All District Health Boards

MINISTRY OF HEALTH
MANATŪ HAUORA

Memo

Date:	8 May 2020
To:	District Health Board Chief Executives, Chief Operating Officers, Chief Medical Officers, Directors of Nursing. For wide circulation.
From:	Michelle Arrowsmith, Chair, Planned Care Sector Advisory Group
Subject:	Further developing Planned Care in response to the National Hospital Response Framework
For your:	Action and Information

1. Background

The following advice is an update to the guidance 'Increasing and improving Planned Care in accordance with the National Hospital Response Framework' released on 21 April 2020.

2. Key messages

- Planned Care services should continue to increase delivery in accordance with the National Hospital Response Framework.
- Services will need to continue to observe enhanced infection control measures (were appropriate and advised) and consider specific patient and health system factors when scheduling cases.
- Prioritisation of patients must continue to be based on clinical need and risk of deterioration and reprioritisation of waiting lists will be necessary.
- Improvements to delivery models, such as increased use of telehealth, a reduction in unnecessary follow -ups and increased use of allied health and nurse led assessments should continue wherever possible.
- Better information flows, support and partnership across the primary – secondary care interface is critical to addressing current needs and embedding improvements to Planned Care delivery.
- All providers must embed enhanced health equity into their services.
- Guidance is also provided around MDTs, supply chain, screening programmes and education and consultation.

Signature Date: 11 May 2020

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Further developing Planned Care in accordance with the National Hospital Response Framework

Advice from the Planned Care Sector Advisory Group

1 May 2020

1. Introduction

This guide is for all health care providers in New Zealand. It follows on from our advice of 21 April 2020 and aims to help providers further develop Planned Care during the reducing risk of COVID-19 and the anticipated winter pressures. The previous guide focused on i) maintaining infection control precautions ii) prioritising collectively to match whole system capacity to the most clinically urgent demand and iii) maintaining COVID-19 surge response capacity. This update says all those actions must continue and expands to other settings such as MDTs, supply chain, screening programmes and education. It also reminds us to consult, update, anticipate regulatory changes and maintain strict visitor policies. We address the clear risk of worsening health inequities as a result of service disruption caused by COVID-19. For example deprived populations may struggle to access video telehealth[1]. All services must embed enhanced health equity into the new norm of the health sector. Finally it signals further changes we can make collectively, to further improve the way we deliver Planned Care. Further guidance, especially on facilitating improvements, is planned.

2. National context

This update is intended to be broad enough for all providers to use under National Alert Level 2 and for hospitals to adapt according to their status on the National Hospital Response Framework. All health services are to operate as normally as possible, while observing enhanced infection control measures and significantly improving models of care. New Zealanders are to maintain physical distancing outside home. People at high risk of severe illness (older people and those with existing medical conditions) are encouraged to stay at home where possible and take additional precautions when leaving home. Such people may attend medical appointments and may also choose to work, but DHBs are updating national occupational health guidelines to make consistent risk assessments.

3. Minimising risk

Most hospitals will be at National Hospital Response Framework GREEN or YELLOW. Some hospitals may move back to higher levels, and would have to adjust their Planned Care activity accordingly. All providers have built up waiting lists, with some analyses predicting it may take over a year to recover pre-COVID-19 waiting times which were already sub-optimal. All providers must therefore urgently increase Planned Care volumes to meet the needs of patients already in the system and those with new referrals. To minimise harm, all prioritisation must be based on clinical need and risk.

[1] Telehealth is the use of information and range of communication technologies to deliver health care when patients and care providers are not in the same physical location. Please see https://www.telehealth.org.nz/telehealth-forum/what-is-telehealth/ for more information.

4. Changing models of primary and secondary care together

It is not enough to simply do more and reprioritise. Making telehealth the default wherever possible; offering allied health and nurse specialist assessments; increasing primary care direct access to diagnostics; more focused collaboration; better information / clinical advice support across the primary – secondary care interface and developing GP s
pecial interest networks are all vital to addressing current needs and embedding the most significant changes in Planned Care delivery that New Zealand has seen. Telehealth resources and support are available at NZ Telehealth Leadership Group's website. These developments must be documented in local Health Pathways so that all providers access the most up to date resources.

5. COVID-19 prevalence

Epidemiological knowledge of COVID-19 and the risk of an asymptomatic patient having COVID-19 remain crucial to logistical planning of services and appropriate use of personal protective equipment (PPE). This knowledge must include flow of patients and staff across DHB boundaries.

6. Winter planning

As in all winters, providers, especially DHBs, must balance their Planned Care volumes with anticipated winter pressures, particularly increased respiratory presentations and staff sickness. In light of the expected ongoing impact of COVID-19, this will be even more important as many patients are likely to meet the MoH case definition for COVID-19. In addition, economic hardship from the effects of COVID-19 may lead to an increase in presentations to hospital emergency departments rather than to urgent care or general practice. DHBs and primary healthcare organisations (PHOs) must increase efforts to divert such demand from hospitals and reduce delayed discharges. This will often mean supporting primary care to keep patients in community settings. It is also very important to ensure optimal influenza vaccine uptake.

7. Physical facilities

Physical distancing is still required. This can be achieved by physical re-configuration of facilities and smart scheduling of arrival times.

Facilities with increased infection control measures such as additional negative pressure rooms must maintain this capacity. Similarly, facilities must retain the ability to physically separate actual and suspected COVID-19 positive patients in the flow through all aspects of the care system. These requirements are necessary to allow rapid escalation to higher alert levels.

8. Screening of patients and any support person for in-person meetings

The three screening questions remain valid.

a. Have you been overseas in the last 14 days? *
b. Have you had in-person contact with a confirmed or probable COVID-19 patient in the last 14 days?
c. Are you unwell or are any of the people in your household bubble unwell with fever or acute (new) respiratory symptoms?

* Recent overseas travel remains an important question as international air and ship crews are exempt from mandatory quarantine provisions.

If the answer to all these questions is “no” the chances of the patient being asymptomatic with COVID-19 is extremely low.

9. Visitors’ policy

Physical distancing reduces throughput and visitors will make this more challenging. Facilities should therefore maintain visitors’ policy in line with the National Hospital Response Framework.

10. Regulatory changes under Epidemic Preparedness (COVID-19) Notice 2020

Providers must plan for the end of the Director General of Health’s temporary flexibilities allowed during COVID-19 (currently scheduled for 24 June 2020). For example, when the current waiver regarding e-prescribing signatures is removed, clinicians must be able to adjust to ensure patients continue to receive their medications. This will ideally be through moving to the NZ ePrescription Service (NZePS).

11. Out-patient prioritisation: First Specialist Assessment (FSA) and follow-ups

Telehealth should be used for any consultation where an in-person meeting is not essential for achieving effective communication and care. Hybrid clinics, with some patients receiving telehealth and others (that require it) in-person should be considered. Telehealth can include electronic advice to patients. This should be done in a way that keeps primary care included such as messaging via primary care or through a portal which the patient and primary care team can access. Patients should be supported to use these portals where they need it.

Prioritisation (for in-person or telehealth) must continue to be based on clinical need irrespective of being FSA or follow-up. Referring clinicians should be encouraged to update referral urgency where they are aware of worse than anticipated deterioration. Traditional planning ratios of FSA : follow-up are irrelevant in the current environment.

Priority should be assigned to i) any known or suspected cancer and ii) FSA’s where deterioration to the point of requiring acute assessment could reasonably be anticipated within a short timeframe. Other important factors include the need for secondary/tertiary advice to maintain the patient’s independence and/or ability to return to or maintain employment. Where applicable, the National Prioritisation Framework should be used to prioritise FSA referrals.

Allied health professionals or specialist nurse assessments should be considered as alternates to assessment by an SMO. This allows those healthcare professionals to work at the top of their scope of practice and where it benefits patients as well as provider capacity, should be encouraged. This activity can be included in national activity returns.

Follow-up strategies should identify and prioritise any additional investigations or reviews necessary to maintain or enhance the health and independence of patients. Guidelines for appropriate follow-up, for instance after cancer treatment, must consider what advice or change in management, if any, will be influenced by such follow-up and if it would add more value than clear advice to the GP.

12. Surgery, other interventional procedures & secondary care diagnostic services

As for outpatients, case selection and scheduling must be based on clinical priority and risk. Prioritisation must be transparent, reliable, valid and reflect clinical judgment. It must be performed within and across specialties with shared resources such as all surgical specialities.

Current clinical need should be judged by the patient and the referring and receiving clinicians, including the patient derived 'Impact on Life' and clinician derived factors. Prioritisation is likely best achieved by a formal tool. The risks and impacts of potential deterioration need to be reflected in any tools. The potential deterioration time-frame should reflect the shifting nature of the current situation (e.g. 6-10 weeks). Non-operative therapy options should continue to be prioritised where safe to do so.

The existing NZ elective surgery prioritisation tools remain valid for prioritising planned care surgery in relevant specialties. However, whilst any hospital is functioning above National Hospital Response Framework GREEN, additional prioritisation is necessary. An effective generic matrix for decision-making should include assessment of the likely benefit of non-operative options and likely negative impact from a delay in surgical treatment, especially over a short to medium timeframe (given that a hospital may spend weeks above National Hospital Response Framework GREEN at any one time). These features, in particular any harmful effects of short to medium term deferral, are not explicitly part of the existing NZ prioritisation tools but are explored elsewhere[2].

Case selection and scheduling must also be considered in conjunction with recognised risk factors as there is still a risk from COVID-19. Patients with recognised risk factors are best deferred if the risk of clinical deterioration from deferral is minimal or nil. These patient factors currently include:

a) Co-morbidities and other factors that are identified as placing the patient at a higher risk of death if they contract COVID-19. However, as the risk of community transmission continues to be very low, the emphasis given to these risk factors, should be as important issues to raise with patients in respect of informed consent and informed choice. These risk factors include: frailty, BMI >40, co-existing respiratory, renal and cardiac disease, diabetes, hypertension, immunosuppression and pregnancy
b) A reasonable expectation of needing ICU/high dependency care
c) Discharge issues including personal circumstances such as lives alone
d) What is the risk of the condition requiring acute admission within a short timeframe?
e) Other time-critical issues where long term outcome will be significantly worsened by further surgical deferral.

Hospital factors must continue to be considered:

a. Bed state of hospital – including what is the policy re patients having single rooms only vs. capacity?
b. Supply chain of consumables, including medicines, devices and PPE (see below)
c. ICU/HDU status
d. Laboratory status: i.e. Planned Care laboratory requests must not compromise the ability to maintain processing of COVID-19 samples.
e. Managing system capacity and demand. It is imperative that cross-service, cross facility and cross provider planning and coordination is maximised as siloed planning is unacceptable. All

[2] For example, see Prachand VN, Milner R, Angelos P, Posner MC, Fung JJ, Agrawal N, Jeevanandam V, Matthews JB, Medically Necessary, Time-Sensitive Procedures: Scoring System to Ethically and Efficiently Manage Resource Scarcity and Provider Risk During the COVID-19 Pandemic, Journal of the American College of Surgeons (2020), doi: https://doi.org/10.1016/j.jamcollsurg.2020.04.011

waiting lists have grown and each health system must prioritise collectively at local and regional level, including private providers, so that clinical risk is minimised for all patients regardless of provider

f. Availability of community services such as district nursing, allied health, NGOs and others to support patients post-discharge
g. Any specific requirements of aged care sector facilities where a patient is expected to reside following discharge from hospital

Where factors exist that indicate a need to re-consider the timing of a planned operation, the presence of any of these factors in themselves does NOT mean a patient MUST be deferred. These factors do, however, highlight the need for a "whole of system" approach to case selection and, where sensible, to defer such cases that can be deferred whilst a heightened risk of COVID–19 exists. As for outpatients, referrers and patients will need clear communications on the reasons for deferral, timing expectations and interim management.

Many patients have waited longer than is desirable based on their current clinical priority. Clinicians must therefore actively manage existing waiting lists and new referrals to potentially adjust the clinical priority of any procedure or investigation. There must be clear and unambiguous communication of any changes with patients, referring clinicians in secondary and primary care, plus documentation of such decisions.

Diagnostic services must prioritise referrals for new diagnoses and follow-ups where the test or procedure requested will likely lead to relevant and important decisions about subsequent management. For example, if a patient has declined further treatment for the diagnosis in question, further tests should be challenged and likely rejected. To illustrate, a request for a surveillance CT to scan for metastases after a patient has made an informed choice to not have surgery or chemotherapy would be unnecessary.

13. Multidisciplinary decision making

Well-established multidisciplinary care processes are generally in place and should be expanded where needed. These must continue and consider additional complexities such as co-morbidities and COVD-19. For example, does a patient's mortality risk if they contracted COVID-19 materially influence the advice of the MDT? If the answer is "yes" the patient and referrer must be involved in further decision making as part of informed choice and consent.

14. Supply chain issues

All providers must ensure they have real-time knowledge of their supply chains. PHARMAC has advised of a world-wide shortage of propofol, a commonly used, important drug, particularly in anaesthesia, intensive care and emergency medicine. Clinicians must be made aware of this and similar issues and take mitigating action if necessary such as using alternatives or deferring. Many implantable devices and disposable clinical items are manufactured overseas. There may be delays in obtaining items. Regional and national planning offers significant advantages to securing supplies.

Availability of PPE must continue to be actively considered and managed and all providers must continue an evidence-based approach to the use of PPE.

15. Consultation

Many changes made during March and April 2020 were at appropriately high speed compared to normal health system change. In most instances these need to be sustained but consultation is required to ensure stakeholders are adequately involved in the way systems work in the future. For example, primary care, consumer councils and unions all have positive contributions to make.

16. System readiness reports

Providers are likely to resume activity volumes in different specialities at different speeds. Primary care teams need to understand the speed and variability of these changes. In large providers, such as DHBs, many clinical and non-clinical support teams also need to know these details and find it difficult to access them. Frequent situation reports covering these details should be considered.

17. Equity

Māori and Pacific people, those of lower socio-economic groups and/or live rurally are especially vulnerable to health inequities. Changes in how care has been delivered including the increased use of telehealth offer opportunities to improve equity of access but also can worsen inequity if processes are not robust. Providers should ensure they have robust practices around:

a. access to and the role of interpreting services
b. improving access to telehealth such as through: facilities which are closer to the patient's home; loan devices; not calling patients from lines with caller ID blocked; Maori and Pacific healthcare provider support
c. follow-up of any patient in which a telehealth contact was unsuccessful

The significantly reduced volume of Planned Care delivered during March and April 2020 also threaten to worsen health inequities. Where measures of health inequity exist, these should be monitored and steps actively taken to prevent further deterioration at the same time as continuing the reduction and eventual elimination of such inequities.

18. Screening programmes

There will be backlogs for the various screening programmes. Clear recovery plans to address the backlog must include effective communication to the community regarding the importance of such programmes. The risk of worsening inequities from reduced acceptance of screening invitations in the most at-risk populations is significant. Programmes that are run predominantly through primary care, such as cervical screening, likely require additional PHO coordination and support. Each provider should track performance against these recovery plans. Guidance and resources in relation to screening can be accessed on the National Screening Unit website - https://www.nsu.govt.nz/

19. Education and training

Tertiary education institutions need to consult and coordinate with DHBs on plans to return to (greater) levels of education and training within hospitals and community services.

Peer group, departmental and hospital-wide education and training sessions should continue, but online where possible, or adhering to distancing requirements where not.

20. Human resources

As travel restrictions are eased, greater numbers of staff may wish to take annual leave. The re-scheduling of specialist examinations by colleges may also significantly impact staff availability and these factors need to be considered in service production planning.

Updated occupational health guidelines must be followed when deciding which staff with personal risk factors can undertake greater clinical activities.

Staff must not come to work if they have respiratory symptoms and must remain off work for at least 48 hours after symptoms have resolved. Any staff with an acute respiratory infection must seek an appropriate medical review +/- testing in line with the latest Ministry case definition to exclude the possibility of COVID-19.

Staff that are able to work from home should continue to do so. The increased delivery of telehealth advice and clinics are highly amenable to remote working arrangements.