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ACEM Submission to the Australian Government Department of Health: National Injury Prevention Strategy 2020 – 2030

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Introduction

The Australasian College for Emergency Medicine (ACEM; the College) welcomes the opportunity to respond to the Department of Health's call for submissions on the National Injury Prevention Strategy 2020 – 2030 (the Strategy). Our submission highlights areas where the Strategy could be enhanced.

As the peak professional organisation for emergency medicine, ACEM is responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine (including trauma care) in Australia and New Zealand. ACEM has a vital interest in ensuring the highest standards of medical care are provided for all patients presenting to an emergency department (ED). Fellows of ACEM (FACEMs) are key specialists in the initial care of patients affected by trauma related injuries, both in pre-hospital and ED settings, and play a vital role in trauma education, research and system leadership. ACEM is therefore active in advocating for and supporting the creation of a national focus on injuries and their prevention.

Overview

The flow of injured patients through the trauma system, including hospital admissions, interhospital transfer and timely access to surgery, allied health rehabilitation, and repatriation to community services affects access to EDs for other patients and impacts on ED crowding and 'access block'. Access block refers to an admitted patient with a total ED time (or length of stay) that exceeds eight hours.[1] In 2018-19, the period of time until most admitted patients (90%) departed the ED for admission to a ward in the same hospital in 2018-19 was 11 hours and 43 minutes across Australia.[2] Based on the most recently available Australian Institute of Health and Welfare (AIHW) data (2017-18) 18% of admitted patients (443,600 patients) experienced an ED length of stay of >8 to ≤24 hours, with an additional 1% (24,600 patients) waiting >24 hours to be admitted from the ED.

The need for prevention across the broadest spectrum of injury and illness has become an increasingly important part of resource stewardship. With the high cost of effective treatments and increased complexity of health and wellbeing, it is essential to have solutions that are proactive rather than reactive. Proactive solutions are more effective than providing treatment and provides extra resourcing for other opportunities that might otherwise be missed. Ageing populations, increased chronic conditions and comorbidities, and worsening climate conditions all highlight the future impacts on our population and eventual burden to our healthcare system.

[1] Australasian College for Emergency Medicine. Position Statement on Access Block. Melbourne: ACEM; 2019. Available from: https://acem.org.au/getmedia/c0bf8984-56f3-4b78-8849-442feaca8ca6/S127_v01_Statement_Access_Block_Mar_14.aspx
[2] Emergency Department Multilevel Data 2011-2019, Australian Institute of Health and Welfare, data extracted 3 January 2020.

In preparing this submission, ACEM has drawn upon relevant literature and the expertise of a cohort of FACEMs who are passionate about supporting the capacity of EDs and the broader community to be prepared for and respond to trauma related injuries. While ACEM supports the key principles of the Strategy, we wish to raise areas where this Strategy could be enhanced.

1. Lack of sufficient data

The lack of available data on injuries, particularly in relation to falls and self-harm, poses a significant challenge to understanding, monitoring and improving injury prevention. There are currently no minor injury recordings for patients who experience fall injuries, while current data collection processes do not allow for accurate recording of patients who present in the ED due to self-harm. Indeed, insufficient data is a key reason for the under reporting of certain ED presentation types. For example, in NSW it has been shown that only 1% of alcohol and other drug (AOD) related ED presentations are identified as having a primary diagnosis related to alcohol, with identification or reporting of secondary diagnoses related to alcohol also under reported.[3] Likewise, the lack of appropriate ICD-10 (International Classification of Diseases version 10) diagnostic codes for acute recreational drugs means that only one in ten amphetamine-type stimulant related ED presentations can be accurately captured.[4]

It is essential to capture the true burden of injuries, especially as suicide, self-inflicted injuries and falls are the leading causes of increased disability adjusted life years (DALYs). Alternative or supplementary data sources are required to inform quality decisions and intervention methods. At present, the Strategy's outcomes are not clear due to the broad data sets. It is unclear how the Strategy, as currently presented, will create meaningful and evidence-informed action without improved data collection. For example, the Australia New Zealand Trauma Registry (ATR) provides better data collection and clearer patient information necessary in monitoring and prioritising key areas for intervention development.[5] The ATR is more resourceful than ICD-10; however, it requires further funding to support regional centres in collecting data for all major and minor injuries and illnesses entering the system whether they are physical, mental and/or both. The ED is a key capture point for a significant proportion of injury related data. ACEM believes there is a need for a binational and all-inclusive Emergency Medicine registry, which captures granulated data and would thus allow for the delivery of quality evidence-informed and patient-centred care.

We commend the Strategy's use of DALYs as a measure of the consequences of injury, in conjunction with a life-stages approach which helps recognise how early childhood impacts later life stages and quality of life. This highlights the importance of collecting data on minor injuries for paediatric patients, and the Strategy could address this gap in the data to inform future intervention discussions. Another gap in data collection that the Strategy could address is understanding of violence and minor injury experienced by pregnant women who present to the ED. In addition, due to the aforementioned under reporting of AOD related ED presentations, there is a need for accurate recording of all AOD presentations in the ED to understand the full scope of this burden to the community and service providers. This would enable improved injury prevention, impact, and management for these patients. However, the implementation of such resources should not come at the expense of patient care, for example by putting the onus on treating clinicians to manage cumbersome electronic health records such as those that have been implemented in other countries.

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[3] NSW Ministry of Health. *The hospital drug and alcohol consultation liaison: model of care.* 2015; NSW Government.

[4] Wood, D.M., Conran, P. and Dargan, P.I. (2011). ICD-10 coding: poor identification of recreational drug presentations to a large emergency department. *Emergency Med. J.* 28(5):387.

[5] Australia New Zealand Trauma Registry: https://atr.org.au/

2. Recognising and supporting the role of carers

The Strategy should also consider the role of carers both within the hospital and in the community, including their key role in injury prevention. By focusing on community responsibility and the burden on carers responsible for older persons who have presented to the ED for falls or other injuries, the Strategy can support local communities with proactive solutions in providing support to carers. We recommend continued engagement with carers in preventing injury and enabling them to be aware of risks and interventions, provide basic needs assessment of facilities or the home, and sustaining change. Carers are an untapped resource with the potential to reach and engage with our ageing rural communities, which is particularly important in light of limited access to healthcare in some rural, regional and remote areas.

3. The role of EDs in preventing injury recidivism

A person who experiences a minor injury, especially falls, is at higher risk of recurring injury if preventative action is not undertaken. The Strategy should consider the key and varied role EDs have in preventing injury recidivism and the overall trauma system. There is a missing component and opportunity to support emergency clinicians with time and resources to review and offer intervention or referrals to services for intervention on the underlying causes of the injury. When a minor injury occurs, the ED is often an entry point into the healthcare system, and EDs provide essential injury treatment which might not be available in general practice, such as suturing and/or casting. The ED and emergency clinicians have a significant role in the referral system when dealing with injuries, and as such ACEM recommends the Strategy is updated to reflect this.

4. Increasing the focus on alcohol and other drug harm

We highly support the Strategy's cross-cutting priority area of alcohol associated injury. Alcohol related harm is a major cause of preventable, non-communicable disease and injury. ACEM has published several policy and advocacy projects highlighting the causes and impacts of alcohol misuse.[6] Indeed, ACEM's Alcohol Harm in EDs (AHED) Project found that 13% of ED presentations were alcohol related, with up to 6% being methamphetamine related in 2018.[7] Based on 2017-18 AIHW data[8] this equated to over one million alcohol related ED presentations, representing a significant (and preventable) burden on Australian hospital EDs. However, these presentations also represent a significant occupational health and safety risk. In a recent survey, almost all (98%) ED clinical staff had experienced alcohol related verbal aggression from patients in the past 12 months, with nine in 10 (92%) experiencing physical aggression.[9] Not only does this significantly impact staff wellbeing, it has a negative impact on the care of other patients. Indeed, more than 80% of ED clinical staff felt that alcohol related presentations adversely affected patient wait times, other patients waiting to be seen, and the care of other patients within the ED. Again, there is minimal to no data collection and review of AOD impact on injuries outside of mandated police bloods. There is also no power to mandate drug and alcohol intervention for violent and repetitive patients presenting to the ED.

The Strategy could benefit with a stronger focus on AOD harm-related implications and prevention, including driving bans for repeat offenders and especially on the relationship with

[6] Additional information can be found at ACEM's work on reducing alcohol and drug harm in the ED. Available online: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Reducing-Alcohol-and-Drug-Harm-in-the-ED

[7] Australasian College for Emergency Medicine. 2018 Alcohol and Other Drug Harm Snapshot Survey. Melbourne: ACEM; 2019. Available from: https://acem.org.au/getmedia/3e940b76-3215-4b6f-a6ae-97b4d30d1d95/2019-Alcohol-and-methamphetamine-snapshot-survey_R2

[8] Emergency Department Care 2017-18, Australian Institute of Health and Welfare, Australian Government, March 2019

[9] Egerton-Warburton, D., Gosbell, A., Wadsworth, A., Moore, K., Richardson, D.B. and Fatovich, D.M. (2016). Perceptions of Australasian emergency department staff of the impact of alcohol-related presentations. *Med. J Aust.* 204(4):155.e1. Available online: https://www.mja.com.au/journal/2016/204/4/perceptions-australasian-emergency-department-staff-impact-alcohol-related

other factors that contribute to injuries such as drug harm, family violence, and mental health. In addition, preventing alcohol-related injuries will be impossible without addressing the systemic factors evidenced as influencing drinking patterns and associated injuries including pricing, availability and marketing. ACEM strongly encourages the addition of actions targeting these factors in the Strategy, and engagement with the alcohol and hospitality industries to achieve reductions in alcohol-related injuries.

5. Taking a systems level view of injury prevention

The Strategy should take a systems view to the prevention and management of injury. Currently, there is no standardised injury assessment framework in Australia which would enable a consistent model for multi-disciplinary teams and fragmented specialties to collaborate and engage in constructing sustainable, multi-level, and holistic interventions for preventing injuries. Trauma management is a highly multidisciplinary process. However, there are no opportunities for combined education, morbidity and mortality review where systems learning and intervention opportunities can be identified, and these must be enabled and given authority at a centralised level. The Strategy should also clearly articulate its place within the broader range of existing work in mental health, suicide prevention, family violence, AOD harm and other relevant areas. Currently, the Strategy is unclear on the specific role and responsibilities it provides, how these responsibilities will link to the stated actions, and how it differentiates from and/or adds to existing government strategies.

An important area for the Strategy to link into is work to address inequitable access to health services for rural, remote, and regional communities. Patients living in rural, regional and remote areas face difficulties in accessing timely, effective, and patient-centred interventions, as well as accessing further follow up, choice in provider, and less access to specialist services.[10] For patients this might look like:

- not having a usual general practice (GP) or place of care, or needing to go to an ED because no GP is available when needed;[11]
- delayed diagnosis, transfer and treatment;[12] and
- needing to travel long distances and undergo lengthy stays away from home to access health services; difficulties in self-managing chronic conditions; compromised continuing recovery after returning home, creating a vicious cycle of increasing ill health. [13]

Our ED clinicians often have a strong understanding of a patient's underlying conditions but have difficulties in following up any interventions prescribed after their visit. The Strategy could put a focus on enabling our rural, remote, and regional communities access to timely injury treatment, management and prevention services and receive ongoing culturally appropriate interventions.

Our Aboriginal and Torres Strait Island populations are also highly vulnerable and are largely over-represented in family violence, self-harm, and suicide with DALYs three times higher than non-Indigenous Australians.[14] There is a lack of reviews of effective injury preventions for our population with the highest needs. Thus, ACEM recommends the Strategy promotes further research in this area to inform best practice and culturally appropriate interventions.

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[10] National Rural Health Alliance, Submission to the Productivity Commission Inquiry into Human Services. August 2016; Australian Government Department of Health. *National Medical Workforce Strategy: Scoping Framework*. July 2019

[11] Australian Institute of Health and Welfare. Survey of Health Care: selected findings for rural and remote Australians. [Online] https://www.aihw.gov.au/reports/rural-remote-australians/survey-health-care-selected-findings-rural-remote/contents/summary

[12] Reema Harrison, Merrilyn Walton, Elizabeth Manias. Patients' experiences in Australian hospitals: a rapid review of evidence. S.l. : Brokered by the Sax Institute for the Australian Commission on Safety and Quality in Health Care, December 2015

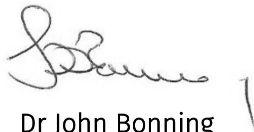
[13] National Rural Health Alliance. The Health of People Living in Rural Australia. [Online] 2016. https://www.ruralhealth.org.au/sites/default/files/publications/nrha-remote-health-fs-election2016.pdf

[14] Hunter K., Bestman A., Elkington J., Anderst A., Scott D, Cullen P, Mitchell R, Clapham K, Killian J, Curtis K, Beck B, Vallmuur K, Lukaszyk C, Ivers RQ, Keay L, Brown J. National Injury Prevention Strategy – Literature Review. July, 2019. Report developed for the Australian Government Department of Health.

ACEM also feels that there is insufficient focus on road trauma and a missed opportunity to link the Strategy with the international 'towards zero' campaign. There is close to 1,200 Australians killed and around 44,000 hospitalised due to road trauma each year, which is estimated to increase to more than 50,000 between now and 2030.[15] Road trauma should be a cross-cutting theme of the Strategy as different modes of transport vary with regards to injury burden. Preventable road deaths and injuries require greater integration with other government departments. These complex interdepartmental relationships between emergency services, transport, and infrastructure are all essential in reducing the burden of injury caused by road trauma. Currently, there are fragmented responses in emergency, transport, and infrastructure departments. ACEM recommends that the Strategy have an overarching theme on road trauma that can coordinate the departments to focus on delivering the same message.

ACEM would like to thank you for the opportunity to provide comment on this Strategy. We welcome further opportunities to provide an ED lens on the Strategy's development and implementation process. To discuss further, please do not hesitate to contact Ms Nicola Ballenden, Executive Director of Policy and Strategic Partnerships (Nicola.Ballenden@acem.org.au; +61 3 9320 0479).

Yours sincerely



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[15] Australasian College for Emergency Medicine. ACEM backs call for national leadership, coordination on road safety. Melbourne: ACEM; 2020. Available from https://acem.org.au/News/June-2020/ACEM-backs-call-for-national-leadership-and-coordi