# Wait List Access Policy Surgical and Non-Surgical Waitlist Handbook

**April 2020**

## Contents

# Glossary

This section provides a reference of key terms. The Australian Institute of Health and Welfare National Health Data Dictionary (NHDD) is recognised as the authoritative source of definitions and should be consulted in conjunction with this list. Available at: http://meteor.aihw.gov.au/content/index.phtml/itemId/268110/letter/A.

## Table 1.

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| **Addition to the waiting list** | As soon as a decision is made that a patient is in need of admission to the hospital and the admission is not required within 24 hours, the treating doctor should complete a Request for Admission (RFA) form and forward it to the hospital within three working days. The patient will be added to the electronic waiting list within two working days of receipt of a complete, accurate and legible RFA form. The date the RFA is received becomes the patient's listing date. This date is used in the calculation of the waiting time. |
| **Admission** | Admission is the process whereby the hospital accepts responsibility for the patient's care and or treatment. Admission follows a clinical decision based upon specific criteria that a patient requires same day or overnight care and treatment.<br>There are two types of admissions:<br>Emergency admission (admission within 24 hours)<br>Elective admission (admission greater than> 24 hours |
| **Admission from booking list** | The standard method of admission for waiting list patients. The patient has been scheduled for treatment and the admission proceeds according to plan. |
| **Admission date** | Date on which an admitted patient commences an episode of care. |
| **Admission from waiting list** | Admission occurs directly from the waiting list without an intervening booking period. In general, this will occur when the respective patient's condition has worsened to the extent that early admission is recommended and no booking can be made, but not to the extent that admission through an Emergency Department is required. This may also occur if an opening in a surgery session schedule occurs at short notice and a patient is found from the waiting list and is able to attend immediately. |
| **Admitted as an emergency for awaited procedure** | Admission of a patient on the waiting list and whose condition has worsened to the extent that they are taken directly to an Emergency Department without an intervening booking period. The patient is removed from the waiting list and is not reported as an elective admission. The patient is to be recorded as a removal from the waiting list with the reason duly noted, and appears on records as an emergency admission. |
| **Anticipated election status** | Recorded when the patient is added to the waiting list, it is the anticipated election the patient will make when admitted for the planned procedure/treatment.<br>Classifications are:<br>Medicare Eligible – Public patient<br>Medicare Eligible – Private patient<br>Medicare Eligible – Department of Veteran Affairs patient (DVA) |

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| | Medicare Eligible – Other (compensable, defence forces etc.<br>Medicare Eligible – Overseas visitor |
| **Booking** | The process of scheduling a patient for surgery. |
| **Booked day patient** | Patient requiring an elective surgical procedure who has a booking date for admission and discharge on the same day. |
| **Booking list** | A booking list is a list of patients who have been allocated a date and time in the operating theatre for surgery. Patients who are booked for elective surgery are considered to be on a waiting list until they are admitted. |
| **Booking number** | A sequential number used to indicate the number of times the patient has been given a booking for admission for the awaited procedure. This data field counts the number of postponements per patient. |
| **Booked patient** | A waiting list patient with an appointment for admission for the awaited surgical procedure. A booked patient should continue to be counted as on the waiting list until they are admitted. |
| **Booked period** | The period that each patient may be listed as booked for their surgical procedure. This time frame varies according to procedure and individual situation. |
| **Cancellation** | Patients shall be deemed to be cancelled if they are permanently removed from the waiting list at the instruction of the patient, consultant or hospital medical staff, for reasons other than that they have had their surgical procedure. Changes in status from RFC to NRFC should not be listed as cancellations. A patient who is transferred to another hospital for treatment shall be cancelled from the originating hospital's waiting list. Postponements due to alterations to theatre lists should not be termed 'cancellations'. |
| **Category** | Refer to clinical urgency. |
| **Census date** | Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list. |
| **Clerical audit** | A clerical audit is a regular and routine clerical check that the information that the hospital has of patients waiting for admission is correct. It will facilitate the identification of patients who no longer require admission or who have duplicate bookings. |
| **Clinical review** | The examination of a patient by a clinician after the patient has been added to the elective care waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician. |
| **Clinical urgency** | The National Health Data Dictionary (NHDD) defines clinical urgency as 'a clinical assessment of the urgency with which a patient requires elective hospital care'.<br>The 2013-2014 National definitions for elective surgery urgency categories project revised simplified time-based definitions of urgency categories are:<br>Category 1 – procedures that are clinically indicated within 30 days<br>Category 2 – procedures that are clinically indicated within 90 days |

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| | Category 3 – procedures that are clinically indicated within 365 days |
| **Cosmetic surgery** | Procedure performed to reshape normal structures of the body, or to adorn parts of the body with the aim of improving the consumer's appearance and self-esteem. These procedures do not attract a Medicare rebate. |
| **Date of removal** | The date that the patient is removed from the waiting list. After this date, the patient is considered to be permanently deregistered from all elective surgery waiting lists. Removal can be either by admission for the awaited procedure or by cancellation. Change in Patient Listing Status (becoming NRFC) is not considered to be a removal. |
| **Day of surgery admission (DOSA)** | Patients are admitted into hospital on the day of their procedure and remain in hospital for at least one postoperative night. |
| **Day only (DO) surgery** | Day Only Surgery involves the patient being admitted and discharged on the day of surgery. |
| **Declined patient** | A patient who declines a planned admission date for treatment. |
| **Deferred patient** | 'Deferred' is one of the two potential reasons for changing patient listing status from RFC to NRFC, the other being 'staged'. Deferred patients are those who for personal or social reasons are not prepared to accept an offer of admission. These patients are NRFC and should be listed as such. |
| | Hospitals are expected to exercise discretion to distinguish between patients who are reasonably negotiating an admission date to suit their particular circumstances and those who declare themselves unavailable for treatment for a prolonged or indefinite period. As a general rule, patients who are unable to present for admission within a six-week period may be considered to be deferred. However, it is stressed that individual circumstances may vary and all due consideration should be given to allow patients to negotiate a mutually convenient admission date. |
| **Discharge intention** | Recorded when the person is added to the waiting list. It identifies whether the referring doctor expects that the person will be admitted and discharged on the same day (i.e. day patient) or will stay at least overnight. |
| **Elective admission** | An admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours (added to the waiting list). An elective admission usually results from a GP consultation, referral to a specialist and a recommendation for admission to a hospital by the specialist (or GP, where appropriate). The medical consultation may take place in a hospital outpatient clinic. |
| **Elective medical treatment** | Elective medical procedures are predominantly non-surgical procedures but do include procedures such as bronchoscopy, colonoscopy, endoscopy, gastroscopy etc. |
| **Elective patients (sometimes referred to as booked patients)** | Elective patients are those who are having an elective admission. |

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| **Elective surgery** | Elective surgery is planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery waiting list. |
| | Tasmania has adopted the nationally agreed definition of elective surgery, as updated in May 2015 on the Australian Institute of Health and Welfare NHDD. |
| | In broad terms, a procedure is elective surgery if it is performed in an operating theatre facility under some form of anaesthesia and admission is not required within 24 hours of the decision by a clinician to admit. It should be a surgical procedure included in the Commonwealth Medicare Benefits Schedule (CMBS) (Operations). |
| | Although this is sometimes not the case for approved new procedures not yet added to the CMBS. Anaesthesia includes general, regional or local anaesthesia or intravenous sedation. |
| **Emergency surgery** | Emergency surgery is surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery at a later time following this unplanned presentation. This includes where the patient leaves hospital and returns for a subsequent admission. Emergency surgery includes unplanned surgery for admitted patients and unplanned surgery for patients already awaiting an elective surgery procedure (for example, in cases of acute deterioration of an existing condition). |
| | Tasmania has adopted the nationally agreed definition of emergency surgery, as updated in May 2015 on the Australian Institute of Health and Welfare NHDD. |
| | These patients are not usually added to the waiting list, however if they are added for organisational reasons then when the patient is admitted they should be removed from the waiting list as an emergency admission. If already on the waiting list the patient should be removed and classified as an emergency. While most emergency admissions are processed or passed through the emergency department, many are referred directly from treating doctor to the ward. |
| **Emergency patients** | Emergency patients are those whose clinical conditions indicate that they require immediate surgery or present for surgery at a later time following trauma or acute illness. |
| **Exceeding clinical priority time frames or overdue** | Patients are considered overdue if they have waited in excess of the time recommended for the assigned RFC clinical priority category. |
| **Estimated duration of procedure** | The estimated duration of the surgical procedure is a clinically based determination made by the surgeon at the time that the patient is referred to the hospital for surgery. This time frame should be entered on the RFA form. This information is important for theatre scheduling purposes. |
| **Expected length of stay** | Expected length of stay indicates whether a person is to be admitted as a same day or overnight patient. If overnight, then the expected number of days is indicated. |
| **Indicator procedure** | The procedure or treatment the patient is to undergo when admitted. There are currently around 200 possible codes. |

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| **Inpatient** | Patients who are formally admitted to a hospital or health service facility. Formally admitted patients can be day only or overnight. |
| **Listing date** | Listing date is the date of receipt of the RFA form. Calculation of waiting time starts from this date. |
| **Listing status** | Indicates the status of the person on the waiting list, which is the extent to which a patient is ready and available for admission. This may change while the patient is on the waiting list; e.g. after a clinical review. |
| | If the patient is registered but is NRFC, the countable waiting period does not begin until the patient acquires RFC status. However, a listing date must be entered even if the patient is NRFS. For example, a patient who must wait several months before they are ready for orthopaedic pin removal must nevertheless be given a listing date, although he/she will not be reported as waiting and cannot appear as overdue. |
| **Long-wait patients** | Medical and surgical patients who are RFC and have been waiting for elective admission longer than 12 months are termed long-wait patients. |
| **Medicare eligibility** | Patients must be identified as being eligible or not eligible for treatment under Medicare for each episode, and a record of the patient's Medicare number is to be made at the time of listing – see Anticipated Election Status. |
| **Not Ready For Care (NRFC)** | A NRFC patient can be defined as a patient who is not available to be admitted to hospital until some future date and is either:<br>Staged – not ready for clinical reasons<br>Pending improvement of clinical condition<br>Deferred – not ready for personal reasons |
| | A postponement of admission by the hospital does not render the patient NRFC. These patients should remain on the waiting list as they are still genuinely waiting, but are delayed. If the patient is registered but is not NRFC, the countable waiting period does not begin until the patient acquires RFC status. However, a listing date must be entered even if the patient is NRFC. For example, a patient who must wait several months before they are ready for orthopaedic pin removal must nevertheless be given a listing date, although he/she will not be reported as waiting and cannot appear as overdue |
| | Refer to the National definitions for elective surgery urgency categories project where these patients are referred to as not ready for surgery. Available at: |
| | http://www.aihw.gov.au/publication-detail/?id=60129543979 |
| **Not Ready for Surgery "Staged"** | Patients who have undergone a procedure or other treatment and are waiting for follow-up elective surgery, where the patient is not in a position to be admitted to hospital or to begin the process leading directly to admission for surgery, because the patient's clinical condition means that the surgery is not indicated until some future, planned period of time. |
| | Examples include a patient who has had internal fixation of a fracture who will require removal of the fixation device after 3 months, a patient who requires a 'check' cystoscopy to check for cancer 12 months after surgery to remove a tumour in the |

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| | bladder, and a patient requiring rectal cancer surgery 6-8 weeks after neoadjuvant chemo-radiotherapy for colorectal cancer. |
| | A patient is said to be staged if for clinical reasons they will not be ready for admission until some future date. It is mandatory to indicate a reason for deferring. The reason a patient is staged may be reported as follows: |
| | Unfit: a co-morbidity exists which, until resolved, renders them unfit for the proposed treatment |
| | Planned: |
| | a patient requiring treatment as part of periodic treatment; |
| | a patient requiring treatment as part of a staged procedure (includes obstetric patients); |
| | a planned re-admission for a patient with a predictable morbid process, requiring periodic treatment of the ongoing disease process; or |
| | a planned re-admission for review of status following previous treatment. |
| **Not Ready for Surgery 'Pending improvement of condition"** | For such patients, a decision has already been made that surgery should take place. Patients should not be regarded as 'not ready for surgery—pending improvement of their clinical condition' when they are undergoing routine monitoring or investigations before a decision is made as to whether surgery is required. |
| **Not Ready for Surgery "Deferred"** | A patient is said to be deferred if for personal reasons he/she is not able to accept a definite date for admission. It is mandatory to indicate a reason for deferring. |
| | The reason a patient is deferred may be reported as follows:<br>A patient is going on holidays and will be unavailable for admission;<br>A patient is unable to obtain home support;<br>A patient is unable to accept a date due to work commitment; or<br>A patient is unable to accept a date for other significant reasons e.g. personal carer. |
| | Deferred patients may be added to the waiting list as NRFS or Suspended. These patients should not be counted as 'waiting' and are excluded from the reported waiting list statistics. |
| **Non-surgical or diagnostic procedure** | In broad terms, a procedure is non-surgical or diagnostic if it is performed outside an operating theatre or not performed by a surgeon - see also Elective Medical Treatment. A descriptive list of non-surgical elective surgery procedures not routinely performed in public hospitals is outlined by the National Health Data Dictionary. |
| **On standby** | A patient is 'on standby' when he or she is willing to accept admission on short notice. |
| **Other Surgery** | Other surgery is where the procedure cannot be defined as either emergency surgery or elective surgery, for example, transplant surgery and planned obstetrics procedures. |
| | Tasmania has adopted the nationally agreed definition of other surgery, as updated in May 2015 on the Australian Institute of Health and Welfare NHDD. |
| **Overdue patient** | The National Health Data Dictionary defines overdue patient as 'one whose wait has exceeded the time that has been |

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| | determined as clinically desirable in relation to the urgency category to which they have been assigned.'<br>A patient is classified as overdue if RFC and waiting time at removal from elective surgery waiting list or waiting time at census date is longer than 30 days for patients in category 1 or 90 days for patients in category 2. It does not apply for patients in category 3 as there is no specified timeframe within which it is desirable that they be admitted (refer Extended Wait Patient). |
| **Patient listing status** | An indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure. |
| **Patient listing status re-assignment date** | The date on which the patient listing status is changed from RFC to NRFC, or vice versa. |
| **Patient listing status review date** | The date by which a patient should be reassessed to determine whether he or she is RFC. |
| **Planned admission date** | The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care. A patient who has been allocated a definite date for admission by the hospital, has been scheduled (i.e. the admission or listing is scheduled) A patient who has not been given a definite date for admission by the hospital is unscheduled (i.e. the admission is unscheduled). |
| **Planned length of stay** | The number of nights the patient is expected to stay in hospital as an inpatient. This information will be used for discharge planning and bed management. |
| **Planned procedure** | The planned procedure is the procedure or treatment the patient is to undergo when admitted. |
| **Pooled lists** | At some hospitals, clinicians in particular specialties have agreed to include their public patients on a combined list for that specialty. This means that patients may be treated by any one of the clinicians belonging to the group. Patients may therefore be added to a waiting list by one clinician but admitted by another clinician. This does not mean that if a particular clinician is part of a pooled list group that this clinician does not also list and admit patients apart from the pooled list patients. Pooled lists are generally set up for the more common routine procedures. A clinician's private patients would not be included on a pooled list. |
| **Postponement** | Postponement occurs when a patient is booked for the awaited procedure and the booking is subsequently put off to another date further in the future. Reasons for postponement may be clinical, patient and hospital related. For example: |
| | Clinical: The booking is postponed because the patient has been assessed by their clinician as being temporarily NRFC due to changes in their clinical condition. |
| | Patient: The booking is postponed at the patient's request for personal, social or other non-clinical reasons. The hospital must exercise discretion to determine whether the patient should be re-booked immediately, cancelled or assigned to NRFC status. |
| | Hospital: The booking is postponed because the operating room, hospital bed, consultant or other hospital resource becomes unavailable, for instance due to unexpectedly large numbers of emergency patients presenting for treatment. |

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| | The patient remains RFC. This sub-category is of most interest to the DOH as it helps identify inappropriate resource allocation and other difficulties. |
| **Pre-admission** | Patients are assessed before admission to the hospital for their suitability to undergo the intended procedure/treatment, associated anaesthetic and discharge plans. |
| **Private/chargeable patients (including DVA and WC etc.)** | Persons admitted to a public hospital who elect to choose the treating clinicians will be charged for medical services and accommodation. |
| **Procedures not routinely provided** | Surgical procedures that should not be undertaken in public hospitals unless the procedures are essential for the patient's clinical good health. |
| **Public patient** | A Medicare-eligible patient admitted to a public hospital who has agreed to be treated by a nominated doctor of the hospital's choice and to accept shared ward accommodation. This means the patient is not charged. |
| **Ready For Care (RFC)** | Patients who are prepared to be admitted to hospital or to begin the process leading directly to admission for surgery. |
| | The process leading to surgery could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests. |
| | A RFC patient is defined as a patient who is available for admission to hospital. RFC patients will be in clinical priority categories1, 2 or 3. |
| | To be RFC, patients must;<br><br>have been diagnosed with a condition that their respective clinicians judge may be appropriately treated through surgery; be deemed clinically fit for immediate surgery by their clinicians; and |
| | be personally prepared for immediate admission (with reasonable leeway for negotiation on specific booking dates for mutual convenience). |
| **Ready For Surgery Care "delayed"** | A patient is regarded as RFS RFC but delayed where the hospital decides to postpone admission and reschedule a person's planned admission date because of: |
| | non-availability of operating theatre (staff, equipment, resources etc.);<br>non-availability of bed; planned bed reductions |
| | non-availability of bed; pressure of emergency admissions; or non-availability of doctor |
| | It is mandatory to indicate the reason for the patient's admission being delayed. |
| **Request for Admission Form (RFA)** | Requests for admission to hospital need to be on an approved form and contain a minimum data set as specified in this policy. |
| | Forms must have a dedicated section for documentation of relevant details regarding the booking, such as contact with patient, clinicians, dates and reasons for changes or delays to planned admission dates. This dedicated section may be either part of the RFA or a particular form attached to the RFA. The documentation needs to provide a clear audit trail for all |

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| | transactions and must be kept as part of the patient's medical record |
| **Referring doctor** | Doctor who is referring the patient to the waiting list. |
| **Removal date** | Date on which a patient is removed from an elective surgery waiting list. Removal date will be the same as admission date for patients. |
| **Removal from waiting list, other than for admission** | The reason why a patient is removed from the waiting list includes: |
| | admitted as an elective patient for awaited procedure;<br>admitted as an emergency patient for awaited procedure;<br>the patient has been transferred to another waiting list; |
| | could not be contacted;<br>patient does not respond to clerical review letter; |
| | patient deceased;<br>treated elsewhere for awaited procedure; |
| | surgery not required or declined on two occasions for personal reasons;<br>transferred to another waiting list; |
| | patient twice fails to arrive for surgery on an agreed date without notice or good reason; or<br>patient defers and exceeds maximum of NRFC day time limit for personal reasons. |
| **Request for admission** | The process of being placed on a hospital's waiting list begins when the consultant sends in a completed RFA form. |
| **Same day patient** | A same-day or day only patient is defined in the Hospitals' Service Data Items and Definitions Manual as a person who: |
| | has been registered as an admitted patient at the hospital;<br>meets the minimum criteria for admission;<br>has undergone a formal admission process; or |
| | is separated prior to midnight on the day of admission. |
| **Scheduled admission date** | The date on which it is proposed that a waiting list patient will commence an episode of care as either a same day or multi-day stay patient. |
| **Short notice/standby patient** | Patients may agree to be available on the short notice list to have their surgery performed if there is a cancelled procedure. The hospital should determine what period of time prior to admission is regarded as short notice and for which procedures are appropriate. |
| **Staged patient** | Staged' is one of two potential reasons for changing patient listing status from RFC to NRFC, the other being 'deferred'. Staged patients are those whose medical condition will not require or be amenable to surgery until some future date. |
| **Status Review Date (SRD)** | This is the date determined for an assessment (clinical or administrative) as to whether a deferred or staged person (i.e. NRFC) has become ready for admission to the hospital at the first available opportunity (i.e. NRFC). |

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| **Surgical Speciality** | Specialist's area of clinical expertise. Where a specialist undertakes surgical procedures, which can be classified into different specialities, then the specialist will have a different list for each specialty (e.g. Obstetrics/Gynaecology) Examples of the broad specialities used in Tasmania's public hospitals are: |
| | Cardiothoracic<br>Ear Nose and Throat (ENT)<br>General Surgery<br>Gynaecology<br>Neurosurgery<br>Ophthalmology<br>Orthopaedic<br>Plastic and Reconstructive<br>Urology<br>Vascular and Endovascular<br>Oral Maxillo Facial<br>Paediatric Surgery |
| | Hospitals may have additional specific clinical areas identified but these should be categorised under the main specialty headings for central reporting. |
| **Treated** | When a patient has been admitted to hospital and undergone their surgical procedure. |
| **Treating clinician** | The medical officer/senior clinician (a visiting practitioner, staff specialist or academic clinician) responsible for the care of the patient, and under whose care the patient is to be admitted. |
| **23-hour service model/admission** | Is a model of care for elective surgery patients who require no more than one overnight stay. The 23-hour care model recognises the selected procedures, not otherwise suitable for day surgery, can be provided within a 23-hour period in a non-inpatient environment. In these units, patients can be monitored post-operatively and discharged within 23-hours. The model is not an alternative or substitute for day surgery, but an extension of services for patients unsuitable for day surgery. |
| **Waiting list** | A waiting list is kept by the hospital. This contains the names and details of patients registered as requiring elective surgery at that hospital and can wait more than 24 hours. Admission may be for same day (admission and discharge on the same day) or other acute inpatient services requiring overnight or longer stay. |
| | It includes patients without a scheduled admission date and booked patients. It includes patients who have been transferred from another hospital's waiting list. The waiting list includes patients who are RFC and NRFC, however these should be counted separately. |
| **Waiting time** | Time a patient spends as RFC. |

# Introduction

Waiting lists enable the hospitals and treating clinicians to manage the increasing demand for elective surgery. A well-managed waiting list system, where patients wait in turn according to their clinical need ensures only those patients who require surgery and are available for treatment are listed. Appropriately listed patients with a defined clinical need for surgical intervention will improve access to elective surgery and reduce waiting times for patients regardless where they live in Tasmania.

## Complementary agreements and policies

This handbook complements current and future state-wide policies that will be used by the single Tasmanian Health Service (THS). This will include policies and protocols arising from the One Health System reforms, including the decisions presented in the White Paper relating to the development of a Tasmanian Role Delineation Framework (TRDF) and Tasmanian Clinical Service Profile (TCSP). The handbook should be read in conjunction with the overarching document Waitlist Access (Surgical and Non-Surgical) Policy.

## Responsibilities and delegations

All DoH and THS employees and agents (including visiting medical officers and other partners in care, contractors, consultants and volunteers), involved in the delivery of elective surgery services and the coordination and maintenance of elective surgery waiting lists are required to comply with this policy.

## Policy Objectives

These guidelines are designed to assist hospital staff to manage waiting lists consistently across the State in a single Tasmanian Health Service (THS). The operation of a safe, equitable and efficient elective surgery waiting list system will maximise Tasmania's elective surgery outcomes.

Hospitals are expected to comply with the policy components of this document. The policy principles and operational guidelines in this document are considered best practice and should be adopted unless circumstances require otherwise.

A key element of this Access Policy is to empathise with and improve the patient's elective surgery journey.

Patients and carers are the primary focus of elective surgery services and should be informed, educated and supported throughout their elective surgery experience. Patients and carers should participate in decision making and be actively involved in their health care management.

## Policy Scope

This policy applies to the registration of public and private patients onto the elective surgery and other procedures waiting list in any Tasmanian public hospital.

This policy and guideline document does not include data management, bed management or theatre scheduling components however adherence to the Admission and Discharge Manual and State-wide Clinical Coding Framework Strategy when recording and counting data is mandatory: http://www.DoH.tas.gov.au/intranet/system/activity_based_funding_abf/activity_based_funding_abf_resources2

## Provision of indemnity cover

The Crown indemnifies persons including State Servants such as THS employees, and 'eligible medical practitioners', subject to Employment Direction (ED) 16. "Eligible Medical Practitioner" means a registered medical practitioner who is employed by the Crown as a medical practitioner, but only in relation to any activity being undertaken for which he or she is not entitled to bill and retain in full any fee charged for the activity. ED16 provides detailed guidance on indemnity and should be referred to in addition to this summary.

People covered by ED16 may be subject to legal claims/actions despite the fact that they are acting in good faith, within the scope of their duties or in the course of their employment. It is therefore necessary that they receive appropriate legal representation and be protected from personal liability subject to ED16.

Treating clinicians who are practicing privately or engaged as independent contractors cannot avail themselves of the indemnity provided by the Crown and must have their own indemnity insurance cover in place. Visiting Medical Officers (VMOs) are specifically only indemnified for their work as a part-time Crown employee. The VMO's private practice work is not indemnified.

For further information please refer to:

Employment Direction No. 16 Indemnity and Legal Assistance Supplementary Guidelines for the Grant of Indemnities and Legal Assistance to Medical Practitioners in the Tasmanian State Service available at:

http://www.dpac.tas.gov.au/__data/assets/pdf_file/0004/220981/ED._16_-_Indemnity_and_Legal_Assistance.pdf

Policy and Guidelines for the Grant of Indemnities and Legal Assistance to Public Officers of the State of Tasmania (January 2014) available at:

http://www.dpac.tas.gov.au/__data/assets/pdf_file/0008/219284/ED_No_16_Attachment_1_Policy_Guidelines_for_the_Grant_of_Indemnities_and_Legal_Assistance_to_Public_Officers_of_the_State_of_Tasmania.PDF

# 1. Referring patients to the waiting list

## Policy

1.1. Patients who are assessed by a treating clinician as requiring elective surgery and who are RFC (clinically ready to receive their elective surgery procedure) will be registered onto the waiting list.

1.2. Patients can be referred to an elective surgery waiting list from either a hospital's outpatient department or a treating clinician's private consulting rooms.

1.3. Regardless of the source of referral, the referring clinician must submit the approved RFA form for all patients.

1.4. The referring treating clinician should inform the patient about:

- the nature of the proposed surgical procedure;
- the risks associated with the procedure;
- the need for consent;
- being placed on the elective surgery waiting list of a public hospital which means they will be prioritised according to clinical need, regardless whether they elect to be treated as a public or private patient;
- the reason for referral to the waiting list; and
- the waiting list process including the clinical urgency categories.

1.5. All the essential fields on the front page of the RFA the Consent for Medical Procedure/Treatment page must be completed prior to the patient being added to the waiting list.

1.6. Request for surgery from clinician's private rooms must include relevant documents such as GP referral and patient history. The referring consultant's letter to the GP is to be cc'd to the hospital surgical booking office and scanned to the DMR, and a copy kept with the patient's RFA.

1.7. Incomplete requests for registration onto the waiting list will not ordinarily be accepted and will be sent back to the treating clinician. The hospital may exercise discretion to accept requests for registration if the missing information is not essential.

1.8. The Patient Health Questionnaire pages of the RFA will be fully completed at the time of submission to the hospital so that adequate triaging can be completed before the patient is added to the waiting list.

1.9. It is the responsibility of the treating clinician completing the referral form to assign an urgency category. Under no circumstances should clerical staff or any other clinical staff member assign the urgency category if it is overlooked.

1.10. Patient consent is normally obtained at the time of consultation, prior to referral to the elective surgery waiting list. 'Direct Access' patients can provide their consent on the day of surgery. Consent should not be routinely obtained at the pre-admission clinic or at the time of hospital admission, although it is encouraged to confirm consent at these times.

1.11. Consent must be confirmed in writing using the approved hospital patient Consent for Medical Procedure/Treatment section of the state-wide RFA form.

1.12. Patients placed directly on elective surgery waiting lists from private rooms should not be referred to outpatient clinics to obtain consent unless a consultation is clinically required.

1.13. Hospitals should provide consultants with approved consent and waiting list referral forms.

1.14. It is recommended that a new Consent for Medical Procedure/Treatment Form is provided for the patient to complete under the receiving clinician's/clinical team where the patient is transferred to another hospital, another section of the same hospital for treatment, or to a different clinician.

1.15. The referring State-employed or contracted treating clinician's must have obtained the patient's informed consent to undergo the surgery or other medical procedure in line with the requirements outlined in DOH policy.

1.16. The patient must have elected to be treated as a public or private patient and agreed to be placed on the public hospital waiting list.

1.17. The referring State-employed treating clinician must have admitting rights to the hospital to which the patient is referred.

1.18. The referring State employed treating clinician must provide the hospital, at the time of referral, all the information reasonably requested in the elective surgery waiting list referral and consent documentation issued by the relevant public hospital.

1.19. The hospital must accept the referral and either admit the patient or confirm the patient has been added to the waiting list for treatment at that hospital.

# 2. Registering patients on the waiting list

## Policy

2.1. Ready for Care (RFC) status is defined by a patient's readiness to begin the process leading directly to being admitted to hospital for elective surgical care. Only patients who are RFC should be included in statistics that describe people who are on the waiting list.

2.2. Hospitals must register patients on the waiting list within two working days of receiving a completed and signed referral form. The RFA forms will be date stamped and entered into the waiting list module on that same day or the next day. The listing date and RFC date will be the date that the completed form was received.

2.3. Flagging patients who would benefit from multidisciplinary case coordination at the beginning of the waiting list episode can reduce unnecessary postponements and assist in reducing long waits.

2.4. In the event of a change in a patient's condition/category appropriate changes are to be made to the patient's record in addition to being actively managed within the waiting list system.

2.5. Any changes to patient's care status should be entered on the waiting list module.

2.6. Incomplete referral forms should not be registered. The hospital should make reasonable attempts to obtain the missing information by contacting the medical specialist.

2.7. If the treating clinician or approved delegate is not available, the referral form should be returned to the originator for completion. Hospitals should use common sense when returning forms for completion if non-essential information is omitted including the practice of pre registering the patient on the waitlist.

2.8. Where a referral is refused on medical grounds or related to hospital policy, the health service must advise the medical practitioner or surgeon immediately.

# 3. Written and Phone Communication

## Policy

3.1. Hospitals are required to advise all patients in writing within five working days of registration that they have been placed on an elective surgery waiting list.

3.2. A Waiting List Confirmation Letter should be sent out to the patient and General Practitioner where noted, when the patient is entered on the waiting list that includes:

- the date of placement on the waiting list;
- surgical unit responsible for care;
- speciality urgency category; and treatment time per category (within 30 days for Category 1, within 90 days for Category 2 and within 365 days for Category 3).

3.3. The waiting lists for non-emergency surgery and non-emergency procedures – Patient Information Pamphlet should be included with the confirmation letter. It contains information on the patients' rights and responsibilities, including:

- the requirement to advise change of address or contact details;
- the requirement to advise if surgery is no longer required or wanted;
- what to do if their condition changes;
- interpreter contact information;
- the explanation that the surgeon who performs the surgery may not be the same surgeon that placed the patient on the waiting list;
- the right to choose public or private admission;
- the importance of informing the hospital if they are a Department of Veteran Affairs (DVA), Defence Forces ,Workers Compensation, or Motor Accidents Insurance Board member or candidate; and
- a phone call from the Elective Surgery Access staff will be made to Staged NRFC patients who are contactable when the staged procedure date is known or when the patient is fit for surgery. Otherwise an Elective Surgery Booking Letter can be sent at this stage.

3.4. A Pre-Admission Clinic Letter should be sent to the patient prior to their pre-admission to a surgery assessment clinic.

3.5. An Admission Offer Surgery Booking Letter is sent when the surgery has been booked.

3.6. An Elective Surgery Postponement Letter is available and can be sent when the patient's procedure has been postponed by the hospital and they cannot be contacted by phone.

3.7. A Waiting List Review Letter or Audit Letter is sent to all patients on the waiting list who have waited more than six months in order to:

- keep them informed of their situation on the waiting list;

- ensure that the patient's condition has not changed;
- notify them in the event that a clinical review may be required;
- ensure the patient wishes to remain on the waiting list; and
- ensure the patient's contact details are kept up to date.

3.8. The Not Ready for Surgery letter can be sent to patients who are not in a position to accept an offer of hospital admission for personal reasons and will include:

- the personal NRFC time limit policy for patients who: exceed 30 days for category 1; exceed 90 days for category 2 and exceed 180 days for category 3. See section 4.10 of this policy.

## Implementation Guidelines

Consider the communication needs of patients/carers from non-English speaking backgrounds or those with an intellectual or physical disability or who have a mental health condition. Interpreter services should be provided whenever required.

Patients must be advised if changes are made to their waiting list status, such as a change to their urgency category or RFC status.

Patients must be advised that failure to comply with their responsibilities can result in their removal from the waiting list according to the guidelines in Section 9 of this policy document – "Removing Patients from the Waiting List". When this occurs the relevant staff should keep a record of the Removal from Waiting List notification.

For some procedures the hospital should advise patients that to provide surgery sooner, it might have to be performed at another hospital.

Patients who have been waiting significantly longer than their clinical category will be recommended for clinical review. See section 8.1 of this policy document.

## Patient information

3.9. Patients are provided with updated meaningful information about elective surgery waiting lists and their rights and responsibilities.

3.10. Non-English speaking patients and carers will be provided with information in an appropriate language. Access to interpreter services will be provided when the patient does not clearly understand all aspects of their referral or treatment. Advocates or family members will not be used to translate information as they may have limited understanding to translate clinical terms and may make assumptions about not including important information in their discussions with the patient, placing unnecessary risk on the patient and hospital staff.

3.11. Translator Interpreting Service (TIS):

- https://www.tisnational.gov.au/ or phone 131 450
- Patients who are hearing impaired or deaf may need to use the following services to understand all aspects of their referral or treatment:
- NRS (National Relay Service) – an Australian Government phone/internet relay call solution: http://relayservice.gov.au/

- 24-hour relay call numbers:
- TTY/Voice - Ph: 133677
- Speak/Listen options - Ph:1300 555 727SMS relay - Ph: 0423 677 767

3.12. Patients who are hearing impaired and or deaf who use sign language may need to use the following services to understand all aspects of their referral or treatment:

- NABS (National Auslan Interpreter Booking and Payment Service): http://www.nabs.org.au/about-nabs.html or phone 1800 24 6945

## Notifying the general practitioner

3.13. The hospital should notify the patient's nominated GP of the patient's receipt and registration of referral on the waiting list within 10 days of registration. The notification should include:

- the date the patient was placed on the waiting list;
- the planned speciality/unit as stated on the referral form;
- the urgency category;
- who to contact at the hospital if the patient's condition changes; and
- the personal NRFC time limit policy for patients who: exceed 30 days for category 1; exceed 90 days for category 2 and exceed 180 days for category 3. See section 4.10 of this policy.

3.14. If approval to provide notification to the GP has been sought and not given, the patient must be advised of the importance of informing their GP of their placement on the waiting list.

## Patients from correctional facilities

3.15. The patient may be advised that at some time in the future they may attend a hospital for surgery.

3.16. For security reasons, the patients and their relatives must not be informed of surgery and admission details until the day of surgery.

3.17. Details of dates for admission and surgery are to be arranged by the appropriate nursing staff at the Prison/Detention Health Centre in liaison with the Hospital Bed Co-ordinator or After Hours Clinical Nurse Manager.

3.18. Discharge planning will commence on admission. A minimal length of stay with early return to the correctional facilities' hospital for ongoing care is to be implemented where possible.

3.19. If public enquiries are received concerning patients, hospital staff may respond to health enquiries but refer all other enquiries to the Chief Custodial Officer at the respective correctional facility.

3.20. Patient care and discharge planning will be discussed with the appropriate clinical contact not with Corrective Services Custodial Officers.

# 4. Managing Patient Status

## Policy

4.1. The National definitions for elective surgery urgency categories project proposes jurisdictions change their terminology from not ready for care to not ready for surgery. This change provides clarification for situations in which patients that are not ready for surgery may be receiving medical or health care. Patients can be NRFC for any of the following reasons:

## NRFC patients – staged patients

4.2. Staged patients have undergone surgery or some other treatment and are waiting for follow up surgery that needs to occur at a particular, known time in the future. These patients should be designated as ready for surgery at the beginning of the window of time during which the procedure is indicated. They should be allocated to the urgency category that is appropriate for the size of the window that applies to their clinical condition at that time.

***For example, if a patient needs a check cystoscopy between 12 and 15 months after their initial urological cancer surgery, they should be staged for the 12 month period after the initial surgery, and then have their status changed to ready for surgery, in urgency category 2. Their waiting times would be measured from the time their status changes to ready for surgery, that is, from 12 months after their original surgery.***

4.3. Staged patients will include those who:

- are unfit for surgery - the patient's health status has temporarily declined to the extent it is inadvisable to proceed with the awaited procedure.
- need staged procedures - there is a planned clinical pathway that requires a predictable and sequential series of treatments on successive occasions whereby progress to the next treatment depends on the successful completion of the previous operation.
- need programmed procedure - the patient will not require or be amenable to surgery until some future date; for example, those having a 12-monthly cystoscopy.

## NRFC patients - pending improvement of clinical condition

4.4. These are patients who are not ready for surgery because of a medical condition that requires treatment or management (or simply time to pass) so that the patients is suitable for the surgery. The time that will elapse before the patient is suitable for surgery is usually not known or accurately predictable.

***For example, a patient has poor respiratory function that needs to be improved before open abdominal surgery. They are managed medically and, 6 weeks later, tests show that their respiratory function has improved and the patient is assessed as suitable for surgery. The patient should be added to the waiting list when they are assessed as suitable for surgery, that is, after the 6 weeks spent improving their respiratory function. Their urgency category should be assigned at the time they are added to the waiting list, and their waiting time would be measured from that point, that is, from 6 weeks after the initial clinical assessment.***

## NRFC patients - deferred for personal reasons

4.5. There are patients who are not ready for surgery, for personal (non-clinical) reasons, such as work commitments. The deferred patient's RFA should be added to the waiting list as part of the initial referral by the clinician and comments added.

4.6. If the patient does not meet the addition to the waiting list criteria, the request is to be discussed with the referring clinician.

4.7. Waiting times should only be measured for these deferred patients when they are ready for surgery. Once placed on the list, any time subsequently spent deferred should be subtracted from the amount of time recorded as waiting.

4.8. Deferred patients are usefully managed through elective surgery waiting list management systems. This is because the patient needs to be recorded as waiting for a procedure, so that the allocation of their surgery can be managed. This includes patients who choose to defer for:

- work or social commitments

## Electing not to be Ready for Care (NRFC)

4.9. Patients who are not in a position to accept an offer of hospital admission for either personal or medical reasons are termed NRFC. These patients should be maintained on the waiting list module but not counted as 'waiting'. An expected RFC date should be arranged with the deferring patient.

4.10. Hospitals must monitor NRFC times for their patients. After consultation, Tasmania has introduced a system used in other states that sets agreed time limits for patients who elect to defer for personal reasons.

4.11. Hospitals must advise and contact patients listed as NRFC:

- immediately for all category 1 patients – you cannot defer treatment for personal reasons.
- allow 90 days for category 2 patients.
- and 180 days for category 3 patients.

4.12. Hospitals can remove patients whose periods of NRFC exceed the above times when the patient elects to become NRFC for personal reasons. Individual patient circumstances and medical episodes might require specific consideration when removing patients from the waiting list.

4.13. As a general rule, patients who are unable to present for admission within a six week period may be considered to be deferred. However individual circumstances vary and consideration should be given to allow patients to negotiate a mutually convenient admission date.

4.14. Patients who defer on two occasions following the provision of at least two weeks' notice should be discussed with the referring clinician in the first instance, then referred to their GP for clinical review.

4.15. Patients listed as NRFC must be advised:

- they have been listed as NRFC;
- the maximum NRFC time available for their urgency category. Exceeding the new personal NRFC time limit policy will result in their removal from the waiting list or the need for clinical reassessment by the treating clinician;
- that while listed as NRFC patients are not considered to be waiting for surgery;
- that their waiting time has stopped; that is, time spent as NRFC does not contribute to their total waiting time;
- each episode of NRFC accumulates with prior episodes towards total NRFC time;
- when they become RFC only the time they have actively waited is considered in determining their date for surgery; and
- that they are required to advise the hospital when they are RFC.

4.16. Category 1 patients who are NRFC require active management by the waiting list team in consultation with the Treating Clinician. A management plan that includes a documented RFC date must be activated for all category 1 patients listed as NRFC.

4.17. Category 2 and 3 patients who are NRFC at time of registration can be registered if:

- the patient is NRFC as part of a clinical pathway associated with a staged procedure. The patient should only be registered for the next treatment required as part of the staged procedure.
- the patient's NRFC status is part of the pre-operative preparation process, as long as this process is scheduled for completion within the recommended timeframes.
- the patient's NRFC status is part of a programmed procedure. Only the next treatment should be registered.
- Category 2 and 3 patients who become NRFC after registration remain registered if:
- the patient's NRFC status is for a clinical reason expected to be resolved within timeframes specified in section 4.11.
- the patient elects to become NRFC for personal reasons and expects to be RFC within the timeframes specified in section 4.11.
- the patient elects to be NRFC for personal reasons for a period not greater than specified in section 4.11 of this policy for their urgency category.

4.18. Category 2 and 3 patients who have exceeded NRFC timeframes may require:

- clinical review by the treating clinician prior to the patient's reinstatement as RFC.
- advising the patient's GP of the patient's NRFC status when they are unfit for surgery.
- active management.
- removal from the waiting list according to section 10 and referred back to the care of their GP.

## Keeping patients fit for surgery

4.19. In collaboration with their GP, referring clinician, other allied health professionals and the hospital patients are expected and encouraged to optimise their health in readiness for surgery. Patients have a responsibility to consult the appropriate health professionals to facilitate the management of their health and any existing conditions while they are waiting for elective surgery.

4.20. Health services have a responsibility to minimise the time patients are waiting RFC and to maximise their fitness for surgery and intervention before any further co-morbidities arise. This includes the provision of the following advice to patients:

- how best to manage their condition while waiting for elective surgery
- the pre-operative health requirements necessary for surgery to proceed
- what to do if the patient believes their condition has deteriorated while waiting for surgery
- the role of the GP in maintaining the patient's general health while waiting for elective surgery
- how to access internal and external services that will maintain health, prevent deterioration and achieve recommended pre-operative health care requirements
- how to access 'Patient information documents' for common surgery specialties.

# 5. Clinical Prioritisation

## Policy

5.1. All hospitals providing elective surgery categorise clinical urgency according to the following simplified national classifications:

Category 1…….Procedures that are clinically indicated within 30 days

Category 2……..Procedures that are clinically indicated within 90 days

Category 3…….Procedures that are clinically indicated within 365 days

5.2. The assigned urgency category must be based on clinical need to ensure those with greatest need, who might suffer adversely without treatment, receive their surgery promptly.

5.3. The assigned urgency category should be consistent with the national urgency category guideline unless the patient's clinical indications require earlier treatment.

5.4. An urgency category must be assigned before the patient is added to the waiting list.

5.5. The treating clinician responsible for referring the patient is required to determine the urgency category. Assigning an urgency category cannot be delegated to non-medical staff.

5.6. The referral cannot be accepted if a category has not been assigned.

5.7. The hospital should collect incomplete information by contacting the referring treating clinician or their delegate.

5.8. Where the referring treating clinician is unable to be contacted, the booking form should be returned to the place of origin for completion. The return of forms should be considered only after reasonable effort has been made to contact the treating clinician.

5.9. Urgency categories should be altered as required to reflect the patient's clinical status. Patients requiring admission in greater than a 24 hour period but less than seven days should be assigned to category 1and actively managed as an elective (or planned) admission within the necessary time frame.

5.10. The reason for changing a patient's urgency category should be documented and dated by the clinician on the original RFA.

5.11. If at the time a request for registration onto the waiting list is received, or at any time after the date of initial registration, the hospital considers that a treating clinician is unable or is unlikely to be able to provide treatment within the assigned urgency category boundary, the hospital may offer the patient the option (where available) of choosing to:

- transfer from one specialist to another equivalently credentialed specialist within the same hospital, or
- transfer to another hospital and specialist that is equivalently credentialed to perform the procedure and where a shorter waiting time to admission is available (see Section 10).

## Implementation Guidelines

Under the National definitions for elective surgery urgency categories project Tasmania has committed to an Implementation Plan that ensures that national principles for 'treat in turn' and 'usual' urgency categorisation are systematically implemented.

Surgeons are expected to facilitate the following principles and best practice in collaboration with the elective surgery access staff.

**'Treat in Turn'**

There are agreed Tasmanian statewide and hospital 'treat in turn' benchmarks. Please refer to the One Health System Elective Surgery Reform Strategy targets, THS Service Agreement and 'Treat in Turn' Quarterly Data Report available through surgical managers.

The national aim is to treat a minimum of 60% of people in turn, within a range of 60% to 80%(rather than 100%), because differing patient requirements (as judged by the treating surgeon) and other aspects (such as efficient use of operating theatre time and training of surgical trainees) should also be taken into consideration.

Clinicians who consistently fail to treat their patients in turn (where there is matching inpatient capacity) will have their patient scheduling practices discussed by the hospital executive and Director of Surgery.

**'Usual' Urgency Categorisation**

The National Elective Surgery Urgency Categorisation Guideline (April 2015) has been developed through the Royal Australasian College of Surgeons (RACS) and twelve surgical colleges and supports an appropriate balance between consistency of practice and clinical decision making when assigning an urgency category. It is available at:

*http://www.coaghealthcouncil.gov.au/Publications/Reports/ArtMID/514/ArticleID/57/National-Elective-Surgery-Urgency-Categorisation-Guideline-April-2015*

This national guideline should be made available to all surgical departments and all key elective surgery co-ordinators and booking staff. The guideline is provided both by speciality which will make it easy for clinicians to use and alphabetically which will make it easier for booking and administrative staff to use.

The national guideline should be used in conjunction with local policy including the Procedures not funded to be routinely provided in Tasmanian Hospitals (see Appendix 2). In the future this 2015 guideline will be replaced with updated versions of the national guideline.

# 6. Scheduling patients for surgery

6.1. Surgery is required to be allocated to patients according to:

- clinical urgency
- the length of time the patient has waited for their surgery in comparison with similar patients
- resource availability (for example, availability of theatre time, the surgeon, equipment and hospital capacity)
- whether the hospital has previously postponed the patient's surgery.

6.2. The Admission Co-ordinator or Elective Surgery Access Co-ordinator is notified when the patient has been cleared through the pre-admission clinic. The procedure for developing the theatre list will vary between locations.

6.3. These patients should be selected firstly from category 1, then from category 2, then category 3, depending on their requirements, theatre utilisation needs and hospitals' policies/priorities.

6.4. Where patients have similar clinical needs, those with longer waiting times or who have experienced postponement should be given some priority.

6.5. The patient should be advised that the hospital can postpone surgery at any time as a result of unpredictable increases in demand, and that should this arise, the patient will be made a priority for the next available session.

6.6. The patient is asked to contact the hospital if a health problem arises before the pre-admission clinic and/or planned surgery.

## Booking patients for assessment prior to admission for surgery

6.7. All elective surgery patients should undergo a pre-admission process prior to their expected date of surgery. Depending on the patient's condition and the nature of surgery, this process could be managed by a liaison or triage nurse over the phone or at the hospital or directly with clinicians at the pre-admission clinic.

6.8. The patient is asked to contact the hospital if a problem arises between the pre-admission clinic assessment and the admission date.

6.9. Patients are selected from the waiting list by the consultant in collaboration with Elective Admission Access Coordinators, liaison and triage nurses, booking clerks and theatre staff where appropriate.

6.10. Access Coordinators can use information gathered through the pre-assessment process to assist the planning of the patient's admission pathway.

6.11. The patient's pre-admission clinic appointment and admission date should be entered into the waiting list module.

6.12. An Elective Surgery Booking Letter is sent to each patient prior to the pre-admission clinic advising of their admission date, if already planned, and inviting them to attend the pre-

admission clinic and/or anaesthetic clinic and giving details of same, such as time, venue. This letter will also include:

- relevant pamphlets in relation to the pre-admission clinic and their proposed hospital stay (this may be given at the pre-admission clinic)
- a request for confirmation of attendance at pre-admission clinic as soon as possible, unless otherwise co-ordinated.

6.13. The patient's confirmation of availability for the pre-admission clinic and admission is entered onto the waiting list module as soon as advised by the patient.

6.14. Where the patient's expected theatre date is delayed (more than six weeks after the pre-admission assessment, or if they have not responded to the Elective Surgery Booking Letter) the patient should be contacted by phone to determine any changes in their health or availability status.

6.15. Discharge planning should commence at the pre-admission clinic. Patients should also be informed of options for acute care in the home following surgery.

6.16. Hospitals are required to provide individual case management for those patients with complex needs, to ensure they are treated within clinically desirable timeframes.

6.17. It is recommended that hospitals identify patients who are available at short notice, who have undergone a pre-admission process and are ready for surgery. Prepared patients allow hospitals to fill vacancies at short notice, allowing the best possible theatre use.

## Selecting Patients from the Waitlist

6.18. The way in which patients are picked from the list for their treatment can have a significant effect on wait list indicators and performance.

6.19. The picking order in itself will not affect throughput numbers or the number of people waiting, but selection of the right patient groups can lead to gains in performance in terms of the following wait list indicators:

- The number of patients seen within the clinically recommended time
- The number of over boundary patients
- The average wait days for patients who have waited beyond the clinically recommended time

6.20. These gains in performance can potentially be achieved across all categories without increase in resources or capacity.

## Placement of patients on theatre lists

6.21. A list of RFC patients is selected from the waiting list to prepare for admission to hospital. This should be done by the treating clinician in collaboration with Elective Surgery Access Co-ordinators and theatre staff 1 to 6 weeks before the date of the majority of surgical procedures, depending on the planning for specific cases / procedures for optimal patient and theatre management.

6.22. Information that may be included on the theatre list but is not limited to:

- planned postoperative destination
- number of hospital related postponements

- estimated surgery time as per RFA including anaesthetic time
- image intensifier/other radiology required intra-operatively and other specialised equipment
- patients (>100kg) with a BMI (>40)
- bariatric patients
- requirement for an ICU or other specialist care bed
- patients from correctional facilities
- patients from aged care facilities
- patients who are dependent on carer's for daily activities
- latex allergy
- alert code defined
- infection control alerts specifically relevant to patient flow.
- **Surgical Access staff should generate an alert on patient documentation or notify other relevant departments of admission of patients with an infective risk or special requirements including Intensive Care and High Dependency units.**

6.23. The theatre list is forwarded to the appropriate peri-operative and associated staff as per hospital policy.

6.24. Key stages and checks of the patient booking process include:

- the preparation of predicted operating theatre lists
- the finalisation of the next day's day surgery and/or main theatre lists.
- a process for theatre list changes after final copy published
- process for additions (emergency) to the theatre list after business hours on the day before surgery.

6.25. A balance needs to be maintained when scheduling theatre lists to ensure that theatres are fully utilised while minimising the risk of patients being postponed, particularly those that are postponed after admission.

6.26. Effective forward planning is essential for all stakeholders. Access Co-ordinators, clinicians and theatre management staff should be liaising constantly to achieve the most effective utilisation of theatre time.

6.27. Where there is uncertainty about either the capacity of theatre resources or the time it will take to complete particular cases, arrangements should be made to have patients put on standby for admission.

6.28. Patients who are willing and understand the standby booking need to live reasonably near the hospital, wait at home and remain fasting until called in for surgery.

6.29. The Admission Nurse will normally contact those standby patients who are not called for surgery before Midday on the day of the operation.

6.30. No elective surgery will be performed on weekends and public holidays in emergency operating theatres without prior negotiation with the relevant manager.

# 7. Postponement of Surgery

## Hospital Initiated postponements

7.1. A hospital-initiated postponement is defined as any rescheduling of a patient's confirmed booking date for any of the following reasons:

- operating theatres become unavailable because emergency treatment needs to be performed or scheduled surgery has taken longer than anticipated
- a surgeon or other staff member has become unavailable
- an intensive care bed, required post-operatively, is not available
- the hospital is fully occupied
- equipment requirements and the availability related to bariatric patient care
- other categories as identified in the patient administration system.

7.2. When a hospital needs to postpone a patient's surgery it should:

- give as much notice as possible of the intention to postpone surgery
- make arrangements for the surgery to be prioritised within the same category and to be considered for the next available/appropriate list
- make arrangements for a subsequent surgery date prior to discharge/or in 5 working days in the event that the patient is already admitted
- with the patient's consent and in collaboration with the treating clinician, advise the patient's GP if significant issues relating to the patient's health arise as a consequence of the postponement

7.3. The clerical process should keep an accurate record and reason of each patient's postponement, proceeding as follows:

- refer to the Tasmanian Health Service Postponement and Removals Guideline and record the postponement reason as per the definition and examples provided
- the responsible staff member for each site will add the correct postponement code to the hospital's Postponement /Cancellation form and return it with the RFA and any other relevant peri-operative paper work to the elective surgery access staff
- the Access Co-ordinator will track all postponements, ensure the patient is re-established on the waiting list, and plan rebooking the patient procedure
- re-booking the patient procedure will be monitored and reported by the Access Co-ordinator
- the clerical staff will ensure the correct postponement code is entered into the system and ensure the patient is discharged from the hospital.

7.4. The patient whose surgery needs to be postponed should be advised of:

- the reason for the postponement
- their rescheduled admission date (mandatory for category 1 patients) or an estimate, if rescheduled admission date cannot be given
- what they should do if their condition deteriorates, including contact with their GP;

- recommendations relating to their medication e.g. restarting anti-coagulants
- how to access a complaints process should they be dissatisfied
- how to access a counselling service if required. This could include the hospital's relevant consumer, safety and quality officers or Consumer Liaison Services (RHH), Quality Improvement Officer (LGH) or the Safety, Risk and Quality Officer (NWRH & MCH) or the patient's GP.

The DOH Complaints and Feedback Management Policy is available at:

http://pssbpr-trim02/PandP/showdoc.aspx?recnum=P2010/0030-001

7.5. A postponed patient who has arrived at the hospital should be accorded open disclosure and provided with the reason for the postponement and an apology. It may be appropriate for the surgeon or surgical registrar to meet with the patient depending on patient circumstances.

7.6. The patient should be assisted with:

- contacting the patient's family/friend if required;
- provision of food and beverage;
- the follow through with preoperative medications;
- information on support services;
- access to a complaints process should they be dissatisfied;
- access to a counselling service if required;
- contacting the Tasmanian Ambulance and Health Transport Scheme for those who have travelled long distances to get to the hospital. Or providing taxi vouchers for those patients who do not have return transport; and
- making the patients aware of the Patient Travel Assistance Scheme which offers assistance with travel and accommodation costs.

Ambulance Tasmania and Patient Transport contacts are available at:

http://www.ambulance.tas.gov.au/

The Patient Travel Assistance Scheme policy is available at: http://www.DoH.tas.gov.au/hospital/ptas

***Important Patient Postponement Protocols:***

***No patient should be postponed for a third time without the express approval of a senior Medical Administrator. Please refer to your site policy.***

***Category 1 patients who have arrived at the hospital must not be postponed without the express approval of a senior Medical Administrator. Please refer to your site policy.***

***A patient's postponement history should be noted on the theatre list in order to assist the decision of which patient is postponed.***

***In the case of urgent patients already admitted they should be notified of a new date for surgery prior to their discharge or within five working days.***

***All hospital-initiated postponements must be documented on the patient's RFA and the patient administration system. Reference Appendix 3 'Postponement and Removal Guidelines'***

## Patient-initiated postponements

7.7. When a patient postpones their surgery, an agreed alternative date for surgery for personal or social reasons is made and a patient-initiated postponement should be recorded in comments in the patient administration system and on the RFA.

7.8. Following consultation with the treating clinician, a patient should be removed from the waiting list if they twice fail to arrive for surgery on an agreed date without notice (if all means of contact and communication avenues have been exhausted)

7.9. Following consultation with the treating clinician, a patient should be removed from the waiting list if they decline their surgery on two occasions for personal or social reasons.

7.10. Patients can be removed whose periods of NRFC exceed the time limit thresholds listed in section 4.11 of this policy framework when the patient elects to become NRFC for personal reasons. Individual patient circumstances and medical episodes might require specific consideration when removing patients from the waiting list.

7.11. Whenever a patient is removed from the waiting list they should be referred back to the care of their GP, in the form of a letter from the patient administration system with additional comments on the reasons for the patient's removal from the elective surgery waiting list.

# 8. Validation & Record Keeping

## Clinical Review

8.1. Where demand for a procedure exceeds a health service's capacity to provide treatment to patients within appropriate timeframes, health services should conduct clinical reviews of all long waiting and over boundary listed patients every 12 months. Such patients may be case managed by the Elective Surgery Access Co-ordinators in each hospital. Patients may then be referred for clinical review following discussion between Access Coordinators and medical staff and with the appropriate supporting documentation.

8.2. Clinical review is a process where the consultant or treating clinician delegated by them, review the original decision about which clinical urgency category should be assigned to the patient.

8.3. The review should consist of an assessment of the patient's condition in circumstances such as:

- recommended for review and monitoring by GP.
- review and monitoring by the treating clinician involved in the patient's care.
- review of medical record by the treating clinician or registrar.

8.4. Criteria for clinical review will include:

- patients who are approaching the review date identified by the treating clinician on the RFA form.
- patients who are well outside their desired waiting time for their category.
- any substantial changes in the patient's condition or circumstances.
- recommendation or referral from the patient's GP.
- patients who on two consecutive occasions defer an offer of surgery or fail to arrive for admission without good reason.
- request from hospital site directors.

8.5. Treating clinicians should advise the hospital, upon submission of a RFA form, of the preferred clinical review date.

8.6. All patients will be notified in writing of the outcome of their clinical review.

8.7. If a patient's condition changes or other health problems arise, the patient should be advised to return to their GP for re-assessment of their condition and, if necessary, for a referral to the clinician for an appointment for a clinical review. A substantial proportion of clinical review will be undertaken through the ongoing relationship between the patient and their GP (as their primary care provider).

8.8. The hospital should ensure that the treating clinician is provided with a list of patients who may require review with their GP or case review by the treating clinician. The identification of patients on the waiting list for the purposes of clinical review is to be conducted on a regular basis. Particular attention should be given to patients with extended waiting times.

8.9. Should a patient be referred for a clinical review, a determination will be made if there is a need to change the clinical urgency of the patient. This could be as a result of a change in the patient's condition and/or the patient's requirement for other treatment prior to surgery. The review will determine whether the urgency categorisation of the patient is still appropriate.

8.10. The treating clinician will notify the Elective Surgery Booking Office staff if there are any changes to the patient's category of urgency or timing of admission to hospital. Any changes are to be noted on the original RFA with a new signature and date of change, as this is a continuation of the one episode of care. Any re-categorisation should be entered on the waiting list module by clerical staff, together with the change date, so that the time waited in each category will be registered appropriately.

8.11. Patients should be requested to indicate their continuing need for the scheduled surgery and alert staff to any significant alteration in their health status that might impact upon their planned operation.

8.12. An anaesthetic Assessment (through PAC) either prior to addition to the elective surgery waiting list or planning for surgery for complex care patients to assess clinical suitability for surgery.

## Clerical review of patients on the elective surgery waiting list

8.13. To ensure the currency and accuracy of the waiting list, and to avoid duplication of bookings, a clerical review will be conducted for patients who have been waiting for twelve months, twelve months or more. The clerical review will identify if there has been any change to a patient's details and whether the patient wishes to remain on the waiting list. The review process could include:

8.14. Contacting each patient if they have been on the waiting list for six months or more, or where there has been no communication with the patient in the preceding six months.

8.15. An appropriate letter referring to this process is posted to the patient by the Elective Surgery Booking Office.

8.16. After one month, the returned letters are reconciled against the review report. Unreturned letters are followed up by phone calls to all contact numbers (including mobile numbers) of the patient and emergency contact person.

8.17. If the first call is unanswered or unreachable (telephone disconnected, does not work), the patient's GP is called to verify the patient's contact details. If the GP confirms the details the patient is called twice more during the following week at various times.

8.18. A cross check of the Patient Master Index (PMI) to review if there are any alternative addresses listed.

8.19. Each attempt made by a staff member to contact the patient/ patients GP/patient next of kin should be updated in the communication section of the patient waiting list entry.

8.20. If contact is still not made, a further review letter is to be sent by registered mail.

8.21. If the patient still does not respond they are removed from the waiting list. A form documenting the above processes is placed in the DMR system. The patient's GP and treating clinician should be informed by the Elective Surgery Booking Office.

8.22. A check on patients admitted via emergency and treated for the condition for which they are on waiting list should be conducted.

8.23. On completing a review, a Batch Summary Outcome Report should be provided to the relevant clinical managers, covering:

- the number of patients removed;
- reasons for removal;
- problems identified and recommended actions;
- the number of patient reviews required;
- the anticipated number of outpatient appointments; and
- the number of patients listed as RFC and the number listed as NRFC.

# 9. Removing patients from the waiting list

9.1. A patient can be removed from an elective surgery waiting list if:

- the patient is deceased; The Patient Information Management Service (PIMS) will update deceased patient's details in hospital records when notification of a patient's death is received from the Births, Deaths and Marriages registry. The Elective Surgery Access staff should check the regular Deceased Patient's Report on a quarterly basis to ensure the reason for removal code is entered on the waiting list screen and the patient is removed from the active waiting list.
- the patient is not contactable. After every effort has been made to contact waiting list patients (see section 8.13-8.23), the Elective Surgery Access Coordinator should be notified and the patient removed from the waiting list;
    - Health services must make reasonable attempts to contact patients (as per section 8.13-8.23). A patient can be removed from the waiting list if they are not contactable. A reasonable attempt to contact a patient might involve attempting to obtain contact details from:
        - the patient's treating clinician;
        - the patient's referring physician or nominated GP;
        - the hospital's medical records;
        - the patient's next of kin; or
        - a telephone directory search.
    - Evidence of a reasonable effort to contact the patient must be included in the patient's medical record at the time the patient is removed from the waiting list (see Appendix 4 Clerical Review Letter Checklist).
    - It is a patient's responsibility to notify the hospital of changes to contact details. Patients must be informed that failure to do so can result in them being removed from the waiting list.

9.2. Patients can be removed from the waiting list, in consultation with the treating clinician, if:

- they twice decline surgery without good reason or no longer wish to receive treatment; or
- they twice fail to arrive for surgery without providing prior notice to the hospital.
- Evidence of the occasions on which the patient declined surgery or failed to attend an appointment or booking date should be documented in the patient's medical record and Request for Admission form (RFA).
- the booked surgery is no longer required;
- the patient fails to attend for treatment/admission on two occasions without providing prior notice to the hospital;
- the patient has permanently relocated to another state or has relocated or is unavailable for extended periods; or
- the patient has declined surgery on two occasions without good reason;

- the patient is not available for treatment for a period exceeding 30 NRFC days for category 1 patients, 90 NRFC days for category 2 patients and 180 NRFC days for category 3 patients for personal reasons.

9.3. The patient removals reason and definition should follow the Tasmanian Health Service Postponement and Removal Guideline. recording as per the examples provided.

9.4. Health services should exercise discretion on a case by case basis to avoid misunderstandings and disadvantaging patients suffering hardship and other extenuating circumstances.

## Identifying Long-Waiting Patients through Exception Reporting

9.5. Elective surgery performance data which includes the patient's waiting and admission times is being tracked and used by the hospitals to actively manage long waiting patients. Clinical access will be initiated when required.

## Notification of removal

9.6. Contactable patients who have been removed from an elective surgery waiting list without receiving the scheduled treatment should:

- receive a Removal from Waiting List letter stating the reason for their removal (with copies sent to the referring GP and specialist); and
- be referred to their GP or treating clinician to discuss their removal.

## Multiple waiting list entries

9.7. Where the patient or treating clinician has advised that one procedure depends on another (for example, bilateral joint replacements), the second procedure should be listed with NRFC status.

9.8. For patients whose waiting list entries are independent of each other (for example, cataract removal and hernia repair), the patient can remain waiting for both procedures.

9.9. It is advised that patients should not be listed for the same procedure at different hospitals. The patient administration system gives hospitals the capacity to verify that there are no multiple listings prior to registration onto the waiting list.

If there is a request for registration onto the waiting list for the same procedure at a different hospital, the request will be refused. The referring clinician will be advised immediately. It is the responsibility of the referring clinician to advise the patient that they cannot be listed for the same procedure at different hospitals.

# 10. Patients Treated in Another Hospital

## Transferring patients to another hospital facility

10.1. The information in this section provides a streamlined system for transferring elective surgery patients from one heath service facility waiting list to another health service facility waiting list in Tasmania.

10.2. There are a number of reasons that may result in patients being transferred to another facility's elective surgery waiting list. These include:

- Service Availability (Repatriation): A surgical service/procedure previously not offered in the patient's local hospital is now available;
- A patient has been waitlisted for a procedure at one facility when they can receive the same procedure within the boundary of the health service region they reside in.
- Where a patient travels out of their own health service boundary to see a surgeon in their private rooms, and the surgeon subsequently places the patient on their public elective surgery waiting list, if the service is available and it is clinically appropriate, the patient's wait list request will be repatriated to the patient's home health service region;
- Capacity Elsewhere: Facilitating the transfer of patients to hospital's and surgeons with shorter waiting times; and
- Patient Proximity: A patient has permanently relocated within the boundary of another health service region.

## Patient Repatriation Process (Same Procedure, Different Doctor/Different Hospital) (Flow Chart 1)

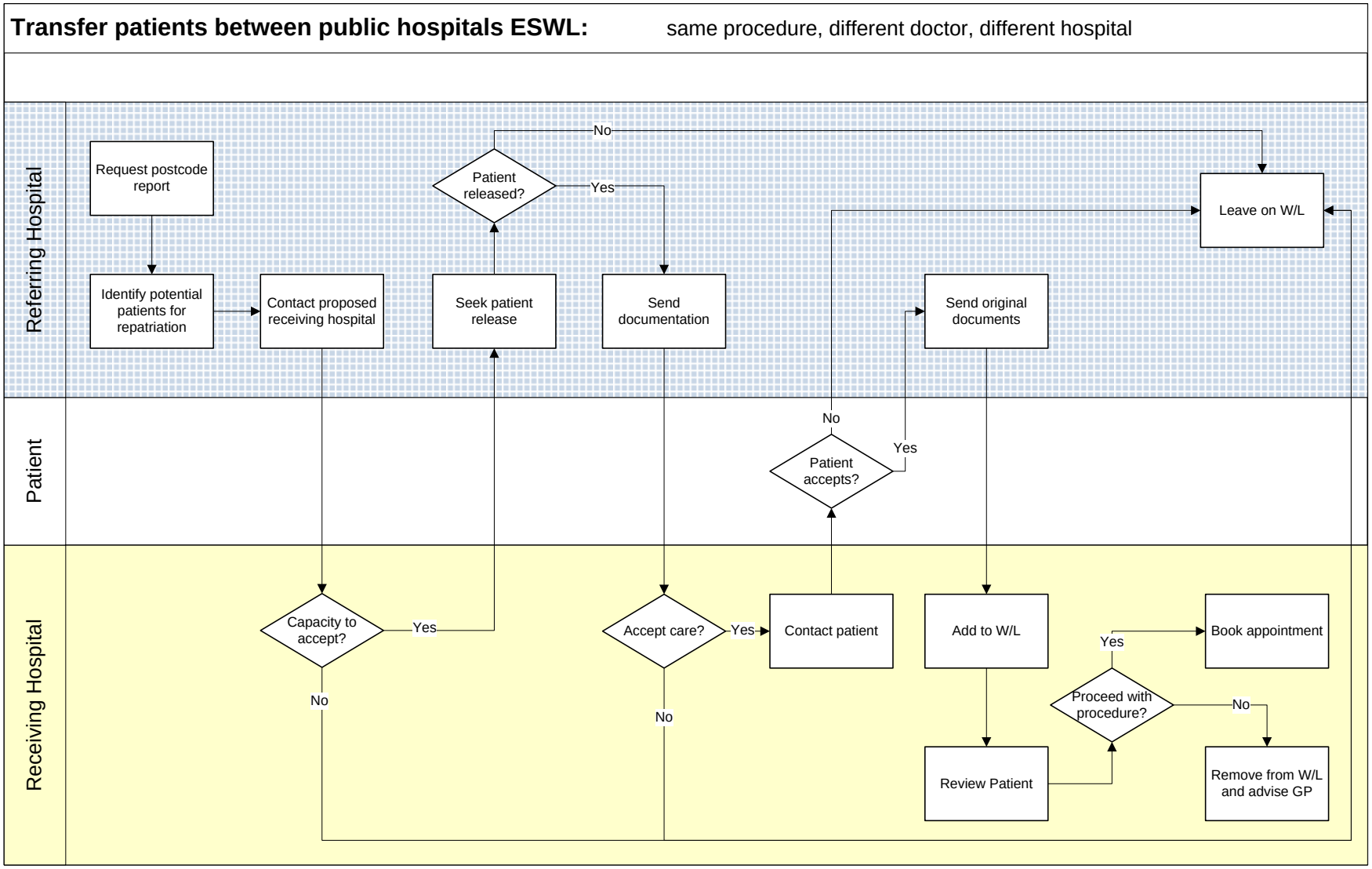
10.3. When a surgical service/procedure not previously offered is now available in a region, patients who reside within the boundaries of this region, and are on waiting lists in other regions for the same procedure, should be offered the opportunity to transfer back to their local region. The advantage for patients to receive treatment closer to where they live is that these patients can better access support services post operatively. It also reduces the cost burden of travel for patient and carer, and possibly eliminates accommodation & PTAS assistance costs.

10.4. Steps to repatriate ESWL patients:

- The referring hospital requests a Waiting List Postcode Report from Acute Services Development and Enhancement Data Analyst. This report will show patients waiting on a waiting list with a residential postcode outside of the area health service boundary.
- The referring hospital identifies patients who live outside of the referring hospital's boundary and could possibly have their procedure/surgery at their local hospital.
- The referring hospital contacts the relevant Elective Surgery Access Coordinator (ESAC)/Assistant Director of Nursing (ADON) at the proposed receiving hospital to discuss whether the receiving hospital has capacity to undertake the proposed procedure/surgery.

- If the receiving hospital agrees that there is capacity to perform the proposed procedures/surgery, the referring hospital contacts the patients for their acceptance of transfer to another facility.
- Where the patient has been referred from private clinics to the public waitlist, if the procedure is appropriate within the patient's own health service region, the waitlist entry is repatriated to the patient's own health service region - there should be the expectation of treatment closest to the patient's home.
- If the surgeon/s at the referring hospital agrees to release the patient/s to another regions waiting list, the ESAC at the referring hospital informs the ESAC at the receiving hospital. A copy of the patient's GP referral, RFA, and any other documentation associated with the patient's waitlisting process to date are scanned to the ESAC at the receiving hospital for discussion with the potential relevant consultant.
- The receiving hospital ESAC consults with the relevant surgeon/s to determine whether the surgeon/s agree to treat the patient/s. The ESAC provides the surgeon/s with scanned copies of the documents, inclusive of the patient's RFA and GP referral letter.
- If the surgeon/s at the receiving hospital agrees to accept the patient/s, the ESAC at the receiving hospital informs the ESAC at the referring hospital, who contacts the patient/s and offers them the opportunity to have their surgery/procedure at their local hospital.
- If the patient declines the offer to be treated locally, the receiving hospital ESAC informs the referring hospital ESAC that the patient/s has declined the offer. The referring hospital records in the patient/s iPM waiting list comments field: patient declined offer to transfer to local region's waiting list.
- If the patient accepts the offer to be transferred to their local hospital, the referring hospital ESAC informs the receiving hospital ESAC.
- The referring hospital photocopies the RFA, GP referral and consultation correspondence, PAC Medical Records and other relevant documentation to date. The photocopies are retained at the referring hospital site. The original copies are sent by Registered Mail to the receiving hospital. The referring hospital removes the Patient from their elective surgery waiting list, using the appropriate removal reason indicating a transfer to another hospital waiting list. A Removal from Waiting List Letter is sent to the patient and their GP
- The receiving hospital adds the patient details to the iPM elective surgery waiting list with the original waiting list date from the referring hospital as per the ESWL stamp. Notation in comments field – transfer from ...name of hospital). A placed on waiting list letter and admission offer letter is generated. The patient's clinical priority is maintained unless changed by the receiving hospital's surgeon.
- The receiving hospital organises the outpatient appointment for the receiving surgeon to review the patient. If the surgeon decides to proceed with the proposed surgery/procedure the receiving hospital allocates a procedure date and Preadmission Clinic date if required.
- If the surgeon reviews the patient in the outpatient's clinic and determines that the procedure is no longer required, the receiving hospital will remove the patient from their waiting list, recording the appropriate removal code in iPM and generating a Removal from Waiting List Letter for the patient and the patient's GP. If the patient is dissatisfied with the surgeon's decision not to proceed, the patient is advised to consult their GP.

## Flow Chart 1: Same Procedure, different Doctor, different hospital



## Surgeon Waiting List & Facility Capacity at an alternative Hospital (Same Procedure, Same Doctor, Different Hospital) (Flow Chart 2)

10.5. Some surgeons have operating rights at more than one public hospital in Tasmania. Options include:

- In some instances, these surgeons may have shorter waiting lists at one particular hospital. If a surgeon has a shorter waiting list and the hospital has the capacity to offer operating sessions, there may be an opportunity to offer patients the option of having their surgery/procedure performed at an alternative public hospital. Refer to Flow Chart 2.
- Where a surgical specialty has differing length waiting times between individual surgeons, it may be appropriate for a different surgeon from the same surgical specialty and facility to be offered patients by the current surgeon to be treated at an alternative hospital. This is to be discussed and co-ordinated by the ESAC/ADON of each site. See Flow Chart 2 below.

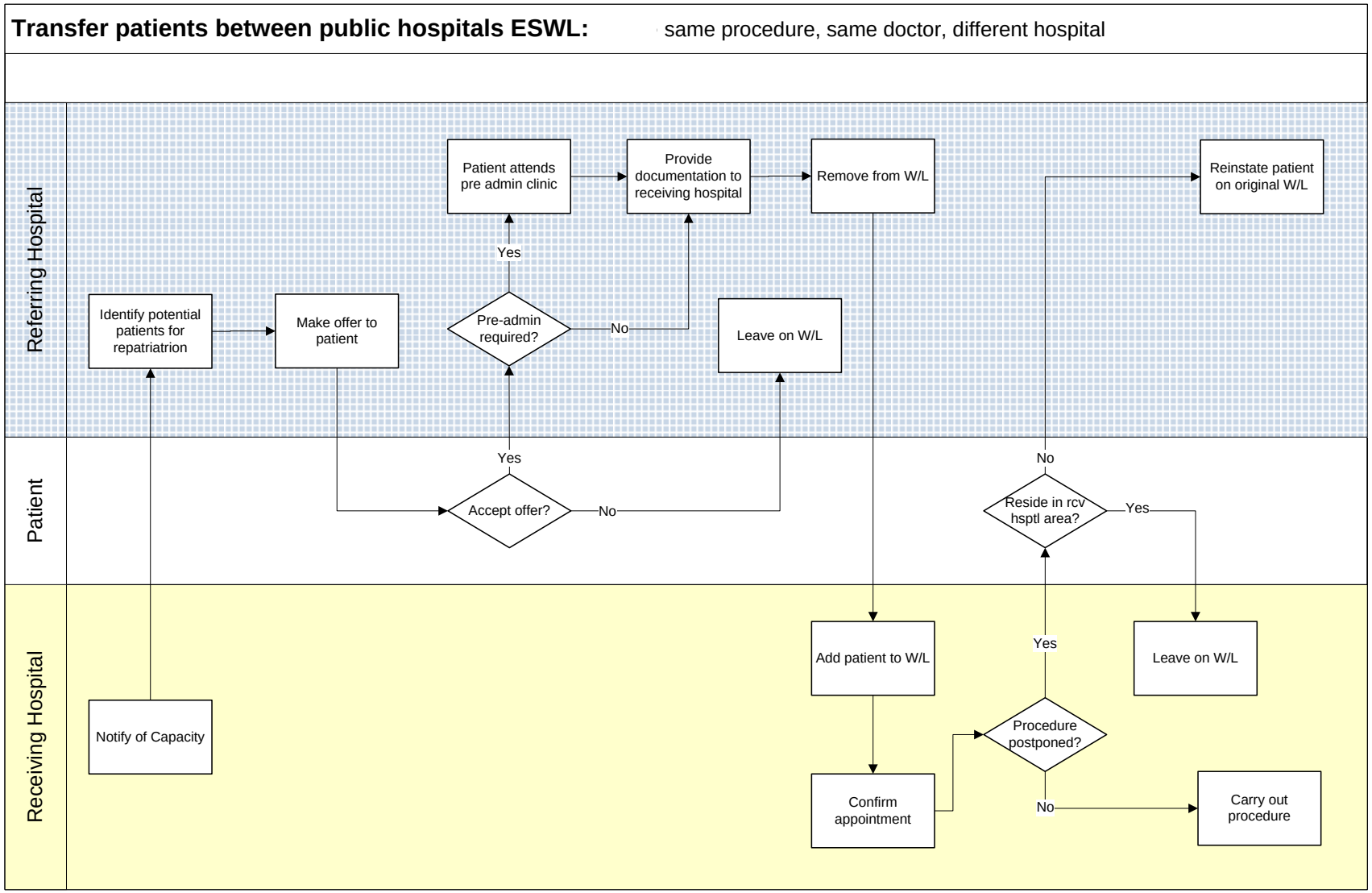
10.6. Steps to transfer patients to an alternative public hospital elective surgery waiting list:

- The surgeon identifies capacity at the receiving hospital in consultation with the Director of Surgery / / Nursing Director.
- The surgeon reviews the waiting list at the referring hospital, in consultation with the ESAC and identifies a selection of patients that can be contacted and provided with the offer to have their procedure at the receiving hospital.
- The referring hospital phones the patient/s and provides the offer for the patient/s to have their procedure at an alternative hospital. Patients are informed that they do not have to accept the offer and if they decide to decline the offer, their position on referring hospital's waiting list will not be affected.
- If the patient accepts the offer, they are informed by the referring hospital that the receiving hospital will contact them by phone (plus they will receive a letter) to plan any perioperative work-up and provide the date for surgery.
- The referring hospital contacts the receiving hospital and provides them with the details of the patients that have accepted the offer.
- The referring hospital scans the RFA and relevant documentation to the receiving ESAC and a copy maintained at the referring hospital until the receiving hospital has added the patient to their waiting list. It is compulsory that the original RFA is sent to the receiving hospital by Registered Mail to follow the patient journey. A Removal from Waiting List Letter is sent to the patient and their GP.
- The receiving hospital adds the patient details to the iPM elective surgery waiting list with the original waiting list date from the referring hospital as per the ESWL stamp. Notation in comments field – transfer from ...name of hospital). A placed on waiting list letter and admission offer letter is generated
- The receiving hospital contacts the patient by phone to plan any perioperative work-up and provide the date for surgery.
- If a patient is postponed by a receiving facility, the first option should be the receiving facility looks for a new date to book the patient in.
- If there is a clinically indicated reason the patient can no longer be treated at the receiving facility and/or the patient agrees to be transferred back, the receiving

hospital returns all of the original documentation by Registered Mail to the referring hospital and removes the patient from their elective surgery waiting list. The referring hospital will reinstate the patient on their elective surgery waiting list at the original waiting list date as per the ESWL stamp.

- If the procedure is postponed/cancelled, and the patient resides within the receiving hospital's region boundary the patient will remain on the receiving hospital's elective surgery waiting list.

## Flow Chart 2: Same procedure, same doctor, different hospital.



## Patients contracted to private and other public hospitals and day procedure centres.

**Note:**

Licensing private health service establishments is carried out under the authority of the *Health Service Establishments Act 2006* (the HSE Act) and the *Health Service Establishments Regulations 2011* (the HSE Regulations).

A private health establishment is limited to the scope of services, they deliver within the bounds of their licence issued under the HSE Act. If a health service undertakes any procedures / surgery outside of its licence it is a finable offence.

The Department of Health Regulation, Licensing and Accreditation Unit audit private health facilities to ensure they comply with their licence conditions.

Consider if the private health service is licenced to perform a procedure that is being referred to them?

10.7. To meet the public elective surgery demand private health services assistance is given careful consideration at each public hospital. Through the State-wide Elective Surgery Access Manager and the facility Elective Surgery Access Co-ordinators, the hospitals will collaborate with surgeons at each site to facilitate the redirection of appropriate patients for elective surgery to an appropriate private/public hospital if required.

10.8. The patients are selected to match the capacity and the clinical scope of the private health facilities licenced with the selected specialty, surgeons and available private hospital operating times or session and resources. This may include booking a complete session or adding a public elective surgery patient to an unfilled private/public session.

10.9. The Elective Surgery Coordination staff at the hospitals will coordinate all required information regarding the bookings to the treating clinician, anaesthetist and private/public health facility manager, including relevant patient correspondence.

10.10 Once the private health facility informs the referring public hospital retrospectively that the procedure is completed or the patient did not attend their surgery, all procedural/inpatient documentation is to be forwarded (within 1 week) to the public facility for scanning into the DMR and accurate removal from the waiting list. The iPM system will be updated accordingly.

10.11 The Elective Surgery Coordination staff and administration managers should follow the latest DOH procurement contract specifications, schedules and documentation. This includes liaison with any central Department Elective Surgery Co-ordination function and the treating private or public hospitals.

# Appendix 1: Revised Policy consultation with key stakeholders

THS

| | |
|---|---|
| Mary Condon-Williams | Nursing Director – Surgical & Perioperative Services, RHH |
| Brian Dickson | Nurse Manager – Elective Surgery Access, RHH |
| Katrina Willis | Co-Director Perioperative and Surgical Services, NW |
| Laurie Larsen | Surgical Access Coordinator, NW |
| Liz Gadsbey | Acting Director of Nursing, Surgery – LGH |
| Michael Parker | Assistant Director of Nursing- Service Development Program |
| Leif Dahl | Senior Business Analyst |
| Hannah Paal | State-wide Manager Acute Service Development and Enhancement |

State-wide Elective Surgery Committee

# Appendix 2: Guidelines on procedures not funded to be routinely performed in Tasmanian public hospitals

From 1 January 2010 some elective surgery procedures were no longer routinely performed in Tasmanian public hospitals. This ensures that public hospital elective surgery is prioritised to treat patients who have an identified clinical need for surgery to improve their health. It also augments the current approach to prioritisation of elective surgery.

Principles

Patients should be referred by surgeons to Tasmanian public hospital waiting lists only when surgery meets an identified clinical need to improve the health of patients.
Prioritisation of surgery will occur according to clinical need.
These principles apply to both public and privately insured patients.

## Exceptional circumstances

The procedures listed in these guidelines will no longer be routinely performed in a public hospital in Tasmania. However, these procedures are able to be performed in a public hospital under exceptional circumstances where patients:

- meet one or more of the exceptional clinical indications for surgery (refer Table 2 below).
- have "other" circumstances which demonstrate an overriding need for surgery. These circumstances will be at the discretion of the Director of Surgery / Nursing Director of Surgery of the public hospital to which the patient was referred.

If a surgeon assesses a patient as meeting the exceptional clinical indications for surgery, the Request for Admission (RFA) form should be completed and the patient placed on the elective surgery waiting list in accordance with hospital processes. The surgeon must clearly indicate on the RFA the reason(s) why surgery is indicated and whether the patient meets any other required criteria such as those related to Body Mass Index (BMI).

If a surgeon is of the view that a patient has "other" circumstances (other than the exceptional clinical indications listed) which demonstrate an overriding need for surgery, the Director of Surgery or, in certain circumstances, the Statewide Surgical and Perioperative Services Committee must give their approval for surgery to proceed.

The hospital approval processes which need to be adhered to under these circumstances are detailed in flowchart 3 over page.

## Procedures not routinely performed

Table 8.1 lists the surgical procedures that should not be performed in a public hospital in Tasmania unless there is an identified clinical need to improve the health of a patient or the patient has other circumstances which demonstrate an overriding need for surgery. This applies to both public and privately insured patients. The clinical indications for these procedures, and information on the hospital approval and patient appeals processes, are detailed below in Flowchart 3 and 4.

## Table 2. Plastic Surgery Procedures

| Body Contouring Procedures | Skin and Subcutaneous Tissue Procedures |
|---|---|
| Abdominal lipectomy | Hair transplant |
| Abdominoplasty | Tattoo removal procedures |
| Apronectomy | Removal of skin lesions (e.g. skin tags) |
| Liposuction | Revision of scar |
| Other skin excisions for contour e.g. buttock, thigh and arm lift. | |
| **Breast Procedures** | **Urological and Gynaecological Procedures** |
| Breast reduction (unilateral and bilateral) | Lengthening of penis procedure |
| Breast augmentation (unilateral and bilateral) | Insertion of artificial erection devices |
| Mastoplexy (breast lift) | Reversal of sterilisation |
| Removal of breast prosthesis /Revision of breast augmentation | Gender reassignment surgery |
| Nipple eversion (for nipple inversions) | Genital surgery aimed at improving appearance |
| Nipple and/or areola reconstruction | Testicular prostheses |
| **Facial Procedures** | **Vascular Procedures** |
| Facelift | Varicose Vein procedures |
| Reduction of upper or lower eyelid | |
| Aesthetic Rhinoplasty/Rhinoseptoplasty | |
| Correction of bat ears(s) (>19 years old) | |
| Repair of external ear lobes | |

This section provides guidance on the clinical factors that a surgeon will need to take into account when determining whether a procedure listed in these guidelines can be performed in a Tasmanian Public Hospital.

## Table 3. Guidance for Clinicians- Exceptional Clinical Indications for Surgery

## Plastic Surgery Procedures

| Body Contouring Procedures | |
|---|---|
| Procedure | Exceptional clinical indications for surgery |
| Abdominal lipectomy<br>Abdominoplasty<br>Apronectomy | Correction of scarring as a result of previous abdominal surgery or trauma<br>Disabling or persistent physical discomfort<br>Intertrigo<br>Post morbid obesity treatment where clinical symptoms present (erg intractable intertrigo) and BMI is <28<br>Required for hernia repair or other abdominal surgery<br>Poorly fitting stoma bags |
| Liposuction | Post traumatic pseudolipoma<br>Lipodystrophy with BMI<br>Gynaecomastia with BMI<br>Lymphoedema<br>Flap reduction<br>Above conditional on BMI <28 |
| Other skin excisions for contour, e.g. buttock, arm, thigh lift | Post morbid obesity treatment where clinical symptoms present (e.g. intractable intertrigo and BMI is <28 |

| Breast Procedures | |
|---|---|
| Procedure | Exceptional clinical indications for surgery |
| Breast reduction (bilateral/unilateral) | Female:<br>Post mastectomy surgery where BMI < 28<br>Chronic head, neck and back ache (where pain is due to breast size) and/or chronic intertrigo.<br>Male (gynaecomastia)<br>Suspected malignancy<br>Pain, 19 years or older, must have been present for more than 2 years and BMI < 28<br>Following treatment for cancer of the prostate<br>This procedure is not provided to patients with a BMI > 35. |
| Breast augmentation (bilateral/unilateral) | Malformation due to disease, trauma or a congenital condition (but not as the result of previous cosmetic surgery as a privately insured patient). |
| Mastopexy (breast lift) | Post morbid obesity treatment where clinical symptoms present (e.g. intractable intertrigo) and BMI is <28 |
| Removal of breast prosthesis/ Revision of breast augmentation | Removal of breast prosthesis and revision of breast augmentation - rupture, Infection or capsular contracture<br>Revision of breast augmentation – as a part of treatment for breast cancer and reconstruction. |
| Nipple eversion (for nipple inversions) | None |
| Nipple and/or areola reconstruction | When performed as a part of a breast reconstruction due to disease or trauma (but not as the result of previous cosmetic surgery). |
| Facial Procedures | |
| Procedure | Exceptional clinical indications for surgery |
| Facelift | Congenital facial abnormalities<br>Facial palsy<br>Specific conditions affecting the facial skin egcutis laxa, pseudoxanthomaelasticum, neurofribromatosis<br>To correct the consequences of trauma<br>To correct deformity following surgery (where the primary procedure was not cosmetic) |
| Reduction of upper or lower eyelid | Visual impairment |
| Aesthetic Rhinoplasty/Rhinoseptoplasty | |
| Correction of bat ear(s) >19 years | None |
| Repair of external ear lobes | Post traumatic surgery i.e. repair of acute laceration, but not as the result of use of expander devices. |
| Skin and Subcutaneous Tissue Procedures | |
| Procedure | Exceptional clinical indications for surgery |
| Hair transplant | Treatment of alopecia due to disease or trauma. |
| Tattoo removal procedures | None |
| Removal of skin lesions (e.g. skin tags) | Suspected malignancy<br>Obstruction of orifice or vision |

| | |
|---|---|
| | Facial disfigurement<br>Recurrent infection<br>Function limitation on movement or activity<br>Pain<br>Located on a site where they are subjected to trauma. |
| Revision of scar | Where scar is the result of surgery, disease or trauma<br>Where scar is the result of neoplastic surgery and is disfiguring and extensive. |

## Urology and Gynaecology

| Procedure | Exceptional clinical indications for surgery |
|---|---|
| Lengthening of penis procedure | Congenital abnormalities in children.<br>Recurrent urinary tract infections where the patient is at risk of requiring renal dialysis. |
| Insertion of artificial erection devices | Patients using urodomes<br>Spinal patients with neurological erectile dysfunction. |
| Reversal of sterilisation | None |
| Gender reassignment surgery | Congenital abnormalities in children. |
| Genital surgery aimed at improving appearance<br><br>Circumcision | Patients requiring prostheses following orchidectomy<br><br>Phimosis, Urinary Tract Infection, Carcinoma of penis |
| Testicular prostheses | Following orchidectomy for malignant disease. |

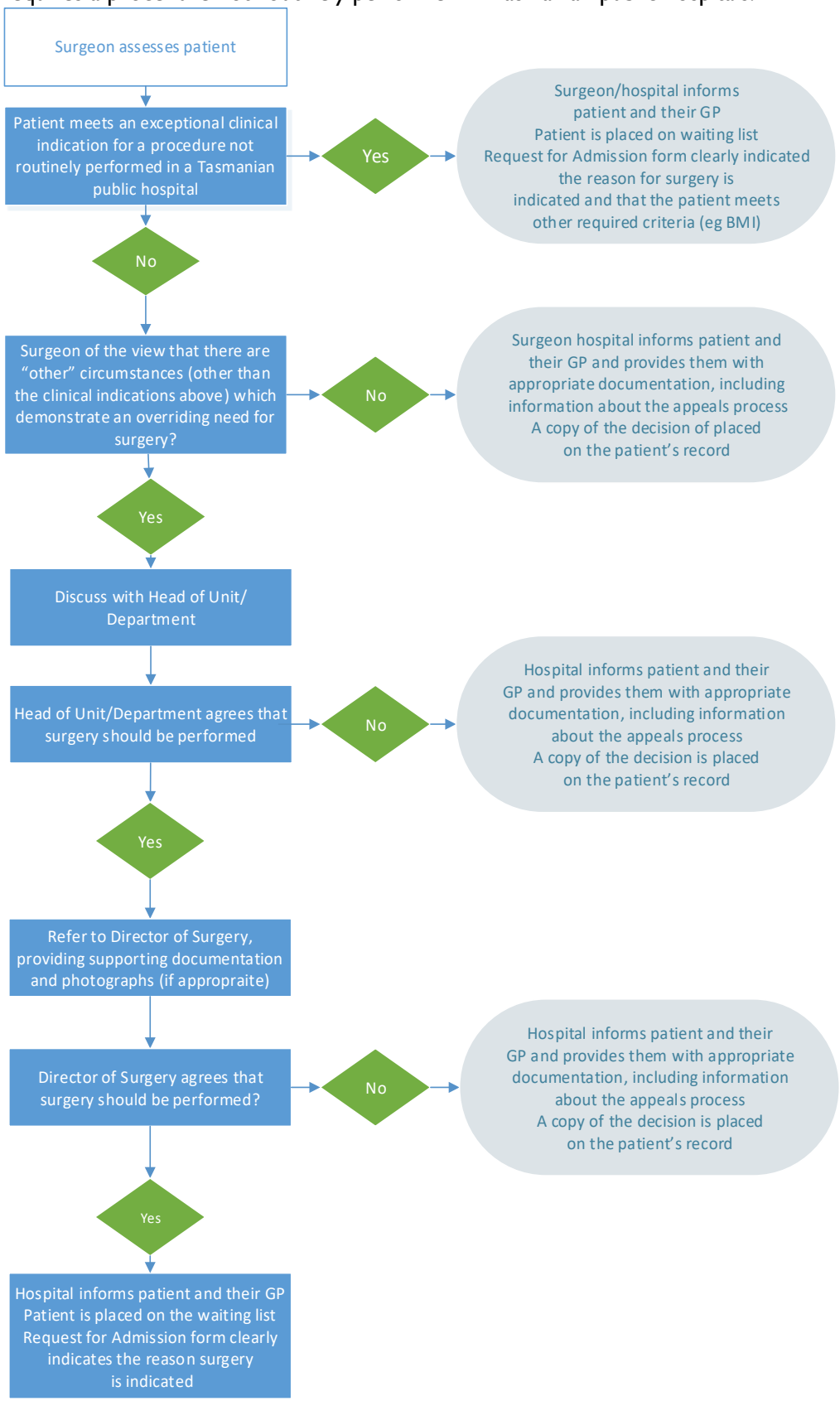
## Vascular Surgery

| Procedure | Exceptional clinical indications for surgery |
|---|---|
| Varicose vein procedures | Chronic leg swelling, chronic dermatitis, leg ulcers or foot infections that fail to heal as a result of severe varicosities causing chronic stasis and venous ulceration.<br>Objective clinical evidence of chronic venous insufficiency.<br>Recurrent (more than 2 episodes superficial thrombophlebitis). |

Notes:
Circumcision is not included in these guidelines. A policy on Circumcision in Tasmania is under development, once completed it will be included in Appendix 3 below.

## Flowchart 3 - Hospital approval process

The flow chart below details the process to be followed should a surgeon be of the view that a patient requires a procedure not routinely performed in Tasmanian public hospitals.



## Patient appeals process

If a patient is referred to a public hospital for a procedure listed in these guidelines and surgery is declined, an appeal can be requested by the patient via their General Practitioner (GP). As patients usually cannot undergo a procedure without the referral of a GP, patients are not permitted to appeal on their own behalf.

Occasionally patients are referred to a private surgeon from a hospital emergency department. In this instance, the patient's GP continues to be the most appropriate person to appeal on their behalf.

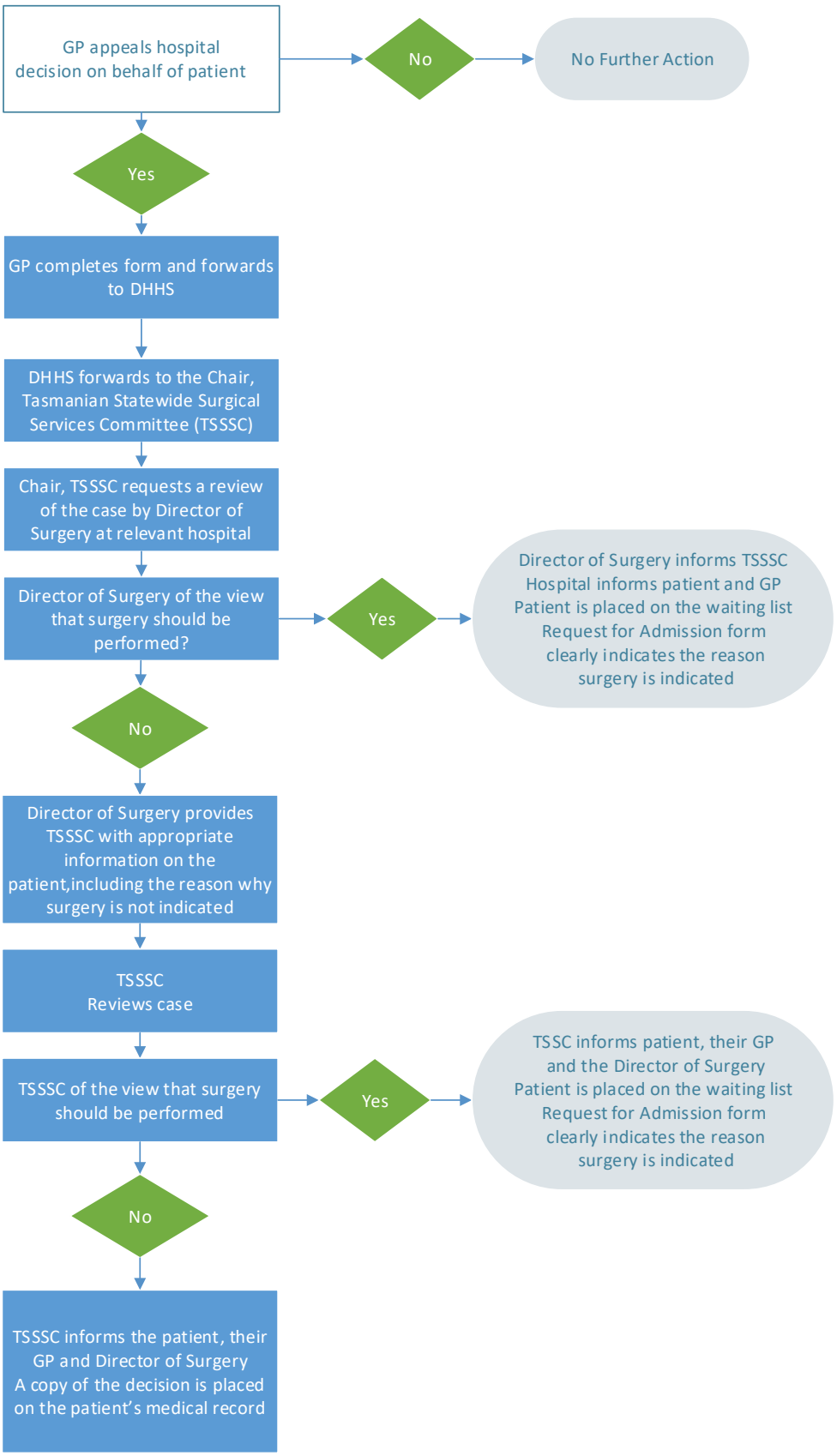
Appeals must be made in writing to the Statewide Surgical and Perioperative Services Committee (SSSC) by completing the form available at:

http://www.DoH.tas.gov.au/hospital/elective_surgery

The SSSC will make its determination in consultation with the Director of Surgery of the hospital where the patient was assessed. The decision of the TSSSC will be communicated in writing to the Director of Surgery and to the patient's GP. A copy of this decision is to be placed on the patient's medical record at the hospital.

Flow chart 4 on the next page details the patient appeals process.

## Flowchart 4 - Patient appeals process



## Patients already on the waiting list

Patients already on the elective surgery waiting list for a procedure not routinely performed in a Tasmanian Public Hospital must be reviewed.

A patient can remain on the waiting list if they:

- meet one or more of the exceptional clinical indication for surgery (refer table 3 pages 48 to 50).
- have other circumstances which demonstrate an overriding need for surgery and the Director of Surgery or the SSSC has given their approval (refer Flowchart 1 "Hospitals approvals process" in Appendix 2).

If a patient is assessed as having an exceptional clinical indication for surgery or if there are overriding "other" circumstances, these must be clearly documented in the patient's medical record.

If a patient is removed from the waiting list as a result of this review process, they must be provided with a letter containing information on the:

- new guidelines and their implementation date
- review process
- reason they were removed from the waiting list
- process for appeal

A copy of this letter should be forwarded to the patient's GP and placed on the patient's medical record at the hospital.

Information for GPs

Information for GPs about these guidelines has been developed and is available at: http://www.DoH.tas.gov.au/hospital/elective_surgery

This includes information on the patient appeals process.

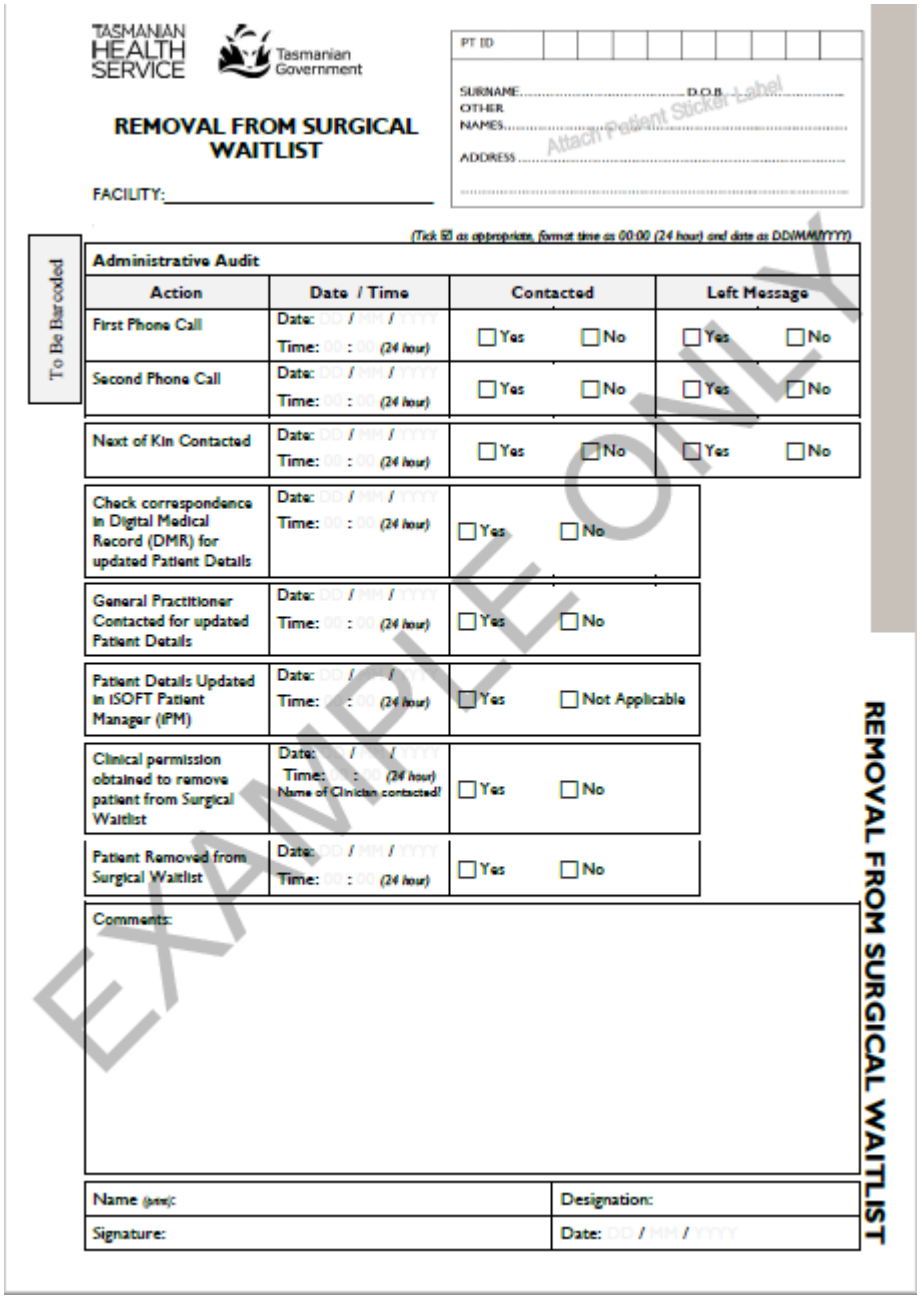
# Appendix 3: Policy Circumcision in Tasmanian Public Hospitals

A Separate Policy on Circumcision in Tasmania is under development.

# Appendix 4: Clerical Review Letter Checklist

PDF

FT000000_RemovalfromSurgicalWaitlist_2(



TASMANIAN HEALTH SERVICE

Tasmanian Government

**REMOVAL FROM SURGICAL WAITLIST**

FACILITY:_____

PT ID

SURNAME..... D.O.B .....
OTHER NAMES.....
ADDRESS.....

Attach Patient Sticker Label

*(Tick ☑ as appropriate, format time as 00:00 (24 hour) and date as DD/MM/YYYY)*

To Be Barcoded

**Administrative Audit**

| Action | Date / Time | Contacted | Left Message |
|---|---|---|---|
| First Phone Call | Date: DD / MM / YYYY<br>Time: 00 : 00 (24 hour) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Second Phone Call | Date: DD / MM / YYYY<br>Time: 00 : 00 (24 hour) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Next of Kin Contacted | Date: DD / MM / YYYY<br>Time: 00 : 00 (24 hour) | ☐ Yes ☐ No | ☐ Yes ☐ No |
| Check correspondence in Digital Medical Record (DMR) for updated Patient Details | Date: DD / MM / YYYY<br>Time: 00 : 00 (24 hour) | ☐ Yes ☐ No | |
| General Practitioner Contacted for updated Patient Details | Date: DD / MM / YYYY<br>Time: 00 : 00 (24 hour) | ☐ Yes ☐ No | |
| Patient Details Updated in iSOFT Patient Manager (iPM) | Date: DD / /<br>Time: 00 : 00 (24 hour) | ☐ Yes ☐ Not Applicable | |
| Clinical permission obtained to remove patient from Surgical Waitlist | Date: / /<br>Time: : (24 hour)<br>Name of Clinician contacted: | ☐ Yes ☐ No | |
| Patient Removed from Surgical Waitlist | Date: DD / MM / YYYY<br>Time: 00 : 00 (24 hour) | ☐ Yes ☐ No | |

Comments:

| | |
|---|---|
| Name (print): | Designation: |
| Signature: | Date: DD / MM / YYYY |

REMOVAL FROM SURGICAL WAITLIST

EXAMPLE ONLY

# Bibliography

National Definitions for elective surgery urgency categories: proposal for the Standing Council on Health, 31 Jul 2013

The National Elective Surgery Urgency Categorisation Guideline, April 2015

We would like to acknowledge the ongoing assistance of the Queensland Department of Health and Human Services in the development of elective surgery policy.

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