I was generously supported by the BSGE Consultant Travelling Award to visit the Wellington Regional Hospital, Wellington, New Zealand. Wellington is the capital of New Zealand and one of the largest centers of population, and manages to keep a civil and friendly culture which permeates through the hospital along with the aroma of the numerous baristas making coffee.

Capital and Coast District Health Board

Wellington Regional Hospital is a tertiary referral centre for O&G which covers a catchment area for the lower North Island and the upper South Island. Services are delivered across the region at Wellington Regional Hospital, Kenepuru Hospital, a mobile bus service and a small proportion are outsourced to the private sector. The hospital is a large modern building constructed on base isolators to protect the inpatient wards and critical infrastructure from earthquakes. The older buildings on the site have had earthquake reinforcement retrofitting performed.

The total number of gynaecological surgery performed annually is around 1500 cases. The public capacity for surgery is fully utilized. This is achieved in Wellington because of 'out sourcing' to the local private hospitals. Approximately equal proportions of the cases are performed as major inpatient surgery and day case surgery. The time from clinic to surgical treatment is 16 weeks. The size of the private sector for gynaecology is around 30%.Urogynaeoclogy and Endometriosis surgery cases together equate to the volume of gynaecology-oncology surgery.

The Maori and Pacific Islander population in New Zealand have poorer health outcomes and generally poorer equity of healthcare access for multifactorial social and culture reasons. Within the Maori culture, there is an expectation that any tissue taken from during surgery is returned. It is common for this to explicitly discussed pre-operatively and histology services have pathways to accommodate this.

Current Surgical Practice

The majority of the sessions I attended were with Dr Nick Bedford or with Dr Simon McDowell, both of whom are experienced in laparoscopic surgery.

I saw a wide range of cases including, total laparoscopic hysterectomy, total abdominal hysterectomy, colpocleisis, laparoscopic excision of endometriosis from the para-rectal space, laparoscopic bilateral salpingo-oophorectomy, cystoscopy, hysteropexy and vault suspension by shortening the uterosacral ligaments, laparoscopic Burch colposuspension, TCRE, botox infiltration to the pelvic floor muscles, ureterolysis, gender confirmation surgery and excision of embedded 'prolift' mesh.

There was a widespread uptake of mesh repair for vaginal prolapse when these devices were first released to the market, and now there is a corresponding recent workload in women presenting with long term mesh related complications, which are challenging to manage.

Theatre cases used a wide variety of energy devices as per surgeon preference. The standard set up for theatre cases has monopolar and bipolar reusable forceps. All women undergoing laparoscopic surgery were placed on a vacuum mattress to maintain position, prevent slippage and reduce the risk of nerve injury with Trendelenburg positon. Almost all women undergoing laparotomy receive regular post-operative bolus injection of local anaesthetic into wound catheters placed by the surgeon.

A recent key improvement was the implementation of an electronic discharge summary. This starts to be completed intra-operatively and the tool enables reporting and tracking of averse gynaecological outcomes. The new process has become embedded into routine practice. The benefits include real-time reporting, allowed early decision making and clear discharge information. Both the patient and the GP receive a copy of the discharge information and any adverse outcomes.

I attended the uro-gynaecological pelvic floor clinic for the assessment of women with more complex symptoms such as recurrent prolapse or mixed urinary problems post surgery. Women with polypropylene mesh related symptoms are seen by specialists in the pelvic floor clinic. Women experiencing symptoms of obstetric anal sphincter injury are seen in a dedicated OASI clinic which is run separately to this clinic. The pelvic floor clinic is run by two consultants with a special interest. This clinic is supported by a team of pelvic floor physiotherapists.

Accident Compensation Corporation

The healthcare system is similar to the NHS in the UK however there is a larger private sector and the ACC. The ACC is the Accident Compensation Corporation, a government funded entity which administers the universal no-fault accidental injury scheme, providing financial compensation and support to residents and visitors who have suffered personal injuries. Treatment Injury Claims are those related to healthcare and have been recognized as a subgroup since 2005 and are defined as an 'injury caused by a registered health professional, which are not a necessarily part nor ordinary consequence of the treatment'.
From observing and asking several of the gynaecologists who undertake complex laparoscopic surgery, I don't feel the existence of the ACC makes any difference to the care and attention to detail provided to the patients pre or intra operatively. The ACC has been part of the healthcare landscape of New Zealand for so long that only a diminishing number of senior doctors can remember the situation before.

One of the perhaps unintended effects of the ACC is that once a patient has been approved for a Treatment Injury claim by the ACC, there is much more *carte blanche* feel. This may be of benefit to the patient in providing reparative care, however can result in more generous use of healthcare resources. The hospital benefits financially by providing Treatment Injury care because the patient is counted towards the throughput of the hospital, and the funding is provided in addition from the ACC.

The ACC is an insurance company however relies upon criteria to make decision upon eligible for claims and offers of financial support. This expertise is inevitably found from expert doctors in the particular field. A sizeable proportion of the doctors who have provided this service to the ACC have found this incongruous to their philosophy and approach to patients in the clinical setting and few stay in the role long term.

Summary

The challenges of benign surgery with rising population obesity, the move towards non-surgical treatment for conditions previously managed surgically and the effect of this on post-graduate training are common to the gynaecology in the UK. I found the support from the BSGE to partly fund my visit to another unit which tackles these

issues their own way was illuminating and will widen the approaches I employ in the NHS.