



Guiding Principles for Outsourcing Elective Surgery Waiting Lists in Australia

CONTRIBUTORS

RACS Queensland State Committee

RACS Health Policy and Advocacy Committee

RACS Rural Surgery Section Committee

Australia and New Zealand College of Anaesthetists

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Introduction

This document is describing guidelines for the safe provision of surgery for public patients in private facilities. It is not an endorsement of this surgery as the opinion of RACS is that 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. Equity of access to surgery is essential, for patients, surgeons and for those from rural and regional areas, avoiding financial conflicts of interest, and prioritization of cases based on funding differences between specialties.

Demand for elective surgery has often outstripped the capacity of the Public Hospital system in Australia to meet this demand. Several methods have been utilized by government to resolve this. They have been:

- Large cash injections for clearing waiting lists over a set period. Sometimes this cash injection is utilized by participating hospitals where these waiting lists are reduced via additional theatre activity after hours and on weekends in the public system.
- Developing contracts and facility arrangements to deliver the required services on a fee-for-service basis in the private sector.
- The arrangements mentioned in point 2 above can be local hospital or district wide or state and territory and nationwide.

COVID has heavily impacted the capacity of hospitals in Australia to meet demand and options for outsourcing elective (planned) surgery are being undertaken in every jurisdiction.

There are several common elements to each of these processes that will form the basis for providing guidance in this document:

- ❖ Governance and Oversight
- ❖ Patient Transfer
- ❖ Surgical Trainee Involvement
- ❖ Quality, Safety and Aftercare

Governance and Oversight

There are some critical decisions in this outsourcing process that require surgical input, provide clarity of contracts and responsibilities. There is a need to have oversight of what is occurring and the impact that can have on patient care and the patient journey through the system.

RACS recommends that if a state-wide outsourcing approach is taken (e.g. Surgery Connect – Queensland) then an oversight Committee should be established that not only has surgical representation from within the Public Hospital system but also includes RACS representation. If the outsourcing is done at the local hospital or health service level, then directors of surgery and directors of specialty surgical units should be involved.

As a checking mechanism, this oversight Committee or other delegated individuals should ensure that all surgeons performing work through this outsourcing process should be appropriately qualified and credentialed for such work. The facility to which the patient is transferring should be appropriately licensed in relation to the work being undertaken. This should be referenced against any clinical service capability framework which may exist in the relevant jurisdiction.

The oversight Committee should look at the issues surrounding medical indemnity and consent. Arrangements should be made that enable trainees on the College's surgical training program to perform this work at private facilities under the supervision of consultants.

Patient Transfer

Other critical elements that require surgical and other medical input that should be built into the system as a mandatory requirement are:

- Appropriate preoperative planning and assessment of each patient in the public hospital to identify suitable cases that can be performed safely at the private institutions bearing in mind any clinical services capability frameworks in the jurisdiction.
 - Accurate and complete clinical notes at the private institution to be transferred to the patient's public hospital chart
 - The patients will also be assessed by the public hospital anaesthetic and medical teams pre-operatively and confirmed to be fit for surgery at a private hospital or facility. along with post-discharge care to be done at the public outpatient clinic.
 - If relations between surgeons at the different facilities is harmonious this model would work but in a statewide system this may cause resentment between those in private facilities and those in the public who would view this as fixing up mistakes made in private.
 - Co-located public and private hospitals or co-located public and day surgery facilities offer the best option in relation to the transfer of patients.
 - Ensure plans are in place for escalation of postoperative care to HDU or ICU if required.
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Surgical Trainee Involvement

RACS as the body with AMC approved responsibility in delivering the surgical training program is concerned that outsourcing of elected work can have a negative impact on trainee learning and development. Primarily there are two areas of concern:

- It is important as part of a trainee's experience that they see the full range of activities related to the delivery of surgical care. This is from outpatient clinics through to surgery and delivery of the required aftercare.
 - Within the approved training programs there is a requirement for trainees to fulfill various logbook entries in relation to their surgical case mix. The removal of large amount of elective work from the public hospitals will have an adverse effect on trainees meeting these requirements. Trainees provide a critical service to the public hospital and are the next generation of surgeons and leaders in the public hospital system of the future. Impacting on their development has severe long term impacts for the public system.
 - Trainees should be included in the arrangements for work at the private facilities and supervision of trainees will need to be maintained in relation to the care of the patient during the patient's course in the private hospital or facility.
 - Trainees and surgeons should also be aware that trainees from other specialty areas (e.g. anaesthesia) may be involved with perioperative care of patients.
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Quality, Safety and Aftercare

As mentioned previously in this document the following are key points in relation to safety, quality and aftercare and are worth reiterating:

- Appropriately licensed private facilities should only be used
- Appropriately FRACS qualified and credentialed surgeons should only be used
- Utilising Trainees who are properly supervised should be a component of the arrangements
- Consultation on the provision of after care should occur between surgeons at both the relevant hospitals and facilities
- However, after care arrangements should be determined up front avoiding potentially damaging relations amongst surgeons. As we are aware poor behaviour and relations between surgeons can lead to poor patient outcomes.
- Audit of list utilisation, and surgical outcomes measuring morbidity, mortality, re-admissions and complications should occur
- Surgeons should take particular care in discharging regional/rural and remote patients following surgery in an urban hospital. The surgeon should take reasonable steps to determine what surgical or rural generalist services are available in the patient's home region, to recognise and respond to clinical deterioration. If the surgeon intends to delegate aftercare to a rural medical colleague or health facility, they should undertake appropriate handover of care, both in writing and by telephone.

Conclusion

The outsourcing program should be appropriately developed and resourced to enable:

- Selection of appropriate patients taking into consideration case complexity, psycho-social factors, surgical / anaesthetic capability at outsourced facility
- Reliable tracking of patients throughout stages of their outsourcing journey
- Appropriate exchange of relevant information (i.e. referral system) between referring and operating surgeons to support safe transfer of care
- Clarity of which clinician is responsible for patient care through various stages of the outsourcing journey
- Appropriate follow up and actioning of investigation and pathology results
- Appropriate patient follow up arrangements
- Reliable, consistent system for identifying and managing post-op adverse events/outcomes
- Patient autonomy in participating and consenting to the outsourcing process
- Communication with the patient's GP at various stages of the outsourcing process
- Systematic peer review audit of patients managed through the outsourcing process
- Ongoing operative training opportunities for SETs

