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WA HEALTH SUSTAINABLE HEALTH REVIEW

EXECUTIVE SUMMARY

The Australasian College for Emergency Medicine (ACEM) welcomes the opportunity to provide WA Health feedback as part of the Sustainable Health Review (SHR, the Review). It is in the public's interest to have a high quality and responsive health system.

ACEM is the not-for-profit organisation responsible for the training of emergency physicians and the advancement of professional standards in emergency medicine in Australia and New Zealand. As the peak professional organisation for emergency medicine in Australasia, ACEM has a vital interest in ensuring the highest standards of emergency medical care are provided for all patients across Australasia.

The West Australian health system is facing increased pressures from a range of sources, and demand for emergency department (ED) care is increasing both in the total number of presentations, as well as in complexity and severity. Across Western Australia (WA), ED usage has increased an average of 2.4% each year between 2011-12 and 2015-16, with over 800,000 presentations in 2015-16 alone. (1) At the same time, community expectations regarding quality and timeliness of care have increased. These trends are likely to continue over the coming decades with an increasingly ageing population, medical advances and political promises. Equity of access also remains a major issue for disadvantaged people and communities, regional areas and those with poor medical literacy.

Throughout its submission, ACEM has highlighted a number of initiatives and strategies for consideration by the SHR team. These include:

- Increased investment to expand public hospital capacity, including but not limited to bed stock
- Increased investment in establishing (and expanding existing) alternative care pathways to improve primary and secondary care options, as a means to reduce hospital admissions
- Significant expansion in mental health and drug and alcohol services across the state. For an already vulnerable population. the supply of services is simply not meeting demand
- Initiatives to increase clinician engagement
- Increased research funding and expansion of research networks. Support for translational and systems research are essential for informing better, more effective and efficient care.

ACEM believes that the SHR provides an opportunity to identify the challenges facing Western Australian hospitals and invest in solutions that can meet demand effectively and efficiently into the future.

PUBLIC HOSPITAL CAPACITY

The inability to move acute patients to hospital wards when their care in the emergency department (ED) is complete – access block[1] – is still the most significant issue facing EDs in WA. Access block is the principal factor leading to ED overcrowding and adversely impacts on all aspects of the acute health care system. Access block manifests acutely in EDs but is a symptom of system wide dysfunction, poor system capacity, and inadequate inpatient flexibility to manage known demand. Access block is linked to increased patient harm, most importantly morbidity and mortality, longer patient waiting times and hospital lengths of stay, poor experiences of care, and staff demoralisation. (2)

Access block and its consequences continue to increase pressure on the WA health system. Demand for ED care is increasing both in the total number of presentations, as well as in complexity and severity. Data shows that between 2012-2013, there was an increase of between 2-3% for those presentations in the higher triage categories, as a proportion of WA attendances (Category 1 and 2). (1,3)

Between 2011-12 to 2015-16, ED presentations increased in WA overall by 2.4% p.a. (well ahead of population growth), with a 3% increase since 2014-15. (1,3) In addition there is an increased older population, with approximately 13% of the state's current population aged 65 years or more – this is expected to double over the next 50 years. (4) Use of medical resources dramatically escalates after age 60-65, with older patients utilising four to six times more medical resources than younger age groups. (5) At the same time, community expectations regarding quality and timeliness of care have increased often driven by political promises, medical advances and associated media coverage. These trends are likely to continue over the next decade.

❖ Access Targets

Introduced in 2016, the WA Emergency Access Target (WEAT) was implemented as a replacement to the National Emergency Access Target (NEAT), as a key strategy to address the longstanding problem of access block and drive system change. Time-based targets are a useful indicator of health care system capacity and capability, providing data on both system dysfunction and the patient experience. (2)(6) Even with these targets access block remains a serious issue, with WA hospital performance against WEAT declining markedly during peak periods e.g. winter flu season when system inflexibility and lack of stretch capacity becomes manifest. (7) Whilst overall ED performance against the target across the state has improved this year (April – June 2017 was 78.5% compared to 74.2% in the same quarter in 2016), it still remains well below the 90% prescribed by WEAT. (7) There are also issues about whether a single target is appropriate for all types of hospitals, with major adult tertiary hospitals unlikely to ever reach a 90% target, whilst rural or paediatric hospitals may manage 90% targets relatively easily (due to better capacity, lower acuity and transfer of sicker patients to larger hospitals).

[1] Access block is defined by ACEM as the situation in which patients who have been admitted and need a hospital bed are delayed from leaving the ED because of lack of inpatient bed capacity.

With the demise of a national target, Queensland, Victoria and New South Wales (NSW) have all introduced revised emergency access targets, with each prescribing an overall lower target percentage (83% in Queensland, 75% in Victoria and 81% in NSW) for ED presenting patients departing within four hours. (8) This has been based on clinician advice and recent research which suggests that an access target of around 80% enables quality care to be delivered, optimises patients outcomes (particularly mortality), whilst still acting as a driver for improvements. (9-11) There is also some evidence that trying to push major hospital EDs to achieve a target greater than 80% may lead to unintended poorer outcomes. (9, 11) ACEM therefore recommends that the SHR consider revising the WEAT to an overall rate between 80-85%, in line with that of other jurisdictions, and also consider flexible targets dependent on hospitals case-mix.

- **Bed Numbers**

ACEM also remains concerned at the below population-level increases in hospital inpatient bed capacity over the last decade. Figures show that the number of available public hospital beds has not been keeping pace with population growth. The average number of available beds (WA public hospitals) decreased 1.4%, between 2011-12 to 2015-16, whilst the number of available beds per 1,000 population also declined, by 2.7% p.a. over the same time period. (14)(15)

To avoid inappropriate deaths, delays to treatment, longer hospital lengths of stay, inefficient care, delays to elective work and overall poorer patient outcomes, ACEM considers that hospitals should rarely run at over 90% occupancy and never over 95%. Whilst acknowledging that it is not absolutely clear what the ideal occupancy levels are for larger hospitals, research suggests that hospital occupancy between 85-90% is preferable, with regards to balancing efficiency and outcomes. ACEM strongly supports investment into research that would clearly delineate ideal occupancy levels for different types of hospitals. (12)(13)

As public hospital capacity struggles to keep pace with population growth, and the increasing complexity and severity of disease, time-based targets for EDs can only work if access to appropriate care and resources during a patient's hospital journey and into post-discharge care are improved. Targets such as WEAT, are primarily intended to drive change throughout hospitals and into the community, not just the ED. The onus is therefore on hospital administrators to ensure that appropriate bed capacity and staffing support is available for all patients when admission is clinically indicated, through improvements in hospital function.

- **Acute surgery**

WA Faculty members have reported that there are significant delays for those patients presenting to outer metropolitan hospitals with acute surgical conditions, requiring inpatient treatment (e.g. orthopaedics, general surgery etc.). These patients are disadvantaged due to the lack of availability of these services after hours and on weekends (or at all times at some sites). They are subsequently transferred to tertiary hospitals, which can lead to significant delays in care, poor outcomes and occasional deaths whilst filling tertiary hospitals with general hospital work. The risks of such delays are well documented for certain conditions e.g. hip fractures. (16)(17)

The introduction of acute surgical lists at outer metropolitan or regional hospitals, would mean that surgeries could be undertaken for appropriate patients who present to those hospitals, and also for appropriate patients selected from tertiary hospitals who could then be transferred back nearer to home. ACEM recommends that regional organisation of acute surgery, with appropriate resources and staffing for high volume conditions, may assist in both improving the quality and timeliness of patient care, and could also assist in alleviating issues of access block at tertiary hospitals.

❖ **Reducing admissions**

Reducing hospital demand may mitigate access block but, as with increasing hospital capacity, requires significant investment from governments. Over the past decade, in attempts to ease ED demand, governments have funded various initiatives including after-hours primary care clinics that are co-located or located near EDs, telephone triage/after-hours helplines and nurse walk-in clinics. Whilst popular with the general public, research suggests these initiatives have minimal or no impact on access block (and some suggest increased ED attendances may occur). Low-acuity primary care-type patients attracted to these services are not a significant proportion of the workload for most large EDs and are unlikely to require admission. (18)

The changing demography of ED presentations must be considered in order for EDs to continue to provide effective care. ACEM supports urgent investigation into integrated and coordinated care models that will improve the medical care and management for patients with chronic disease(s), and the ageing population, outside of the hospital system. This should include the expansion of ED and admission avoidance programs, where these are proven to work. These may includes initiatives for targeting patients who present frequently to EDs because of social problems, substance abuse, homelessness, or with conditions requiring recurrent admission (e.g. heart failure, chronic obstructive pulmonary disease) to assist in (i) diverting hospital presentations (ii) providing alternatives to admission and (iii) reducing length of hospital stay. (18-20)

To date the focus of most hospital-based initiatives has been to focus on improving efficiencies in the ED or inpatient units in order to reduce the overall length of hospital stay. The elderly and those in the last twelve months of life are patient groups that often require recurrent hospital admissions, due to disease comorbidities and the complexity of care required. The risks of continued hospitalisation of the elderly, are well known. (21) These risks should therefore be a major factor when determining their best care pathway, and where admission is likely to result in harm, every effort should be made to avoid this.

ACEM supports tools that would assist in identifying such patients, where hospital admission would be of less benefit, compared to the harm incurred. Secondary prevention refers to enhanced and modified care within the ED for patients that have presented there, so that discharge rates from ED are maximised. The Fiona Stanley ED's work in developing a *falls pathway* is one such model that should be considered. The FSH aged care pathway is utilised for all patients 65 years and over, who present to the ED with a fall. (22) As part of this model:

- The target population is identified as a high priority from the point of triage
- They then receive standardized best practice assessment by ED staff
- This is supplemented by rapid access to a geriatrician in the ED

Under this model, ED discharge rates for this population have increased significantly, whilst hospital admissions have been avoided. (22) Intensive use of observation wards with intensive acute allied health services (as exemplified at Sir Charles Gardiner Hospital) are also a model, which should be investigated further.

Other vulnerable populations, such as those who are homeless (or with no fixed address) also represent frequent ED and hospital inpatients. The Royal Perth Hospital (RPH) has undertaken significant work to establish *Homeless Health Care.* Under this model, patients who present to the ED, and are identified as homeless, are then visited by a *Homeless Health Care* General Practitioner (GP), who assists in linking patients with accommodation and support services that they can access post-discharge. Such a model helps in addressing the underlying social issues that are often the cause of frequent presentations.

To address these gaps in public hospital capacity, ACEM provides the following recommendations:

Recommendations:

1. **Revision of the WEAT** to 80-85% and consideration of modified targets for different hospital types.
2. **Renaming WEAT to the** *Acute Patient Access Target*, as this more appropriately reflects that this is a system wide issue.
3. **Improved capacity -** improvements in hospital inpatient capacity are required. The number of available beds must increase to at least meet national averages, to try and keep pace with population growth, and the growing demand for hospital services, and redress lost capacity in the last decade.
4. **Evidence based alternative care pathways** are developed and researched for appropriate patient populations, which then contribute to avoiding inappropriate hospital admission
5. **Alternative organisation and provision of acute surgery** in outer metro/regional areas should be explored.
6. **Translational research;** There should be a strong support for translational research that can demonstrate optimal pathways of care, reduce admissions and optimize outcomes for acutely unwell patients.

PATIENT PATHWAYS & EXPERIENCE (Primary care; end of life; mental health services))

❖ **Primary care and chronic disease management**

ACEM considers fragmentation of the health system a major issue requiring urgent attention. Attempts to improve patient access to care, by creating subsidised out of hours clinics separate to normal primary care, are misguided, and undermine the long term high quality care which can be delivered through co-ordinated primary care systems. There is no significant evidence that standalone after hours clinics decrease ED attendances, are cost effective or improve patient care. (23) Patients with multiple complex comorbid illnesses need highly skilled coordinated care by a regular General Practitioner (GP), experienced in chronic disease management with access to a good allied heath and nursing support team. Multiple subspecialist services, and episodic acute care by after-hours services are not the answer.

Western Australian ACEM Faculty members provided the following example of poor fragmented care: *"Patients are regularly referred to ED so that the ED can refer the patient to an outpatient clinic. I have then had the outpatient clinic in question refuse the referral because it should have been made by the GP."*

Members also report much confusion amongst primary care providers, and even within hospitals, as to what outpatient clinics are available, and how these can be accessed. Most hospitals and GPs have limited or no available data on outpatient waiting times. Many hospitals are actually unclear what waiting times are for their own clinics. In addition, many clinics are reported as being oversubscribed with patients, and under-supported. There may in fact be alternative options available (although often not) but even if available, these pathways are not clear to the GP, and the patient suffers.

ACEM provides the following recommendations to assess these gaps:

1. **A dedicated website for primary care providers and hospital staff** where hospitals list which outpatient clinics are offered, and include details such as the target patient population. This site should also provide details on how to appropriately refer patients, and how urgent appointments can be arranged and what current wait times are. Ideally this would include any specific investigations to be completed prior to the outpatient appointment and clear inclusion and exclusion criteria for access to the clinics.
2. **Increased funding** of chronic disease management in general practice
3. **Increased investment in** Hospital-in-the-Home and other community based support programs for at risk populations.

❖ **End of life care**

The changing demography of both Australia, more fragmented family structures, and the increase in the prevalence of chronic diseases, have resulted in a growth in the demand for end of life care (EoLC) and palliative care services. The number of EoLC associated ED primary presentations has also increased, despite evidence suggesting EoLC or palliative interventions are more beneficial for the patient if they are begun earlier and in the primary health care sector. (24) The ED has thus become a location where EoLC plans are commonly discussed and initiated, or where established EoLC plans need to be implemented. (25)

As chronic disease and terminal illnesses increase, community education regarding these issues are a sensible first step in addressing the role of hospitals and community health facilities. Raising awareness of palliative and EoLC and advance care planning processes could assist in increasing community willingness to have a discussion involving their EoLC choices with their primary care provider. If these discussions were effectively documented, reviewed and updated through the relevant advance care planning processes and made available through appropriate state based IT systems (or the My Health Record), health services such as residential aged care facilities (RACFs) and EDs would be better equipped with the necessary information to provide EoLC to patients according to their wishes.
Initiatives such as Palliative Care Australia's National Palliative Care Week are vital in raising awareness and understanding of palliative and EoLC. (25) The Palliative Care Australia Dying to Talk website and Discussion Starter, and the Advance Care Plan (ACP) Cooperative 'how to' guide, also assist in raising community awareness of these issues, as well as providing resources to support people in having discussions with their family about their EoL wishes. (25) ACEM is also strongly supportive of the work being progressed by the EoL framework steering group chaired by the Chief Medical Officer in WA.

ACEM provides the following recommendations to assess these gaps:

1. **Increased investment** in end of life care pathways and resources to identify patients entering the EoL phase.
2. **Improved education for all doctors,** particularly for ED and primary care clinicians, on identifying patients needing palliative/ EoLC and planning and how to access palliative care .
3. **Improved community education** about EoL planning, use of palliative care and how to access these systems.

❖ **Mental health patients:**

Mental and behavioural conditions are a significant cause of distress in the community, representing the fourth largest burden of disease in Australia. (26) International evidence shows that the lives of people with serious mental and behavioural conditions are up to 30% shorter than the general population, with much of this excess morbidity due to chronic conditions like diabetes, respiratory illness, cardiovascular disease and cancer. (27) Groups at higher risk of mental health disorders face greater social and economic disadvantage than the general population and include Indigenous people, people who are homeless or unstably housed, unemployed people, refugees and newly-arrived migrants, and people involved with the criminal justice system. These intertwined problems are often difficult to manage separately unless all the issues are managed together.

Emergency departments are often the first point of access to specialist mental health care in the public health system. In 2015-16, there were 29,827 mental health-related presentations throughout WA EDs (or 114.5 per 10,000 population). This represented approximately 3.6% of total ED presentations during that same period. Of these, 32% (n=9,345) were admitted, whilst 61% (n=17,715) completed their visit without being either admitted or referred. (28) ACEM wishes to underscore to the SHR the significant underestimation in national and jurisdictional data collections of the impact of acute mental and behavioural conditions[2] in EDs, e.g. presentations involving self-harm are currently excluded and those involving multiple comorbidities are most likely to be classified under other primary causes. In major EDs local audits suggest 5-8% of all attendances are behavioural as the major cause for presentation. Many other presentations have substance use or underlying psychiatric issues exacerbating their physical illness.

Mental health services suffer from significant fragmentation, and importantly, a major lack of capacity for managing those patients with mental health disorder or substance use disorder. Acute services and admitting beds have been seriously depleted, with delays of days for admission with severe psychosis seen not uncommonly. Acute beds in psychiatry units routinely run at 100% occupancy, with no flexibility for acute demand. Overall, public sector mental health beds only increased in total by 1.4% between 1992-92 and 2014-15. Per 100,000 population, the number of public sector mental health beds has actually decreased by 1.2% p.a. during the same period, to 28.8 per 100,000 (down from 43.6 per 100,000 in 1992-93). (29) Residential services meanwhile have also only increased minimally, by 1.6%, over a twenty-two year period. (29). Community services remain fragmented and hard to access - particularly after hours. Often patients are lost to follow up due to delayed access, poor communication, and lack of early support. Many community services have excessively difficult access requirements and forms, limited hours and often refuse to accept difficult patients.

While playing an essential role in the initial assessment and management of patients with mental and behavioural conditions, the ED is almost never appropriate for the ongoing care of this patient group. In WA, patients presenting to the ED with mental health concerns have unacceptable lengths of stay. Members report that many mental health patients spend more than eight hours in Australasian EDs following triage, with significant numbers of patients (particularly vulnerable groups like adolescents, forensic patients, and those with intellectual disabilities) spending more than 24 hours in EDs while awaiting admission. Enabling timely access that improves mental health patient flow is essential for ensuring that best practice, minimal restraint, equitable medical care is provided to this vulnerable patient group.

ACEM strongly advocates that all patients presenting to the ED with an acute mental and behavioural condition should have a total ED time within WEAT (four hours) i.e. the same time period as patients with any other emergency condition. Indeed the agitating environment of an ED suggests that for many mental health patients the less time stuck in the ED the better. When a patient is assessed in the ED as requiring inpatient admission, a bed should be made available as soon as possible at the delegated receiving unit.

[2] *Mental and behavioural disorders* is the term used by the World Health Organization's (WHO's) classification system to describe the clinical features of a wide range of groups of psychiatric conditions measured using International Classification of Diseases and Related Health Problems (ICD-10) criteria. Mental and behavioural disorders are classified in the ICD-10 codes F01 to F79

ACEM also strongly recommends government investment to establish mental health short stay units (SSU)s – also known as psychiatric intensive care units, mental health observation units/areas, or psychiatric/ behavioural assessment and planning units. These units, led by specialist mental health practitioners, can provide better access to early assessment, community treatment plans and quality care for patients with an acute mental and behavioural condition. These units can be located within psychiatric facilities, hospitals, community-based or co-located with ED depending on the local case-mix.

ACEM provides the following recommendations to assess these gaps:

1. **Investment to establish Mental Health SSUs**
2. **Statewide processes established t**o enable clear pathways for rapid determination of bed availability, so that alternative referrals can be arranged
3. **Improved system-wide capacity** that can provide co-ordinated care and services in the most appropriate environments 24 hours/ 7 days a week
4. **Provide psychiatric-medical units** at least at all tertiary hospitals that provide combined psychiatric and medical care for those with active physical and psychiatric problems in the main hospital.
5. **Psychiatry should be fully re-amalgamated with the rest of medicine –** patients have mental, physical and social needs to maintain or regain health, and silos of care should be avoided.

VIOLENCE IN THE ED

The safety of patients, visitors and staff in the ED is of primary concern to ACEM. While in the vicinity of the ED and the wider hospital, all people have a right to an environment as safe as possible from violence. The ED is well-recognised as a setting in which workplace violence is more likely to occur, with the true incidence unclear due to a culture of under-reporting. A recent meta-analysis[3] found that approximately 36 in every 10,000 ED presentations involve violence, with about 45 in every 100 violent presentations estimated to be associated with alcohol and/or other drugs. (30) However this is considered a major underestimation of the true levels of violence in WA EDs.

In these cases, disturbed behaviour in the ED may relate to distress associated with mental illness, symptoms of psychosis and increasing presentations involving alcohol and other drug intoxication and withdrawal. Emergency department overcrowding and access block can also create environments that contribute to violence. So to, do the previously described delays in assessment or admission of patients with acute behavioural disturbances, who are then forced to remain in the deeply agitating environment of the ED. In WA, EDs are the unit requiring the vast majority of security responses, and members' personal experience is that there has been a significant escalation in workplace violence over the last two decades (personal experiences of multiple consultant staff). The number of staff injured in these responses has also increased dramatically. Anecdotally, members report that security personnel are called to ED's for violence (verbal or physical) three to four times per day, a level of approximately 200 episodes per 10000 attendances. In major hospitals, security responses (code Blacks) to ED are required over 1000 times a year. Pharmacological restraint – or emergency sedation – has become an increasing necessity in EDs, given emergency physicians' duty of care to protect themselves, ED staff, patients and others, from patients exhibiting escalating aggression and violent behaviour.

Workplace violence has significant effects on a worker's psychological and physical health over the short and long term, and significant economic and social costs for workers, their families, workplaces and the wider community. (31) In 2016 survey of its members (Fellows and trainees across Australia and New Zealand) on their health, professional satisfaction, and career longevity, 70% of respondents showed a moderate to high degree of emotional exhaustion and 62% showed a moderate to high degree of depersonalisation – a great concern to ACEM. (32) In addition, the majority reported feeling threatened (88%) by a patient in the past year, and two-fifths reported they had been physically assaulted (43%). While inferential analyses are yet to be undertaken, it is reasonable to suggest a correlation between the high rates of burnout observed among the emergency medicine workforce and specialist emergency physicians' persistent experience of aggression and violence in the ED.

Investment in establishing behavioural assessment units (BAU's) across all EDs, should be considered as part of the SHR with separate rooms for the assessment and management of acutely disturbed or violent patients. These rooms are used for the assessment and management of patients suffering from a behavioural disturbance, and can assist minimising risk of injury to both ED staff and patients. (33) ACEM provides the following recommendations to assess these gaps:

1. **Increase capacity** in both acute mental health services and residential and community services
2. **Government investment** for the state-wide implementation of mental health SSUs and BAUs

INFORMATION TECHNOLOGY

WA Faculty members report major concerns with the significant inefficiencies induced by current information technology (IT) systems. The introduction of CPOE (Clinician Point of Entry) within WA Country Health Service (WACHS) EDs in particular, has resulted in an increase in the length of time required for clinicians to request blood tests - with no improvements in quality or safety. Members also report that NACS (Notification and Clinical Summaries) discharge summaries are extremely time consuming, with reports that at least two EDs have had to employ additional physician time and FTE, in order to meet the requirements of these summaries. Reports indicate that these issues have been replicated in inpatients wards, and it has been estimated the introduction of this system alone has wasted the equivalent of 8-10 medical officer FTE at just one major hospital.

The effects are to increase costs, reduce patient contact time and staff morale, and further reduce already limited teaching and training opportunities. Members also report a slow and cumbersome results system with missed or delayed results contributing to at least one patient death, and a number of near misses. The lack of an overarching strategy for IT services, lack of compatibility and interoperability, poor design processes that ignore clinicians input, and limited beta testing before roll out, have resulted in systematic problems. Members have also report that senior administrators have been slow to respond to clinician concerns, despite these issues being raised continuously.

ACEM provides the following recommendations to assess these gaps:

1. **Processes to ensure** that all new clinical IT systems are designed with clinical input as a priority, and with patient outcomes and clinician utility as there primary aim.
2. **Sufficient beta testing** of all IT infrastructure, before it's full implementation
3. **Response business user groups (BUG)** that are empowered to rapidly respond to new system problems.

WORKFORCE AND CULTURE

ACEM supports strategies to promote a contemporary, adaptable and high performing workforce to support the delivery of quality and improved health outcomes by the WA health system.

WA Faculty members report particular issues in country services. Contract delays have been reported as a major issue, resulting in delays to doctors commencing their roles, with potential staff moving on to other jobs. Existing workforce shortages further compounds this. As a result, overall FTE shortages are often filled by locums, at considerable expense and loss of departmental cohesion.

Workforce issues are also a major factor in physician well-being, and ACEM research supports this feedback. Across all EDs in Australasia, members and EM trainees reported that ED overcrowding, access block and patient expectations are key work stressors impacting on their ability to do their job. Employer responses to assist staff manage these stressors have been insufficient to address their concerns (including often lacking in any response at all), with staff tending to undertake their own stress reduction methods. (32)

ACEM considers that the expertise members bring to their workplace is invaluable and must be considered as part of any major initiatives undertaken by hospital management and WA Health. ACEM therefore recommends that a formal mechanism for clinical engagement with front-line staff is a necessary outcome of the SHR. It is clear that existing processes are not working as intended, with member's reporting a lack of responsiveness from senior administrators and executives, when concerns are raised. Processes and systems are subsequently introduced without consideration of specialist clinical input.

Safer Care Victoria (SCV) is an example of a Government response to a systemic crisis that had adverse patient outcomes. The Victorian Government accepted recommendations to provide an avenue for clinicians and researchers to influence the outcomes of patient safety and health care. This avenue was the establishment of SCV. ACEM strongly supports an approach in WA that improves clinician engagement with senior administrators. Patient outcomes, staff morale and a continuous cycle of quality improvement must be at the forefront of a sustainable health system. This can only occur when all components of the system engage collaboratively.

ACEM acknowledges that SCV is a new initiative – however ACEM strongly recommends the SHR engage with SCV directly, to examine this approach as well as monitor its outcomes.

ACEM provides the following recommendations to address these gaps:

1. **Introduction of initiatives that will increase engagement** with clinicians regarding the implementation and evaluation of decisions affecting health care systems and processes
2. **Continuously measure clinician engagement -** this will monitor if engagement strategies are working and where problems are developing within a hospitals culture**.**

RESEARCH

A robust and well-resourced research environment is essential for an efficient and effective health care system. Translational research is essential in complex environments like the ED with many competing demands, short time frames and complex problems. The Emergency Medicine Foundation (EMRF) in Queensland has been successful in funding comparative effectiveness research in EDs. Currently less than 1% of public health expenditure is dedicated to research, compared to other industries, which typically spend 15-20% of their capital on research and development. Publicly funded research addresses the questions of importance to patients and clinicians.

ACEM therefore recommends that: WA Health consider the invitation from the Queensland Government to join the EMRF, and strengthen the world leading translational research that is being undertaken to make emergency care even more efficient and beneficial to the community.

Thank you for the opportunity to provide feedback. ACEM anticipates further consultation as part of the SHR, and would welcome a meeting with the Review team to discuss the issues outlined in this submission. [redacted]

Yours sincerely,

PROFESSOR DAVID MOUNTAIN
WA FACULTY CHAIR

PROFESSOR ANTHONY LAWLER
PRESIDENT

REFERENCES

1. Australian Institute of Health and Welfare 2016. Emergency department care 2015–16: Australian hospital statistics. Health services series no. 72. Cat. no. HSE 182. Canberra: AIHW.
2. ACEM. S127 Statement on Access Block. Melbourne: ACEM, 2014.
3. Australian Bureau of Statistics, 2016. 3218.0 Regional population growth, Australia 2016, viewed 21 November 2017 http://www.abs.gov.au/ausstats/abs@.nsf/mf/3218.0
4. Australian Bureau of Statistics 2016. 2016 Census QuickStats Western Australia, viewed 21 November 2017 http://www.censusdata.abs.gov.au/census_services/getproduct/census/2016/quickstat/5?opendocument
5. Sheiner Louise. The effects of technology on the age distribution of health spending: a cross-country perspective. Accessed 21 November 2017 https://www.federalreserve.gov/pubs/feds/2004/200414/200414pap.pdf
6. ACEM. S60 Statement on National Time-Based Acute Hospital Targets in Australia and New Zealand. Melbourne: ACEM, 2106.
7. WA Health. Western Australia Emergency Access Target quarterly reports, 6 October 2017. Accessed 21 November 2017 http://ww2.health.wa.gov.au/Reports-and-publications/Western-Australia-Emergency-Access-Target-quarterly-reports
8. Emergency Care Institute. Emergency Treatment Performance – the basics. Accessed 20 November 2017 https://www.aci.health.nsw.gov.au/networks/eci/administration/neat/neat-the-basics
9. Sullivan C, Staib A, Khanna S, et al. the National Emergency Access Target (NEAT) and the 4-hour rule: time to review the target. Med J Aust 2016; 204 (9): 354.
10. Staib A, Sullivan C, Griffin B., et al. Report on the 4-h rule and National Emergency Access Target (NEAT) in Australia: time to review. Aust Health Rev 2016 Jun; 40(3): 319-23.
11. Sullivan C, Staib A, Eley R., et al. National Emergency Access Targets metrics of the emergency department–inpatient interface: measures of patient flow and mortality for emergency admissions to hospital. Aust Health Rev. 2015 Nov; 39(5): 533-8.
12. Forster A.J., Stiell I., Wells G., et al. Alan J. The Effect of Hospital Occupancy on Emergency Department Length of Stay and Patient Disposition. Acad Emerg Med. 2003 Feb; 10(2): 127-33.
13. Sprivulis P.C., Da Silva J., Jacobs I.G., et al. The association between hospital overcrowding and mortality among patients admitted via Western Australian emergency departments Med J Aust 2006; 184 (5): 208-212.
14. Australian Institute of Health and Welfare 2017. Hospital resources 2015–16: Australian hospital statistics. Health services series no. 78. Cat. no. HSE 190. Canberra: AIHW.
15. Australian Medical Association. AMA Public Hospital Report 2017 report card. Barton: AMA.
16. Shiga T., Wajima Z., Ohe Y. Is operative delay associated with increased mortality of hip fracture patients? Systematic review, meta-analysis, and meta-regression
17. Ong M., Guang T.Y., Yan T.K. Impact of surgical delay on outcomes in elderly patients undergoing emergency surgery: A single center experience
18. Nagree Y, Mountain D, A CP, Fatovich DM, McCarthy SM. Determining the true burden of general practice patients in the emergency department: The need for robust methodology. Emergency Medicine Australasia. 2011;23(2):116 - 9. 24.
19. Sprivulis P, Grainger, S., Nagree, Y. Ambulance diversion is not associated with low acuity patients attending Perth metropolitan emergency departments. Emergency Medicine Australasia. 2005;17(1):5.
20. Medicare Benefits Review Taskforce. Urgent after-hours primary care services funded through the MBS Taskforce findings. Department of Health. June 2017.

21. Admi H., Shadmi E., Baruch., Zisberg A. From Research to Reality: Minimizing the Effects of Hospitalization on Older Adults https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4422456/
22. Dumas S., Wahby O., Leyte N. et al. Assessment project at Fiona Stanley Hospital http://www.subacutecare.org.au/j/images/FINAL_POSTER_FALLS_PATHWAY_12.pdf
23. Medicare Benefits Schedule Review Taskforce – preliminary report for consultation – urgent after-hours primary care services funded through the MBS http://mbsreview.com.au/pdf-reports/after-hours-report.pdf
24. Australian Institute of Health and Welfare 2014. Palliative care services in Australia 2014. Cat. no. HWI 128. Canberra: AIHW. ACEM. P455 Policy on End of Life Care. Melbourne: ACEM, 2015.
25. Australian Institute of Health and Welfare. Diversity and disadvantage in Australia [Internet]. Canberra: Australian Institute of Health and Welfare; 2017 [09/02/17]. Available from: http://www.aihw.gov.au/australias-welfare/2015/diversity-and-disadvantage/#t3.
26. Royal Australian and New Zealand College of Psychiatrists. Keeping body and mind together: Improving the physical health and life expectancy of people with serious mental illness. Melbourne: RANZCP, 2015.
27. Australian Institute of Health and Welfare. Mental health services provided in emergency departments [Internet]. Canberra: Australian Institute of Health and Welfare; 2016
28. Australian Institute of Health and Welfare. Mental health services in Australia. Accessed 21 November 2017 https://mhsa.aihw.gov.au/home/
29. Safe Work Australia. Workplace violence: a definition [Internet]. Canberra: Safe Work Australia; 2017 [updated 2017 Mar 27]. Available from: https://www.safeworkaustralia.gov.au/workplace-violence
30. ACEM. Workforce Sustainability Survey Report, November 2016. Melbourne: ACEM, 2016.
31. ACEM. G15 Guidelines on emergency department design. Melbourne: ACEM, 2014.
32. Victorian Government. Safer Care Victoria Accessed 19 November 2017 https://www2.health.vic.gov.au/hospitals-and-health-services/safer-care-victoria