Elective Surgery Services Implementation Standard

Department of Health Standard
QH-IMP-342-1:2017

1. Statement

The Elective Surgery Services Implementation Standard outlines the suite of business rules and processes for ensuring equitable access for all patients requiring elective surgery 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

Elective surgery is defined as planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery waiting list.

The standard applies to all patients who are registered on an elective surgery waiting list 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 elective surgery services as defined by the Australian Institute of Health and Welfare Metadata Online Registry (METeOR) – elective surgery waiting list episode – surgical specialty.

2.1 Out of scope

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

- Emergency surgery - surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery at a later time following this unplanned presentation. This includes where the patient leaves hospital and returns for a subsequent admission. Emergency surgery includes unplanned surgery for admitted patients and unplanned surgery for patients already awaiting an elective surgery procedure (for example, in cases of acute deterioration of an existing condition)
- Elective caesareans and medical inductions of labour - appropriate guidance on business rules and clinical decision-making for patients requiring these procedures should be obtained from Queensland Health's *Maternity Clinical Guidelines*
- Procedures that are not publicly funded in Queensland
- Any surgery that is excluded from the national definition of elective surgery - E.g. transplants, endoscopic procedures, diagnostic/investigative procedures (biopsies), cosmetic procedures, non-Medicare Benefits Schedule rebatable dental procedures, in-vitro fertilisation/assisted reproductive technology procedures.

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

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3. Requirements

3.1 Guiding principles

Provision of elective surgery services in Queensland public Hospital and Health Services (HHSs) must be in accordance with the details contained in the business rules for the National Healthcare Agreement and HHS Service Agreements.

Elective surgery services should:

1. have patients and 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 surgery 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 surgery 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. minimise the time patients are not ready for surgery through early and active management of comorbidities
10. provide patients with information that identifies their rights and responsibilities and the process for lodging compliments and complaints.
11. be coordinated to promote the most effective use of available resources
12. be the shared responsibility of the health service, listing and treating surgeon, the referring practitioner and the nominated general practitioner
13. ensure transparent, valid and reliable record keeping (electronic and written) and reporting is maintained
14. ensure referrals for surgery are clinically appropriate and represent the most suitable treatment for the patient's reason for referral
15. 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
16. exercise discretion to avoid disadvantaging patients in the case of hardship and other extenuating circumstances
17. consider the principles and requirements of the *Elective Surgery Services Implementation Standard* when entering into collaborative arrangements with private elective surgery providers.

3.2 Eligibility

Eligible patients are those patients who have been referred via a valid referral, are registered on an elective surgery waiting list and:

- have a condition that cannot be managed by a primary healthcare practitioner and for whom there is evidence that all non-surgical treatment options have been pursued unsuccessfully prior to registration on the elective surgery waiting list **and**
- are awaiting surgery for a procedure listed within the scope of publicly-funded services **and** are either:
  - Medicare eligible (including 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.

Elective surgery 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 elective surgery is only possible through registration of patient details on the elective surgery waiting list of a HHS.

The responsibility of HHSs to provide elective surgery 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. In the case of state-wide surgical services, HHSs have a responsibility to provide services to the whole of Queensland
- self-assessed surgical service capability (as defined by Queensland Health's Clinical Services Capability Framework)
- the volume and type of surgical 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 surgical service.

It is mandatory for HHSs to accept elective surgery 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 surgical service capability to provide the service 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 surgery for that service, 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 elective surgery, and assess if the current level of self-sufficiency in relation to elective surgical 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.

HHS's 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 surgery in time.

In situations where elective surgery 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 elective surgical 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 elective surgery 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 elective surgery services must ensure treatment within the clinically recommended timeframe for patients accepted onto the elective surgery 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 elective surgery 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 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 surgery. 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 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 elective surgery waiting list and record each listing date as the date each patient was initially registered on the referring hospital's elective surgery waiting list
- ensure that Not Ready for Surgery (NRFS) periods are not applied for any period of the transfer process in accordance with section 3.8.3: *Not ready for surgery.*

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 waiting list of the HHS where the outreach elective surgery service will be provided. This is usually the HHS where the patient resides. HHSs that manage elective surgery waiting lists for outreach/visiting surgical services are responsible for ensuring that patients are only waitlisted for elective surgery at facilities where the schedule of visits is such that the surgery can reliably be delivered within clinically recommended timeframes. Category 1 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 surgery 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 elective surgery 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 Referral management

3.6.1 Referral sources

Patients can be referred for registration onto the elective surgery waiting list from a Queensland public hospital Specialist Outpatient clinic, a surgeon within a Queensland public hospital or a surgeon working from private consulting rooms.

Only surgeons with admitting and operating rights for the hospital can request registration of a patient on the hospital's elective surgery waiting list.

Patients referred from the private rooms of a surgeon who has admitting and operating rights for the hospital and who elect to be treated as a public or private patient should not be referred to outpatient clinics for review prior to placement on the elective surgery waiting list unless further assessment by another surgeon from a different specialty is required.

3.7 Waiting list registration (including consent)

Regardless of the source of referral, patients may only be registered on a public hospital elective surgery waiting list once all of the following have been confirmed by the listing surgeon:

- A valid and complete request for elective surgery has been received via an elective surgery booking form

- The surgeon who completed the elective surgery booking form (the listing surgeon) is prepared to commence the procedure without requiring further surgical review of the patient. Where surgery is indicated but further non-routine medical investigations and/or non-routine anaesthetic review is required to determine if the patient is fit to undergo surgery, the patient may be registered on the elective surgery waiting list as '*Not Ready for Surgery – Clinical*' providing the timeframe to undertake such assessment does not exceed the maximum NRFS thresholds as outlined in section 3.8.5: *Not ready for surgery thresholds and review requirements*

- The patient is personally ready and available for surgery or will be ready for surgery not exceeding the maximum NRFS thresholds outlined in section 3.8.5: *Not ready for surgery thresholds and review requirements*

- A valid Queensland Health consent form, signed by the relevant surgeon (or their delegated attending medical officer) and the patient or their legal guardian has been received by the relevant area in the hospital that manages elective surgery bookings or verbal informed consent has been obtained from the patient or their legal guardian and evidence documented and retained in the patient's medical record. In circumstances where it is only practical to obtain verbal informed consent for surgery prior to registration on the elective surgery waiting list (e.g. telehealth / telephone consultations), the following processes must be followed:

    a) Evidence must be retained in the patient's medical record, including documentation of the verbal informed consent process in accordance with Queensland Health's *Guide to Informed Decision-Making in Healthcare*

    b) The patient or their legal guardian must return the signed Queensland Health consent form in person, or by mail, prior to the day of surgery. Patients may bring the original, signed consent form with them on the day of surgery only in exceptional circumstances (e.g. Category 1 patients who will present for surgery before a form could reasonably be returned by mail.) However, this is not recommended due to the risk that they may forget to bring the form with them on the day of surgery

    c) A notation that verbal informed consent has been obtained must be documented on the elective surgery booking form by the surgeon (or their delegated attending medical officer) who obtained verbal informed consent from the patient or their legal guardian. This notation must be signed and dated or the patient cannot be registered on the elective surgery waiting list.

Elective surgery booking forms that are submitted without evidence of informed consent should not be accepted by the hospital and should be returned to the listing surgeon. The patient should not be registered on the hospital's elective surgery waiting list (no consent, no registration business rule) until such time as consent has been obtained in accordance with Queensland Health's *Guide to Informed Decision-Making in Healthcare*.

Where a patient is referred from the private rooms of a surgeon with admitting and operating rights to the public hospital, it is permissible to accept a non-Queensland Health consent form. However, it is the responsibility of the treating surgeon to ensure that consent has been obtained having regard to the requirements of *Queensland Health's Guide to Informed Decision-Making in Health Care.*

Upon receiving a completed and signed elective surgery booking form and evidence of patient consent as above, an appropriate nominated delegate of the HHS Chief Executive must determine whether the request for registration onto the elective surgery waiting list will be accepted or refused within:

- one business day for urgency category 1 patients
- two business days for urgency category 2 and 3 patients.

If a request for registration is not accepted, the HHS Chief Executive (or their nominated delegate) must inform the listing surgeon of the reason for refusal within one business day (for category 1 patients) or two business days (for category 2 and 3 patients) from the date the request is not accepted. It is then the responsibility of the listing surgeon to advise the patient that the request has not been accepted. The reason for refusal must be documented and retained in the patient's medical record.

If a request for registration is accepted, urgency category 1 patients should be registered on the elective surgery waiting list within 24 hours of the elective surgery booking office receiving the elective surgery booking form, and the patient must be given a scheduled surgery date at the time of placement on the waiting list.

Urgency category 2 and 3 patients should be registered on the elective surgery waiting list within five business days of the elective surgery booking office receiving the elective surgery booking form.

The date recorded on the elective surgery booking form (when signed by the medical officer) must be used as the patient's listing date on the elective surgery waiting list. This date should be the same date the decision to refer the patient for surgery was made.

Where a consultant is required to approve an elective surgery booking form completed by a junior medical officer, the listing date should be the date the junior medical officer completed the booking form and not the date of approval by the consultant. I.e. Where the Elective Management System (EMS) is used and where consultant approval is required, the listing date should be the date the draft elective surgery booking form was completed.

This is to prevent delays in the approval process delaying a patient's registration on the waiting list. This date is referred to as the listing date.

3.7.1 Waiting list registration information

Requests for registration on an elective surgery waiting list must include the following information (at a minimum) on the elective surgery booking form:

- patient identification details
- patient contact details
- referral source
- planned admission accommodation status (private, public)

- ready for surgery status
- planned procedure details (ACHI procedure code to be assigned at the time of elective surgery waiting list registration)
- clinical urgency category - category 1, 2 or 3
- anaesthetic type
- planned patient admission type (day surgery, day of surgery admission, inpatient)
- estimated length of stay
- pre-admission details (investigations and results)
- surgeon details and signature
- date the elective surgery booking form was completed
- consent status (written or verbal.)

Patients must be notified, in writing, of the date that they were registered on the elective surgery waiting list. The listing date in the elective surgery 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 Waiting list registration exclusions

A patient cannot be registered on an elective surgery waiting list if they:

- require deferment from the time of placement on the elective surgery waiting list for either clinical and/or personal reasons if the cumulative period of NRFS days will exceed the maximum NRFS thresholds (with the exception of staged procedures. See section 3.8.3: *Not ready for surgery*) or
- are already on an elective surgery 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 waiting list they should remain on. A patient can only be registered on one public hospital 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 surgery 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 surgery 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 surgery and an appropriate NRFS 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- operative care and family support when determining which hospital the patient should be waitlisted.

3.7.4 Urgency category assignment

Patients who require elective surgery must be assigned an urgency category by the treating clinician (or an appropriate clinical delegate) prior to registration on the elective surgery waiting list. Where a procedure is listed in the *National Elective Surgery Urgency Categorisation Guideline* – April 2015 (NESUCG), the recommended urgency category should be assigned unless there is a clinical reason not to do so.

Category 2 and 3 patients referred with a clinical priority urgency category outside of the national guidelines and with no documentation of a clinically verifiable reason should be added to the elective surgery waiting list in accordance with the NESUCG. The listing surgeon must be notified in writing that this has occurred. If a clinically verifiable reason exists for allocation to a higher/lower category, the listing surgeon must submit a re-categorisation form for processing within seven (7) days stating the clinically verifiable reason for change. This does not apply to Category 1 patients. In all circumstances, HHS's must ensure robust processes are in place to confirm that the listing surgeon has received notification of the override of the patient's category and the process and timeframe for appealing the change as described above.

Where a national urgency category recommendation does not exist, the urgency category should be appropriate to the patient and their clinical situation and not influenced by the perceived or actual availability of resources.

Assessment of a patient's clinical situation should include consideration of their medical condition, life circumstances (including issues related to activity limitations, restrictions in participation in employment and other life situations), carer responsibilities and access to carer and other supports.

Elective surgery booking forms that are submitted without an urgency category should be returned to the listing surgeon on the grounds that they are incomplete. This should be actioned promptly to prevent delays. Patients should not be registered on the elective surgery waiting list until information on the patient's urgency category is completed. Where a booking form is resubmitted after being returned for being incomplete, the listing date should remain the date the original (incomplete) booking form was completed.

3.7.5 Ready for surgery

Patients must only be registered onto the elective surgery waiting list if they:

- are currently ready for surgery or
- will be ready for surgery not exceeding the maximum NRFS thresholds outlined in section 3.8.5: *Not ready for surgery thresholds and review requirements* or
- are referred for a staged procedure.

Where further non-routine assessment or review is required to determine if a patient is anaesthetically or medically fit to undergo surgery, the patient must be registered onto the elective surgery waiting list and an appropriate NRFS period applied under 'Not Ready for Surgery – Clinical' providing the timeframe for clearance will not exceed the maximum NRFS thresholds outlined in section 3.8.5: *Not ready for surgery 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.

Patients awaiting routine pre-admission and pre-anaesthetic assessments are not to be recorded as NRFS whilst awaiting such reviews or assessment.

HHSs must actively monitor the total number of days a patient is NRFS to ensure they do not exceed maximum NRFS thresholds. HHS's must also ensure that patients are not recorded as NRFS whilst awaiting routine pre-admission and pre-anaesthetic review or assessment. For more information on NRFS, see sections 3.8.3: *Not ready for surgery* – 3.8.5: *Not ready for surgery thresholds and review requirements.*

3.7.6 Procedure code assignment

A planned procedure code, using *the Australian Classification of Health Interventions* (ACHI), must be assigned at the time of registration on the elective surgery waiting list. Elective surgery booking forms that are submitted without surgical procedure details (to enable assignment of an ACHI procedure code) should be returned to the listing surgeon on the grounds that they are incomplete. Patients should not be registered on the elective surgery waiting list until information on the patient's planned surgical procedure is completed.

3.7.7 Patients requiring multiple procedures

Patients waiting for multiple procedures that will not occur within the same admission require case by case assessment by the treating surgeons to determine the order in which the procedures should be performed and registered on an elective surgery waiting list.

If one procedure is not going to alter the indications or fitness for surgery of a subsequent procedure/s, the following business rules should be applied:

1. Waitlist the patient as ready for surgery for both surgical procedures.
2. Schedule the highest urgency category first.
3. Once a date has been arranged for the first procedure, insert a NRFS - clinical loop for the subsequent surgery from the first procedure surgery date until the expected date of fitness for the subsequent surgery taking into consideration recovery following the previous surgery (this may exceed NRFS thresholds).
4. Schedule the subsequent surgery within the clinically recommended timeframe; this may be immediately at the exit of the NRFS loop.

If it is confirmed that the two surgeries are such that one will impact on fitness for the next, the patient should not remain on the elective surgery waiting list for the subsequent surgery. The patient should be referred back to the Specialist Outpatient Department or to their referring practitioner (and where not the same, the nominated general practitioner should be notified) for a review, to reassess the indication and suitability for surgery. The patient will require a new referral and/or elective surgery booking form once fit and ready to proceed with the subsequent surgery.

3.8 Waiting list management

3.8.1 Urgency categorisation review and re-categorisation

Reclassification of clinical urgency category can only occur following a review of the patient (at minimum, a chart review) by the treating surgeon, or an appropriate clinical delegate acting on behalf of the treating surgeon. Details of the reason for change must be retained in the patient's medical record and updated on the elective surgery waiting list information system, and the patient and their referring practitioner (and nominated general practitioner where not the same) must be notified.

Where a procedure is listed in the *National Elective Surgery Urgency Categorisation Guideline*, the recommended urgency category should be assigned (unless there is a clinical reason not to do so) at the time of placement on the waiting list. However, where this does not occur and a later audit identifies that the original assigned category was not appropriate, a record of this must be retained in the patient's medical record and updated on the electronic patient waiting list record with a valid clinical reason.

When updating HBCIS EAM to record a re-categorisation, the newly assigned category should be inserted (rather than replaced) to enable an audit trail of changes. However, where a patient is upgraded to a more urgent clinical category, consideration to the patient's previous waiting time should be taken into account as the days wait will reset from the date the new category is inserted in HBCIS. At all times, the decision to re-categorise a patient must only occur following a review of the patient by the treating surgeon, or an appropriate clinical delegate acting on behalf of the treating surgeon.

HHS's 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 surgeon resources.

3.8.2 Changes to originally waitlisted procedure

The following requirements apply when changes are made to the originally waitlisted procedure and only if the new procedure is for the treatment of the same condition:

- Where the changes are such that a **different principal procedure** is required, the original waiting list entry on HBCIS should be removed as 'no longer required'. The new request must then be registered onto the waiting list with the listing date backdated to the listing date of the original procedure's request date. This is to ensure days already waited continue to accrue
- Where the changes to the originally listed procedure are only **minor** (i.e. the principal procedure remains the same), the procedure description field of the HBCIS waiting list entry screen should be edited / amended and a notation regarding the changes should be made in the comments field on EAM.

Such changes are best communicated by completion of a new booking form; however, in the event that the original booking form is amended, it is necessary that details of the original booking form remain clear and visible for audit purposes.

Where a new booking form has been completed, it should be filed with the old booking form and a notation made on the original booking form that the procedure has been changed to ensure there is no confusion about the current surgery details.

3.8.3 Not ready for surgery

Once registered on an elective surgery waiting list, the patient's condition may change such that they are no longer ready for surgery (due to personal or clinical reasons) for a defined period of time. In this case, they should be assigned a not ready for surgery (NRFS) status on the elective surgery 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 surgery or to begin the process leading directly to admission for surgery will be classified as NRFS using the appropriate national listing status for patients who are not ready for surgery as below:

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

  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 NRFS should not be added to the waiting list until their clinical condition improves.

  Therefore, NRFS – 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 surgery for a defined period, not in excess of the maximum NRFS 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 surgeon should not initiate NRFS – clinical.) Patients who meet the criteria for NRFS - clinical must be assigned code 'C' denoting *not ready for surgery - clinical*.

- **Personal**—Patients who, for personal reasons, are not yet prepared to be admitted to hospital. Examples include patients with work or other commitments that preclude their being admitted to hospital for a time. NRFS - 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 surgery during the time that they are waitlisted. These patients must be assigned code 'D' denoting *not ready for surgery - deferred for personal reasons*.

- **Staged**—Patients who have undergone a procedure or other treatment and are waiting for follow-up elective surgery, where the patient is not in a position to be admitted to hospital or to begin the process leading directly to admission for

surgery, because the patient's clinical condition means that the surgery is not indicated until some future, planned period of time. Patients who are identified as NRFS - staged should be placed on the elective surgery waiting list, with a not ready for surgery status in place until the last day of the preceding month when treatment is due. These patients must be assigned code 'S' denoting *not ready for surgery— staged*.

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

3.8.4 Application and use of not ready for surgery periods

The use and application of not ready for surgery 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 surgery for clinical reasons.

  The decision, reason and timeframe for registering a patient as not ready for surgery – 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 surgery due to illness (e.g.: the flu), this may be recorded as NRFS – 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 surgery from progressing.

- **Personal**: may be applied by both administration and clinical staff on direction / advice from the patient regarding their ready for surgery status and/or where there is evidence that the patient was not available for surgery for personal reasons. This is also applicable to patients who refuse an offer of a booking date for surgery or pre-operative appointment. These patients must be assigned not ready for surgery - deferred for personal reasons from the appointment/surgery date which was refused until the date of the next appointment date / booking date for surgery, acknowledging that this should not exceed the maximum threshold periods for not ready for surgery.

- **Staged**: must only be applied under the direction of the listing surgeon at the time of referral to the elective surgery 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 surgeon.

3.8.5 Not ready for surgery thresholds and review requirements

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

- 15 days—urgency category 1
- 45 days—urgency category 2
- 90 days—urgency category 3.

HHSs should:

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

If a formal case review has been undertaken and the decision has been made not to remove the patient from the elective surgery 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 elective surgery waiting list information system. If it is determined that the patient is still not clinically or personally ready for surgery the HHS may, at their discretion, extend the not ready for surgery period for a further:

- 15 days—urgency category 1
- 45 days—urgency category 2
- 90 days—urgency category 3.

If the patient is still not clinically or personally ready for surgery after the second formal case review has been undertaken, they should be removed from the elective surgery waiting list and a new referral initiated when they are clinically and/or personally ready for surgery. Days waited from the previous listing are unable to be carried forward and will not be included in the waiting time calculation for the new listing.

Patients who are removed from the 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 surgeon 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 elective surgery waiting list.

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

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

3.8.6 Pregnancy

If a patient becomes pregnant while waiting for an elective surgical procedure, a clinical review must be undertaken by an appropriate clinical delegate and a determination made as to whether or not surgery will be performed during the gestation. If it is determined that surgery will not proceed, the patient and their referring practitioner (and nominated general practitioner where not the same) must be contacted and advised that they are being removed from the elective surgery waiting list for clinical reasons. In removing these patients from the elective surgery waiting list, the patient must be given an appointment date for review in a specialist outpatient clinic postpartum. The date of this review must be included in correspondence to the patient and their referring practitioner (and nominated general practitioner where not the same).

If it is determined at the outpatient review that the patient is clinically and personally ready for surgery, the patient should be assigned an urgency category and registered on the elective surgery waiting list. Days waited from the previous listing are unable to be carried forward 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 elective surgery 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 surgery 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, where a patient is reclassified to a higher urgency category, any days the patient was waiting at a less urgent category are excluded from the total days waiting calculation. However, where a patient is reclassified to a less urgent category, any period a patient waited at the higher urgency is included in the total days waiting calculation method.

For outsourced patients, when the Outsource Entry Screen within HBCIS EAM has been completed, the patient's waiting time will cease accruing from the date recorded in the 'Accepted Date' Field [06]. This is despite the patient still actively waiting for surgery. Outsourced patients will be reported by the Department as having been removed from the elective surgery waiting list from the date entered in the outsource screen's 'Accepted Date' field.

Despite being reported as 'removed', HHSs have a responsibility to ensure that outsourced patients are treated within clinically recommended waiting times and/or within the closest time possible.

If the patient is accepted for treatment at another hospital but is subsequently unable to be treated and is returned to the referring hospital, the return date within the Outsource Entry screen must be completed and should reflect the date of return notification. The patient's days wait will continue to accrue from this return date in addition to any days previously waited before being outsourced.

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. It is reasonable that some elective surgery patients are seen more urgently within an urgency category because of their condition. Therefore, the treat-in-turn principle allows for flexibility for these patients. To balance clinical need with equity of access, at least 60 per cent of patients within each urgency category should be treated in waiting time order. The order of treatment should not be based on admission accommodation status (public/private).

Patients who are registered on an elective surgery waiting list but subsequently present and are treated as an emergency patient should be excluded from treat-in-turn calculations. Category 2 and 3 elective surgery 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 3.8.7: *Calculating Waiting Time.*

3.9.2 Standby patients

To support full utilisation of available theatre 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-operative investigations and pre-admission assessments
- 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 surgery dates based on the order they have been placed on the elective surgery 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.) To be eligible as a standby patient, the maximum timeframe for notice that a patient can nominate/request is seven days. Declining an offer for surgery where it has been offered within seven days' notice 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 surgery and anaesthetic prior to placement on the waitlist.

A pre-admission assessment is required for all patients scheduled for elective surgery and may be undertaken via a screening questionnaire, or a telehealth or face-to-face consultation. The preadmission assessment should be completed at least six weeks in advance of the expected date of surgery for category 2 and 3 patients, and at least seven days prior to surgery for category 1 patients 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 surgery.

Where a patient fails to attend a pre-admission assessment, surgery may be postponed and a NRFS - personal period applied from the date the patient failed to attend until the next pre-admission appointment, noting this should not exceed maximum NRFS thresholds as per section 3.8.5: *Not ready for surgery thresholds and review requirements*. Failure to attend two pre-admission assessments may result in removal of the patient from the elective surgery waiting list.

3.9.4 Leave management

HHSs should have specific processes in place to manage planned leave for surgical 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 designated Specialist Outpatient service 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 designated Specialist Outpatient service 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 elective surgery lists.

3.9.5 Management of failure to attend

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

For **category 1** patients who fail to attend, the following principles should apply:

- A phone follow up within two (2) business days is required and an agreement sought for a new appointment/surgery date. Following patient consultation, the reason for FTA and the new scheduled appointment/surgery date must be documented and retained in the patient's medical record and electronic waiting list record
- If the patient nominates as 'Not ready for Surgery' (NRFS), the patient must be recorded in the Elective Admissions module as 'NRFS', and a clinical review of the referral should be undertaken
- 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 elective surgery waiting list following clinical consultation
- If a patient fails to attend a second pre-op appointment and/or surgery date for the same waiting list episode, clinician guidance must be sought to determine if the patient will be offered a subsequent appointment / surgery date or will be removed from the waiting list and referred back to the referring practitioner (and nominated general practitioner where not the same).

For **category 2 and 3** patients who fail to attend, the following principles should apply:

- Written notification (or other appropriate communication measures) of FTA for a booked appointment or surgery date, together with the appropriate requested action, must be sent to the patient and the referring practitioner (and nominated general practitioner where not the same) within five (5) business days of the FTA
- Patients are required to contact the HHS (or provider) within fourteen (14) calendar days to notify of their Ready for Surgery status after initially failing to attend.
- If the patient fails to contact the HHS or provider within this timeframe to notify of the reason for FTA and is unable to be contacted, the patient may be removed from the elective surgery waiting list following clinical consultation.

Hospitals can suspend the count of days waiting by assigning a not ready for surgery status and timeframe from the date that the patient failed to attend until the date of the second appointment / surgery date. The NRFS period should not exceed the maximum NRFS thresholds as per section 3.8.5: *Not ready for surgery thresholds and review requirements.*

Patients who fail to attend a second pre-op appointment and/or date for surgery for the same waiting list episode should be removed from the elective surgery waiting list in accordance with section 3.12: *Removing patients from the waiting list.*

When a patient is removed, the patient, treating surgeon 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 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.

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 elective surgery waiting list
- implementing systems to have patients confirm offers of appointment and surgery
- telephone or SMS reminders of booked appointments within appropriate timeframes prior to the appointment/surgery date
- regular administrative auditing and clinical review of patients on the waiting list.

3.9.6 Management of declined offers

Patients should only be offered a maximum of two booking dates for surgery for the same 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 surgery should be removed from the elective surgery waiting list on the basis that they are not ready for surgery, unless there are extenuating circumstances which the HHS Chief Executive (or their nominated delegate) agrees warrants offering the patient a third booking date for surgery. This includes offers for surgery under an outsourcing arrangement.

All booking dates for surgery 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-op appointment or surgery, patients must be advised that declining a second offer for surgery may result in removal from the elective surgery 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 surgery.

A minimum seven (7) days' notice for Category 1 and a minimum 14 days' notice for Category 2 and 3 patients 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-op appointment or surgery should be assigned NRFS – personal from the booking date offered until the date of the second appointment or surgery date. NRFS periods applied for the management of declined offers must comply with section 3.8.5: *Not ready for surgery thresholds and review requirements* and not breach NRFS thresholds.

When a patient is to be removed for declining two offers, the public hospital where the patient is waitlisted must liaise with the patient's treating surgeon 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 elective surgery waiting list, with the reason for removal.

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

3.10 Cancellations

When a scheduled elective surgery is not performed on the intended date, a cancellation code must be applied. Depending on the timing and the reason for the cancellation, a cancellation code may need to be applied to both the operating theatre information system and the HBCIS EAM module.

The Cancellation codes used to cancel a procedure in the operating theatre information system should be identical to the codes used in the HBCIS EAM module to allow read/write capabilities between the two systems. See HBCIS EAM Reference files '*Booking Status Codes*' and '*Waiting List Status Codes*' for a full list of the current codes and corresponding cancellation group codes. A current list of cancellation and removal codes and definitions is included in Appendix A.

The following principles also apply to outsourced patients and providers.

3.10.1 Management of hospital-initiated cancellations

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

- notify the patient as soon as possible that their surgery has been cancelled
- make arrangements for the surgery 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 surgery status on the elective surgery waiting list.

Urgency category 1 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 Surgery, Executive Director of Medical Services or another appropriate delegate) under delegation of the HHS Chief Executive.

Patients should not incur a second hospital-initiated cancellation of their date for surgery 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 surgery date
- what to do if their condition deteriorates.

Where the patient has already been admitted to the hospital and their surgery is cancelled due to a hospital-initiated reason, a subsequent surgery date should be provided to the patient prior to discharge.

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

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

3.10.2 Management of patient-initiated cancellations

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

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

The hospital must send notification to the patient's treating surgeon and referring practitioner (and nominated general practitioner where not the same), in writing, of the removal of these patients from the waiting list, within five days of removal, where the patient is classified as urgency category 2 or 3.

Urgency category 1 patients are not to be removed from the elective surgery waiting list without the approval of the treating surgeon and a member of the executive management team under the delegation of the HHS Chief Executive.

If a patient cancels a date for surgery for personal or clinical reasons, or fails to arrive for surgery, the hospital can suspend the count of days waiting from the date of the cancelled surgery booking or failure to attend by assigning not ready for surgery—personal until the next appointment / surgery date. However, the NRFS timeframe should not exceed the maximum NRFS period as per section 3.8.5: *Not ready for surgery 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

HHS's 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 operating theatre time or substituting operating theatres sessions with another specialist and/or specialty
2. transfer of care from one Queensland Health employed surgeon to another within the same specialty and hospital/HHS. HHSs have the right to construct a single specialty elective surgery waiting list through combining or pooling waiting lists for specialties or subspecialties and may allocate patients to any appropriately credentialed surgeon with the required scope of practice to deliver the surgery. Patients on pooled lists can expect to be treated in turn by any appropriately credentialed surgeon.

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 elective surgery 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 elective surgery is 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 surgery 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 surgeon.

- 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 surgeon or hospital, appropriate arrangements must be made for:
    - notification of changes to the treating surgeon 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 elective surgery waiting list information system by the referring hospital
    - assessment of the patient by the receiving treating surgeon who will undertake the surgery (where required).

- Where a patient declines an offer for surgery with another treating surgeon 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 surgery and an appropriate NRFS 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 surgery. This includes being provided with the planned date for surgery 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 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 NRFS period applied should be from the date offered at the alternate hospital until the next available vacant surgery slot at the originating hospital (as at the time of the decision). Where this deferment period exceeds the maximum NRFS thresholds as per section 3.8.5: *Not ready for surgery thresholds and review requirements*, the patient may be allowed to remain on the

waiting list; however, a formal case review must be undertaken to assess their clinical urgency and suitability.

Details regarding offers of surgery 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. surgery 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 surgery 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 elective surgery 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 surgery 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 surgery at the original hospital, they can be made NRFS - personal for declining as per section 3.8.3: *Not ready for surgery*.

Where a patient is transferred from one public hospital's elective surgery 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 elective surgery 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 NRFS 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 surgery,* a patient cannot be NRFS 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 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 surgery 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 waiting list, the patient's placed on list date must be backdated to match the date the patient was originally added to the 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 elective surgery 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 elective surgery 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 surgical service. The public hospital where the patient is registered must retain the patient on their public hospital 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 surgery 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 elective surgery waiting list and record the date as when they were initially registered on the referring hospital's elective surgery 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 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 surgery,* a patient cannot be NRFS 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.

Where a patient consents to being treated in a private facility, the HHS where the patient is currently registered must either:

- independently organise and pay for treatment in a private facility with the capability to provide the surgical service, using locally negotiated or state-wide contracts or standing offer arrangements (SOAs), or
- refer the patient to the Surgery Connect program for treatment with a provider with the capability to deliver the surgery in accordance with the Surgery Connect Business Rules.

When a patient is outsourced to another facility at a cost to the referring hospital, or where the patient is transferred to Surgery Connect, the Outsource Entry screen within HBCIS EAM must be used and the following business rules applied:

- the outsource request date is the date the referring hospital requests a transfer to another hospital/facility or to Surgery Connect
- the acceptance date is the date that the contracted hospital/facility or Surgery Connect accepts the patient
- the Referred Facility is the facility code of the hospital/facility that the transfer request is sent to
- when the referring hospital receives notification that the patient was treated or removed at the contracted facility or Surgery Connect, the referring hospital records either the date of treatment or date of removal as the removal date in HBCIS using an appropriate removal reason. For treated patients, the appropriate code to use is '46 – *Transferred to a non QH Facility*'. For removals, the relevant removal reason must be used.

Where a patient is outsourced to a private facility, they are not to be removed from the referring hospital's waiting list until confirmation that the patient has been treated (with the actual date of surgery provided) or until sufficient evidence that the patient no longer requires surgery has been obtained.

The patient is classified as not waiting at the referring hospital from the outsource acceptance date and will be reported by the Department as having been removed from the elective surgery waiting list from that date.

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 within the Outsource Entry screen must be completed and must reflect the date of return notification.

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 surgery as close as possible to their clinically recommended timeframe and as close to the patient's place of residence, where possible.

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 either through direct contractual arrangements between the HHS and private providers or through Surgery Connect.

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

- The urgency category assigned by the listing surgeon aligns with the nationally recommended urgency category for that procedure (where applicable) or there is a clinically verifiable reason documented.

- The listing surgeon can demonstrate compliance with the 'treat-in-turn' principle, specifically within each urgency category (excluding urgency category 1) where greater than 60% of patients are treated in the order in which they have been registered on the elective surgery waiting list or there is valid reason as verified by the HHS Chief Executive (or their nominated delegate) where this is not reasonable.

- The listing surgeon has submitted to the HHS a proposed date for surgery in the private sector which is earlier than the surgery date that the HHS could provide.

- Another publicly employed surgeon 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 listing surgeon could treat them in the private sector (it is recommended that documentation to support this is retained 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 waiting list and who, following later assessment (e.g. at pre-anaesthetic clinic) are identified as not being suitable for surgery 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 surgery.

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 waiting list until written confirmation of acceptance from the receiving hospital has been obtained.

3.12 Removing patients from the waiting list

A patient should only be removed from a hospital's elective surgery 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 surgery and/or pre-operative appointment for the same waiting list episode
- The patient fails to respond to two audit measures (clinical and/or administrative) within a minimum of 14 days from the second audit measure
- The patient no longer requires surgery 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 waiting list
- The patient has accepted *transfer* to another public hospital and the receiving hospital has confirmed acceptance of the patient onto their waiting list
- The patient has been *outsourced* to another private facility and has been treated
- The patient exceeds their deferred not ready for surgery threshold for their assigned category (not applicable to staged deferments)
- The patient dies
- The treating surgeon requests removal of the patient from the waiting list for clinical reasons

Removals from the elective surgery waiting list, other than as a result of the patient having undergone surgery or being deceased, should be authorised by the treating surgeon, 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 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 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 waiting list.

When a patient is removed from the elective surgery waiting list:

- The patient (except where deceased), the referring practitioner (and the nominated general practitioner where not the same) and the treating surgeon (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 elective surgery waiting list at their own request (without having undergone surgery 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 surgery and options for alternative management.

3.13 Validation of waiting lists

HHSs must keep accurate records of elective surgery waiting list information including any change to a patient's clinical urgency category, ready for surgery 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 waiting list status should be recorded and retained in their medical record including:

- a change to the patient's ready for surgery status
- a change to the patient's clinical urgency category
- removal of a patient from the hospital's 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 surgery and reasons for declining
- not ready for surgery periods
- information provided to patients regarding policy requirements (e.g. NRFS thresholds, FTA rules etc.)
- advice regarding estimated waiting times for surgery
- patient enquiries.

3.13.1 Clinical and administrative audits

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

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 elective surgery 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 elective surgery waiting list should occur on a regular, ongoing, rolling basis that includes auditing of:

- category 1 patients who have waited longer than 20 days for treatment and who do not have a booking date for surgery
- category 2 patients who have waited longer than 60 days for treatment and who do not have a booking date for surgery
- category 3 patients who have waited longer than 300 days for treatment and who do not have a booking date for surgery.

The administrative audit of the elective surgery 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 surgery is still required (i.e. has not had the surgery elsewhere)
- clarification that the patient is ready for surgery
- clarification regarding whether the patient is on a waiting list at another hospital for the same or another procedure.

A range of other administrative audits should be maintained to ensure 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 surgeon
- category 1 patients who have waited more than 20 days since last review, and have not been ready for surgery for personal or clinical reasons for more than 15 cumulative days and who do not have a booking date for surgery (i.e. total wait is 35 days)
- category 2 patients who have waited more than 60 days since last review, and have not been ready for surgery for personal or clinical reasons for more than 45 cumulative days and who do not have a booking date for surgery (i.e. total wait is 105 days)
- category 3 patients who have waited more than 300 days since last review, and have not been ready for surgery for personal or clinical reasons for more than 90 cumulative days and who do not have a booking date for surgery (i.e. total wait is 390 days).

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

- the surgery 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 surgery
- the patient should be removed from the elective surgery waiting list.

3.14 Communication requirements

HHSs are responsible for communicating with relevant clinicians and patients regarding aspects of the patient's interaction with elective surgery 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.

HHS's should inform the patient regarding:

- confirmation of placement on a hospital's elective surgery waiting list, including the following details:
  - the listed procedure
  - clinical urgency category
  - date of placement on the 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 surgery may be performed by a surgeon other than who referred the patient and/or at another hospital
- appointment and surgery offers, with sufficient and reasonable notice, including details of: time, date, location, what to bring (e.g. x-rays, investigation results, medications) as well as any other special requirements (if applicable)
- postponements / rescheduling of offered appointment or surgery dates
- the time within which to confirm appointments / surgery dates
- how to confirm, reschedule or cancel appointments / surgery dates
- the 'two-strikes' policy for patient-initiated cancellations
- maximum thresholds for deferment
- changes to the patient's clinical urgency category
- removal from the 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 elective surgery waiting list, including details of:
  - the listed procedure
  - clinical urgency category
  - date of placement on the 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 patients clinical urgency category
- confirmation of the patient's completed surgery and post-op instructions
- removal of the patient from the 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 elective surgery waiting lists
- types of specialties offered
- estimated waiting times
- National Elective Surgery Urgency Categorisation Guidelines
- 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 elective surgery appointment details. In such instances, details of dates for any appointments or surgery 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 waiting list activity, dynamics and performance. This is to ensure a proactive approach to 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 and by specialty
- 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 waiting lists as well as additional referral trends
- proportion of patients treated in clinically recommended timeframes by category
- number of patients treated from the elective surgery waiting list by specialty
- number of patients added to the elective surgery waiting list by specialty
- number of patients removed from the elective surgery waiting list by specialty including:
  - all removal reasons
  - removals where treatment was not required
  - removals where treatment was provided elsewhere
- hospital and patient-initiated cancellation rates (Day of surgery and total cancellations)
- proportion of patients treated in turn
- alignment to National Elective Surgery Urgency Categorisation Guidelines for in-scope procedures.
- list of patients who have or will exceed maximum NRFS 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 elective surgery 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

- Hospital and Health Service Agreements
- Scope of Publicly Funded Services Policy - Queensland Health. https://www.health.qld.gov.au/__data/assets/pdf_file/0026/396143/qh-pol-336.pdf

5.3 Procedures, guidelines and protocols:

- Australian Institute of Health and Welfare 2015. National Elective Surgery Urgency Categorisation Guideline – April 2015 http://www.coaghealthcouncil.gov.au/Publications/Reports/ArtMID/514/ArticleID/57/National-Elective-Surgery-Urgency-Categorisation-Guideline-April-2015
- Clinical records management policy and supporting standards and guidelines. https://www.health.qld.gov.au/__data/assets/pdf_file/0032/395825/qh-pol-280.pdf
- Credentialing and defining the scope of clinical practice policy and guideline. https://www.health.qld.gov.au/__data/assets/pdf_file/0032/670973/qh-pol-390-23.10.17.pdf and https://www.health.qld.gov.au/__data/assets/pdf_file/0034/670975/qh-imp-390-1-23.10.17.pdf
- Data management policy and supporting standards and guidelines. https://www.health.qld.gov.au/__data/assets/pdf_file/0025/396052/qh-pol-279.pdf
- Operating Theatre Efficiency Guideline https://www.health.qld.gov.au/__data/assets/pdf_file/0022/640138/qh-gdl-443.pdf
- Queensland Health – Guide to Informed Decision-making in Healthcare http://qheps.health.qld.gov.au/metronorth/mental_health/documents/specialty-services/qh-guide-id.pdf
- Queensland Health—Maternity Clinical Guidelines http://www.health.qld.gov.au/qcg/html/publications.asp
  https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/service-delivery/cscf
- Specialist Outpatient Implementation Standard—Queensland Health https://www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf

5.4 Forms and templates

- Elective Management System (EMS) electronic booking form
- Queensland Health elective surgery letter suite
- Queensland Health consent form
- Clinical Urgency Recategorisation Form

5.5 Related documents

- Australian Charter of Healthcare Rights http://www.safetyandquality.gov.au/wp-content/uploads/2012/01/Charter-PDf.pdf
- 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. http://www.aihw.gov.au/publication-detail/?id=60129543979&tab=2

- Australian Institute of Health and Welfare Metadata Online Registry (METeOR) http://meteor.aihw.gov.au/content/index.phtml/itemId/344850
- Private Practice in the Queensland public health sector Guideline https://www.health.qld.gov.au/__data/assets/pdf_file/0025/438055/pp-guidelines.pdf
- Queensland Hospital Admitted Patient Data Collection (QHAPDC) Manual. http://qheps.health.qld.gov.au/hsu/datacollections.htm#qhapdc
- Visiting Medical Officer – Engagement, entitlements and duties https://www.health.qld.gov.au/__data/assets/pdf_file/0035/395666/qh-pol-256.pdf

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 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 urgency	A clinical assessment of the urgency with which a patient requires elective hospital care, as represented by a code.	Australian Institute of Health and Welfare – Metadata Online Registry
Day surgery	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
Elective surgery	Elective surgery is planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery waiting list.	Australian Institute of Health and Welfare – Metadata Online Registry
Elective surgery booking form	A form required to be completed by the listing surgeon to request registration of a patient onto the elective surgery waiting list. This may be a paper or electronic form.	
Elective surgery waiting list	A repository listing all patients waiting for elective surgery and their planned surgery details.	

Term	Definition/Explanation/Details	Source
General Practitioner	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. 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). 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 specialist outpatient service. See definition for R*eferring practitioner.*	
Listing Surgeon	The surgeon (with admitting and operating rights to the hospital) responsible for the decision to place the patient on the elective surgery waiting list.	
Medical Record	A collection of data and information gathered or generated to record the clinical care and health status of an individual or group. NOTES: 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. **(NB:** in the context of the ESIS, electronic patient administration systems (e.g. HBCIS, ESM) do not constitute a medical record.)	Australian Standard AS 2829.1-2012 as referred to in QH-IMP-279-2:2013 Documentation of date and time in the paper based health record

Term	Definition/Explanation/Details	Source
Not ready for surgery (NRFS)	**Clinical** - Patients for whom surgery 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 surgery should take place. Patients should not be regarded as 'not ready for surgery—pending improvement of their clinical condition' when they are undergoing routine monitoring or investigations before a decision is made as to whether surgery is required. **Personal –** Patients who for personal reasons are not yet prepared to be admitted to hospital. Examples include patients with work or other commitments that preclude their being admitted to hospital for a time. **Staged** - Patients who have undergone a procedure or other treatment and are waiting for follow-up elective surgery, where the patient is not in a position to be admitted to hospital or to begin the process leading directly to admission for surgery, because the patient's clinical condition means that the surgery is not indicated until some future, planned period of time.	Australian Institute of Health and Welfare – Metadata Online Registry
Ready for surgery (RFS)	Patients who are prepared to be admitted to hospital or to begin the process leading directly to admission for surgery.	Australian Institute of Health and Welfare – Metadata Online Registry
Referring practitioner	The practitioner who initiated the referral of the patient to the public hospital specialist / surgeon for assessment. This may or may not be the patient's general practitioner.	
Specialist	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.	Medical Board of Australia
Treating Surgeon	The surgeon responsible for providing the treatment and surgery for the patient. This may or may not be the same as the listing surgeon.	

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 elective surgery waiting list from the date they were added to the 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	1 June 2015	Final version QH-IMP-342-1:2015 approved. Effective from 03 June 2015.
V 2.0	31 October 2017	Revised version approved for publication. Updated to ensure current best-practice waitlist management processes.

8. Appendix

Appendix A - Cancellation and removal codes:

See http://qheps.health.qld.gov.au/caru/surgical/docs/ormis-EAM-guide.pdf