Restoration of Elective Surgery

Objective

To be able to increase the availability of elective surgery in a safe and equitable way on a nationally consistent basis. Elective surgery to become incrementally available without increasing the risks of the COVID-19 pandemic and ensuring the capacity of the hospital system is maintained to respond when needed.

Context

A large proportion of hospital care has been deferred to ensure adequate hospital capacity to respond to COVID-19.

Activity in hospitals has slowed and much of this has been due to formal restrictions on non-urgent treatment, but also, in part, this has resulted from clinician and patient perceptions of risks including COVID-19 transmission risk, system capacity constraints and personal protective equipment (PPE) availability.

While an initial large peak in COVID-19 infections has currently been mitigated by the successful public health measures, there will be a need to prevent secondary outbreaks for months to come. Continuing current levels of general healthcare deferral for that period could result in significant harm to patients, with diagnosed conditions deteriorating and missed opportunities for early diagnosis and intervention. There is currently excess hospital capacity in all jurisdictions, and these harms can be reduced by taking initial steps to restore some care.

In line with National Cabinet decisions, any restoration of elective surgery also needs to take into account PPE modelling, the proper use of PPE in clinical settings, as per national PPE clinical guidelines, intensive care unit (ICU) availability and flow on health system requirements (for example rehabilitation, physiotherapy etc).

A cautious approach may achieve this without reducing COVID-19 preparedness.
Existing national restrictions will not be reversed, but rather relaxed to reflect the current situation.

Restrictions will be lifted in an incremental way to ensure effects can be comprehensively assessed and to avoid risks associated with increased patient density and flow through hospitals.

Elective surgery restoration is reliant on agreements between jurisdictions and private hospitals being in place, in line with the National Partnership Agreement on Private Hospitals and COVID-19 (COVID-19 NPA).

Risks

Re-introduction of elective surgery presents the following risks:

- Increased burden on ICUs leading to diminished capacity to treat COVID-19;
- Increased infection control risks and the potential for a hospital based outbreak;
- Increased burden on PPE supplies due to increased use in theatres and clinical staff requesting excessive enhanced PPE when it is not indicated; and
- Increased burden on testing regime presented by some individual clinicians conducting pre-operative testing as a perceived risk mitigation strategy, leading to undermining of the surveillance activities of Public Health Units.

Principles around reintroduction of hospital activity

1. Equity of access for all patients determined by clinical decision making and safety.
    a. Clinical urgency and risk of the health to the patient due to further delays should guide restoration of elective surgeries at the local level and in all cases.
2. Preservation and appropriate use of PPE including consideration of:
    a. Availability, quantity, type and quality to ensure a safe working environment for clinicians and patients;
    b. Compliance with clear and consistent national guidelines on use of PPE, released by the Commonwealth;
    c. Hospital and day surgery reporting of PPE usage on a minimum weekly basis (PPE burn rate) in both public and private settings; and
    d. Ensuring numbers of staff are at a safe and clinically appropriate level.

3. Clear timeframes to monitor and review the situation:
    a. Weekly monitoring and review of PPE supplies in public and private settings, and the number of positive tests; and
    b. An overall review/reassessment at 2 and 4 weeks based on:
        i. Number of positive cases (health care worker or patient) linked to increased activity;
        ii. PPE use and availability; and
        iii. Volume of procedures and hospital/system capacity.

4. Restoration of elective surgery will be consistently applied in both public and private settings.
    a. Work in private sector should be consistent with national guidance and agreement with Commonwealth and States regarding COVID-19 NPA and viability guarantee.
    b. For private hospitals, restoration of elective surgeries need to be agreed with the respective state government to ensure there is ample hospital capacity for COVID-19 health response.

5. Decisions on elective surgery are subject to local hospital capacity, jurisdiction capacity, transport availability and any other relevant quarantine arrangements in place.
    a. Every patient undergoes pre-operative risk assessment as per national guidelines.
6. Restrictions may be reintroduced depending on whole of system demand constraints related to COVID-19 and will be based on outcomes of review and reassessment mechanisms. Restrictions may also be introduced at a hospital or regional level in the event of an outbreak.
7. National COVID-19 testing guidelines will be adhered to, in line with the national disease surveillance strategy.

Patient Selection Principles for First Tranche of Elective Activity Re-commencement

1. Restoration of elective activity will be guided by avoiding harm and mitigating risk of deferral of procedure or services in line with clinical guidelines, and appropriate use and supply of PPE. This will be based on clinical decisions with a focus on:
    a. Procedures representing low risk, high value care as determined by specialist societies;
    b. Selection of patients who are at low risk of post-operative deterioration (based on ASA category 1 and 2);
    c. Children whose procedures have exceeded clinical wait times;
    d. Assisted reproduction;
    e. Endoscopy;
    f. Cancer Screening programs (noting that National Cabinet has not previously supported the cessation of these programs); and
    g. Expand dental services to level 2 restrictions (see Appendix 1).

Suggested Approach for Elective Surgery

Consistent with these principles and to allow some volume regulation while patient selection processes are refined, it is proposed that in the initial two week period of recommencement (from Monday 27 April 2020) the following will apply:

- Public and private Health Services will aim to reopen approximately 1 in 4 (25%) of theatre and endoscopy lists currently closed, subject to local circumstances;
- Health services and their clinicians will be responsible for selection of patients for these lists based on clinical urgency, PPE use, ICU capacity and consistent with the principles in this document;
- Procedures should focus on those normally categorised in the public hospital system as category 2 and can include assisted reproduction and other non-surgical interventional procedures. Category 1 procedures continue unchanged. Some category 3 procedures will also recommence, such as arthroplasty and cataract extraction;

- Cosmetic or other procedures not addressing significant medical conditions must not be included;
- Physical distancing should be applied in the lead up and management of surgery – for example with telehealth for perioperative assessments;
- The National Medical Stockpile should not be used for elective activity, and private hospitals will continue to source PPE through their own procurement processes. A notional state allocation of the stockpile should be predetermined to ensure no state uses up its own supply becoming reliant on the National Medical Stockpile for any surge required and potentially resulting in inequity of access in the longer term;
- States focus their efforts on specialties with longest wait times, however have flexibility to manage their work consistent with the principles;
- Jurisdictions can choose to perform lower clinical urgency work which requires limited or no routine PPE – i.e. outpatients, breast screen and other screening programs, and diagnostic procedures; and
- Activity volumes are reported fortnightly.

These arrangements will be reviewed at the end of the initial two week period.

Appendix 1

Dental Services Expansion

AHPPC has previously supported a 4 level infection control-based restriction of dental services during the COVID-19 outbreak. Dental services are currently operating at level 3 restrictions. AHPPC supports the current recommendation by the Australian Dental Association (ADA) that Dentists now move to level 2 restrictions, which will allow a broader range of interventions to be undertaken, including all dental treatments that are unlikely to generate aerosols or where aerosols generated have the presence of minimal saliva/blood due to the use of rubber dam.

The ADA advises that dentists can now procure their own supply of PPE to enable this expansion.