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The National Screening Unit
The Ministry of Health
Wellington

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Tēnā koe

Breast Reconstruction – National Guidelines for Best Practice

Tōpūtanga Tapuhi Kaitiaki o Aotearoa, the New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Breast Reconstruction – National Guidelines for Best Practice *(The Guidelines)*.

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand, representing 51,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment matters. NZNO embraces Te Tiriti o Waitangi and contributes to the improvements of the health status and outcomes of all people of Aotearoa New Zealand through influencing health, employment, and social policy development.

Furthermore, we share the intent of the Ministry of Health's definition of equity which equally applies to NZNO work across professional, industrial and member activities.

NZNO has consulted with members and staff in the preparation of this response.

Breast Reconstruction – National Guidelines for Best Practice

1.2 Background

The Guidelines do not contain information that speaks to the number of women seeking and successfully receiving breast reconstruction post cancer surgery and within an appropriate timeframe. How many women by ethnicity and domicile have been offered and accepted immediate or delayed reconstruction? This information needs to be available to inform the consultation process.

2.2 The discussion about breast reconstruction

NZNO supports a discussion being undertaken about a patient's suitability for breast reconstruction (immediate and delayed) and for whom mastectomy is recommended by the Multi-Disciplinary Team (MDT). We recommend that each patient is acknowledged as an individual and is considered in the content of their personal situation and aspirations.

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2.4 The referral pathway

If an immediate breast reconstruction is most appropriate, this means that there are critical timeframes and organising surgical resources within the clinically appropriate faster cancer treatment (FCT) timeframe can often be challenging. While this approach may be the gold standard, we acknowledge that the health sector may not be able to provide immediate services regardless of a woman's preferences and MDT agreement. How will this be addressed?

2.5 The referral process for breast reconstruction

The Guidelines note the requirement for a clear framework of patient management and referral should be agreed within and between the responsible members of the MDT and the patient's primary health care practitioner. The Guidelines are assuming that every patient has a dedicated primary care practitioner or even access to a primary care provider. What if they do not have access to a primary care provider?

Figure 1: The pathway to breast reconstruction post mastectomy

What are the timeframes for each step of the pathway? For example: First Specialist Appointment (FSA) to Diagnosis, staging, decision to treat – how many working days from FSA to diagnosis? While the algorithm documents the steps involved it does not provide the level of detail required by women and their family and whānau.

In the first instance if a woman opts out of breast reconstruction, how do they re-enter the pathway for breast reconstruction – can they do so? If yes, will they be allocated to the end of the wait list or prioritised to the front?

3.2 Patient factors

Interesting to see the order of patient factors. Why is the likely impact of recovery time on the patient's family, employment, and daily activities last on the list for consideration?

3.3. Equity

How will the variation between Breast Units be addressed? For example: At the referral acceptance stage for breast reconstruction, some breast units apply an eligibility criteria, such as being a non-smoker and BMI of under 30; both parameters are equity reducing measures that disproportionately affect Māori and Pacific women. Also, different breast units accept different BMIs for immediate and/or delayed breast reconstructions. Why are there mixed messages?

Furthermore, why are there inequities? For example: It is important that breast units work towards reducing the inequities currently seen in access to breast reconstruction. In some instances, this may involve accepting variance from the BMI criteria as discussed above.

3.4 Psychological assessment

The statement - Breast reconstruction units should work towards providing comprehensive psychological assessment for all patients. If this is currently unavailable, then patients may be able to be referred to support available through the breast cancer pathway, although it should be noted that these practitioners may not be specifically trained to support women through issues associated with reconstruction. Again, national variation is apparent within the Guidelines and access to staff who can support a women's psychological state is variable. We recommend additional actions are required to improve access to these services.

3.5 Photographic assessment

How are patients / women able to access clinical photos, and not just the acquisition of clinical photos for patient files? How can this be expedited?

4.2 Supporting patients' decision-making

How can women access a second opinion if they are not happy with the advice provided? Where does a second opinion fit in the greater scheme of things?

4.4 Information about available support

What information is available re: Health and disability funding, Travel and Accommodation, Work and Income (WINS), Housing benefits, Child support etc.?

4.5 Information about the outcomes of breast reconstructive surgery

Will the likely timeframe for surgery contain information about delays due to availability of treatment providers?

4.6 Information about inpatient stay

What to expect – Does there need to be a dot point acknowledging that some patients will experience restricted mobility and / or movement. For example: Being able lift their arm on the side of the reconstructed breast?

4.7 Patient support during the inpatient stay

Religious or spiritual support, will that be available for patients?
Working towards offering each patient – is this a given or best attempt? Will there be adequate psychological support to patients? How will the issue be addressed if the support is not available, what is the alternative?

4.8 Quality criteria

What if the patient does not have a GP (as the practice is closed to new patients, they are a transient etc.)? Who is the letter sent to provide supervision and support to the patient?

5.1 Implants

We support the establishment of a national database to record implant use and to support subsequent review, audit, and response in the event of product failure and / or recall. The location of a national data base to be determined as part of the pending health sector reforms.

5.3 Discharge expectations

The wearing of compression stockings recommendation should contain and suitable foot ware to avoid slipping, trips, and falls.

Prior to giving a patient a drain chart, the clinician should ensure the patient knows how to empty the drain and the process confirmed by the clinician.

Referral to an outpatient clinic for a follow-up appointment – consideration should be given for home visits depending on the location, ability of the patient to travel and access to a vehicle.

6.1 Long-term complications and unplanned reoperations

Do timeframes for follow-up services need to be documented? For example within 5 years?

6.2 Patient support

What is being undertaken to increase the availability of lymphoedema support services? Stating that are not available is not a solution.

Access to a breast CNS or breast reconstruction CNS – is this months or years? Is this available in both the public and private sectors?

7.1 Data - General requirements

NZNO agrees that all breast reconstruction units should be working towards setting up an appropriate auditing system, and monitoring reconstruction uptake with the aim of improving reconstruction rates to match international best practice.

We also support summary audit data related to key performance indicators should be presented as part of the unit's peer review process and should be used in revalidating the unit. Furthermore, the non-identifiable data should be compared with other units across New Zealand for benchmarking and quality improvement.

Thank you for the opportunity to participate in the consultation process.

Nāku noa nā

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