

## **Summary of consultation: Guidance for New Zealand emergency departments regarding the interface with primary health care**

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The document *Guidance for New Zealand emergency departments regarding the interface with primary health care* (the guidance paper) was developed by the Ministry of Health's Shorter Stays in Emergency Departments (ED) team after it became apparent from interactions with the sector that there are varying perceptions of what the interface between EDs and primary care should look like and how it should operate. As a consequence, disagreement and confusion have arisen on issues such as 'inappropriate' ED attendance, 'triaging away' from the ED and whether EDs duplicate care available in primary care.

The guidance paper is intended to provide some guiding principles for those who develop and deliver hospital ED services about how they should relate to and interact with primary health care.

Initial consultation on the guidance paper was sought from the ED Services Advisory Group, the Australasian College of Emergency Medicine and the Royal New Zealand College of General Practitioners. Following this a draft version of the guidance paper was made available for wider consultation in May 2010.

Feedback was received from a range of individuals and organisations and was generally supportive of the paper and in agreement with the principles outlined. However, some concerns and suggestions were noted. This document provides a summary of the feedback and advises whether it has resulted in a final change to the guidance paper.

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### **Individuals and organisations that provided feedback during the consultation period:**

#### *Professional colleges/organisations:*

- Accident and Medical Practitioners Association
- College of Emergency Nurses New Zealand
- College of Nurses Aotearoa
- Health & Disability Commissioner
- New Zealand Medical Association
- Royal New Zealand College of General Practitioners

#### *District Health Boards (DHBs):*

- Auckland DHB
- Bay of Plenty DHB
- Counties Manukau DHB
- Lakes DHB

- MidCentral DHB
- South Canterbury DHB
- Southern DHB
- Waikato DHB
- Waitemata DHB

*Individuals/groups:*

- Auckland GP
  - ED Clinical Director, Christchurch ED
  - ED Director, Whanganui DHB
  - ED Physician, Christchurch Hospital
  - GP and Head of the Emergency Department, Hawke's Bay DHB
  - GP Leaders, Capital & Coast DHB
  - GP Liaison, Taranaki DHB
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**Summary of feedback:**

***General***

Concern was raised about the use of terms such as 'best suited', 'best undertaken', 'best care' etc and it was suggested that this be replaced by 'more/most appropriate' or similar.

Response: We have tried to avoid using the term 'appropriate' as we believe that interpreting what is 'appropriate' has contributed to much of the current debate.

Given that the principles of the paper include that primary health care is the principal provider of routine and urgent health care to the New Zealand population and that all urgent health care should be provided within the framework that the patient will, as much as possible, receive their ongoing care from primary health care, we consider that where we have described primary health care as being 'best' or 'better' suited that this is accurate.

A comment was made that in attempting to view all sides of the argument that the guidance paper is at times ambiguous and fails to deliver firm recommendations.

Response: We considered it important that the guidance paper try to respect, as much as possible, the different perspectives on this issue. The intention of the guidance paper is to provide a general framework that can be used as a reference in local discussions on how to arrange and deliver services.

Comments were also made that the guidance paper does not address deeper issues in the New Zealand health system, including within primary health care.

Response: We did not consider it appropriate or within the scope of the guidance paper to comment on issues relating to the wider health system or primary health care.

Concern was raised about the level of primary health care input into the guidance paper.

Response: Although input was sought from primary health care, including the Royal NZ College of GPs and the Ministry's Primary Health Care Implementation team, it is acknowledged that this guidance paper has been developed from an ED perspective. For this reason, it is directed at the providers of New Zealand's hospital ED services and we encourage them to engage with their local primary health care providers to discuss how these principles might compare to and inform how services are arranged and delivered locally.

Various comments were made along the lines that the requirement for 'further clinical assessment, over and above triage, to determine the primary health care is better suited to meet the patient's needs' defeats the purpose of referral to primary care; that there is no confidence that the approach will stem the rising tide of ED attendances; that in actual practice returning to a situation where ED is not seen as the main alternative to the GP for minor problems will be difficult; and that determining if a patient can be better managed in primary care will be a time consuming process and therefore referral to primary care won't necessarily lead to any reduction in demand/overcrowding.

Response: The focus of the guidance paper is not on reducing ED demand and its purpose is not to endorse a process to turn away some patients who present to the ED. Rather the guidance paper is intended as a guide to how EDs should relate to and support primary health care. As part of this we consider long-term strategies to reset expectations and understanding of the public about the respective roles and skills of both ED and primary health care and when it is appropriate to access each as important. In respect to the Shorter Stays in ED health target, any decision to 'refer' patients to primary care should be carefully thought through and should not be expected to reduce the workload of the ED in the short-term. Paragraph 4.6 has been changed to more clearly state this.

There was a comment that the guidance paper is 'wordy' and at times this results in ambiguity.

Response: Changes have been made to the document generally to try and make it clearer and more direct.

### ***Section 1: Defining the roles and relationship between ED and primary health care***

In general, there was good support for the distinction made between primary health care and ED care.

It was queried whether the guidance paper should refer to PHOs.

Response: We decided on no change at present as PHOs are currently an important primary health care structure and the paper does state 'enrolment with a PHO *through a primary health care provider...*'.

Comment was made that accident and medical clinics provide facilities and a skill set which help to bridge the gap between primary health care and EDs and that it would be useful to make a statement on their role.

Response: We have not made specific reference to Accident & Medical (A&M) clinics within the guidance paper as we consider A&Ms to be more of an urban occurrence and our intention is to keep this paper as nationally relevant as possible. We also consider A&Ms to come under the term 'primary health care provider'.

A number of submissions suggested that reference be made to the requirement of PHOs/primary care to provide 24/7 care to their enrolled populations, and the need for DHBs and PHOs/primary care to look at the provision of acute and urgent care, particular after-hours.

Response: While these comments were noted we did not consider it appropriate to make comment on this within the guidance paper.

Request to use the term 'emergency' rather than the "overly dramatic" 'crisis' in paragraph 1.5.

Response: No change; the term 'emergency' also has disadvantages, including that there are individual interpretations on what constitutes an 'emergency'.

## ***Section 2: Referring patients from ED to primary health care for ongoing care***

There was a suggestion that *all* patients should be referred directly back to their GP after discharged – that is, unless the situation is urgent, referral on to a specialist should be done by the GP following receipt of a recommendation from ED.

Response: No change; we expect that to the extent that this can happen it is already happening. We do support the reconnecting of patients back to their usual primary health care provider and the prompt transfer of appropriate clinical information after any ED or hospital attendance and feel that this is covered by sections 2 and 3.

It was clear from a number of submissions that greater clarity was needed around the expectations of referral from ED to primary health care.

Response: Change to paragraph 2.3 (previously 2.4) to state that EDs should be clear about what the expectation is of primary health care.

## ***Section 3: Connecting patients back to primary health care following an ED attendance***

A request was made for hospitals and EDs to be encouraged to routinely send a copy of the discharge summary/letter to the referring doctor, as well as the patient's GP, if these differ. The rationale for this suggestion is that this would assist with the referrer's ongoing medical education with the referrer comparing their findings with those of the hospital.

Response: While reference to this has not been included within the guidance paper we consider this to be a potentially worthwhile suggestion and encourage DHBs to consider how they can support feedback to other health care providers (e.g. A&Ms) on the outcome of their referrals.

It was suggested that reference be made to the patient responsibility to follow the instructions given by the ED staff regarding follow-up with the GP.

Response: No change; this document is intended for ED and hospital providers rather than the public and so it is not considered useful to include reference to the patient's responsibilities.

Several commented that current IT systems do not adequately support the principles of the guidance paper and/or that improved IT systems are needed.

Response: This is probably a fair comment and we hope that the guidance paper encourages DHBs (and others, including the Ministry) to consider how IT systems might be improved so that they are better able to facilitate the flow of patient information.

Paragraph 2.5 has been integrated into this section to avoid repetition in the guidance paper.

#### ***Section 4: Identifying and referring patients for whom primary health care is best suited to meet their needs***

There was significant comment on paragraphs 4.1 and 4.2 about why individuals present to ED and/or why they might not access primary health care and the level of impact this has.

Response: We acknowledge that there are a variety of views on this issue, largely because the impact and likely causative factors vary from place to place. We have tried to provide a national view.

There was general support for paragraph 4.3 and that triage should not be used to assess the 'appropriateness' of patient presentations to the ED. Slight changes have been made to this paragraph to make it clearer, including stating what triage is about (rather than just what it isn't),

There was some disagreement about what level of action is required before a patient can be referred to primary health care, as per paragraph 4.4.

Response: While the intention of the guidance paper is to provide guidance on when and how patient's who present at ED may be able to be referred to primary health care for treatment or ongoing care, ensuring patient safety is obviously critical. We also draw reference to the *Tier One Emergency Department Services Service Specification* (available of the Nationwide Service Framework Library <http://www.nsf.health.govt.nz/>) which states, under section 4 'Access': "Emergency Departments should contribute to public education and the development of systems which allow patients to access the most appropriate care, but should not deny care to those who seek it." We

believe that the minimum requirements outlined in the guidance document are necessary to ensure that these factors are met.

Comments were made that the scope of the 'appropriate clinical assessment' should be defined.

Response: The previous paragraph 4.5, and other additional wording, has been incorporated into paragraph 4.4 to try and respond to this. However, we continue to try and avoid being too prescriptive and our view is that DHBs that wish to implement a process to identify and refer patients whose needs can be met by primary health care should work with their ED staff, primary health care and consumers to agree on a process that all are comfortable with.

One submission that we considered insightful stated: "There is a difference between offering alternative services that may have a shorter wait as an option, as opposed to triaging away or making people feel as though they should not be there".

There was a comment that referral from ED to cardiology etc. is not 'facilitatory' and therefore why should this soft approach apply to primary care?

Response: Because referral to primary health care has cost, location, availability and other implications associated with it that referrals into the hospital, such as to cardiology services, do not.

### ***Section 5: Improving access to acute hospital services***

This section, including its title, has been somewhat overhauled to make it clearer and more logically fit within the overall guidance paper.

There were a few of suggestions that the guidance paper should refer to specific high risk areas such as residential aged care and mental health.

Response: Paragraph 5.4 (previously 4.7) has been changed to include a reference to improving health care services to the elderly.

A comment was made that some criteria is needed around what is appropriate for referral into inpatient referral.

Response: We agree and expect that this would be developed at the local DHB level.