

Consultation Paper

21 September 2005

# Emergency Access Strategy

## Foreword

The Emergency Access Strategy has been developed by the Department of Human Services, in consultation with the Emergency Access Reference Committee. The Strategy aims to provide health and community providers with a five year direction for continued reform and performance improvement in the area of emergency access.

The Emergency Access Strategy has been developed to standardise emergency access and care across Victoria and to achieve improved patient outcomes, shorter waiting times, equitable access and quality care.

The document is a draft for consultation. In recognition of the knowledge and expertise of clinicians and managers in the field, the Department of Human Services would like to seek feedback on this document.

All feedback should be provided by **31 October 2005** to Ruth Smith, Senior Policy Officer, Statewide Emergency Program via:

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It is anticipated that the final version of the Strategy will be available in early December 2005. It is also expected that work associated with the Strategy will continue to evolve over the next few years.

The Department of Human Services looks forward to working collaboratively with health and community providers during this important phase of work.

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# 1 Introduction

## 1.1 Background

The Hospital Demand Management Strategy (2001 to 2005) is a series of linked programs that aim to improve patient access to hospital emergency services, by:

- Reducing attendances to emergency departments by people who could receive appropriate treatment elsewhere (Hospital Admission Risk Program)
- Decreasing the number of patients admitted to inpatient services from emergency departments (diversion to other service options where clinically appropriate)
- Improving processes to reduce time taken in triage, assessment and treatment
- Increasing the number of referral options for patients in emergency departments
- Increasing the inpatient capacity of hospitals (funding growth and new facilities)

During 2004, the Victorian Auditor General<sup>1</sup> found these strategies to have been substantially effective, with performance against a range of indicators improving since 2000. The next phase of work in emergency care will focus on reducing long waits in emergency departments, improving communication with patients, and further rollout of successful substitution models of care.

The Victorian Government has adopted a two-year investment strategy called Hospital Futures, which will provide an additional \$149million to focus on maintaining hospital bypass at current levels, shortening waits for emergency patients, reducing long waits for elective surgery and further reducing avoidable hospital use for people with chronic diseases and elderly people with complex co-morbidities. An additional \$337.4million will also be invested in new capital projects to continue the expansion and upgrading of public hospital facilities, including the development of additional hospital capacity.

Governance structures for Health Services have been significantly reformed, and improved accountability mechanisms have been established between Boards and the Minister for Health. Accountability requirements have been standardised across the metropolitan health services and the major regional health services, while requirements for small rural health services have been simplified. This has created an environment which will support enhanced collaboration, innovation and performance management.

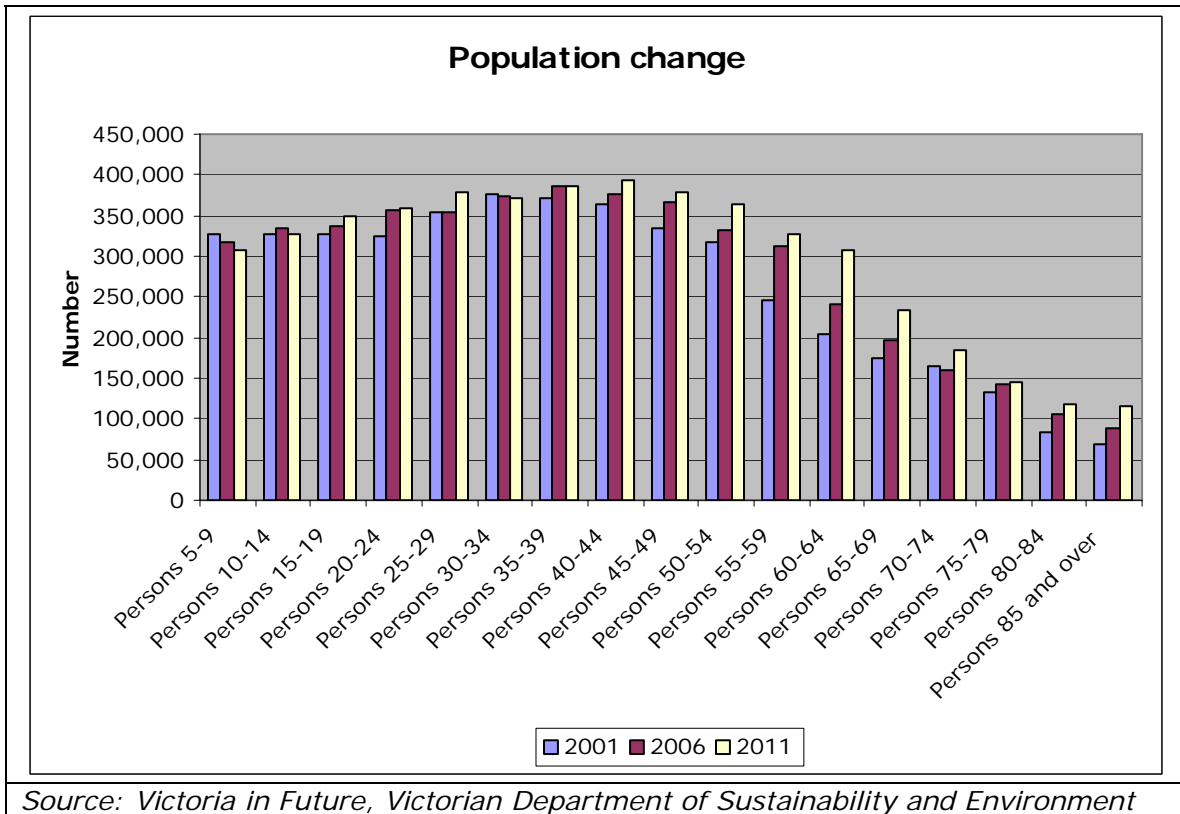
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<sup>1</sup> Auditor General Victoria, May 2004. *Managing emergency demand in public hospitals*. Melbourne, Victoria.

## 1.2 Demand for health services

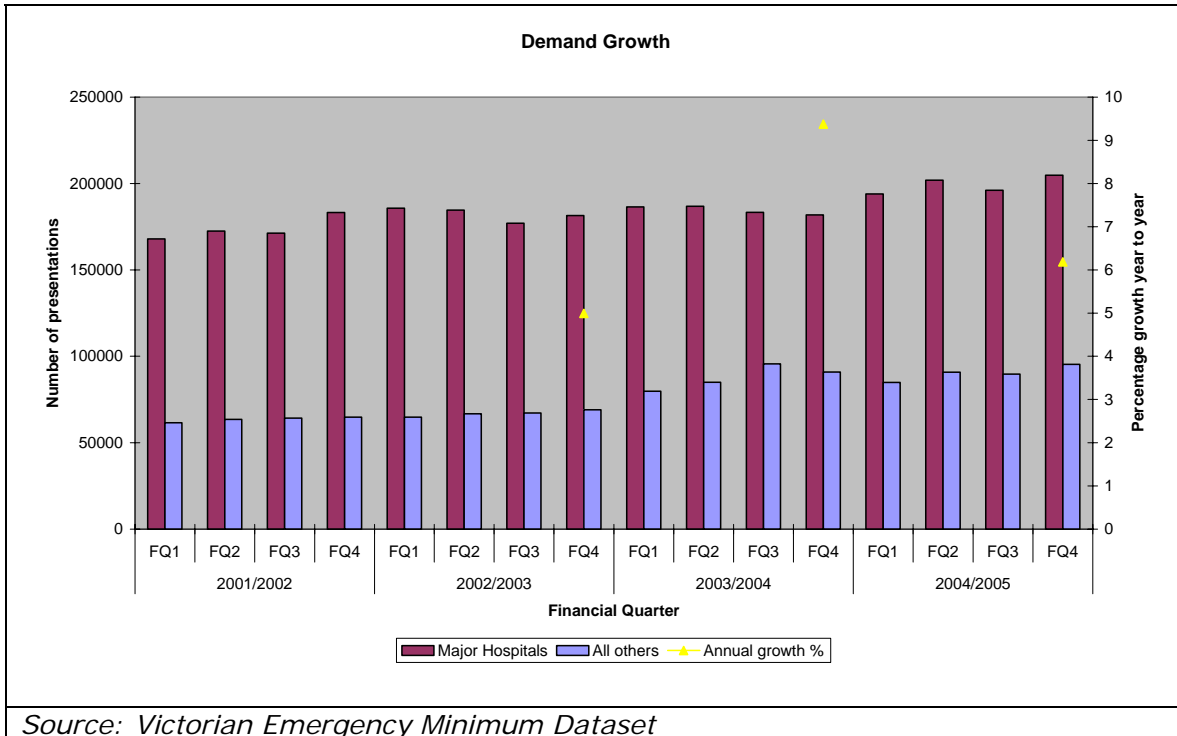
The Hospital Demand Management Strategy has been successful in slowing demand growth and improving patient access to health services. The Strategy has been implemented against a backdrop of continued population growth and change, as well as overall growth in demand for hospital services. Figure One demonstrates growth and change in the Victorian population during the five years of the Strategy, and a projection five years into the future. During the past five years, the Victorian population has grown by between one and two per cent per annum.

**Figure One – Victorian Population Change 2001 to 2011**



Demand for emergency services has grown across Victoria, and at a stronger rate than population growth. Figure Two shows emergency presentations for 19 major emergency departments (14 in metropolitan Melbourne and five major regional hospitals), and emergency presentations for all other emergency departments. Both groups have experienced strong growth during the period, with annual percentage growth between five and ten per cent.

**Figure two – Growth in demand for emergency services**



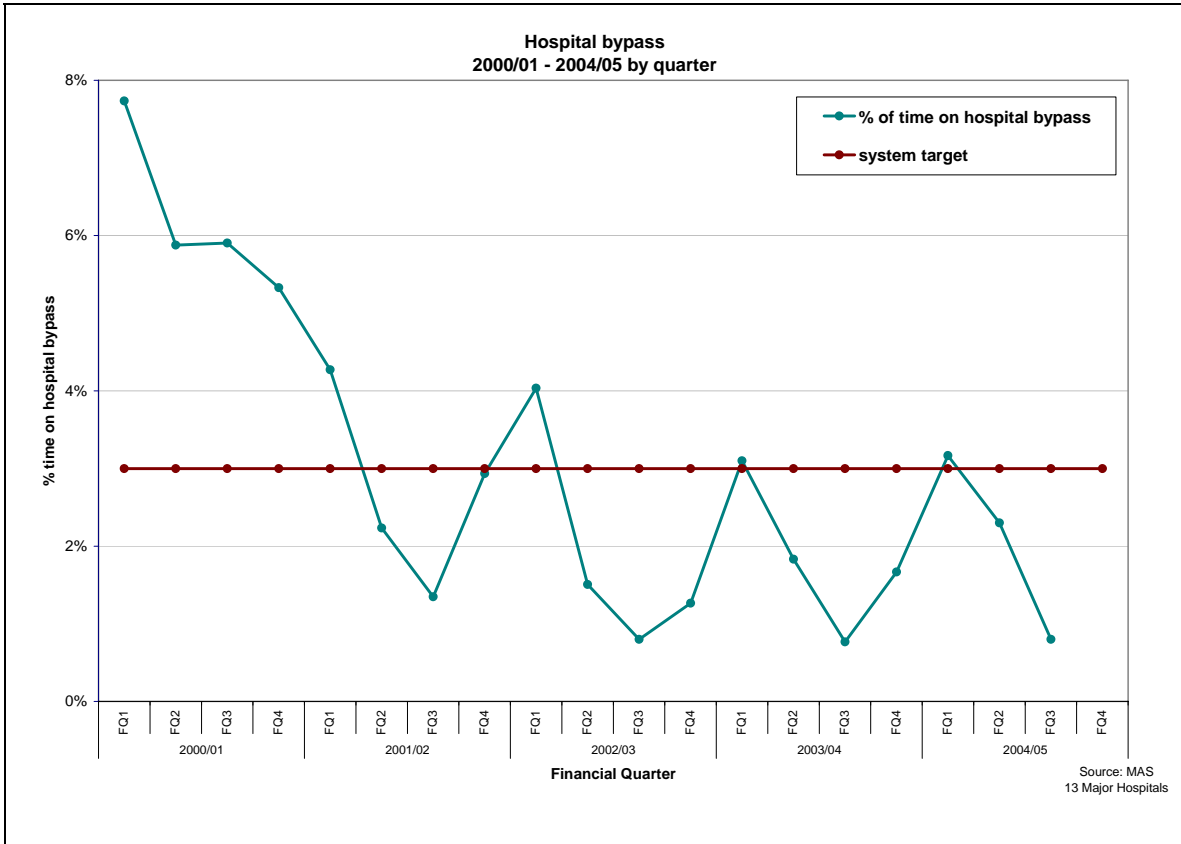
Source: Victorian Emergency Minimum Dataset

This increase in emergency presentations is part of a broader increase in demand across the major hospitals. All separations (elective and emergency) have grown over the past five years, although growth has slowed during the last two years.

Despite this continued growth in demand, particularly for emergency services, performance against targets has improved.

Figure Three demonstrates the reduction in time hospitals spent on bypass since 2000. While performance continues to fluctuate seasonally, it is clear that the 13 major metropolitan hospitals whose performance is measured against this indicator have successfully brought their bypass performance to within acceptable limits during the period.

**Figure Three – Bypass performance**

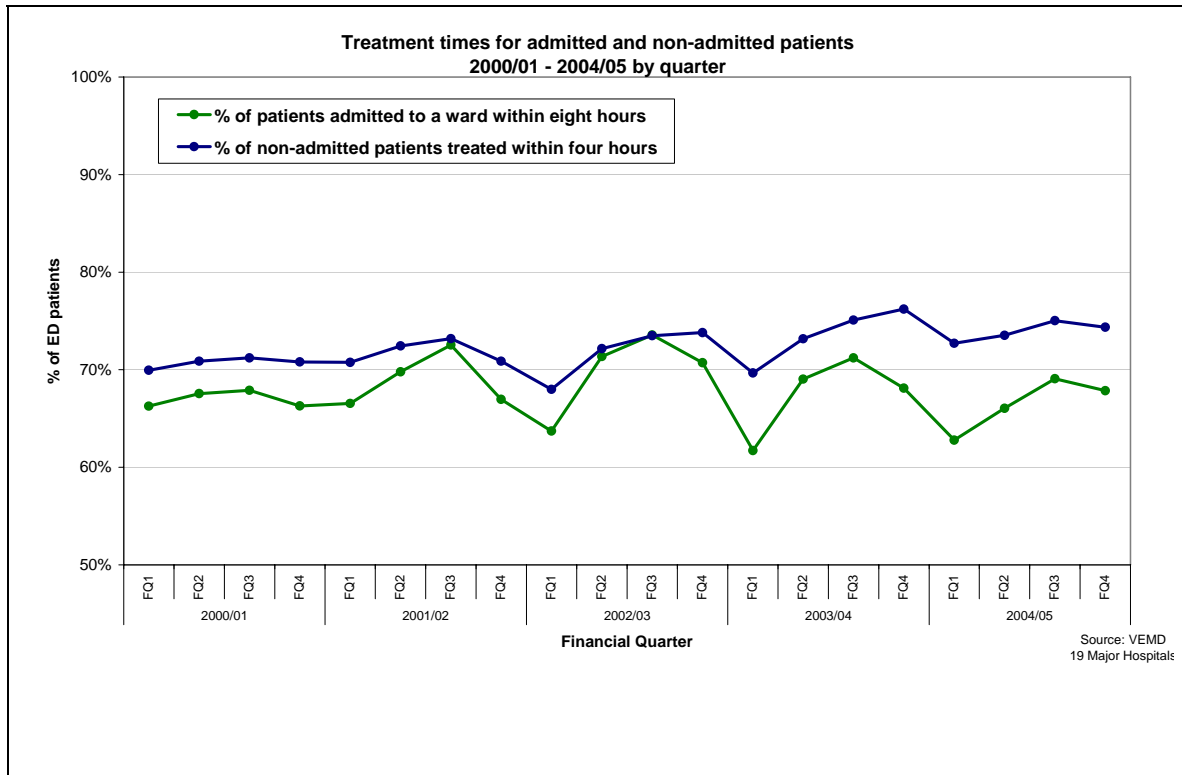


However, performance against emergency waiting time indicators requires more improvement. Figure Four shows treatment times performance for two groups of patients:

- those who are admitted to a ward, for whom a waiting time of less than eight hours is the target (note the target was 12 hours until July 2005)
- those who are treated and discharged home or to another service provider, for whom a treatment time target of four hours has been implemented from July 2005

While performance against these indicators has improved overall, the system as a whole did not meet the previous target to admit 90 per cent of patients to a ward within 12 hours. The introduction of a target to admit 80 per cent of patients to a ward within eight hours indicates government's concern about waiting times. Figure Four demonstrates health services' performance against these indicators.

**Figure Four – Treatment time performance**



Further improvement is needed because:

- There has been an absolute increase in demand
- Patient safety must be protected. There is evidence that long waits in emergency departments can impact on patient outcomes and are associated with increased length of inpatient stays
- Patients and their families expect improved access to and quality of emergency services
- The incidence of chronic illness and need for complex care is increasing as the population ages

New models of care have been developed, and new service models are available to meet these requirements. However, the structure of the health workforce limits Victoria's capacity to innovate, because:

- some areas experience a shortage of general practitioners
- workforce training has not kept pace with changing clinical practice

As well, across Australia, it has been found the trend to increased length of stay in emergency departments is correlated with the trend to decreased bed numbers in hospitals and community residential care facilities, and with changes in workforce and community attitudes. A coordinated strategy is required to respond to all of these issues.

### 1.3 Hospital Futures

The second phase of the Hospital Demand Management Strategy, Hospital Futures, aims to consolidate these gains and to promote further improvement in hospital services. Additional funds have been provided under Hospital Futures and the Rural Patient Initiative program, to focus on the following priority policy outcomes:

- Treatment within reasonable timeframes
- Prevent avoidable hospital admissions
- Positive patient experience
- Invest in a quality workforce

Ten priority areas have been identified to address emergency access during this new phase:

More than one service  
Improve referral processes  
Working in partnership  
The best care  
New models of care  
Keep patients moving  
New ways of working  
The best path  
A comfortable wait  
Better access and shorter delays

### 1.4 Hospital Demand Management initiatives mainstreamed

Many of the successful projects funded under the Hospital Demand Management Strategy have demonstrated a positive impact on emergency access, and are now expected to form part of health services' core services:

- Fast track services - a process for rapidly screening, assessing and managing emergency patients, thus reducing waiting times and improving the flow of patients through the emergency department
- Enhanced triage – strategies consisting of integrated medical and nursing triage processes implemented at times of peak demand, to fast-track the movement of patients through the emergency department
- Emergency department care coordination – a process whereby patients undergo interdisciplinary review and are referred to an appropriate substitute service, thus averting hospital admission

- Observation medicine:
  - Short Stay Observation Units; designed to provide observation care and treatment for patients who have an expected length of stay between 4 and 24 hours
  - Emergency Medical Units; a central unit designed to streamline the care planning process for patients with general medical conditions, prior to transfer to a ward or discharge home
  - Medical Assessment and Planning Units; a designated ward designed to receive medical inpatients for observation, care and treatment prior to transfer to an appropriate ward or discharge home
- Medihotels - accommodation provided to patients who cannot go home between treatments, yet do not need full acute care facilities overnight
- Day treatment centres – an independent facility for patients who require day treatment and who do not need to occupy a multi-day inpatient bed or emergency department cubicle

The other main component of the Hospital Demand Management Strategy has been the Hospital Admission Risk Program. This Program has now been mainstreamed into the Victorian Chronic and Complex Care Program, which continues to develop new service models for people with chronic illness and complex needs.

## 2 Community expectations

Victorians expect equitable access to the right services. They want access to a range of service alternatives in their own locality, so that attendance at an emergency department is not the only option for people who are ill or injured. They want information about service options to help them decide how and where to seek care. Victorians expect emergency departments to act as part of an integrated system of health care.

DHS has commissioned focus groups, which found:

- People who attend emergency departments expect to wait, but want to know how long before they will receive care. They want to know what their triage category is, and what this means for waiting time. If their condition is not assessed to be serious, they want to know whether they could go to an alternative provider such as a general practitioner
- Patients want regular monitoring and communication from nurses. They want reassurance about their condition and about their likely waiting time
- Patients want to hear about their condition in a language they understand, not in medical jargon
- Physical amenity is important. Patients expect emergency departments to be clean and professional. They want access to water, and information about availability of food if they are likely to be waiting for some hours
- Above all, patients want a sense of safety while they are in the emergency department—they want to believe they will receive appropriate care in an appropriate timeframe

### 3 Government objectives and policies

Hospital Futures has been established around four key themes:

- Treatment within reasonable timeframes
- Prevent avoidable hospital admissions
- Positive patient experience
- Invest in a quality workforce

These themes are consistent with government's broader policies for the Victorian health system, as expressed in the Metropolitan Health Strategy<sup>2</sup>, which was released during 2003. The Strategy aims to achieve a better distribution of health service capacity across Melbourne, while placing greater emphasis on new service models, including ambulatory care, to increase efficiency and improve patient access.

The Department has also developed new policies for improving care for older people<sup>3</sup>, which is a key strategy to reduce demand for hospital inpatient services. These policies include commitments to the development of more integrated services, provided on an ambulatory basis where possible (including in patients' homes) and a greater emphasis on the development of primary care. A number of recently released policies have continued these policy directions:

- Community Health Services—creating a healthier Victoria
- The Victorian ambulatory care framework
- Sub-Acute Ambulatory Care Services Framework
- Strengthening Palliative Care – A policy for health and community care providers 2004-2009
- Victorian Chronic and Complex Care Program Guidelines, 2005
- Elective Surgery Access Policy, 2005

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<sup>2</sup> Metropolitan Health and Aged Care Service Division, 2003. *Directions for your health system: Metropolitan Health Strategy*. Victorian Government Department of Human Services, Melbourne, Victoria.

<sup>3</sup> Metropolitan Health and Care Services Division, 2003. *Improving and integrating care for older people*. Victorian Government Department of Human Services, Melbourne, Victoria.

## 4 Ten priorities

In Victoria, all people who present to an emergency department are assessed, and provided with clinically appropriate care. Emergency departments are part of a continuum of care, with a responsibility to determine the appropriate service for each patient, and facilitate their rapid access to those services, within and outside the hospital.

The next phase of the Hospital Demand Management Strategy aims to achieve better patient outcomes, less waiting, equitable access and quality care. DHS is supported in this by the Emergency Access Reference Committee, which has been established to monitor and advise on the implementation of the strategy. The Committee's Terms of Reference are:

- To identify strategies to improve equitable access to emergency services on the basis of need
- To implement the key recommendations handed down in a report by the Auditor General, "Managing emergency demand in public hospitals" (May 2004)
- To develop access improvement initiatives, including key performance indicators and benchmarks and initiatives to deal with specific issues affecting statewide emergency services performance
- To provide advice on issues arising from developments at the Commonwealth level, which affect access to emergency services.

Expected outcomes from the strategy are:

- Reduced wait times and length of stay in emergency departments
- Increased access to inpatient beds
- Focus on very long waiting patients in the emergency department
- Improved communication to emergency patients about waiting times
- Implementation of the recommendations of the emergency department audit to improve the patient experience

There needs to be a confirmed focus on processes within emergency departments as well as opportunities to improve coordination between emergency departments, primary care and ambulance services. Also, hospitals are expected to focus on improving coordination between emergency departments and inpatient services such as acute, sub-acute, aged and mental health services.

### 4.1 More than one service

#### *Issue*

Some patients attend an emergency department because:

- They do not know about appropriate service alternatives and how to access them

- They have not been able to prevent an exacerbation of a chronic condition or illness

#### *Evidence*

The recent evaluation of the Hospital Admission Risk Program demonstrates that the provision of effective alternative services in the community, with appropriate information strategies, can reduce emergency attendances by patients with chronic conditions. Lack of local access to general practitioners can increase the incidence of primary care type presentations to emergency departments.

#### *Strategy*

There will be continued development of new service models, particularly models to bring primary care and general practice into closer relationships with emergency departments.

Increased investment in community based services for people with chronic and complex care needs will reduce avoidable hospital attendances.

For people who do not have easy access to general practice, particularly after hours, the Health Assist Line will be available for self-care and referral advice. The aim of the Health Assist Line is to meet currently unmet demand for health advice, and to direct people to appropriate services including emergency departments.

## 4.2 Improve referral processes

#### *Issue*

For many people, attendance at an emergency department is one stage in a more lengthy episode of care. Their care is compromised by poor communication between service providers, resulting in duplication of assessments, uncoordinated treatment regimes and long waits.

#### *Evidence*

Through greater attention to relationships between primary, secondary and tertiary health providers, Great Britain's National Health Service was able to reduce inpatient bed days, reduce length of stay, and improve occupancy rates. As well, care for individuals was improved through better discharge and stronger community services.

#### *Strategies*

Better referrals and communication between patients' general practitioners and hospitals will help patients by:

- Providing a more streamlined service
- Making sure useful information is provided to the patient and all relevant care providers

- Making sure patients receive follow-up care which may reduce their likelihood of further hospitalisation

This will be assisted by the development of a program of work for General Practice Liaison Officers in emergency departments. Information systems will be developed to facilitate information sharing and to support the continued development of better discharge protocols.

## 4.3 Working in partnership

### *Issues*

For those people who present to an emergency department because they are experiencing an acute occurrence within a longer episode of disease or disability, the emphasis of treatment needs to move away from the acute occurrence. This can only be achieved when different parts of the service system work together.

The availability of residential and community-based services for older people in Victoria is a key constraint for the Victorian health system. Given the Victorian Government is not responsible for the management of the residential aged care sector, the resolution of these issues will continue to be negotiated between Governments.

### *Evidence*

The development of better relationships between acute and sub-acute services has provided more appropriate services for patients, while assisting health services to better manage resources. The acute /subacute interface project demonstrated the vital contribution of ambulatory services to meeting demand, as well as promoting patient satisfaction.

Automated systems for referrals to residential aged care have been implemented in Calgary, Canada, where there have been significant reductions in the average period of waiting experienced by older people, while dramatically reducing the investment of hospital and family resources in searching for appropriate placements. As well, it has increased average occupancy levels for residential aged care services.

### *Strategies*

#### Sub-acute

DHS plans to continue to strengthen the sub-acute service system and improve the interface between acute and sub-acute services by:

- Integrating projects previously funded under the Hospital Admission Risk Program into a new program targeted towards people with chronic and complex needs who frequently attend hospital
- Developing strategies to move from “push” systems to “pull” systems in transferring patients from acute to sub-acute services

- Specifying the range of sub-acute inpatient, ambulatory and assessment services to be provided by health services

#### Residential Aged Care

Transition Care is a new model based on the Interim Care program. There is a risk this development will not address the underlying capacity issues in the residential service system, and older people may continue to wait too long for an appropriate aged residential placement. The aged/acute interface continues to be of key importance, and a number of ideas will be investigated for application in Victoria:

- New information systems which allow aged residential service providers to notify acute hospitals when vacancies are available and facilitate matching of possible candidates with the services provided (a "pull" system)
- Greater emphasis on ambulatory services for older people, and a greater focus on prevention and self-management for frail older people with complex needs
- Greater focus on providing services to older people where they live, whether at home or in residential care. This will require greater coordination between sub-acute, aged care, emergency and primary care systems, and development of greater capacity for these service systems to respond to emergencies in situ

#### Mental Health

Emergency Department triage protocols for mental health patients presenting to the emergency department will be reviewed and implemented. Area Mental Health Services have been funded to provide psychiatry liaison positions in emergency departments; these positions will assist people who present to the emergency department with a mental health crisis, and coordinate services within the hospital and with community-based organisations.

### 4.4 The best care

#### *Issue*

To shorten waits in emergency departments, hospitals must focus on streamlining and standardising processes of care. As well, attention must be paid to patients' overall needs in order to improve discharge and referral processes.

#### *Evidence*

Better management of care can reduce patients' length of stay in emergency departments through:

- early identification of patient needs
- early identification of discharge destination and issues
- early commissioning of investigations and treatment

## *Strategies*

Patients will be streamed into clinical groupings:

- those who can be treated and discharged quickly (fast track)
- those who will need a period of observation and are expected to be discharged home
- those who are likely to need admission to hospital

Clinical and administrative processes can be established for each group, to bring the right decision makers to the patient as quickly as possible, with access to the right tools and information. In some emergency departments, and at some times, it may be suitable to reform triage processes.

Point of care technologies may be introduced and connected to electronic patient records. These systems bring testing to the patient's bedside, reducing processing times, patient and/or specimen transports, and queues in other parts of the hospital.

New models for observation medicine will be developed and implemented, drawing from international and Australian experience. The existing observation units (Short Stay Observation Units; Medical Assessment and Planning Units; Emergency Medical Units) will continue to be a key feature of emergency departments.

Care coordinators will continue to review patients' needs, and to ensure their social and psychosocial needs are taken into account in decision making.

DHS will examine the suitability of resourcing some emergency departments to provide more highly specialised services for some groups of patients transported by ambulance or police, based on the successful model adopted for trauma patients. This may include resources for patients presenting with a mental illness, or with a cardiac condition.

## 4.5 New models of care

### *Issue*

The Victorian Auditor General found that a major cause of overcrowding in emergency departments is lack of access to inpatient services.

### *Evidence*

International evidence demonstrates reduced inpatient length of stay can relieve demand pressures on emergency departments, by freeing up inpatient resources and improving patient flow. Several new service models have been developed in Victoria, and health services should continue to implement these where necessary:

- Day treatment centres
- Medihotels
- Hospital in the Home
- Observation medicine

### *Strategy*

DHS, with health services, will continue to develop new models of care and service types. Continued improvement in technology and equipment will continue to reduce lengths of stay in some specialties, while an increasing number of surgical and medical interventions are suitable to be delivered on a same-day basis. DHS will continue to implement new models of care to support these clinical developments.

Referral tools and bed management tools will be developed to assist health services to identify appropriate resources for patients (in the community or in other health or residential services), to facilitate referrals and promote effective discharge.

## 4.6 Keep patients moving

### *Issue*

Blockages and long waits in emergency departments are symptomatic of patient flow blockages throughout the hospital, and the issue must be addressed on a systematic basis.

### *Evidence*

Development of coordinated and automated information systems with agreed protocols throughout the hospital can assist bed managers to identify all resources available, and free up resources to assist with increases in demand.

### *Strategies*

Resource management tools will be introduced, to assist hospital staff to manage patient flow between clinical units, and to allocate suitable beds for patients. Integrated information systems throughout hospitals help to coordinate patient records and patient flows, streamlining care and reducing error. Hospitals will continue to promote practice review, information sharing and appropriate allocation of responsibility to provide rapid responses to patients in emergency departments.

## 4.7 New ways of working

### *Issue*

Changes in the nature of emergency care and workforce shortages are key drivers for change. Hospitals are challenged to increase staff satisfaction, use available staff in the most effective way, and contain the costs of hospital care. Emergency departments also provide clinical teaching and training.

### *Evidence*

The development of new direct care roles and assistant roles can free senior clinicians from delivery of care and allow them to focus on decision-making, management of patient outcomes and management of discharge or referral

requirements. Staff satisfaction can be improved by better management of workload and workflow.

### *Strategies*

Two strategies are important. The first is to develop and implement models for multi-disciplinary care, and the second is to use business process engineering principles to most effectively allocate roles and functions between team members. In order to facilitate both of these, DHS will continue to participate in national initiatives to redesign and increase the health workforce.

Health services will develop new staffing models to bring allied health, pharmacy and other roles into the emergency department, in order to best match resources with each hospital's demand patterns. DHS has developed the "Better Skills, Best Care" approach, which aims to develop an understanding of the most effective use of staff resources to achieve safe, quality care. This approach will:

- Introduce direct care roles for more people who have been trained in the vocational training sector
- Design more "assistant" roles
- Review and redesign the scope of jobs where possible
- Reflect the learnings from real-world practice into curriculum design for new entrants to the health workforce

The first new roles for emergency departments to be developed under this strategy will be Advanced Practice Nurse and Advanced Physiotherapist.

Continued training and development for existing staff is an important strategy for health services to promote cultural change.

## 4.8 The best path

### *Issue*

While attention was paid to clinical change during the Emergency Breakthrough Collaboration, and through the Patient Flow Collaborative, Victorian emergency departments have not adopted standard practices for key clinical pathways.

### *Evidence*

Adoption of standard care bundles, clinical guidelines and pathways can reduce error, promote better outcomes and reduce treatment times. In emergency departments, the increased efficiency that is promoted through adoption of these clinical tools will be a key enabler for better care and further reduction of waiting times.

*Care bundling* identifies which services should be provided, 100 per cent of the time, to specific groups of patients, and develops tools to promote standard provision of the bundles of care.

*Clinical pathways* are plans of care drafted in advance, for predictable patient groups. They are used by multidisciplinary teams, and form part of the written documentation. Pathways include mechanisms for recording and analysing variance.

*Clinical guidelines* are systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Guidelines provide recommendations for effective practice in the management of clinical conditions where variations in practice are known to occur and where effective care may not be delivered uniformly.

The National Health and Medical Research Council has published a handbook series on preparing clinical practice guidelines<sup>4</sup>. This provides a useful framework for Victorian health services, in collaboration with DHS, to develop and implement clinical guidelines and pathways for emergency departments. Many of the elements which have demonstrated effectiveness in supporting better clinical pathways (for example: short stay units, fast track streams, liaison services, care coordination) are now in place or planned in Victorian emergency departments.

### *Strategy*

The “Better Skills, Best Care” project aims to address issues related to professional interrelationships and training. Care bundles, clinical guidelines and pathways provide an opportunity to assign responsibilities for assessment, diagnosis, treatment and referral to the most appropriately qualified staff, freeing senior staff from routine decision making and implementation. Clinical leadership will be required if changes are to be implemented and maintained, and DHS will provide support and overall guidance.

Senior clinicians and managers will be identified and assisted to lead the development and dissemination of bundles, guidelines and pathways. A variety of strategies will be developed and implemented, including educational approaches (personal and written materials), decision support systems, audit and feedback, the use of opinion leaders, local consensus processes, incentives and penalties, and administrative interventions.

## 4.9 A comfortable wait

### *Issue*

Government policy is to minimise waits in emergency departments. However it is inevitable that patients and their families will spend periods of time in the waiting room, during which time they should be comfortable, cared for and informed.

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<sup>4</sup> National Health and Medical Research Council, 1999. *A Guide to the Development, Implementation and Evaluation of Clinical Practice Guidelines (Handbook Series on Preparing Clinical Practice Guidelines)*. <http://www.nhmrc.gov.au/publications/subjects/clinical.htm>

### *Evidence*

A recent audit identified three broad areas for improvement:

- Improving the physical amenity of waiting areas
  - Seating, signage, food and drink
  - Facilities for particular groups (children, people with disabilities, people with mental illness)
- Improving communication with patients
  - Communication training for “front of house” staff
  - Patient information: paper-based and electronic
- Improving service for patients in the waiting room
  - Regular reviews for those waiting to be seen
  - Follow-up of at-risk “did not waits”

### *Strategy*

Health services will be required to develop and implement a waiting room policy that ensures patients who are waiting are continuously reassessed. Health service’s communication capacity will be improved through targeted communication and customer service training for emergency department staff. Health services will be expected to establish information boards for patients, to complement electronic information systems. Interpretation and translation services will be provided for patients whose first language is not English.

A Patient Satisfaction Measure will be developed to seek feedback from emergency department patients.

## 4.10 Better access and shorter delays

### *Issue*

When emergency departments are full, ambulance access can be blocked and ambulance response times are likely to be affected.

### *Evidence*

Better communication between ambulance services and hospitals can improve ambulance decision-making about the right destination for an individual patient. Standardised communication and handover procedures reduce capacity for error, and reduce time taken.

### *Strategy*

In collaboration with the Metropolitan Ambulance Service and Rural Ambulance Victoria, DHS will continue to investigate ways to improve the interface between ambulance services and emergency departments, including standardised handover protocols and improved communications technologies.

Strategies will be developed with the ambulance services to distribute ambulances more evenly across hospitals, recognising the needs of patients must take priority. This may include creating roles for some emergency departments to provide specialist services to a particular group of patients.

## 5 Implementation and next steps

DHS will continue to play a leadership role, but will redevelop the role to change focus from managing and monitoring project implementation. During this next phase of work, DHS will focus on developing strategies to standardise emergency access and care across Victoria. The Emergency Access Reference Committee will support the continued development of the Strategy.

Through this phase, there will be continued emphasis on performance management, with new accountability measures to support Boards and health services to improve their performance. The performance monitoring framework and associated bonus funding system are designed as a tool to drive improvement towards statewide benchmarks.

As a first step in implementation, DHS will conduct a series of workshops with health services, professional bodies and Community Advisory Committees. The workshops will aim to elicit informed support from stakeholders, and to establish an agreed basis for developing formal implementation plans, including roles, responsibilities and timetables for action. Implementation responsibilities will then be reflected in Statements of Priority and agreed priority actions and timetables.