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for Emergency Medicine

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Canberra Health Services Strategic Plan
September 2019

Introduction

The Australasian College for Emergency Medicine (ACEM, The College) welcomes the opportunity to provide a submission to Canberra Health Services as it works to develop its Strategic Plan.

ACEM is the peak body for emergency medicine and has a vital interest in ensuring the highest standards of emergency medical care for all patients. ACEM is responsible for the training and ongoing education of emergency physicians and the advancement of professional standards in emergency medicine (EM) in Australia and New Zealand.

Emergency Departments (EDs) are essential components of Canberra's healthcare system. Canberra's EDs are staffed by EM specialists who are dedicated to providing timely and high quality care to all patients. This care is challenged through the prevalence of access block and ED overcrowding, the rising demand for ED services, and current resourcing (staffing levels and infrastructure). ACEM considers this presents a timely opportunity to shape the direction of CHS in order to address systemic in-efficiencies and to better meet the needs of patients across the ACT.

ACEM provides its response against the questions asked by CHS below:

1. What do you perceive as the greatest strengths of Canberra Health Services that we should build on in our Strategic Plan?

1.1.1 The geographical proximity of Canberra's health services, supports the healthcare workforce to communicate, collaborate and network for the benefit of patients.

1.1.2 Our Faculty Members enthusiastically report that the professional and personal relationships formed within and across Canberra's EDs results in an emergency medicine workforce that is respectful, kind and dedicated to providing exceptional care to Canberra's community.

1.1.3 Further, a positive culture within the ED provides for a supportive workplace for trainees and is a key driver of retaining an emergency medicine workforce.

1.1.4 Another positive element of Canberra Health Services is a willingness to develop innovative models of care (for example, the Hospital in the Home program– HITH).

2. What is the single most important area for improvement, and why?

2.1.1 There is an urgent need for the current CHS leadership team to improve the relationship between hospital executives, hospital clinical teams and the ED. A well-functioning ED is indicative of a well-resourced and functioning system – this requires shared responsibility.

2.1.2 The final report of the Independent Review into the Workplace Culture within ACT Public Health Services found, among other things, a history of poor leadership from previous executive teams, and within ACT Health, which enabled a status quo of bullying and harassment.

i. This restricted the capacity to develop professional and respectful partnerships within and across clinical teams.
ii. Ultimately, this negatively impacted on patients' experience of care, particularly for complex patients groups requiring care across multiple clinical streams (for example, mental health and geriatric patient presentations).

2.1.3 Poor leadership is a common theme for ACEM Members across Australia and New Zealand, and our ACT Faculty Members agree that those in leadership positions must set the tone for respectful, supportive and engaged collaboration.

2.1.4 The impact of poor executive leadership has resulted in a lack of shared responsibility across the hospital for patients experiencing access block and long waits in the ED.

i. Unfortunately, patients in the ACT experience some of the longest ED waits in Australia. ACEM's latest access block snapshot data shows that compared to the national average, approx. twice as many patients in the ACT were experiencing access block (8.5 patients waiting 8 hours or more) and three times as many patients in the ACT were waiting longer than 24 hours in the ED (1.5 patients).
ii. ACEM's Annual Site Census for FY2017-18 recorded 518 patients who spent 24 hours or longer in the ED at The Canberra Hospital, and 660 patients at Calvary Hospital ED.

2.1.5 Two areas requiring leadership and support from the executive are highlighted.

i. Existing patient flow processes limit the capacity of the ED to function effectively. For example, EDs follow a 24 hour a day / 7 day a week model of accessibility in recognition of the needs of the community. Yet, the rest of the hospital generally follows a traditional 'business hours' model of care. This disconnect is not patient centred and limits the effectiveness of patient flow through the hospital.
ii. Reporting metrics are often used to hold the ED to account for responsibilities that lie outside of the EDs ability to influence. For example, patients are often access blocked in the ED due to a lack of inpatient resourcing. When reported, the focus for poor performance is on the ED rather than triggering a whole-of-hospital response to ensure the patient's needs are met.

3. What one metric would you use to determine our future success?

3.1.1 ACEM strongly encourages Canberra Health Services to adopt a mandatory reporting regime based on breaches of 12 and 24 hour LOS in EDs. The evidence is clear that waits in excess of 12 hours are an unacceptable risk to patient health and wellbeing; reporting on breaches of safe LOS should therefore be embedded in the key performance indicators of Hospital Executive's. Further evidence is now emerging that all patients presenting to an overcrowded, access blocked ED are at much greater risk of adverse events, poorer health outcomes and a greater likelihood of death.

i. Any patient that experiences a wait in the ED of 12 hours triggers a mandatory report to the hospital CEO. We expect this would trigger an internal process across the hospital to get the patient into the required inpatient or community based service.
ii. Any patient that experiences a wait in the ED of 24 hours triggers a mandatory report to the Health Minister.

iii. The overall goal of these measures is timely access to care, with a 24 hour LOS in the ED a "never event" that results in escalated reports to the Health Minister.

3.1.2 We consider this is an effective tool for:

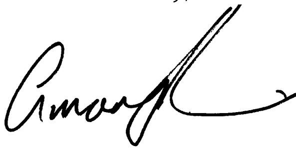
i. ensuring hospital CEOs and the Health Minister are accountable for the provision of safe, quality care for patients in the ED;
ii. optimising safety for patients and ED staff;
iii. embedding accountability for hospital wide performance improvements in the KPIs of hospital executive; and
iv. increasing the visibility of system wide issues for Health Department Executives and the Health Minister.

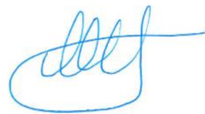
3.1.3 ACEM is also developing a new series of time-based metrics that is more reflective of the whole-of-hospital responsibility for patients presenting to EDs.

- We welcome the opportunity to discuss these further, and consider the ACT to be a prime jurisdiction to test and assess the feasibility of these metrics.

Thank you again for the opportunity to provide our feedback and we welcome the opportunity to discuss any of the issues raised in this submission with you directly. If you require further information, please do not hesitate to contact the ACEM General Manager of Strategic Partnerships, Ms Amelia Howard, on (03) 9320 0444 or amelia.howard@acem.org.au.

Yours sincerely,





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