Q-bital
Healthcare Solutions

COVID-19 AND THE SURGERY BACKLOG

AUSTRALIA NEEDS A RESPONSE THAT **CUTS IT**

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Foreword

The elective surgery backlog has been a long-standing issue for successive Australian, state and territory governments.

Exacerbated by COVID-19, it is estimated that half a million Australians could be waiting for elective surgery by June 2023. The backlog affects people in every corner of the country.

For many Members of Parliament, in both metropolitan and regional electorates, we know this because our constituents tell us; as a physician with 40 years of professional experience, I am aware that our hard-working health services are often under tremendous pressure; and as someone driven to politics by a passion for healthcare, I understand that finding the right policies to address the problem is no simple task.

However, while this white paper presents in stark detail the scale of the elective surgery issue, it also highlights that there are potential solutions.

As Co-Chair of the Parliamentary Friends of Medicine I hope that it stimulates discussion and helps key decision makers build the case for measures that can get Australians access to the treatments they need.

Dr Mike Freelander MP FRACP

Member for Macarthur
Australian Labor Party
Chair of the Standing Committee on Health

Dr Freelander practiced medicine as a paediatrician for 40 years, and still lectures at Western Sydney University School of Medicine.

Contents

Executive Summary

This report has been prepared by Q-bital Healthcare Solutions to highlight the scale of the elective surgery backlog crisis in Australia, resulting from COVID-19.

As the Australian Medical Association identifies, elective should never be confused as not needed. It is medically necessary, and often treats life-threatening conditions or illnesses that prevent patients from living a normal life.

With the advent of COVID-19, Australia's health system – like many others – attempted to curb the spread of the virus by suspending services in a number of areas, including elective surgeries. A backlog existed before the pandemic, but the most recent figures from the Australian Institute of Health and Welfare indicate that **by June 2023 the elective surgery backlog could exceed half a million**.

Other routine services, such as screenings, diagnostic procedures and outpatient specialist appointments were also suspended or deferred. Patients also changed their health-seeking behaviour. Consequently, **additions to the waiting list fell 17.4 per cent in 2021-22.** There are undoubtedly many Australians who are not aware that they have conditions requiring surgery.

As normal services resumed and services attempted to catch up, **in 2021-22 outpatient services increased 23 per cent, with over 8.5 million more referrals than the previous year.** The "hidden waitlist", the period between GP appointment and referral to a specialist, has therefore also increased exponentially.

With millions of procedures, consultations and diagnostic services completed in outpatient settings every year, **patients often wait months or years for specialist appointments even before they go on the elective surgery wait list.**

Another phenomenon arising from the pandemic was the movement of people from urban to regional and rural areas. The Australian Government's Centre for Population shows that during the pandemic, record levels of internal migration has occurred in regional areas, while for the first time on record the combined population of capital cities declined.

Regional health systems have some of the least capacity and most stretched resources, exacerbating the backlogs of elective surgery waiting lists. **Across regional Local Health Networks (LHNs), the number of elective surgeries delivered late rose 134 per cent, compared to an 88 per cent rise in urban LHNs.**

When it comes to the elective surgery backlog, Australia needs a plan that cuts it. Concerted, fully-funded, long-term plans are required to increase hospital capacity.

Elective surgeries: A COVID-19 casualty

COVID-19 has significantly disrupted health services and treatment pathways across Australia. Since the onset of the global pandemic, necessary measures to mitigate the spread of the virus in health settings reduced patient traffic and postponed elective procedures. Patient health-seeking behaviour also changed, with people avoiding treatments and postponing appointments.

A major casualty of the disruption caused by COVID-19 has been elective surgeries.

On 25 March 2020, with the arrival of COVID-19 in Australia, the newly formed National Cabinet – comprised of all Commonwealth, State and Territory leaders – agreed to immediately pause elective surgeries. The intention was to protect critical services and vulnerable patients from hospital transmission of COVID-19, while making space for the anticipated influx of critically ill COVID-19 patients.

Consequently, with the onset of the pandemic, admissions from elective surgery waiting lists across Australia fell 70,000, from 758,136 in 2018-19 to 688,302 in 2019-20.[1]

In December 2022, the Australian Institute for Health and Welfare (AIHW) released the latest elective surgery figures. Last year, across Australia admissions from public hospital elective surgery waiting lists were lower still. At 622,988, elective surgery admissions are now at a 10-year low, falling 17.5 per cent from the previous year.[2]

Australia now has a "backlog of biblical proportions."

- AMA, January 2023.

In response, Steve Robinson, President of the Australian Medical Association (AMA), has publicly stated a "backlog of biblical proportions" now exists in Australia.[3]

By applying admission growth rates in the years prior to COVID-19, it is possible to estimate that by the end of the 2022-23 reporting period, the elective surgery backlog will grow to 507,764.[4]

Notwithstanding the tremendous backlogs already created, logjams like this at any point in a health system – even momentary pauses – cascade through the treatment pathway, accumulate over time, and bleed into other areas of service. Conditions progress and worsen, requiring additional and more advanced treatment later on.

"...if hospitals do not expand their capacity to address the backlog", it could reach a projected 507,764 by June 2023.

- AMA, January 2023.

Health systems across the country have remained under extreme pressure. In July 2022, record numbers of COVID-19 patients were occupying hospital beds across Australia.[5] Experts warned of increased numbers as the winter cold and flu seasons took hold, peaking in August.[6,7] In Queensland, for example, by November 2022, hospitalisations doubled as cases rose over 60 per cent.[8] In December, Victoria's Alfred and Royal Melbourne hospitals cancelled elective surgeries amid staff infections.[9]

The challenge for decision makers is to continue mitigating future waves of COVID-19, while also addressing the problems it continues to cause in our wider health system – including for elective surgery waiting lists.

Elective does not mean non-essential

Elective surgeries – including those deemed non-urgent – should not be confused with "not needed". Elective surgery is any surgery that can be delayed for at least 24 hours, but that is considered medically necessary.

In this way, as Royal Australian College of Surgeons (RACS) President, Dr Sally Langley, stated in February this year, "Elective surgery is not an optional procedure that a patient or doctor elects to have – it is essential surgery. It is surgery to address often life-threatening conditions and conditions that prevent patients from living a normal life because of severe pain or dysfunction."[10]

The percentage of patients waiting over a year for their surgery has tripled since 2018-19.[11]

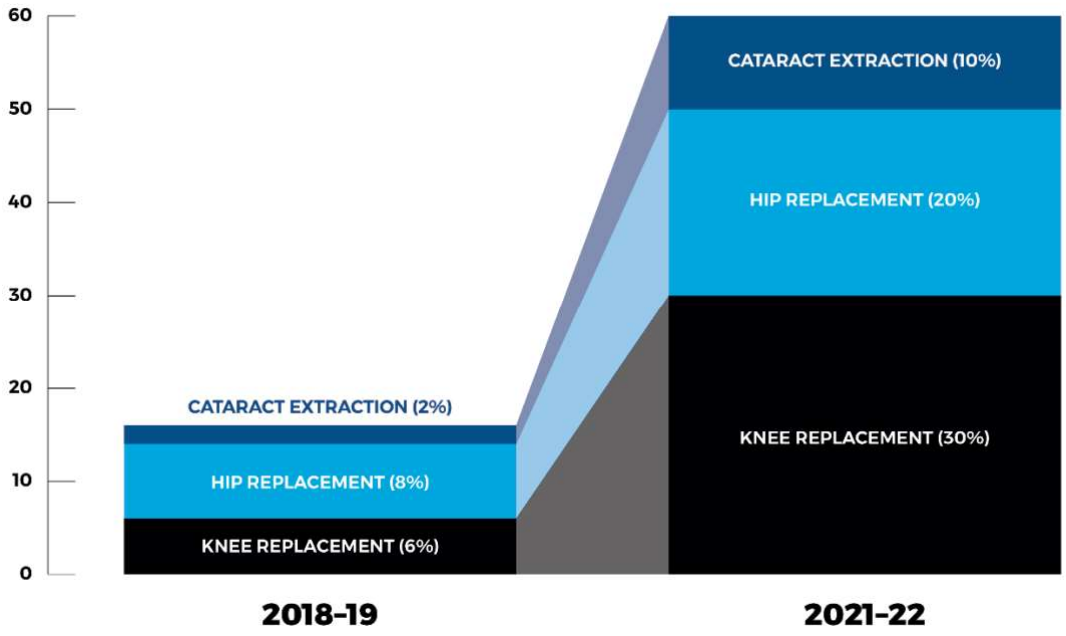
Among the three most common categories of elective surgery, compared to the previous year, nearly 14,000, 13,500 and 12,500 fewer patients were admitted from elective surgery waiting lists to receive ophthalmological, orthopaedic, and general surgery, respectively.[12]

The latest AIHW figures show that 30 per cent of patients requiring a knee replacement waited more than a year in 2021-2022, 20 per cent for hip replacements and 10 per cent for cataract extractions.[13]

These are enormous increases compared to 2018-19, where just 6 per cent, 8 per cent and 2 per cent of patients had to wait more than a year.[14]

Paediatric surgeries have also been affected. Compared to 2020-21, the number of paediatric surgeries fell by 774, some 8.6 per cent, from the previous year.[15]

Percentage of patients waiting more than a year for knee replacements, hip replacements and cataract extractions.



Regarding cancers, the number of breast excisions and/or biopsies performed in Australia compared to 2020-21 have fallen by 554.[16] The number of prostatectomies performed has fallen by twice as much, with 1,061 less procedures performed in 2021-22.[17]

The number of men waiting more than a year for their procedure has increased five-fold since the beginning of the pandemic, while the number of women waiting for breast excisions and/or biopsies has increased by 25 per cent.[18]

Treatments can sometimes be deferred, but disease, ill health and injury cannot. This is true in terms of existing patients already on waiting lists, and the continued accumulation of new patients during the COVID-19 pandemic.

In this way, it is easy to understand that missed diagnoses, delayed elective procedures, and the adoption of watch-and-wait protocols have resulted in the growth of enormous backlogs. However, delays also cause tremendous anguish for thousands of patients and – crucially – the worsening of conditions.

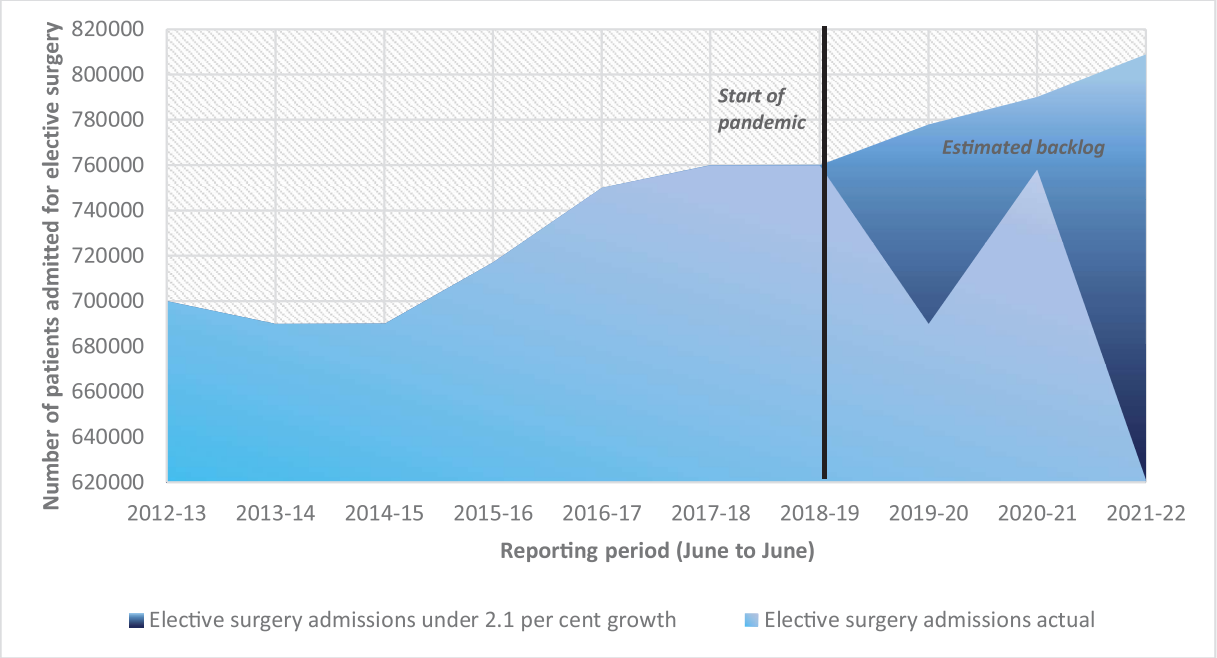
As AMA President, Dr Omar Khorshid, describes, “For many patients waiting in line, in pain, to have a critical operation, the delays in surgery can be devastating.”[19]

Under these circumstances, and in combination with those who have missed diagnoses altogether, there is little doubt that some patients will have experienced the progression of their conditions, such that they require additional or more advanced intervention later down the line. Patients may experience poorer outcomes, and health systems may be forced to mobilise additional resources to treat more serious conditions.

The size of the backlog

The annual growth of elective surgery admissions between 2014-15 and 2018-19 was 2.1 per cent. However, in 2021-22 admissions declined 17.4 per cent on the previous year, and 17.8 per cent since the last reporting period before COVID-19 2018-19.[20] By applying the annual growth rate of admissions prior to COVID-19 to these years, it can be calculated that the estimated surgery backlog is 306,281 patients, a backlog of five months. In January 2023 the AMA confirmed this figure.[21] At this rate, it is estimated that by the end of the 2022-23 reporting period, this will grow to 507,764, or an eight-month backlog, “if hospitals do not expand their capacity to address this backlog”.[22]

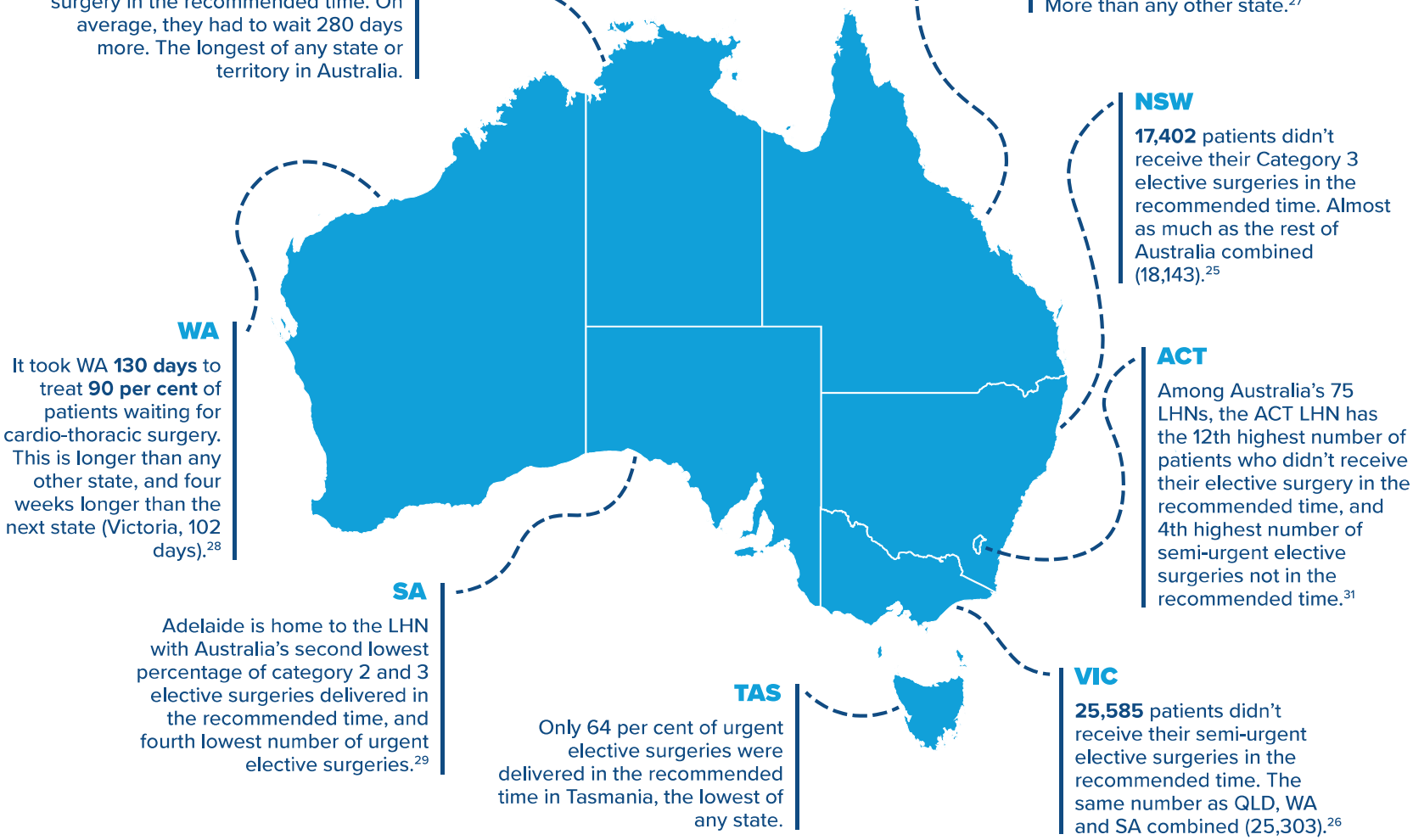
Public Hospital Elective Surgery Admissions 2012-13 to 2021-22



Growth and share of backlog by state or territory.

State	Backlog	
	2021-22	2022-23 (Projected)
New South Wales	77,845	144,999
Victoria	134,950	203,045
Queensland	34,462	63,677
Western Australia	31,642	57,085
South Australia	18,913	30,154
Tasmania	2,055	1,161
Australian Capital Territory	1,593	2,803
Northern Territory	2,822	4,839

Q-bital has analysed the latest 2021-22 AIHW elective surgery statistics, including those for Local Health Networks (LHNs), and large metropolitan, large regional and major hospitals. In doing so, it is possible to see how backlogs play out in each state: [23,24]



The invisible numbers

The undiagnosed

The figures outlined in this paper so far just consider figures from admissions and waiting lists. They do not reveal the scale of those patients still on the waiting list, or those who have missed diagnoses altogether during the pandemic.

For example, as AMA President, Dr Omar Khorshid, states, "the lack of screening procedures has resulted in patients presenting with more advanced cancers, and in some cases, it has dramatically altered their prognosis."[25]

At the onset of the pandemic, Dr Debra Graves, CEO of the Royal College of Pathologists of Australasia, noted that the pathology sector saw a 40 per cent drop in routine pathology testing, meaning that an estimated 60,000 Australians were not getting the tests they needed every day.[26] Appointments with specialist out-patient services also plummeted.[27]

This means there are undoubtedly many Australians who are not even aware that they have conditions requiring surgery. This can be interpreted from the elective surgery admissions figures.

In 2018-19, additions to public hospital elective surgery waitlists stood at a record 893,031, having risen precipitously since at least 2015, when 834,886 additions were made. Despite this trend, with the arrival of COVID-19 in 2019-20, additions to the waitlist fell back to this level (837,839).[28] This represented a fall of almost 10 per cent (9.2) on the previous year.[29]

The most recent figures show that in 2021-22, just 783,715 additions to the elective surgery waiting list were made, a fall of 12 per cent on the previous year.[30] It's therefore no wonder that the number of admissions from the elective surgery waiting list fell 17.4 per cent from 2020-21 to 2021-22.[31]

In short, fewer people are being diagnosed, added to the waitlist and undergoing their procedure.

Furthermore, when a patient is added to an official elective surgery waiting list, they have already been waiting the period between receiving the referral from their general practitioner, and the date of their appointment with an out-patient specialist to assesses the urgency of the surgery required.

The hidden waitlist

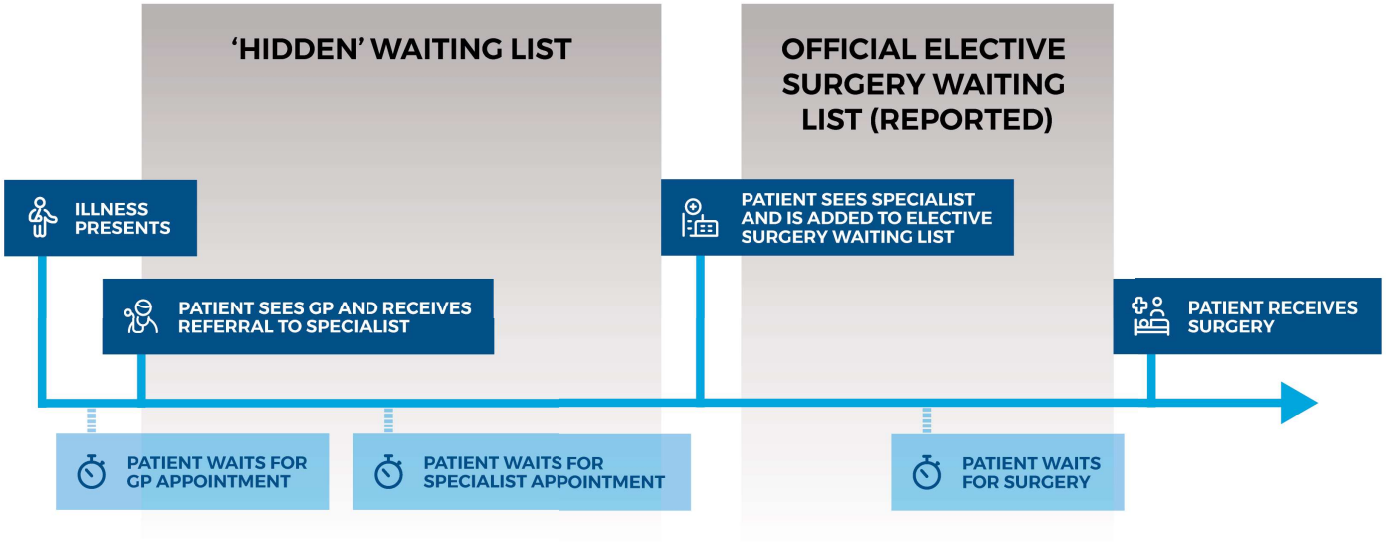
An often-lengthy process is required before a patient undergoes an elective surgery procedure. Patients first attend their GP, who can refer them to a specialist in a public hospital outpatient clinic.

Demand for these outpatient services have steadily increased in recent years. From 2014-15 to 2018-19, total non-admitted patient services increased from 34,911,563 to 39,014,521.[32]

When the pandemic struck in 2019-20, non-admitted patient services fell by almost 1 million, to 38,152,773 before exponentially increasing in 2020-2021 to 46,846,617. This was an increase of 8,693,844, or nearly 23 per cent.[33]

As the AMA state in their report on 'hidden' waiting lists, this is undoubtedly reflective of the lifting of COVID-19 restrictions, hospitals beginning to process backlogs, and telehealth began taking a larger role in referrals.[34]

Consequently, by the time patients are admitted to the elective surgery waiting list, they have already waited for an appointment with their GP and subsequent appointment with a specialist. The period between these two appointments constitutes the "hidden' waitlist.



With millions of procedures, consultations and diagnostic services completed in outpatient settings every year, some patients are often forced to wait months or even years for these appointments. This has been particularly exacerbated by COVID-19, their suspension and the reduction of referrals to outpatient services.

Measuring the hidden waitlist

Like elective surgeries, the clinical urgency categories are assigned to patients when placed on the outpatient waiting list; Category 1 urgent (should be seen within 30 days), Category 2 semi-urgent (should be seen within 90 days), Category 3 non-urgent (should be seen within 365 days).

Unlike with elective surgeries, however, there is no national reporting on the hidden waiting list. NSW, NT and ACT provide no publicly available data. Nor are there standardised measures across Australian states and territories.

However, by examining the data provided by other states in Australia, it is possible to discern a national pattern of not meeting targets:[35]

State	Reporting period and measure	Hidden waiting time for specialist appointment		
Victoria[36]	July-September 2022 90th percentile waiting time	Urgent 42 days	Semi-Urgent -	Non-Urgent 431 days

Queensland[37]	October 2022 90th percentile waiting time	Urgent 62 days	Semi-Urgent 275 days	Non-Urgent 489 days
Tasmania[38]	November 2022 75th percentile waiting time	Urgent 97 days	Semi-Urgent 339 days	Non-Urgent 544 days
Western Australia[39]	December 2017 Median waiting time for first outpatient appointment	All urgency categories 267 days (from 180 days in 2012)		
South Australia[40]	September 2022 Median waiting time for first outpatient appointment	All urgency categories 212 days (At the extreme end, some patients waited 56 months for a cardiology appointment, 62 months for a plastic and reconstructive surgery consultation, and 66 months for an orthopedic consultation.[41])		

The AIHW is currently working with jurisdictions towards a future publication on outpatient waiting times. Without this data, however, it is difficult to accurately gauge the full scale and impact of elective surgery backlogs in Australia. That said, the figures outlined above demonstrate that the 'hidden' waitlist is also enormous, and indicative of the fact that backlogs at one point in the system cascade into others.

Regional pressures and population movements

As the Regional Movers Index identifies, in recent decades more people have been moving from Australia's capital cities to regions than in the opposite direction.[42] A well-publicised phenomenon arising from the pandemic was the increased migration of large numbers of people from urban centres to regional areas.

Compared to the previous year, in 2019-20 the population growth of most state capital cities declined. Conversely, population growth in regional areas increased.[43] According to Australian Bureau of Statistics data, between 30 June 2011 and 2019 major cities of Australia experienced an average annual population growth of 309,908, or 1.81 per cent.[44]

With the onset of COVID-19 this growth began to collapse, falling to 1.24 per cent in 2019-2020.[45] In 2020-2021, the population of major Australian cities fell 0.21 per cent, some 40,000 people. With the closure of Australian borders in March 2020, a decline in population between July 2020 and July 2021 (the date for which ABS population estimates are provided) can only be accounted for by deaths and internal Australian population movements.

In this same period, inner regional, outer regional, and remote Australia continued to experience population growth. Between 2020-2021 these areas experienced population growths of 64,000, 8,000 and 1,100 respectively. For the same reasons outlined above, this can only be attributed to internal population movements and births.

The Australian Government's Centre for Population likewise confirms that regional areas in all states and territories had higher net internal migration in 2019-2020.[46] The most recent available analysis shows in the 12 months to June 2021, the combined capital cities population declined for the first time on record, while record levels of internal migration saw regional areas gaining 49,000 people from capital cities in 2020-21, up from 30,000 in 2019-20.[47]

December 2020 saw regional areas experience their highest net internal migration gain on record in the year to December 2020, driven by a drop in people moving to capital cities.[48]

"This pattern of movement places further pressure on regional centres and hospitals, some of which have the least capacity and most stretched resources, exacerbating the backlogs of elective surgery waiting lists."

With the increased adoption of working from home practices, and the relatively lower cost of housing in country areas, it is anticipated that this trend will continue.

Indeed, data provided by the Regional Australia Institute further demonstrates that the flow of people from capital cities to regional Australia has been sustained since the pandemic, increasing by 16.6 per cent to a new high in the March 2022 quarter.[49] This number of people moving from capitals to regions is some 9 per cent higher than the post-pandemic average and, 26.7 per cent higher than average during the two years prior to the pandemic.[50]

The latest data shows that capital to region migration remains well above pre-COVID-19 levels, long after the easing of public health measures. Quarterly migration flows in the past 12 months have averaged a level that is 15.1 per cent higher than during the two years prior to the pandemic.[51]

This pattern of movement places further pressure on regional centres and hospitals, some of which have the least capacity and most stretched resources, exacerbating the backlogs of elective surgery waiting lists.

The Impact on Regional Health Systems

By analysing the latest AIHW elective surgery statistics for 2021-2022, regional areas disproportionately feature in those failing to deliver elective surgeries on time, especially compared to pre-pandemic figures:[52]

Urban LHNs Regional LHNs

Urgent Elective Surgeries

14 of the 20 LHNs (6 of 15 in 2018-2019) with lower-than-average percentages of urgent elective surgeries delivered in the recommended time treat regional patients.

7 of the 15 LHNs (3 of 11 in 2018-2019) with the highest number of late urgent elective surgeries treat regional patients.

20 of the 34 LHNs (12 of 29 in 2018-2019) with longer than average median waiting times for urgent elective surgeries treat regional patients.

Semi-Urgent Elective Surgeries

13 of the 35 LHNs (14 of 28 in 2018-2019) with lower-than-average percentages of semi-urgent elective surgeries delivered in the recommended time treat regional patients.

22 of the 35 LHNs (16 of 27 in 2018-2019) with longer than average median waiting times for semi-urgent elective surgeries treat regional patients.

5 of the 9 LHNs (1 of 1 in 2018-2019) with a median waiting time in excess of the clinically recommended 90 days for semi-urgent elective surgeries treat regional patients.

Non-Urgent Elective Surgeries

16 of the 35 LHNs (11 of 21 in 2018-2019) with lower-than-average percentages of non-urgent elective surgeries delivered in the recommended time treat regional patients.

9 of the 25 LHNs (9 of 25 in 2018-2019) with higher-than-average number of non-urgent elective surgeries delivered in the recommended time treat regional patients.

Half of the 10 LHNs (4 of 10 in 2018-2019) with the highest number of non-urgent elective surgeries delivered in the recommended time treat regional patients.

The two LHNs with a median waiting time in excess of the clinically recommended 365 days for non-urgent elective surgeries treat regional patients (in 2018-19 all LHNs had a median waiting time within the clinically recommended 365 days).

20 of the 38 LHN's (16 of 21 in 2018-19) with longer than average median waiting times for non-urgent elective surgeries treat regional patients.

9 of the 10 LHNs (same in 2018-2019) with the longest average median waiting times for non-urgent elective surgeries treat regional patients, and 17 of the top 22.

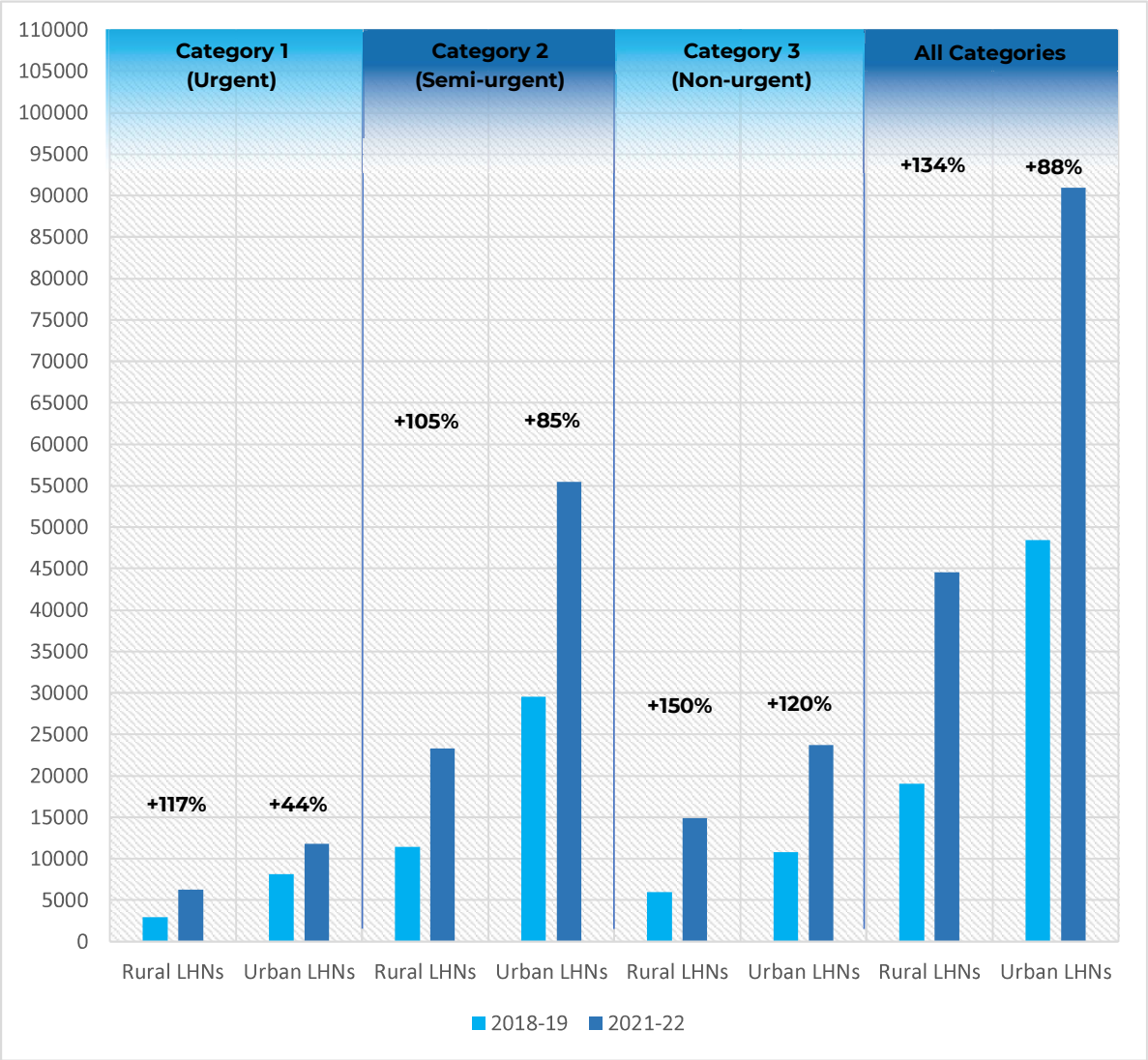
In many respects, regional LHNs have fared worse than they city counterparts with regard to the impact of COVID-19 on elective surgeries.

In 2018-19 one fifth of LHNs with a higher-than-average total number of late elective surgeries served regional patients, by 2021-22 this had risen to one third.

In the same time period, regional LHNs experienced a 117 per cent rise in the number of late urgent elective surgeries, a 105 per cent rise for semi-urgent elective surgeries, and a 150 per cent rise for non-urgent elective surgeries. In total, the number of elective surgeries delivered late rose 134 per cent.

Comparatively, LHNs in cities experienced an 88 per cent rise in the total number of elective surgeries delivered after the clinically recommended time.

Growth in number of elective surgeries delivered after the clinically recommended times



Responses to the backlogs so far have not been sufficient

The pace and degree to which elective surgeries resumed varied from jurisdiction to jurisdiction.

For example, with their suspension at the onset of the pandemic, in New South Wales Category 2 and 3 (semi-urgent and non-urgent) public patient elective surgeries did not restart until 16 June 2020. Conversely, on 30 June 2020 Victoria announced a return to tougher elective surgery restrictions. Only in February 2022 was the green light fully restored for Victorian public hospitals to resume all types of elective surgery.[53]

With subsequent waves of COVID-19, these and other states periodically suspended and reinstated elective surgeries. This has made formulating a national strategy to improve the situation extremely challenging.

To examine some of the responses to date, on the 16 June 2020 the NSW government committed $388 million funding boost to fast-track the delivery of elective surgeries delayed by COVID-19.[54] AIHW LHN data indeed shows that compared with the previous year, in 2020-21 4,292, more urgent elective surgeries took place in NSW and 28,483 more non-urgent. However, the number of semi-urgent non-elective surgeries fell by 16,409.[55]

It is possible to infer that urgent surgeries (those required within 28 days) and non-urgent surgeries (those required within 365 days and where many patients had already been waiting the longest) were prioritised at the expense of semi-urgent surgeries.

Additionally, the LHN average for the median number of days a patient had to wait for their surgery rose across all the three categories. In total, despite efforts to address the issue, in 2020-21, 39,011 patients in NSW did not receive their surgery within the recommended time.[56]

Similarly, on 1 April 2020, the Victorian government announced a $60m funding with the aim of fast-tracking 7,000 elective surgeries.[57] Across Victorian LHNs, the number of urgent elective surgeries did increase by 3,429. However, the number of semi-urgent and non-urgent elective surgeries fell by 6,502 and 7,025, respectively.[58] Again, it is possible to infer that this is the result of prioritisation.

Between 2019-20 and 2020-21, According to AIHW LHN data Victorian elective surgery numbers fell by 10,098.[59] In the same time, the average percentage of category 2 and 3 elected surgeries delivered in the recommended time also decreased exponentially, from 78 and 93 per cent, to just 66 and 78 per cent, respectively.[60]

The situation would likely be much worse in these states were it not for these interventions. But ultimately, health experts across Australia recognise that “one-off funding packages and elective surgery blitzes will not be enough”.[61]

Finding the solutions

When it comes to the elective surgery backlog, Australia needs a plan that cuts it. Concerted, fully-funded, long-term plans are required to ensure hospitals have the required capacity. These should include "surgical hubs".

AMA Professor Steve Robson has referred to the anticipated 500,000 patient elective surgery backlog as a "horror figure", stating that the country is "now at a critical point where access to timely elective surgery is out of reach for many Australians".[62]

There is no indication that the pressure on public hospitals is abating, and they continue to face workforce shortages, increased ambulance ramping, maximum capacity (particularly in emergency departments) and access block.[63]

To do this, the AMA has called for:[64]

1) Long-term funding commitments from the Australian and state and territory governments that deliver permanent capacity in our public hospital system.
2) Upfront advance payments from the Commonwealth to support state governments to expand capacity.
3) Providing funding to state/territory governments and/or direct to health services to assist in expanding the number of outpatient specialist appointments.
4) Reviews of the current backlog to identify where alternative care pathways may be appropriate.
5) A robust and regular reporting framework that reports on the number of patients on the waiting list (including the hidden waiting list), and demonstrates the increase in activity directly from the funding.

Q-bital endorses all of these recommendations, noting the AMA's statement that "significant investment will be required to restore the capacity of public hospitals and provide access to all those who require it within the clinically recommended timeframes… establishing enough capacity to meet the population demand while factoring in repeat waves of COVID-19 infections into the future."[65]

If the critical issue of the hidden waitlist is successfully addressed, even if alternate care pathways are identified, the necessary expansion of outpatient services will mean admissions to the elective surgery waiting list will only further increase, compounding backlogs further.

With this in mind, it is important to note that increasing capacity, such as developing surgical infrastructure and workforce, including developing new hospitals and surgical wings, takes considerable time, during which backlogs continue to grow.

Certainly, there are no shortcuts and all these measures are necessary, but ultimately Australian patients on the elective surgery waiting list – some of whom have already been waiting years for their procedures – need capacity to increase now.

International comparisons: Surgical hubs

Australia is by no means the only country whose health system is under immense pressure as a result of COVID-19. The UK, for example, is facing similar challenges in its National Health Service (NHS), and has begun to implement novel solutions to address them.

This presents an opportunity for Australian decision makers to examine possible approaches to dealing with backlogs here. As in Australia, in the UK elective surgeries were suspended en-masse at the beginning of the pandemic.

As services were reinstated, the growing backlog of elective procedures have been further compounded by the increased demands of infection control and high numbers of staff infection, reducing the number of operations performed.[66]

With 6.5 million people on the elective waiting list in England, the figures are the worst ever reported.[67]

In 2021 the British Government committed a total £1.5 billion to the creation of "surgical hubs", including increased bed capacity and equipment.[68] In this way, surgical hubs have been introduced to maximise infection control and increase vital surgical capacity, and their development has had a significant impact.

One eye hospital in England has successfully reduced the time cataract patients spend in hospital to 90 minutes, with surgery itself taking between 20 and 40 minutes. Most eye operations typically last between 30 and 90 minutes.[69] Consequently, it has therefore managed to perform up to 725 operations in one week.[70] This is reflective of the efficiencies that can be gained by focusing on specific categories of surgery.

On 13 July 2022, in collaboration with the NHS Strategy Unit, The Royal College of Surgeons of England released a white paper making the case for the wider introduction of surgical hubs across the UK to deal with the elective backlog. Devolved governments have similarly drafted long-term plans to adopt surgical and elective care hubs[71].

About Q-bital Healthcare Solutions

Q-bital Healthcare Solutions is a clinical Healthcare Spaces provider, operating a range of mobile and modular clinical facilities that can facilitate the majority of surgical procedures performed in a major acute hospital.

To date, more than 300,000 surgical procedures have been undertaken in Q-bital facilities globally. Solutions are bespoke to the needs of health settings and can include day surgery facilities, laminar flow operating theatres, outpatient clinics, decontamination and sterilisation facilities, and visiting hospitals to remote regions.

With existing infrastructure projects in Victoria and Queensland, Q-bital continues to cement a growing presence in Australia, building on 20 years of experience as a trusted partner to the NHS and private healthcare providers in the UK.

Q-bital's flexible facilities are able to support hospitals maintain targets, improve patient flow and address backlogs anywhere in Australia, including regional and remote communities.

A mobile laminar flow operating room facility comprises of an anaesthetic room, procedure room, first stage recovery room, scrub area, dirty utility area and a staff changing area. The facility is equipped with fully integral IPS, UPS, integrated water system, medical gas bank, HVAC system, vacuum and scavenging systems.

The unit is connectable to other mobile facilities as well as to existing hospital buildings through an attached walkway and externally built corridor, ensuring that capacity can be integrated, increased or decreased as necessary.

Crucially, it can be commissioned within 10-14 days.

Prince Charles Hospital Case Study

In 2021, Q-bital Healthcare Solutions installed a two-room colonoscopy facility at Prince Charles Hospital in Brisbane, Queensland.

Comprising a mobile operating theatre, a mobile ward and a modular decontamination unit, the facility will provide an additional 24-27 colonoscopy procedures each day, or 6,600 each year.

The mobile and modular operating room facilities offer a significant increase in capacity for the duration of high patient demand periods. The operating room solution has provided Prince Charles Hospital with a reliable, safe answer to capacity pressures.

All operating room facilities offer High-Efficiency Particulate Absorbing-filtered (HEPA) environmental air that conforms to Grade C EU Good Manufacturing Practices and all applicable Australian Standards for optimal clinical care delivery.

The mobile and modular endoscopy suites are designed to accommodate a complete patient pathway, including on-board decontamination facilities for flexible endoscope reprocessing. With HEPA-filtered environmental air and integral medical gas, vacuum and scavenging systems, as well as decontamination equipment and storage for endoscopes, it provides a safe and comfortable environment for both patients and staff.

The introduction of this facility is supporting the hospital to maintain targets, improve patient flows and address backlogs, and cements Q-bital's growing presence in Australia. It builds on 20 years of experience as a trusted partner to the NHS and private healthcare providers in the UK, and previous infrastructure projects in Victoria and Queensland. This considerable experience enables Q-bital to offer versatile, tailored and measurable solutions to help meet individual hospitals' unique challenges.

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