legal responsibilities and obligations pursuant to the quality assurance provisions of the *Health Services Act 1991*; and
- c. May not appoint proxies.

10. Procedural Guidelines

The Council shall develop and procedural guidelines for the conduct of its business and the functions of sub-committees and working parties.

Relevant Legislation, Policy and Guidelines:

Health Act 1937

Health Services Act 1991

Ambulance Services Act 1991

For Assistance Contact:

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