New Zealand Medical Association
Te Hauora mō ngā Iwi Katoa

2 February 2017

Electives & National Services, Integrated Service Design
Service Commissioning
Ministry of Health
PO Box 5013
Wellington 6145

By email: Elective_Services@moh.govt.nz

Model of care for vascular services in New Zealand

Dear Sir/Madam

Thank you for inviting the New Zealand Medical Association (NZMA) to provide feedback on the above consultation. The NZMA is New Zealand's largest medical organisation, with more than 5,500 members from all areas of medicine. The NZMA aims to provide leadership of the medical profession, and to promote professional unity and values, and the health of all New Zealanders. Our submission has been informed by feedback from our Advisory Councils and Board.

1. We congratulate the Ministry on its work in leading the development of a model of care for vascular services. We particularly welcome the use of the New Zealand Role Delineation Model (RDL) and descriptors for each RDL. However, we are concerned that the consultation document itself has a number of deficiencies. We elaborate on our concerns in the paragraphs below. We also provide responses to the specific questions posed in the consultation (see Appendix).

2. We note that the consultation document refers to a project advisory group convened by the Ministry of Health, with the support of DHB General Managers Planning and Funding, but does not list authors and contributors. It is our view that all such consultation documents developed by the Ministry should explicitly identify the authors and contributors. Doing so would contribute to greater confidence in the quality of the Ministry's decision making and help ensure that all key stakeholders are included during the consultation development stage.

3. It is of concern that, to the best of our knowledge, thoracic or cardiac surgeons do not appear to have been consulted during the development of this model of care. There is an overlap between vascular services and cardiothoracic surgery in the management of descending aortic

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dissections and transection of the aorta, both relatively common conditions that are not specifically mentioned in the consultation. While RDL level 6 requirements mention the need to support cardiothoracic surgery, we suggest this would be better framed as a collaborative relationship between vascular services and cardiothoracic surgical services; the management of transection of the aorta could involve specialists from either discipline.

4. We welcome the document's recognition of optimising prevention and detection. However, there are some concerns that prevention is not given sufficient in-depth consideration. For example, there is no mention of the major epidemiological risk factors for vascular disease, which correspond to those for cardiovascular disease in general, especially smoking. Given that improved prevention will reduce demand and take pressure off vascular services that would otherwise be at risk of collapse in the face of the rising prevalence of obesity and diabetes, we suggest that prevention warrants greater emphasis. Nevertheless, we are pleased that the document acknowledges the importance of cardiovascular risk assessment in the prevention and detection of vascular conditions, and we welcome the recommendation for the next review of the Primary Care Handbook to include advice on peripheral vascular disease.

5. It is our view that every time the Ministry promulgates a new model of care (for vascular services or anything else), it should also state that appropriate funding will be allocated to the model's implementation. By doing so, the model is more likely "to ensure access to the right level of care in a seamless and timely manner". In the absence of adequate funding, there is a risk that any new model of care may not actually ever be implemented.

6. We are concerned that the consultation is limited with respect to matters relating to equity. Health equity should underpin all models of care.[1] While recommendation 6 says that "elective pathways should be agreed within the region, to facilitate equitable access to vascular care", current defects in equitable access to care are not identified. It is important to identify these. If the data to do so are lacking, then we believe the authors should call for an urgent and ongoing equity audit of models of service delivery to ascertain the proportionate universality of services.

7. We are disappointed that the document fails to include a single reference to Māori. Elsewhere on the Ministry's website, it is noted that "the total cardiovascular disease mortality rate among Māori was more than twice as high as that among non-Māori".[2] The failure to specifically address Māori appears to represent a lapse by the Ministry of its own modelling of parameters relating to health equity. We suggest the Ministry review the reasons for this lapse and expand its model of care for vascular disease to include a specific focus on Māori. We suggest that the model also needs to address the needs of Pacific and South Asian people, as well as those from a low socioeconomic background, given that these populations experience a disproportionately greater burden of cardiovascular disease.[3]

8. We note that the stated intent of the consultation document is "to develop a tier two service specification for vascular services that describes minimum requirements for a DHB intending to deliver vascular services, to ensure an integrated and safe service for patients". Elsewhere, the document states that the goal of the model of care is to improve quality of care for patients through four strategies: optimise prevention and detection; reduce clinical variation;

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[1] NZMA. Health Equity. Position Statement, 2011. Available from https://www.nzma.org.nz/__data/assets/pdf_file/0016/1456/Health-equity-2011.pdf

[2] http://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-mana-hauora-tutohu-health-status-indicators/cardiovascular-disease

[3] Thornley S, et al. Sociodemographic differences in prevalence of diagnosed coronary heart disease in New Zealand estimated from linked national health records. N Z Med J. 2011 May 13;124(1334):21-34.

enhance the intervention pathway; integrate services effectively. While these are laudable intentions and goals, we submit that the most important aim should be to secure better outcomes for patients. We recommend that this be specifically acknowledged in the document.

9. It is our contention that the important role of GPs is not given adequate attention in the model of care. For example, while a number of different types of service providers are identified on page four, GPs are conspicuously absent. We suggest that the document should give greater emphasis to integrated health care, with specific attention to the important role that GPs play with respect to vascular disease in terms of prevention, diagnosis, organising further investigations, treatment, referral, follow up and coordination of care.

10. An important aspect of the post-surgical management of patients with vascular disease is treating dyslipidaemia (plus addressing hypertension, smoking, lack of exercise, etc). Essentially, all such patients should receive advice on diet and lifestyle, as well as intensive lipid modifying therapy. Yet in clinical practice, many post-surgical patients do not receive adequate treatment of their underlying risk factors. This has been shown to be the case in New Zealand[4] as well as overseas.[5] We consider it important for the model of care to extend beyond a primary focus on acute intervention to more comprehensively address prevention as well as care post-intervention.

11. Finally, we consider that the document needs to afford greater recognition of the role of anaesthetists and intensive care providers. Specifically, recommendation 5 should include anaesthetists and intensive care providers along with vascular providers. Recommendation 6 should include access to pre-anaesthetic clinics to assess risk stratification and optimise peri-operative care and outcomes. Level 5 and 6 services should include anaesthetists that are specially trained in vascular (open and endoluminal) procedure management. Multi-disciplinary meetings should include anaesthesia and ICU providers.

We hope that our feedback has been helpful and look forward to learning the outcome of this consultation.

Yours sincerely

Dr Stephen Child
NZMA Chair

[4] Looi KL, et al. Under-use of secondary prevention medication in acute coronary syndrome patients treated with in-hospital coronary artery bypass graft surgery. N Z Med J. 2011 Sep 23;124(1343):18-27. Available from https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2011/vol-124-no-1343/article-looi

[5] Pande RL, et al. Secondary prevention and mortality in peripheral artery disease: National Health and Nutrition Examination Study, 1999 to 2004. Circulation. 2011 Jul 5;124(1):17-23. Available from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3139992/

Appendix. Questions for consultation

1. Do you agree that a Regional Model of Care with six levels of Vascular provider is appropriate within a New Zealand context, and are the levels described adequately? (Recommendation 4)

Please indicate the level of your agreement

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☒	☐	☐	☐

2. Do you agree with the four high level strategies identified in the Model of Care for Vascular Services? (Recommendation 2)
a. Optimise prevention and detection
b. Reduce clinical variation
c. Enhance the intervention pathway
d. Integrate services effectively.

Please indicate the level of your agreement
a) Optimise prevention and detection

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Please indicate the level of your agreement
b) Reduce clinical variation

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Are there alternatives which should be considered? Do you have any additional comments?
These should be aimed at best medical practice premised on evidence-based medicine.

Please indicate the level of your agreement
c) Enhance the intervention pathway

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Please indicate the level of your agreement
d) Integrate services effectively

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

3. Do you agree with the recommendation to align Vascular with Cardiovascular disease in optimising Prevention and Detection of Vascular disease? (Recommendation 3)

Please indicate the level of your agreement

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Are there any alternatives which should be considered? Do you have any additional comments?

Should focus on more than just assessment of risk.
Risk assessment should be at the same age for men and women.
Should target risk factors such as smoking, dyslipidaemia, hypertension, exercise, etc, and measure hard outcomes.
Should expand on criteria for screening for abdominal aortic aneurysms.

4. Do you agree with the recommendations to Reduce Clinical Variation through:
a. Adopting the identified purchase units to allow more consistent reporting (Recommendation 1)
b. Using a regional hub and spoke model of care with a regional implementation approach to support clarity of pathway and formal after hours arrangements (Recommendation 4)
c. Developing process and access indicators that will be added to existing monitoring and oversight indicators; and regularly auditing referral pathways; and undertaking further work to introduce national reporting of Vascular quality and clinical outcome measures (Recommendation 9)

Please indicate the level of your agreement
a) Adopting the identified purchase units to allow more consistent reporting (Recommendation 1)

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Please indicate the level of your agreement
b) Using a regional hub and spoke model of care with a regional implementation approach to support clarity of pathway and formal after hours arrangements (Recommendation 4)

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Please indicate the level of your agreement

c) Developing process and access indicators that will be added to existing monitoring and oversight indicators; and regularly auditing referral pathways; and undertaking further work to introduce national reporting of Vascular quality and clinical outcome measures (Recommendation 9)

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Are there any alternatives which should be considered? Do you have any additional comments?

We support public access to high quality data reported by unit, not by individual surgeons or teams. The public reporting of clinician-specific raw outcome/performance data is fraught with difficulties and associated with various unintended negative consequences.[6]

5. Do you agree with the recommendations to Enhance the Intervention Pathway through:

a. Having regionally agreed pathways for patients presenting with acute vascular conditions or trauma (Recommendation 5)

b. Having regionally agreed elective pathways to facilitate equitable access to vascular care as close to home as appropriate; (Recommendation 6) and

c. To developing an agreed set of prioritisation criteria for first specialist assessment and elective surgical/endovascular treatment (Recommendation 6)

Please indicate the level of your agreement

a) Having regionally agreed pathways for patients presenting with acute vascular conditions or trauma (Recommendation 5)

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Please indicate the level of your agreement

b) Having regionally agreed elective pathways to facilitate equitable access to vascular care as close to home as appropriate; (Recommendation 6)

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☒	☐	☐	☐

Are there any alternatives which should be considered? Do you have any additional comments?

Having access to vascular care close to home should not over-ride having access to best medical practice premised on evidence-based medicine, which should be the primary aim.

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[6] NZMA Submission. Response to the discussion paper 'Better Data–the benefits to the profession and the public' 8 June 2015. Available from https://www.nzma.org.nz/__data/assets/pdf_file/0007/42928/NZMA-Submission-on-MCNZ-discussion-document-Better-Data-the-benefits-to-the-profession-and-the-public.pdf

Please indicate the level of your agreement
c) To developing an agreed set of prioritisation criteria for first specialist assessment and elective surgical/endovascular treatment (Recommendation 6)

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Are there any alternatives which should be considered? Do you have any additional comments?
Should also have criteria for follow up.

6. Do you agree with the recommendations to Integrate Services Effectively through:
a. Implementing formally agreed processes for conducting Vascular MDMs (Recommendation 7)
b. Each region is responsible for addressing any identified workforce and technology needs (Recommendation 8)

Please indicate the level of your agreement
a) Implementing formally agreed processes for conducting Vascular MDMs (Recommendation 7)

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

Please indicate the level of your agreement
b) Each region is responsible for addressing any identified workforce and technology needs (Recommendation 8)

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☐	☐	☒	☐

Are there any alternatives which should be considered? Do you have any additional comments?
This should also include national responsibilities.

7. Are the Recommendations for implementing the Model of Care for Vascular Services right/appropriate?

Please indicate the level of your agreement

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☐	☒	☐	☐	☐

Are there any alternatives which should be considered? Do you have any additional comments?

Should give more emphasis to the important role of GPs in prevention, diagnosis, investigations, treatment, referral and follow up.
Should give particular attention to the specific health needs of Māori, Pacific and South Asian people, as well as people with socioeconomic deprivation. These population groups experience a disproportionately greater burden of cardiovascular disease.[7]

8. Do you endorse the Tier Level Two Service Specification for Vascular Services?

Please indicate the level of your agreement

Strongly Agree	Agree	Undecided	Disagree	Strongly Disagree
☒	☐	☐	☐	☐

[7] Thornley S, et al. Sociodemographic differences in prevalence of diagnosed coronary heart disease in New Zealand estimated from linked national health records. N Z Med J. 2011 May 13;124(1334):21-34.