Royal Australasian College of Surgeons

Te Whare Piki Ora o Māhutonga

Principles for Outsourcing Planned Surgery Waiting Lists in the Aotearoa New Zealand Health System

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Position Statement

RACS does not endorse the concept of outsourcing, the opinion of RACS is public patients should have their surgery within public facilities to enhance patient safety, their continuity of care, and to ensure trainee surgeons have access to the full extent of opportunities to enhance their training in all surgical competencies.

However, outsourcing, outplacing, and insourcing surgical waiting lists should follow a clinical governance approach.

- Surgeons should be involved at all stages of designing, implementing, and monitoring the system. Some critical decisions require surgical expertise and professional attention.
- Patient safety should be considered at every step of the journey when a public sector surgical waiting list is outsourced.
- Contracts must include mandatory quality and safety standards and be designed to ensure sustained quality of care.
- Design and implementation require particular attention to the transitions in the patient journey, from the initial selection process, through surgery to post-operative care.
- Contractual processes should be open, transparent and fair to all involved.
- Surgeons should maintain an open professional culture and focus on professional values to deal with the inevitable challenges of operating such a model, including potential conflicts of interest.
- Education and training of Trainee surgeons must be incorporated into any arrangements.

Purpose

The Royal Australasian College of Surgeons (RACS) is the leading advocate for surgical standards, professionalism and surgical education in Aotearoa New Zealand. RACS works to improve equity and quality in delivery of care that meets the needs of our diverse communities.

Clear and agreed principles for outsourcing surgical waiting lists will enable surgeons working in both the public and private sectors to better provide timely access to surgical services. These will support surgeons to respond consistently and professionally to opportunities to collaborate with government to reduce waiting lists whilst upholding our commitment to train future surgeons and ensure quality and safety for patients.

Context

Demand for surgery has outstripped the capacity of the Aotearoa New Zealand public health system with long waiting lists for planned (elective) surgery in the public sector. Public hospitals are constrained in their ability to make significant reductions in their waiting lists given the requirement to prioritise trauma and acute surgery, along with lack of sufficient theatres, support services, beds, and variable availability of the workforce to utilise these. A collaborative approach by government, the health sector, and surgeons is needed to reduce waiting lists for planned surgery and ensure adequate opportunities are provided for the education and training of future surgeons.

Increasing the level of outsourcing of public sector surgical waiting lists to private hospitals and day surgery facilities would utilise spare capacity in private operating theatres, support services, beds, and workforce, including after hours and at weekends. This would help reduce the increase in waiting lists across a range of surgical specialties.

Commissioning of surgery from the public to the private sector should follow a clinical governance approach. Surgeons should be involved at all stages of designing, implementing and monitoring the system, and should maintain an open professional culture to deal with the inevitable challenges, including conflicts of interest.

Patient safety should be considered at all stages. Surgeons and other doctors will need to pay particular attention to additional steps in the individual patient journey from patient selection, pre-operative assessment, through surgery and preferably to post-operative care, potentially in other localities. These transitions may present professional, quality and safety challenges and need to be addressed upfront. This involves input from surgical administrators and includes pre- and post-operative care.

The contractual processes should incorporate mandatory quality and safety standards that match the standards expected in public hospitals and include the expectations regarding the education and training of surgical trainees. Contractual processes must be open, transparent and fair to all involved, including to others in the surgical teams and management at both the public and private facilities, including potential conflicts of interest.

Design of the outsourcing models needs to mitigate the risk that outsourcing significant portions of the planned surgery programme would reduce the opportunities for Trainees to see the full range of activities related to the delivery of surgical care, from outpatient clinics through surgery to post-operative care.

Surgeons Involved at All Stages

Surgeons and surgical training committees should be involved at all stages of designing, implementing, and monitoring the system. Some critical decisions require surgical expertise and professional attention. This has often been inadequate in current arrangements.

The aspects that need to be considered include:

- recent moves by Te Whatu Ora to standardise current surgical outsourcing arrangements
- information from surgeons working in the public and/or private sector about waiting lists
- information about training capacity in both public and private sector and how it will be increased and incorporated in the commissioning arrangements
- the impact on rostered surgical coverage in the public sector
- a range of perspectives on what is working well and what isn't.

Design of different outsourcing models should include:

- recognition there are many ways of delivering outsourcing, utilising both public and private sector initiatives
- mandatory quality and safety standards, including cultural safety, with regular monitoring and audit requirements
- guidelines on training, supervision, and funding requirements for surgical Trainees – ensuring they are present at lists, where appropriate lists are viewed as training lists, and enabling Trainees to be the primary operator when appropriate (an MOU between the New Zealand Orthopaedic Association, Te Whatu Ora, and New Zealand Private Surgical Hospitals Association provides these guidelines for the Orthopaedic specialty)
- guidelines on which decisions about outsourcing initiatives should be made at national, regional or local level
- guidelines on negotiating realistic rates to recognise revenue issues for both facilities
- guidelines for remunerating a surgeon who works at both facilities and for handling any conflicts of interest

- standard commissioning/purchase and remuneration agreements with standard terms and conditions as above, contract duration, reporting, monitoring and audit requirements.
- joint clinical governance should also be strong at the regional or local level where contracts for a specific surgical list or group of lists are negotiated and implemented, involving directors of surgery and directors of specialty surgical units
- an open, transparent and timely contracting process, with reasonable timeframes.

Quality and safety standards

Contractual processes must include mandatory quality and safety standards designed to ensure sustained quality of care, and continuous improvement. As a mandatory baseline:

- All surgeons working under an outsourcing should be qualified and vocationally registered by Te Kaunihera Rata o Aotearoa and credentialed by the private facility
- All Trainees involved should be credentialled by the private facility with appropriate patient consent.
- All surgeons and Trainees working under such an arrangement should have medical indemnity insurance.
- The private facility should be licensed in relation to the work being undertaken, with reference to the relevant clinical service capability framework, and provide evidence of specified consent processes and medical indemnity arrangements.
- Standards and procedures for the patient journey as below.

The Patient Journey

Equity of care for rural and regional patients and other disadvantaged patient groups should be considered when identifying patients for outsourcing, outplacing and insourcing pathways.

Surgeons and other clinicians should advise on standards and procedures for the additional steps in the individual patient journey under these models - from identification of public patients suitable for private intervention, preoperative care, through surgery, to post-operative care, potentially in other localities.

The transitions need to be addressed upfront in the standards, in the contractual arrangements between specific hospitals, and for individual patients.

Standards and procedures approved should include a mandatory baseline:

- appropriate pre-operative planning and assessment of each patient by the public hospital anaesthetist and medical team to identify suitable cases for surgery at the private facility
- suitability of cases as training cases and how training will be prioritised and facilitated
- the private facility, surgeon and anaesthetist review the cases and check they are suitable for surgery in the facility
- accurate and complete clinical notes transferred between the public and private hospital with detailed pre- and post-operative plans
- plans are in place for escalation of postoperative care to HDU and ICU if required
- agreement in advance as to who is responsible in the event of a complication.

For each surgical list, clinicians from the specific public and private facilities involved should consult carefully on patient selection, provision of care and options for provision of post-operative care and reflect this explicitly in the commissioning agreement.

Commissioning arrangements already in existence should be readily available, with information shared so they can be more widely used in appropriate locations. These arrangements include, but are not limited to, the following five models:

1. **Fully outsourced:** Private facility provides the full surgical team, operating theatre, bed (if required), and administrative support.
   - The private surgeon provides continuity of care from pre-operative consultation, through surgery, to an agreed a schedule of post-operative follow-up, with patient/surgical information moving from the public electronic management system to private and back to public electronic management system.
   - Greatest reduction in demand on surgical teams and facilities in the public hospital.
   - Increased consideration needs to be given to how Surgical Trainees are incorporated into this model across specialties other than Orthopaedics.

2. **Outsourced without post-operative care**: The private surgeon provides pre-operative consultation and surgery with post-operative care by the public hospital outpatient clinic.
   - Potentially reduced continuity in the patient journey i.e. from a public hospital surgeon to a private hospital surgeon, then back to the public hospital surgeon in outpatient clinic, with additional steps thus risk in miscommunication of patient information; this may be mitigated by the same surgeon working at both the public and private facility.
   - Lower reduction in demand on surgeons and facilities in the public hospital.

3. **Outsourced with some support**: Private facility provides the surgeon, operating theatre, bed (if required), and administrative support. The private surgeon is supported onsite by public hospital Trainees, anaesthetist, technicians, and potentially nurses.
   - The private surgeon provides continuity of care from pre-operative consultation, through surgery, to an agreed a schedule of post-operative follow-up, with the patient information moving from the public hospital electronic patient management system to private and back to the public system.
   - Potentially utilises private surgeon and theatre time more efficiently.
   - Addresses shortage of public hospital facilities where this is the main constraint.

4. **Outplaced/ Wet leased**: Public hospital surgical team operates in a private facility that provides the theatre space and administrative support.
   - The public surgeon provides continuity of care from pre-operative consultation, through surgery, to post-operative follow-up; patient information remains on the public hospital electronic patient management system and is required to be duplicated into the private system only if the patient is admitted overnight.
   - Addresses shortage of public hospital facilities where this is the main constraint.

5. **Fully insourced:** A full surgical team from the private sector operates in public hospital operating theatres at the weekend.
   - A private company may provide most of the personnel required for the procedures (doctors, theatre and recovery nurses, technicians for cleaning equipment) or personnel may be provided by the public health system from those volunteering to provide care at the weekend.
   - The public sector medical team is responsible for the patient journey apart from the actual surgery, with all patient information remaining in the public hospital patient management system.
   - Addresses the shortage of staff in a public hospital where this is the constraint.

Open Professional Culture

RACS advocates for professionalism, standards, and education for surgeons working in the public and private sectors. Some surgeons are involved in the businesses that operate private hospitals and day surgery facilities. A range of different professional and commercial perspectives are at play in outsourcing surgical lists. At the local commissioning stage, effective outsourcing requires careful attention to professional relationships.

The processes to manage all real or perceived conflicts of interest must be explicit and robust. RACS believes that transparency and openness result in the most effective processes. Avoidance of any bias in awarding of outsourcing contracts is key to maintaining collegial working relationships between surgeons and facilities alike. In many instances surgeons will work in both the public and private facility, which would facilitate continuity of care. It is imperative that patient selection is made in a transparent and equitable fashion ensuring that individual surgeons do not have undue influence.

Patients should be selected using well defined patient selection protocols, as an independent process based on factors such as suitability for the facility, ease of procedure and time on the waiting list. Patients will be pulled across all waiting lists within a speciality and their allocation to an outsourced list should not be consultant-specific except when there is a particular sub-specialist skill set that only one consultant can provide. This should be independent of which clinician has placed them on the waiting list.

The commissioning arrangements should include well defined patient selection protocols and information sharing for a situation where a complication from surgery in either the public or private facility that requires further intervention in the other facility to ensure patient handover and ongoing management are maintained at the highest level.

If relations between surgeons in the public and private facilities involved are harmonious, the outsourcing model should work effectively.

Responsibility for Surgical Trainees

RACS is responsible for surgical training and education in Aotearoa New Zealand, with publicly funded surgical training occurring in accredited training posts mostly in public hospitals. Trainees provide a critical service within public hospitals and are the next generation of surgeons and leaders in the health system of the future.

Trainees must experience the full range of activities related to the delivery of surgical care, from outpatient clinics through surgery and post-operative care. Within approved training programmes, Trainees must fulfill various logbook requirements in relation to their surgical case mix. Trainees are expected to be the primary operator for public lists when appropriate. It is important when a Trainee would have been primary operator in the public hospital, they are enabled to take this role when the patient moves to the private sector.

With an increasing volume of a range of surgeries transferring to the private sector, these surgeries need to be reflected in the Trainee's case mix. Supervision of Trainees should be maintained over all aspects of the patient journey in the private facility, from patient selection, pre-operative care and planning, through surgery, and post-operative care. Utilising surgical Trainees who are properly supervised to work and train at private facilities must be part of the commissioning agreement. Trainees from other speciality areas such as Anaesthesia may also be involved in the peri-operative care of patients.