

Gastrointestinal Endoscopy Services Implementation Standard

Department of Health Standard
QH-IMP-461:2019

1. Statement

The Gastrointestinal Endoscopy Services Implementation Standard (GESIS) outlines the suite of business rules and processes for ensuring equitable access for all patients requiring gastrointestinal endoscopy services at Queensland public hospitals by providing best-practice waitlist management processes aimed at facilitating treatment of patients within clinically recommended timeframes.

This standard does not replace, but is additional to, the professional self-regulation and individual accountability for clinical judgement that are an integral component of healthcare.

2. Scope

The following procedures are in scope for the Gastrointestinal Endoscopy Services Implementation Standard:

- Gastroscopy (adult and paediatric)
- Colonoscopy (adult and paediatric)
- Endoscopic Retrograde Cholangiopancreatography (ERCP)
- Endoscopic Ultrasound (EUS)
- Manometry (upper and lower)
- Flexible Sigmoidoscopy
- Capsule Endoscopy.

The standard applies to all patients who are registered on a waiting list for a gastrointestinal endoscopy procedure at a public hospital in Queensland, referred to hereafter as Hospital and Health Services (HHSs). Compliance with this standard is mandatory for all employees, contractors and consultants within Queensland HHSs, departmental divisions and commercialised business units that are involved directly or indirectly (via support services or management functions) in the provision of endoscopy services.

2.1 Out of scope

The following services are out of scope for the business rules and processes outlined in the Gastrointestinal Endoscopy Services Implementation Standard:

- Emergency endoscopies – endoscopies to treat acute illness subsequent to an emergency presentation. The patient may require an immediate endoscopy or present for an elective endoscopy at a later time following this unplanned presentation. This includes where the patient leaves hospital and returns for a subsequent admission. Emergency endoscopies include unplanned endoscopies for admitted patients and unplanned endoscopies for patients already awaiting an endoscopy (for example, in cases of acute deterioration of an existing condition)
- Gastrointestinal endoscopy procedures not defined in scope
- Procedures that are not publicly funded in Queensland.

However, where appropriate, the business rules and processes outlined in the Gastrointestinal Endoscopy Services Implementation Standard should be used as a guide for managing some out of scope procedures unless covered by another guideline or implementation standard.

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3. Requirements

3.1 Guiding principles

Provision of gastrointestinal endoscopy services in Queensland public Hospital and Health Services (HHSs) must be in accordance with the National Healthcare Agreement and HHS Service Agreements.

Gastrointestinal endoscopy services should:

1. have patients and their carers as the primary focus
2. be proactive, equitable and transparent in the management and delivery of services
3. support patients to be provided with the treatment option that will result in an endoscopy as close to their home as possible, by the most appropriate clinician for the level of care required
4. provide patients with the appropriate treatment option that will result in an endoscopy as close as possible to their clinically recommended timeframe
5. optimise continuity of care by facilitating patients being seen by the same clinician or team wherever possible
6. deliver coordinated care, clinical follow-up and appropriate discharge planning for patients and carers
7. empower patients to participate in decision making and to make informed choices about their pathway of care
8. ensure appropriate processes are in place to seek informed consent from the patient, guardian or attorney prior to undertaking designated treatments or procedures
9. provide patients with information that identifies their rights and responsibilities and the process for lodging compliments and complaints
10. be coordinated to promote the most effective use of available resources
11. be the shared responsibility of the health service, listing and treating clinician, the referring practitioner and the nominated general practitioner
12. ensure transparent, valid and reliable record keeping (electronic and written) and reporting is maintained
13. ensure referrals for endoscopies are clinically appropriate and represent the most suitable treatment for the patient's reason for referral
14. ensure communication with patients, referring practitioners and general practitioners is in a timely and efficient way that provides easy-to-understand information appropriate to the intended audience to facilitate optimum patient treatment
15. exercise discretion to avoid disadvantaging patients in the case of hardship and other extenuating circumstances
16. consider the principles and requirements of the Gastrointestinal Endoscopy Services Implementation Standard when entering into collaborative arrangements with private endoscopy providers.

3.2 Eligibility

Eligible patients are those patients who have been referred via a valid endoscopy booking request, are registered on an endoscopy procedural waiting list and:

- have a condition that cannot be managed by a primary healthcare practitioner **and**
- are awaiting a procedure listed within the scope of publicly-funded services **and** are either:
 - Medicare eligible, **or**
 - patients referred from the Department of Corrective Services), **or**
 - compensable patients (note that charges will apply) **or**
 - private patients referred to a nominated HHS staff specialist, visiting medical officer or health professional with right of private practice and who elect to receive treatment as a private patient. This may only occur when participation of staff in the private practice scheme in no way compromises or adversely affects the timeliness or quality of treatment of public patients.

Endoscopy services may be offered to Medicare ineligible patients (patients from another country where there is no reciprocal agreement but are holders of relevant health insurance policy - note that charges will apply) at the discretion of the HHS. HHSs should have appropriate processes in place for managing the treatment and payment of Medicare ineligible patients.

3.3 Access

Access to publicly funded endoscopy services is only possible through registration of patient details on the endoscopy waiting list of a HHS.

The responsibility of HHSs to provide endoscopy services is determined by:

- the geographic catchment or population for which that HHS is responsible for providing health services for, as articulated in their service agreement with the Department
- self-assessed endoscopy capability (as defined by Queensland Health's Clinical Services Capability Framework)
- the volume and type of endoscopy activity that a HHS has agreed to provide in the current service agreement with the Department. This may include activity that has historically flowed from one geographic catchment to another because a patient's place of residence does not have the service capability to safely provide the endoscopy service.

It is mandatory for HHSs to accept endoscopy registrations for patients outside of their geographic catchment where the service is not available in the patient's usual place of residence (this information must be formally documented at the time of referral / request for registration) and:

- the relevant service is provided by the receiving HHS either by local staff, public-private partnerships or outreach/visiting specialists, and
- the receiving HHS has the endoscopy service capability to provide the service (as defined by Queensland Health's Clinical Services Capability Framework) or
- historical flows of activity have been incorporated into their service level agreement with the Department or the flow of activity has been included in the estimated future activity of the HHS.

Where a service is not available within a patient's usual place of residence and the nearest HHS that provides the service refuses to accept a referral for an endoscopy, the HHS where the patient resides

should notify the Chief Executive (or their nominated delegate.) Where unable to be resolved, the issue should be tabled for discussion at the Relationship Management Group meeting.

Any disputes regarding purchased activity should be managed in accordance with the dispute resolution section of the relevant service agreement.

The Department will annually assess the performance of each HHS in relation to the delivery of endoscopy services, and assess if the current level of self-sufficiency in relation to endoscopy services is appropriate to meet the needs of the population that the HHS serves, using estimated future activity projections. Any changes in the volume or type of activity purchased will be negotiated with HHSs and incorporated into their service agreement with the Department, or described in a memorandum between the HHS and Department.

HHSs have a responsibility to regularly monitor their demand and capacity to ensure timely access to services is sustainable. Where it is identified that there is insufficient capacity to treat patients within clinically recommended waiting times, the HHS must investigate strategies to align demand and capacity either internally or seek alternative, suitable arrangements to provide endoscopies in time.

In situations where endoscopy services are provided through a cooperative arrangement between hospitals, a service agreement between HHSs should clearly identify the service with the responsibility for each aspect of clinical and administrative service provision.

3.4 Service continuity

HHSs must be able to demonstrate to the Department that they have taken all reasonable steps to maintain local continuity for services that they have agreed to deliver under the current service agreement. Deferment, suspension or discontinuation of services for periods greater than 30 days for endoscopy services agreed to under the current service agreement may result in activity being transferred to another public or private provider with the appropriate capability to deliver the service, unless the HHS can demonstrate that they have secured an alternate service provider with equivalent service capability and capacity to provide the service.

The HHS Chief Executive (or their nominated delegate) must notify the Department (via the Healthcare Purchasing and System Performance Division) in writing, that a service has, or will, cease temporarily (for a period exceeding 30 days) or for the foreseeable future, within five days of being notified internally, including details of the proposed management plan. The HHS Chief Executive (or their nominated delegate) must also notify, in writing, any other services likely to be impacted by the service discontinuation, such as those to which outreach services are provided within five business days of being notified internally. HHSs should also refer to the relevant service agreement between the HHS and Department of Health regarding cessation of service delivery.

HHSs must not register patients on the endoscopy procedural waiting list for the discontinued service from the date that they notify the Department that the service has ceased until an alternate service provider with the required service capability can be secured, unless directed to do so by the Department.

HHSs that cease provision of endoscopy services must ensure treatment within the clinically recommended timeframe for patients accepted onto the endoscopy procedural waiting list prior to the date that services were suspended.

Where a HHS ceases or suspends a service and it has been agreed with the Department and another HHS that patients who were accepted onto the endoscopy procedural waiting list prior to the service

being discontinued are to be referred to the other HHS as negotiated, the following must be undertaken:

The hospital where the patients are currently registered must:

- retain each patient on their public hospital procedural waiting list until such time as the receiving public provider has clinically reviewed the patient (or referral as appropriate) and confirmed in writing that they will provide the endoscopy. This is done to mitigate the risk of the patients becoming lost in the transfer process and to ensure that responsibility for the finalisation of the patients' care is retained by the referring hospital
- update each patient's waiting list status to 'transferred to other Queensland Health facility' upon confirmation that the patient has been accepted
- provide details as described in section 3.11.2: Patients who permanently relocate from one HHS to another to the receiving hospital to allow the total days waiting for each patient on the receiving hospital's procedural waiting list to accurately reflect the original patient record
- notify the patient and referring practitioner (and nominated general practitioner where not the same) of the outcome of the transfer request once confirmed.

The responsible officer at the receiving hospital must:

- provide confirmation of receipt of the transfer request within the timeframe negotiated with the Department and referring HHS
- arrange an appropriate review of the patient transfer request and notify the referring hospital regarding the decision to accept or reject the transfer within the timeframe negotiated with the Department and referring HHS. NB: timeframes will be dependent on the volume of patients being transferred; however, should be expedited to reduce delays in patient care
- register the patients on their endoscopy procedural waiting list and record each listing date as the date each patient was initially registered on the referring hospital's endoscopy procedural waiting list
- ensure that Not Ready for Care (NRFC) periods are not applied for any period of the transfer process in accordance with section 3.8.3: Not ready for care.

Where the receiving hospital has accepted patients who have or will exceed clinically recommended waiting times from the HHS who has ceased or suspended the service, they should retain a record of such patients for reporting at the Relationship Management Group meeting.

3.4.1 Outreach and visiting services

Outreach services are services delivered in sites outside of the HHS area to meet or complement local service need. Outreach services include services provided from one HHS to another as well as state-wide services that may provide services to multiple sites.

Patients must be placed on the procedural waiting list of the HHS where the outreach endoscopy service will be provided. This is usually the HHS where the patient resides. HHSs that manage endoscopy procedural waiting lists for outreach/visiting services are responsible for ensuring that patients are only waitlisted for endoscopies at facilities where the schedule of visits is such that the endoscopy can reliably be delivered within clinically recommended timeframes. Category 4 patients should not be waitlisted at facilities where the provider's schedule between visits is 30 days or more.

In the event where outreach services cannot be provided within clinically recommended timeframes, the originating HHS should investigate options to expedite endoscopies within clinically recommended timeframes.

For outreach and visiting services, a service agreement between HHSs should clearly identify the service with the responsibility for each aspect of clinical and administrative service provision.

3.5 Duty of care

Hospitals have a non-delegable duty of care to their patients. The scope of the duty will depend on the nature of the services to be provided to the patient. Medical and other health professionals also owe a duty of care to their patients.

The duty of care owed by a HHS for patients registered on a public endoscopy procedural waiting list includes taking reasonable efforts to provide appropriate care within clinically recommended timeframes, communicating with patients and nominated practitioners and responding to information regarding changes to a patient's condition during this time appropriately.

3.6 Endoscopy booking request management

3.6.1 Sources

Access to gastrointestinal endoscopy services is only possible through the lodgement of a booking request from a recognised source. Recognised request sources include:

- General Practitioners (including via direct access arrangements)
- Queensland Health employed Senior Medical Officers
- Queensland Health employed Visiting Medical Officers
- Privately employed Medical Officers
- Nurse practitioners with a valid provider number

Patients may be referred to a public endoscopy service for continued treatment following an initial consultation in a private setting. HHSs should have appropriate processes in place to manage and record these occasions of service in accordance with relevant funding requirements. The order of treatment should not be based on the public / private status of the patient.

3.6.2 Endoscopy booking request validity

Requests for gastrointestinal endoscopy procedures must provide adequate information for safe transfer of care. In order to be accepted, the request (both internal and external) must:

- contain adequate information to allow for informed categorisation of clinical urgency and prioritisation
- comply with Clinical Prioritisation Criteria where CPC are available
- be received in writing, either in hard copy or via an approved electronic method.

3.6.3 Declined requests

Requests received that do not meet referral criteria and/or CPC (where available) or are not suitable for treatment must be:

- redirected back to the referring practitioner with suggestions for management, following clinical review of the request or
- redirected to another appropriately qualified allied health practitioner, nurse practitioner, advanced practice nurse or registered nurse employed or contracted by Queensland Health for further assessment and/or treatment, following clinical review. The referring practitioner and patient must be notified of this course of action in writing (letter/email) within five (5) business days of the decision (refer to section 3.8.2: *Alternate pathways of care*).

Requests should be declined by a HHS in the following circumstances:

- the patient does not meet the requirements of section 3.2: *Eligibility*
- the request is illegible
- the request does not contain sufficient information to accurately categorise the level of clinical urgency
- the request is for a service that the HHS does not have the capability to provide and there is evidence that the HHS has not accepted purchased activity in relation to the service via the current service agreement negotiated between the Department and the HHS.

In any instance where a request is declined, the referring practitioner must be notified in writing of the reason for non-acceptance and alternate referral options outlined for services not provided locally (either temporarily for periods greater than thirty (30) calendar days or for the foreseeable future) within five (5) business days of receipt of referral. A record of the receipt of referral and non-acceptance of the referral must be maintained in the patient's medical record and outpatient services information system.

HHSs must implement processes to appropriately manage requests received for services that are not provided (or have been deferred or suspended) and ensure patients and referring practitioners are notified within five (5) business days of the decision to decline the request and that alternative arrangements for treatment will be required.

3.7 Endoscopy procedural waiting list registration (including consent)

HHSs must comply with the requirements outlined in the Queensland Health Guide to Informed Decision-Making in Healthcare when seeking and obtaining consent for gastrointestinal endoscopy procedures. Further guidance regarding consent for colonoscopies is detailed in the Colonoscopy Clinical Care standard published by the Australian Commission on Safety and Quality in Healthcare. These requirements must be adhered to, regardless of the source of the request (i.e. internal, external, direct access).

3.7.1 Endoscopy procedural waiting list registration information

Requests for registration on an endoscopy procedural waiting list must include the following information (at a minimum):

- patient identification details
- patient contact details
- referral source

- nominated general practitioner's details, if the nominated general practitioner is different from the referring practitioner
- planned admission accommodation status (private, public)
- ready for care status
- planned procedure details
- clinical urgency category - category 4, 5, 6 or surveillance
- planned patient admission type (day procedure, day of procedure admission, inpatient)
- pre-admission details (investigations and results)
- listing clinician details and signature
- date the request was completed
- consent status (written or verbal.)

All requests received by the HHS must be recorded on an electronic waiting list management system from the time that the HHS receives the request until the patient has been removed from the procedural waiting list. Where an endoscopy booking form has been used, this should be the date recorded on the form. A request received by a HHS that is allocated an urgency category is referred to as an 'accepted request.'

Patients must be notified, in writing, of the date that they were registered on the endoscopy procedural waiting list. The listing date in the endoscopy waiting list information system is the date that a hospital should include in correspondence to the patient.

The HHS must ensure appropriate processes are in place for confirming the details of the patient's nominated general practitioner, which are registered on the waiting list information system, are correct and up-to-date and that the patient has been advised that information regarding the patient may be provided to their registered nominated general practitioner.

3.7.2 Endoscopy procedural waiting list registration exclusions

A patient cannot be registered on an endoscopy procedural waiting list if they:

- require deferment from the time of placement on the endoscopy procedural waiting list for either clinical and/or personal reasons if the cumulative period of NRFC days will exceed the maximum NRFC thresholds (with the exception of staged procedures. See section 3.8.2: Not ready for care) or
- are already on an endoscopy procedural waiting list at another hospital for the same procedure

3.7.3 Duplicate listings

In the event that a duplicate listing for the same patient is detected within or across HHSs, a clinical review of the patient's medical record must be undertaken by an appropriately qualified specialist (or their clinical delegate) at each hospital to confirm that the patient is waiting for the same procedure.

If it is confirmed that the patient is waiting for the same procedure at more than one public hospital, the patient must be contacted to ascertain which hospital's procedural waiting list they should remain on. A patient can only be registered on one public hospital procedural waiting list for the same procedure. In determining which waiting list the patient will remain on, the following should be applied:

1. The patient must be provided the treatment option that will result in an endoscopy within (or where not possible, as close as possible to) their clinically recommended timeframe and as close as possible to their place of residence.

2. If the patient declines the option that will enable their endoscopy within (or where not possible, as close as possible to) their clinically recommended timeframe and it is within 50km of their nearest public hospital, this should be considered a decline of an offer for an endoscopy and an appropriate NRFC applied – refer to section 3.11.3: Patients who are transferred from one public hospital to another.
3. If the patient has acquired a duplicate referral due to permanently relocating, refer to section 3.11.2: Patients who permanently relocate from one HHS to another.

At all times, consideration should also be given to the patient's social circumstances in relation to post- procedure care and family support when determining at which hospital the patient should be waitlisted.

3.7.4 Ready for care

Patients must only be registered onto the endoscopy procedural waiting list if they:

1. are currently ready for care, or
2. will be ready for care not exceeding the maximum NRFC thresholds outlined in section 3.8.4: Not ready for care thresholds and review requirements or
3. are referred for a staged, surveillance or recall procedure.

Where further non-routine assessment or review is required to determine if a patient is anaesthetically or medically fit to undergo an endoscopy, the patient must be registered onto the endoscopy procedural waiting list and an appropriate NRFC period applied under 'Not Ready for Care – Clinical' providing the timeframe for clearance will not exceed the maximum NRFC thresholds outlined in section 3.8.4: Not ready for care thresholds and review requirements. HHSs must ensure that they have local procedures and processes in place to monitor and coordinate care across healthcare providers where medical clearance is required from multiple healthcare professionals.

HHSs must actively monitor the total number of days a patient is NRFC to ensure they do not exceed maximum NRFC thresholds. For more information on NRFC, see sections 3.8.2: Not ready for care – 3.8.4: Not ready for care thresholds and review requirements.

3.7.5 Patients requiring multiple procedures

Where patients require two endoscopic procedures (e.g. upper and lower), consideration should be given to scheduling both procedures for the same day. In cases where this is deemed appropriate, patients should be waitlisted as a single waiting list entry (inclusive of both procedures) according to the procedure with the highest urgency category e.g. a surveillance upper endoscopy and an urgent colonoscopy.

If one procedure is not going to alter the indications or fitness for a subsequent procedure/s and they are to be undertaken separately, the following business rules should be applied:

4. Waitlist the patient as ready for care for both procedures
5. Schedule the highest urgency category first
6. Once a date has been arranged for the first procedure, insert a NRFC – Staged loop for the subsequent procedure from the first procedure date until the expected date of fitness for the subsequent procedure taking into consideration recovery following the previous procedure (this may exceed NRFC thresholds)
7. Schedule the subsequent procedure within the clinically recommended timeframe; this may be immediately at the exit of the NRFC loop.

3.8 Endoscopy procedural waiting list management

3.8.1 Urgency category assignment

Patients who require a gastrointestinal endoscopy must be assigned an urgency category by a clinician involved in the patient's care prior to registration on the endoscopy procedural waiting list.

- **Category 4 (priority):** Completion of an endoscopy 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 5 (semi-urgent):** Completion of an endoscopy within 90 days is desirable for a condition that is likely to deteriorate significantly if left untreated beyond 90 days.
- **Category 6 (not-urgent):** Completion of an endoscopy within 365 days is acceptable for a condition that is unlikely to deteriorate quickly and does not have the potential to become an emergency.
- **Surveillance endoscopy:** Recommendations for surveillance colonoscopy timeframes must be in accordance with the National Health and Medical Research Council Clinical Practice Guidelines for surveillance colonoscopy. Surveillance endoscopies for Barrett's oesophagus must be undertaken in accordance with the Cancer Council Australia's recommended timeframes.

3.8.2 Urgency categorisation review and re-categorisation

Referring practitioners (and nominated general practitioners where not the same) should be notified of the need to monitor the patient's clinical condition and communicate any changes to their condition, in writing, to the endoscopy service. If changes in the patient's clinical condition occur, the triaging clinician will review the additional information and a determination regarding a change to the patient's urgency category must be made within five (5) business days of receipt of information.

A record of notification of any changes to the urgency category of patients registered on the endoscopy procedural waiting list, or the decision not to change the patient's urgency category must be maintained in the patient's medical record and the endoscopy information system and communicated, in writing, to the patient and the referring practitioner (and nominated general practitioner where not the same) within five (5) business days of the decision to re-categorise.

HHSs must ensure that re-categorisation is not used as a tool to manage waiting times and that the urgency category is appropriate to the patient and their clinical situation and not influenced by the availability of hospital or specialist resources.

3.8.3 Not ready for care

Once registered on an endoscopy procedural waiting list, the patient's condition may change such that they are no longer ready for care (due to personal or clinical reasons) for a defined period of time. In this case, they should be assigned a not ready for care (NRFC) status on the endoscopy waiting list information system. The reason for the change in status must be retained in the patient's medical record.

Patients who are not ready to be admitted to hospital for an endoscopy or to begin the process leading directly to an endoscopy will be classified as NRFC using the appropriate listing status for patients who are not ready for care as below:

- **Clinical:** Patients for whom an endoscopy is indicated, but not until their clinical condition is improved. For such patients, a decision has already been made that an endoscopy should take place. Patients should not be regarded as 'not ready for care—pending improvement of their clinical condition' when they are undergoing routine monitoring or investigations. Routine monitoring or investigations includes any tests, appointments or reviews which would normally form part of the standard pathway for the listed procedure.

Given that recovery times from illness or injury are variable and unpredictable, patients whose clinical condition would result in them exceeding the maximum thresholds for NRFC should not be added to the procedural waiting list until their clinical condition improves.

Therefore, NRFC – clinical can only be used for patients whose clinical condition alters in such a way that it would prevent them from being able to undergo an endoscopy for a defined period, not in excess of the maximum NRFC thresholds, during the time that they are waitlisted.

This is not to be used for patients who are awaiting a clinical review for a reason other than their clinical condition has changed (e.g. a review in outpatients for treatment with a different clinician should not initiate NRFC – clinical.)

- **Personal:** Patients who, for personal reasons, are not yet prepared to have an endoscopy. Examples include patients with work or other commitments that preclude their attending hospital for a time. NRFC - personal can only be used for patients whose personal circumstances alter in such a way that it would prevent them from accepting an offer of an endoscopy during the time that they are waitlisted.
- **Staged:** Patients who have undergone a procedure or other treatment and are waiting for a follow-up endoscopy, where the patient is not in a position to attend hospital or to begin the process leading directly to an endoscopy, because the patient's clinical condition means that an endoscopy is not indicated until some future, planned period of time. Patients who are identified as NRFC - staged should be placed on the endoscopy procedural waiting list, with a not ready for care status in place until the last day of the preceding month when treatment is due. This does not include surveillance endoscopies, discussed in more detail in section 3.8.8 Surveillance.

Patients who advise the HHS that they are not ready for care for personal reasons must be informed of the maximum periods for deferment and that exceeding these thresholds may result in removal from the endoscopy procedural waiting list.

3.8.4 Application and use of not ready for care periods

The use and application of not ready for care periods should only occur in the following circumstances:

- **Clinical:** must only be applied under the direction of a clinician involved in the patient's care or where there is documented evidence (E.g. Emergency Department admission record) to indicate the patient was not ready for care for clinical reasons. The decision, reason and timeframe for registering a patient as not ready for care – clinical must be retained in the patient's medical record by the clinician. Where a patient notifies the hospital that they are not ready for care due to illness (e.g.: the flu), this may be recorded as NRFC – clinical and details of the conversation must be documented and retained in

the patient's medical record. Where appropriate, a clinical review should be offered to determine if the illness would prevent the patient's endoscopy from progressing.

- **Personal:** may be applied by both administration and clinical staff on direction / advice from the patient regarding their ready for care status and/or where there is evidence that the patient was not available for care for personal reasons. This is also applicable to patients who refuse an offer of a booking date for an endoscopy or pre-procedure appointment. These patients must be assigned not ready for care - deferred for personal reasons from the appointment/endoscopy date which was refused until the date of the next appointment date / booking date for the endoscopy, acknowledging that this should not exceed the maximum threshold periods for not ready for care.
- **Staged:** must only be applied under the direction of a clinician involved in the patient's care at the time of referral to the endoscopy procedural waiting list. The decision, reason and timeframe for deferment as a staged procedure must be documented and retained in the patient's medical record by the listing clinician.

3.8.5 Not ready for care thresholds and review requirements

HHSs should undertake a formal case review to determine if a patient should remain on the endoscopy procedural waiting list if a patient is NRFC for clinical and/or personal reasons for a period exceeding the following maximum number of cumulative days:

- 15 days—urgency category 4, and 1 year surveillance patients (from due date of surveillance procedure)
- 45 days—urgency category 5, and 2-5 year surveillance patients (from due date of surveillance procedure)
- 90 days—urgency category 6, and 6-10 year surveillance patients (from due date of surveillance procedure)

HHSs should:

- notify patients of the maximum NRFC thresholds at the time of placement on the endoscopy procedural waiting list
- contact patients before they exceed the maximum deferment thresholds for NRFC, and
- advise the patient that they may be removed from the endoscopy procedural waiting list if they exceed the maximum NRFC timeframes.

If a formal case review has been undertaken and the decision has been made not to remove the patient from the endoscopy procedural waiting list, the HHS must document the date that the initial formal case review was undertaken and retain a record in the patient's medical record and in the endoscopy procedural waiting list information system. If it is determined that the patient is still not clinically or personally ready for care the HHS may, at their discretion, extend the not ready for care period for a further:

- 15 days—urgency category 4, and 1 year surveillance patients (from due date of surveillance procedure)
- 45 days—urgency category 5, and 2-5 year surveillance patients (from due date of surveillance procedure)
- 90 days—urgency category 6, and 6-10 year surveillance patients (from due date of surveillance procedure)

If the patient is still not clinically or personally ready for care after the second formal case review has been undertaken, they should be removed from the endoscopy procedural waiting list and a new referral initiated when they are clinically and/or personally ready for care.

Patients who are removed from the procedural waiting list should receive written notification of their removal by the hospital that clearly states:

- reason for removal
- date of removal
- who the patient should contact if they have a query or concern.

The hospital must liaise with the patient's treating clinician prior to removal and advise the patient's referring practitioner (and nominated general practitioner where not the same), in writing, when a patient is removed from the endoscopy procedural waiting list.

Patients are entitled to appeal the decision to be removed from a public hospital endoscopy procedural waiting list through the HHS's complaint management process.

The calculation of NRFC thresholds for patients who have been re-categorised must follow the same premise as days wait calculation for upgrades or downgrades of category:

- Where a patient is reclassified to a higher urgency category, not ready for care days accrued at the lower urgency category must not be included in the count of maximum, cumulative not ready for care days for case review and removal
- Where a patient is reclassified to a less urgency category, not ready for care days accrued at the higher urgency category must be carried over and included in the count of maximum, cumulative not ready for care days.

Patients awaiting a surveillance endoscopy are excluded from the NRFC thresholds outlined above prior to the due date to their procedure. However, once their endoscopy procedure is due, the timeframes above will be applied. Upon being offered an appointment or procedure date, surveillance patients will also be subject to the requirements outlined in section 3.9.5 Management of failure to attend, and 3.9.6 Management of declined offers.

3.8.6 Pregnancy

If a patient becomes pregnant while waiting for a gastrointestinal endoscopy, a clinical review must be undertaken by an appropriate clinician and a determination made as to whether or not an endoscopy will be performed during the gestation. If it is determined that the endoscopy will not proceed, the patient may either be made not ready for care for clinical reasons, or removed from the procedural waiting list. If the patient is made not ready for care, the usual thresholds may be waived, and the patient offered a procedure date following their expected date of delivery. If it is determined that the patient is to be removed from the procedural waiting list, the patient must be given an appointment date for review in a specialist outpatient clinic postpartum.

If the patient is to be made not ready for care for the duration of the pregnancy or removed from the procedural waiting list, their referring practitioner (and nominated general practitioner where not the same) must be contacted and advised of the chosen course of action. If it is determined at the outpatient review that the patient is clinically and personally ready for care, the patient should be assigned an urgency category and registered on the endoscopy procedural waiting list. Days waited from the previous listing are unable to be carried forward in this instance and should not be included in the waiting time calculation for the new listing.

3.8.7 Calculating waiting time

Waiting time is defined as the time elapsed (in days) for a patient on the endoscopy procedural waiting list from the date they were registered on the waiting list to a designated date (e.g. census date) or the removal date, excluding any not ready for care periods and any time the patient was listed at a less urgent category.

For corporate reporting purposes and in respect to the urgency category at a census date or removal date, any days the patient was waiting at a less urgent category must be excluded from the total days waiting calculation. This means that any period a patient waited at a more urgent category and any previous period waiting at the same urgency category must be included in the total days waiting calculation method.

For further information regarding calculating waiting time for surveillance endoscopies, see section 3.8.8 Surveillance.

For patients outsourced to a private facility, the actions outlined in section 3.11.4: Outsourcing patients to private facilities must be undertaken. This will result in the outsourced patient's waiting time being suspended for the period whereby the patient is made not ready for care.

3.8.8 Surveillance

All surveillance colonoscopy recommendations regarding frequency must follow current National Health and Medical Research Council Clinical (NHMRC) Practice Guidelines for surveillance colonoscopy. Surveillance intervals for Barrett's oesophagus must comply with the Cancer Council Australia's recommended schedule. Further guidance regarding surveillance intervals and categorisation is available in the relevant Clinical Prioritisation Criteria (CPC).

Individual endoscopists, endoscopy units and HHSs should aim to achieve 90% compliance with surveillance recommendations, with regular audits performed.

HHSs should cease routine colonoscopies after the age of 75 years. This is in keeping with similar established practice for the National Bowel Cancer Screening Program. This does not prevent patients >75 years or their General Practitioners/Specialists from recommending an urgent, elective or surveillance colonoscopy, based on an individual's clinical need.

Each HHS will assume responsibility for maintaining a list of patients requiring further surveillance endoscopies. As the HHS is providing an investigative procedure conducted by a suitably qualified clinician, the HHS has assumed responsibility for ongoing care arising from this procedure. It is therefore the responsibility of the HHS to keep records of patients requiring follow-up and such obligation is in addition to any responsibility on the part of the General Practitioner.

Each HHS will assume responsibility for issuing reminders to patients requiring surveillance. HHSs must have in place rigorous record keeping and recall systems to ensure the appropriate follow-up of patients and their test results. In addition to the above, best practice requires that the patient's General Practitioner receives a copy of the reminder as both a back-up and as a courtesy to let them know that the patient is seeing the specialist and that regular surveillance is occurring. General Practitioners are encouraged to take a proactive approach to follow-up in all circumstances.

In cases where patients do not respond to attempts to be contacted, HHSs should follow the steps outlined in section 3.12: Removing patients from the waiting list.

Surveillance long wait thresholds

The due date for surveillance procedures entered into the electronic waiting list management system will align with the surveillance intervals recommended by the NHMRC for colonoscopies, or Cancer Council Australia for Barrett's oesophagus.

A long wait threshold reflecting a proportion of the recommended surveillance interval will be applied following the due date before the patient is considered to be overdue for their procedure. This will enable the procedure to take place within a reasonable timeframe following the due date.

The following timeframes reflect the long wait thresholds for the most commonly recommended surveillance intervals:

Surveillance interval	Long wait threshold
1 year	30 days
2-3 years	60 days
4-5 years	90 days
6-10 years	180 days

Long wait thresholds should be taken into account by facilities when reporting waiting list information, with only those patients whose waiting time has exceeded the relevant long wait threshold being considered to have breached their clinically recommended timeframe.

3.9 Booking and scheduling management

3.9.1 Treat-in-turn

Treat-in-turn is a model of care for waiting list management that ensures patients are treated in the order that they were placed on the list - first on, first off when all other relevant factors are equal. It is reasonable that some endoscopy patients are seen more urgently within an urgency category because of factors such as:

- the acuity of a patient's condition
- pathological process
- patient co-morbidities
- medication requirements
- patient, social and community support
- equipment availability
- utilisation of points system to facilitate optimal procedural list management
- patient access factors (e.g. distance of residence from the treating hospital; availability of transport and accommodation).

Patients who are registered on an endoscopy procedural waiting list but subsequently present and are treated as an emergency patient should be excluded from treat-in-turn calculations. Category 5 and 6 endoscopy patients who have been reclassified during the period should have the treat-in-turn calculation adjusted to take account of their new urgency category and time waited in that category as in accordance with the business rules specified in Section 3.8.6: Calculating Waiting Time.

3.9.2 Standby patients

To support full utilisation of available procedure room sessions, the HHS should identify patients who are willing to accept an offer of appointment at short notice by contacting patients and confirming that they:

- agree to be on standby
- have completed all pre-procedure investigations, assessments and preparation (including bowel preparation if applicable)
- have completed the informed consent process
- can be easily contacted (e.g. via telephone)
- have no significant co-morbidity history
- are able to arrive at the hospital for admission within three hours and reside within a reasonable travelling distance to the hospital.

Standby patients should be offered endoscopy dates based on the order they have been placed on the endoscopy procedural waiting list.

When identifying standby patients, the hospital where the patient is registered must contact the patient and confirm the patient's nominated standby timeframe (i.e. the minimum notice required to be available.) Declining an offer for a procedure where it has been offered to within an agreed standby period should not be considered a strike under the 'two strikes' policy.

3.9.3 Pre-admission assessment

Hospitals should ensure appropriate processes are in place for identifying and managing patients who require early intervention to optimise their fitness for an endoscopy and anaesthetic prior to placement on the waitlist.

A pre-admission assessment may be required for patients scheduled for an endoscopy and may be undertaken via a screening questionnaire, or a telehealth or face-to-face consultation to:

- determine the patient's readiness for the planned procedure/s
- optimise the patient's health status prior to admission
- ensure adequate preparation for hospitalisation and discharge
- maximise service efficiency.

Hospitals should have appropriate processes in place to identify and review patients where a significant period of time has lapsed between pre-admission and their procedure.

Where a patient fails to attend a pre-admission assessment, the endoscopy may be postponed and a NRFC - personal period applied from the date the patient failed to attend until the next pre-admission appointment, noting this should not exceed maximum NRFC thresholds as per section 3.8.4: *Not ready for care thresholds and review requirements*. Failure to attend two pre-admission assessments may result in removal of the patient from the endoscopy procedural waiting list.

3.9.4 Leave management

HHSs should have specific processes in place to manage planned leave for endoscopy services staff due to the critical impact that these staff have on the timely and quality provision of these services, including:

- establishment of a leave management process that is in accordance with industrial and human resource standards and is underpinned by a communication strategy
- establishment of processes to review and develop management plans for affected patients and waiting lists
- notification by Staff Specialists of approved leave to the Responsible officer, director of the service and other relevant staff no later than four (4) weeks in advance
- notification by Visiting Medical Officers of intended leave to the Responsible officer, director of the service and other relevant staff no later than four (4) weeks in advance
- timely notification to the executive management team (Director of Service, Executive Director of Medical Services or another appropriate delegate) under delegation of the HHS Chief Executive about upcoming leave that will affect pre-admission clinics and/or endoscopy lists.

3.9.5 Management of failure to attend

HHSs must ensure procedures to identify and contact patients who fail to attend their confirmed endoscopy are in place. The following principles also apply to outsourced patients and providers.

For category 4 patients who fail to attend the following principles should apply:

- a phone follow up as close as is practically possible to the scheduled time of the procedure is required and an agreement sought for a new procedure date. Following patient consultation, the reason for FTA and the new scheduled procedure date are to be documented and retained in the patient's medical record and endoscopy waiting list information system
- if the patient nominates as 'not ready for care' (NRFC), the patient will be recorded in the endoscopy waiting list information system as 'NRFC' from the date of the FTA until the date of the second appointment and the deferment period should not exceed NRFC thresholds (See section 3.8.4: Not ready for care thresholds and review requirements)
- all efforts to contact the patient should be made; however, if the patient fails to contact the HHS or provider within fourteen (14) calendar days to notify of the reason for FTA or is unable to be contacted, the patient may be removed from the endoscopy procedural waiting list following clinical review
- a clinical review of the referral is to be undertaken and the patient's referring practitioner is to be notified
- if a patient fails to attend a second confirmed appointment for the same procedure, clinician guidance must be sought to determine if the patient will be offered a subsequent procedure date or if the referral should be returned to the referring practitioner (and nominated general practitioner where not the same) for ongoing care of the patient
- the patient and referring practitioner (and nominated general practitioner where not the same) must be notified in writing of the decision to remove the patient from the procedural waiting list, the decision to transfer responsibility for ongoing care to the referring practitioner (and nominated general practitioner where not the same) and the need to initiate a new referral if the patient still requires the service in the future.

For category 5 and 6 patients and surveillance patients that fail to attend the following principles should apply:

- written notification (or other appropriate communication measures as required) of FTA for a booked endoscopy procedure, together with the appropriate requested action,

should be sent to the patient and the referring practitioner within five (5) business days of the FTA

- patients are required to contact the HHS within fourteen (14) calendar days to re-book a procedure after initially failing to attend
- if the patient fails to contact the HHS within this timeframe to notify of the reason for FTA and is unable to be contacted, the patient may be removed from the endoscopy procedural waiting list following clinical review
- hospitals should suspend the count of days waiting from the date that the patient fails to attend until they confirm a second procedure date by assigning a not ready for care status until the date of the second procedure, and the deferment period should not exceed NRFC thresholds
- patients who re-book a procedure and fail to attend the second confirmed procedure date, should be removed from the endoscopy procedural waiting list
- the patient, treating specialist and referring practitioner (and nominated general practitioner where not the same) must be notified in writing (or via appropriate communication measures) of the decision to remove the patient from the procedural waiting list, the decision to transfer responsibility for ongoing care to the patient's referring practitioner (and nominated general practitioner where not the same) and the need to initiate a new referral if the patient still requires the service in the future.

Removal from the endoscopy procedural waiting list for the same reason for referral following a total of two failures to attend a confirmed appointment applies whether the failure to attend are consecutive or not.

HHSs must implement strategies to reduce FTA rates. These may include (but are not limited to):

- keeping the patient and the referring practitioner (and nominated general practitioner where not the same) informed through written and verbal communication that the patient is registered on an endoscopy procedural waiting list
- implementing systems to have patients confirm offers of procedure dates
- telephone or SMS reminders of booked appointments 1-7 calendar days prior to the procedure date
- potential redirection of referrals to another HHS that can provide the service closer to the patient's residential address
- follow-up visits only as clinically required and with the consent of the patient
- discharge of patients to the care of the referring practitioner (and nominated general practitioner where not the same) on completion of treatment
- regular administrative auditing and clinical review of patients on the procedural waiting list.

3.9.6 Management of declined offers

Patients should only be offered a maximum of two booking dates for the procedure for which they are waitlisted on a public hospital's waiting list. This excludes offers made and withdrawn by the provider (i.e. hospital-initiated cancellations).

Patients who refuse a second offer of a booking date for an endoscopy should be removed from the endoscopy procedural waiting list on the basis that they are not ready for care, unless there are extenuating circumstances which the Service Director agrees warrants offering the patient a third booking date for an endoscopy. This includes offers for endoscopies under an outsourcing arrangement.

All booking dates for endoscopies that are offered to patients must be documented by the provider (either public or private where outsourced) who contacted the patient along with the reason for any refusals. After declining an offer for pre-procedure appointment or endoscopy, patients must be advised that declining a second offer for a procedure may result in removal from the endoscopy procedural waiting list.

An offer can only be considered as 'declined' where the HHS has received acknowledgement that the patient has received the offer with sufficient notice. E.g.: If a patient is sent a booking letter by post but fails to receive the mail in time, this should not be considered a decline of an offer for an endoscopy.

A minimum seven (7) days' notice for Category 4 and a minimum 14 days' notice for Category 5 and 6 patients and surveillance patients for an offer of an endoscopy may be deemed sufficient before it is considered a decline of an offer.

Patients who refuse a first offer of a booking date for a pre-procedure appointment or endoscopy should be assigned NRFC – personal from the booking date offered until the date of the second appointment or endoscopy date. NRFC periods applied for the management of declined offers must comply with section 3.8.4: Not ready for care thresholds and review requirements and not breach NRFC thresholds.

When a patient is to be removed for declining two offers, the public hospital where the patient is waitlisted must liaise with a clinician involved in the patient's care prior to removal and advise the patient's referring practitioner (and nominated general practitioner where not the same), in writing, when the patient is removed from the endoscopy procedural waiting list, with the reason for removal.

Patients are entitled to appeal the decision to be removed from a public hospital endoscopy procedural waiting list through the HHS's complaint management process. The above principles also apply to outsourced patients and providers

3.10 Cancellations

3.10.1 Management of hospital-initiated cancellations

A hospital-initiated cancellation is defined as any rescheduling of a patient's endoscopy booking date, for a reason that is related to the hospital's inability to proceed with the endoscopy. When a hospital-initiated cancellation occurs, the hospital is required to:

- notify the patient as soon as possible that their endoscopy has been cancelled
- make arrangements for the endoscopy to be undertaken on the next available list
- keep an accurate record of the postponement and the reason
- maintain the patient's current ready for care status on the endoscopy procedural waiting list.

Patients who have already arrived at the hospital should not be postponed without the approval of a member of the executive management team (Director of Gastroenterology, Executive Director of Medical Services or another appropriate delegate) under delegation of the HHS Chief Executive. This is particularly relevant to those who have already undergone bowel preparation.

Patients should not incur a second hospital-initiated cancellation of their date for endoscopy if it will cause the patient to wait longer than their clinically recommended timeframe. Where this is clinically unavoidable, the patient should be appropriately booked on the next available list, or arrange alternative treatment at another public or private hospital.

When a hospital-initiated cancellation occurs, the patient must be advised of:

- the reason for cancellation
- a rescheduled endoscopy date
- what to do if their condition deteriorates.

Where the patient has already arrived at the hospital and their endoscopy is cancelled due to a hospital-initiated reason, a subsequent endoscopy date should be provided to the patient prior to them leaving the hospital.

HHSs are not permitted to suspend the count of days waiting by assigning patients a not ready for care period for hospital-initiated cancellations under any circumstances.

HHSs should ensure local escalation policies and procedures are in place for the review and approval of hospital-initiated cancellations on the day of the endoscopy to ensure all alternatives and considerations have been investigated prior to the decision to cancel the endoscopy.

3.10.2 Management of patient-initiated cancellations

When a patient cancels a date for an endoscopy for personal reasons, a patient-initiated cancellation must be recorded.

Patients who decline an endoscopy date and/or appointment on two occasions will be deemed to have declined treatment. A patient may be removed from the endoscopy procedural waiting list if they decline, cancel and/or fail to arrive for a second appointment and/or endoscopy date for the same procedural waiting list episode.

The hospital must send notification to the patient's treating clinician and referring practitioner (and nominated general practitioner where not the same), in writing, of the removal of these patients from the procedural waiting list, within five days of removal, where the patient is classified as urgency category 5 or 6 or surveillance.

Urgency category 4 patients are not to be removed from the endoscopy procedural waiting list without the approval of the treating clinician and a member of the executive management team under the delegation of the HHS Chief Executive.

If a patient cancels a date for an endoscopy for personal or clinical reasons, or fails to arrive for an endoscopy, the hospital can suspend the count of days waiting from the date of the cancelled endoscopy booking or failure to attend by assigning not ready for care—personal until the next appointment / endoscopy date. However, the NRFC timeframe should not exceed the maximum NRFC period as per section 3.8.4: Not ready for care thresholds and review requirements.

Where patients are offered and subsequently decline an offer for a standby booking, this must not be recorded as a patient-initiated cancellation given the short notice. See Section 3.9.2: Standby patients.

3.11 Transferring and outsourcing patients

HHSs must proactively monitor waiting times and take decisive action to ensure patients are treated within the clinically recommended timeframe. Decisive action should include reviewing all internal options prior to transferring or outsourcing patients.

Internal options should include, at minimum:

1. increasing internal capacity at the hospital where the patient is waitlisted either by allocating additional procedure room time or substituting procedure room sessions with another specialist and/or specialty
2. transfer of care from one Queensland Health employed clinician to another within the same specialty and hospital/HHS.

Where internal options are not possible, options for transferring patients to other public hospitals or outsourcing to private providers should be considered as below:

External options:

1. the option for transfer to another public hospital that provides the services and where a shorter waiting time for endoscopy is available
2. the option for outsourcing to a private facility with appropriate service capability to deliver the service and where a shorter waiting time for endoscopies are available. It is the responsibility of the contracting entity to establish and monitor the safety, quality and efficiency of agreements with private providers to enable the transfer of patients in a timely manner.

For the purpose of clarity, the following terms are used quite distinctly to differentiate between:

- **Transfers:** where patients are referred from one public hospital to another public hospital for treatment
- **Outsourcing:** where patients are referred from a public hospital to a private facility for treatment.

3.11.1 Principles for patient transfers and outsourcing

The best interests of the patient must take precedence over the interests of the referring and receiving hospital.

- The treatment option chosen should result in the patient receiving their endoscopy within or, where not possible, as close as possible to the clinically recommended timeframe for the patient's urgency category. The option must take account of the time it typically takes to transfer the care of a patient to another public or private provider, including the time it takes for the receiving provider to conduct a clinical review prior to accepting the care of the patient, as well as the typical time lag in securing a booking date with the provider.
- The patient must be notified prior to arrangements being made for transfer or outsourcing.
- The HHS should have defined governance processes for identifying and approving patients for transferring and outsourcing which should include, at minimum, notification to the listing clinician.
- Each HHS/hospital must nominate a responsible officer for coordinating patient transfers and outsourcing. The responsible officer at the referring HHS must contact the responsible officer at the receiving HHS/hospital prior to initiating a patient transfer and/or outsourcing.

- For outsourcing to the private sector, patients must provide consent for transfer of relevant medical records and patient information between the public and private providers. Evidence of informed consent (written or verbal) must be documented and retained in the patient's medical record.
- The patient must be advised of indicative and comparative timeframes for treatment at each hospital (referring and receiving) when transferring or outsourcing is offered.
- Where the receiving hospital has accepted patients who have or will exceed clinically recommended waiting times, they should retain a record of such patients for reporting at the Relationship Management Group meeting.
- Where a patient accepts an offer for transfer or outsourcing to another treating clinician or hospital, appropriate arrangements must be made for:
 - notification of changes to the treating clinician and referring practitioner (and nominated general practitioner where not the same) by the referring hospital
 - documentation of the transfer details which are to be retained in the patient's medical record and recorded in the endoscopy waiting list information system by the referring hospital
 - assessment of the patient by the receiving treating clinician who will undertake the endoscopy (where required).
- Where a patient declines an offer for an endoscopy with another treating clinician or at another hospital (public or private) which is within 50km of the patient's nearest public hospital to enable treatment within (or, where not possible, as close as possible to) clinically recommended timeframes, this should be recorded as a decline of an offer for an endoscopy and an appropriate NRFC period applied. However, this should only be applied where all of the following criteria are met:
 - the patient was provided with the necessary information to make an informed decision regarding their wait for an endoscopy. This includes being provided with the planned date for endoscopy in the alternate hospital being offered compared to the expected waiting time should they choose to decline and remain at the originally waitlisted hospital, and
 - the patient was notified at the time of placement on the procedural waiting list that their treatment may be provided by another doctor and/or at another Queensland Health hospital or private facility contracted to provide public services, and
 - the patient has been advised of the implications on their eligibility for the Patient Travel Subsidy Scheme (PTSS).

Where the above criteria have been met, the NRFC period applied should be from the date offered at the alternate hospital until the next available vacant endoscopy slot at the originating hospital (as at the time of the decision). Where this deferment period exceeds the maximum NRFC thresholds as per section 3.8.4: Not ready for care thresholds and review requirements, the patient may be allowed to remain on the procedural waiting list; however, a formal case review must be undertaken to assess their clinical urgency and suitability.

Details regarding offers of endoscopy at alternate hospitals must be clearly documented and retained in the patient's medical record including:

- date the patient was contacted
- what information was provided to the patient (e.g. endoscopy date offered at alternate hospital, estimated waiting times if declined etc.)
- the patient's decision and outcome.

3.11.2 Patients who permanently relocate from one HHS to another

Patients should be provided the treatment option that will result in an endoscopy within (or where not possible, as close as possible to) their clinically recommended timeframe and as close as possible to their place of residence.

Patients who are currently registered on a public hospital endoscopy procedural waiting list, who permanently relocate, should be entitled to transfer to the nearest public hospital regardless of their current waiting time provided there is a public hospital closer to where they now permanently reside that has the service capability to safely perform the procedure.

The nearest public hospital to the patient's new permanent place of residence must not decline to accept the transfer and the patient's waiting time must continue to accrue. If the patient has been waiting longer than clinically recommended the Chief Executive (or their nominated delegate) of the receiving HHS must be notified by the responsible officer prior to the acceptance of the transfer.

However, if the patient's endoscopy can be offered within (or where not possible, closer to) their clinically recommended timeframe at the original hospital where it is within 50km of their new nearest public hospital, the patient must be notified prior to transferring. If the patient declines the earlier offer for an endoscopy at the original hospital, they can be made NRFC - personal for declining as per section 3.8.2: Not ready for care.

Where a patient is transferred from one public hospital's endoscopy procedural waiting list to another due to permanently relocating, the days wait which the patient has already accrued at the referring hospital must be carried over to the receiving hospital.

Transfer to another public hospital should be organised by the HHS where the patient is registered at the time of the request. The referring hospital must communicate with the responsible officer at the receiving hospital and provide (at minimum):

- a copy of the original endoscopy booking form
- copy of the patient contact details and registration screen details, including referring and nominated general practitioner details (where not the same) and next of kin details
- confirmation of any NRFC periods (previous, current and future)
- confirmation of any previous categorisation changes
- details of any previous booking cancellations and/or FTAs.

It is the responsibility of the nominated officer at the referring hospital to notify the patient and referring practitioner (and nominated general practitioner where not the same) of the outcome of the transfer request.

The responsible officer at the receiving hospital must:

- provide confirmation of receipt of the transfer request within two business days
- arrange an appropriate clinical review of the patient transfer request and/or patient (where required) and notify the referring hospital regarding the decision to accept or reject the transfer request as soon as possible following the review. As per section 3.8.3: Not ready for care, a patient cannot be NRFC whilst awaiting a clinical review unless it is due to a change in their clinical condition. Hence it is advantageous for the receiving

hospital to facilitate the review of the transfer request and/or patient as soon as possible from the time the transfer request is received to ensure the patient can be treated within their clinically recommended timeframe.

Where a patient is transferred from one public hospital to another due to relocating, they are not to be removed from the referring hospital's procedural waiting list until such time as the receiving public provider has undertaken a suitable clinical review of the transfer request and/or patient (as required) and confirmed in writing that they will provide the endoscopy for the patient. Upon confirmation that the receiving public hospital provider has accepted the patient, the patient's waiting list status must be updated to 'transferred to other Queensland Health facility' at the hospital where the patient was originally waitlisted.

When the patient is registered on the receiving hospital's procedural waiting list, the patient's placed on list date must be backdated to match the date the patient was originally added to the procedural waiting list of the referring hospital and the patient should be treated in-turn. Any prior periods of deferment or category changes must also be recorded in the endoscopy waiting list information system at the receiving hospital to allow the total days waiting for the patient to accurately reflect the original patient record.

Following confirmation that the receiving hospital has accepted the patient, the patient must be contacted by the receiving hospital to notify the patient of their responsibility to provide:

- name and contact details for their nominated general practitioner at the new place of residence
- updated contact details

If the above information is not received within 30 calendar days, an administrative audit process should be commenced. If the patient fails to respond to two audit measures, the patient may be removed from the endoscopy procedural waiting list as per section 3.12: Removing patients from the waiting list.

3.11.3 Patients who are transferred from one public hospital to another

Where a patient consents to being treated in another public hospital, the HHS where the patient is currently registered must organise treatment in another public hospital with the capability to provide the endoscopy service. The public hospital where the patient is registered must retain the patient on their public hospital procedural waiting list until such time as the receiving public provider has undertaken a suitable clinical review of the transfer request and/or patient (as required) and confirmed in writing that they will provide the endoscopy for the patient, ideally, on a given date. This is done to mitigate the risk of the patient becoming lost in the transfer process and to ensure that responsibility for the finalisation of the patient's care is retained by the referring hospital.

Upon confirmation that the receiving public hospital has accepted the patient, the patient's waiting list status must be updated to 'transferred to other Queensland Health facility' at the hospital where the patient was originally waitlisted.

The receiving public hospital that agreed to accept the patient must register the patient on their endoscopy procedural waiting list and record the date as when they were initially registered on the referring hospital's endoscopy procedural waiting list.

In addition, the referring hospital must provide details as described above in section 3.11.2: Patients who permanently relocate from one HHS to another to allow the total days waiting for

the patient on the receiving hospital's procedural waiting list to accurately reflect the original patient record.

The responsible officer at the receiving hospital must:

- provide confirmation of receipt of the transfer request within two business days (48 hours)
- arrange an appropriate clinical review of the patient transfer request and/or patient (where required) and notify the referring hospital regarding the decision to accept or reject the transfer request as soon as possible following the review. As per section 3.8.3: Not ready for care, a patient cannot be NRFC whilst awaiting a clinical review unless it is due to a change in their clinical condition. Hence it is advantageous for the receiving hospital to facilitate the review of the transfer request and/or patient as soon as possible from the time the transfer request is received to ensure the patient can be treated within their clinically recommended timeframe.

It is the responsibility of the referring hospital to notify the patient and referring practitioner (and nominated general practitioner where not the same) of the outcome of the transfer request.

3.11.4 Outsourcing patients to private facilities

For outsourced services, a service agreement between the HHS and private provider should clearly identify the service with the responsibility for each aspect of clinical and administrative service provision. This includes clear articulation of which service will provide ongoing care if required e.g. further surveillance endoscopies or surgery, and the process by which the endoscopy report will be provided back to the HHS.

When a patient consents to being treated in a private facility, the HHS where the patient is currently registered must independently organise and pay for treatment in a private facility with the capability to provide the gastrointestinal endoscopy service, using locally negotiated or state-wide contracts or standing order arrangements.

When a patient is outsourced to another facility at a cost to the referring hospital, all relevant details must be recorded in the electronic waiting list management system. Service events should be recorded as per the requirements of the Monthly Activity Collection manual or Queensland Health Admitted Patient Data Collection to ensure that activity is appropriately recorded.

This includes at a minimum:

- The outsource request date
- The acceptance date
- The facility the patient has been referred to
- The date of treatment or removal, as advised by the contracted facility.

When a patient is referred to a private facility, they are not to be removed from the referring hospital's procedural waiting list until confirmation that the patient has been treated or until sufficient evidence that the patient no longer requires the procedure has been obtained.

If the patient is accepted for treatment at another facility but is subsequently unable to be treated and is returned to the referring hospital, the return date must be recorded in the electronic waiting list management system.

It is the responsibility of the referring HHS where the patient is waitlisted to monitor waiting times and ensure that patients are offered the option that will enable access to an endoscopy as close as possible to their clinically recommended timeframe and the patient's place of residence.

3.11.5 Conflicts of interest

HHSs are responsible for monitoring and managing actual, or perceived, conflicts of interest in relation to the flow of publicly waitlisted patients to private providers including through direct contractual arrangements between the HHS and private providers.

Examples of evidence that may be considered when monitoring conflicts of interest may include:

- The urgency category assigned by the treating specialist aligns with Clinical Prioritisation Criteria (CPC), where available.
- The treating specialist has submitted to the HHS a proposed appointment date for care in the private sector which is earlier than the appointment date that the HHS could provide.
- Another publicly employed specialist within 50km of the patient's nearest public hospital could not treat the patient within the clinically recommended timeframe or on a date prior to the date that the treating specialist could treat them in the private sector. It is recommended that documentation to support this is included in the patient's medical record.

3.11.6 Patients transferred to another public hospital based on clinical need

Patients who have been placed on a hospital's procedural waiting list and who, following later assessment (e.g. at pre-anaesthetic clinic) are identified as not being suitable for an endoscopy at the original hospital due to clinical complexity beyond the scope of the original hospital, should be referred to the nearest public hospital with the clinical services capability to provide the endoscopy.

When arranging the transfer of such patients, the public hospital where the patient is originally registered must provide a clinical letter of referral to the receiving hospital to validate the need for transfer and to ensure supporting details on the patient's condition are communicated.

Patients should be provided the option to receive treatment as close as possible to their place of residence where it is clinically safe and appropriate to do so.

Where a patient is transferred from one public hospital to another based on clinical need, they are not to be removed from the referring hospital's procedural waiting list until written confirmation of acceptance from the receiving hospital has been obtained.

When the patient is registered on the receiving hospital's procedural waiting list, the patient's placed on list date must be backdated to match the date the patient was originally added to the procedural waiting list of the referring hospital and the patient should be treated in-turn. Any prior periods of deferment or category changes must also be recorded in the endoscopy waiting list information system at the receiving hospital to allow the total days waiting for the patient to accurately reflect the original patient record.

3.12 Removing patients from the waiting list

A patient should only be removed from a hospital's endoscopy procedural waiting list for any of the following reasons:

- The patient's treatment has been finalised
- The patient fails to attend, cancels and/or declines two offers of endoscopy and/or pre-operative appointment for the same procedural waiting list episode
- The patient fails to respond to two audits (clinical and/or administrative) within a minimum of 14 days from the second audit measure
- The patient no longer requires the endoscopy for which they are listed
- The patient advises they have or will be attending elsewhere for treatment for the same waitlisted procedure under their own arrangements
- The patient requests to be removed from the procedural waiting list
- The patient has accepted transfer to another public hospital and the receiving hospital has confirmed acceptance of the patient onto their procedural waiting list
- The patient has been outsourced to another private facility and has been treated
- The patient exceeds their deferred not ready for care threshold for their assigned category (not applicable to staged deferments)
- The patient dies
- The treating clinician requests removal of the patient from the procedural waiting list for clinical reasons

Removals from the endoscopy procedural waiting list, other than as a result of the patient having undergone an endoscopy or being deceased, should be authorised by the treating clinician, or in their absence the head of unit or a delegated senior clinician, and approval documented and retained in the patient's medical record.

Where a patient is removed from the procedural waiting list due to failure to respond to two audit measures, evidence of a reasonable effort to contact the patient must be recorded and retained in the patient's medical record at the time the patient is removed from the procedural waiting list.

Where a patient has received treatment at another hospital/facility, the HHS must ensure that they have appropriate procedures and processes in place to adequately document and confirm with the patient (or their provider in the event of outsourcing and transfers) that they have received the awaited procedure at another hospital prior to removal from the procedural waiting list.

When a patient is removed from the endoscopy procedural waiting list:

- The patient (except where deceased), the referring practitioner (and the nominated general practitioner where not the same) and the treating clinician (if not the authorising officer) must be notified including details of the reason for removal, date of removal and who to contact if they have any queries.

- Appropriate documentation must be retained in the patient's medical record and the electronic waiting list record.

Any patient who is removed from a HHS's endoscopy procedural waiting list at their own request (without having undergone an endoscopy at another health service) should be advised to contact their referring practitioner and/or general practitioner to discuss the potential risks associated with not proceeding with the endoscopy and options for alternative management.

A patient who has been removed from a procedural waiting list and contacts the service within 30 days of removal may be reinstated to their original position on the procedural waiting list at the discretion of the HHS.

3.13 Validation of waiting lists

HHSs must keep accurate records of endoscopy procedural waiting list information including any change to a patient's clinical urgency category, ready for care status or scheduled admission date. The records must also include the reasons for the change, substantiating evidence where appropriate, and the name of the person who authorised the change.

Any change to a patient's booking or procedural waiting list status should be recorded and retained in their medical record including:

- a change to the patient's ready for care status
- a change to the patient's clinical urgency category
- removal of a patient from the hospital's procedural waiting list.

Where verbal notifications or communications with a patient or nominated next of kin have taken place, a record of the conversation should be retained in the patient's medical record including:

- date and time of the conversation
- names of the people involved in the conversation
- key points of discussion.

This may include but is not limited to details of:

- declined offers of appointments and endoscopies and reasons for declining
- not ready for care periods
- information provided to patients regarding policy requirements (e.g. NRFC thresholds, FTA rules etc.)
- advice regarding estimated waiting times for endoscopies
- patient enquiries.

3.13.1 Clinical and administrative audits

HHSs must manage a system of administrative and clinical audits to ensure that the endoscopy procedural waiting list provides an accurate record of patients waiting for endoscopies.

When undertaking an audit, all reasonable efforts should be made to contact the patient including:

- contacting the patient's referring medical or nominated general practitioner
- accessing the hospital's medical records and utilising The Viewer
- contacting the patient's nominated next of kin or contact searches of the telephone directory.

Removing a patient from the endoscopy procedural waiting list for failing to respond to two audit measures should only occur after the patient has failed to respond within, a minimum of, 14 days of the second audit measure.

Administrative audits of the endoscopy procedural waiting list should occur on a regular, ongoing basis. At a minimum, an audit should be undertaken at the time that a patient breaches the clinically recommended timeframe.

The administrative audit of the endoscopy procedural waiting list requires contacting patients via telephone, letter or other appropriate method to obtain the following information:

- current contact details
- details of current general practitioner
- confirmation that an endoscopy is still required (i.e. has not had the endoscopy elsewhere)
- clarification that the patient is ready for care
- clarification regarding whether the patient is on a procedural waiting list at another hospital for the same or another procedure.

A range of other administrative audits should be maintained to ensure procedural waiting lists are up-to-date and accurate and that management practices are in accordance with this standard.

Clinical audits should be undertaken in the following circumstances:

- on the request of the referring practitioner, nominated general practitioner or treating clinician
- when a patient has breached not ready for care thresholds.

The hospital should also ensure processes are in place to regularly conduct clinical reviews of patients on the hospital's procedural waiting list, where appropriate, to determine if:

- the endoscopy is still required (i.e. the patient's treatment plan and/or condition has not changed)
- there is any change in clinical status, or change in priority

- the clinical urgency category remains appropriate
- the patient is fit to proceed to endoscopy
- the patient should be removed from the endoscopy procedural waiting list.

3.14 Communication requirements

HHSs are responsible for communicating with relevant clinicians and patients regarding aspects of the patient's interaction with endoscopy services. In circumstances where the referring practitioner is not the patient's nominated general practitioner, HHSs should ensure that the patient's nominated general practitioner is also kept informed regarding the patient's treatment.

The communication process and method of transmission should be flexible according to the information required and the intended audience and needs to be inclusive of:

- different styles to suit the intended message and the audience – written, telephone, SMS, video, face-to-face
- special needs – interpretation, translation, cultural differences
- privacy requirements - HHS staff should refer to the relevant cyber security and information security policies and standards when determining appropriate communication mediums. This includes, but is not limited to, responsibilities when emailing clinical and organisational sensitive information.

HHSs should inform the patient regarding:

- confirmation of placement on a hospital's endoscopy procedural waiting list, including the following details:
 - the listed procedure
 - clinical urgency category
 - date of placement on the procedural waiting list
 - the course of action to be followed if changes occur in their clinical condition
 - patient rights and responsibilities (e.g. advising of any change of name, address or telephone number, or inability to attend appointments)
 - that in order to treat patients within (or, where not possible, as close as possible to) clinically recommended timeframes, their endoscopy may be performed by a clinician other than who referred the patient and/or at another hospital
- appointment and endoscopy offers, with sufficient and reasonable notice, including details of: time, date, location, what to bring (e.g. x-rays, investigation results, medications), how to prepare as well as any other special requirements (if applicable)
- postponements / rescheduling of offered appointment or endoscopy dates
- the time within which to confirm appointments/endoscopy dates
- how to confirm, reschedule or cancel appointments/endoscopy dates
- the 'two-strikes' policy for patient-initiated cancellations

- maximum thresholds for deferment
- changes to the patient's clinical urgency category
- removal from the procedural waiting list including the reason, date of removal and what to do if treatment is still required
- their responsibility to notify the hospital of any changes to their nominated general practitioner and next of kin details.

HHSs should inform the referring practitioner (and nominated general practitioner where not the same), where applicable, regarding:

- confirmation of the patient's placement on a hospital's endoscopy procedural waiting list, including details of:
 - the listed procedure
 - clinical urgency category
 - date of placement on the procedural waiting list
 - the referring practitioner's (and, where not the same, nominated general practitioner's) responsibility to continue to monitor the patient's condition and notify the hospital if there is a change in the patient's condition
- changes to the patient's clinical urgency category
- confirmation of the patient's completed endoscopy and post-procedure instructions
- removal of the patient from the procedural waiting list including the reason and date of removal.

Designated staff should respond to information requests made by referring practitioners and nominated general practitioners to support the achievement of timely clinical outcomes and effective referral practices. Referring practitioners and general practitioners may request access to information regarding:

- status of endoscopy procedural waiting lists
- estimated waiting times
- Clinical Prioritisation Criteria (where applicable)
- special requirements (as applicable).

3.14.1 Department of Corrective Services

Patients from the Department of Corrective Services, including correctional centres, watch houses and secure mental health facilities must be accorded the treatment available to all patients – however, for security reasons, the patient and their relatives must not be informed of endoscopy appointment details. In such instances, details of dates for any appointments or endoscopies must be directly conveyed to the delegate from the Department of Corrective Services or appropriate authority.

3.15 Reporting requirements

In addition to the minimum reporting requirements that form part of HHS Service Agreements, HHSs should seek to undertake regular monitoring, review and analysis of procedural waiting list activity, dynamics and performance. This is to ensure a proactive approach to procedural waiting list management whereby capacity issues can be identified and acted on early to ensure waiting times remain appropriate and are sustainable.

Hence, it is recommended that at minimum, the following metrics should be reported and monitored by HHSs on a regular basis (census each month):

- number of long waits at census by category
- number of booked and unbooked at-risk patients who are due for treatment over the following 30, 90 and 365 days to ensure there is sufficient capacity to manage existing procedural waiting lists as well as additional referral trends
- proportion of patients treated in clinically recommended timeframes by category
- number of patients treated from the endoscopy procedural waiting list
- number of patients added to the endoscopy procedural waiting list
- number of patients removed from the endoscopy procedural waiting list including:
 - all removal reasons
 - removals where treatment was not required
 - removals where treatment was provided elsewhere
- hospital and patient-initiated cancellation rates (Day of procedure and total cancellations)
- proportion of patients treated in turn
- list of patients who have or will exceed maximum NRFC thresholds.

4. Aboriginal and Torres Strait Islander considerations

Queensland public hospital services and staff recognise and commit to the respect, understanding and application of Aboriginal and Torres Strait Islander cultural values, principles, differences and needs when caring for Aboriginal or Torres Strait Islander patients.

Each individual HHS is responsible for achieving successful provision of culturally appropriate endoscopy services to and with Aboriginal and Torres Strait Islander individuals and their communities within the respective HHS catchment.

Equally, the respect and acknowledgement extended to Aboriginal and Torres Strait Islander people will be extended to all participants, irrespective of ethnic background or membership of community group

5. Supporting documents

5.1 Legislation

- Hospital and Health Boards Act 2011. <https://www.legislation.qld.gov.au/view/html/inforce/2017-03-05/act-2011-032>

5.2 Authorising policy and standards

- Gastrointestinal Endoscopy Services Policy

5.3 Related documents

- Specialist Outpatient Services Implementation Standard
- Elective Surgery Implementation Standard

6. Definitions

Term	Definition/Explanation/Details	Source
Census date	Date on which the hospital takes a point in time (census) count of and characterisation of patients on the procedural waiting list.	Australian Institute of Health and Welfare – Metadata Online Registry
Clinical audit	Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change.	National Institute of Health and Clinical Excellence
Clinical review	A clinical review is a review of the patient's medical record and/or referral by an appropriately qualified clinician with the ability to make decisions regarding changes to the patient's urgency category or treatment pathway.	
Clinical urgency	A clinical assessment of the urgency with which a patient requires hospital care, as represented by a code.	Australian Institute of Health and Welfare – Metadata Online Registry
Day procedure	An operation/procedure, excluding an office or outpatient operation/procedure, where the patient would normally be discharged on the same day.	Australian Day Surgery Council

Term	Definition/Explanation/Details	Source
Endoscopy booking form	A form required to be completed by the listing clinician to request registration of a patient onto the endoscopy procedural waiting list. This may be a paper or electronic form.	
Endoscopy procedural waiting list	A repository listing all patients waiting for gastrointestinal endoscopies and their planned procedure details.	
General Practitioner	<p>The General Practitioner (GP) is the patient's usual first point of contact in relation to a personal health issue and is responsible for coordinating the care of the patient.</p> <p>The nominated General Practitioner is the GP that the patient has nominated as their regular GP and is recorded as the General Practitioner in the patient's registration details on the HHS's patient administration system (e.g. HBCIS Registration Screen).</p> <p>NB: The nominated general practitioner may differ to the referring practitioner where a practitioner other than the patient's usual GP has referred the patient to the gastrointestinal endoscopy service. See definition for <i>Referring practitioner</i>.</p>	
Listing Clinician	The clinician responsible for the decision to place the patient on the endoscopy procedural waiting list.	

Term	Definition/Explanation/Details	Source
Medical Record	<p>A collection of data and information gathered or generated to record the clinical care and health status of an individual or group.</p> <p>NOTES:</p> <ol style="list-style-type: none"> 1. This includes information such as assessment findings, treatment details, progress notes, registration and information associated with care and health status. 2. The term 'health record' includes paper-based health records, clinical records, medical records, digitized health records, Electronic Health Records, healthcare records and personal health records. 3. Personal health records have specific variations which should be taken into consideration when applying this Protocol. 	<p>Australian Standard AS 2829.1-2012 as referred to in QH-IMP-279-2:2013</p> <p>Documentation of date and time in the paper based health record</p>

Term	Definition/Explanation/Details	Source
<p>Not ready for care (NRFC) Not ready for surgery (NRFS)</p>	<p>Clinical - Patients for whom an endoscopy is indicated, but not until their clinical condition is improved, for example, as a result of a clinical intervention. For such patients, a decision has already been made that an endoscopy should take place. Patients should not be regarded as 'not ready for care—pending improvement of their clinical condition' when they are undergoing routine monitoring or investigations before a decision is made as to whether an endoscopy is required.</p> <p>Personal – Patients who for personal reasons are not yet prepared to undergo a procedure. Examples include patients with work or other commitments that preclude their attending hospital for a time.</p> <p>Staged - Patients who have undergone a procedure or other treatment and are waiting for a follow-up endoscopy, where the patient is not in a position to attend hospital or to begin the process leading directly an endoscopy, because the patient's clinical condition means that the endoscopy is not indicated until some future, planned period of time.</p>	<p>Australian Institute of Health and Welfare – Metadata Online Registry</p>
<p>Ready for care (RFC) Ready for surgery (RFS)</p>	<p>Patients who are prepared undergo a procedure or to begin the process leading directly to an endoscopy.</p>	<p>Australian Institute of Health and Welfare – Metadata Online Registry</p>
<p>Referring practitioner</p>	<p>The practitioner who initiated the referral of the patient for an endoscopy. This may or may not be the patient's general practitioner.</p>	
<p>Specialist</p>	<p>A registered medical professional who has been assessed by an Australian Medical Council accredited specialist college as having the necessary qualifications in the approved specialty to be included on the Specialist Register.</p>	<p>Medical Board of Australia</p>
<p>Treating clinician</p>	<p>The clinician responsible for providing the endoscopy for the patient. This may or may not be the same as the listing clinician.</p>	

Term	Definition/Explanation/Details	Source
Treat-in-turn	Patients are treated in accordance with their urgency category but, within each urgency category, most patients are treated in the same order as they are added to the waiting list.	Australian Institute of Health and Welfare 2013. National definitions for elective surgery urgency categories: Proposal for the standing council on Health. Cat. No. HSE 138. Canberra: AIHW
Waiting time	The time elapsed (in days) for a patient on the endoscopy procedural waiting list from the date they were added to the procedural waiting list for the procedure to the date they were removed from the waiting list.	Australian Institute of Health and Welfare – Metadata Online Registry

7. Version control

Version	Date	Comments
V 1.0	December 2018	Final version for publication, revised post consultation