Queensland Clinical Senate

Connecting clinicians to improve care

Queensland Clinical Senate
27–28 March 2014 meeting
Report and recommendations

National Emergency Access Target: is 90% the right target?

Royal on the Park, Brisbane, Queensland

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Abbreviations

Clinical Service Redesign	CSR
Emergency Department	ED
Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services	Expert Panel
Hospital and Health Service	HHS
Length of Stay	LOS
Medical Assessment and Planning Unit	MAPU
National Elective Surgery Target	NEST
National Emergency Access Target	NEAT
Princess Alexandra Hospital	PAH
Queensland Clinical Senate	QCS
Rapid Response Time Calls	RRTC
Standardised Hospital Mortality Ratio	SHMR
Western Australia	WA

1. Summary

The National Emergency Access Target (NEAT) was introduced in January 2011 in response to growing demand for emergency department (ED) services. The intent of a time based, stretch target for ED care was to drive process improvement and address patient safety concerns related to access block.

NEAT is measured as the percentage of patients presenting to an ED whose length of stay in ED is within four hours. Based on recommendations from the Expert Panel Review of Elective Surgery and Emergency Access Targets (2011)[1] under the National Partnership Agreement on Improving Public Hospital Services, NEAT was implemented incrementally with the final target of 90 per cent to be achieved by 2015. States have different annual targets based on their starting four hour performance. The target for Queensland in 2014 is 83 per cent.

NEAT has provided a much needed mandate for process redesign and cultural change. Many Australian public hospitals have made significant improvements in quantitative and qualitative performance across the entire health system. NEAT performance in Queensland has improved from 67 per cent in 2012 to 76 per cent in 2014. Western Australia (WA), having the advantage of a three year head start, remains the only jurisdiction to achieve their current NEAT target. WA however, has struggled to maintain their performance and despite improvements nationally, a number of jurisdictions are struggling to make improvements towards achieving their target. This is generating a level of despondency in some jurisdictions with a risk of loss of motivation towards the NEATobjective.

The end-point NEAT target has been set for 90 per cent in 2015. The evidence underpinning this 90% target remains unclear. The impact on quality of care and the sustainability of the 90% target are also without any evidence base.

Even in jurisdictions pioneering NEAT reform, advances brought about by innovative models of care are beginning to plateau well short of the 90 per cent target. Process redesign and business methodologies are unlikely to be enough without fundamental changes to the way core business is conducted, the potential risks of which are difficult to predict or mitigate.

Currently no major Australian adult hospital consistently achieves NEAT of over 85 per cent—thus there is no precedent to assist with forecasting safety and quality or to identify the tipping point at which the risks of the target outweigh the benefits. Specific concerns include:

[1] Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services - Report to the Council of Australian Governments 30 June 2011

1. whether safety and quality gains achieved above current performance targets justify additional expenditure (which may be better invested in other priority areas)
2. the potential for demand for public hospital services to increase as performance improves
3. the risk of disengaging clinicians and key stakeholders should perverse outcomes be realised.

The objective of the Queensland Clinical Senate (QCS) meeting was to:

- highlight the advantages in improved performance driven by NEAT
- consider the potential risks associated with NEAT in its current form
- deliberate and propose a sustainable long term model with an evidence based NEAT target embedded within a quality framework.

2. Queensland Clinical Senate recommendations

The NEAT must be recognised as a whole-of-system performance target.

NEAT must focus on better patient outcomes, improved patient experiences and more efficient hospital systems as critical measures of success.

The QCS acknowledges the positive outcomes achieved in Queensland to date.

The QCS supports ongoing political commitment to an appropriate target and strong clinical leadership to drive comprehensive reform.

The QCS recommends:

- **Pausing jurisdictional NEAT targets at their current 2014 targets (83 percnet for**
- **Queensland)**
- **Completion of a scientific review to better inform ongoing policy and targets beyond 2015. This review should specifically consider:**
  - **The value of a differentiated target for admitted and discharged patients**
  - **Development of a suite of safety and quality indicators directly related to NEAT**
- **The Minister and Department advocate amongst their jurisdictional peers for these recommendations to be adopted at a National level.**

Dr David Rosengren

Chair, Queensland Clinical Senate

30 April 2014

3. Introduction

On 27-28 March 2014, the QCS met to consider NEAT and debate the evidence for the target and sustainability in its current form. The meeting brought together a broad group of health professionals from within Queensland and around Australia.

This report outlines the key issues, opportunities and recommendations for consideration by the Queensland Department of Health and Queensland Government in relation to the implementation of a sustainable performance target for ED and hospital access.

4. What is the National Emergency Access Target?

As a signatory of the National Partnership Agreement on Improving Hospital Services, Queensland has committed to work towards national targets for access to emergency services and inpatient care. The aim of the target is that in 2015, 90 per cent of all patients presenting to public hospital EDs will physically leave the ED (i.e. admitted to a bed in a ward, transferred to another hospital or discharged home) within four hours.

Professor Chris Baggoley – Commonwealth Chief Medical Officer and Chair of Expert Panel

The target is being implemented incrementally and has been designed to improve patient safety and quality of care by removing the barriers to effective patient flow through:

- Clinical service redesign
- whole of hospital/system change
- Improved consumer experience.

NEAT performance is calculated across participating hospitals in each jurisdiction over the calendar year.

Ten guiding principles for the implementation of NEAT were identified by the Expert Panel[2]:

1. Targets, and the changes required to meet them, will require commitment right across the health and hospital system.

[2] Expert Panel Review of Elective Surgery and Emergency Access Targets under the National Partnership Agreement on Improving Public Hospital Services - Report to the Council of Australian Governments 30 June 2011

2. hospital executives will need to work in partnership with clinicians to achieve sustainable change
3. clinician engagement and clinical leadership will be essential
4. targets must drive clinical redesign with a whole-of-hospital approach
5. clinical redesign must ensure patient safety and enhance quality of care
6. definitions must be clear and consistent across all jurisdictions
7. the performance of jurisdictions is not comparable
8. progress towards targets needs to be linked with continual monitoring of safety and quality performance indicators
9. the impact of targets on demand needs to be monitored and early strategies developed to ensure achievements are sustainable
10. quality of training is maintained.

5. Emergency Department overcrowding – the need for reform

Demand for public health services in Australia has risen over the past two decades, primarily in response to the demands of an ageing population and higher rates of chronic disease. Similarly, the number of ED presentations per 1000 population has increased without a corresponding rise in inpatient beds, leading to very high hospital occupancy rates.

In the mid to late 1990s, Queensland experienced major ‘access block’ (inpatients waiting more than eight hours for a bed) and EDs were compromised by overcrowding with patients awaiting transfer to inpatient beds. ED overcrowding and ambulance ramping became a major public health issue.

ED overcrowding was not unique to Queensland and has been recognised as a major public health issue internationally. In response to ED access block, a four-hour rule was introduced in the United Kingdom in 2002 and a six hour rule in New Zealand in 2009. WA was the first Australian state to move to a time based ED performance target implementing the Four Hour Rule Program (FHRP) in 2009.

In Queensland, an Access Block National Target was adopted which required less than 20 per cent of admitted patients to wait more than eight hours from arrival time to inpatient bed. This was not accompanied by formal clinical services redesign initiatives and did not bring about widespread process change. Models of care were modified in an incremental and uncoordinated way without significant sustained improvement. Additional subacute services and early discharge programs were able to reduce the length of stay for inpatients and

improve bed availability, but their effects were modest and the benefits rarely seen at an ED level.

The introduction of a significant stretch target in the form of NEAT has provided the stimulus to force models of care to change significantly, resulting in definite improvements in the function of ED and the whole-of-hospital system.

6. National Emergency Access Target performance in Queensland

The incremental NEAT targets for Queensland:

2012	2013	2014	2015
70%	77%	83%	90%

Emergency department performance

Major improvements in patient flow from ambulances and reductions in ED overcrowding have been demonstrated in Queensland following the introduction of NEAT reform. However, improvements have come at much lower percentages than the ultimate 90% 2015 target.

Queensland achieved an overall NEAT performance of 76% in the calendar year (2013).

As a case study, the Thermostat model of care (implemented at the Royal Brisbane and Women's Hospital ED in 2013) provided sudden and dramatic improvements in performance including:

- 21% reduction in ED length of stay (from 248 min to 195 min)
- 37% reduction in time to referral (from 200 min to 125 min)
- 43% reduction in medical handover time (from 165 min to 94 min)
- 43% reduction in triage category 3 performance times (from 30 min to 17 min)
- dramatic improvements in Queensland Ambulance Service offload times.

Dr John Burke – Emergency Physician

"How you introduce the change to clinicians will determine how willing they are to give it a go"

Dr John Burke, Emergency Physician, Royal Brisbane and Women's Hospital

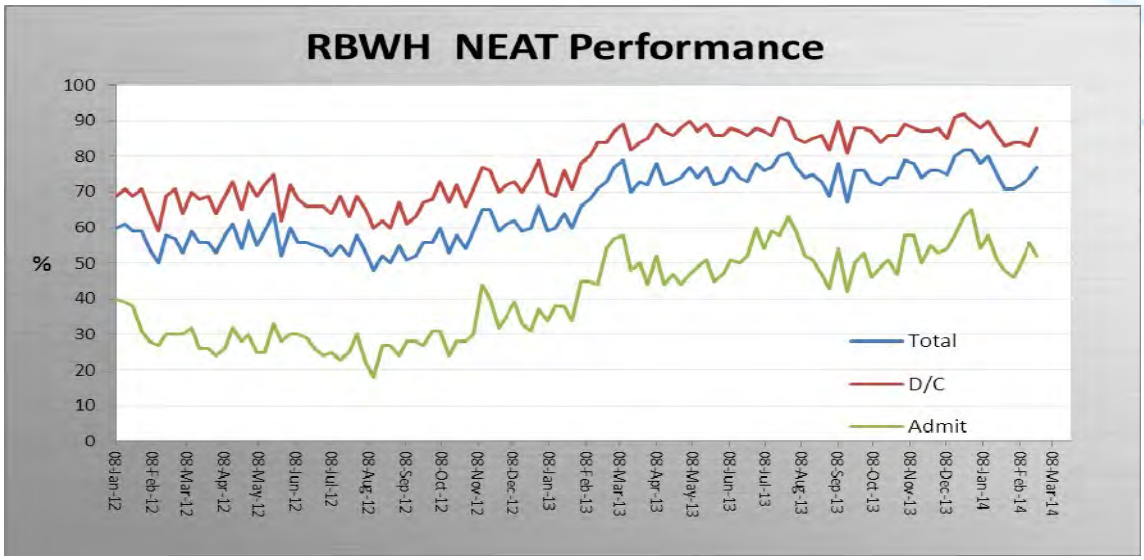


Figure 1: Royal Brisbane and Women's Hospital NEAT performance following the implementation of Thermostat

Inpatient National Emergency Access Target

Strong evidence links ED overcrowding and access block to poorer patient outcomes and contributes to prolonged inpatient length of stay (LOS) in Australia:

- Time to disposition plan less than four hours is associated with a 57 per cent increase in mortality in general medicine patients (corrected for age, gender and triage category) *(Mitra et al. Internal Medicine Journal. 2012)*
- Length of ED stay independently predicts inpatient LOS - average excess LOS for inpatients: 0.39 days for ED LOS ≤ 4 hour; 2.35 days for ED LOS >12hrs *(Liew et al. Medical Journal of Australia. 2013)*
- 34 per cent increase in risk of death at 10 days among admitted patients presenting during periods of ED overcrowding *(Richardson. Medical Journal of Australia. 2006)*
- ED overcrowding in Perth's three tertiary hospital associated with an estimated excess 120 deaths in 2003 (Sprivulis et a. Medical Journal *of Australia. 2006)*
- Among patients well enough to leave ED after being seen, longer ED LOS (> six hours) compared to shorter LOS (< one hour) resulted in 80 per cent increase in death and 100 per cent increase in admission at seven days in high acuity patients *(Guttmann et al. BMJ. 2011)*
- Increased readmission and ED return visits; inappropriate follow up care (discharge planning) *(Forero & Hillman, 'Access block and overcrowding: A literature review', prepared for Australasian College of Emergency Medicine)*

— Prolonged pain, patient/carer dissatisfaction, violence, ambulance diversions/ramping, reduced efficiency *(Derlet & Richards. Emergency Medicine Journal. 2000).*

To achieve NEAT, patient-centred whole of hospital/system change is required. The ability of large high volume hospitals to achieve NEAT can only be realised with improvement in inpatient NEAT (i.e. addressing patient flow issues for admitted patients to remove access block).

Inpatient NEAT involves the sickest and most complex (and costly) patients presenting to the ED. As another case study, strategies implemented at the Princess Alexandra Hospital (PAH) have seen the organisation's NEAT results improve from being the nation's worst to the most improved NEAT performer.

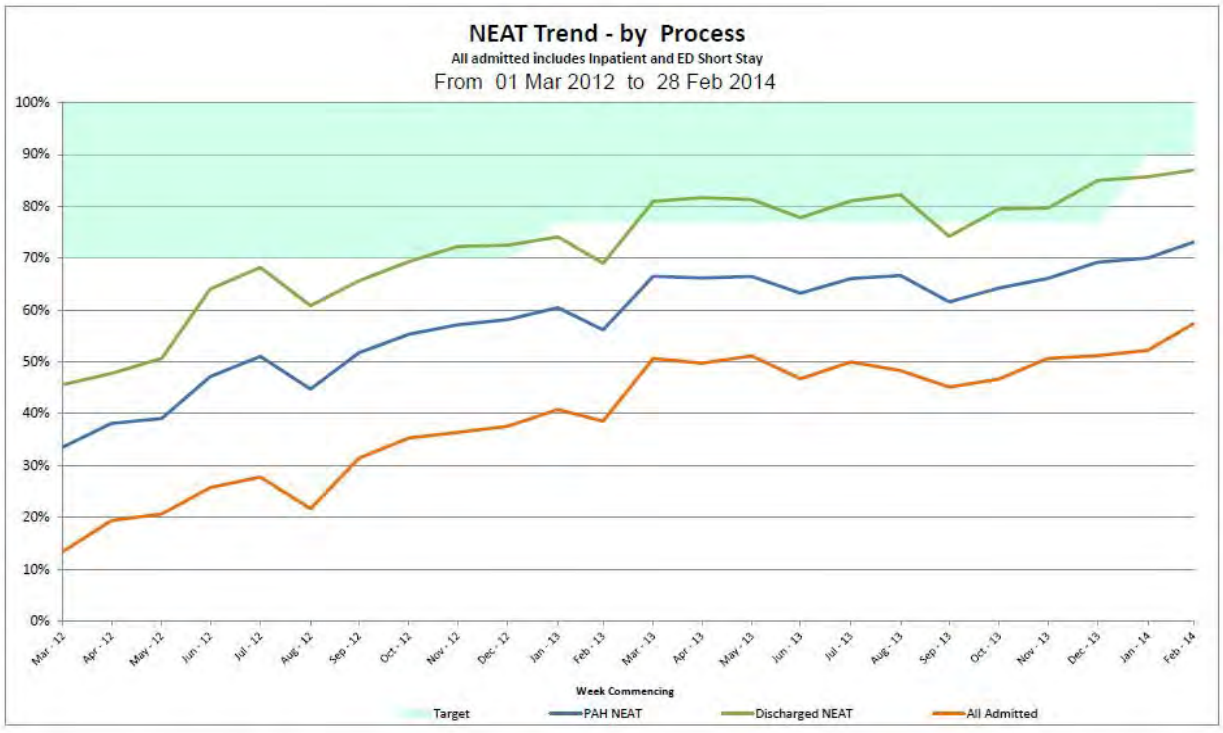


Figure 2: Princess Alexandra Hospital NEAT Performance

New models of care with a strong focus on culture, leadership and patient centred care resulted in a NEAT improvement of ~ 45% (25-70) at a cost of ~$750k (recurrent). Following an initial focus on discharged patients, efforts concentrated on improving admitted NEAT results.

Focussing on the ED-inpatient interface requires specialties with traditionally differing cultures to agree on a plan of care within four hours.

Factors critical to making the ED-inpatient interface as efficient and safe as possible include:

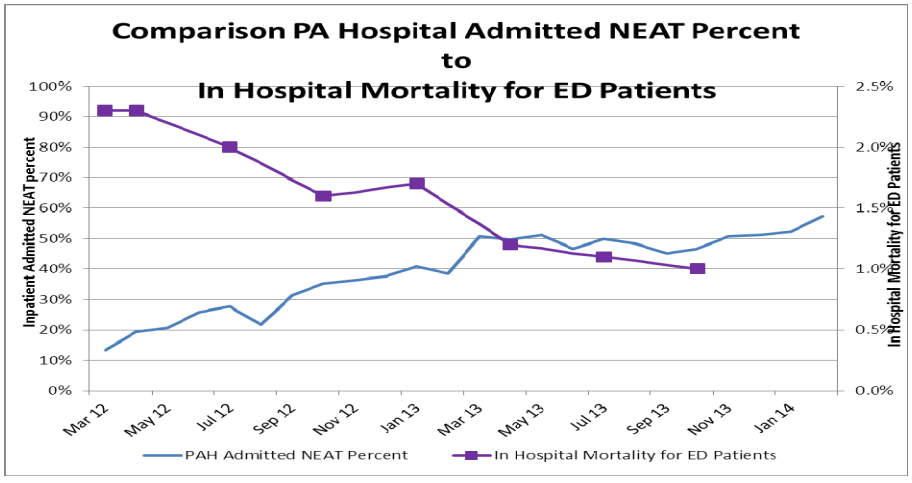
- maintaining a patient focus and breaking down "silos" of care
- frequent communication and troubleshooting
- ensuring resources were available to allow cooperation and collaboration between specialties
- focusing on safety by allowing data (not emotion) to guide decision making.

In order to engage inpatient teams, rigorous safety indicators had to be developed and a PAH NEAT safety dashboard was developed (Figure 3).

NEAT Dashboard Princess Alexandra Hospital	Pre Implementation				Post Implementation							
	2011				2012				2012 / 2013			
Quality and Clinical Outcome Measures	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct - Dec	Jan - Mar	Apr - Jun	Jul - Sep	Oct – Dec
Re-presentation to PAH ED < 48 hrs of discharge from ED	3.4	2.8	2.6	2.8	3.1	3.1	3	3.8	3.8	3.4	3.1	3.2
Inpatient mortality for patients admitted from PAH ED (%)	2	2.4	2.5	2.6	2.3	2.3	2	1.6	1.7	1.2	1.1	1
PAH Standardised Hospital Mortality Ratio	80		85		85		74		61			
RRT calls to PAH Inpatients admitted < 24 hrs from PAH (rate per 1000 admissions)	4.9	8.1	7.3	6.7	9.4	8.3	10	8.9	9.9	14	13	13
Cardiac Arrest calls to PAH Inpatients admitted < 24 hrs from PAH (rate per 1000 admissions)	1.4	0.9	0.9	1	1.1	0.4	1.1	1.4	1	0.8	1.1	0.5

Figure 3: NEAT Dashboard Princess Alexandra Hospital

From the safety dashboard, it could be demonstrated that improved NEAT compliance at the PAH has been associated with a reduction in deaths in patients being admitted from the ED (the death rate has halved). This has further reinforced the engagement of the inpatient teams by demonstrating NEAT might actually be good for patients rather than "just a KPI".



"437 potential non-statistical lives have been saved during the Princess Alexandra Hospital NEAT period"

Dr Clair Sullivan, Director of Physician Training, Princess Alexandra Hospital

Figure 4: Comparison Princess Alexandra Hospital Admitted NEAT Precent to In Hospital Mortality for ED Patients

Although it is difficult to prove causality, at a statewide level, the hospital standardised mortality ratio has declined as inpatient NEAT has improved (Figure 5).

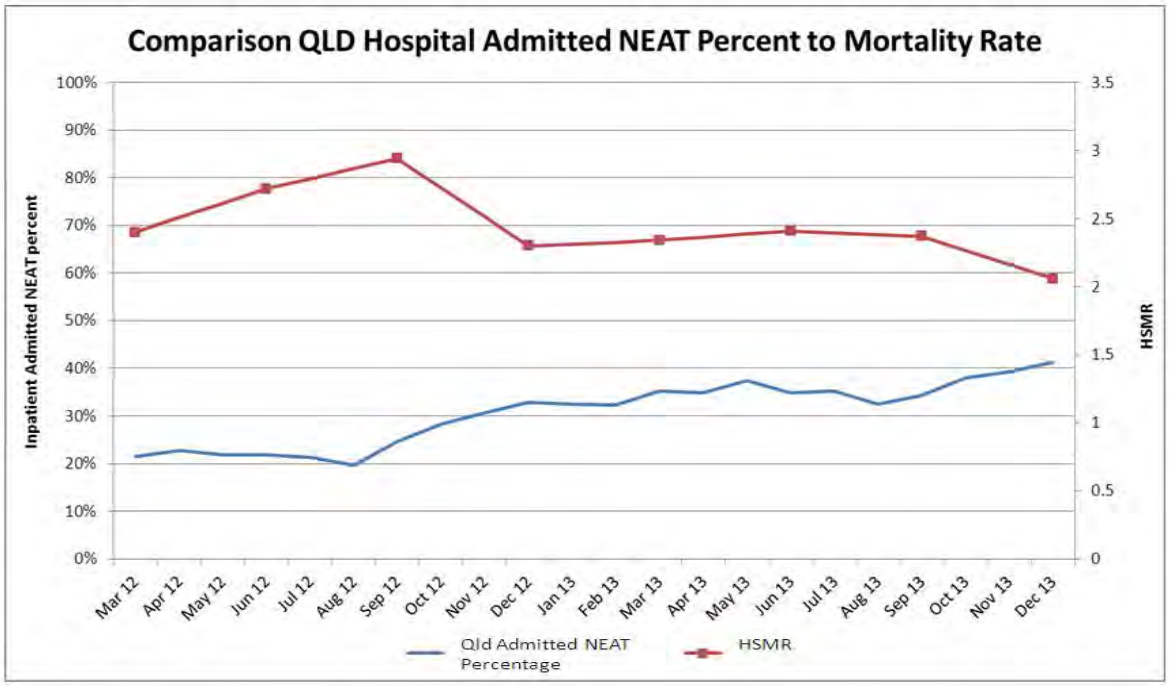


Figure 5: Comparison Queensland Hospital Admitted NEAT Percent to Mortality Rate

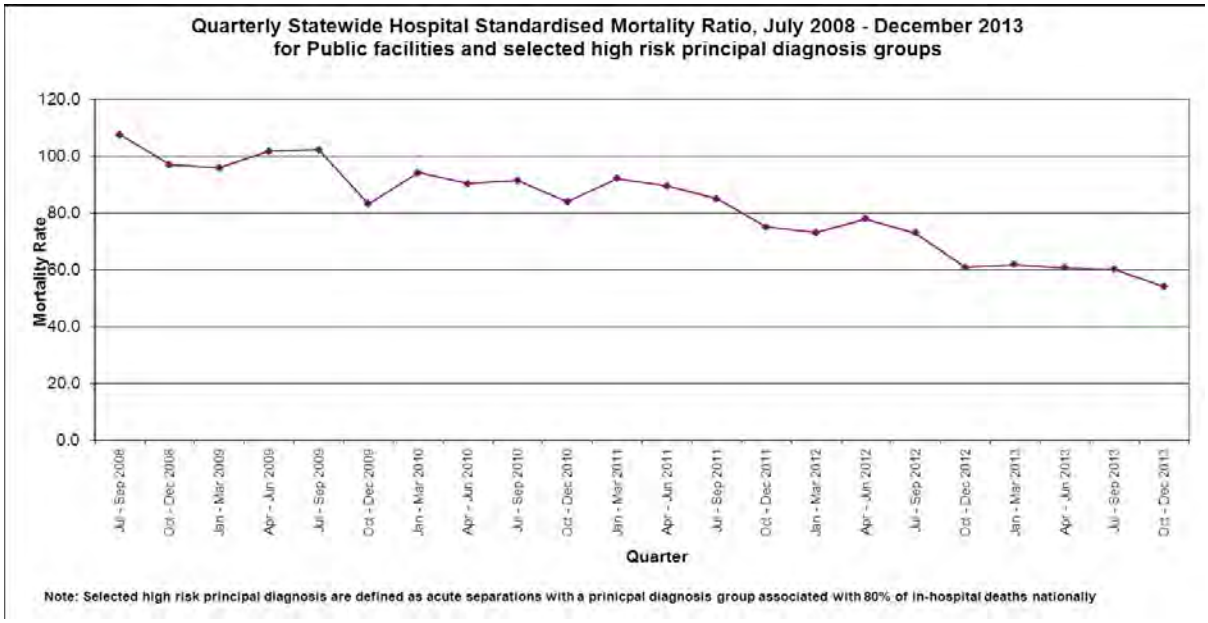


Figure 6: Quarterly Statewide Hospital Standardised Mortality Ratio July 2008-December 2013

Substantial gains in safety and efficiency at inpatient NEAT targets of 60 per cent have been realised. To increase inpatient NEAT performance will require significant recurrent expenditure. Future plans being considered by the Princess Alexandra Hospital to achieve a further 10 per cent increase include the implementation of a medical admission zone/decision making unit at a cost of ~$2.5 million (recurrent).

Dr Clair Sullivan – Endocrinologist PAH
Dr Andrew Staib – Emergency Physician PAH

Clinicians question whether safety and quality gains achieved above a 'moderate inpatient NEAT target' justify additional expenditure given it will be very difficult to improve the current very low mortality rates (the law of diminishing returns).

7. Issues, challenges and opportunities of the National Emergency Access Target in its current form

Most clinicians would agree that the introduction of NEAT has presented challenges, opportunities and benefits. Clinical Service Redesign (CSR) initiatives to improve efficiencies and patient flow within the system have been widely adopted and embraced at all levels.

QCS meeting participants identified the inclusion of quality indicators to provide a more balanced approach to assessing NEAT outcomes as a key opportunity - (i.e. a measure of timeliness, quality of care, patient experience and staff experience). Chances to improve patient care, implement culture change, rethink how things are done, and benchmarking were viewed as strengths.

Dr David Green - Emergency Physician

"Spending too much time in an ED can be unsafe for patients. Spending too little time in an ED can be unsafe for patients. The challenge is to set the right target and maintain quality of care"

Dr David Green, Director, Emergency Department, Gold Coast Hospital and Health Service

Clinicians have raised concerns that progressing above 75% NEAT performance was proving increasingly difficult and costly for jurisdictions to achieve. There is evidence to support benefits associated with the current NEAT performance. There is no evidence to support perceived benefits from the higher NEAT target.

QCS meeting participants raised the following concerns and risks in pursuing the 90% target:

- The potential risks to patient safety by changes to the models of care and 'gaming' as a result of an excessive focus on output-based targets.
- The lack of evidence for the optimal percentage target for the best patient care.
- That achieving 90% NEAT for high volume high acuity EDs may require considerable investment for unproven extra clinical benefit – is the additional expenditure required to achieve a 90% target better invested in other priority areas in healthcare?
- Creation of inefficiencies in other areas (e.g. elective surgery) as a result of the bluntness of the tool and capacity management constraints.
- That the current NEAT takes no account of volume or acuity or quality of care – Triage Category 5 patients have the same target as Triage Category 1 patients.
- Problems with performance comparison associated with reporting a combined admitted and non-admitted NEAT (allowing hospitals with high volumes of non-admitted patients to 'out-perform' hospitals with a higher acuity case-mix).
- The need for a target driven system to include quality indicators (as evidenced by the events of Mid Staffordshire NHS Foundation Trust[3]).
- The risk of inadequate communication and coordination between acute care settings and primary/community care services.
- The potential for increased demand on ED services as a result of improved performance and decreased demand for general practice services.
- The erosion of emergency medicine as a specialty.

[3] Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry February 2013

The United Kingdom formally recognised these anxieties in their decision in 2010 to adjust their target of 98 per cent to a reduced target of 95 per cent of patients and the introduction of a suite of eight quality indicators to support continuous improvement in the quality of care provided.

> ***"NEAT is a target – if it's driving perverse behaviour you need to know about it and act on it"***
>
> *Professor Chris Baggoley, Chief Medical Officer Commonwealth Department of Health*

8. The future of the National Emergency Access Target

Improved patient outcomes, patient experience and hospital systems lie at the centre of NEAT reform. Consistent political commitment and drive; a stretch target; and a comprehensive simultaneous program of reform within individual hospitals across jurisdictions are considered key principles to success in this work.

WA implemented a program of clinical service redesign in 2011. The FHRP has seen significant improvement in patient flow. Whilst a few hospitals have achieved a NEAT performance of 90 per cent, this was not widespread and has not been sustained. Despite this WA is the only jurisdiction to achieve their jurisdictional NEAT target in 2013. QCS meeting participants were provided with an overview of the Western Australian experience.

Dr Mark Monaghan, State Clinical Lead for the FHRP advocated for the lack of evidence in WA to suggest that 90 per cent NEAT target is unsafe. In WA improved NEAT performance has been intermittently achieved without a negative impact on safety and quality.

Dr Mark Monaghan, WA Clinical Lead FHRP

> ***"In the absence of a nation-wide suite of safety and quality data, we can see no case to be made for reducing the target on these grounds"***
>
> Dr Mark Monaghan, Co-Director, Emergency Department, Fremantle Hospital

A recent (September 2013) review by United Kingdom NHS expert Professor Derek Bell[4] suggested that while WA currently report over 82 per cent NEAT (tertiary sites 78-80 per cent), an increase in performance by 6-8 per cent should be achievable with attention to detail and no additional clinical risk. Creating an environment that is more responsive to capacity and requirement needs will require clinicians to 'own' capacity generation and access to care.

The difficulties in calculating a cost-benefit associated with an aspirational target are clear. Dr Monaghan noted that inefficient hospitals with increased access block and outliers have increased LOS and patient complication rates that increase costs. NEAT reform directly addresses these issues. In most cases, well-considered redesign does not rely on significant economic investment to be successful. Dr Monaghan advised that the bulk of investment should be in resourcing and improving change management skills rather than capital works or full time equivalent creation.

Five years into the WA NEAT experience, Dr Monaghan stressed that there still exists significant reform opportunity to create a true whole of hospital accountability for access to care and capacity generation. Passionately advocating maintenance of the current target, Dr Monaghan was supportive of the concept of an expert review of the current incremental target slope linked to reward funding, provided the political will to incentivise the work continues. He supported the need to look at initiatives to make the target 'smarter' (e.g. distinguishing between admission and discharge streams, and creating hospital peer groups with specific targets).

9. A quality framework for the National Emergency Access Target

To date, systematic reviews of quality indicators appropriate for emergency access remain predominantly time based. Furthermore, the use of ED based operational indicators in isolation has retained the focus on the emergency phase of care when whole of hospital processes impact directly on patient flow out of the ED. Other indicators are variably reported within a number of domains including patient safety, patient satisfaction, clinically specific time stamps and clinical incidents.

With the aim of generating outcomes for patients, being mindful of their experience, where resources are used responsibly it was agreed that any time based target must be nested within a quality framework. To that end the relationship between quality of care and cost was

[4] Professor Derek Bell, Faculty of Medicine, Department of Medicine, Imperial College London

cased in terms of value for patients where outcomes are the focus of continued improvement efforts.

The outcome hierarchy proposed by Porter[5] can be modified in this context to serve as the framework within which the appropriate time based target is included:

- Tier 1 – Health Status (i.e. system barometer)
- Tier 2 – Process of Recovery (i.e. attainment of definitive care) – N.B. time based target included here
- Tier 3 – Sustainability of health (i.e. person centred measures).

The choice of specific quality indicators within each tier is subject to finalisation, however examples may include:

- Tier 1
    - Inpatient mortality for patients admitted via ED (per cent)
    - Standardised Hospital Mortality Ratio (SHMR)
    - Either of Rapid Response Time Calls <24 hours for patients admitted or Cardiac arrest calls <24 hours.
- Tier 2
    - NEAT
    - Either of: unexpected ICU admissions with 24 hours of ED admission; or transfers to other units within 24 hours of ED admission
    - <20 per cent patients transferred in from other hospitals go to the ED.
- Tier 3
    - Consumer experience metrics
    - Unscheduled representations to ED <48 hours post discharge from ED
    - Access block under 10 per cent.

The value paradigm for the healthcare system as a result of a more balanced approach ensures a quality driven patient focus without losing time based drivers for system improvement and change at a justifiable cost.

[5] Porter,M. 'What Is Value in Health Care?'. New England Journal of Medicine. 2010

10. Considerations for an alternative National Emergency Access Target proposal

QCS meeting participants supported a patient outcome focussed model that included: a time-based target and a quality framework with quality indicators. Several options were debated:

1. Leave the current targets in place (i.e. 90 per cent NEAT) and extend the timeframe jurisdictions have to achieve the target
2. Split the discharge/admitted target (90 per cent discharge 70 per cent admitted).
   - Queensland is currently (2013) achieving 87 per cent non-admitted NEAT and 51 per cent admitted NEAT
   - Many members were supportive of splitting the target and believed the stretch target of 70 per cent would continue to drive positive change and where evidence demonstrates improvements in patient outcomes.
3. Maintain a four hour target but change the percentage target (e.g. 85 per cent).

   Participant opinion was diverse and there was considerable input from the membership.

   The final consensus recommendation was:
   Pausing the jurisdictional target at the current 2014 level (83 per cent for Queensland)

   This would allow time to commit to a formal evidence based scientific analysis to inform ongoing policy around NEAT. It was agreed that this should include an examination of:
   - the potential value of differentiating between admitted and discharged patient targets
   - potential Quality Indicators to be incorporated in NEAT performance reporting.

It was agreed by the QCS that even if continuation of NEAT was not supported at a national level from 2015, Queensland should identify its own performance targets to continue to drive improvement.

Appendix 1: Panel members and guest speakers

Panel members

- Dr Richard Ashby, Chief Medical Officer, Metro South Hospital and Health Service
- A/Professor Anthony Bell, Queensland Emergency Department Strategic Advisory Panel
- Dr Anita Green, General Practitioner, University of Queensland
- Ms Joyce Jacquet, Nurse Unit Manager, Emergency Department, Rockhampton Hospital
- Dr Mark Monaghan, Emergency Physician, Co-Director Fremantle Hospital Emergency Department
- Mr Brett Sellars, Business Practice Improvement Officer, Gold Coast University Hospital, Gold Coast Hospital and Health Service
- Dr Clair Sullivan, Director of Physician Training and Endocrinologist, Princess Alexandra Hospital, Metro South Hospital and Health Service
- Dr Jess Tipene, Medical Registrar, Emergency Department Trainee, Gold Coast University Hospital. Gold Coast Hospital and Health Service

Guest Speakers

- Hon. Lawrence Springborg MP, Minister for Health: Opening Address
- Professor Chris Baggoley AO, Chief Medical Officer, Department of Health: Commonwealth perspective on the issues surrounding the NEAT
- A/Professor Anthony Bell, Chair, Queensland Emergency Department Strategic Advisory Panel: NEAT 2.0 – Turning Time into Value
- Dr John Burke, Emergency Physician, Royal Brisbane and Women's Hospital: Thermostat – the two hour evaluation and referral model
- Dr David Green, Director, Emergency Department, Gold Coast Hospital and Health Service: Emergency Department Time and Tide – the evolution of NEAT – an historical perspective
- Dr Mark Monaghan, Emergency Physician, Co-Director Fremantle Hospital Emergency Department: A discussion on the future of National NEAT targets
- Dr Clair Sullivan, Director of Physician Training and Endocrinologist, Metro South Hospital and Health Service and Dr Andrew Staib, Deputy Director, Emergency Department, Princess Alexandra Hospital: NEAT and the patient – all things in moderation
- Dr Glen Wood, Co-Chair, Queensland Clinical Senate Clinician Education and Training Working Party: Clinician Education and Training – report back

Appendix 2: QCS National Emergency Access Target working party members

A QCS meeting working party was established to prepare for the QCS meeting. Membership included:

- Dr Jason Acworth, Director, Paediatric Emergency Medicine, Department of Emergency Medicine Royal Children's Hospital, Children's Health Queensland Hospital and Health Service
- A/Professor Anthony Bell, Chair, Queensland Emergency Department Strategic Advisory Panel
- A/Professor Victoria Brazil, meeting Facilitator, Emergency Physician
- Dr John Burke, Emergency Physician, Royal Brisbane and Women's Hospital, Metro North Hospital and Health Service
- Dr David Green, Director, Emergency Department, Gold Coast University Hospital, Gold Coast Hospital and Health Service
- Dr David Rosengren, Chair, Queensland Clinical Senate; Director Emergency Centre, Greenslopes Private Hospital
- Dr Niall Small, Emergency Physician, The Townsville Hospital, Townsville Hospital and Health Service
- Dr Andrew Staib, Deputy Director, Emergency Department, Princess Alexandra Hospital, Metro South Hospital and Health Service
- Dr Clair Sullivan, Director of Physician Training and Endocrinologist, Princess Alexandra Hospital, Metro South Hospital and Health Service
- Dr Elizabeth Whiting, Director, Internal Medicine Services, The Prince Charles Hospital, Metro North Hospital and Health Service.