

Targeting More Elective Operations

Improved Access to Elective Surgery

Our target: The volume of elective surgery will be increased by an average 4000 discharges per year (compared with the previous average increase of 1400 per year).



Improved
access to



Elective Surgery



Providing improved access to elective surgery



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Improved access to elective surgery is a Government health target

Thousands of people undergo operations each year in surgical theatres around the country. Some of these operations are unplanned (for example, the result of an accident), but others have been scheduled as part of a patient's ongoing medical treatment plan. The planned operations are called elective surgery.

Elective surgery is for patients who do not need an operation right away, and the Government wants people to have more access to this form of surgery.

All countries with publicly funded health care systems have to prioritise their health spending so that people get the treatment they need. Advances in technology and medicines coupled with the fact people are living longer means the demand for elective services, including surgery, is expected to continue growing. New Zealand is not alone in having limited taxpayer funding available for elective services.

New Zealand's frontline clinicians and the district health boards (DHBs) they work for are coming up with innovative solutions to improve access to elective surgery.

The elective surgery health target requires DHBs, which run the country's public hospitals, to ensure that:

The volume of elective surgery will be increased by an average 4000 discharges per year (compared with the previous average increase of 1400 per year).

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Why this is important

In the past, the growth in elective surgical discharges did not keep up with population growth. The rate of growth of elective surgery needs to increase, which in turn, will increase patients' access to this important service.

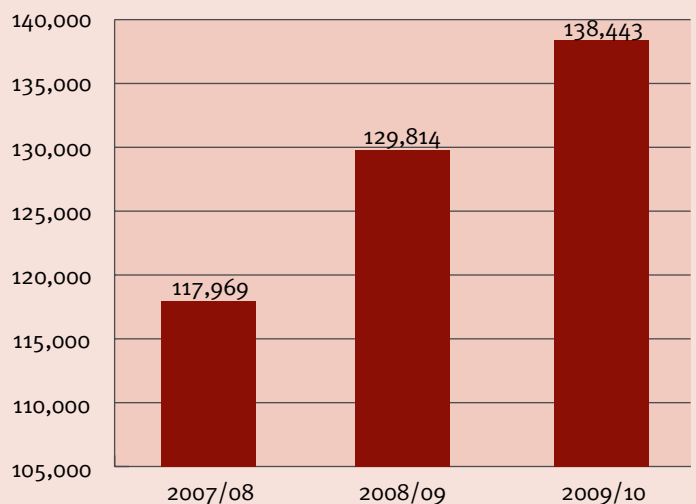
Elective surgery operations improve quality of life and help reinstate a person's independence, maintain that independence as the person ages or provide the person with continuing opportunities to take part in activities they enjoy. For example, a hip replacement can reduce pain, allowing a person to get back to enjoying physical and social activities and being independent with shopping or other daily tasks. A cataract operation may ensure someone is able to see well enough to read or to drive their car, while a grommet operation might restore proper hearing to a young person with 'glue ear'.

What is being done?

In this publication we look at how DHBs and their staff are working to achieve this health target and discuss the real gains being made thanks to the clinical leadership of those on the frontline, both in hospitals and in the community.

Increasing elective surgery (national minimum data set, Ministry of Health)

In recent years, DHBs have significantly increased the number of people they provide with elective surgery.



Improved access to elective surgery: the Ministry of Health's role



Clare Perry, Elective Services Manager, National Health Board, sees a direct relationship between greater access to elective (planned) surgery and continued quality of life as people get older.

‘Elective surgery can fix things that prevent a person seeing properly or being able to move around independently,’ Ms Perry explains.

‘That really matters when you think of all the activities we take for granted – being able to walk around a supermarket, play with the kids on a beach or drive to visit friends, and so on.’

Improving access to elective surgery, therefore, is a priority.

Ms Perry says the health target aims to increase the number of elective surgery discharges by an average 4000 a year, significantly more than the previous annual increase of 1400.

‘That earlier rate of increase just wasn’t enough to keep up with our population growth, so the sector has had to refocus. This year, for instance, we’re aiming to provide elective surgery to 140,000 people.’

She says DHBs have made considerable progress in recent years in providing more planned operations, implementing initiatives to increase efficiencies and improving communication with patients.

‘Because health services are provided within an integrated system, a difficulty in one area can cause a backlog or an issue in another area. Many of the improvements we’re seeing in access to elective surgery are the result of taking a close look at the whole system and the processes used to manage patients.’

‘Successfully meeting this health target relies on clinicians and health board managers having a shared vision and working together to achieve results.’

‘Successfully meeting this health target relies on clinicians and health board managers sharing a vision and working together to achieve results.’ – Clare Perry

Patients booking their own appointments to suit their needs

It's a problem every DHB struggles with: how to reduce the number of people not showing up for their outpatient appointments.

For Hutt Valley DHB, the solution has been both innovative and startlingly simple.

'We decided to let patients book appointments for the days and times that suit them,' says Sarah Boyes, the manager of Women's, Children's and General Outpatient Services at Hutt Valley DHB.

'We used to dread Mondays. We'd send out appointment cards on Thursdays and Fridays, and then the phone would ring all day Monday with people wanting to change their appointments.'

'The outpatients' administrative staff would spend ages rebooking appointments, but problems would still arise because the bookings were made so far in advance.'

'And even when staff did have a list of confirmed outpatient appointments, there was no guarantee the clinic would be full that day as a significant percentage of patients would not show up for their appointments.'

Ms Boyes says that all that changed a year and a half ago when the DHB introduced U Book –

based on a United Kingdom system and adapted for Hutt Valley DHB's circumstances.

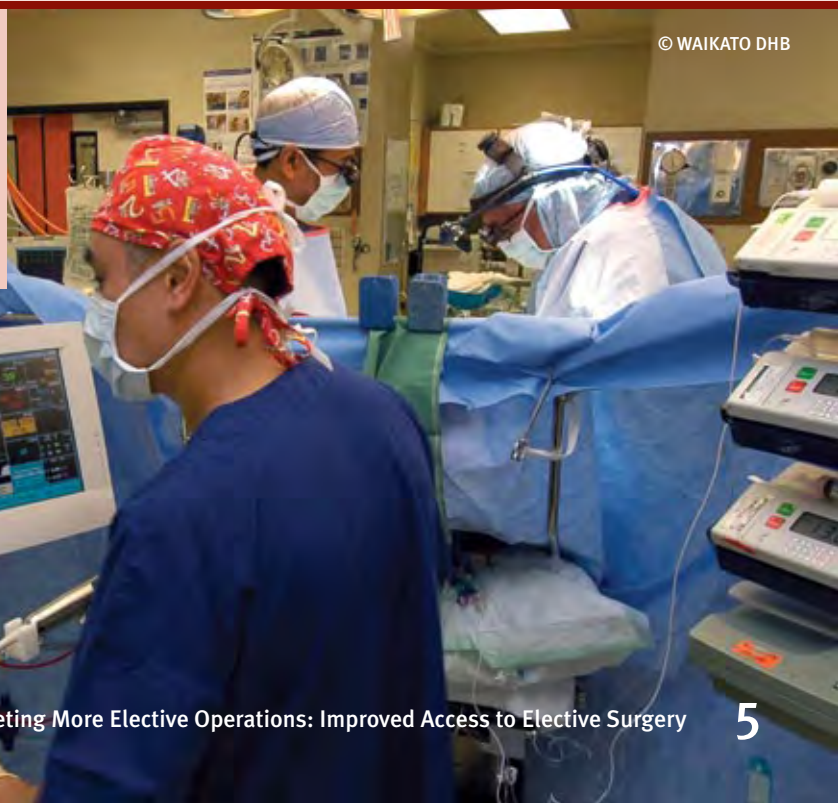
Text reminders to patients before their appointment is being trialled. It is very popular, particularly with the younger group and those with children. The DHB is looking to roll it out across many other departments.

While there are still people who don't show up for appointments, the number of no-shows has fallen by 30 percent for general surgery outpatients and by 33 percent for gynaecology outpatients.

Outpatient appointments are the first step in the elective surgery process. Patients come to outpatient services to see a specialist, who then decides if elective surgery is the best option for that person. Helping people to see specialists sooner is an important step in improving access to surgery.

As a result of the changes, Ms Boyes says patients are happier because they have more choices, staff are happier because they are spending less time re-doing work, the DHB's clinics are able to see more people because there are fewer gaps caused by 'did not shows', and people are likely to get on surgical waiting lists sooner.

'We used to dread Mondays ... the phone would ring all day with people wanting to change their appointments.'
– Sarah Boyes



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Cardiac waiting lists continue to reduce

Better reporting, more collaborative management and a focus on close monitoring has led to a drop in waiting lists for cardiac surgery, says Nelson Marlborough DHB clinical cardiologist Dr Andrew Hamer.

Fundamental to this success has been the clinician-led National Cardiac Surgery Clinical Network established in 2009 to improve services through smarter approaches.

The Network, led by Dr Hamer, meets quarterly and comprises five leading heart surgeons (the clinical directors of all the cardiac surgery departments), nurses, anaesthetists, intensive care specialists and DHB representatives. National Health Board and Ministry of Health staff attend meetings as appropriate.

‘Getting those people together meant we could get a clear picture of what was happening in cardiac units, where the issues were and what was needed to make the whole process run more smoothly,’ explains Dr Hamer.

Cardiac waiting lists nationally have reduced by 40 percent since the Network was established, and the number of cardiac operations carried out has increased by nearly 14 percent.

The Network began a weekly reporting process that Dr Hamer explains enabled the National

Health Board, DHBs and the Minister of Health to focus on what needed to happen to increase the number of procedures being done.

‘It meant we could work smarter. We could look at what was working and what wasn’t, and make collaborative decisions about how to balance resources with needs.’

Dr Hamer says that some of the initiatives used have come from watching collaborative processes in other specialty areas, such as urology and orthopaedics.

‘The new funding models have also helped. They gave us the flexibility we needed to make smarter decisions and focus on getting waiting lists down.’

In Tairāwhiti, for instance, there was a higher-than-average incidence of cardiac disease. The DHB responded there by increasing specialist cardiology clinics to identify and assess cardiac need, and it also got involved in the Quality Improvement Plan for Diabetes and Cardiovascular Disease pilot project to better plan and manage local population needs for cardiac services.

‘And now Tairāwhiti, which used to have poor access to cardiac services, is among the best in the country,’ Dr Hamer says.

‘The new funding models ... gave us the flexibility we needed to make smarter decisions and focus on getting waiting lists down.’ – Dr Andrew Hamer



Improving access to musculoskeletal services

A new approach to helping patients with musculoskeletal issues is improving patients' access to the right services and reducing surgical waiting times for Cantabrians.

Dr Ian Holding, a musculoskeletal specialist and a senior lecturer in musculoskeletal medicine at the University of Otago, says specialist musculoskeletal clinics established in Christchurch have also reduced the number of people being referred for hospital treatment by giving them care in the community. The clinics have seen about 800 people in their first year of operation.

Dr Holding says unnecessary hospital referrals were a big problem before the clinics were established. They contributed to longer specialist assessment waiting times and were often not a good use of specialists' time.

'Many patients with musculoskeletal problems don't need hospital orthopaedic treatment and can receive faster and more appropriate care in the community,' he says. 'Specialist clinics have allowed people to be seen who would previously not have been accepted for referral and have reduced the number of people being referred for hospital treatment they did not need.'

Statistics show that 15 to 20 percent of GP consultations are for musculoskeletal issues, which are often referred to hospital-based

services. However, half of all patients referred to hospital orthopaedic departments do not meet the threshold for surgical assessment and could have been assessed and treated in the community by musculoskeletal treatment services, such as physiotherapists, occupational therapists, sports' doctors, etc.

Dr Holding says community-based musculoskeletal clinics provide a central point of entry to the health system for patients with musculoskeletal issues – known as the Orthopaedic Referral Gateway. The clinics use rapid access diagnostics (MRI and ultrasound) to assess and diagnose the problem. They can then provide treatment advice to the GP and refer the patient to secondary care orthopaedic outpatient services, the musculoskeletal clinic or to other hospital-based services.

Fewer than 5 percent of musculoskeletal clinic patients end up needing to be referred to other specialists. One consequence of better access for people with ill-defined problems has been the detection of early stage inflammatory joint disease.

Dr Holding says one measure of the service's efficiency is the fact that patients being referred to hospital specialists are now mostly those that require surgery.

'Specialist clinics have allowed people to be seen who would previously not have been accepted for referral and have reduced the number of people being referred for hospital treatment they did not need.' – Dr Ian Holding

What is musculoskeletal medicine?

Musculoskeletal medicine is an important and developing specialty. It is the study of how the muscles and skeleton work together. This branch of medicine provides a patient with alternative treatment options when surgery isn't necessarily required but the patient needs more specialist care than a general practitioner can provide.



Left to right: Jacqualene McGivern, Patient Flow Coordinator, and Patricia McNeill, Surgical Services Manager, checking Hutt Valley DHB's theatre list.

'... we're able to do a degree of planning ... that we've never been able to do before.' – Patricia McNeill

CASE STUDY: Hutt Valley DHB (2)

Planning for the unexpected

You might think there are just two types of surgical patients – urgent and non-urgent – but Hutt Valley DHB has invented a third: the non-urgent acute. And this third option is helping the DHB complete more operations, reduce waiting times and cancellations, save money and provide a safer and more satisfying work environment. This is important for elective surgery as it means patients who need elective treatment are not constantly having that treatment cancelled to accommodate the unplanned acute.

Surgical Services Manager Patricia McNeill says that the DHB, like others around the country, has to juggle the competing needs of planned and unplanned surgery.

'Someone comes to the emergency department after a car accident or a fall, and they need surgery,' she says. 'That's acute because it's unplanned, and we have to respond to that need within a short timeframe.'

The problem with juggling planned and unplanned surgery is that patients' elective operations can end up being cancelled if something requiring immediate attention comes into the emergency department.

'That can be really frustrating for elective patients,' Ms McNeill acknowledges. 'They might have gone the whole day without eating, in preparation for

their operation, only to have it cancelled at the last minute. It also means that ward nurses can't plan for bed use.'

In response, the DHB decided to create specific surgical sessions for acute patients who need to have their operations completed within the seven-day timeframe but who don't need them right away.

'For example, if someone comes in with a broken wrist, we may not want to operate right away because we want the swelling to go down,' says Ms McNeill. 'So we can admit them, if needed, and book them in for an operation in two days' time. What this means is that we're able to do a degree of planning within the schedule of unplanned surgeries that we've never been able to do before.'

As a result, these patients know when they will be operated on, the scheduling of their operations means the theatre can be set up specifically for their needs, ward nurses can plan for bed use more effectively and fewer elective operations are being cancelled because they are less likely to be pushed aside by incoming acute cases.

'This is about looking at things from the patient's perspective,' Ms McNeill explains. 'This system gives patients more certainty as they know when they are going to be treated. It's working really well.'

CASE STUDY: Hawke's Bay DHB

Team approach to improving access to urology services

Nurse practitioner Trish White and urologist Kim Broome are working together to improve services for urology patients in Hawke's Bay.

Trish White was New Zealand's first urology nurse practitioner and is employed by the Hawke's Bay DHB. She is able to assess, diagnose, order investigations, develop a treatment plan (including prescribing medicines) and evaluate the response to treatment.

She says the team approach she and Mr Broome take to providing urology services works extremely well.

'I assess the patients and decide if they need to see the urologist or if some other care or expertise is needed,' she explains.

'This type of referral process means the urologist is only seeing those patients who need his expertise. That means patients who need specialist-level assessment and care have faster access, and so do the patients I see.'

'The two streams of care that we offer have created a win-win situation for patients.'

Urologist Kim Broome agrees and says working together in this way has helped to speed up identifying cancer patients.

'... patients who need specialist-level assessment and care have faster access, and so do the patients I see – The two streams of care that we offer have created a win-win situation for patients.' – Trish White



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Increasing the number of elective surgeries

Professor Geoffrey Horne doesn't like making patients wait for treatment, so he decided – as the then president of the New Zealand Orthopaedic Association – to see how access to orthopaedic surgery could be improved.

As a result of his work on the Orthopaedic Joint Replacement Initiative, the number of orthopaedic operations carried out has increased. For example, about 4500 hip and knee operations were carried out in 2004, but this rose to around 9000 operations a year by 2010.

Professor Horne used data from a variety of sources to develop a case for priority around orthopaedic surgery.

He also looked at what happens when people are forced to wait for surgery.

'Specifically we looked at all the costs of not doing the operation. We considered the cost of

having people on sick leave and the cost of them claiming ACC or sickness benefits. What we were able to show was that the cost to the country of having people waiting for surgery for more than six months was higher than the cost of providing the treatment.'

The programme used a variety of techniques to increase the number of procedures. One involved changing the funding model.

'The funding model we used allowed orthopaedics the chance to be more innovative about how resources were managed. For example, surgeons and anaesthetists could be put on incentive-based contracts.

'As well, we had a set cost for the procedures so everyone was looking for ways to be more efficient. It also provided incentives for purchasing supplies more wisely.'

'... the cost to the country of having people waiting for surgery for more than six months was higher than the cost of providing the treatment.' – Professor Geoffrey Horne





CASE STUDY: Southern DHB

Improving the use of GP skills

A simple observation, made during visits to general practices in rural Southland, sparked a project which is now benefiting the public, and the hospital system.

Southland hospital's GP liaison Caroline Corkill and surgical services manager Peter Bramley were visiting rural practices in Southland in 2009.

'We got to talking about the wealth of expertise in these GP practices, and how there must be ways to make more use of those skills to deliver services closer to where people live,' Caroline recalls.

That observation blossomed into a project where many rural patients are able to have minor skin lesion surgery at their local GP practices.

The project targets lesions which might be cancerous, and where removal is the best way to know for sure and treat the problem.

'In the past the only funded option for people from rural Southland in that category was to drive, often for two or three hours to the hospital in Invercargill then, after a

20 minute surgical procedure, drive for hours to get home again.

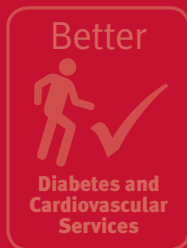
'Giving them funded access at an approved general practice closer to home is much more convenient for those patients. If the GP and the patient decide that the most appropriate treatment is to remove the lesion, they then agree on a time which suits them both.

'It saves the patient's time, improves their access to surgery, and delivers services in a more convenient location.

'The GPs who provide this service already had skills and experience in minor surgery, and also received a visit from a surgeon to observe them in action and assess that they are suitably skilled.

'We now have GPs funded by the DHB to do these operations in Te Anau, Lumsden, Queenstown, Mataura, Gore, Otautau and Riverton.

'That frees up hospital staff, procedure rooms and operating theatres for other elective procedures. It really is a win-win situation all round,' Caroline Corkill says.



The last word –

Kevin Woods, Director-General of Health



As incoming Director-General of Health, I'm delighted to see the way clinicians around the country are working together to improve the care provided to New Zealanders in a number of key health target areas.

The process of changing the way we work to improve quality and efficiency in a tight fiscal environment challenges the ingenuity and creativity of health professionals. It's clearly paying dividends, with various initiatives making a positive difference to improve DHBs' performance against the health targets.

The innovations and stories featured in this publication are part of an integrated health care system that continues to deliver results for patients.

There are significant challenges and no 'one size fits all' solutions, which is why it's so heartening to read about how local health communities are working collaboratively to deliver good health and independence outcomes for New Zealanders.

Health targets provide a clear and specific focus for action.

People in New Zealand have high expectations that they will have good access to health care services when they need them. This is as it should be – which is why it's so important that we continue to evaluate performance and report on our progress.

While substantial success has been achieved, I look forward to working with you to see continued improvements that will benefit all New Zealanders.

Additional information

More information on health targets can be found at www.govt.nz/healthtargets

More information on elective services can be found at www.moh.govt.nz/electiveservices

Clinicians and those involved with the target can access further resources and tools relating to the target on the Health Improvement and Innovation Resource Centre website – www.HIIRC.org.nz