APPSA Journal

Association for Peri-operative Practitioners in South Africa

Vol 9 Issue 2 May 2023

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Table Top Galbiati PRIMA

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SINCE 1935

GENERAL INFORMATION

- The Journal is the official publication of APPSA (Association for Peri-operative Practitioners in South Africa). It provides personnel in the operating room and related services with original, practical information, based on scientific fact and principle

- APPSA is a non-profit organisation which exists for the benefit of its members. This is accomplished by way of congresses, local meetings and travel grants, with the express goal of raising the standard of peri-operative practice in South Africa

- Revenue is raised from, among other sources, the sale of advertising in the APPSA Journal

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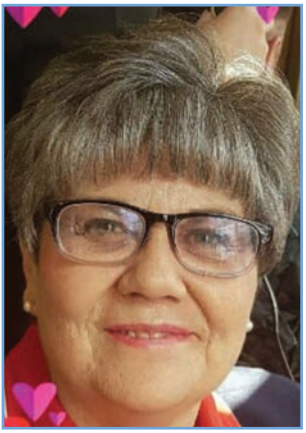

From The PRESIDENT

I hope you were all blessed with a rewarding Nurses' Day on 12 May 2023.

Colleagues, our patients need the best quality peri-operative care we, as peri-operative practitioners, can provide. To achieve this, we need to strive towards attaining and maintaining only the highest standards to ensure that peri-operative practice will be enhanced, and that theory and practice integration and skills will increase. Over the years, important developments have been achieved in the sphere of nursing and healthcare, in part due to our professionalism compassion, caring, sacrifice and perseverance. But there are concerns that have been raised regarding the new nursing model - particularly in the areas of specialisation. Students wishing to pursue a career in peri-operative practice - or any other nursing specialisation - first have to obtain a qualification and registration in midwifery. This is going to seriously impact our profession in the future.

SANC News, Vol 2 March/April 2023 highlights the following: The Post-graduate Diploma (PGDip) in Nursing is the qualification through which specialist nurses are developed. These are nurses who are already registered as Professional Nurses and Midwives, or a General Nurse with a Midwifery Qualification. After 1986, these nurses would have historically followed one of the following three legacy qualification routes, which on completion and with experience, enabled nurses to be admitted to specialist studies:

- A two-year Diploma (bridging course) leading to registration as General or Psychiatric Nurse offered under Regulation 683 of 14 April 1989, as amended, followed by a one-year Diploma in Midwifery offered under Regulation 254 of 14 February 1975, as amended; OR
- A four-year Diploma in Nursing and Midwifery offered under Regulation 425 of 22 February 1985, as amended; OR
- A four-year Bachelor's Degree offered under Regulation 425 of 22 February 1985, as amended

In addition to the minimum requirements for admission to the PGDip (described on page 35 of the HEQSF (CHE, 2013) as follows: 'The minimum admission requirements is an appropriate Bachelor's Degree or an appropriate Advanced Diploma', Nursing Education Institutions offering the PGDip in Nursing can also consider applicants who have followed the three legacy routes above for admission to the PGDip in Nursing. As the APPSA National Executive, we feel that institutions offering the PGDip in Nursing must take cognisance of the diverse qualifications routes that students have followed and put appropriate measures in place to support students, including addressing content and skills gaps where these may exist. In the light of the special concession above, it should be noted that the articulation pathways describe the problem adequately, but we also have a huge gap in our ORs regarding unrecognised Prof Nurses, including but not limited to the PACU Prof Nurse with no qualification; and the Anaesthetic RN/EN working as the Anaesthetist Assistant at all times -– with no qualification.

SANC - and all relevant authorities - must also be made aware of the shortfalls and address them urgently. In closing, as winter approaches, stay warm, stay safe, look after yourselves ... and your patients

Marilyn de Meyer

From The EDITOR'S DESK

In 1948, Alan Paton wrote the book, *Cry, The Beloved Country,* a social protest story about the structures of a society that would later give rise to Apartheid. The book follows the story about a black village priest and a white farmer who have to deal with the news of death, murder and destruction - of families, of lives and of hope.

Very often, in 2023, this saying is used to describe the feelings of despair so many of us feel about what we are seeing about so many different aspects of life in South Africa: rolling blackouts, extreme levels of poverty, the high cost of living - and it seems like no one seems to care. I use this saying most when I describe the state of healthcare in South Africa. Not a day goes by when this country is not rocked by another healthcare scandal in one way or another. And who suffers the most? The patients.

On 10 May, *MedicalBrief* reported that the Chris Hani Baragwanath Academic Hospital was thrust into the spotlight again, over a drastic shortage of food for patients. Gauteng Health denied the food shortage, despite a source saying the hospital is 'borrowing food from other institutions' and that patients are being fed baked bean soup, with staff desperately trying to make a plan about how to feed them. The root of the problem appears to lie in maladministration at the Gauteng Provincial Health Department and the failure to pay suppliers on time, reports *Daily Maverick,* which was first alerted to the problem a week earlier when a departmental head contacted the news site, saying: "Once again there is a food crisis at Bara - suppliers weren't paid, also there is no soap and hand towels - and as a result infections are spreading."

The health worker said this was a long-standing problem that 'has now reached crisis point - companies are refusing to deliver because of non-payment'. The issue appears to be linked to companies being awarded tenders to supply a number of different products: 'So, for example, if they are not paid for eggs, they refuse to deliver milk'. She said the hospital had been 'dealing with the crisis day-to-day from petty cash, which was depleted. Today patients are now having baked bean soup as a protein because the supplier has not been paid. It's unacceptable that our patients are going through this.' Another senior health worker confirmed the allegations.

In Gqeberha (or Port Elizabeth) orthopaedic supplies have been in such short supply for so long that people simply cannot be operated on. Departments of Health lurch from one crisis to another - apparently without a care in the world ... and patients are merely collateral damage.

What happened to the Hippocratic Oath that doctor's have to sign, and the Nurses' Pledge? Or do these not apply to hospital management, only to the medical profession? What happened to the oath of *First, Do No Harm*? Is access to quality healhcare not written in our Constitution?

What has become of our right to dignity?

I don't know, but one thing I do know for certain ... our patients deserve better than they are getting in State Hospitals. And so I say again, *Cry The Beloved Country*.

Madeleine Hicklin

HOSPITAL UTILISATION
And Healthcare Planning

By Ronald Lagoe and Shelly Littau, Hospital Executive Council, Syracuse New York, USA

ABSTRACT

This study evaluated changes in in-patient adult medicine and adult surgery services in the metropolitan area of Syracuse, New York. These are the two largest in-patient hospital services. The study involved the use of these services as a basis for healthcare planning over time. The first component of the study focused on changes in hospital discharges for adult medicine and adult surgery. It demonstrated that, between the first three quarters of 2019 and 2022, before and after the coronavirus epidemic, numbers of adult medicine and adult surgery discharges declined by 16% to 21%. The second component of the study focused on changes in hospital lengths of stay for adult medicine and adult surgery. It demonstrated that, between the first three quarters of 2019 and 2022, hospital in-patient lengths of stay increased by approximately 19% to 21% at the aggregate and hospital specific levels. Effective planning involving utilisation indicators such as hospital discharges and efficiency will be necessary if the potential for effective management of this sector is to be preserved. This planning should involve comparisons of data such as hospital discharges and stays, and identification of the sources of these developments at the community level.

INTRODUCTION

Within the last 100 years, the need to support healthcare has been a major challenge in the United States and elsewhere. Maintaining the health of large populations has required large expert staff and extensive financial resources to support them. Much of this challenge has grown out of the fact that healthcare has developed in a rapid manner through a wide range of private and public organisations. Providers and payors have worked to provide care with good intentions but not always in an organised manner[1, 2]. Within these parameters, the planning of healthcare services has not always had the highest priority. Health planning has frequently been relegated to a lower priority than the provision of care and the resources needed to pay for it[3].

One of the most interesting environments for the development of health planning has been the United States. Unlike many other nations, the United States developed much of its healthcare systems through payor organisations. These included publically-sponsored payors such as Medicare and Medicaid, as well as not-for-profit and for-profit payors. The result has been a healthcare system that contains large numbers of providers and payors that function in different ways[4, 5, 6]. Health planning arrived in the United States belatedly. It appeared after providers and payors were already in place. It was contained in the Health Care Planning and Development Act that was passed by the federal government in 1976. This legislation provided a federal framework for health planning at the state and regional levels[7,8].

Health planning at the federal level did not last long. After 20 years, the original legislation expired. States, regions, and localities were left to pursue this function with their own providers of care. This approach resulted in a variety of approaches to planning for needed services[3, 7].

POPULATION

This study described examples of efforts to plan the efficiency of health services in the metropolitan area of Syracuse, New York. It included programmess to address this subject implemented by local providers. The focus of these efforts was the Syracuse Hospitals. These included Crouse Hospital (18 217 in-patient beds excluding well newborns, 2021); St. Joseph's Hospital Health Center (20 720 in-patient beds excluding well newborns, 2021), and Upstate University Hospital (32 245 in-patient beds excluding well newborns, 2021).

The Syracuse Hospitals provide a full range of acute care to an immediate services area of approximately 600 000. They also provide tertiary services to the 11 county Central New York Health Service Area with a population of 1 400 000. Historically, the Syracuse Hospitals have worked co-operatively to improve the efficiency and outcomes of care in the community. A number of these efforts have involved the Hospital Executive Council, a joint planning organisation.

METHOD

This study reviewed efforts by the Syracuse Hospitals to evaluate in-patient adult medicine and adult surgery utilisation between 2019 and 2022. These years included the time periods before and after the coronavirus epidemic. This information provided an opportunity to review major utilisation indicators as a basis for planning at the community level. The study included January to March, April to June, and July to September for each of the two years. These intervals included the most recent in-patient data available.

The first component of the study included in-patient adult medicine and adult surgery discharges for January to March, April to June, and July to September for each of the combined totals and within the three hospitals. The analysis focused on changes in numbers of discharges that occurred among the seasonally-adjusted quarters. The analysis focused on percent differences among the three calendar quarters. During the three years, these differences could be used as a basis for the planning of healthcare services at the community level.

The second component of the analysis included in-patient hospital adult medicine and adult surgery lengths of stay between January to March, April to June, and July to September for the combined hospitals and each of the acute care facilities. As in the discharge data, this analysis focused on changes that occurred among the seasonally-adjusted quarters.

RESULTS

The initial component of the analysis focused on changes in in-patient adult medicine and adult surgery discharges in the Syracuse Hospitals during the three most recent calendar quarters that were available. Relevant data are summarised in Table I.

Table 1. Inpatient hospital adult medicine and adult surgery discharges, by quarter, Syracuse hospitals, January-September 2019, 2022.

	Adult Medicine				Adult Surgery			
	1Q	2Q	3Q	Total	1Q	2Q	3Q	Total
Crouse Hospital								
2019	2064	2159	2145	6368	1142	1234	1109	3485
2022	2033	2224	2065	6322	875	1036	882	2793
Percent Difference	−1.50	3.01	−3.73	−0.72	−23.38	−16.05	−20.47	−19.86
St. Joseph's Hospital Health Center								
2019	3437	3401	3207	10045	2200	2088	2229	6517
2022	2083	2261	2289	6633	1444	1657	1586	4687
Percent Difference	−39.39	−33.52	−28.62	−33.97	−34.36	−20.64	−28.85	−28.08
Upstate University Hospital-SUNY UMU								
2019	3886	3984	4088	11958	1924	2045	2051	6020
2022	3231	3471	3473	10175	1256	1640	1648	4544
Percent Difference	−16.86	−12.88	−15.04	−14.91	−34.72	−19.80	−19.65	−24.52
Total								
2019	9387	9544	9440	28371	5266	5367	5389	16022
2022	7347	7956	7827	23130	3575	4333	4116	12024
Percent Difference	−21.73	−16.64	−17.09	−18.47	−32.11	−19.27	−23.62	−24.95

Adult medicine data exclude Diagnosis Related Groups concerning surgery, obstetrics, psychiatry, alcohol/substance abuse treatment, rehabilitation, and all patients aged 0 - 17 years. Adult surgery data exclude Diagnosis Related Groups concerning medicine, obstetrics, psychiatry, alcohol/substance abuse treatment, and all patients aged 0 - 17 years. Source: Hospital Executive Council.

This information demonstrated that total adult medicine discharges for the combined hospitals declined by 18.47% percent between January to March and July to September 2019 and 2022. These differences were similar during the three time periods, 16.64% to 21.73%. The adult medicine data also identified differences between 2019 and 2022 in-patient discharges within the individual hospitals for January to March and July to September. The largest reductions occurred at St. Joseph's Hospital Health Center, 33.97%, while the smallest changes occurred at Crouse Hospital, 0.72%.

The adult surgery in-patient data in Table 1 also demonstrated that in-patient discharges declined by 24.95% between January to March and July to September 2019 and 2022 in the Syracuse Hospitals. This information declined from 19.27% to 31.11% between the calendar quarters. The reductions were larger than those for adult medicine.

The study data also identified that reductions in adult medicine discharges also occurred within the individual hospitals. The largest changes involved St. Joseph's Hospital Health Center and Upstate University Hospital 28.08% to 24.52%. These data demonstrated that numbers of in-patients in the Syracuse Hospitals have not reached levels that occurred before the movement of in-patients to out-patient services and the coronavirus epidemic. These changes have involved the two largest hospital in-patient services. They suggested that the declines in utilisation have been accompanied by reductions in hospital resources.

The second component of the study involved changes in adult medicine and adult surgery in- patient lengths of stay in the Syracuse Hospitals during the three most recent calendar quarters. Relevant data are summarised in Table 2.

Table 2. Inpatient Hospital Adult Medicine and Adult Surgery Mean Lengths of Stay (Days), by Quarter, Syracuse hospitals, January-September 2019, 2022

	Adult Medicine				Adult Surgery			
	1Q	2Q	3Q	Total	1Q	2Q	3Q	Total
Crouse Hospital								
2019	5.18	4.93	4.75	4.95	4.42	4.09	4.49	4.33
2022	6.85	6.13	6.07	6.34	5.94	5.35	5.81	5.68
Percent Difference	32.24	24.34	27.79	28.08	34.39	30.81	29.40	31.18
St. Joseph's Hospital Health Center								
2019	4.49	4.23	4.24	4.32	4.84	4.75	4.57	4.72
2022	4.91	4.71	4.89	4.83	5.36	5.64	5.70	5.57
Percent Difference	9.35	11.35	15.33	11.81	10.74	18.74	24.73	18.01
Upstate University Hospital-SUNY UMU								
2019	5.35	5.21	5.08	5.21	7.10	6.71	6.58	6.79
2022	6.44	6.12	6.24	6.26	8.50	7.58	7.68	7.87
Percent Difference	20.37	17.47	22.83	20.15	19.72	12.97	16.72	15.91
Total								
2019	5.00	4.79	4.72	4.84	5.58	5.35	5.32	5.41
2022	6.12	5.72	5.80	5.87	6.61	6.30	6.52	6.47
Percent Difference	22.40	19.42	22.88	21.58	18.46	17.76	22.56	19.59

Adult medicine data exclude Diagnosis Related Groups concerning surgery, obstetrics, psychiatry, alcohol/substance abuse treatment, rehabilitation, and all patients aged 0 - 17 years. Adult surgery data exclude Diagnosis Related Groups concerning medicine, obstetrics, psychiatry, alcohol/substance abuse treatment, and all patients aged 0 - 17 years. Source: Hospital Executive Council.

This information demonstrated that in-patient adult medicine stays for the combined hospitals increased by 21.28% between January to March and July to September 2019 and 2022. These increases were similar during the three calendar quarters, 19.42% to 22.88%. These increases amounted to reductions in in-patient efficiency. The data demonstrated that changes in hospital stays differed among the three hospitals. The smallest increases were produced by St. Joseph's Hospital Health Center, 11.81%. The largest increases were generated by Crouse Hospital, 28.08%.

The study data indicated the in-patient lengths of stay for adult surgery also increased during the three time periods, 19.59%. Reductions for the combined hospitals ranged from 17.76% to 22.56%. At the individual hospital level, in-patient lengths of stay increased from 15.91% at Upstate University Hospital to 31.18% at Crouse Hospital. Differences in stays were also identified for the individual three-month periods. The length of stay data suggested that the in-patient efficiency in the Syracuse Hospitals declined during the period of the study. The longer in-patient lengths of stay consumed additional hospital resources and reduced efficiency for both major services.

CONCLUSIONS

The first component of the study focused on changes in hospital discharges for adult medicine and adult surgery. It demonstrated that, between the first three quarters of 2019 and 2022, before and after the coronavirus epidemic, numbers of adult medicine and adult surgery discharges declined by 16% to 21%. The study demonstrated that these changes were related to reductions in the use of in-patient care over time. These changes implied that hospital revenue and resources declined between 2019 and 2022. They resulted from the movement of in-patients to out-patient care, as well as the coronavirus.

The second component of the study focused on changes in hospital lengths of stay for adult medicine and adult surgery. It demonstrated that, between the first three quarters of 2019 and 2022, hospital inpatient lengths of stay increased by approximately 19% to 21% at the aggregate and hospital specific levels. The study suggested that these changes were related to declines in hospital efficiency over time. It implied that increases in lengths of stay were related to longer turnover times for hospital beds. These reductions in efficiency consumed additional hospital resources.

DISCUSSION

Historically, the evolution of healthcare in the United States has focused on the use of in-patient services over time. This utilisation has developed at the community level through aggregate and institution specific data. This study evaluated changes in in-patient adult medicine and adult surgery services in the metropolitan area of Syracuse New York. These are the two largest in-patient services. The study involved the use of these services as a basis for healthcare planning over time.

The past several decades have demonstrated the importance of healthcare to the societies and the economies of healthcare in the United States and other nations. The data in this study suggested the limitations of this sector at the community level. Effective planning involving utilisation indicators such as hospital discharges and efficiency will be necessary if the potential for effective management of this sector is to be preserved. This planning should involve comparisons of data such as hospital discharges and stays, and identification of the sources of these developments at the community level.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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REVIEWING THE FLOW OF PATIENTS IN AND OUT OF THE NHS

The Issue Of Bed Availability

By Kate Woodhead, RGN, DMS

INTRODUCTION

The perfect storm is hitting the NHS at present, with patients queuing at the front door and not being able to progress any further for hours at a time. Patients are waiting to be admitted and are stuck until a bed becomes available - or they are in the back of an ambulance until such time as they can be seen and triaged in A&E. Due to other pressures, it is also proving problematic to release some patients back home or to a community system following their treatment. The whole system is, thus, gridlocked.

It is a significant problem for both the patients and the healthcare professionals trying to deliver care. The consequences across the NHS are considerable, despite the preparation and planning which has gone into place since last year. Social care, too, has immense problems and despite many residential homes having rooms available, they have no staff to support patients, so patients stay in hospital although they are medically fit to be discharged.

Politicians are staying remarkably quiet, leaving patients and clinicians to fill the media with pictures and quotes. There are no easy answers, but a short review of the ideas and plans which have been put in place may help to inform everyone about this dire situation.

THE PROBLEM

The bed capacity of the NHS has been declining since the 1980's due to the advent and development of day surgery and day care, reducing length of stay for many other patients and is part of a global trend. Many people are now able to be treated in the community rather than being admitted to hospital. This is due, in part, to services which are available from primary and domiciliary care. Telemedicine and other technologies are playing their part. However, there are also many fewer acute and mental health beds since 2010 - which is said to have seen a reduction of 17 000[1] beds. However, it is not possible to open more beds without the associated workforce, and that presents another key challenge for finding solutions.

It may seem to be an obvious aspect of the supply and demand conundrum, but surely the key to this is to find alternative solutions to the acute admission route? This could include options such as ensuring that those who do not absolutely need to be in a hospital bed should be treated as an out-patient, find diagnostic services away from the hospital, or make arrangements for treatments to be carried out using the independent sector, or even other options. Community facilities such as using pharmacists for local advice and prescribing were successfully brought into the fold during the COVID-19 pandemic, and could once more provide useful services to prevent people sitting in A&E for hours on end.

The management of discharges is also an essential element of managing the flow of patients out of hospital, but this has already received considerable attention and is being actively worked on by the new Integrated Care Boards and others.

WINTER PRESSURE CAPACITY PLANNING

In a bid to get ahead of the crisis, last August, NHS England set out steps they would take to increase NHS capacity and resilience[2]. The number of beds was increased by 7 000 through a mixture of new hospital beds (previously mothballed beds), virtual ward spaces and other initiatives to improve patient flow in winter. More call handlers for both 111 and 999 services were employed to help staff meet record demand. There was also a prediction, which has now come around that both influenza and COVID will cause additional stress to hospital capacity. There were also plans to increase timely discharge by working with social care as well as creating more virtual wards. In addition, a taskforce has been set up to recruit international staff into critical roles across the system with promises that the process will be ethical.

DEMAND AND SUPPLY

Demand for elective care has increased due to the COVID-19 backlog and despite many recent successes with reducing two-year waits for surgical care, there are still many people awaiting procedures and care today. It was reported that the figures were 7.2-million people waiting to start treatment at the end of October 2022 - sadly a new record high. Urgent cancer referrals are at also at a record high with 118% of pre-pandemic levels[3].

The Kings Fund identified that elective care waiting lists and waiting times are a product of the fluctuations in, and disparities between, the demand for and available supply of healthcare[4]. Understanding the root causes of these disparities, and taking corrective action to restore balance between demand and supply - and optimising the conditions within the healthcare system - is therefore considered key to any strategy to reduce waiting times and sustain them at that level. The forces affecting supply and demand of healthcare are numerous, broad and change over time. However, they can be summarised into three broad categories:

- **Supply side factors**, including levels of funding, investment in and capacity of the health and care workforce, beds, equipment, facilities and technology to deliver healthcare
- **Demand side factors**, including the healthcare needs of the population, levels of presentations to healthcare services, the availability of treatments, thresholds and criteria for administering treatment and the attitudes and approaches of healthcare professionals in referring for/administering treatment
- **Factors impacting the conditions** of the healthcare system that affect the management of waiting lists and waiting times, specifically:
  - Cultural and environmental factors
  - Operational and practical factors

There was a clear focus in the NHS in 2000s to reduce waiting times. NHS Trusts worked their socks off and were successful in reducing waiting times for a variety of procedures to meet the 18-week target. A key focus which made it all possible was:

- Increased funding and capacity

- Central direction and oversight
- Performance management and incentives
- Targeted support
- Leadership and relationships at all levels
- Mobilising the know-how and skills on the ground
- Wider NHS reform

From a then NHS managers' perspective it was 'all hands to the pumps' with relentless pressure to meet extra surgical operating lists every weekend, and a programme which continued for months. It was very difficult to fulfil all the shifts each weekend and there was huge disparity in payment for extra medical sessions and overtime payments for lower-grade staff. It was all very hastily organised and set up a great deal of resentment between hitherto well-working team members. Times have changed and a number of different strategies are in place and a host of new scenarios in place which were not relevant in the past.

URGENT AND EMERGENCY CARE

The rising demand of 13% over the last 10 years in attendances at A&E departments has made it increasingly difficult to manage demand in a timely manner. There is a change to the perception of the general public as to how they should see a healthcare professional when they have an issue. Many are currently struggling to see a GP and so head down to the nearest A&E department, where, it seems, they are happy to wait for many hours. Seeing everyone for everything has meant that emergency departments are victims of their own success and they are currently unable to function effectively.

One of the ways that could help both patients and staff - as outlined by NHS Confederation[5] is to devise a scheme that separates non-time-critical work that is urgent (or some definitely not even urgent care) is diverted elsewhere, so that Emergency Departments can deal effectively with time critical patients using their skills and talents to save lives. The present situation is not sustainable and needs to be reformed.

The patients who need to be admitted from A&E also need to be assured that they can be returned to their home with appropriate support or find an assisted place in care. Social care, as well as healthcare, has many problems with staff shortages and there are as many issues with assessments for discharge as there is a shortfall of social workers. Patients who are medically-fit to be discharged are unable to be sent out of hospital until their needs can be met elsewhere. This requires assessment and therein lies another issue. This delayed discharge once again has the effect of blocking beds for other patients.

DISCHARGE

Discharge, in itself, is a complex area involving the needs of the patients as well as the wishes of the family. This all has to be co-ordinated and delivered by a number of organisations who may be waiting for adaptations to housing, a rehabilitation bed in the community or a bed in a nursing home. Some of the waits endured by patients can be months of extra care in hospital when and where, in reality, they would really like to be elsewhere. There has been a reduction in the number of community hospitals where immediate rehabilitation from major surgery could be

undertaken or major wound healing or an intense programme of physiotherapy is available. Virtual wards have become one of the solutions for patients and the Operational Planning Guidance 2022/23 has emphasised them further, as well as expanding the Hospital-at-Home Programme that has even attracted funding, which has proven to be most beneficial.

Virtual wards support patients who would otherwise be in hospital to receive the care, by monitoring and supporting them and their needs in a place they call home. This may include either prevention of admission into hospital or early supported discharge out of hospital while remaining under consultant care. Patients in virtual wards are supported and monitored on a daily basis using remote monitoring apps, utilising technology platforms, and using pulse oximeters (for example) to record regular data.

Hospital-at-Home is another scheme run by some areas where patients are supported to remain at home while being supported by a multi-disciplinary team who visit as often as necessary. It provides hospital-level interventions and diagnostics such as point-of-care tests, endoscopy as well as IV fluids, therapy and Oxygen while being carefully monitored. These interventions come with strict inclusion and exclusion criteria.

Alternatives are being supplied by some Integrated Care Boards, notably in Bristol, Devon and Cornwall who commissioned private healthcare companies to support discharged patients in local hotels from January 2023 until March 2023 . It remains to be seen how successful these were, on review, but it seems to have been a sensible idea and could release beds in the acute sector, to unblock some of the obstacles, increasing the flow in the acute hospital.

HEALTHCARE WORKFORCE

A crucial element to all of the unblocking activities and reforms required cannot but avoid the key factor of staff shortages. Staff shortages hamper every element of healthcare delivery and care - on every level. Developments and new activities are almost impossible to implement when staff are under such pressure and vacancies across the professions are having such an impact. But if the system is not to collapse altogether, solutions must be found. International recruitment of staff into the UK may provide some answers, but it is known that new staff, particularly from overseas, need a great deal of help and support to settle in and find their feet. Some Trusts have appointed specific individuals to support new staff, which can only be to their benefit. Additional care needs to be taken not to 'deplete the pool from which the staff are sourced' as well, thereby creating a ripple effect of depriving other countries of much-needed and valued staff to supplement the NHS resources to the detriment of other countries.

CONCLUSION

If the separation of urgent and emergency care is to occur in order to relieve ambulance services and long queues in A&E, then there needs to be a comprehensive public education programme. People need to be re-taught how to use their local departments to best effect. This would include the use of 111 services, the Urgent Care Centres which have been set up all around the country, and any other options available to the public for consultation in the event of minor problems. This includes a 'first port of call' option such as a visit to pharmacies. To ease the constant flow of particularly elderly into hospital with complex problems, some areas are

setting up crisis teams in localities which provide services in the home and prevent unnecessary admission to hospital. Referrals can be made by a wide range of people including ambulance staff, GPs and other healthcare professionals.

Admission avoidance is the objective here[6]. There is a wealth of ideas around, which may help to relieve the blockages, but little time to put them into place. Money has flowed from the centre to help hospitals and integrated care boards to find and implement solutions. However, the 'twindemic' of COVID-19 and influenza has somewhat hampered the efforts, and the current and ever-growing staff shortages have further damaged the potential developments. It is to be hoped that the peak of the viral wave is soon spent and a return to normal winter pressures provides relief for everyone.

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CULTURALLY-APPROPRIATE CARE TO SUPPORT MATERNAL POSITIONS DURING SECOND STAGE OF LABOUR: Midwives' Perspectives In South Africa

By Maurine R Musie; Mmapheko D Peu; Varshika Bhana-Pema

INTRODUCTION

The need for 'culturally-appropriate' maternity care services is core to the World Health Organization's (WHO) strategy for improving maternal and new-born health and ending preventable maternal mortality.[1,2] Health professionals (including midwives) are expected to provide culturally-appropriate care to child-bearing women.[3] Culturally-appropriate care includes, among others, the involvement of the labouring women in the decision-making regarding preferred birth choices and maternal birth position during labour.[4] Moreover, other studies reported culturally-appropriate care during labour that includes allowing women the comfort and support from a birth companion of choice.[5] This inclusion of women in decision-making is noted as one of the key indicators of culturally-appropriate care that fosters quality care and long-lasting relationships between a woman and the healthcare professionals including midwives as embedded in the respectful maternity care (RMC) principles.[1,6]

Minority ethno-linguistic or religious child-bearing women often have limited access to maternity care services than the rest of the population.[1] This is very true in the South African context as well, *'Midwives attend to women from various ethnic and religious backgrounds during intra-partum care'*. This is due to migration and globalisation in the country that led to diversity and a global village of maternity care facilities that have been utilised by women from indigenous populations from several African countries (such as Zimbabwe, Ethiopia, Somalia and Nigeria) who have their own cultural preferences and practices during birth pertaining to birth position during the second stage of labour. A study conducted in Zimbabwe indicates that most child-bearing women perceive the health facilities as foreign environments that were not comforting as traditional and cultural sources of care.[7,8] In a country like Uganda, cultural customs like the use of herbs, a non-supine birth position, and placental disposal are regarded as some of the sacred cultural preferences held by women.[9]

A systematic review conducted in various sub-Saharan African countries (Ethiopia, Kenya, Ghana and Nigeria) indicate that most women prefer to adopt maternal upright positions such as kneeling and squatting, which are guided by their instincts and cultural norms rather than being restricted on supine lithotomy positions during birth.[7] The lack of women's choice of birth position led to women preferring to have home births conducted by a traditional midwife and traditional birth attendant (TBA) rather than facility births with midwives, as facility care is not tailored towards the child-bearing women's cultural preferences and norms.[7] Similarly, in Australia, there have been reports of disparities in terms of culture and cultural practices that exist between nurses and child-bearing women. As a result, this has affected women's utilisation of formal healthcare services.[10] Thus, it is mandatory for skilled birth attendants (SBAs) (including midwives) to respect the cultures, values and beliefs of women.[10]

According to Mselle,[11] the child-bearing women's choice of birthing positions is influenced by women's empowerment and involvement in the birth process, age, parity, culture, the biomedical model and the birth attendants who are primary caregivers during the labour process. Presently, there is an outcry by some of the women from Africa (in countries such as Tanzania), complaining that the childbirth facilities are not culturally appropriate towards the women's choices and are often termed as dehumanising.[11] A systematic review, done by Jones, found that the lack of culturally-appropriate care in maternal health can impede women's utilisation of skilled birth care.[1] In the context of the study, the authors focus on women's cultural beliefs and practice regarding maternal positions adopted during the second stage of labour. The second stage of labour starts when the cervix reaches full dilatation (10 cm) and ends with the delivery of the baby.[12] The maternal guidelines in South Africa indicate that a woman should be given a freedom of choice to mobilise and adopt upright maternal positions that come naturally to her during birth.[12] Several advantages have been associated with the other upright birth positions that include more improved maternal outcome of the good progress of labour as a result of adequate labour contractions, increased pelvic outlet, adequate foeto-placental perfusion and reduced perineal tears.[13] However, this is not a reality in South Africa where women are restricted on lithotomy/supine position.

The right of choice of birth position, freedom of movement during birth and continuous support during the first and second stage of labour has been overlooked in various midwifery settings.[14] Approximately one in five births, which is approximately 22%, took place outside the healthcare facility globally.[15] A study conducted in Northern Ghana further indicated that about 60% of women in Africa prefer home births assisted by TBA rather than facility birth with the midwives. The current healthcare system can be presumed to lack culturally-appropriate care interventions, as the right of women to make an informed decision regarding birth position is often overridden and that can be seen as mistreatment during birth and labour.[16] Women from various ethnic groups are assisted during ante-natal, intra-partum and post-partum care at the health facilities. These women have certain cultural preferences regarding their birth process, which is often overlooked. Women are not included in the decision-making regarding their cultural preferences in relation to birthing positions. This lack of involvement of women is associated with negative birthing experiences.[16] The midwives continue to position a significant majority of 68% women to give birth lying on their back in contradiction to their own choice of birth position.[3] Furthermore, evidence-based practices for intra-partum care and midwifery care guidelines[12] stipulate *'that women should not be restricted to supine position during second stage of labour'* as this practice is associated with negative maternal and neonatal outcomes. Some of the negative maternal outcomes reported include prolonged labour, increased perineal trauma, and post-partum haemorrhage.[17] Post-partum haemorrhage (PPH) accounts for 22% of maternal mortality and morbidity for every 100 000 live births.[18] PPH is one of the big five causes of maternal mortality in South Africa and accounts for one-third of maternal deaths in Africa.[18] Consequently, health professionals continue to turn a blind eye and continue to routinely place women on lithotomy position and restrict the women's movement during the second stage of labour.

'Lack of culturally appropriate care and intervention to the women's needs is a global concern and has been noted as barrier'.[1,2] Culturally-appropriate care includes the simplest things, such as the midwives respecting women's home language; however, in this study, it is clear that midwives found that the ethno-linguistic aspect was a barrier to provide culturally-appropriate care, which is not in line with the WHO recommendations. The WHO vouch for *'culturally-*

appropriate' maternity care services to improve maternal and neonatal outcomes, which later informs RMC.[1] Most recently, the WHO made recommendations on intra-partum care for a positive childbirth experience, which alludes that it is mandatory that midwives should provide RMC.[4] Respectful maternity care refers to midwives, taking the authority and responsibility to care for the women in a way that their rights, dignity and choices are respected. One of the fundamental rights of a woman include respect of her religion, beliefs and culture regarding choices during labour.[12] We also trace back since time immemorial that birth positions could be freely changed and modified according to the parturient's desires. Previous research studies indicate the history of birth position in Africa. It is evident that women were giving birth in various alternative birth positions, such as sitting, upright position, squatting, kneeling and using hands and knees and the left lateral birth positions.[19] Furthermore, it is noted that the use of these alternative birth positions gives comfort to the women and is associated with better outcomes during birth. For changes to occur within the healthcare system and from the individual point of view, there is a need to look at the practices currently done within the maternity units, in order to assess whether they incorporate culturally-appropriate care. The aim of this study was to explore and describe midwives' perspectives on culturally-appropriate care to support maternal positions during the second stage of labour.

METHODS

Study Design

A qualitative, exploratory and descriptive research design was used to explore and describe the culturally-appropriate care to support women's choice of maternal position during labour. This approach enabled the researchers to gain more in-depth understanding of the phenomenon studied.

Setting

The study was conducted in a public hospital premises situated in Pretoria in the City of Tshwane Metropolitan district. The selected hospital operates 24-hours a day, and the services provided are low-risk maternal healthcare services that include ante-natal, intra-partum and post-partum care. Overall, the hospital caters for rural and urban areas surrounding the hospital.

The study took place in the maternity ward of the hospital. This is a 30-bedded ward, with eight ante-natal beds in one cubicle (two admission beds, two isolation, two first-stage and four second-stage/delivery beds located in private individual rooms). The labour ward offers services to low-risk child-bearing women, without any obstetrical complication or high-risk conditions (such as pre-eclampsia). On average, about 300 to 350 women give birth monthly in the maternity ward.

The study population includes midwives (registered with the South African Nursing Council [SANC]) offering maternal health services to women from various ethnic backgrounds such as Tshwane speaking, Shona, Indian, Somalian, Venda, Zimbabwean, among others. These women come to the labour units for intra-partum care, and they have cultural practices and traditions that they follow (for example, Muslims prefer consuming *halaal* food and some herbal drinks for protection during labour, while women from African countries prefer squatting during labour). Other low-risk child-bearing women come as referrals from local clinics within the sub-district of Tshwane, and some are referrals from the nearby high-risk hospitals. The staff ratio is about eight

midwives during the day and night shift who are present in the ward, which is in line with the SANC regulation.

Population and sampling strategy

The researchers were working at the labour ward during the time of data collection in 2018. Permission was obtained from the hospital authorities as part of the recruitment strategy. The researchers utilised purposeful sampling to select the participants. The population of the study comprised 20 midwives who met the inclusion criteria and agreed to participate. All the midwives selected for the study were registered with SANC per the inclusion criteria (refer to Table 1 for demographic information on the participants).

TABLE 1: Demographic characteristics of the participants.

Variable	*n*	%
Professional designation		
Advanced midwife	7	35.00
Professional nurse	13	65.00
Community service	2	10.00
Age profile (years)		
20–29	7	35.00
30–39	7	35.00
40–49	3	5.00
50–59	2	10.00
60–69	1	0.05
Gender		
Female	20	100.00
Years of experience		
< 1	2	10.00
1–5	9	45.00
6–10	4	20.00
11–20	2	10.00

The identified midwives were then approached for participation in the study. Explanation was given to the participants regarding the nature of the study. Those who showed interest to participate in the study were also informed that their participation is voluntary. The characteristics of the population in this study were professional nurses with midwifery qualifications integrated during the comprehensive nursing degree/diploma training or three-year diploma course, and advanced midwives with a speciality in midwifery. The midwives were responsible for assisting women during the first and second stages of labour.

Data collection

The study was conducted over four months during June 2018 to September 2018. Individual semi-structured, face-to-face interviews were employed to explore the midwives' perspectives on culturally-appropriate care to support maternal positions during the second stage of labour. First, the researchers scheduled suitable interview dates with the midwives for data collection. The interview took place in a quiet, private room in the labour ward without disrupting the daily routine of the midwives. The researchers were flexible to work around the availability of the midwives. Labour wards are very busy; thus at times, the researchers had to wait for midwives to complete the duties first and hand over the women to other midwives while doing the interview.

Most of the interviews were done at the end of the day shift at 19:00 after staff changes, due to the hectic and busy periods of the labour ward. Informed consent was obtained before conducting the interview. Each interview lasted between 30 and 45 minute duration. The interviews were held in English. The researchers used the semi-structured interview guide to aid the interview. Probing and clarification were performed to gain a full understanding of the comments and responses during the interview. Throughout the data collection, the researchers kept a journal to write field notes. Also, an audio recorder was used once consent was gained from participants to record the interviews. The interviews were ended once data saturation was reached, when no new information was emerging from the interviews.

Data analysis

The data analysis followed eight steps of the Tesch analysis method.[20] This method of data analysis was chosen due to its ability to convert written verbatim transcripts and audiotaped data into a more narrative form.[20] (1) During the first step, the researchers read the entire transcripts to obtain a sense of the whole and (2) thought about the underlying meaning of the information and (3) then made a list of emerging themes and grouped similar themes together as gathered from the transcripts. (4) The process was repeated with all transcripts and codes assigned to the grouped themes. (5) Furthermore, the researchers found more descriptive wording for the themes to show the relation of the identified themes and sub-themes. (6 and 7) Final arrangement made and preliminary analysis was made by asking peer researchers to read the transcripts to confirm the themes gathered. (8) Consensus was reached between the researchers and the peer researchers.

Trustworthiness and rigour

Measures of trustworthiness refer to ensuring the truth value of the research findings by Guba and Lincoln (1985 under reference 21 of Polit and Beck). The researchers ensured truthfulness through authenticity, credibility, confirmability and transferability.[21] First, credibility was ensured through prolonged engagement, where the researchers stayed for a long duration of four months in the data collection field and data were triangulated using various data collection sources. Confirmability was ensured firstly through member checking at the end of interview; the researchers gave a summary of the interview and an audit trail performed where the participant was asked to verify whether all the points were captured accurately. Furthermore, both the researcher and co-researcher verified all the themes and sub-themes generated from the data collected. Furthermore, transferability was ensured by recording the entire interview using the audiotapes and conducting thick description was ensured through the extensive literature review of the phenomenon studied.

Ethical considerations

Ethical clearance to conduct the study was granted by the University of Pretoria, Research Ethics Committee, Faculty of Health Sciences before commencement of the actual research (ethical clearance certificate: 133/2018). Permission was obtained from the Department of Health and the Chief Executive Officer of the hospital in Tshwane. The researchers maintained the following ethical principles that guided the study: Beneficence, respect for human dignity and justice as outlined in the Belmont report. Informed consent was sought from the participants before the data collection commenced. Participants were informed of their right to partake or withdraw from the study at any given point. Participants were informed that should they express any discomfort during the interviews; additional psychological support would be made available to them.

FINDINGS

The analysis process yielded the following three themes as indicated in Table 2.

TABLE 2: Themes and sub-themes that emanated from results.

Themes	Sub-themes
Theme 1: Barriers to culturally appropriate care in maternity service	Sub-theme 1.1: Ethno-linguistic barriers
	Sub-theme 1.2: Uncooperative behaviour of women during birth
Theme 2: Midwives imposing own personal adapted cultural beliefs on childbearing women	Sub-theme 2.1: Midwives' own adopted culture
	Sub-theme 2.2: Disrespect of tradition and culture by midwives
	Sub-theme 2.3: Midwives' preconceived fears regarding childbirth
Theme 3: Midwifery Unit workplace culture	Sub-theme 3.1: 'Following what the Roman's do in Rome'

Theme 1: Barriers to culturally-appropriate care in maternity care service

The barriers to culturally-appropriate care in maternity services have been identified as the main theme. The midwives in the study indicated that it is challenging for them to care for women from various ethnic groups. The following sub-themes also emanated from the main theme: ethno-linguistic barriers and due to not being able to understand the child-bearing women language and cultural beliefs of the following women for example (women from Somalia or women from Zimbabwe speaking Shona), these are unfamiliar languages to the midwives. The consequence of ethno-linguistic barrier becomes and results in unco-operative behaviour of the women during labour also becomes a barrier to provide the culturally-appropriate care. The following quotes support the main emergent theme.

Sub-theme 1.1: Ethno-linguistic barriers

The midwives in the study indicated that they experience ethno-linguistic difficulties during birth in which they are unable to understand what the women are saying especially when dealing with the various ethnic groups of women who utilise the maternal healthcare services in South Africa. Lack of understanding of these women's language hampers the midwife's ability to provide care that is in line with the womens' cultural preferences regarding birth and maternal positions to adopt during the second stage of labour:

One of the midwives reported on their experience that:

'I had an experience one time with a Shona women, we could not communicate due to language barrier. This woman was also not following instructions given. It's easy for the midwife to use lithotomy/supine position because; this woman was wrestless and I could not convince her to use other birth position such as squatting …'

(Participant 5, registered nurse/midwife, 32 years old)

Another midwife indicated that they even try to use a translator or non-verbal gestures when dealing with women who do not understand English or their native languages:

'We get a lot of women coming from other African countries who don't understand English to deliver at our unit. You cannot instruct someone who does not understand you. So with lithotomy position it's safe because, once they look up maybe you the midwife can look at a woman during birth and use gestures to instruct her. With other birth positions like squatting, they might be looking down and not understanding what you are saying.'

(Participant 11, registered nurse/midwife, 31 years old)

Another view regarding women's culture came out of the interviews:

'We deal with women from East Africa who come with those traditional herbs mixed in bottle. We cannot allow that in the ward and others even tell you that from my culture I am used to squatting because that is how I have been taught. We as midwives we cannot allow that.' (Participant 4, registered midwife, 24 years old)

Notably, the issue of language and communication difficulty came as a barrier for midwives to provide culturally-appropriate care.

Sub-theme 1.2: Unco-operative behaviour of women during birth

The second sub-theme that emanated from the findings was the unco-operative behaviour of women during birth, experienced as a result of a language barrier with the women from different ethnic groups. The midwives in the study told that most of the time women do not co-operate during labour. Lack of co-operation makes it difficult for them to try and think of utilising other maternal birth positions. The quotes below support the sub-theme identified.

One of the midwives indicated that:

'The challenges we are facing as midwives have to deal with unco-operative patients, especially from the women from other countries, and sometimes with the increased workload and high patient influx we are not able to use other birth positions …'
(Participant 6, registered nurse/midwife, 29 years old)

Another midwife raised an assumption that child-bearing women have cultural beliefs and practices and have their own preferences during labour, but midwives are not able to cater for the cultural preferences. The language barrier meant that there was a lack of understanding between midwives and childbearing women:

'The women will tell you that in their culture, they prefer to squat. Most of these women from African countries are unco-operative patients who fear childbirth pain; they start lifting buttock during labour, while in the lithotomy position. The others even close their legs during labour, but it is a better position because you can see the perineum, how will they be able to co-operate on position such as squatting.'
(Participant 11, registered nurse/midwife, 31 years old)

It is noted that midwives are not rendering culturally-appropriate care due to the challenges resulting from the lack of co-operation from most of the women from other ethnic groups because of the language barrier.

Theme 2: Midwives imposing own adopted cultural beliefs on child-bearing women

The findings of the study identified the second main theme, which indicates that midwives impose their own cultural attributes on child-bearing women. The midwives in this study disregarded the child-bearing women's cultural preference concerning the maternal position. The following sub-themes emerged to support the main theme including the conundrum of own personal cultural beliefs and midwives' preconceived ideas and fears regarding labour.

Sub-theme 2.1: The midwives' own adopted culture

This sub-theme describes midwives' adopted culture (culture explained as a way of doing

things), which poses a challenge to them taking into consideration women's preferences and cultural beliefs concerning maternal positions during birth. One of the midwives indicated that they normally follow their own personal beliefs:

'I personally prefer using the supine position, as it is a position I prefer. Moreover, I developed the culture and norm for using the lithotomy position, It is a position I prefer irrespective of what the women prefers of chooses …'
(Participant 6, registered nurse/midwife, 29 years old)

The midwives acquired this norm in the wards where they practised their midwifery skills. They learned the cultural practice and followed the practice done in the ward:

'The lithotomy position is a position most of us are using somehow it's like a norm in the ward. We have never tried other positions, I mean everywhere I worked before as a student it's a position that is always used …'
(Participant 3, registered nurse/ midwife, 30 years old)

Midwives follow their own norms and disregard the women's norms:

'The other factor that contributes to midwives not using other birth positions is because of comfortability. You know the religious position the lithotomy position is mostly done for the comfort of midwife, they're not much concerned of patients comfort but the midwife needs to be more comfortable with position …' (Participant 20, advanced midwife, 40 years old)

It is evident from the findings that midwives found an existing culture in the maternity wards and adopted the culture of following the norm in the ward and disregard the cultural beliefs that women have concerning their childbirth process.

Sub-theme 2.2: Disrespect of women's tradition and culture by midwives

The participants reported disrespect or disregard for the traditions and culture of women who come to give birth. They acknowledged that they do not recognise the traditions and norms but instead encourage the westernised, evidence-based medicine that is provided in the hospital. The following quotes support the sub-theme.

One of the midwives told that women would indicate that they prefer to squat in their own preferred culture:

'The women will tell you that in their culture, they prefer to squat [Shona women from Zimbabwe].' (Participant 11, registered nurse/midwife, 31 years old)

Some midwives would disregard the women's choices and beliefs:

'We always found the lithotomy being used here, and no we never give the woman a choice of birth position.' (Participant 1, advanced midwife, 36 years old)

'We only use the lithotomy position because we are used to this position …'
(Participant 13 advance midwife, 60 years old)

The midwives further mistreat the women, by indicating that some women are not well educated. This indicates that some women are not treated equally due to their educational background:

'The women are not literate enough to know their rights or maybe the information that needs to be given to them. To be honest we don't even inform them at all of the birth

positions available, they are not given an option because we are not going to go with her option. We only use birth positions that suit us not the patient …'
(Participant 1, advanced midwife, 36 years old)

Sub-theme 2.3: Midwives' preconceived fears regarding childbirth
The third sub-theme to support the main theme indicates that midwives have preconceived fears concerning labour and that affects them being able to support the women's choices and cultural beliefs concerning birth. Some of the midwives verbalised their cultural beliefs, and some of the preconceived fears have a role to play on them not allowing the women's own choice of birth position and not rendering culturally appropriate care to support the women's choices.

One midwife indicated that the fears she have are a barrier to her providing culturally-appropriate care and to give preference to the women's choice of maternal position:
'I think we fear of the unknown of what if something goes wrong, we need to break the culture of putting woman on one position …'
(Participant 9, registered nurse/midwife, 24 years old)

Another midwife indicated that other fears included unfamiliarity with other birth positions:
'Suppose the woman is giving birth on the commode [birth stool] and something happens it is not easy to get down there. The woman might not get up quickly, you might not identify the problem quickly for example cord around the neck, and you could end up in a lot of trouble …'
(Participant 7, advanced midwife, 55 years old)

One of the midwives was worried about safety as well:
'The lithotomy position is safe, isn't that we want a happy mother and an alive baby at the end of the day. So you have to weigh the options do you want to deliver this woman looking down and not understanding you. Not knowing what will happen? I am unsure about the other positions …' (Participant 11, registered nurse/midwife, 31 years old)

Finally, one of the other midwives indicated the necessity of receiving training to alleviate the fears as one of the suggestions for them to support the women's choices:
'Well it can start with alleviating the fear midwives have of being resistant to change and receive more education, skills and training on other birth positions showing them that there is actually no harm of using alternative birth positions on the mother and the baby and the culture associated to women preferences …'
(Participant16, registered nurse/midwife, 30 years old).

Theme 3: Workplace culture in the midwifery unit
The last theme that contributes to the midwives' lack of culturally-appropriate care is the workplace culture followed in the maternity unit. This is a culture already followed in the ward, irrespective of the women's preferences or cultural beliefs concerning maternal positions during the second stage of labour. Institutional norms and practices were reported as barriers that limited the midwives from promoting culturally-appropriate care or involving the women in the decision-making processes of their labour.

Sub-theme 3.1: 'Following what the Romans do in Rome'

This sub-theme emanated from the findings from most of the midwives, which indicated that they are following the workplace culture already found in the maternity unit.

One of the midwives indicated that this is a workplace culture that they have been accustomed to:

'It is more of a developed culture and norm for us to utilise the lithotomy position, It is a position I prefer …' (Participant 6, registered nurse/midwife, 29 years old)

'We don't see other birth positions being utilized in our working institutions, thus we developed a culture in the ward of using the supine position, despite the preference of the woman …' (Participant 4, community service/midwife, 24 years old)

'The other factor that contributes to midwives not using other birth positions is because of comfortability. You know the religious position the lithotomy position is mostly done for the comfort of midwife, they're not much concerned of patients comfort but the midwife needs to be more comfortable with position …' (Participant 20, advanced midwife, 40 years old)

Some midwives even gave a phrase to describe the culture they are now being accustomed to in the wards, which is 'Do what the Romans do'. The culture we adopted from the midwifery unit, as expounded by some of the midwives:

'I place the woman on lithotomy position because it is what I found being done in the unit. I think it is a culture of this unit and I know I was taught on other birth positions during studies but I have never practice it. I guess we are just joined what the Romans do in Rome, so I adopted the culture …' (Participant 9, registered nurse/midwife, 24 years old)

Another midwife decided to disregard the theoretical lessons learnt during midwifery training and followed the norm in the labour ward:

'I only studied other birth positions in school during the third year, in midwifery as an undergraduate. But when you get to practice [labour ward] it is like you do what the Romans do, we never got a formal lecture on birth positions. It is like when you go into practice, and find things being done like that and you just follow what they do …' (Participant 16, registered nurse/ midwife, 30 years old)

DISCUSSION

Barriers to culturally-appropriate care in maternity care service

The purpose of the study was to explore the midwives' perspectives on culturally-appropriate care to support maternal positions during the second stage of labour. The key findings of the study indicate that currently culturally-appropriate care is not rendered in the maternity units, due to barriers such as organisational culture and the personal adapted beliefs of the midwives that prevent them to honour the culture of the child-bearing women. The study argues that maternal healthcare professionals need to be more aware of the cultures and subcultures of the child-bearing women across all ethnic groups and understand the women's preferences and choices regarding the maternal position in order to abide by the WHO strategy for culturally-appropriate care.[4] Culturally-appropriate care can be as simple as respecting the language of the child-bearing women, as it was found in this study that the language barrier was actually an obstacle to the provision of culturally-appropriate care, which is not in line with the WHO strategy. A systematic review argues that the lack of culturally-appropriate maternity care services has an effect on the

women's uptake of skilled birth care during pregnancy, birth and post-partum period.[4] Thus, it is mandatory that SBA (including midwives) should treat and care for all women equally, irrespective of the women's cultural or ethnic backgrounds. The minority of ethno-linguistic groups in most countries have poor access to the maternal healthcare system, thus consequently exposing them during pregnancy and childbirth to poor maternal health outcomes[1].

In this study, it was noted that the midwives need to be aware of the women's cultural choices from all ethnic groups. The interpersonal interaction between the midwife and pregnant woman should foster respectful maternity care (RMC), which respects women's choices during labour as mandated by the WHO.[22] Findings emanating from a systematic review indicate results from countries such as Australia (targeted the Indigenous Aboriginal and Torres islander women); United States indicated that the following interventions to foster culturally-appropriate care in maternal health should include training staff members on different cultural practices to improve cultural awareness, using health professionals with the shared linguistic background as the patients (in this regard the child-bearing women) and lastly incorporating culturally-appropriate practices.[1] This is very true for South Africa, and these recommendations can be made to maternal health services in order to promote culturally-appropriate care.

Midwives imposing own adopted cultural beliefs on child-bearing women

Midwives should not impose their own adopted culture regarding the way of doing things and disregard the women's choices during labour. It is evident from the midwifery curriculum that the midwives are taught all the various birth positions that can be used. The maternity guidelines in South Africa[7] further indicate that women should be given the options; however, this is not done within the study context.

Studies indicate that the lack of women's autonomy to make informed decisions regarding their own care, which is seen as mistreatment of women during labour.[23] High-quality RMC is a global priority. The WHO[2,22] released eight standard areas of RMC. One of the standards includes respect and commitment; this can be further explained as implementation of women-centred care, and informed decision-making processes should be respected by the midwives.[23] Furthermore, the WHO quality care standards regarding the protection of human rights in childbirth need to be adhered to, as they are essential to optimising positive birth outcomes.

In countries such as Ethiopia,[24] it is further indicated that women are mistreated at health facilities. This affects their choice to give birth at facilities or even accessing the facilities on time, which may also contribute to some of the avoidable causes of mortality and morbidity rates. Numerous studies show the importance of midwives changing their attitudes and start being culturally sensitive to women. Being culturally appropriate fosters women-centered[25] care that encapsulates the biological, psychological, social and cultural tenets of care during labour as envisaged by the WHO recommendations on intra-partum Care for a Positive Childbirth Experience.[22] The midwives should work in partnership with the women thus improving the women's experience of childbirth.[24] Furthermore, the midwife needs to change her mindset, towards humanising childbirth in order to provide culturally-appropriate care and to give preference to the women's choice around the birthing position. Furthermore, it is significant that the midwives respect the tradition of the women if it does not impact the safety and quality of care.[26]

Workplace culture in the midwifery unit

The last theme identified the workplace culture acting as an obstacle to the provision of culturally-appropriate care in midwifery units. Many studies indicate that the midwifery unit should promote humanising caring standards and promote RMC. The current findings of the study are in synergy with the recent systematic review by Bradley.[27] The systematic review designed a conceptual framework that further explores the different stakeholders that contribute to intra-partum care and the role played regarding maternal health services. From the macro-level factors, things such as policy play a role in the practice of the midwives. The meso-level factors in this instance being the Midwifery Unit, which includes the environment where currently the midwives are conducting the birth position during the second stage of labour.

These factors have an influence on the day-to-day practice in the micro-level of the midwives.[27] With relevance to the study, the midwives found that the supine position was done routinely in the maternity unit, and they decided to follow suit without regarding the evidence-based protocols, which indicate that the supine birth position should be avoided. To move forward with the provision of culturally-appropriate midwifery care, there is a need to address all barriers from macro to micro-level.[27] Furthermore, research should be implemented on policies that foster culturally-appropriate care in the maternity units. At micro-level, midwives need to be aware that child-bearing women are individuals with cultural preferences and choices regarding their labour, in this regard maternal position during the second stage of labour. The currently held beliefs that choice of birth position should be limited and the on-going disrespect for the women's choice and tradition need to be addressed.[11]

In summary, women cognitively evaluate the experience of labour differently. Some women remember their birth experiences in detail for a lifetime. Therefore, their birth experience does affect how they perceive birthing (Simkin 1991, 1992).[28] The birth experience influences the woman's narrative of herself as a mother and a human being and has the capacity to affect her sense of self and well-being.[28] Thus, it is imperative that midwifery practice needs to be functionally embedded within the healthcare system, which includes available, accessible, acceptable (organisation of care), respectful, understanding strengthens resources and take a non-interventional stance (philosophy). Midwives and other healthcare providers need to be interpersonally and culturally appropriate and maintain clarity of roles and responsibilities in their inter-professional relationships with their patients to ensure optimal maternal and neonatal outcomes.[29]

RECOMMENDATIONS

Global perspectives from the WHO published guidelines and policies on the provision of culturally-appropriate care still need to be implemented in clinical settings. Furthermore, changes to incorporate culturally-appropriate care need to be carried on and supported from the macro-level hospital management to ensure it is implemented in the micro-level maternity wards. Recommendations can be made to realign the protocols to ensure that women are given a choice during labour on their preferred maternal position as it is in line with the women's cultural beliefs and norms (perhaps include language interpreters as well). Bottom-up approach needs to be followed for changes to the current workplace culture of restricting women to assume other birth positions and restricting women's movement should start at the micro-level so as to influence care and render culturally appropriate care.[27]

At the micro-level, in-service training can be provided on cultural beliefs that women have during labour, and this will raise cultural awareness about women from various ethnic groups who are not familiar to the midwives in South Africa. Guidelines for education and training on culturally-appropriate care need to be implemented from the higher education institutions. Culturally appropriate care and relation to scientific evidence-based midwifery care interventions should be developed for the institution under study. Other institutions may benefit through the dissemination of findings. Further research can focus on the experiences of women from various ethno-linguistic groups regarding culturally-appropriate care.

STRENGTH AND LIMITATIONS

The study provided a broader understanding and insight into maternal healthcare services provided to women during the first and second stages of labour. The findings of the study also enhance support and encourage midwives to be more aware of their practice and advocate for them to be supportive and provide culturally-appropriate care to women. The limitation of the study is that the findings cannot be generalised because the study took place in a specific district hospital in Tshwane, Gauteng with a specific population of interest. Although the study was conducted only in one hospital, the findings of the study can be transferable to other public hospitals within and outside the district.

CONCLUSION

The findings of this study demonstrate that midwives need to be aware and provide care that considers the child-bearing women's cultural preferences and practices regarding maternal position during labour and ensure the provision of culturally-appropriate care to achieve optimal maternal and neonatal health as recommended by the WHO recommendation. Currently, the maternal healthcare is not tailored towards culturally-appropriate care and that affects the women's utilisation of skilled birth facilities.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Authors' contributions

M.R.M. conducted the study and drafted the manuscript. M.D.P. and V.B.-P. supervised the project, provided support during the study and edited the article.

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Data availability
The raw data used to support the findings of this study are included in the article.

Disclaimer
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YOUR VALUE NEVER CHANGES:
You Make A Difference

By Sheila L Allen, BSN, RN, CNOR (E), CRNFA (E)

INTRODUCTION

As a Registered Nurse and Louisiana native, I feel very privileged to serve with the nurses of Louisiana. I have enjoyed travelling across our state and many others and networking with other nurses in an effort to support and encourage the nursing community while also advocating for our patients. During Nurses' Month it is imperative that we, as nurses, take time to reflect on the impact of our profession and our daily contributions to serve our communities. *Nurses Make A Difference* continues to resonate. Nurses **DO** make a difference, and it shows every day in everything thing you do for each other, our patients and for our community.

HISTORY IN THE USA

Each year in the United States, there has historically been time set aside to honour the nursing profession. It began in 1953 when Dorothy Sutherland of the US Department of Health, Education, and Welfare sent a proposal for a proclamation; however, it did not occur. Efforts by various individuals continued by legislators, governors, and various nursing organisations until 1982 when President Ronald Regan signed a formal proclamation for a *National Recognition Day for Nurses* to be May 06, 1982. In 1990, the recognition was expanded to a week-long recognition from May 06 to May 12 to end with the acknowledgment of the birthday of Florence Nightingale.

The American Nurses Association (ANA) declared May 06 to May 12 as the permanent week to celebrate nurses in 1993. Now 30 years later, at over 4-million strong, nurses are the largest group of healthcare professionals that the American public consistently ranks as the most honest and ethical! Nurses' Month is intended to celebrate nurses in a meaningful way to increase the understanding of the value of nursing by raising the visibility of the profession and the critical work nurses do. By elevating the profession, ANA hopes to spur greater investment in the support and increased capacity of the nursing workforce.

THIS YEAR: 2023

This year for Nurses' Month, the Association has selected an evergreen theme that reflects gratitude as well as positivity toward our nursing community - *You Make A Difference*. An evergreen theme means that the theme will not change from year to year - it will always be *You Make A Difference*. However, the graphics and materials will be refreshed each year. The ANA Enterprise will focus on a different theme each week during May. The goal is to inspire nurses to engage in activities that make a positive difference in their own health and well-being, professional development, and in their own community.

Here is the list for each weekly theme in Nurses' Month with corresponding dates:

- Week 1: Self-care (01 May to 07 May)
- Week 2: Recognition (08 May to 14 May)
- Week 3: Professional Development (15 May to 21 May)
- Week 4: Community Engagement (22 May to 31 May)

At the website: https://www.nursingworld.org/ana-enterprise/nurses-month/ you may find more information about the initiatives for each week.

WHY DO NURSES MAKE A DIFFERENCE?

The impact by nurses all over the world is unparalleled. Nurses bring vast knowledge and expertise to every healthcare setting across a wide range of specialties, serving our patients and communities throughout the continuum of life and care. We truly make a difference by influencing and shaping health policy decisions that ensure all people have access to high-quality, affordable healthcare coverage. Regardless of where the practice setting may be, nurses contribute to the creation of improved healthcare for patients. To understand why nurses are so important in healthcare today, we need to take a look at what a registered nurse does - from the relationships they foster with patients to the ways in which they work with other practitioners.

Nurses spend more time with patients. Think back to the last time you went to a doctor's rooms for an appointment. Chances are the nurse was the person who checked your vital signs and talked with you about your reason for the visit. The time nurses spend with patients also provides them with unique insights into their patients' wants and needs, behaviours, health habits, and concerns, thus making them important advocates in their care. Patient advocacy might also mean helping co-ordinate a patient's care with another provider's office, or making sure that a patient has provided informed consent prior to undergoing a procedure.

Nurses devote a lot of their time and energy to educating patients. This could mean helping them understand a treatment or procedure, describing medications and side effects, emphasising the importance of proper nutrition and good hygiene, or explaining how a clinic operates (in the case of on-going treatment). In today's complex healthcare environment, it is the nurse who monitors the patient's care and keeps accurate documentation of the care that is provided. From ensuring the most accurate diagnoses to the on-going education of the public about critical health issues; nurses are indispensable in safe-guarding public health. Nursing can be described as both an art and a science; a heart, a touch, and a mind.

NURSES AND THE FUTURE

Jim Cagliostro has been a nurse since 2007 with a wide variety of diverse experiences that make him confident that nurses remain uniquely situated to craft healthcare because of their understanding of patient care and their team approach. His 10 reasons are summarised below because I agree with him. I might not have put the reasons in this particular order; nevertheless, his reasoning is certain well crafted:

1. **Calm under pressure.** The current healthcare environment places a great deal of pressure on everyone. Job performance doesn't merely mean the organisation is profitable, it can mean the difference between life and death for a patient. Nursing is multi-tasking at its

finest; nurses must learn to prioritise effectively while remaining calm. In addition, they have the responsibility to comfort and reassure the anxious patient and family

2. **Attention to detail.** Nurses must learn to process data rapidly and recognise subtle changes in the breath sounds or the wound appearance of the patient. The documentation of orders precisely and the careful attention to medication details is absolutely critical to keeping patients safe, and optimises recovery and healing
3. **Critical thinking**. This process involves rational and unbiased evaluation of both qualitative and quantitative data to reach the best outcome. Nurses gather medical history, family history, collect data, and listen to the patient and family. While some tests may lead to a definitive diagnosis, it is the nurses observation and analysis that can mean the difference in the continuum of care
4. **Flexibility and creativity.** Medicine and technology change at an amazing speed and nurses must know of the innovations and be able to teach patients about their care. Work schedules are demanding as well as flexible. Many of our facilities depend on the creativity of the staff to provide the foundation for excellent care
5. **Teamwork.** Studies have shown that better patient outcomes are linked to how well the team functions. This effective co-ordination helps the team achieve better patient approval, less staff turnover, and higher job satisfaction. Teamwork can be seen in every department; however, the place where it can be more quickly identified as such is the peri-operative environment
6. **Communication.** Nurses act as coaches, drill sergeants, parents, cheerleaders, and therapists at any given time. These are some of the skills needed in effective communication:
    - Mindful listening skills. The words listen and silent have the same letters!
    - Effective verbal communication. They must be easily understood and communicate to gain a stranger's trust
    - Cultural awareness. Our patients come from diverse cultural backgrounds; therefore, we must be able to acknowledge differences and always treat the patient and their family respectfully.
7. **Empathy and compassion.** These are also part of communication. There is a delicate balance between caring for a patient's situation and appearing detached. This requires a stability and strong emotional intelligence to juggle this balance to provide care without taking an emotional toll on the caregiver in the form of compassion fatigue
8. **Integrity.** In the Gallup Poll in the US that rates the trust of the public for different occupations, nurses have ranked #1 for 21 years! Nurses must be true to their word and be competent and caring to establish trust with the patient and family. Always remember, patients place their lives in our hands
9. **Prioritise the patient**. This means that your priority should always be first for the patient. It is our obligation to advocate and speak up to whomever is not prioritising the patient's rights and safety
10. **Understanding the community**. Nurses must provide discharge instructions along with answers to any questions presented by the patient. This equips them to become better care co-ordinators, connecting patients with the services that will help to ensure their long-term health. Therefore, they must be aware of the common community issues and the services or resources available.

As facilities face increasing financial burden and increasing regulation, operating margins are under pressure, often making solutions complex and challenging.

NURSES MAKE A DIFFERENCE

I know you have heard this story before; nevertheless, I am sharing it again to lift up your spirits and tell you how wonderful I know you are:

A Congress Speaker held up a $20 dollar bill and asked the audience, "Who wants this bill?" Of course, a few hands were raised, but not all as some were unsure where the speaker was headed. The speaker then crushed and wadded up the bill and again asked, "Who wants this bill?" More hands went up. Then the speaker threw the bill on the floor and stomped on it, and again asked, "Who wants this bill?" Nearly everyone in the audience had a hand raised. Then the speaker said, "You cannot have it as it is my lunch money."

The audience smiled.

The speaker explained that no matter what she did to the $20 dollar bill, there were those who still wanted it. She explained that the demonstration was to show that there are days when we feel crushed, or used up, or disheartened, or even as though we had been kicked to the ground. Nevertheless, just like the $20 dollar bill, ***we never lose our value.***

"Nurses use their specialised knowledge, experience and skill set to initiate life-saving measures, improve and promote the health and well-being of the planet, and ease pain, suffering, and loss. We are all united in that common mission - regardless of where we work, our position title or whether we're employed, unemployed, or self-employed." (Cardillo, 2013). In a way, we are rather like that package that comes in the mail that says, "Damaged in transit ... but still deliverable."

None of us is perfect. We all come with quirks, faults, and opinions. Nevertheless, in this line of work we must remember to be tender with the young, compassionate with the aged, sympathetic with the striving, and tolerant of the weak. And wrong, because at some point in our lives, we have been those as well.

At work, we are obligated to create a work environment together to maintain a positive outcome for all involved. Regardless of the size of the action you take to impart kindness, the impact can be immeasurable. In fact, frequently it is the small acts of kindness that are cherished and remembered. The smile, the kind word, or the time to listen may be the little thing that means the most to someone.

Sheila Allen served as the National AORN President between 2001 and 2002 and the IFPN Secretary between 2001 and 2007. She is a regular contributor to the APPSA Journal and offers contemporary studies and opinions of great value and interest. She wrote this paper specifically for the APPSA Journal.

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PERI-OPERATIVE ULTRASOUND AMONG SOUTH AFRICAN ANAESTHETISTS:
A Survey Of Current Practice And Availability

By MIS Kathrada; M Jagga; YN Mzoneli; J Swanevelder; and MW Gibbs

INTRODUCTION

Point-of-care ultrasound (POCUS) plays an important role in vascular access placement, regional nerve blocks, and heart and lung assessments in the peri-operative period. Its use has been shown to reduce failure and complication rates, thereby improving patient safety and procedural efficiency.[1] Ultrasound (US) use among anaesthesiologists has gained greater importance in post-graduate training. Specialist training milestones, such as those developed by the Accreditation Council for Graduate Medical Education (ACGME) and the American Board of Anesthesiology (ABA), have incorporated US for nerve blocks, vascular access and certain pain procedures.[2]

Many international guidelines, including those issued by the National Institute for Health and Care Excellence (NICE) in the United Kingdom (UK) and the Canadian Anesthesiologists' Society (CAS), have recommended the routine use of US guidance when performing invasive procedures such as central venous cannulations.[1,4] As per the 2018 guidelines of the South African Society of Anaesthesiologists (SASA), US is now considered as part of the basic skill set of an anaesthesiologist.[3] The introduction of US technology has revolutionised the field of regional anaesthesia.[3] Focused assessment using transthoracic echocardiography (FATE) is an invaluable peri-operative extension to the clinical examination.[3] Also, the use of US imaging aids with rapid diagnosis of severe and life-threatening pathological conditions, and may change clinical management and impact on patient outcome.[5,6] In many international centres, US is included in the training of anaesthesiologists from the outset.[3]

In South Africa, however, there is limited knowledge as to the availability of ultrasound for POCUS and the skills necessary for training among anaesthetists. It is not clear what factors affect the uptake of POCUS in a resource-limited setting such as South Africa. The primary objective of this study was to determine how US is used peri-operatively for vascular access placement, nerve blocks, and heart and lung assessments. The study also sought to identify training experiences, desire for further US training and preferences in modes of training from participants. Secondary objectives were to identify the barriers and limitations preventing US use among South African anaesthetists.

METHODS

This study was conducted using a questionnaire that was made available in an on-line digital format. Approval was obtained from the Human Research Ethics Committee of the University of Cape Town (HREC 397/2020) prior to distribution of the questionnaire. This questionnaire that was used was adapted (with permission) from a similar survey conducted by Chui *et al.*[1] in 2018

in Southwestern Ontario. The questionnaire was modified to suit the South African context and validated by doing a pilot survey with a small sample of 12 anaesthetists who use POCUS.

The questionnaire was run for a six-week period from 19 August 2020 to 02 October 2020. Participants were recruited via a link which was either sent by email to all SASA members, or distributed through a web-based link on anaesthesia departmental mailing lists, and on social media WhatsApp groups. Follow-up reminders were sent out during the six-week period.

All anaesthesia practitioners from South Africa were eligible to participate. SASA members working in South Africa were especially approached for inclusion as they represent a feasible and reliable sample of all potential respondents that could be reached via the SASA membership database. Specialists, trainees and non-specialist anaesthetists were included. The survey was composed of 39 questions and was estimated to take less than five minutes to complete. The questions were designed to address five main aspects: i) respondent characteristics, ii) institution characteristics, iii) individual practice, iv) training in US and US training preferences, and v) barriers and limitations to using US. Informed consent was obtained electronically prior to respondents participating in the survey.

Data were captured using REDCap, in collaboration with Safe Surgery SA and the Anaesthesia Network for South Africa (ANSA). The survey data were analysed using Microsoft Excel. Descriptive statistics, including mean, modes and percentages, were reported as appropriate to assess the data. From the SASA membership, based on a confidence level of 95% and confidence interval of 5, the minimum sample size required was 324 (response rate 15.6%).

RESULTS

Participants

Eligible participants for this study include doctors who currently practise anaesthesia in South Africa. This included specialists, registrars (trainee specialists) and non-specialists (medical officers and GP anaesthetists). At the time of the survey, there were 2 082 doctors on the SASA membership database currently practicing anaesthesia in South Africa. The total number of respondents was 580, of which 472 were SASA members. Nine surveys were incomplete and therefore discarded (Figure 1). With a sample size of 478 out of 2 082 SASA members (response rate 22.9%), the confidence interval is 3.94.

The demographics of the respondents and the institutions at which they practice are summarised in Table I and Table II, respectively. Respondents were mostly between 30 and 49 years of age (70.9%). Most of the respondents were consultant anaesthetists (55.7%), 25.7% were registrars and 14.7% were medical officers. Only a small minority were GP anaesthetists (3.9%) and 4.4% had no anaesthesia qualifications. Almost all of the respondents were full-time anaesthetists (93.0%). Of the respondents, 58.8% worked in state hospitals, 32.4% in private hospitals and 8.8% worked in both.

The majority of respondents work in the four most populated South African provinces, namely Western Cape (34.9%), Gauteng (25.7%), KwaZulu-Natal (20.3%) and Eastern Cape (8.4%). Detailed data about the respondents regarding their designation and the institutions where they work is available in Supplementary File 1.

Table I: Respondent data ($n = 571$)

	n	%
Gender		
Male	303	53.1
Female	265	46.4
Prefer not to disclose	3	0.5
Age group		
20–29	41	7.2
30–39	266	46.6
40–49	139	24.3
50–59	77	13.5
60–69	43	7.5
> 69	5	0.9
Designation		
Medical officer	84	14.7
Registrar	147	25.7
Consultant	318	55.7
GP anaesthetist	22	3.9
Highest anaesthesia qualification		
None	25	4.4
DA	224	39.2
FCA (or equivalent)	305	53.4
Subspecialists	17	3.0
Full-time practice	531	93.0
Part-time practice	40	7.0
State practice	336	58.8
Private practice	185	32.4
Both	50	8.8
Province of practice		
Eastern Cape	48	8.4
Free State	30	5.3
Gauteng	147	25.7
KwaZulu-Natal	116	20.3
Limpopo	2	0.4
Mpumalanga	9	1.6
Northern Cape	14	2.5
North-West	6	1.1
Western Cape	199	34.9

DA – Diploma in Anaesthesia, FCA – Fellow of College of Anaesthetists

Table II: Institutional data ($n = 571$)

	n	%
Level of hospital		
District	56	9.8
Regional	171	29.9
Tertiary	442	77.7
No of operating rooms		
1–3	18	3.2
4–10	245	42.9
≥ 10	308	53.9
No of US machines for perioperative care		
0	13	2.8
1	176	30.8
2	134	23.5
3	64	11.2
4	58	10.2
≥ 5	126	22.1
US readily available during daytime (07h00–17h00)		
Yes	393	68.8
Sometimes	152	26.6
No (locked away/special authorisation)	26	4.6
US readily available after hours and weekends		
Yes	438	76.7
Sometimes	87	15.2
No (locked away/special authorisation)	46	8.1
US is common practice for cardiac assessments		
Yes	188	32.9
Sometimes	172	30.1
No	211	36.9
US is common practice for lung assessments		
Yes	78	13.7
Sometimes	220	38.5
No	273	47.8
US is common practice for regional anaesthesia		
Yes	475	83.2
Sometimes	72	12.6
No	24	4.2
US is common practice for neuraxial (spinals/epidurals)		
Yes	36	6.3
Sometimes	87	15.2
No	448	78.4
US is common practice for CVC insertions		
Yes	447	78.2
Sometimes	93	16.3
No	31	5.4
US is common practice for difficult A-line insertions		
Yes	283	49.5
Sometimes	205	35.9
No	83	14.5
US is common practice for difficult peripheral line insertions		
Yes	153	26.8
Sometimes	219	38.4
No	199	34.9

Institutional characteristics

Of the respondents, 77.7% worked mostly at tertiary level hospitals, 29.9% at regional and the remaining 9.8% at district hospitals. Respondents predominantly worked at either large (≥ 10 operating rooms; 53.9%) or medium (4 to 10 operating rooms; 42.9%) facilities. Most of the institutions (97.2%) had at least one US machine available for peri-operative care and US was available for 24-hour use at most facilities (76.7%). The data pertaining to the institutions at which respondents worked is presented in Table II.

Most respondents observed that the use of US is common practice for central venous catheter (CVC) insertions (78.2%) and regional anaesthesia (83.2%) at their institutions. US for difficult arterial insertions was a common practice at almost half (49.5%) of the respondents' institutions, whereas US for difficult peripheral line insertions was less common. US was used less commonly for cardiac assessments (32.9%) and lung assessments (13.7%) whenever indicated. US was not commonly practiced for neuraxial anaesthesia.

In terms of individual practices, as detailed in Table III, a vast majority of respondents reported that they "always" or "frequently" used US for CVC insertion (77.9%) and when performing regional anaesthesia (82.3%), but much less frequently for neuraxial anaesthesia (1.4%). The use of US for arterial cannulation and difficult peripheral line insertion, was also uncommon. Regarding POCUS for cardiac and lung assessment, 49.0% and 62.2% of respondents respectively "never" or "seldomly" used this modality.

Table III: Individual data ($n = 571$)

Individual practice	Always	Frequently	Sometimes	Seldom	Never
I use ultrasound guidance when inserting a central line	325 (56.9)	120 (21.0)	55 (9.6)	29 (5.1)	42 (7.4)
I use ultrasound guidance for arterial cannulation	23 (4.0)	73 (12.8)	194 (34.0)	169 (29.6)	112 (19.6)
I use ultrasound guidance for difficult peripheral line insertion	23 (4.0)	60 (10.5)	137 (24.0)	143 (25.0)	208 (36.4)
I use ultrasound guidance when performing regional blocks	367 (64.3)	103 (18.0)	38 (6.7)	19 (3.3)	44 (7.7)
I use ultrasound guidance for spinal and epidural blocks	3 (0.5)	5 (0.9)	33 (5.8)	95 (16.6)	435 (76.2)
I use ultrasound for cardiac assessments whenever indicated	60 (10.5)	91 (15.9)	140 (24.5)	103 (18.0)	177 (31.0)
I use ultrasound for lung assessments whenever indicated	36 (6.3)	65 (11.4)	115 (20.1)	134 (23.5)	221 (38.7)

All results are presented as *n* %.

Two-thirds of respondents reported that they had received some form of US training (as summarised in Table IV), but only one-third of respondents "strongly agreed" or "agreed" that they felt confident regarding their US skill set. Participation in workshops was the most common form of training (58.0%) and 27.3% of respondents had received US training during their registrar training. Of the respondents, 84.4% indicated that they would still like to receive US training, and 71.1% were planning to undertake some form of US training, with workshops and peer-to-peer training being the preferred choices. Almost all respondents (96.5%) "strongly agreed" or "agreed" that US is an important skill for anaesthetists.

Table IV: Training data ($n = 571$)

	n	%
Have you received training in perioperative ultrasound use?		
Yes	382	66.9
No	189	33.1
I feel confident in my POCUS skills		
Strongly agree	44	7.7
Agree	154	27.0
Neutral	141	24.7
Disagree	145	25.4
Strongly disagree	87	15.2
I have received training in POCUS through		
Registrar training	156	27.3
Fellowship training	15	2.6
Peer-to-peer training	176	30.8
Workshops (e.g. FATE)	331	58.0
Self-trained	187	32.7
Is there a colleague with whom you can review your POCUS findings if needed?		
Always	56	9.8
Frequently	188	32.9
Sometimes	165	28.9
Seldom	103	18.0
Never	59	10.4
I would like to receive ultrasound training		
Yes	482	84.4
No	28	4.9
Maybe	61	10.7
I plan to undertake ultrasound training		
Yes	406	71.1
No	33	5.8
Maybe	132	23.1
If you PLAN to undertake training, in what format should the training be?		
Hands-on workshop(s) (e.g. FATE)	462	80.9
Online workshops/webinars	240	42.0
Formal fellowship training	105	18.4
Peer-to-peer training within your institution	261	45.7
Self-training	138	24.2
I am NOT planning to undertake ultrasound training because		
I have sufficient training	15	2.6
Training is not available easily in my institution	8	1.4
It is not needed in my practice	7	1.2
I have no interest in ultrasound training	5	0.9
I do not see the benefit in ultrasound training	3	0.5
Ultrasound guidance is an important skill for all anaesthetists		
Strongly agree	464	81.3
Agree	87	15.2
Neutral	13	2.3
Disagree	6	1.1
Strongly disagree	1	0.2

DISCUSSION

This is the first study of its kind, evaluating the current practice pattern of peri-operative US use among South African anaesthetists. A similar study of 66 anaesthetists conducted in a well-resourced Canadian context in 2018 identified the major barrier to the use of POCUS being limited US resources, with US in this context most commonly used for regional anaesthesia and CVC insertion.[1] These findings are similar to our findings in that 78.2% of South African respondents regularly use US for CVC insertion compared to 90% in the Canadian group.[1] The NICE guidelines state that "US guidance should be used in most clinical circumstances where CVC insertion is necessary and that all those involved in placing CVCs using US guidance should undertake appropriate training to achieve competence".[4]

The use of US in peripheral nerve block has been shown to reduce block performance time, increase block success, improve block quality, and allow adequate visualisation of surrounding structures, needle and catheter (American Society of Regional Anesthesia [ASRA] guideline: Level Ib evidence).[7] Our current practice of regional anaesthesia pattern appears to be in line with the current recommendation with US being used "always" or "frequently" by 82.3% respondents, which is higher than that of high-income countries (67%). Although US-guided arterial cannulation has been shown to improve first-pass success and reduce the number of attempts,[8] the adoption rates of US for arterial lines insertion is low with only 16.8% of respondents using US guidance "always" or "frequently".

The uptake of US for neuraxial anaesthesia among South African anaesthetists was very low, with only 1.4% of respondents using US "always" or "frequently". The majority (92.8%) "never" or "seldom" used US. The practice of central neuraxial block (CNB) has traditionally relied on the palpation of bony anatomical landmarks, namely the iliac crests and spinous processes, together with tactile feedback during needle insertion.[9] There is consistent evidence to suggest that neuraxial ultrasound can be used to identify vertebral levels more accurately than palpation of surface anatomical landmarks. A 2015 systematic review highlighted the poor correlation between vertebral levels determined by ultrasound and palpation, with rates of agreement varying from 14% to 64%.[10] As per the ASRA guidelines, the use of US in neuraxial blockade shortens the procedural time, improves block success and allows better prediction of epidural depth.[7] Further training in US guidance for neuraxial anaesthesia may be valuable.

FATE is an invaluable peri-operative extension to the clinical examination.[11] The bedside use of ultrasound imaging aids with rapid diagnosis of severe and life-threatening pathological conditions that may change clinical management and impact on patient outcome.[11] This study showed that only 49.0% and 62.2% of respondents "never" or "seldom" used US whenever indicated for cardiac and lung assessments, respectively. These findings suggest that most South African anaesthetists may not have integrated POCUS for cardiac and lung assessment into daily clinical practice. Given that POCUS is becoming the standard of care in anaesthesia internationally, this suggests that further training and formalisation of POCUS standards is essential in South Africa. As Neethling *et al.*[11] suggests, "by incorporating POCUS as part of our armamentarium, we might see it reach its full clinical potential, optimising patient care and improving patient outcomes".

An important barrier to US as identified by our respondents was lack of US training at the post-graduate level. It is important to note that only 27.3% of respondents received US training as

a registrar and 32.7% of respondents were self-trained. The latest published FCA curriculum (2014) does not mention US skills nor competence required from a specialist trainee, nor is there any formal logbook of US procedures required for qualification.[12] However, questions on POCUS do form a significant part of the final FCA exams. In this regard, there seems to be a gap in the current curriculum, suggesting that an updated curriculum incorporating POCUS skills is necessary. This is in contrast to The College of Emergency Medicine of South Africa (CEMSA) which has a credentialing procedure for emergency physicians or other clinicians who wish to perform emergency ultrasound in the emergency department for diagnostic purposes, or even as an adjunct in the placement of CVCs.[13] Fellows of the CEMSA are expected to have both appropriate training and practical experience to perform and interpret basic emergency US examinations.

Mahmood *et al.*,[14] representing a group of international experts in the fields of cardio-thoracic, general and regional anaesthesiology, critical care and pain medicine, recommended that peri-operative US training should be continuous and structured. They advocate that residency programmes should create their own teaching tools and evaluation metrics to demonstrate the progression of learners. The findings of this study suggest that there is a need to incorporate US in the under-graduate curriculum. In a study evaluating training medical students, with no previous US experience to perform basic US-guided vascular access and basic FATE, Heiberg *et al.*[15] showed that medical students were able to rapidly improve their skills from baseline with the use of an e-learning package and a four-hour hands-on session. It is believed that clinicians are more likely to incorporate US into their daily practice if it is introduced at an early stage of their careers.[15]

There are currently multiple different courses available for training in POCUS: FATE as previously mentioned, extended focused assessment with sonography for trauma (e-FAST), bedside lung ultrasound in emergency (BLUE), focused echo-cardiographic evaluation in life support (FEEL), focused intensive care echocardiography (FICE) and haemodynamic echocardiography examination in real time (HART), among many others.[11] All these have a similar goal, that is to provide a structure to non-cardiologist practitioners to diagnose or confirm a specific clinical cardio-respiratory emergency that is responsible for patient haemodynamic instability. POCUS is easily taught, non-invasive and readily available.[11] This study showed that 58.0% of the study respondents had US training through courses and workshops. Some respondents felt that there is a lack of awareness of POCUS benefits and courses available. By promoting access to these courses nationally and advocating the benefits, there may be more interest in completing these courses. This study did not evaluate which courses the survey respondents attended, but establishing which courses would be most useful for our context would be of value.

The assumption that a lack of availability of US equipment would be a major barrier to the use of POCUS in South Africa was refuted as 68.8% of respondents had US readily available during daytime, and even more reported availability after hours (76.7%). Factors limiting use, such as limited numbers of machines being shared by multiple theatres during daytime hours, were not elucidated. The findings, however, suggest that using POCUS when indicated within a resource-limited setting is achievable and should be encouraged. South African anaesthetists, however, still perceived that one of the most important barriers to US was lack of equipment. There may be institutional logistical factors that could contribute to this perception. For example, US equipment being stored or locked away outside operation theatres and thus not readily

accessible in an emergency setting. In solo private practice, surgical slate pressure and lack of peer support may also limit the use of POCUS. Barriers that could be addressed in the promotion of more widespread US use include appropriate provision of equipment and increased formal training in order to improve competence and confidence.[16] With improved skills and confidence in POCUS use, time spent performing exams becomes less of a factor. The importance of continued training and supervision should be emphasised for skill maintenance. Although respondents indicated that they would like to use US, had the requisite training and generally had access to US equipment, respondents also indicated that the two most important barriers to POCUS use in South Africa were lack of equipment and lack of training at the post-graduate level. Other perceived barriers to POCUS use in South Africa were lack of training at under-graduate level, lack of POCUS courses nationally, and lack of awareness of its benefits. Specific feedback from some respondents indicated that there are certain circumstances, such as pressure from surgical colleagues, that discourage an anaesthetist from gaining self-confidence in using US.

STUDY LIMITATIONS

The response rate for this study was 22.9% among SASA members. Although the confidence interval of 3.9 is acceptable, the sample was self-selected, and given the fact that this was an on-line survey, there may have been selection bias by POCUS practitioners. Therefore, the results may underestimate the practice and availability of US among less enthusiastic users, or those with less access to US machines. Not all South African doctors who provide anaesthesia are registered with SASA, and some may not have received the invitation to participate in the survey. The results of this study may therefore not necessarily be generalisable to the entire country as smaller provinces were less represented. This study could also have been biased towards obtaining information from physicians with access to the internet, smart phone applications, WhatsApp accounts and an active email address. However, this was not expected to be a significant limitation, considering the general easy accessibility and widespread use of email and social media. Response rates to emailed or web-based surveys are comparable to a mailed hard copy survey.[17] The researchers also did not survey the hospitals independently or cross-checked equipment availability with hospital and anaesthetic department management. Further, this study did not interrogate the availability of the different types of US equipment; for example, the different types of US probes available, portability of US machines, or the availability of special needles for regional anaesthesia. Importantly, one must not disregard the costs of US equipment and related disposables, which may be extremely relevant in a resource-limited setting like South Africa. Given the rapidly diminishing cost of small, handheld ultrasound machines, economics may be less of a factor in the acquisition of ultrasound devices in future.

RECOMMENDATIONS

A national audit of POCUS equipment for anaesthesia at hospitals would provide more insight into US equipment available for peri-operative care. Comparing such information with clinical practice may truly reflect the uptake of POCUS among South African anaesthetists. We strongly recommend formalising POCUS in the FCA curriculum and the use of procedural logbooks for US procedures and skills as part of the FCA portfolio of learning. The use of ultrasound (US) should be included from the outset of specialist training of anaesthetists and tested in the FCA OSCE exam, similar to the American Board of Anesthesiology (ABA) Applied exam.[2,3] Making POCUS workshops or online modules more accessible will also increase training opportunities for

anaesthetists, especially for those who do not work in major cities or centres. In addition, there must be on-going emphasis and awareness about the benefits of POCUS in peri-operative care, and opportunities must be afforded to anaesthetists to practice skills learnt under supervision.

CONCLUSION

US in the South African peri-operative setting is common for CVC insertion and regional anaesthesia, but less frequent in relatively new applications such as cardiac and lung assessments, as well as peripheral vascular access and neuraxial anaesthesia. Ultrasound machine availability should not be a barrier to the widespread use of POCUS by local practitioners. South African anaesthetists are enthusiastic about upskilling themselves and introducing US more regularly into their practice. However, there may be some shortcomings in the current training standards and curricula that can potentially hinder further US adoption. A matched administrative effort at formalising US training, incorporating procedural logbooks in the FCA curriculum, and making US training or workshops more accessible with the input from The College of Anaesthetists of South Africa may assist in improving the fate of POCUS in our daily practice.

Supplementary File 1

Institutional characteristics	Total (*n* = 571)		Medical officers (*n* = 84)		Registrars (*n* = 147)		Consultants (*n* = 318)		GP anaesthetists (*n* = 22)	
	n	%	*n*	%	*n*	%	*n*	%	*n*	%
Level of hospital										
District	56	9.8	12	14.3	18	12.2	22	6.9	4	18.2
Regional	171	29.9	39	46.4	32	38.1	87	27.4	13	59.1
Tertiary	442	77.7	44	52.4	144	98.0	244	76.7	10	45.5
No of operating rooms										
1–3	18	3.2	3	3.6	0	0	13	40.9	2	9.1
4–10	245	42.9	68	81.0	25	17.0	139	43.7	13	59.1
≥ 10	308	53.9	13	15.5	122	83.0	166	52.2	7	31.8
No of US machines for perioperative care										
0	13	2.8	1	1.2	0	0	10	3.14	2	9.1
1	176	30.8	40	47.6	7	4.8	113	35.5	16	72.7
2	134	23.5	29	34.5	27	18.3	75	23.6	3	13.6
3	64	11.2	10	11.9	17	11.6	37	11.6	0	0
4	58	10.2	1	1.2	28	19.0	29	9.1	0	0
≥ 5	126	22.1	3	3.6	68	46.3	54	17.0	1	4.5
US readily available during daytime (07h00–17h00)										
Yes	393	68.8	64	76.2	91	61.9	229	72.0	9	40.9
Sometimes	152	26.6	18	21.4	47	31.9	79	24.8	8	36.4
No (locked away/special authorisation)	26	4.6	2	23.8	9	6.1	10	31.4	5	22.7
US readily available after hours and weekends										
Yes	438	76.7	66	78.6	122	83.0	240	74.5	10	45.5
Sometimes	87	15.2	10	11.9	15	10.2	56	17.6	6	27.2
No (locked away/special authorisation)	46	8.1	8	9.5	10	6.8	22	6.9	6	27.2
US is common practice for cardiac assessments										
Yes	188	32.9	11	13.1	79	53.7	92	28.9	6	27.2
Sometimes	172	30.1	40	47.6	47	32.0	119	37.4	5	22.7
No	211	36.9	33	39.2	21	14.3	107	33.6	11	50.0
US is common practice for lung assessments										
Yes	78	13.7	8	9.5	42	28.6	27	8.5	1	4.5
Sometimes	220	38.5	25	29.8	73	49.7	119	37.4	3	13.6
No	273	47.8	51	60.7	32	21.8	172	54.1	18	81.8
US is common practice for regional anaesthesia										
Yes	475	83.2	71	84.5	139	94.6	253	79.6	12	54.5
Sometimes	72	12.6	9	10.7	5	3.4	53	16.7	5	22.7
No	24	4.2	4	4.8	3	2.0	12	37.7	5	22.7
US is common practice for neuraxial (spinals/epidurals)										
Yes	36	6.3	7	8.3	10	6.8	19	6.0	0	0
Sometimes	87	15.2	8	9.5	21	14.3	54	17.0	4	18.2
No	448	78.4	69	82.1	116	78.9	245	77.0	18	81.8
US is common practice for CVC insertions										
Yes	447	78.2	67	79.8	131	89.1	240	75.5	9	40.9
Sometimes	93	16.3	11	13.1	16	10.9	59	18.6	7	31.8
No	31	5.4	6	7.1	0	0	19	59.7	6	27.2
US is common practice for difficult A-line insertions										
Yes	283	49.5	37	44.0	85	57.8	154	48.4	7	31.8
Sometimes	205	35.9	31	36.9	45	30.6	121	38.1	8	36.3
No	83	14.5	16	19.0	17	11.6	43	13.5	7	31.8
US is common practice for difficult peripheral line insertions										
Yes	153	26.8	14	16.7	59	40.3	80	25.2	0	0
Sometimes	219	38.4	35	41.7	59	40.3	115	36.2	10	45.5
No	199	34.9	35	41.7	29	19.7	123	38.7	12	54.5

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Conflict of interest
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COVID RECOVERY
Delivery Plans And Lessons To Learn

By Kate Woodhead, RGN, DMS

INTRODUCTION

The 6.1-million people in the UK who are waiting for a letter to tell them they have an appointment to discuss their immediate healthcare needs will be interested in the recently published Delivery Plan for tackling the COVID-19 backlog of elective care[1]. People who are waiting for care, especially those who have waited the longest, are suffering in pain and disability and are becoming increasingly desperate to receive their surgery or their treatment.

As we know, elective care covers a broad swathe of non-urgent services often delivered in the acute sector, from diagnostic tests, scans, cancer treatments and surgical procedures. Hospitals are already working really hard already to reduce the long waiting lists which have occurred as a result of many of those services closing or being reduced throughput during the COVID-19 pandemic. Together with COVID patients, it was as much as many hospitals could manage to deal with urgent and emergency patients.

A recent report from the Nuffield Trust[2] sets out an interesting review of how the UK performed relative to 16 other countries developed health systems, providing some lessons for us to review and consider as part of preparation for another pandemic and recovery. It suggests that other well-equipped health systems have been left in vulnerable positions and many countries are now facing the very same catch-up imperatives as the NHS. The struggle that the NHS will have in completing the ambitious plans which are set out in the delivery plan are based on the view on the parlous state of the workforce, in terms of professional vacancies and the added difficulties of exhaustion and burnout. Not only this key element but also that the whole focus is placed on the acute care sector, when far more emphasis needs to be placed on community and primary care - and on enabling discharge from hospitals into the social care service. This is not only a huge missed opportunity, but may well provide many barriers to success.

ENGLAND'S DELIVERY PLAN

The Plan commits the NHS to using a funding add-on for Elective Care that is designed to deliver around 30% more elective activity than it was doing before the pandemic by 2024/25, after accounting for the impact of an improved care offer thorough system transformation and advice and guidance.

The NHS will continue to work to return to pre-pandemic performance as soon as possible. In addition:

- The plan sets out to reduce maximum waiting times, so that waits of longer than a year for elective care are eliminated by March 2025. Within this, no one will wait longer than two

years by July 2022, or longer than 65 weeks by March 2024. By March 2024, 99% of people on the waiting list will be waiting less than a year

- Diagnostic tests are a key part of many elective care pathways. By March 2025, 95% of patients needing a diagnostic test will receive it within six weeks
- The plan aims to return the number of people waiting more than 62 days to start treatment after being urgently referred due to suspected cancer back to pre-pandemic levels by March 2023. By the following year, 75% of patients who have been urgently referred by their GP for suspected cancer symptoms will have been diagnosed or have cancer ruled out within 28 days

ACTION STEPS:

The plan says that it will be able to deliver these ambitious targets by:

- Increasing capacity, not least by expanding workforce capacity by identifying gaps across key staff groups and sectors. Part of the expansion will be by enlisting reservists, 75 000 are planned, to assist in different areas of the hospital including wards and departments that have shortages and need a 'helping hand'. At the launch it was claimed that full training will be given and continuing support will be managed by existing full time staff on a buddy system. They will be paid.
- Retaining current staff will also be a focus for the hospitals facing huge workloads to tackle the backlog. Supporting staff needs equal focus, to look after their metal and physical health through up to 40 planned mental health hubs and free access to a range of self-help apps and helplines.
- Diagnostic centres will form part of the separation of different areas of the service, reducing the need for patients always to attend hospitals. This is extended by urgent and emergency care being delivered in different places from elective care. They will be known as elective hubs and will focus on providing high volume, low complexity surgery such as cataract surgery and hip and knee replacements.
- Further aspects of the delivery plan include providing better information to patients with a new digital platform - entitled My Planned Care - which will provide transparency on waiting times and clinical support information for patients in the run-up to their care episode.
- In addition, there is an element of levelling up being proposed in that areas of deprivation in the UK tend to have longer waiting lists and in order to provide more equality, NHS systems will be required to analyse their waiting lists by looking at age, deprivation, and ethnicity characteristics by speciality. *What ever happened to clinical need?*
- There will be a new national network for long waiters which will be managed by the national NHS team. It appears that patients may be sent some distance from where they live in order to prioritise their treatment. This may be provided by either the independent sector or the NHS. In addition, there is a promise to provide more use of digital technology in order to continue the use of telemedicine for out-patient consultations and the concept of virtual wards, so that more care can be delivered at home.

WORKFORCE ISSUES

None of the above will be able to be delivered comprehensively or safely unless the reported 100 000 vacancies are managed. There is a desire to recruit 10 000 more nurses from other countries this year, which is a very big number considering that the same shortages are affecting

other developed nations healthcare systems, post COVID, so we will all be recruiting from the same pool. We had better not be relying on the developing world to provide for us, that would be immoral. In the past, Nelson Mandela urged the developed world not to recruit too many nurses from Africa or other developing nations and this stemmed the tide, for a while. Proposals in the delivery plan include 5 000 healthcare support workers together with the reservists, but the training and supervision of them will be left to the dwindling number of qualified staff. The workforce plan which we have been waiting for has not yet emerged and is critical to the success of the delivery plan.

LESSONS LEARNED

The Nuffield Trust report highlights some challenges which COVID-19 has created; identifying that none of the healthcare systems was prepared for the disruption that COVID-19 caused. There are a number of different and common strategies that are being faced by them all including catch-up on care backlogs and reform to the services to be better prepared for future difficulties.

The pandemic has served as a catalyst to move system reforms further, so that long-standing structural weaknesses and priorities are addressed. There is a move towards greater virtual care delivery together with flexible staffing models. It is also apparent that there is focus, not just on the acute sector but also many systems are prioritising primary, community and long-term care capacity. The emphasis on non-acute health services identifies the interconnected nature of the health system recovery, and how efforts to catch up on elective care will be futile if primary care, community care, and long-term care are not also strengthened[3].

The health and economic consequences that must now be addressed by many countries are variable, depending on the waiting lists which countries had going into the pandemic, how effectively they managed to contain COVID-19 infections, as well as how well systems protected access to routine and planned activity. All these variables will impact on how quickly countries are able to catch up with the backlogs and what is needed to increase resilience and rebuild service strength.

Workforce challenges are one of the most intractable constraints to recovery across all countries, and there is recognition that reducing backlogs and waiting times must not cause increased burnout and further healthcare staff leaving the professions.

While the NHS is implementing similar strategies to other countries to clear care backlogs, its path to recovery may be longer than many other systems. We entered the crisis with higher bed occupancy rates and fewer doctors, nurses, beds and capital assets than most other high-income health systems, while experiencing higher rates of excess deaths during the pandemic relative to many countries. Waiting lists were rising in the NHS before the pandemic started, indicative of the challenges health services already faced in keeping pace with the demands placed on them. Countries with greater pre-existing capacity and that have more effectively contained coronavirus are likely to be in a better position to cope with care backlogs arising from the pandemic and recover from its consequences[4]. For highly efficient systems like the NHS, the pandemic has shown how it is not possible to run services at more than 90% capacity and expect them to rise to the challenge when there is a surge in demand.

But the NHS has also demonstrated other significant strengths that are foundational to system resilience. These include the ability to rapidly collect and share information across the systems, centralised mechanisms for co-ordinating services and redistributing capacity, and the ability to inject funds where needed and ensure financial solvency during periods of great uncertainty. All of these will be important assets to the NHS as it seeks to recover elective backlogs and deal with unforeseen shocks.

CONCLUSION

One of the great ironies of this plan for recovery is that it seeks to free up space for additional capacity by separating services - such as urgent and emergency care and elective care. Many believe this is a very short-term gain particularly when the current trend in healthcare efficiency and development is by integrating systems recognising that patient pathways are co-dependent on other parts of the system. Integrated care systems are currently getting to know each other and developing plans to deliver services in a more effective way, by taking out barriers. Separating elective care away from the hospital sets up opportunities for barriers to be re-instated.

Patients do not play to standardised plans, and elective patients need to be able to access ICU as well as professionals who are experienced in advanced care, should they need it. It would not be good for care quality to be shipping patients across cities by ambulance in order to get the appropriate care in the appropriate place.

There are a vast number of challenges implicit in the recovery programme and it needs to be delivered to reduce pain and suffering to patients who have already waited way beyond the best time for their clinical condition. However it must also be done with care for the staff who are still suffering the after effects of COVID-19.

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4. *Ibid*

This article first appeared in the Clinical Services Journal and appears here, courtesy of the author. Kate Woodhead qualified in 1978. She has worked in peri-operative care since then and runs her own business as an Operating Theatre Consultant. Kate was Chairman of from 1998 to 2001. She is the former President of the IFPN (2002 to 2006) and now works as an Advisor to WHO on the Safe Surgery Saves Lives Campaign. She is the Chairman of Trustees at Friends of African Nursing. For more information on FoAN please go to www.foan.org.uk.

APPSA GUIDELINES

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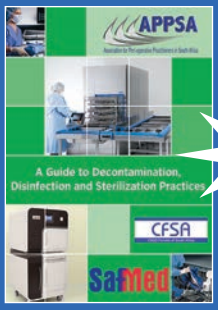

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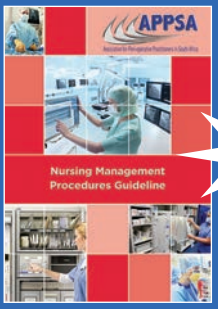

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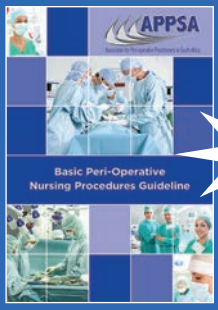

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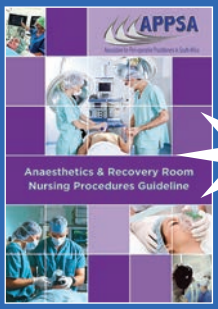

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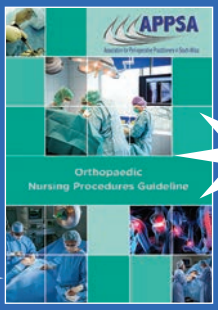

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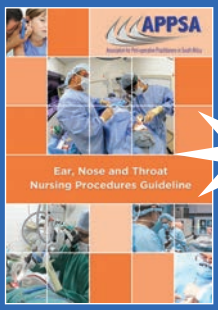

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