Australasian College
for Emergency Medicine

Policy Priorities
for emergency and acute health

NOVEMBER 2020 | BRIEFING DOCUMENT

About us

Australasian College for Emergency Medicine

The Australasian College for Emergency Medicine (ACEM) was established in 1981 and now has over 5,000 members, Fellows (known as 'FACEMs') and trainees. It is the peak representative body responsible for training of vocationally registered (specialist) and non-specialist emergency medicine doctors across Aotearoa New Zealand (NZ) and Australia, and the advancement of professional and clinical standards in emergency medicine. ACEM's mission is to ensure all patients receive the highest quality of medical care in hospital EDs.

ACEM is accredited by both the Medical Council of New Zealand (MCNZ), as well as the Australian Medical Council (AMC) on behalf of the Medical Board of Australia (MBA) to offer five emergency medicine programmes that includes a Fellowship (specialist), Certificate, Diploma and Advanced Diploma in Emergency Medicine, and a Diploma in Pre-hospital and Retrieval Medicine (PHRM).

There are currently 3,041 active Fellows of ACEM and 2,474 FACEM trainees across Australia and NZ. All FACEMs complete continuous professional development (CPD) through our accredited recertification programme in emergency medicine.

The Aotearoa New Zealand Faculty

The NZ Faculty is one of nine regional faculties of ACEM throughout NZ and Australia. The NZ Faculty comprises 338 active FACEMs and 226 FACEM trainees.

Contact details

Head Office
34 Jeffcott St
West Melbourne VIC 3003
Australia

+61 3 9320 0444
admin@acem.org.au

Wellington, NZ Office
Level 1, 114 The Terrace
Wellington 6011
New Zealand

(+64) 04 471 2333/4
acemnz@acem.org.au

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The artwork in this document

Ngā Rau o Tāne Mahuta –
The Leaves of Tāne Mahuta

Rain captured by a single leaf can nourish the pillars of Tāne Mahuta (God of the Forest) and the veins of Papatūānuku (the land, Earth Mother).

The pattern represents rain captured on a leaf and fed into the body of a tree to give it strength so that it may protect the younger shoots. The veins of Papatūānuku are the roots that nourish, care and give mauri to the life of Tāne Mahuta.

Executive summary

We look forward to working with you to ensure all patients receive the best care, in particular those requiring acute care in Aotearoa New Zealand.

Making a difference in emergency and acute health

Education, training and the workforce

In order to train and develop a steady supply of a skilled workforce, ACEM offers five accredited emergency medicine education and training programmes, from emergency medicine certificates and diplomas through to specialist Fellowships. We also facilitate CPD through an accredited recertification programme for all our members. While our specialist workforce supply is currently threatened/impacted by various factors, our top priorities to address this are:

1.1 Increasing the number of trainees and access to positions

1.2 Improving the wellbeing of emergency medicine doctors and building a sustainable workforce

1.3 Reducing the impact of COVID-19 on the current and future workforce

Emergency and acute care

With over a million presentations to EDs in NZ annually, we are continuously advocating for improved levels of acute patient care delivered in EDs, stressing that acute care is a continuum across the entire healthcare system.

Learning from the successes and failures of the last decade, we believe there is a need for the Ministry to re-focus on acute care to prevent avoidable harm to patients.

Although classified as secondary care, emergency medicine really sits in between primary and secondary care, and is therefore impacted by barriers and levers affecting both.

Consequently, our emergency and acute care policy and advocacy focus areas are nested within complex and emerging healthcare systems, and the communities we serve. These are listed on the following page.

2.1 Improving acute care access

The most significant issue EDs face is their inability to admit acute patients to hospital wards when their initial care in the ED is complete. The Ministry of Health Shorter Stays in Emergency Departments (SSED) time-based targets for public hospitals (implemented in 2009) required 95% of patients in public EDs to be admitted, transferred or discharged within six hours.

By 2015, DHB performances peaked at 85% receiving initiative care within six hours. However, Government's priorities soon changed and there was a steady decline in support for this work. Disappointingly, current DHB performances are as low as it was in 2009.

While we support the notion of access measures and time-based targets such as SSED targets, it must be accompanied with a quality framework and quality measures to achieve better quality health outcomes for patients presenting to the EDs. ACEM has endorsed a new set of acute care access measures that has been promoted bi-nationally.

We also recommend that, to ensure there is accountability for patient flow across different aspects of the hospital, ED lengths of stays (LOS) targets are set for different patient streams, specifically for admitted/transferred patient with separate measures for discharged and short stay units (SSU) patient streams.

2.2 The re-establishment of a National Acute Care Advisory Group

We strongly advocate for the re-establishment of a National Acute Care Advisory Group (NACAG) (Expert Group) within the Ministry. This will enable them to provide national oversight, leadership and strategic direction for acute care in NZ.

2.3 Mental health and addiction in EDs

Over the past few years, the number and type of mental health and addiction presentations to EDs have increased significantly – i.e. an increase in acute demand and increasing complexity of patients. Most presentations happen outside of 'office hours'. We support Government's plan to better manage mental health with alternative and home-based services in the community. However, Government must still ensure that EDs are properly resourced to manage with existing and future demand and address the dangerously long waits faced by people who need appropriate and compassionate emergency mental and addiction healthcare.

2.4 Addressing Māori health inequity

ACEM is committed to achieving equity for Māori patients, their whānau and staff in NZ EDs. Our Māori health equity strategy, *Te Rautaki Manaaki Mana* (Manaaki Mana), was launched in May 2019 and contains actions to grow, support and retain the Māori emergency medicine workforce that are culturally competent, and ensure our EDs are culturally safe.

2.5 Improved national data collection and reporting

Currently there is a scarcity of consistent national data sets in NZ. We need improved data, accurate reporting on patient health outcomes, and services provided in EDs. This will inform researchers and policymakers in setting national benchmarks and hold key decision-makers accountable for the provisions of ED care, with the goal of improved quality of care. Such transparency and accountability could also improve public confidence in acute and emergency are services.

A consistent national implementation of SNOMED CT would also require DHBs to have adequate assistance, funding and monitoring, to enable SNOMED CT to be rolled out to all DHBs in 2021. At present, many DHBs are struggling with the roll-out and implementation due to a lack of information and communication technology (ICT) resources and are unlikely to meet this deadline.

2.6 Resource stewardship, Choosing Wisely and Choosing Equity

ACEM has been actively involved in the advocacy for resource stewardship through the *Choosing Wisely* campaign, in both NZ and Australia. We continue to avidly promote its principles of equity to identify inequitable healthcare delivery, rational resource stewardship to reduce unnecessary and/or harmful healthcare practices and increase provision of care to those missing out.

We recommend an increased investment to expand and support the *Choosing Wisely* campaign (currently sitting with the Health Quality and Safety Commission (HQSC)) and related activities across all DHBs and all areas of healthcare.

We commend these priorities for your consideration.

Our policy priorities

1. Education, training and the workforce

Policy priorities

1.1 Increasing the number of trainees and access to positions

The delivery of the FACEM Training Program primarily occurs within hospitals. With support from ACEM, these hospitals provide teaching and learning opportunities and the clinical experience necessary for trainees to obtain Fellowship (their specialist qualification).

Training is a partnership between training sites, vocational (specialist) trainees, Fellows and ACEM. This partnership supports the provision of patient-centred care that is respectful of, and responsive to the preferences, needs and values of patients. This partnership is now under pressure.

To date, the Government has not adequately determined the actual emergency medicine workforce needs in NZ. It has been left to the discretion of DHBs to determine, and funds are not ringfenced. Due to competing priorities, emergency medicine workforce needs remain unmet, particularly in rural and remote communities[1].

While NZ now retains more of its own graduates than previously[2], government continually demands an increased number of registered specialists per year to meet the Organisation for Economic Co-operation and Development (OECD) average by 2021[3].

ACEM's trainee numbers have steadily increased since 2011, but access to training positions, and specialist positions (once trainees receive Fellowship), have not.

The introduction of the new ACEM trainee selection process and a moratorium on trainee intake at the end of 2017 resulted in a smaller increase in new trainees in 2018 and 2019[4].

Trainees who are able to secure a position (particularly in the larger Metropolitan DHBs), are often reluctant to apply for other temporary training positions in rural areas outside of their DHB as they would forfeit their permanent training position in their current DHB.

We would encourage solutions that allow trainees to gain essential experience in rural areas outside their DHB, even if only for shorter periods, like a six-month rotation at a time, without it negatively impacting on their permanent training position (e.g. for a six months rotation in Lakes DHB).

Only fifteen of the 20 DHBs have hospitals with ACEM-accredited EDs and are therefore deemed suitable to train FACEMs across NZ (see table at right). The remaining five are a priority for ACEM. While they may have FACEMs in their EDs, such DHBs usually depend on a workforce supply from General Practice or Rural Hospital Medicine doctors, which is not ideal or best practice. Research shows[5] that EDs staffed with emergency medicine specialists have better health outcomes for their patients in the ED.

The 20 District Health Boards and hospitals with an ACEM-accredited ED

District Health Board (DHB)	Hospitals with an ACEM-accredited ED
North Island	
Auckland District Health Board	Auckland City Hospital Auckland Starship Children's Health
Bay of Plenty District Health Board	Tauranga Hospital
Capital & Coast District Health Board	Wellington Hospital
Counties Manukau District Health Board	Middlemore Hospital (ED and their Paediatric ED)
Hawkes Bay District Health Board	Hawkes Bay Regional Hospital
Hutt Valley District Health Board	Hutt Hospital
Lakes District Health Board	Rotorua Hospital
Mid Central District Health Board	Palmerston North Hospital (accreditation visit due Dec 2020)
Northland District Health Board	Whangārei Hospital
Tairāwhiti District Health Board	-
Taranaki District Health Board	Taranaki Base Hospital
Waikato District Health Board	Waikato Hospital
Wairarapa District Health Board	-
Waitematā District Health Board	North Shore Hospital Waitakere Hospital
Whanganui District Health Board	-
South Island	
Canterbury District Health Board	Christchurch Hospital
Nelson-Marlborough District Health Board	Nelson Hospital Wairau Hospital (Provisional accreditation, visit due July 2021)
South Canterbury District Health Board	-
Southern District Health Board	Dunedin Hospital Southland Hospital
West Coast District Health Board	-

We recommend Government:

- **determines the emergency medicine/acute care workforce needs of NZ, in relation to the growing number of vocational (specialist) trainees. This would require a national workforce strategy across the whole sector.**
- **increases available emergency medicine position for trainees and Fellows, and associated funding across all DHBs.**

[1] https://www.aaem.org/UserFiles/file/novdeccommonsense-06_em-newzealand.pdf
[2] https://www.mcnz.org.nz/assets/Publications/Workforce-Survey/434ee633ba/Workforce-Survey-Report-2018.pdf
[3] https://www.newzealandnow.govt.nz/work-in-nz/nz-jobs-industries/healthcare-jobs
[4] https://acem.org.au/getmedia/974b8982-9e78-44ce-bfd2-12f1a7bab0b4/2019_FACEM_and_Trainee_Demographic_and_Workforce_Report
[5] https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients

1.2 Improving the wellbeing of emergency medicine doctors and building a sustainable of the workforce

ACEM commissioned an internal issues paper, *Future of the Emergency Medicine Workforce* (October 2020) which identified that the sustainability of the emergency medicine workforce is most adversely affected by burnout (due to workload and regular occupational violence experienced in the EDs), poor workplace culture, and system-level and employment status issues.

It also found that more FACEMs are reducing hours of clinical practice in favour of part-time work, or moving out of direct clinical work in the ED and into other clinical areas (e.g. retrieval, ambulatory care), or areas not involved in direct clinical care.

This is partly driven by FACEMs' experiences of ED overcrowding and access block* , which FACEMs have ranked as two of the top three workplace stressors and cause of moral injury to FACEMs.

Sixty-one per cent of FACEMs and 70% of trainees that responded to ACEM's 2019 *Sustainable Workforce Survey* reported that they are likely to reduce their hours of clinical practice in the next 10 years.

27% per cent of FACEMs and 15% of emergency medicine trainees reported they are likely to leave clinical practice in the next 10 years.

After consulting our members on the *Future of the Emergency Medicine Workforce* issues paper, ACEM will comlete a wider consultation and stakeholder engagement process. From there, ACEM will seek to discuss our findings and possible recommendations for addressing these workforce challenges with the Ministry of Health.

We recommend Government:

- **recognises the importance of emergency medicine doctors as a key part of its emergency and acute care response in NZ, and prioritises factors impacting on their wellbeing.**

*__Access block__ is the term used to describe an ED's inability to move patients to inpatient wards within eight hours from arrival at the ED to when their assessment and treatment in the ED is complete.

1.3 Reducing the impact of COVID-19 on the current and future workforce

Due to the COVID-19 pandemic, there has been a significant impact on national rotations, redeployment, rostering, and recruitment of specialist doctors and trainees. Other immediate impacts of COVID-19 on the emergency medicine workforce include the following:

Workforce health and wellbeing
Frontline healthcare workers see acute patients daily, and are therefore at a higher risk of contracting COVID-19. Compounding this, large numbers of staff are furloughed after contracting COVID-19, being a suspected COVID-19 case, and/or being a close contact of a confirmed or suspected case. This puts further pressure on those left holding the fort.

Progression through the FACEM Training Program
This is due to the impact of COVID-19 and the ability of Primary and Fellowship examinations to be undertaken without compromising the intergrity of the training programme or its assessment.

Increased workload and rostering challenges
This is due to the factors aforementioned, as well as a decrease in supply of overseas-trained medical staff. Many of them were scheduled to start in EDs in 2020, but due to the current international travel restrictions, were unable to do so.

We anticipate there may be a deficit with a historical reliance on international doctors to complement the NZ ED doctor workforce and the current and future COVID-19 travel restrictions in place. While it is still unknown how this will impact the broader emergency medicine workforce and service provision in the long term, this issue remains of significant concern to ACEM.

Overseas-trained professionals account for 41.5% of our total healthcare workforce in NZ.

To mitigate the risks arising from COVID-19, ACEM undertook a significant amount of work supporting its members during the pandemic. While some initiatives are listed below, they will continue to evolve, as we all fight this pandemic globally.

We recommend Government:

- **monitor workforce needs, given NZ's heavy reliance on overseas-trained doctors.**

ACEM's initiatives during the COVID-19 pandemic in 2020:

In March 2020, ACEM published its first set of *COVID-19 Clinical Guidelines for EDs in Australia and NZ*[6], a resource urgently developed to provide guidance to doctors across a range of subjects during the COVID-19 pandemic. Later versions also included guidelines for pandemic planning, triage and reception of patients, ED design, personal protective equipment (PPE), an ED-ambulance interface, and the 'New normal'.

The guidelines continue to be updated as a 'living document' to be in line with latest research and recommendations of the authoring group. It also includes a focus on improving Māori patient outcomes during COVID-19, following the release of a joint statement[7] with Tumu Whakarae and Te Ohu Rata o Aotearoa (Te ORA) on supporting Māori patients and whānau in EDs during COVID-19. The COVID-19 Toolkit for Rural Emergency Facilities in Australasia[8] has also been developed as a complementary companion resource.

ACEM conducted a number of webinars on a range of topics as the COVID-19 situation evolved globally and locally. These webinars are available on the COVID-19 Events page of the ACEM website[9].

ACEM held regular meetings with the NZ Faculty Board and members to share concerns, solutions and identify opportunities for ACEM to provide support. ACEM has undertaken significant advocacy with leaders in NZ, or more locally as required, to support members on issues such as PPE, COVID-19 testing and surveillance planning, information sharing and highlighting or addressing other workforce-related concerns.

A case-by-case approach was also adopted to support trainees and EDs impacted by the pandemic. Without compromising on quality medical education and training, some flexibilities were considered and given to ensure all trainees were able to progress through their training without delay.

[6] acem.org.au/Content-Sources/Advancing-Emergency-Medicine/COVID-19/Resources
[7] acem.org.au/News/April-2020/ACEM-Joint-Statement-with-Tumu-Whakarae-Te-ORA
[8] acem.org.au/getmedia/3ecc6790-6751-478a-9114-080040282476/Rural-Emergency-Toolkit-v1-0
[9] acem.org.au/Search-Pages/Events/COVID-19-Events

2. Emergency and acute care

Policy priorities

2.1 Improving acute care access

Acute care access failures such as extensive wait-times for admission due to access block, frequently result in poor health outcomes for patients presenting to the ED, including an increased risk of mortality. The management of these patients waiting to be admitted to a ward, accounted for just under a quarter of the NZ ED workload in 2019.

In addition to prolonging patient ED stays, access block prevents others from receiving the timely care they need and creates unnecessary burdens and costs for the healthcare system. More information on access block can be found on our website[10].

In 2009, under the leadership of Health Minister, The Hon. Tony Ryall, Shorter Stays in Emergency Departments (SSEDs) targets were introduced. These required 95% of patients to be admitted, transferred or discharged from the ED within six hours of arrival.

This was in response to sector demand to prevent a developing crisis in acute care, which saw prolonged stays of patients in EDs mainly due to significant delays to hospital admissions for acute patients leading to significant harm. It was hoped that DHBs would respond to the SSED targets with whole-of-system reform, including reducing inefficiencies in their hospitals and improving overall quality of acute care.

To facilitate this desired outcome, a national Emergency Departments Advisory Group (EDAG) was set up as a locus within the Ministry. It was chaired by Professor Mike Ardagh in his role as National Clinical Director for the ED programme, and supported by two senior advisors.

By 2015, most ED performances improved significantly. The average performance (according to the SSED targets) were 85% where patients spend less than six hours in the ED, from the time they arrived, to the time they were admitted, discharged or transferred.

Despite the ongoing increase in acute demand and complexity of patients presenting to the ED,

In two quarters of 2015, almost 95% of all ED patients were admitted, transferred or discharged from the ED in under six hours.

coupled with the challenges of dealing with an aging population, many aspects of the quality of care improved significantly. Scientific analysis showed that as a result of the SSED target, there was an improvement in both ED patient and elective patient mortality". It included a reduction in hospital length of stay (LOS), ED access block and the number of patients who left ED prior to receiving care[11].

However, the focus on the ED LOS target was not associated with improvements in all aspects of quality[12]. Anticipating these findings in 2014, the EDAG recommended a quality framework and suite of quality measures that DHBs should be addressing alongside the SSED target[13].

With the change in Health Minister in 2014, there was a significant reduction in ministerial support for SSED targets and the quality framework[14].

Since 2016, there was a gradual withdrawal of Ministry resourcing to support the SSED programme, including the informal dis-establishment of the EDAG, the downgrading of the National Clinical Director role and reduction from two senior ministry advisors, to now a single part-time advisor only.

This reduction cultivated the perception that there is no longer a specific locus with the Ministry providing national oversight, leadership and strategic directions for acute care in NZ.

The ongoing increase in complex acute demand, coupled with an exhaustion of 'quick fix' responses and resource constraints within DHBs, were also important contributors to the reduction in performance. As time passed, the early improvements in performance as a result of these 'quick fixes' plateaued.

Fundamental issues with strategic planning and hospital culture remains largely unchanged[15]. Performance has since dropped to dangerously low levels, last seen in 2009 (as starkly illustrated in the figure, over). This figure shows the change in patient LOS* by DHB from 2009 to 2020 and their deterioration to levels nearly as bad as in 2009. This shows all the initial SSED good work, has not been sustained.

There is good evidence in both NZ and Australia to show that measures like SSED targets can improve access block in EDs.

ACEM believes that a more carefully constructed set of time-based targets, applied to the ED but also actioned across the entire hospital system, will reduce the time spent in EDs and help move patients to definitive care more efficiently.

At present, DHBs are still required to report on their six-hour ED targets to the Ministry and are published quarterly. However, these are perceived as ED targets and not a reflection of the DHB's (whole-of-system) performance. Adverse outcomes within EDs are often the result of wider systemic issues within the hospital, and are therefore not effectively addresssed.

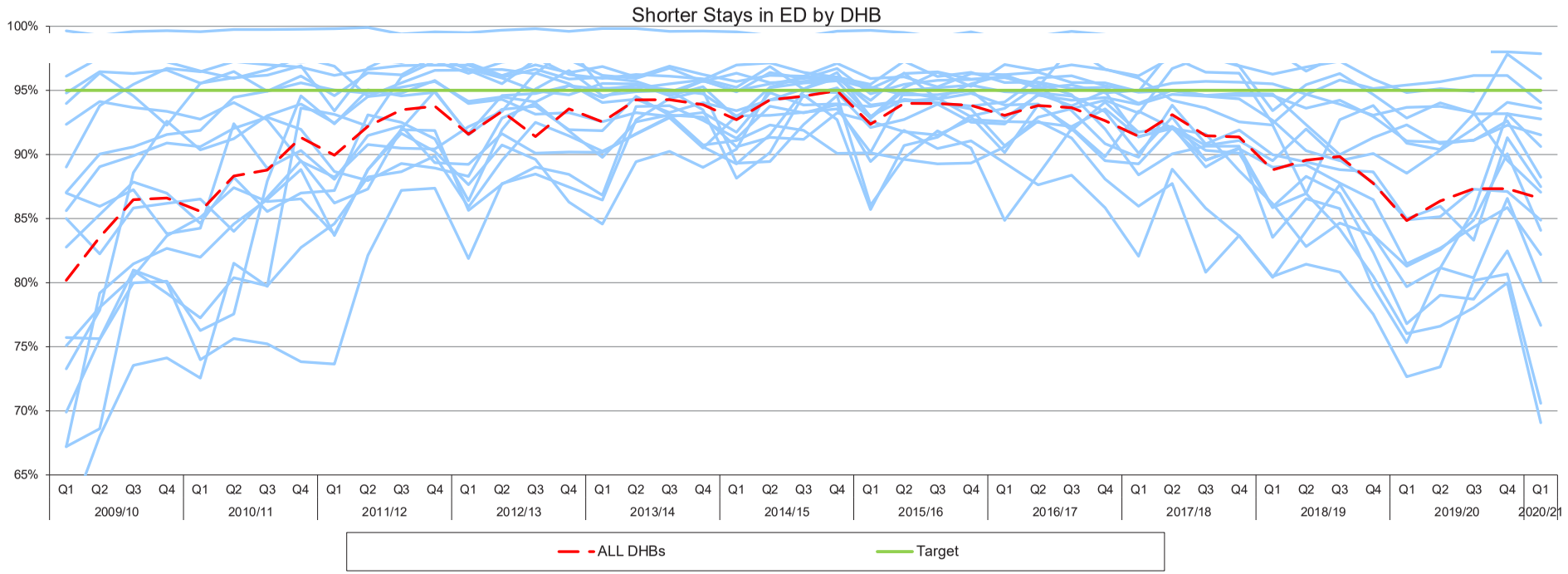
In 2019, ACEM endorsed a set of acute care access measures that has since been promoted bi-nationally[16]. In 2020, ACEM consulted its members on ED access measures (with time-based targets) to ensure there is accountability for patient flow across different aspects of the hospital.

ACEM recommends that ED LOS targets are set for different patient streams – specifically a primary measure for the admitted/transferred patient stream; and secondary measures for the discharged and short stay units (SSU) patient streams. SSUs consist of an area under the control of ED doctors, which are intended for short-term treatment, observation and re-assessment of patients. While they have been triaged and assessed in the ED and need a slightly prolonged stay, they do not need admission under an inpatient service. A common example of this is a patient that requires a period of observation (usually less than eight hours) before being discharged.

Admitted/Transferred Stream ED LOS[17] is the primary access measure, and is equivalent to 'time of admission/transfer' minus the 'arrival time'. Time of admission/transfer is the time whereby the patient physically leaves the ED to be admitted to an inpatient ward or transferred to another hospital or community care facility. Our specific recommendations for these access measures and its associated time-based targets are listed on page 13.

* ED length of stay (ED LOS) is defined as the time spent in the ED treatment area. It is measured as the departure time (physical departure from the ED) subtracted from the arrival time.

Short stays in EDs by DBH from 2010 to 2020



We recommend access measures with time-based targets:

Primary access measures for Admitted/Transferred patients:

- ≥60% ED LOS no greater than four hours from the time of arrival;
- ≥80% ED LOS no greater than six hours from the time of arrival;
- ≥90% EDLOS no greater than eight hours from the time of arrival; and
- 100% EDLOS no greater than 12 hours from the time of arrival.

As part of this primary access measure, we recommend:

- mandatory incident notification must be made to the hospital CEO for any Admitted/Transferred patient with an ED LOS greater than 12 hours.
- mandatory incident notification must be made to the Health Minister for any Admitted/Transferred patient whose ED LOS exceeds 24 hours.

Secondary access measures for Discharged patients for Discharged patients[18]:

The Discharge Stream EDLOS and SSU Admission Stream EDLOS are secondary measures. This is not to imply that these patients or measures are inferior to the Admitted/Transferred patient stream measure. Rather, it acknowledges the different patient flow processes for discharged and SSU admitted patients when compared to the Admitted/Transferred patient stream.

- ≥95% ED LOS no greater than six hours from the time of arrival; and
- 100% ED LOS no greater than 12 hours from the time of arrival.

As part of this secondary access measure, we recommend:

- mandatory incident notification must be made to the hospital executive for any Discharged patient with an ED LOS greater than 12 hours.
- mandatory incident notification must be made to the relevant Health Minister for any Discharged patient whose ED LOS exceeds 24 hours.

Secondary access measures for SSU Admission patients[19]:

SSU Admission Stream ED LOS is equivalent to 'time of SSU admission' minus the arrival time', where time of SSU admission represents the time that a patient arrives in the SSU for further assessment, treatment, and/or observation.

- ≥60% ED LOS no greater than four hours from the time of arrival;
- ≥90% ED LOS no greater than eight hours from the time of arrival; and
- 100% ED LOS no greater than 12 hours from the time of arrival.

As part of this secondary access measure, we recommend:

- mandatory incident notification must be made to the hospital executive for any SSU Admission patient with an EDLOS greater than 12 hours prior to SSU admission.
- mandatory incident notification must be made to the relevant Health Minister for any SSU Admission patient whose EDLOS exceeds 24 hours prior to SSU admission.

"GP-type patients in EDs are not the problem. These patients present with minor ailments, which are relatively quick to resolve without admission.

Access block is caused by an inability to admit acutely unwell or injured patients to hospital when their initial care in the ED is complete."

– Dr John Bonning
ACEM President

2.2 The re-establishment of a National Acute Care Advisory Group (Expert Group) within the Ministry of Health

One of the criticisms of the previous EDAG, was that its name suggested that solutions (and thus the problems) lay within the remit of the ED. In fact long ED stays relate more to a hospital's ability to cope with the competing demands for acute and elective patient admissions.

With a renewed focus on the continuum of acute care (instead of in EDs only), we strongly advocate for the re-establishment of a National Acute Care Advisory Group (NACAG Expert Group) within the Ministry.

Such national oversight, leadership and strategic direction will be able to highlight significant acute care quality concerns and be able to address it both promptly and effectively.

Whilst its membership would need to include emergency medicine doctors and ED nurses, it would also need to include others involved in acute care inpatient doctors and nurses or acute care doctors and hospital executives. We also recommend the Ministry considers including EM into other relevant emergency response expert groups, as EM expertise is often overlooked.

2.3 Mental health and addiction presentation in Emergency Departments

There has been a steady increase in acute demand and complexity of patients presenting to the ED. This has been seen particularly for those in mental health and addiction crisis.

Increased mental health presentations in EDs

ACEM recognises Government's ongoing commitment to mental health and wellbeing, and its increased investments in an attempt to address its historic underfunding in NZ. However, we remain concerned that the role of EDs in providing care to people presenting in an acute mental health crisis are overlooked.

Presentations to EDs of people with acute mental health needs are increasing rapidly in both relative and absolute terms across all age groups, particularly outside of traditional office hours when other services are unavailable. Disappointingly, the *He Ara Oranga: Government Inquiry into Mental Health and Addiction* report (2018) contained no specific recommendations in relation to EDs, acute and crisis care. However, EDs will often be a first port of call for many people in psychological distress, particularly out of office hours, and they need adequate resources to provide timely access to appropriate quality care.

Currently, patients requiring mental health treatment are often kept waiting longer than other patients in the ED for definitive care with or without admission. Their distress is compounded by the crowded, non-secure, noisy, brightly-lit ED environments and, when required, the use of restraint and seclusion.

These delays are due to a lack of mental healthcare resources dedicated to acute care, unavailable inpatient psychiatric beds, appropriate and timely community-based acute services, and the resourcing to fully assess and treat people in a mental health crisis.

ACEM supports initiatives to better mental health and provide the appropriate treatment in the community. This will prevent unecessary attendances to an ED.

Frontline staff in EDs have a unique perspective to contribute to the mental health system and will continue to have a core role in supporting such people in distress. ACEM's June 2019 *Communiqué on Mental Health in the ED in NZ*[20] and our September 2020 report, *Nowhere Else To Go*[21], contains further information and detailed recommendations.

ACEM recognises the importance of the planned additional services to manage mental health in the community. However, Government needs to increases its investment in psychiatric capacity and other resources within EDs. Appropriate EDs designs will also enable respectful, culturally appropriate, safe and compassionate treatment of patients presenting in a mental health crisis. ACEM hopes to work with the Ministry of Health on this.

Increased alcohol and drug-related presentations
As with mental health, EDs are also at the forefront of responding to and treating the consequences of alcohol and other drug (AOD)-related harm which has a significant effect on other patients, workforce morale, and the functioning of EDs.

ACEM's 2019 *Alcohol and Other Drug Harm Snapshot Survey*[22] (published in 2020) found that 16% of all NZ ED presentations at the time of surveying were alcohol harm-related and 1.9% were related to methamphetamine use (more than double the proportion seen in previous years). During AOD peak patient presentation times (particularly Friday and Saturday nights), up to one in three patient presentations are associated with alcohol.

Not only does this affect ED function, the associated verbal and physical assaults on staff significantly impact staff wellbeing and has a negative impact on the care of other patients.

In a recent survey, almost all (98%) ED clinical staff had experienced alcohol-related verbal aggression from patients in the past 12 months, with 92% experiencing physical aggression.

More than 80% of ED clinical staff also felt that alcohol-related presentations adversely affected patient wait-times, other patients waiting to be seen, and the care of patients within the ED.

92% of ED clinical staff experienced physical aggression.

ACEM supports an approach which minimises harm and centres on people-focused policies and interventions which recognise the socio-economic and cultural context of context of AOD care. We do not support prohibitionist and punitive approaches, and welcome recent investment into alcohol and drug services.

In the past 12 months, 98% of ED clinical staff experienced alcohol-related verbal aggression from patients.

We recommend Government:

- **invests in appropriate ED resources that includes improved models or care integrating mental health, general medical, and AOD/ toxicological care. This will ensure patients receive appropriate continuity of care after being discharged from the ED**.

2.4 Addressing Māori health inequity

ACEM has made a commitment to achieving equity for Māori patients, their whānau and staff in NZ EDs. ACEM's Māori equity strategy, *Te Rautaki Manaaki Mana (Manaaki Mana)*[23], was launched in May 2019. *Manaaki Mana* has a particular focus on ensuring te Reo me ngā tikanga Māori is embedded in ED practice. It also contains actions to grow, support and retain the Māori emergency medicine workforce.

Currently only 3.6% of FACEM trainees in NZ identify as Māori[24]. We recognise that a strong Māori ED workforce is fundamental to realising our vision for health equity in NZ. All trainees that identify as Māori, are invited to join ACEM's Indigenous mentorship programme and Māori Champions (ngā kaikōkiri) have been appointed to most EDs across NZ.

The first stages of a companion resource, *Te Kete Rauemi mō ngā Kaikōkiri (The Champions Resource Kit)*[25] have been published on our website to provide them with a network and additional support.

In 2020, ACEM signed a partnership agreement with Te Ohu Rata o Aotearoa (Te ORA) and has representatives on the CMC's Interdisciplinary Māori Advisory Group Meeting (IMAG). We also made the appropriate equity reform to our constitution[26] to reflect and support this important work.

However, all Medical Colleges and their Māori advisory partners are required to resource these initiatives themselves. Similarly, the majority of Medical Colleges are bi-national Colleges (Australian and NZ/ Australasian). With a limited footprint in NZ, their ability to roll-out and provide appropriate cultural competence training and support is reduced. It could be strengthened with national oversight, leadership and financial support across all scopes of practices, and DHBs in NZ.

We recommend Government:

- **increases resources to support and enhance culturally safe EDs, and to develop a culturally competent workforce.**

2.5 Improved national data collection and reporting in EDs

Currently there is a paucity of national and consistent data sets for emergency and acute care in NZ. This makes it difficult to set national benchmarks regarding what care is appropriate to provide in EDs and to hold decision-makers accountable for ED presentation numbers, waiting times, access block, and addressing those issues affecting our vulnerable populations.

ACEM seeks improved multi-level data on patients and their presentations within EDs. This would include data regarding mental health prevalence, the services provided, and outcomes to assist our understanding of their healthcare requirements.

We also support the implementation of SNOMED CT as a national dataset of ED attendances to accurately monitor what occurs in EDs

At present, many DHBs are struggling with the roll-out and implementation due to a lack of information and communication technology (ICT) resources and are unlikely to meet the mid-2021 deadline.

Government must support, fund and monitor DHBs to ensure its national implementation is both consistent and effective.

We recommend Government:

- **improves its current data sets to ensure they are accurate, usable and timely to inform policy-makers to set national benchmarks and hold decision-makers to account.**
- **supports, funds and monitors the national implementation of SNOMED CT across all DHBs.**

2.6 Resource stewardship, *Choosing Wisely* and *Choosing Equity*

ACEM is actively involved in the advocacy for resource stewardship[27]. As an executive CMC member, ACEM played a key role in the *Choosing Wisely* campaign[28], and continue to do so. This is done by identifying unnecessary and/or harmful healthcare practices that either need to be avoided or decreased due to low evidence of effectiveness and/or increased risk of harm to patients.

Introduced in 2015, *Choosing Wisely* is an international campaign, including every speciality in medical care with participating organisations from Canada, the United Kingdom, Europe, and the United States. In NZ, *Choosing Wisely* was established and run by the CMC, but has been transferred to the HQSC in 2020.

Choosing Wisely is doctor-led and patient-centred with an aim at improving quality healthcare by promoting elimination of low value, inequitable, inappropriate and/or harmful healthcare interventions. Research identified that large numbers of low value healthcare practices continue to be supported and publicly funded. Examples include radiological imaging for lower back pain, and numerous practices around laboratory testing such as coagulation tests. Several DHBs have funded *Choosing Wisely* co-ordinators to manage their DHB's initiatives with significant resource saving shown.

Recommendations[29] from *Choosing Wisely* have already had an impact in NZ. Several hospital EDs reporting a reduction in unnecessary blood and urine tests, as well as decreased use of intravenous cannulae, both of which have been identified in some circumstances as being of limited patient benefit. While the principal aims of *Choosing Wisely* is to rationalise care, it must not be branded as a cost-cutting exercise, rationalising not rationing. Rather, *Choosing Wisely* allows considerable re-investment of resources in better value healthcare.

In 2020 the *Choosing Wisely means Choosing Equity* report also focussed on Māori health equity. Māori continue to experience marked inequities in health outcomes, access and satisfaction. Māori children and adults are more likely (than non-Māori) to experience unmet need for primary care, having difficulty with getting appointments at their usual medical centre within 24 hours, not being able to attend due to cost or transport issues, and to miss out on medication because of cost.

Māori receive fewer tests and referrals; are less likely to get satisfactory explanations or answers to questions or feel listened to by health professionals; and are more likely to experience racism/discrimination. By accepting this, we are not *Choosing Wisely* or *Choosing Equity*.

We recommend Government:

- **fosters ongoing collaboration between the Ministry, the HQSC, medical specialties and regulators to continue the expansion of the principles of *Choosing Wisely (and Choosing Equity)*, and its message of appropriate healthcare resource stewardship.**
- **increases its investment to expand and facilitate the *Choosing Wisely* campaign and related activities across all DHBs and areas of healthcare.**

[10] acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Better-Outcomes-for-Patients/Access-Block.
[11] Jones, P; Wells, S; Harper, A; Le Fevre, J; Stewart, J; Curtis, E; Reid,P; Ameratunga, S. 2017. Impact of a national time target for ED length of stay on patient outcomes.New Zealand Medical Journal, Vol. 130, Nr 1455: 15-34. New Zealand Medical Association.
[12] Jones, P; Le Fevre, J; Harper, A; Wells, Stewart, J; Curtis, E; Reid, P; Ameratunga, S. 2017. Effect of the shorter stays in EDs time target policy on key indicators of quality of care. New Zealand Medical Journal, Vol. 130, Nr 1455: 35-44. New Zealand Medical Association.
[13] www.health.govt.nz/publication/quality-framework-and-suite-quality-measures-emergency-department-phase-acute-patient-care-new
[14] EDAG. 2014. A quality framework and suite of quality measures for the ED phase of acute patient care in NZ. Wellington: Ministry of Health.
[15] Tenbensel, T; Chalmers, L; Jones, P; Appleton-Dyer, S; Walton, L; Ameratunga, S. 2017. NZ's ED target – did it reduce ED length of stay, and if so, how and when? BMC Health Services Research, Vol. 17:678.
[16] ACEM (2019) Guideline G554 – Emergency department short stay units. Melbourne: ACEM. Available from: https://acem.org.au/getmedia/08df119c-9625-4fe1-b420-6d768d1e80ff/G554-%20Guidelines-on-Emergency-Department-Short-Stay-Units_for-web.
[17] Acknowledging the Admitted/Transferred Stream EDLOS targets differ between NZ with a six-hour target and Australia with a four-hour target.
[18] We acknowledge that the SSED in New Zealand aims for ≥95% of discharged patients to have an ED LOS of no greater than six (6) hours.
[19] These recommendations are not for the length of time a patient spends within the SSU. This is referred to in ACEM's *Guideline on Emergency Department Short Stay Units.*
[20] acem.org.au/getmedia/155a3761-26a8-4b03-82e9-8a39d2e9fb25/ACEM-Draft-Communique-on-Letterhead-7-June-2019-1
[21] acem.org.au/nowhereelsetogo
[22] acem.org.au/getmedia/f7bec2c4-6573-471f-8cf4-f9a0bc466506/Alcohol-Snapshot-Report_R6
[23] acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Achieving-Equity-for-Maori-in-Aotearoa-New-Zealand
[24] acem.org.au/getmedia/974b8982-9e78-44ce-bfd2-12f1a7bab0b4/2019_FACEM_and_Trainee_Demographic_and_Workforce_Report
[25] acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Indigenous-Health-and-Cultural-Competency-Resource/Kete-Rauemi-mo-nga-Kaikokiri-Champions-Toolkit
[26] acem.org.au/getmedia/66230b2a-3aa4-40e1-960e-d75bffd5015f/Constitution
[27] acem.org.au/getmedia/3a246ebd-a786-4026-ba2d-59bf55c4d715/P435_Resource_Stewardship_AUG_15.aspx
[28] choosingwisely.org.nz/
[29] choosingwisely.org.nz/choosing-wisely-means-choosing-equity-research-report/

Our leadership

Dr John Bonning, FACEM
President

Dr Bonning is the current President, having been elected for a two-year term commencing in late 2019. He is first New Zealander to hold this role, and also chairs the Council of Medical Colleges (CMC). Dr Bonning is based in the Waikato DHB.

Dr André Cromhout, FACEM
NZ Faculty Chair

Dr Cromhout is the Chair of the NZ Faculty of the ACEM. He is based in the Capital and Coast DHB.

Dr Kate Allan, FACEM
NZ Faculty Deputy Chair

Dr Allan is the Deputy Chair of NZ Faculty. She is based in the Waitematā DHB.

Australasian College for Emergency Medicine
34 Jeffcott St
West Melbourne VIC 3003
Australia
+61 3 9320 0444
admin@acem.org.au

acem.org.au

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