Elective Services Access Standard

This document must be read in conjunction with MP 0169/21 Elective Services Access and Management Policy

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Glossary

This section provides a reference of key terms. The Australian Institute of Health and Welfare National Health Data Dictionary is recognised as the authoritative source of definitions and must be consulted in conjunction with this list.

Term	Definition
Ambulatory Surgery Initiative (ASI)	A strategy introduced to mitigate increased waiting times for speciality services. Patients can choose to be referred to specialists working in their private capacity at a participating general hospital, with the costs bulk billed to Medicare. Only available for specific procedures at specific sites.
Clinical review	Review of a patient to consider appropriateness of the assigned clinical urgency category, to assess the patient's clinical condition during the waiting period, or after an extended period when classified as 'Not Ready for Surgery.'
Clinical urgency	A clinical assessment of the urgency with which a patient requires elective hospital care Category 1: Procedures that are clinically indicated within 30 days. Category 2: Procedures that are clinically indicated within 90 days. Category 3: Procedures that are clinically indicated within 365 days.
Clinically ready	Patients should only be registered on the waitlist if they are ready for care. Patients should not be added to the waitlist if they are required to lose weight or stop smoking in order to have their recommended procedure.
Direct access	Direct access services are those which, by prior agreement, routinely accept requests for registration onto the elective waiting list (where specified referral guidelines are met) from external sources (e.g. General Practitioner), without assessment of the patient by a specialist in an outpatient clinic. E.g. Adult Gastrointestinal Endoscopy Services (refer Supporting Information).
Elective services	Elective services are defined as planned surgical and non-surgical procedures that can be booked in advance following a specialist assessment resulting in placement on the elective waiting list.
Excluded procedure	Any procedure not routinely performed in the Western Australian public health system as defined in the Excluded Procedures Manual.
Health Service Provider	As per section 6 of the *Health Services Act 2016,* a Health Service Provider established by an order made under section 32 (1)(b).

Listing status	Indicates the status of the person on the waiting list, which is the extent to which a patient is ready and available for admission.
Not Ready for Surgery – Deferred for Personal Reasons	The listing status of patients who for personal reasons are not yet prepared to be admitted to hospital – for example, patients with work or other commitments which preclude their being admitted to hospital for a period of time.
Not Ready for Surgery – Pending Improvement of Clinical Condition	The listing status of patients for whom a procedure is indicated, but because of a medical condition, they require treatment or management (or simply time to pass) to be suitable for the procedure.
Not Ready for Surgery – Staged/Periodical/Planned	The listing status of patients who have undergone an elective procedure or other treatment and are waiting for a follow-up elective procedure, where this follow-up procedure is not indicated until some future, planned period of time.
Over boundary	Term used to identify cases that have waited longer than the clinically recommended timeframe for their urgency category.
PAS	Patient Administration System (e.g. webPAS).
Premature admission	Where a patient is scheduled for an elective service earlier than is clinically indicated by their Urgency Category. E.g. Category 2 patient scheduled earlier than 31 days after registration on elective waiting list or Category 3 patient scheduled earlier than 91 days after registration on elective waiting list.
Ready for Surgery	The listing status of patients prepared to be admitted to hospital or to begin the process leading directly to admission for elective services.
Referring specialist	The specialist who has made a request to register a patient onto the elective waiting list.
Request	A request for admission (either paper or electronic).
Responsible officer	A Health Service Provider nominated person who is responsible for managing the elective waiting list at each hospital.
Scheduled admission date	The date for an elective procedure that has been entered into the Patient Administration System (PAS).
Short notice patient	A patient who is prepared to be contacted at late notice that they may have their procedure performed due to a cancellation. Also referred to as a standby patient.
Specialist	Credentialed specialist medical practitioner eligible to request admission of patients to a public hospital.
‘Treat in turn’	The principle by which all patients are to be treated in order of their registration onto the waiting list unless clinically indicated and/or in exceptional circumstances.

Treating specialist	Credentialed specialist medical practitioner eligible to request admission of patients to a public hospital and who has operating rights to that public hospital.
Triaging clinician	Credentialed specialist medical practitioner eligible to request admission of patients to a public hospital.
Working days	Days that fall between Monday and Friday inclusively (excluding public holidays).

1. Roles and Responsibilities

1.1 General Practitioner

- collaborate with the patient, the treating specialist and the hospital to ensure the patient is keeping fit and ready for care while on the waitlist. This may include pre-admission weight loss management, smoking cessation and opioid reduction.
- liaise with the treating specialist regarding any change in the patient's health with implications for planned admission.
- conduct the initial assessment of the patient's suitability and eligibility for Direct Access criteria referrals and in the case of Bariatric Services, the patient's eligibility for Bariatric Surgery (refer Appendix 1).
- submit any Direct Access referrals and referrals for Bariatric Surgery to the Central Referral Service (CRS) (procedures to be undertaken at metropolitan hospitals only).

1.2 Hospital/Surgical Executive (e.g. Executive Director/CEO, Surgical Director, Nurse Director or Co-Director)

- appoint a responsible officer for the elective waiting list
- ensure regular administrative and clinical audits of elective waiting list are conducted
- ensure processes are in place to validate data sent to WA Health Inpatient Data Collections
- ensure mechanisms are in place for health service-wide load sharing of patients
- ensure processes are in place to minimise the incidence of hospital-initiated postponements
- ensure processes are in place for optimising utilisation of available resources
- ensure processes are in place to manage patients 'Not Ready for Surgery – Pending Improvement of Clinical Condition'
- ensure management plans are in place for over boundary patients who have waited longer than clinically recommended
- ensure processes for optimal outcomes and quality service delivery while patients are in hospital
- assist in the co-ordination of the transfer of patients to other facilities (including facilities outside of their jurisdiction) where required.

1.3 Surgical/Medical Head of Department (or equivalent)

- oversee appropriate clinical categorisation within the specialty and the allocation of patients to the appropriate level hospital to receive treatment
- manage medical staff/surgeon leave and make arrangements to ensure continuity of service delivery and reallocation of patients to ensure timely access to services where required

- monitor performance and initiate improvement strategies to promote and facilitate waiting list management by clinicians and across all levels of hospital management
- provide clinical advice to the elective waiting list responsible officer where the treating specialist is not available, or where decisions require escalation
- liaise with the elective waiting list responsible officer to facilitate the admission of over boundary patients on the waitlist, including the transfer of patients to other specialists or facilities where appropriate
- monitor specialist compliance with:
    - the *National Elective Surgery Urgency Categorisation Guideline (2015)*
    - Treat in turn principle.

1.4 Referring Specialist

- explain proposed procedure or treatment, alternative options for treatment and potential complications to the patient before requesting registration onto the elective waiting list
- provide the anticipated length of stay for bed management purposes
- obtain written informed consent from the patient or, when appropriate, carer or guardian
- assign a procedure code(s) as it applies to the individual patient
- assign an appropriate clinical urgency category for the procedure/treatment, using the recommended categories in the *National Elective Surgery Urgency Categorisation Guideline (2015)* as a guideline.
- indicate when patient will be ready for care, if not currently
- ensure that requests for admission are legible and the minimum information required by the hospital is provided
- forward completed requests for admission and patient consent forms directly to the elective waiting list responsible officer (or their delegate) as soon as possible, following the patient agreeing to the proposed procedure/treatment
- initiate prompt communication with the patient's General Practitioner and/or other specialist regarding management of the patient as required
- ensure own availability to perform the procedure within the clinical urgency category timeframe or make arrangements for another clinician to perform the procedure within the appropriate clinical timeframe.

1.5 Treating Specialist

- review waiting list as per local policy
- ensure clinical management plans are in place for over boundary patients
- authorise removal of patients from the elective waiting list in accordance with this Standard
- liaise with the elective waiting list responsible officer to prioritise patients according to clinical urgency and length of wait.

1.6 Responsible Officer (e.g. Clinical Nurse Manager Waitlist or equivalent)

- manage and maintain the hospital elective waiting list

- ensure appropriate processes are in place for communication with patients and their General Practitioners (where requested)
- provide the treating specialist with accurate details of patients on their elective waiting list to facilitate admission according to clinical urgency and length of wait
- identify over boundary patients and work with appropriate medical staff to expedite admission or transfer to an alternative hospital as appropriate
- facilitate the timely processing of admission requests, including:
    - coordination of the relevant patient information required for admission in consultation with the Medical/Surgical Head of Department (or equivalent)
    - facilitation of transfer of patients between treating specialists, specialty units and facilities to minimise waiting time, in collaboration with medical staff
- conduct regular administrative elective waiting list audits
- communicate with patients, treating specialists, Heads of Department, Director of the Surgical Division, referring General Practitioner's and other hospitals.

1.7 Pre-Admission Service

- coordinate patients progress to admission and communicate with patients, elective waiting list responsible officer, and medical officers regarding elective admission and discharge planning considerations.

1.8 Clinical Excellence Division

- provide custodianship of the *Elective Services Access and Management Policy*
- coordinate approved system-wide elective services access projects
- provide analysis and strategic advice to the Director General, Minister for Health and WA Health Executive Committee (HEC) as required.

1.9 Purchasing and System Performance Division

- undertake data custodianship responsibilities
- collate, analyse and disseminate state-wide elective waiting list information
- monitor and manage Health Service Provider performance against agreed elective surgery access performance targets
- ensure data quality and appropriate accessibility
- provide regular reports for the WA health system
- manage reporting obligations to Commonwealth and other bodies.

1.10 Health Support Services (HSS)

- develop, maintain and support information systems which facilitate the effective management of elective waiting lists and bookings by hospitals.

1.11 Bed Management Services

- optimise patient flow and admissions for elective procedures without compromising emergency surgery access, in consultation with elective waiting list responsible officer.

1.12 Central Referral Service (CRS)

- allocate referrals for direct access services and requests for bariatric surgery to the appropriate hospital site.

2. Referring Patients to the Waiting List

2.1 Patients who are assessed by a referring specialist as requiring an elective service and who are clinically ready to receive their elective service can be referred to the waiting list.

2.2 Patients can be referred to an elective waiting list from a specialist working in a hospital outpatient clinic, a public emergency department, a public inpatient ward or a specialist working in a private consulting room and who has admitting and operating rights to the hospital.

2.3 The referring specialist should verify the patient's demographics, confirm they have a valid Medicare card and ensure the patient resides in a catchment area that is accepted by the hospital.

2.4 To ensure continuity of care for regional patients, Visiting Medical Practitioners with clinics (public or private) in regional areas that are outside of the metro site catchment area they have admitting and operating rights to, must ensure they have an agreement with their metro site before referring a patient to the metro site. In the absence of an agreement, Visiting Medical Practitioners must adhere to the requirements listed in MP 0183/24 *Access to Care for Country Residents Policy*.

2.5 Regardless of the source of referral, the referring specialist must submit the approved Request for Access (RFA)/Request form (either written or electronic) for all patients to the hospital waitlist team or equivalent.

2.6 The referring specialist must inform the patient about:

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

2.7 Where a direct access criterion has been established, referrals can be accepted without a specialist outpatient appointment. These referrals are required to be clinically assessed and triaged against the relevant specified referral guidelines before they are accepted. This includes referrals for services provided under the Ambulatory Surgery Initiative (ASI):

- the listing date for a direct access request is within 5 days of the date the triaging clinician has reviewed and assigned an urgency category
- if a direct access referral is assessed by the triaging clinician as not meeting the access criteria, they are to be returned to the referrer with a brief explanation of the reason for return

- the CRS will send the letter to the referrer on behalf of the hospital[1].

2.8 Requests must be fully complete, that is, all fields are mandatory and must be populated with the relevant patient information, prior to the patient being added to the waiting list.

2.9 Requests that do not contain all required information will (depending on the information missing) either be returned to the referring specialist for completion, or the referring specialist and/or patient will be contacted via phone to ascertain the missing details and facilitate the patient's timely access to elective services.

2.10 Requests from specialists private rooms must, in addition to the request (and patient consent), include any relevant documents such as a General Practitioner referral, patient history and previous relevant imaging.

2.11 It is the responsibility of the referring specialist completing the request to assign an urgency category noting that:

- a summary of usual urgency categories for some common procedures is advised in the National Elective Surgery Urgency Categorisation Guideline (2015)
- urgency category 3 should not be assigned to referrals accepted under Direct Access Adult Gastrointestinal Endoscopy Service Criteria.

2.12 Patient consent must be obtained by the referring specialist completing the request before registration onto the elective waiting list (this includes patients referred from private consulting rooms) except in the following situations;

- for urgent category 1 patients, waitlisting can occur in the absence of consent; however, consent must be obtained as close to waitlisting as possible
- patients undergoing repeat procedures may be waitlisted for their repeat procedure prior to the completion of a new consent form
- direct access patients can provide their consent at a pre-admission appointment or on the day of admission, prior to the procedure for simple procedures.

2.13 Consent must be confirmed using an approved hospital patient consent form. Allowance exists for patients consenting via telehealth (refer to MP 0175/22 *Consent to Treatment Policy*).

2.14 A copy of the Consent must be held in the patient's medical record.

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[1] This only applies to referrals within the metropolitan areas that have been submitted via the CRS. Direct Access Services within WACHS will be responsible for sending return letters to referrers.

3. Registering Patients on the Waiting List

3.1 All requests for elective services must be actioned (accepted or rejected) within five (5) working days. This does not apply to requests for excluded procedures which must follow the sites documented approvals process.

3.2 Incomplete requests must not be registered. The hospital must make reasonable attempts to obtain the missing information by contacting the referring specialist and/or patient verbally or in writing. This must be done within the same 5-day period of receiving the request. If these attempts are unsuccessful, the request is to be returned to the referring specialist for completion.

3.3 Where a request is refused on medical grounds or related hospital policy, the Health Service Provider must inform the referring specialist of the reason for refusal. Grounds for refusal include:

- the request for admission is for an excluded procedure without a strong clinical indication (refer to Excluded Procedures Manual)
- the patient has a duplicate waiting list entry
- the patient is ineligible for the provision of treatment (refer to the WA Health Fees and Charges Manual)
- the patient is unable to undergo treatment within 365 days (e.g. where post-operative recovery and rehabilitation prevents further treatment).

3.4 If the decision of refusal is upheld, it is the responsibility of the hospital to advise the patient of this. The decision must be documented in the PAS, as well as the patient's medical record, where available.

3.5 If a request is accepted, the patient must be registered onto the elective waiting list within that same period of five (5) working days. The date on which the request is first received by the hospital waitlist office is the date used for elective waiting list registration.

3.6 Patients must be registered on the elective waiting list at the hospital best matched to their care requirements based on complexity, medical workforce, hospital capacity, location and waiting time.

3.7 Patients identified as benefitting from multidisciplinary case coordination at the point of waitlisting must be flagged to reduce unnecessary postponements and assist in reducing long waits.

3.8 In the event of a change in a patient's condition, the treating specialist may change an assigned urgency category. The reason must be documented on the PAS and the patient's medical record, if available. The patient is also to be notified of the change.

Multiple Waiting List Entries

3.9 Multiple waiting list entries are to be accepted if the treatments/procedures are independent of each other (e.g. cataract extraction and joint replacement).

3.10 The patient's ability to undergo multiple procedures within a short period of time must be considered before registration on the elective waiting list.

3.11 Bilateral procedures are not to both be listed as 'Ready for Surgery' unless the procedures are being completed on the same day.

3.12 Where a patient is admitted for one of their waitlisted procedures, the elective waiting list responsible officer, in consultation with the relevant treating specialist/s must determine if the patient is to be deemed 'Not Ready for Surgery' for the other waitlisted procedure(s) while the patient is recovering.

Duplicate Waiting List Entries

3.13 If an elective waiting list entry already exists for the same procedure at either the same or different hospital (duplicate request), the request must be refused.

- Elective Services Wait List Data Collection provides reports that identify potential duplicate wait list entries, to assist hospitals in appropriately managing duplicate cases.

3.14 If a patient's clinical requirements change, it is the responsibility of the referring specialist to notify the relevant site that the original request is to be cancelled and the updated request accepted.

3.15 If it is identified that a patient has been registered on the elective waiting list for the same procedure at multiple hospitals, all but one of the waitlist events must be removed following consultation between the relevant hospitals and the patient.

3.16 In all cases the patient, their General Practitioner and the referring specialist are to be advised of the situation and the duplicate booking policy.

Transferring Requests for Registration on the Elective Waiting List

3.17 When a request to register a patient onto the elective waiting list is received and the hospital determines the current treating specialist is unable or unlikely to be able to provide the procedure within the assigned clinical urgency category timeframe the hospital must (where feasible):

- transfer the patient from one treating specialist to another equivalently credentialed specialist within the same hospital
- transfer the patient to another hospital and specialist that is equivalently credentialed to perform the procedure where a shorter waiting time to admission is available
- consider theatre utilisation and the option of additional session

- consider transferring the patient to a private provider.

3.18 Public patients who decline transfer to another specialist or hospital (including private hospitals) must be considered as declining an offer of treatment and this must be recorded on the PAS.

3.19 Patients referred from a specialist working from private consulting rooms who indicate that they will elect to be admitted as private patients may choose whether to accept the transfer to another specialist or hospital:

- consent must be obtained from the private patient and the referring specialist prior to transfer to another specialist or hospital
- private patients who decline transfer to another specialist or hospital are not to be considered as declining an offer of treatment.

3.20 The hospital is to liaise with the patient, the referring specialist and the General Practitioner (where relevant) regarding the transfer arrangement and patient's registration onto the elective waiting list at the receiving hospital.

3.21 When a procedure request is transferred to another hospital/treating specialist and the patient requires further medical assessment there will be no additional cost to the patient.

3.22 When initiating a transfer to another hospital/treating specialist the responsible officer at the initial site should be in contact with the responsible officer at the transfer site to discuss the process for transferring the patient to ensure waiting time is accurately captured and considered.

3.23 The date on the initial request for registration onto the elective waiting list must be transferred and maintained with the patient to the receiving public hospital elective waiting list to ensure the waiting time is accurately captured and to ensure equitable patient management.

3.24 If the patient is removed from one hospital waiting list and successfully transferred to another hospital, this must be documented in the patient's medical record and/or PAS for audit and reporting purposes.

4. Communicating Information

4.1 Hospitals are required to advise all patients within five (5) working days of the registration that they have been placed on an elective waiting list.

4.2 A waiting list confirmation letter must be sent out to the patient and General Practitioner where noted, when the patient is entered on to the waiting list that includes:

- the date of the placement on the waiting list
- surgical/medical unit responsible for care
- proposed procedure
- specialty urgency category and treatment time for category
- contact number for information about the waiting list and changes in personal details
- who to contact if clinical condition changes or if contact details change
- information on the Did Not Attend/Cancellation Policy.

4.3 Patients must be informed of their responsibility to notify the hospital of any changes to their contact details and the outcome for failing to do so.

4.4 Information relevant to the continuing care and management of a patient on the elective waiting list is to be shared with the patient's nominated General Practitioner (where available), unless the patient expressly does not consent. The patient's decision is to be documented in their medical record and in the PAS.

4.5 Patients must be notified in writing when their elective service is scheduled (except in the case of short notice patients) and of a requirement to attend any pre-admission clinic. This does not preclude patients also being notified via phone.

4.6 In the case of short notice patients being contacted to fill vacancies created by cancellations (see Section 8- Short Notice Patients), this notification may occur by telephone.

4.7 Hospitals must notify the patient of any changes to their urgency status on the elective waiting list either in writing or by telephone.

4.8 Hospitals must ensure that an up-to-date record of all communication is maintained in the PAS and in the patient's medical record, where available.

4.9 For security reasons, patients from Correctional & Forensic Secure Mental Health Facilities (and their relatives) must not be informed of admission details (e.g. booked or expected procedure date). These patients may be advised that at some point in the future they will attend a hospital for admission. Instead, details of the dates for admission must be directly conveyed to the relevant accountable authority at the correctional facility or forensic secure mental health facility.

5. Managing Patient Status

Listing Status

5.1 When a patient is registered on the elective waiting list, the patient's readiness to undergo their procedure must be reflected by selecting the appropriate listing status:

1. Ready for Surgery
2. Not Ready for Surgery – Staged/Periodical/Planned
5. Not Ready for Surgery – Pending Improvement of Clinical Condition
6. Not Ready for Surgery – Deferred for Personal Reasons

5.2 A 'Not Ready for Surgery' status must not be used for waitlist management purposes (e.g. indicating surgeon or theatre unavailability) as this results in inaccurate reporting of the patient's overall waiting time on the elective waiting list.

5.3 The relevant date fields in the PAS must be completed to ensure that the time when the patient is not ready for admission is accurately recorded.

5.4 Patients must be informed that while they are listed as 'Not Ready for Surgery' they are not considered to be waiting.

5.5 Hospitals must actively monitor 'Not Ready for Surgery' patients to ensure they become ready for care and receive their elective procedure or alternatively, are removed from the elective waiting list.

Ready for Surgery

5.6 For the patient to be listed on the elective waiting list as 'Ready for Surgery', the patient must be "prepared to be admitted to hospital or to begin the process leading directly to admission for surgery".

5.7 The process leading to admission could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests".

5.8 Only patients listed as 'Ready for Surgery' are included in state-wide elective services performance reporting.

Not Ready for Surgery – Pending Improvement of Clinical Condition

5.9 These are patients who are 'Not Ready for Surgery' because of a medical condition that requires treatment or management (or simply time to pass) so

that the patient is suitable for the admission. The time that will elapse before the patient is suitable is usually not known or accurately predictable.

For example, a patient with respiratory insufficiency that requires physiotherapy to maximise respiratory function before a hernia repair.

5.10 The patient's nominated General Practitioner is to be advised if the patient has been listed as 'Not Ready for Surgery – Pending Improvement of Clinical Condition', where a significant delay in care is anticipated and/or for clinical issues potentially requiring management by the General Practitioner. Where care is delayed for a short period for minor health complaints (e.g. upper respiratory tract infection, gastroenteritis) General Practitioner notification is not required.

Not Ready for Surgery – Deferred for Personal Reasons

5.11 This includes patients who require treatment but for personal (non-clinical) reasons are not yet prepared to be admitted to hospital. This includes patients with work or other commitments that preclude their being admitted to hospital for a period of time.

For example, inadequate home support post operatively for self, caring for another person and unable to secure respite care, holiday planned or a work commitment.

5.12 Where feasible, hospitals must work with patients to assist them to become 'Ready for Surgery', this may involve providing information about home support options, or access to other support services that may assist patients to become fit.

5.13 Any patient listed as deferred for personal reasons must be advised by the hospital that they are listed as deferred, what the maximum cumulative deferred time is for their urgency category and that exceeding this time may result in their removal from the waiting list.

5.14 The maximum cumulative length of time (except where there are documented extenuating circumstances), for a patient deferring their procedure for personal reasons is:

- Category 1 – 15 days
- Category 2 – 45 days
- Category 3 – 120 days.

5.15 Patients who have exceeded these timeframes may require clinical advice/management by the treating team or General Practitioner, or removal from the elective waiting list.

Not Ready for Surgery – Staged/Periodical/Planned

5.16 This status is to be used for patients who have undergone a procedure or some other treatment and are waiting for follow-up elective services that needs to occur at a known time in the future.

For example, a patient requiring rectal cancer surgery six weeks after a neoadjuvant chemo-radiotherapy for colorectal cancer.

5.17 This status is to also be used for surveillance procedures, where the procedure is required at an identified interval. A ready for care date must be set 2 months prior to the procedure being due. Referrals for surveillance procedures due more than 12 months after receipt of the referral are to be returned to the referrer, with advice to re-refer the patients when their procedure is due within 12 months.

For example, a patient requiring a surveillance endoscopy within 12 months of completion of a previous procedure.

Keeping Fit for Admission

5.18 In collaboration with their General Practitioner, referring specialist and the hospital, patients are expected and encouraged to optimise their health in readiness for admission. This may include weight loss management, smoking cessation and opioid reduction.

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

- how best to manage their condition while waiting for elective services
- the pre-operative health requirements necessary to proceed
- what to do if they believe their condition has deteriorated while waiting
- how to access services and the role of their General Practitioner in helping them to maintain general health.

6. Scheduling Patients for Elective Services

6.1 Surgery/Procedures are required to be allocated to patients according to:

- clinical urgency
- the length of time the patient has waited in comparison with similar patients ('treat in turn' principle)
- resource availability (e.g. availability of theatre time, the surgeon, equipment and hospital capacity)
- whether the hospital has previously postponed the patient's admission.

6.2 Health Service Providers must have in place appropriate local policies and procedures to actively support the implementation of 'treat in turn'.

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

6.4 For paediatric patients, Children in Care are to be given priority within their clinical urgency category.

6.5 Consideration is to be given to patients who are required to travel a significant distance (i.e. regional to metropolitan areas). Where possible, multiple appointments are to be coordinated on the same day/visit, and/or be conducted via Telehealth to minimise travel time and costs. However; geographic location (i.e. distance to be travelled and catchment area) must not hinder the selection of patients being scheduled for treatment.

6.6 Effective forward planning is essential for all stakeholders. Waitlist coordinators, clinicians and theatre management staff must work collaboratively to achieve the most effective utilisation of theatre time.

6.7 Patients must not be prematurely booked (premature admission) unless clinically indicated and/or in exceptional circumstances i.e. short notice patients. The thresholds for booking are as follows:

Category	Threshold
2	Booked date to be no earlier than 31 days after addition to the elective waiting list (and no later than 90 days)
3	Booked date to be no earlier than 91 days after addition to the elective waiting list (and no later than 365 days)

7. Postponement of Elective Services

Hospital-Initiated Postponements

7.1 A hospital-initiated postponement is defined as any rescheduling of a patient's confirmed admission date due to the inability of the hospital to deliver the required service.

7.2 The hospital may need to postpone due to unforeseen circumstances (e.g. major trauma, unplanned staff leave), or other factors relating to human resources, equipment or facilities that may compromise the safety and quality care of the patient.

7.3 When a hospital initiates the postponement of a patient's elective procedure, the hospital must:

- give the patient as much notice as possible
- make arrangements for the procedure to be undertaken as soon as possible; or transfer the patient to another specialist/hospital with a shorter wait time.

7.4 The patient must be advised of:

- the reason for the postponement
- the rescheduled admission date (must be provided immediately for Category 1 patients)
- any changes to the intended specialist/hospital providing the treatment
- what they should do if their condition deteriorates
- the opportunity to discuss with a doctor any medical issues that might arise as a result of the postponement of surgery (as clinically required – e.g. patients requiring advice regarding re-commencement of anti-coagulant medication).

7.5 The hospital is to ensure that a record of changes and communication is maintained on the PAS and the patient's medical record, where available.

7.6 A patient who is being postponed for a second time must be brought to the attention of the Hospital Executive acting under the delegation from the Chief Executive.

Patient-Initiated Postponements

7.7 A patient who requires postponement of a confirmed booking due to personal reasons can defer treatment (see section 5.11).

7.8 A patient who initiates a second postponement, defers an admission date a second time, declines an available date on two occasions, or fails to arrive on the scheduled admission date for a second time without prior notice and without good cause may be removed from the elective waiting list. The

patient’s referring specialist and nominated General Practitioner (where recorded) must also be advised of the removal.

7.9 Where good cause is given, elective waiting list staff are to work with the treating specialist and the patient to reschedule their procedure.

7.10 In the case of Category 1 patients, a clinical review is required prior to removal from the elective waiting list.

7.11 The hospital is to exercise discretion to distinguish between patients who negotiate an admission date due to extenuating circumstances and those who declare themselves ‘Not Ready for Surgery’ for a prolonged period.

7.12 The hospital must record patient-initiated postponements on the PAS.

8. Managing the Waiting List

Short Notice Patients

8.1 Hospitals must maintain a record of 'standby' patients who have indicated that they are available for admission at short notice to ensure full utilisation of elective lists.

8.2 Short notice patients must be given as much prior notice as possible regarding the date of their procedure.

8.3 Where feasible, the 'treat in turn' principle must be applied to patients being contacted on short notice.

8.4 Patients who decline an admission date that is offered at short notice are not recorded as having declined an offer of admission.

8.5 If a patient has been called in on short notice and their procedure does not go ahead, a definite planned date of admission must be made to ensure the patient is not further inconvenienced.

Transfers after Registration onto the Elective Waiting List

8.6 If, after initial registration on the elective waiting list, it is established that the treating specialist is unable or unlikely to be able to provide treatment (e.g. due to resignation or service changes) in the recommended timeframe, the hospital must:

- transfer the patient from one specialist to another credentialed specialist within the same specialty at the same hospital
- transfer the patient to another credentialed specialist at another hospital within the WA health system that performs the procedure and with a shorter waiting time to admission.

8.7 These options are to be coordinated in consultation with the patient, whilst also advising the patient that if they decline to transfer to an alternative specialist or hospital they are deemed to have declined an offer of treatment, which must be recorded in the PAS.

8.8 Care must be taken not to unfairly disadvantage patients. Extenuating circumstances, such as carer support needs, family requirements or other personal matters, can impact on the patient's ability to accept an alternative elective waiting list.

8.9 Where a patient is transferred to another specialist or hospital, the elective waiting list responsible officer is to ensure appropriate arrangements are made for:

- notifying the referring specialist and original treating specialist
- assessment of the patient by the specialist who will undertake the procedure, as required

- post-operative care for the patient
- clear documentation of the transfer of the patient in the patient medical record and on the PAS
- transfer of the medical record, as required.

8.10 The above approach is also to be used by Health Service Providers to better manage distribution of elective cases for patients who do not have a booked date for their procedure and who are approaching the boundary for their urgency category.

8.11 In this case, patients are not to be recorded as declining an offer of treatment if they elect to remain with their originally referred specialist, but they must be advised that declining a transfer may mean a longer wait until treatment.

Management of Doctor's Absence – Temporary or Permanent

8.12 Where a treating specialist has either resigned or is taking a period of absence, a management plan is to be developed and implemented for all affected patients (i.e. those with an affected scheduled admission date and those who will exceed clinical priority timeframe during period of absence).

8.13 The transfer of care plan is the responsibility of the responsible officer (in conjunction with the Head of Department) who must ensure affected patients are:

- assured that their position on the waitlist will not be affected
- advised who the replacement treating specialist will be
- advised if clinical review is required, (noting this additional clinical review must not impact negatively on the patient's waiting time)
- provided with information regarding their expected waiting time.

8.14 All communication with patients must be documented in the PAS.

Removing Patients from the Waiting List

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

- the patient is not contactable, provided the hospital has made reasonable attempts to contact the patient. This includes attempts to identify the patient's correct contact details via the patient's treating specialist, General Practitioner, Hospital Medical Records, the patient's next of kin (in the case of minors) or a telephone directory search. Evidence of a reasonable effort to contact the patient must be included in the patient's medical record at the time the patient is removed from the waiting list
- the patient is deceased (note that further requirements in Section 8.20 do not apply to these cases).

8.16 Patients can be removed from the waiting list subject to the requirements in Sections 8.17 and 8.18, if they:

- indicate they no longer wish to receive treatment at the hospital
- twice decline an offer of treatment without good reason or cause
- record a second failure to attend without good cause and without prior notice to the hospital (includes failure to attend pre-admission outpatient clinic appointments)
- have permanently relocated to another state/country or are unavailable for extended periods
- have deferred their procedure beyond the maximum cumulative length of time allowed for their urgency category for personal reasons (refer section 5.14).

8.17 Category 1 patients who meet the criteria for removal from the elective waiting list must be brought to the attention of the treating specialist and/or relevant Head of Department. Depending on the patient's diagnosis, the treating specialist or Head of Department may request that the patient attend a clinical review for reassessment of their condition and to discuss options and the consequences of not proceeding.

8.18 Category 2 and 3 patients who meet the criteria for removal from the elective waiting list may be automatically removed, with advice to contact their referring General Practitioner or specialist if they wish to proceed with treatment later, or if their condition deteriorates.

8.19 When removing any patient from the waitlist the hospital is to exercise discretion on a case-by-case basis to avoid disadvantaging patients in the case of genuine hardship, cultural sensitivities, misunderstanding and other unavoidable circumstances.

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

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

8.21 The reason for removal of a patient from the elective waiting list must be documented in the PAS and where available, the patient's medical record.

8.22 The hospital must also notify the patient's referring specialist and nominated General Practitioner within five (5) working days of removal.

9. Monitoring the Waiting List

9.1 Each hospital is to identify a person (responsible officer) responsible for overseeing and monitoring the elective waiting list.

Clerical Review of the Elective Waiting List

9.2 The elective waiting list is to be reviewed regularly (minimum of weekly) to identify and prioritise unbooked patients who have exceeded, or are approaching, the clinically recommended timeframe for their urgency category. Where required, the treating specialist or Head of Department must be consulted to assist with patient prioritisation.

9.3 Hospitals must have in place a process for conducting administrative audits at regular intervals to ensure waitlist accuracy is maintained. The audit process should aim to confirm:

- patient and General Practitioner contact details are current
- patient still requires surgery (i.e. has not had surgery elsewhere) and wishes to proceed
- patient is not on an elective waiting list at another hospital (i.e. duplicate booking)
- patient's short notice availability.

9.4 Other tasks that must be completed include:

- an evaluation of the audit process
- identifying and removing duplicate waitlist entries
- completing missing details in the waitlist record
- reviewing cases with a booked date in the past who remain on the waitlist
- identifying and contacting patients who have not confirmed their availability to attend their pre-admission clinic or booked admission date.

Clinical Review of the Elective Waiting List

9.5 Hospitals must have processes in place to identify and manage patients on the elective waiting list who may require a clinical review (e.g. patients who have waited longer than the clinically recommended time for their urgency category, patients waitlisted for multiple procedures, when notification is received that the patient's clinical condition has changed).

9.6 The clinical review process may include a review of the medical records, a telephone interview or clinical appointment with the treating specialist or Anaesthetist, or referral to the patient's General Practitioner.

9.7 The outcome of any clinical review is to be notified to the responsible officer (or their nominated delegate), recorded in the PAS and the patient's medical record (where available).

9.8 Patients (as well as their referring specialist and/or General Practitioner where available) must be notified of the outcome of their clinical review where they are deemed not ready for care or are to be removed from the waitlist.

Waitlist Data

9.9 Elective Services Wait List Data Collection provides a range of reports to support hospitals to manage their waitlists in accordance with MP 0169/21 *Elective Services Access and Management Policy* and maintain the data integrity of the elective waiting list. These reports can be accessed via the Department of Health intranet site.

9.10 Hospitals are required to maintain their waitlist data in compliance with the requirements specified in the MP 0164/21 *Patient Activity Data Policy*.

10. Related Documents

- Excluded Procedures Manual
- WA Health Financial Management Manual
- MP 0164/21 Patient Activity Data Policy
- MP 0175/22 Consent to Treatment Policy

11. Supporting Information

- WA Health Referral Access Criteria

Appendix 1: Access Criteria for Bariatric Surgery in Public Hospitals in Western Australia

<table>
<tr><th colspan="2">Condition: Bariatric Surgery</th></tr>
<tr><td colspan="2">Referral to Emergency Department:

If any of the following are present or suspected, please refer the patient to the Emergency Department (via ambulance if necessary) or seek emergency medical advice if in a remote region.
Early post-operative patients (up to 6 weeks) with haemodynamic compromise secondary to suspected haemorrhage, anastomotic leak, perforation, bowel obstruction
Contact the relevant surgeon/service that completed the initial surgery for immediate review. If unable to contact, then discuss with on-call registrar or service to arrange an immediate general surgical assessment (seen within 7 days):
Any of the following post-operative issues:
Poor oral intake
Dehydration
Persistent nausea/vomiting
Worsening pain
To contact the relevant service, see Clinician Assist WA: General Surgery Requests (external site).</td></tr>
<tr><td>Clinical indications for outpatient referral</td><td>Resistant obesity where the patient is aged between 16-55 (inclusive) and any of the following:
BMI ≥40
BMI ≥35 with associated obesity related co-morbidities (e.g. Type 2 Diabetes, obstructive sleep apnoea)
NB: For definition of resistant obesity, see ‘Useful information for referring practitioners’ section below.</td></tr>
<tr><td>Mandatory Referral Information
*Required for accurate and timely clinical triage Referral will be returned if this information is not included</td><td>History
Age
Details of current/previous treatment and outcome, e.g. supervised weight loss program, medical therapies (e.g. GLP-1 agonist therapy, semaglutide)
Details of whether there has been any previous bariatric procedure, e.g. gastric band, gastric sleeve
Examination
BMI
Height
Weight
Referrals missing 'mandatory information' with no explanation provided may not be accepted by site. If 'mandatory information' is not included, the explanation must be provided in the body of the referral (e.g. patient unable to access test in regional or remote areas or due to financial reasons).

This information is required to inform accurate and timely triage. If unable to attach reports, please include relevant information/findings in the body of the referral and advise where (provider) investigation/imaging was completed.</td></tr>
<tr><td>Highly Desirable Referral Information</td><td>History
Relevant history, impact on patient’s functional capacity</td></tr>
</table>

**The inclusion or exclusion of this information will not impact the referral being accepted.*	• Current smoking/vaping status
	• Full medical history including
	    ○ Presence of obesity related co-morbidities, e.g. diabetes, sleep apnoea, MAFLD, GORD, degenerative major weight bearing joint disease (and candidacy for joint replacement)
	    ○ Details of current contraceptive plan (e.g. long-acting reversible contraception)
	    ○ Other medical conditions that would increase morbidity or mortality risk of bariatric surgery (e.g. Multiple Sclerosis, ischaemic heart disease, chronic respiratory disease)
	• Psychiatric history (e.g. mood disorders, substance abuse, eating disorders, psychosocial functioning)
	• Psychosocial assessment (e.g. weight problems, relationship to food, available support, current or past violence or abuse/major stressors or life events/drug or alcohol abuse)
	• Age-appropriate cancer screening
	
	Examination
	• For adolescents provide Tanner pubertal development (suitability for surgery is ≥stage 4)
	Investigations
	• FBC
	• Thyroid function
	• U&E
	• LFTs
	• Fasting lipid screen
	• Fasting glucose and HbA1C

Exclusions for Bariatric Surgery	• Aged <16 at time of referral
	• Aged >55 at time of referral
	• Pregnancy or expecting pregnancy within 2 years post-operatively
	• Untreated major depression or psychosis
	    ○ See Clinician Assist WA: Mental Health and Addiction
	• Uncontrolled and untreated eating disorders
	    ○ See Clinician Assist WA: Mental Health and Addiction
	• Current drug and alcohol abuse
	    ○ See Clinician Assist WA: Mental Health and Addiction

Useful information for referring practitioners (Not an exhaustive list)	• For patients with acute post-operative complications from bariatric surgery (e.g. acute upper gastrointestinal obstruction or limited oral intake, ongoing pain, regurgitation, or refractory reflux), the primary pathway for follow up should be via the surgeon/hospital who provided the bariatric surgery
	• Resistant obesity refers to obesity that has failed weight loss techniques including dietary changes, exercise, and behaviour modification program under supervised weight loss program
	• Severe reflux is a contraindication for sleeve gastrectomy. Surgical options should be discussed with Bariatric Surgeon
	• To be considered for bariatric surgery, patients should:
	    ○ be well-informed, motivated and have the capacity to understand the associated risks of surgery
	        ▪ See Bariatric Surgery Patient Education Video
	    ○ have had a comprehensive psychosocial evaluation
	    ○ be able to comply with and adhere to the behavioural changes required after surgery
	    ○ Consider maintaining contraceptive protection for first 2 years post-operatively due to changes in fertility following bariatric surgery

	• Consider if your patient is eligible for a Chronic Disease Management Plan. This will support the patient to receive Medicare rebates for required dietician and other allied health appointments • For information on weight management advice, see Clinician Assist WA: Weight Management • For further information on Bariatric Surgery, see Clinician Assist WA: Bariatric Surgery