Improving time to treatment

Tasmania's Elective Surgery Access Policy

Department of Health and Human Services
As part of rebuilding Tasmania’s health system and the One State, One Health System: Better Outcomes reform package, the Tasmanian Government has committed to update Tasmania’s Elective Surgery Access Policy.

A high level policy document will guide this updated policy framework once the Tasmanian Health Organisations (THOs) transition to a single Tasmanian Health Service by 1 July 2015.

Although out of date, we believe it is important to keep the existing policy framework available on the internet for Tasmanian public hospital elective surgery access staff to guide their waiting list management and for access managers to assist the updating of this framework.

The policy principles and much of the elective surgery waiting list management steps remain relevant.

Please note that the referenced policies and internet hyperlinks are out of date and cannot be accessed via this document.
Under Active Review (1 July 2015)

Improving Time to Treatment

Tasmania’s Elective Surgery Access Policy Framework

Department of Health and Human Service
Tasmanian Government
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Under Active Review (1 July 2015)

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1. Introduction

Each year Tasmania treats over 16,000 public hospital elective surgery patient admissions. 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.

2. Purpose of policy guideline

These guidelines are designed to assist hospital staff to manage waiting lists consistently across the State. The operation of a safe, equitable and efficient elective surgery waiting list system will maximise Tasmanian’s elective surgery outcomes.

Hospitals and health services 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.

3. 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.

4. Complementary policies


This policy framework complements the following DHHS Strategy Planning and Performance policies and hospital policies:

- The Admission and Discharge Policy (No.4/02)
- Request and Consent to Medical Procedure and Treatment Policy (No.3/03)
- Correct Patient, Correct site, Correct Procedure Policy (07/08)
- Guidelines on Hospital Initiated Postponements (No.03/06)
- Clinical Risk Management Policy (No. 05/06)
- Complaints Policy (No.4/02)
- Patient Satisfaction Policy (No.13/97)
- Credentials and Clinical Privileges Guidelines (09/05)
5. Responsibilities and delegations

All DHHS 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.
6. Policy principles

6.1 Patient Focus

A key element of the access policy and a priority of Tasmania’s Elective Surgery Improvement Plan (TESIP) 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.

6.2 Patient information

Patients are provided with meaningful information about elective surgery waiting lists and their rights and responsibilities. A range of appropriate information for patients such as the Elective Surgery Information Website and patient information brochures will be implemented. This information will enable patients and clinicians to assess time to surgery and help inform their planning of patient care to assist in managing individuals waiting time.

Non-English speaking patients and carers are 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: may make assumptions about not including important information in the discussion and it places unnecessary risk on the patient, and hospital staff.

Translator Interpreting Service (TIS) Ph: 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:
- TTY/Voice – Ph:133 677
- Speak/Listen options Ph:1300 555 727
- NABS (National Auslan Interpreter Booking and Payment Service) - Ph 1800 246 945

6.3 Patient consent

Patients are fully informed and have given formal consent to the treatment offered.

Information relevant to the patients continuing care while on the waiting list will be routinely shared with the patient’s nominated general practitioner unless the patient does not consent.
6.4 Equity of access

1. Timeliness of surgery

The elective surgery system has a duty of care to ensure patients are treated within the assigned urgency category time frame. All patients will be prioritised based on clinical urgency and where no clinical urgency differentiation exists, patients will be treated in order of their registration on the waiting list (first on, first off).

The DHHS aims to provide patients access to the shortest waiting period. This may involve movement of long-waiting patients to hospitals and clinicians with shorter waiting times subject to patient and clinician approval.

2. According to clinical need

Clinical need is determined by categorising surgery into urgency categories. There have been significant categorisation inconsistencies across Australia and in Tasmania in the past which has resulted in patients experiencing longer waiting time. This pattern affects the efficient functioning of the elective surgery categorisation system and requires considerable additional resources to treat the backlog of long waiting patients.

6.5 Active and innovative management of waiting lists

Waiting lists are managed by hospitals to ensure all patients are treated in clinically appropriate timeframes. Best practice waiting list management should be transparent, performance driven and promote the most efficient use of resources.

A key pillar of strengthening the coordination and active management of waiting lists is the appointment of Elective Surgery Access Coordination staff in each public hospital. The staff will work directly with senior and operational Hospital staff and DHHS to improve patient access to elective surgery through active and collaborative waiting list management.

6.6 System wide coordination and collaboration

To promote elective surgery reform the ongoing collaboration and consultation between the Australian Government Department of Health and Ageing, public and private hospital sector, general practitioners, treating clinicians, appropriate industry and consumer reference and advisory groups and the DHHS is critical.

The challenge of ensuring the right patient is seen by the right clinician at the right time with the right resources will be greatly influenced by the clinical and administrative partnerships, feedback and resource sharing developed through the current and future elective surgery initiatives.

The use of best practice management models will be supported by the co-ordinated use of meaningful data. Waiting list information is currently stored in the iSoft/HOMER system in each hospital. The Elective Surgery Management Information System (ESMIS) is the current information source for reporting elective surgery performance.
The development and staged implementation of the new iPM (i.Patient Manager System) has commenced and will replace ESMIS in the future. The utilisation of the Checklist (waiting list management) and Qlikview (surgery categorisation and theatre utilisation) reporting tools will enable hospital managers and co-ordinators, clinicians and DHHS to continue to improve waiting list management.

6.7 Evidence-based clinical practice

Procedures routinely performed and funded in Tasmania’s public hospitals should meet an identified clinical need to improve the patient’s physical health. Patients, health professionals and the general public should be provided with a clear message of those elective surgery procedures that are routinely performed within the public system based on the best available evidence.

Clinical expertise and patient values are fundamental in the delivery of elective surgery. Such an approach will assist to prevent patients receiving treatments that may cause harm or do not resolve a health related issue. Importantly this process will provide future protocols and pathways to match and facilitate patients to access effective non-surgical alternatives.

6.8 Performance management

1. Quality management

The DHHS has a responsibility to ensure that elective surgery is safe, effective, suitable for a patient’s condition and provided on the basis of clinical need. DHHS is committed to the delivery of responsive, integrated services which reflect Tasmania’s Health Plan and the national elective surgery standards relating to safety, quality and use of clinical evidence.

Elective surgery services are constantly evaluated and improved within a quality framework which combines the relevant Tasmanian government priorities, the broader policy and standards of The Primary Health Services Plan, Clinical Services Plan and involvement of consumers through the Consumer and Community Engagement Strategy.

DHHS is committed to waiting list performance reporting which conforms to the national standards agreed by the Australian Institute of Health and Welfare, the Australian Government Department of Health and Ageing and the benchmarks set by other Australian states and territories.

2. Risk management

Decisions involving elective surgery services will be made within an integrated risk management framework. The Tasmanian elective surgery system will be managed in accordance with the Clinical Risk Management Policy 2006 and the Acute Health Service (AHS) Safety and Quality Framework 2006. The policy will be reviewed every three years in accordance with the DHHS policy review cycle.
3. Key performance indicators

The key question for most elective surgery patients is how long they will have to wait to receive treatment. As the second highest provider of elective surgery per head of population, the Tasmanian public hospital system is committed to reducing long waiting times. To help achieve this expectation goals related to Elective Surgery access and Key Performance Indicators (KPIs) have been incorporated into performance agreements that are negotiated with Tasmania’s major public hospitals on an annual basis. These include:

- percentage of category 1 patients admitted within 30 days (see section 8 for explanation of category classifications)
- percentage of category 2 patients waiting less than 90 days
- percentage of category 3 patients waiting less than 365 days
- the number of hospital initiated postponements – after the patient has arrived or been admitted to the hospital for treatment
- percentage of patients on the elective surgery waiting list that are over boundary
- percentage of elective surgery (multi-day stay) patients admitted on the day of surgery

It is expected that these Elective Surgery KPI’s will be regularly reviewed in line with changing statewide priorities as well as against the national benchmarks for patient waiting times, admission times, and hospital related postponements. The Australian Institute of Health and Welfare (AIHW) collects and benchmarks national elective surgery data for all the states and territories based on the following key indicators:

- median waiting time – or the number of days which 50 per cent of patients were admitted from waiting lists
- 90th percentile – or the number of days within which 90 per cent of patients were admitted from waiting lists
- the percentage of admitted patients who wait longer than 365 days for surgery.
7. Waiting list procedures

7.1 What is a waiting list?

An elective surgery waiting list is a register of patients who have been assessed as needing elective surgery in hospital. Elective patients are those patients who in the opinion of a treating clinician can wait more than 24 hours for admission for a surgical procedure.

All patients who fall within this accepted definition of elective surgery must be placed on the elective surgery list. This includes non emergency patients who have been booked for surgery and are placed on the waiting list and admitted within a few days.

Elective patients wait on the list and are selected according to their clinical condition and the availability of appropriate facilities and clinical staff.

The elective surgery waiting list does not include patients waiting for non-surgical and other procedures frequently undertaken by non-surgical clinicians.

Patients remain on the waiting list until their surgery is completed or they meet one of the criteria for removal identified in Section 8.12. The waiting list includes patients with and without a booked date for admission to hospital.


7.2 Record keeping and maintenance

Hospitals must keep accurate records of waiting list information. This includes any change to a patient’s urgency category, booking or ready-for-care (RFC) status, together with reasons for the change, substantiating evidence where appropriate, and the name of the person who authorised the change.

7.3 Referring patients to the waiting list

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.

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.

3. Regardless of the source of referral, the referring clinician must submit the approved Request for Admission form (RFA) for all patients.

4. The referring treating clinician should inform the patient about:
   - the nature of the proposed medical procedure
   - the risks associated with the procedure
   - the need for consent
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- 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

- the waiting list process including the clinical urgency categories.

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

6. 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.

7. The patient health questionnaire pages of the RFA can be completed after the patient has been added to the waiting list. The patient can be contacted by phone or a Questionnaire Request letter can be sent out with a pre-paid envelope to non-category 1 patients subject to the discretion of the responsible hospital staff.

8. 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.

7.4 Consent for surgery/treatment

1. 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.


Refer also to the following individual Health Service Consent Policies:

Consent to Medical Procedures and Treatment -41, North West Area Health Service 04/09

Medical and Dental Consent, Northern Area Health Service (NAHS): LGH Policy 21-09

Informed Consent Policy, RHH 06/2002


3. 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.
4. Hospitals should provide consultants with approved consent and waiting list referral forms.

5. 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.

7.5 Provision of indemnity cover

1. Only treating clinicians employed by the Crown (DHHS) are provided with State-covered indemnity insurance for any liability arising out of a patient’s placement on the waiting list.

2. 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 (VMO’s) are specifically only indemnified for their work as a part-time Crown employee. The VMO’s private practice work is not indemnified.

3. The referring State-employed 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 the Policy for Request and Consent to Medical Procedures and Treatment (03/2003). Available at DHHS intranet: http://intra.dhhs.tas.gov.au/dhhs-online/page.php?id=7275

4. 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.

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

6. 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.

7. 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.

For further information please refer to The Tasmanian State Services Act 2000, Ministerial Direction No. 8: 2003 Attachment 2 ‘Guidelines for the Granting of Indemnity against Legal Process for Medical Practitioners’.
7.6 Registering patients on the waiting list

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. Hospitals must register patients on the waiting list within two working days of receiving a completed and signed referral form. The Request for Admission (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.

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.

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.

5. Any changes to patient’s care status should be entered on the Waiting List module.

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

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.

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.

7.7 Notifying the patient

Written and Phone Communication

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

2. A Waiting List Confirmation Letter should be sent out when the patient is entered on the waiting list that includes:
   - the date of placement on the waiting list
   - surgical unit responsible for care
   - planned procedure
   - urgency category
   - the personal Not Ready for Care (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. (Following introduction of PAS iPM) See section 8.2.2 of this policy. Note: See section 8 for explanation of category classifications.
3. The Admission for Elective Surgery 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
- 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. (Following introduction of PAS iPM) See section 8.2.2 of this policy.

4. 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.

5. A Pre-Assessment Letter should be sent to the patient prior to their pre-admission to a surgery assessment clinic

6. A Surgery Booking Letter is sent when the surgery has been booked

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

8. A Waiting List Review Letter or Audit Letter is sent to all patients on the waiting list every six months in order to:

- keep patients informed of their situation on the waiting list
- ensure that the patient’s condition has not changed
- notify patients in the event that a clinical review may be required
- ensure the patient wishes to remain on the waiting list
- ensure the patient’s contact details are kept up to date.
9. The Not Ready for Care letter can be sent to patients who are not in a position to accept
an offer of hospital admission for either personal or medical 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. (Following
 introduction of PAS iPM) See section 8.2.2 of this policy.

The development of key elective surgery letters, forms and pamphlets will be advanced during
the tenure of this policy through statewide consultation with the Elective Surgery Access Co-
ordinators (ESAC’s), ESCU Manager and the DHHS elective surgery team.

General Communication Steps

1. 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.

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

3. Patients must be advised that failure to comply with their responsibilities can result in 
   them being removed from the waiting list according to the guidelines in Section 8.11 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.

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

5. Patients who have been waiting significantly longer than their clinical category will be 
   recommended for clinical review. See section 8.3 of this policy document.

7.8 Notifying the general practitioner

1. The hospital should notify the nominated General Practitioner 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 provisional diagnosis as stated on the referral form
- the planned procedure as stated on the referral form
- the urgency category
- the surgical unit responsible for care
- who to contact at the hospital if the patient’s condition changes
- 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. (Following
 introduction of PAS iPM) See section 8.2.2 of this policy.
2. If approval to provide notification to the General Practitioner has been sought and not given, the patient must be advised of the importance of informing their General Practitioner of their placement on the waiting list.

7.9 Management of patients requiring residential aged care or aged assessment team referral

Each hospital has specific policies that guide the timely discharge planning of patients from a hospital to a residential aged care facility or a supported home environment.

These policies include the principles and processes of: patient consent for Aged Care Assessment Team (ACAT) assessment; the patient’s discharge planning preference; the Guardianship and Administration Act 1995 for patients whose decision-making is impaired by a disability; the importance of raising the patient’s and their families awareness of residential aged care and transitional care costs. The specific policies are available at DHHS intranet.

| Management of patients assessed as requiring or likely to require, low level care in a residential aged care facility –COC-63 RHH |
| Referral of patients to Aged Care Assessment Team A and R - I-003 |
| Management of aged care patients waiting Residential Care LGH Policy 05-08 |
| Patients awaiting Nursing Home Placement (NWRH) - I-3 |

These policies ensure:

- Early identification and a documented management plan and referral of patients requiring additional support and or ACAT assessment.

- All patients who are being considered for placement in a residential aged care facility (RACF) are assessed by the ACAT team.

- A multidisciplinary management plan is in place/developed to facilitate the patient’s transition and discharge into a RACF.

- That when patients, including those who require low level care in a RACF, no longer require acute care, arrangements should be made for them to be cared for in the community.

- The coordination of a Transition Care Program (TCP) which provides short term care, therapy and support for older patients who have been in hospital. In some circumstances where no safe discharge destination can be identified or there is a shortage of acute beds, the patient could be transferred to a transitional care facility or a district hospital.

An Australian Government booklet entitled ‘5 steps to entry into Residential Aged Care’ is available at:

7.10 Patients contracted to private hospitals

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

The patients are selected to match the capacity of the private hospital 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 session.

1. The Elective Surgery Coordination staff at the hospitals will coordinate all required information regarding the bookings to the Treating clinician, Anaesthetist and private Hospital Manager, including patient medical records.

2. The day prior (24 hours) to the procedure the patients are advised to confirm by phone their surgery instructions and arrangements regarding the day of surgery with the private hospital staff.

3. Once the private facility informs the referring public hospital retrospectively that the procedure is completed or the patient did not attend their surgery, the PAS system will be updated accordingly.

7.11 Patients from correctional facilities

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

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

3. 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.

4. 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.

5. 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.

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

More detail regarding the corrective patient’s hospital entry, supervision, communication, privileges and separation is available in the RHH Patients Detained by Corrective Care Policy available at DHHS intranet: http://intra.dhhs.tas.gov.au/dhhs-online/page.php?id=11687
8. Managing elective surgery patients

8.1 Determining the appropriate clinical urgency category

1. All hospitals providing elective surgery categorise clinical urgency according to the following classifications:

   **Category 1 – Urgent**
   
   Admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it might become an emergency.

   **Category 2 – Semi-urgent**
   
   Admission within 90 days is desirable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency.

   **Category 3 – Non-urgent**
   
   Admission at some time in the future is acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and does not have the potential to become an emergency.

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.

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

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

5. The referral should not be accepted if a category has not been assigned.

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

7. 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.

8. 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 1 and actively managed as an elective (or planned) admission within the necessary time frame.

9. The reason for changing a patient’s urgency category should be documented on the patient’s RFA and in their Digital Medical Record (DMR) and dated.

10. 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:
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- 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.

8.2 Managing patients Not Ready for Care

Patients can be Not Ready for Care (NRFC) for any of the following reasons:

1. clinical – staged patients
   - unfit for surgery - the patient’s health status has temporarily declined to the extent it is inadvisable to proceed with the awaited procedure.
   - 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.
   - programmed procedure - the patient will not require or be amenable to surgery until some future date; for example, those having a 12-monthly cystoscopy.

2. personal – deferred patients
   - work or social commitments
   - electing to be NRFC

Electing not to be Ready for Care

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 a deferring patient.

1. Hospitals must monitor NRFC times for their patients. After consultation, Tasmania will introduce a system (following the implementation of iPM PAS) used in other states that sets agreed time limits for patients who elect to defer for personal reasons.

2. Hospitals must advise and contact patients listed as NRFC in excess of 30 days for category 1 patients, 90 days for category 2 patients, and 180 days for category 3 patients.

3. 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. 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.

5. Patients who defer on two occasions following the provision of at least two weeks notice should be referred for clinical review to their GP.
6. 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
   - patients 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 (following introduction of PAS iPM)
   - when patients become RFC only the time they have actively waited is considered in determining their date for surgery (following introduction of PAS iPM)
   - patients are required to advise the hospital when they are RFC.

7. Category 1 patients 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 being listed as NRFC.

8. Category 2 and 3 patients 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.

9. 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 8.2.2.
   - the patient elects to become NRFC for personal reasons and expects to be RFC within the timeframes specified in section 8.2.2.
   - the patient elects to be NRFC for personal reasons for a period not greater than specified in section 8.2.2 of this policy for their urgency category.

10. Category 2 and 3 patients who have exceeded NRFC timeframes may require:
    - clinical review by the treating clinician
    - advising the patient’s General Practitioner of the patient’s NRFC status when they unfit for surgery
    - active management
    - removal from the waiting list according to section 8.13.
8.3 Clinical review

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 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.

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.

1. The review should consist of an assessment of the patient’s condition in circumstances such as:
   - recommended for review and monitoring by General Practitioner
   - review and monitoring by the treating clinician involved in the patient’s care
   - review of medical record by the treating clinician or Registrar
   - discussion between Access Coordinators and medical staff.

2. 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 General Practitioner
   - patient’s who on two consecutive occasions defer an offer of surgery or fail to arrive for admission without good reason
   - request from hospital nurse managers or CEO.

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

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

5. If a patient’s condition changes or other health problems arise, the patient should be advised to return to their general practitioner 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 General Practitioner.

6. The hospital should ensure that the treating clinician is provided with a list of patients who may require review with their General Practitioner 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.

7. 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. The treating clinician will notify the patient and 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 re-categorisations 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.

9. 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 reflect upon their planned operation.

8.4 Keeping patients fit for surgery

In collaboration with their General Practitioner, 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.

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 General Practitioner 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.

8.5 Booking patients for assessment prior to admission for surgery

1. 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 the clinician at the pre-admission clinic.

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

3. 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.
4. Access Coordinators can use information gathered through the pre-assessment process to assist the planning of the patient’s admission pathway.

5. The patient’s pre-admission clinic appointment and admission date should be entered into the Waiting list module.

6. 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.

7. 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.

8. 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.

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

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

11. 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.

12. Surgical Access staff should notify other relevant departments of admission of patients with an infective risk or special requirements including Intensive Care and High Dependency units.

8.6 Scheduling patients for surgery

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.

1. 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.
2. 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.

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

4. 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.

5. The patient is asked to contact the hospital if a health problem arises before the pre-admission clinic.

8.7 Placement of patients on theatre lists

1. 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 seven to 14 days before the date of the majority of surgical procedures. For joint replacement surgery a selection period of four to six weeks is recommended.

2. 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
   - image intensifier/other radiology required intra-operatively
   - bariatric patients (> 120kg) with a BMI (>40)
   - requirement for an ICU or other specialist care bed
   - patients who are dependent on carer’s for daily activities
   - latex allergy
   - alert code defined.

3. The theatre list is forwarded to the appropriate peri-operative and associated staff.

4. 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.

5. 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. 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.

7. 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.

8. 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.

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

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

8.8 Hospital-initiated postponements

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 ESMIS/PAS.

I. 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 general practitioner if significant issues relating to the patient’s health arise as a consequence of the postponement

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

- 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 Systems Information Manager.

the clerical staff will ensure the correct postponement code is entered into the system and ensure the patient is discharged from the hospital.

3. 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 can’t be given
- what they should do if their condition deteriorates, including contact with their General Practitioner
- how to access a complaints process should they be dissatisfied.


The LGH Complaints telephone line PH: 1800 008 001


- how to access a counselling service if required. This could include the hospital’s Consumer Advocate (RHH), Quality Improvement Officer (LGH), Director of Safety, Risk and Quality (NWRH) Safety, Risk and Quality Officer (MCH) or the patient’s general practitioner.

4. 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.

5. 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.
making the patients aware of the **Patient Travel Assistance Scheme** which offers assistance with travel and accommodation costs.

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<tr>
<td>Patient Travel Assistance Scheme policy is available at DHHS intranet:</td>
<td><a href="http://intra.dhhs.tas.gov.au/dhhs-online/page.php?id=1863">http://intra.dhhs.tas.gov.au/dhhs-online/page.php?id=1863</a></td>
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**Notes:**

- 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 in the patient’s medical record and the patient administration system.

| More detailed information on hospital initiated postponement principles and protocols are provided in the *Guidelines on Hospital Initiated Postponements* available at DHHS intranet: | http://intra.dhhs.tas.gov.au/dhhs-online/page.php?id=13865 |

### 8.9 Patient-initiated postponements

1. 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.

2. 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.

3. 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.

4. Patients can be removed whose periods of NRFC exceed the time limit thresholds listed in Section 8.2.2 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.
### 8.10 Procedures not routinely performed

Table 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 in Appendix 2.

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<thead>
<tr>
<th>Body Contouring Procedures</th>
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<td>Mastoplexy (breast lift)</td>
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<td>Removal of breast prosthesis /Revision of breast augmentation</td>
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<td>Nipple and/or areola reconstruction</td>
<td>Testicular prostheses</td>
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<td><strong>Facial Procedures</strong></td>
<td><strong>Vascular Procedures</strong></td>
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<td>Facelift</td>
<td>Varicose Vein procedures</td>
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<td>Reduction of upper or lower eyelid</td>
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<tr>
<td>Rhinoplasty (including septrhoplasty and removal of nasal polyps)</td>
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<tr>
<td>Correction of bat ears(s) (&gt;19 years old)</td>
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<tr>
<td>Repair of external ear lobes</td>
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Under Active Review (1 July 2015)

8.11 Clerical review of patients on the elective surgery waiting list

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 six 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:

1. 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.

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

3. 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.

4. If the first call is unanswered, the patient’s General Practitioner is called to verify the patient’s contact details. If the General Practitioner confirms the details the patient is called twice more during the following week at various times.

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

6. 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 General Practitioner and treating clinician should be informed by the Elective Surgery Booking Office.

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

8. On completing a review, a 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
   - the number of patients listed as RFC and the number listed as NRFC.
8.12 Removing patients from the waiting list

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

- the patient is deceased
- the patient is not contactable. After every effort has been made to contact waiting list patients, the Consultant, the Director of Surgical Services, or equivalent, should be notified and the patient removed from the waiting list
- the patient has declined surgery on two occasions without good reason
- 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
- the patient 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:

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

8.13 Patient 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 to ensure the reason for removal code is entered on the waiting list screen and the patient is removed from the active waiting list.

8.14 Patient not contactable

Health services must make reasonable attempts to contact patients. 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’ referring physician or nominated general practitioner
- the hospital’s medical records
- the patient’s next of kin
- 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.

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.
8.15 Surgery declined or not required

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
- 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.

8.16 Notification of removal

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)
- be referred to their General Practitioner or treating clinician to discuss their removal.

8.17 Multiple waiting list entries

- 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.
- 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.
- It is advised that patients should not be listed for the same procedure at different hospitals. With the implementation of the iPM PAS system, hospitals will have 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.
9. Managing long-waiting patients

9.1 Identifying Long-Waiting Patients through Exception Reporting

Elective surgery performance data which includes the patients 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.

9.2 Individual case management and clinical reviews

Criteria for clinical review will include:

- patients who are approaching the review date identified by the consultant on the RFA form
- patients who are well outside the their desired waiting time for their surgical category
- where there is substantial changes in the patients condition or circumstances
- where their specialist has resigned or is no longer available and the elapsed time and nature of the patients condition warrants a review
- recommendation or referral from the patient’s General Practitioner
- at the patients request following an endorsement from their General Practitioner
- at the request from hospital nurse managers, CEO’s or the Elective Surgery Access Coordinators
- when patients who defer an offer of surgery or fail to arrive for admission without good reason or prior notice on two consecutive occasions.

9.3 Private patients in public hospitals

The following principles apply to all Tasmanian public hospitals in their management of private patients:

- eligible patients have the right to elect to be treated publicly or privately
- public hospitals treat all eligible patients regardless of their insurance status
- access to elective surgery waiting lists in public hospitals is to be coordinated according to clinical urgency, resource availability and time of placement on the waiting list
- insurance status or willingness to pay must not result in preferential treatment for access to services within public hospitals.

A signed In-patient Election Form by the admitted patient (who elects to be private), or their authorised representative, is required. This acknowledges they have been fully informed of the consequences of their election, that they understand those consequences, and have not been directed by a hospital employee to make a particular decision.

9.4 Public patients in private hospitals

Each of the public hospitals may have arrangements with private hospitals to provide surgery for public waiting list patients. Further initiatives to use the private sector to target and reduce long
waiting patients where it is clinically suitable may be implemented at times and will follow the
broad process outlined in section 7.10 of this policy.
10. Definitions

This section provides a reference of key terms. The National Health Data Dictionary is recognised as the authoritative source of definitions and should be consulted in conjunction with this list. Go to http://meteor.aihw.gov.au/content/index.phtml/itemid/268110/letter/A.

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 Recommendation 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

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.

There are two types of admission:

- emergency admission (admission within 24 hours)
- 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.

Classifications are:

- Medicare Eligible - Public patient
- Medicare Eligible - Private patient
- Medicare Eligible - Department of Veterans’ Affairs patient
- Medicare Eligible - Other (compensable, defence forces etc)
- Medicare Ineligible - 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

Review of a patient on the waiting list to ensure that their waiting time is appropriate for their clinical condition.

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’. The following state definitions have been adapted from the NHDD.

category 1: Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency OR for diagnostic procedures requiring urgent answers, or for urgent neoplastic conditions.

category 2: Admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.

category 3: Admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.
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 (ie 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 General Practitioner consultation, referral to a specialist and a recommendation for admission to a hospital by the specialist (or General Practitioner, 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.

Elective surgery

Elective surgery is surgery performed on patients, that in the opinion of the Treating clinician is necessary, and for which admission can be delayed for 24 hours. Tasmania has adopted the nationally agreed definition of elective surgery, as specified by the Australian Institute of Health and Welfare. 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 admission

An admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission should occur within 24 hours. 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 admission to hospital within 24 hours.

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.

**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 that is the extent to which a patient is ready and available for admission. This may change while the patient is on the waiting list; eg 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 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.

**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:

- staged – not ready for clinical reasons
- 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 yet RFC, 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.

**Not Ready for Care “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.
Under Active Review (1 July 2015)

The reason a patient is deferred may be reported as follows:

- a patient is going on holidays and will be unavailable for admission
- a patient is unable to obtain home support
- a patient is unable to accept a date due to work commitments
- a patient is unable to accept a date for other significant reasons eg personal carer.

Deferred patients may be added to the waiting list as NRFC or Suspended. These patients should not be counted as ‘waiting’ and are excluded from the reported waiting list statistics.

Not Ready For Care “Staged”

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
  - a planned re-admission for review of status following previous treatment

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.
Overdue patient

The National Health Data Dictionary defines overdue patient as ‘one whose wait has exceeded the time that has been determined as clinically desirable in relation to the urgency category to which they have been assigned.’ 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 (ie the admission or listing is scheduled) A patient who has not been given a definite date for admission by the hospital is unscheduled (ie 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:
Under Active Review (1 July 2015)

1. 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.

2. 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.

3. 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. The patient remains RFC. This sub-category is of most interest to the DHHS 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)

A RFC patient is defined as a patient who is available for admission to hospital. RFC patients will be in clinical priority Categories 1, 2 or 3.

RFC patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. To be RFC, patients must:

• 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 Care “delayed”

A patient is regarded as 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)
• non-availability of bed; planned bed reduction
• non-availability of bed; pressure of emergency admissions
• non-availability of doctor

It is mandatory to indicate the reason for the patient’s admission being delayed.

Request (recommendation) 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 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
• admitted as an emergency patient for awaited procedure
• the patient has been transferred to another waiting list
• could not be contacted
• patient does not respond to clerical review letter
• patient deceased
• treated elsewhere for awaited procedure
• surgery not required or declined on two occasions for personal reasons
• transferred to another waiting list.
• patient twice fails to arrive for surgery on an agreed date without notice or good reason
• patient defers and exceeds maximum number 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
• meets the minimum criteria for admission
• has undergone a formal admission process
• 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).

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 (eg Obstetrics/Gynaecology) Examples of the broad specialities used in Tasmania’s public hospitals are:

<table>
<thead>
<tr>
<th>Speciality</th>
<th>Ear Nose and Throat</th>
<th>General Surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiothoracic</td>
<td></td>
<td>General Surgery</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td></td>
<td>Ophthalmology</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>Plastic</td>
<td>Urology</td>
</tr>
<tr>
<td>Vascular</td>
<td>Plastic</td>
<td>Paediatric Surgery</td>
</tr>
</tbody>
</table>

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
Under Active Review (1 July 2015)

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.
Appendices

Appendix 1: Policy consultation key stakeholders

North Western Area Health Area:

Jane Holden CEO
Scott Fletcher Director of Surgery
Simon Foster Director Corporate and Support Services NWRH
Geraldine Hanigan Manager (PIMS)
Bill Kerr Theatre Manager (Operating Theatres)
Katrina Willis Assistant Director of Nursing Peri-operative Regional Services
Grace Kamphius Nurse Unit Manager

Northern Area Health Service

John Kirwan CEO
Dr Bernie Einoder Director of Surgery
Cassandra Sampson Assistant Director of Nursing (Surgery)
Belinda Russell Team Leader (Elective Surg Systems/Patient Flow)

Southern Tasmania Area Health Service

Michael Pervan CEO
Craig Quarmby Clinical Director - Surgical Services
Cheryl Carr Assistant Director of Nursing (Access and Redesign)
Gail Sillery Nursing and Services Director
Mary Condon-Williams NUM Pre-operative Unit
Michelle Muir Nurse Unit Manager - Surgical Access RHH
Leanne Syrett Booking Clerk
Allison Connolly Elective Surgery Liaison Nurse
Nathan Dadswell-Booth Clinical Nurse-Residential Aged Care Liaison Team

Department of Health and Human Services

Jill Harley Director Strategy, Coordination and Implementation Design
Jane McKercher Policy Officer
Jayne Hay Manager Contract Legal Support
Fleur Dewhurst Medico-Legal Advisor
Pam McGrath Private Practice/Liaison Off
Andrew McGown Communications Advisor (Graphic Designer)
Appendix 2: Guidelines on procedures not funded to be routinely performed in Tasmanian public hospitals

From 1 January 2010 some elective surgery procedures will no longer be routinely performed in Tasmanian public hospitals. This will ensure 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

1. 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.

2. 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 1 pages 50 to 53).

- have “other”circumstances which demonstrate an overriding need for surgery. These circumstances will be at the discretion of the 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 Tasmanian Statewide Surgical Services Committee (TSSSC), 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 1.
Under Active Review (1 July 2015)

Flowchart 1 - 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.

- Surgeon assesses patient.
- Patient meets an exceptional clinical indication for a procedure not routinely performed in a Tasmanian public hospital?
  - Yes: Surgeon/hospital informs patient and their GP. Patient is placed on waiting list. Request For Admission form clearly indicates the reason surgery is indicated and that the patient meets any other required criteria (e.g. BMI).
  - No: Surgeon of the view that there are "other" circumstances (other than the clinical indications above) which demonstrate an overriding need for surgery?
    - Yes: Discuss with Head of Unit/Department.
    - No: Surgeon/hospital informs patient and their GP and provides them with appropriate documentation, including information about the appeals process. A copy of the decision is placed on the patient's medical record at the hospital.

- Head of Unit/Department agrees that surgery should be performed?
  - Yes: Hospital informs patient and their GP and provides them with appropriate documentation, including information about the appeals process. A copy of the decision is placed on the patient's medical record at the hospital.
  - No: Refer to Director of Surgery, providing supporting documentation and photographs (if appropriate).

- Director of Surgery agrees that surgery should be performed?
  - Yes: Hospital informs patient and their GP.
  - No: Patient is placed on the waiting list. Request For Admission form clearly indicates the reason surgery is indicated.
Under Active Review (1 July 2015)

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 Tasmanian Statewide Surgical Services Committee (TSSSC) by completing the form available at: www.dhhs.tas.gov.au

The TSSSC 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 2 on the following page details the patient appeals process.
Flowchart 2 - Patient appeals process

**GP appeals hospital decision on behalf of patient?**
- **No**
  - **No further action.**
- **Yes**
  - **GP completes form (available on DHHS website) and forwards to DHHS.**
  - **DHHS forwards to the Chair, Tasmanian Statewide Surgical Services Committee (TSSSC).**
  - **Chair, TSSSC requests a review of the case by Director of Surgery of relevant hospital.**
  - **Director of Surgery of the view that surgery should be performed?**
    - **Yes**
      - **Director of Surgery informs TSSSC.**
      - **Hospital informs the patient and their GP.**
      - **Patient is placed on the waiting list.**
      - **Request For Admission form clearly indicates the reason surgery is indicated.**
    - **No**
      - **Director of Surgery provides TSSSC with appropriate information on the patient, including the reason why surgery is not indicated.**
      - **TSSSC reviews case.**
      - **TSSSC of the view that surgery should be performed?**
        - **Yes**
          - **TSSSC informs patient, their GP and the Director of Surgery.**
          - **Patient is placed on the waiting list.**
          - **Request For Admission form clearly indicates the reason surgery is indicated.**
        - **No**
          - **TSSSC informs patient, their GP and Director of Surgery.**
          - **A copy of the decision is placed on the patient’s medical record at the hospital.**
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 1, pages 50 to 53).
- have other circumstances which demonstrate an overriding need for surgery and the Director of Surgery or the TSSSC has given their approval (refer flowchart 1 Hospitals approvals process on page 46)

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:

www.dhhs.tas.gov.au

This includes information on the patient appeals process.
Guidance for Clinicians – exceptional clinical indications for surgery

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 1.1 Plastic Surgery Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Exceptional clinical indications for surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal lipectomy</td>
<td>• Correction of scarring as a result of previous abdominal surgery or trauma</td>
</tr>
<tr>
<td>Abdominoplasty</td>
<td>• Disabling or persistent physical discomfort</td>
</tr>
<tr>
<td>Apronectomy</td>
<td>• Intertrigo</td>
</tr>
<tr>
<td></td>
<td>• Post morbid obesity treatment where clinical symptoms present (e.g. intractable intertrigo) and BMI is &lt;28</td>
</tr>
<tr>
<td></td>
<td>• Required for hernia repair or other abdominal surgery</td>
</tr>
<tr>
<td></td>
<td>• Poorly fitting stoma bags</td>
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</tbody>
</table>

Liposuction

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Exceptional clinical indications for surgery</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>• Post traumatic pseudolipoma</td>
</tr>
<tr>
<td></td>
<td>• Lipodystrophy with BMI</td>
</tr>
<tr>
<td></td>
<td>• Gynaecomastia with BMI</td>
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<tr>
<td></td>
<td>• Lymphoedema</td>
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<td></td>
<td>• Flap reduction</td>
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<td></td>
<td><strong>Above conditional on BMI &lt;28</strong></td>
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</tbody>
</table>

Other skin excisions for contour, e.g. buttock, arm, thigh lift

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<thead>
<tr>
<th>Procedure</th>
<th>Exceptional clinical indications for surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Post morbid obesity treatment where clinical symptoms present (e.g. intractable intertrigo and BMI is &lt;28)</td>
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</tbody>
</table>

Under Active Review (1 July 2015)
# Under Active Review (1 July 2015)

## Breast Procedures

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Exceptional clinical indications for surgery</th>
</tr>
</thead>
</table>
| **Breast reduction**  
(bilateral/unilateral) |  
**Female:**  
- Post mastectomy surgery where BMI < 28  
- Chronic head, neck and back ache (where pain is due to breast size) and/or chronic intertrigo.  
**Male (gynaecomastia):**  
- Suspected malignancy  
- Pain, 19 years or older, must have been present for more than 2 years and BMI < 28  
- Following treatment for cancer of the prostate  
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 (eg intractable intertrigo) and BMI < 28 |
| **Removal of breast prosthesis/Revision of breast augmentation** | Removal of breast prosthesis and revision of breast augmentation - rupture, Infection or capsular contracture  
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). |
### Under Active Review (1 July 2015)

<table>
<thead>
<tr>
<th>Facial Procedures</th>
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<tbody>
<tr>
<td><strong>Procedure</strong></td>
</tr>
<tr>
<td>Facelift</td>
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<td></td>
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<tr>
<td></td>
</tr>
<tr>
<td>Reduction of upper or lower eyelid</td>
</tr>
<tr>
<td>Rhinoplasty (including septoplasty and removal of nasal polyps)</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Correction of bat ear(s) &gt;19 years</td>
</tr>
<tr>
<td>Repair of external ear lobes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin and Subcutaneous Tissue Procedures</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Procedure</strong></td>
</tr>
<tr>
<td>Hair transplant</td>
</tr>
<tr>
<td>Tattoo removal procedures</td>
</tr>
<tr>
<td>Removal of skin lesions (eg skin tags)</td>
</tr>
<tr>
<td></td>
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<tr>
<td></td>
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<td></td>
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<tr>
<td>Revision of scar</td>
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</table>
Table 1.2  Urology and Gynaecology

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Exceptional clinical indications for surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lengthening of penis procedure</td>
<td>• Congenital abnormalities in children.</td>
</tr>
<tr>
<td></td>
<td>• Recurrent urinary tract infections where the patient is at risk of requiring renal dialysis.</td>
</tr>
<tr>
<td>Insertion of artificial erection devices</td>
<td>• Patients using urodomes</td>
</tr>
<tr>
<td></td>
<td>• Spinal patients with neurological erectile dysfunction.</td>
</tr>
<tr>
<td>Reversal of sterilisation</td>
<td>• None</td>
</tr>
<tr>
<td>Gender reassignment surgery</td>
<td>• Congenital abnormalities in children.</td>
</tr>
<tr>
<td>Genital surgery aimed at improving appearance</td>
<td>• Patients requiring prostheses following orchidectomy</td>
</tr>
<tr>
<td>Testicular prostheses</td>
<td>• Following orchidectomy for malignant disease.</td>
</tr>
</tbody>
</table>

Table 1.3  Vascular Surgery

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Exceptional clinical indications for surgery</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicose vein procedures</td>
<td>• 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.</td>
</tr>
<tr>
<td></td>
<td>• Objective clinical evidence of chronic venous insufficiency.</td>
</tr>
<tr>
<td></td>
<td>• Recurrent (more than 2 episodes superficial thrombophlebitis).</td>
</tr>
</tbody>
</table>

Notes:

- Circumcision is not included in these guidelines and will be considered at a future date.
- A DHHS careway for morbid obesity surgery is currently being developed.
12. Bibliography


Tasmanian Department of Health and Human Services, *Tasmania’s Elective Surgery Improvement Plan; Getting Our Waiting Times Down*, 2008


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