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Stroke Clot Retrieval Consultation

Thank you for seeking feedback from the Australian and New Zealand College of Anaesthetists (ANZCA) on the Stroke Clot Retrieval (SCR) Action Plan.

ANZCA fellows have been involved in stroke clot retrieval procedures for a number of years and in the development of guidelines. One of our fellows, Dr Doug Campbell, was on the Endovascular Clot Retrieval Working Group.

There is no doubt that the cost utility and quality-adjusted life year (QALY) data supports the roll-out of this procedure. Although we support implementation of the Action Plan we do have concerns about the impact on the workforce and after-hours cover.

ANZCA considers that the plan for SCR expansion has to be costed and resourced adequately and sustainably. In addition, acknowledgement of the logistical issues that this procedure creates could be strengthened in the Action Plan, including the impact it will have on other patients competing for the same resource.

The Action Plan does not detail the impact on the anaesthetic workforce in managing these cases. The overwhelming majority of SCR patients in New Zealand have a general anaesthetic for the procedure and all have an anaesthetist in attendance. The emergent nature of SCR cases has a major impact on anaesthesia services and, in particular, on the after-hours cover that is required in addition to the standard cover already provided in the hospitals.

For instance, Auckland DHB (Auckland City Hospital) has a 20-minute call-back roster and has had to create a separate after-hours roster just to cover SCR cases. Other hospitals will have differing solutions that will all have a cost. As the service expands in Wellington, Christchurch and ultimately Waikato and possibly Dunedin, anaesthesia departments will have to plan and be funded accordingly.

ANZCA considers there needs to be much more emphasis in the Action Plan under SCR workforce, priority area 3 and priority 5 on the availability of anaesthesia/nursing staff (medical, technical and PACU) as well as radiology staff who work as a seamless emergency team in this scenario. There is only cursory mention of other team

members at present. Cost and workforce implications are considerable and vital to factor in. These patients can be complex to manage for PACU and there are after-hours implications for that workforce, also.

Adequate staffing is crucial for SCR services to work. ANZCA is aware that the view from the neurology perspective is markedly disparate to anaesthesia in terms of case numbers expected and full-time equivalent (FTE) staff required to support the service, particularly the after-hours work. For example, at Capital and Coast DHB (Wellington Hospital) there is considerable concern that the current approval for 0.2 FTE for anaesthesia will be inadequate when the service is expanded. That number does not include any allowance to provide for daytime cover for anaesthetists who have been called in overnight to assist with SCR.

For an anaesthetist to be immediately available for a SCR procedure they cannot have other responsibilities, that is, be on another roster at the same time or providing anaesthesia care to other patients. This poses logistical and financial challenges for DHBs. Canterbury DHB (Christchurch Hospital), for example, does not have a separate anaesthetic roster for SCR patients. Hence, the real 'cost' of the SCR service is borne by lower acuity surgical patients who simply get bumped for a SCR. Similarly, there are additional hidden 'costs' of vacant theatres and theatre nurses with nothing to do until the anaesthetist becomes available.

It is unclear from the document whether this service should be SMO-led or at the discretion of individual hospitals. Many of these cases occur after-hours. Generally, it is registrar level anaesthetists who are on-site after hours with SMOs available from home. By the nature of the condition, the type of patients presenting for clot retrieval are frequently complex and have multiple co-morbidities. If it is not a SMO-led service, consideration should be given to the minimum seniority and experience of the trainees doing these cases after-hours. These cases are not appropriate for junior trainees to be doing independently.

If this is to be a SMO-led service then a separate on-call SMO roster for clot retrieval (as is the current practice in Auckland) will almost certainly be necessary. The current on-call SMO rosters exist to provide supervision and support for trainees doing other acute cases and the SMOs need to be available for this. The additional workload generated by clot retrieval will reduce their availability and hence a second person will need to be available to the trainee. This is a large and expensive resource, which would require significant commitment financially and impacts on workforce planning.

If you have any questions or would like to discuss this submission, please contact Mary Harvey (Senior Policy Adviser) in the first instance on 04 495 9780 or at mharvey@anzca.org.nz.

Yours sincerely

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Chair, New Zealand National Committee