New Zealand
SOCIETY OF
Anaesthetists

Wednesday 23 November 2022

Dear
Rt Hon Andrew Little, Minister of Health
Margie Apa, CEO Te Whata Ora
Riana Manuel, CEO Te Aka Whai Ora
Fionnagh Dougan, National Director, Hospital & Specialist Services, Te Whatu Ora
Dr Peter Watson, Interim Medical Lead, Te Whatu Ora

Re: **Feedback on planned care taskforce reset and restore plan**

Thank you for the significant amount of work that has been put into this comprehensive review of the current state of planned care in Aotearoa and for the resultant recommendations you have made.

This letter offers our feedback on the reset and restore plan. We believe this feedback is an example of the value we can add and look forward to providing meaningful feedback with future working groups. Anaesthesia is the largest single collective specialist group, and it is our hope to be a part of the specialist services group establishing the strategic clinical networks on health priorities in relation to hospital services and elective services.

There are many recommendations within the plan that we commend, including those focussed on providing equitable care for the people of Aotearoa. We also appreciate the acknowledgment that system capacity, staff shortages, acute care demands, and higher admission numbers significantly impact the volume of planned care work being undertaken currently. This resulting in planned care not meeting current demand and most certainly not addressing the backlog.

We believe that the lack of Anaesthesia and Perioperative Medicine input into this working group has led to gaps and omissions within the review. Anaesthetists touch every aspect of planned surgical care across all surgical subspecialties. We have a unique overview of the entire planned care workload, and many Anaesthetists work closely with planned care coordinators and management teams to ensure processes are optimal.

We were pleased to hear recently from Minister Little and his recognition that specialist groups such as ours will be essential in the on-going work towards the development of the taskforce's recommendations.

Comments

5 - Equitable Care
We commend the recommendations within this section. Specifically:

- The collection of reliable and useful data that allows reporting, monitoring and correction of inequity in access and delivery of planned care. If we are not routinely collecting ethnicity data, how can we begin to address these disparities?

- The recommendation to develop standardised recommendations in relation to BMI, HbA1c and smoking requirements prior to planned care is essential. The current use of arbitrary and inconsistent cut-offs for these parameters contribute to access barriers that enhance inequity for our Māori and Pacific populations. We recognise that there is work currently being done in the Bay of Plenty to deliver a targeted Māori Health Intervention for management of difficult to control diabetes. This is a collaborative project between Anaesthesia, Diabetes Nurse Practitioners, and Māori Health and could be used to model care nationally.
- Changing the management of bookings for patients that 'do not attend' or are uncontactable. Routine removal of such patients from elective wait lists, without consideration to the barriers preventing attendance or contact further promotes inequity. We agree that more thought needs to go into how to locate and engage these patients.
- The prioritisation of Māori and Pacific patients who are currently on the waiting list for planned care. Expedited access for these patients is essential if we are to begin to address the inequities that have been further enhanced due to the pandemic.

In addition to cultural inequity, it is our recommendation that gender inequity in the delivery of planned care is actively reported on and addressed. Service provision must be adequately funded and resourced to meet the need for the Women of Aotearoa. For example, in planned care, we would recommend the separation of obstetric (often urgent/emergent) and elective gynaecological surgical streams to minimise interruptions to gynaecological planned care.

6 - Planned Care Overview

As highlighted in the plan, it is essential that there is a robust system in place for data collection that will allow monitoring of indicators such as referrals seen, imaging waiting lists and FSA timings all in real-time. There must be agility in the system to allow interventions to be implemented and changes in measures to be seen in a timely manner.

Two areas where separation of acute and elective services would be hugely beneficial are orthopaedic and gynaecological services. It is not surprising that elective orthopaedic surgery has a large waiting list. The constant interruption to elective services from the acute orthopaedic workload in the public service means that it is challenging to receive elective surgery. Hip and knee arthroplasty, in particular, are procedures that provide great benefit to patients by reducing disability, improving function and often enabling return to work. Similarly gynaecological services have an immense backlog, with primary care referrals effectively having ground to a halt in some regions. The burden on quality of life for women in Aotearoa is significant.

It is crucial that waiting list targets are managed appropriately and consistently and that regional variations in waiting list targets are eliminated. We have seen the threshold for additions to a waiting list being elevated to keep the waiting list numbers in check. This does not provide the care our people deserve.

Improving clinical pathways and incorporating the use of alternative providers such as Nurse Practitioners will be valuable. We do recognise that these workforces are also in a critical state at present.

7. Interventions

Perioperative Care and Prehabilitation

Included in the reset and restore plan should be the improvement of perioperative processes. Careful preoperative optimisation and planning must become routine to ensure our patients have the highest quality surgical journey. Discharge planning should be considered at the time of

contemplation of surgery. Postoperative complications are both expensive and result in significantly prolonged hospital stays, limiting bed availability for future patients.

Three key areas where we can see potential to reduce perioperative complications are:

- **Preoperative optimisation of modifiable risk factors**
  Evidence is emerging for comprehensive packages of care including modification of risk factors such as smoking and alcohol consumption, nutrition optimisation, exercise interventions, and optimisation of chronic health conditions such as anaemia and diabetes. Time of surgery is recognised as a 'teachable moment', a point in time when a patient may be more motivated to change their behaviour. There is potential for long lasting, lifelong improvement in health going forward.

- **Preoperative risk stratification and shared decision making**
  Ensuring patients are receiving procedures that are evidence-based and consistent with their values and life goals: right patient, right surgery, right time. We recommend that all surgical departments have a shared decision-making process in place. Where a recommendation is made to not proceed with surgery there must be alternative care pathways e.g., pain clinics, palliative care, or allied health programmes. Risk stratification will also assist with appropriate resource allocation e.g., HDU beds

- **Early identification and management of complications**
  There is currently a gap in the provision of postoperative care for high-risk patients in Aotearoa. Promising initial data from Professor Guy Ludbrook's group at the Royal Adelaide Hospital (not yet published) is likely to show a significant reduction in postoperative complications with their Advanced Recovery Room Care model. This is likely an area where significant improvements can be made in the future.

- **A national benefit of care models**
  In addition, we would value seeing a commitment to ensuring benefit of care - national guidance on what procedures should be prioritised, using an evidence-based approach. It may be that not all procedures currently offered can (and/or should) continue to be delivered in our public health system.

Within the recommendations for intervention is a large increase in the remit of primary care. Our concern is that increasing the load of primary care physicians may have further implications on existing primary care services, which are already stretched and under-resourced.

7.13 – Intervention

We question the relevance of the data produced by Ernst Young. There are many factors that contribute to underutilisation of theatres for example staff shortages (theatres may not have run at all or sessions may have been cut short) and bed shortages (meaning elective cases are cancelled – often at the last minute). It is not necessarily true that these gaps represent missed opportunities to provide further operative care. Perhaps, more importantly, planning to run lists to finish at the very end of the session time will result in at least an equal number of late finishes to early finishes. Late finishes have significant implications to staff wellbeing but also to patient safety. Delivering patients to PACU and then to the ward after hours is associated with higher complication rates than 'in hours' care, as well as compromising out of hours acute care capability.

7.15 - Private sector capacity
The recommendation for private commissioning may not be sustainable, and it comes with risks. We reiterate the risk mentioned (page 51) of the potential impact on public workforce capacity.

This also comes with the risk of further exacerbating inequities. To mitigate this, outsourcing guidelines and criteria must be in place and attempts made to discourage or disenable 'cherry picking' of patients if this recommendation is taken forward. By the current nature of the facilities housed in private hospitals, straightforward patients are most likely to be selected for outsourcing and receive surgery sooner (it is often Māori and Pacific patients that have comorbidities that preclude them from outsourcing).

7.18 – Facilities
We strongly agree with the recognition in the plan that the "*separation of planned care resources from acute care resources offers greater opportunity of uninterrupted service delivery*." Any long term and equitable solutions need to include dedicated facilities for both acute and elective care in each region. Facilities that are built for purpose, developed to serve their locality, and fit for population growth in that specific region especially when population growth is in excess of the national average.

Planning needs to begin now both for these physical facilities and, more significantly, the workforce they will require.

7.14 – Follow ups
The focus on eliminating unnecessary follow ups is very reasonable, as long as there is a system to ensure essential follow ups are not missed. As is the utilisation of phone calls and virtual tools to save time and increase convenience. We agree the 'virtual/phone advice as required' model is one that should be looked at closer for widespread adoption for best accessibility nationwide.

Workforce
Whilst we appreciate workforce planning is beyond the scope of this taskforce we stress that the two are intrinsically intertwined and their planning cannot be exclusive to ensure any recommendations are effective and resilient.

Conclusion
As outlined above there are many aspects of the reset and restore plan we commend, and we hope through our comments we have demonstrated our desire to provide meaningful feedback going forward and the additional perspectives that can be provided with the inclusion of Anaesthesia representation in future working groups.

Nga mihi nui,
Dr Morgan Edwards, President NZSA

About the New Zealand Society of Anaesthetists (NZSA)
The NZSA is a professional medical education society which represents over 760 anaesthetists in New Zealand. Our members include specialist anaesthetists in public and private practice, specialist

pain medicine physicians (SPMPs), and trainee anaesthetists. Our key roles are advocacy, facilitating and promoting education, and strengthening networks of anaesthetists nationwide.