Australian Government
Australian Institute of Health and Welfare

ROYAL AUSTRALASIAN COLLEGE OF SURGEONS

National definitions for elective surgery urgency categories

Proposal for the Standing Council on Health

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Contents

Acknowledgments

The Australian Institute of Health and Welfare and the Royal Australasian College of Surgeons would like to acknowledge the contributions of the range of stakeholders who provided valuable comments and suggestions for this report.

They included representatives of the Australian Government, states and territories, public hospitals, surgical specialty and other clinical stakeholder groups, and health consumer groups.

Members of the Expert Panel for the Review of Elective Surgery and Emergency Access Targets also provided valuable advice.

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Abbreviations

ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AHMAC	Australian Health Ministers' Advisory Council
CIHI	Canadian Institute of Health Information
COAG	Council of Australian Governments
CPAC	Clinical Priority Assessment Criteria
DoHA	Department of Health and Ageing
HPC	Hospitals Principal Committee
MAPT	Multi-attribute Arthritis Prioritisation Tool
METeOR	Metadata Online Registry
NHA	National Healthcare Agreement
NEST	National Elective Surgery Target
NMDS	National Minimum Data Set
NHDD	*National health data dictionary*
n.p.	not publishable because of small numbers, confidentiality or other concerns
NPA IPHS	National Partnership Agreement on Improving Public Hospital Services
NSW	New South Wales
NT	Northern Territory
OECD	Organisation for Economic Co-operation and Development
Qld	Queensland
RACS	Royal Australasian College of Surgeons
SA	South Australia
SCoH	Standing Council on Health
Tas	Tasmania
Vic	Victoria
WCWL	Western Canada Waiting List
WA	Western Australia

Summary

There are apparent inconsistencies in clinical urgency categorisation among the states and territories, so recent national reporting of comparable elective surgery waiting times data has not used the national data on clinical urgency category. Variation in the recording of waiting times for patients who are *not ready for care*, for example, for planned follow-up surgery, has also been apparent.

The Expert Panel established by governments to report on elective surgery and emergency access targets noted this variation in its report to the Council of Australian Governments (COAG) in July 2011. In this report, it recommended to COAG that, in order to develop consistent national elective surgery categories, the Australian Institute of Health and Welfare (AIHW) work with the Royal Australasian College of Surgeons (RACS) to, as a matter of urgency, develop national definitions for elective surgery categories, including *not ready for care*.

This report was submitted to the Standing Council on Health (SCoH) in December 2012 by the AIHW and the RACS in response to a request from the Council following the Expert Panel's recommendation.

It was informed by extensive advice and inputs from representatives of the Australian Government, state and territory health authorities, surgical specialty and other clinical stakeholder groups, and health consumer groups. It was also informed by comments from the Australian Health Ministers' Advisory Council and the Council of Australian Governments' Expert Panel for the Review of Elective Surgery and Emergency Access Targets.

The national elective surgery urgency category definitions package

The proposed approach to improve the consistency and comparability of elective surgery urgency categories comprises a package of six integrated components:

1. A statement of an overarching principle for urgency category assignment:
    - Patients who require an elective procedure should be assigned an urgency category by the treating clinician. The urgency category should be:
        - Appropriate to the patient and their clinical situation
        - Not influenced by the availability of hospital or surgeon resources.
2. Simplified, time-based urgency category definitions.
3. A listing of the usual urgency categories for higher volume procedures, to be developed by surgical specialty groups.
4. Comparative information disseminated about urgency categorisation.
5. 'Treat in turn' as a principle for elective surgery management.
6. Clarified approaches for patients who are *not ready for surgery*, because of clinical or personal reasons.

More uniform assignment of urgency categories by treating clinicians will be particularly informed by two measures that should be seen together as an important sub-component of the package: a listing of the usual urgency categories for higher volume procedures, and the dissemination of comparative information about urgency categorisation.

It is also recommended that urgency categorisation, management through elective surgery or similar management systems and local, jurisdictional and national waiting times reporting be established for a range of procedures (such as colonoscopy) currently not part of the national elective surgery waiting times reporting arrangements.

Implementation of the package

Consistency of urgency categorisation will be achieved by adopting this package of measures as part of the overall management of elective surgery provision by hospitals, local hospital networks, states and territories and nationally.

Successful implementation could be facilitated by fostering arrangements for local peer/team leader review of urgency categorisation; encouraging effective communication between surgeons and waiting list managers; continuing engagement with the RACS and surgical specialty groups; and strong monitoring of the effectiveness of the package, with a leadership role played by the Expert Panel.

It is recommended that work is undertaken in 2013 so that the national elective surgery urgency category definitions package is fully implemented by 1 January 2014.

If procedures such as colonoscopy are brought within scope, an implementation date of 1 July 2014 should be planned for this component.

Introduction

Variation in urgency category assignment for elective surgery

Access to elective surgery has been the subject of community discussion for many years. It is also the subject of national performance reporting, with waiting times information reported on a regular basis through the AIHW's *Australian Hospital Statistics* series of reports, through the COAG Reform Council's National Healthcare Agreement (NHA) Performance Report series, and on the *MyHospitals* website. Waiting times information is also used locally in the management of elective surgery.

National data on elective surgery waiting times includes data on the *clinical urgency* of the patient, that is, on how quickly the patient should have surgery. This information is designed to be used to plan and to assess access to surgery dependant on the clinically-assessed condition of the patient. However, because of apparent large inconsistencies in clinical urgency categorisation among the states and territories, recent national reporting of comparable elective surgery waiting times data has not used the national data on clinical urgency category. Variation in the recording of waiting times for patients who are *not ready for care*, for example, for planned follow-up surgery, has also been apparent.

Appendix 1 provides information on the variation apparent among the states and territories in urgency category distribution in 2011-12, and also the apparent variation in recording of waiting times for patients who were *not ready for care* for part of the time that they waited.

The proportion of patients admitted for surgery who were urgency category 1 varied from 23% in Western Australia to 41% in Queensland. Some variation among the jurisdictions could reflect variation in casemix. However, the variation also exists for individual surgical specialities (for example, 2% of cardiothoracic surgery is category 2 in Tasmania and 48% is category 2 in the Australian Capital Territory) and for individual procedures (for example, 21% of hip replacements are category 2 in South Australia and 82% are Category 2 in the Australian Capital Territory). For individual procedures, in particular, differing distributions of urgency categories would not be expected, and are likely to reflect structural issues such as the varying definitions used by jurisdictions (outlined in Appendix 2).

Recommendations of the Expert Panel

In February 2011, the Heads of Agreement—National Health Reform and the National Health Reform Agreement—National Partnership Agreement on Improving Public Hospital Services (NPA IPHS) was signed by the Australian Government and all state and territory governments. In May 2011, an expert panel was established under these agreements to provide advice on the implementation of elective surgery and emergency access targets and incentives outlined in the agreements, including the National Elective Surgery Target (NEST). The NEST incorporated targets defined using clinical urgency categories.

The Expert Panel for the Review of Elective Surgery and Emergency Access Targets under the NPA IPHS (the Expert Panel) reported to COAG on 30 June 2011 (Expert Panel 2011a, 2011b). The report put forward 15 recommendations. Recommendation 10 relates to the development of national definitions for urgency categories for elective surgery:

Recommendation 10:

That, in order to address the current inconsistencies in the application of elective surgery urgency categories:

i. as a matter of urgency, national definitions for elective surgery urgency categories be further developed, agreed and implemented across all states and territories. This should be led by the Australian Institute of Health and Welfare, working with the Royal Australasian College of Surgeons, and replace the planned review under the existing Clause A47 of the National Partnership Agreement on Improving Public Hospital Services:

> A47. During the transition period referred to in A47, a review will be conducted of elective surgery categories, focusing on safety issues and practical impediments to achieving the targets that have been set under this Agreement from 2014 onwards. The review will be auspiced by Health Ministers and involve senior clinical input. (Source: the National Parternship Agreement, page 23);

ii. a nationally consistent definition of 'Not Ready for Care' be developed and applied; and

iii. whilst new definitions are under development, more detailed guidelines should be developed and applied to the existing urgency categories to ensure as much consistency as possible in measurement and data collection, both within and between jurisdictions.

COAG agreed to all the Expert Panel recommendations and they were incorporated into the revised NPA IPHS signed by COAG in July 2011.

The revised NPA IPHS states under Schedule A, Section 54—Joint roles of the Commonwealth and the States and Territories:

> In order to develop consistent national elective surgery categories, the parties agree that the Standing Council on Health will request that the Australian Institute of Health and Welfare work with the Royal Australasian College of Surgeons to, as a matter of urgency, develop national definitions for elective surgery categories, including 'not ready for care' (COAG 2011).

The SCoH (Australian Government, state and territory health ministers) conveyed this request to the AIHW in January 2012, asking that the definitions be developed by December 2012.

This document

This document is a proposal developed by the AIHW and RACS in response to the request from SCoH.

It has been informed by extensive advice and inputs from representatives of the Australian Government, state and territory health authorities, surgical specialty and other clinical stakeholder groups, and health consumer groups. It has also been informed by comments from the Australian Health Ministers' Advisory Council and the Council of Australian Governments' Expert Panel for the Review of Elective Surgery and Emergency Access Targets.

The document provides:

- brief background on this work (this section)
- a description of the objectives of the work
- a definition of elective surgery that underpins the approach proposed
- the proposed package to improve the consistency and comparability of elective surgery urgency categories, including for patients *not ready for care*
- some other issues for consideration
- some notes on implementation of the proposed approach
- appendices presenting:
  - current data on urgency categorisation for states and territories
  - information on the varying definitional practices in Australia
  - information on international approaches to urgency categorisation
  - a summary of consultations undertaken for this report
  - examples of feedback material on comparative urgency categorisation.

Objectives

This report will recommend to the Australian Government, state and territory health ministers, agreed national elective surgery urgency category definitions (including for patients *not ready for care)* that will enable consistent application across all states and territories.

The national definitions are expected to:

- facilitate access to elective surgery for patients
  - according to clinical need
  - maximising equity of access
  - minimising harm associated with delayed access
- support an appropriate balance between consistency of practice and clinical decision-making when assigning an urgency category
- support consistent and transparent reporting against the NEST and for other national reporting of Elective surgery waiting times performance
- enhance overall elective surgery waiting list management with benefits for:
  - individual patients and their families
  - clinicians
  - elective surgery service managers, and
  - policy makers.

The development of the national definitions will include consideration of patients *not ready for care*, that is:

- patients who are waiting for surgical care that is a follow-up to earlier clinical care
- deferred patients who are clinically ready for surgical care but have delayed surgery for personal reasons.

Definition of ‘elective’ surgery

The current national definition for *elective care* is ‘care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours’ (METeOR identifier 476370). It is used to distinguish between ‘elective care’ and ‘emergency care’, for which admission is defined as being desirable within 24 hours.

This distinction between emergency and elective admissions being based on whether admission could be delayed for at least 24 hours does not reflect actual practice in relation to elective surgery.

The definition used to underpin the approach to improving consistency of urgency categories for elective surgery in this proposal more accurately reflects actual practice:

> Elective surgery is defined as surgery for patients whose clinical condition requires a procedure that can be managed by placement on a waiting list.

This definition is not proposed at this stage as a national standard, and should be further considered in connection with related work being undertaken by the AIHW with advice from the RACS, to develop definitions for emergency surgery.

Comments:
The current definition may not be contributing to variation in the types of patients managed through elective surgery management systems and therefore in scope for Elective surgery waiting times reporting. However, it is considered important to clarify the definition so that it reflects actual practice, and the link between ‘elective surgery’ and waiting lists is made clearer. The clarified definition should also be useful in assisting consumers to understand the term ‘elective’ as not meaning ‘optional’. While the Expert Panel review found that there was preference for use of the term ‘planned’ rather than ‘elective’ surgery, this view was not prominent in the consultations for this report.

The national elective surgery urgency category definitions package

The proposed approach to improving the consistency and comparability of elective surgery urgency categories comprises a package of six integrated components (Figure 1):

1. A statement of an overarching principle for urgency category assignment.
2. Simplified, time-based urgency category definitions.
3. A listing of the usual urgency categories for higher volume procedures.
4. Comparative information disseminated about urgency categorisation.
5. 'Treat in turn' as a principle for elective surgery management.
6. Clarified approaches for patients who are *not ready for surgery*.

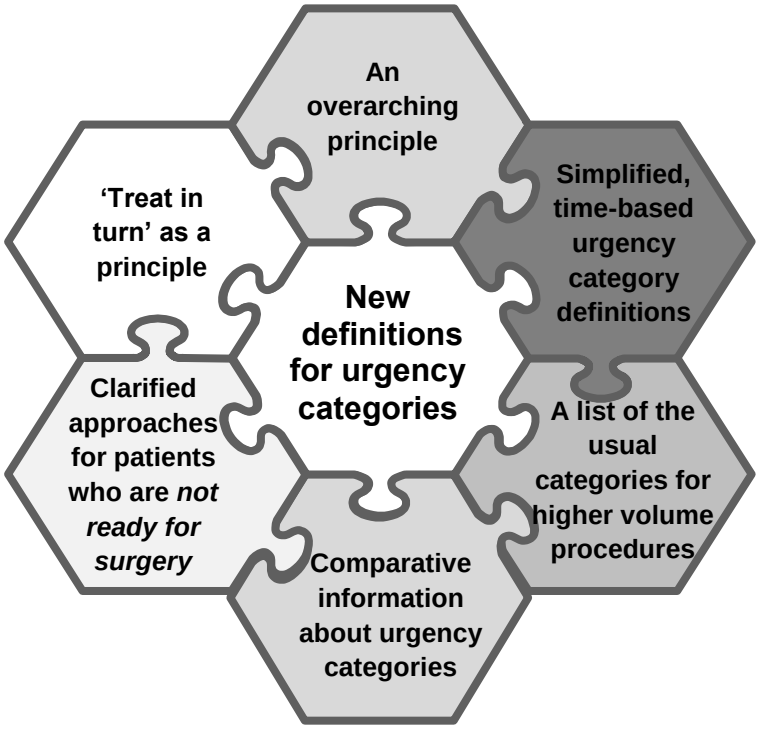


Figure 1: The national elective surgery urgency category definitions package

How will consistency be achieved?

Consistency of urgency categorisation will be achieved by adopting this package, as part of the overall management of elective surgery provision by hospitals, local hospital networks, states and territories and nationally.

More uniform assignment of urgency categories by treating clinicians will be particularly informed by two measures that should be seen together as an important sub-component of the package: a listing of usual urgency categories for higher volume procedures and the dissemination of comparative information on urgency categorisation.

1. A statement of an overarching principle for urgency category assignment

It is recommended that the following is adopted as a statement of the overarching principle to be applied in elective surgery urgency categorisation.

> Patients who require an elective procedure should be assigned an urgency category by the treating clinician. The urgency category should be:
>
> - appropriate to the patient and their clinical situation
> - not influenced by the availability of hospital or surgeon resources.

Comments:
The notion that the patient's clinical situation is the overriding consideration for urgency categorisation is regarded as an important principle, and important enough to be explicitly stated as part of the national elective surgery urgency category definitions package. The clinical situation of the patient is taken to encompass the patient's medical condition and the patient's 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. Also important is that the clinical urgency category should not be influenced by actual or perceived availability of resources. In the NHA, states and territories have agreed to provide public hospital services on the basis of Medicare Principles, which include that access to services is to be on the basis of clinical need and within a clinically appropriate period (Clause 4). The principles for elective surgery urgency categorisation are consistent with this. The assignment of urgency categories is regarded as a responsibility of the 'treating clinician', rather than of other hospital staff. The treating clinician is the clinician with responsibility for the patient at the time of urgency categorisation. The treating clinician's decision would be made in the context of other components of the package proposed here, including the definitions for urgency categories, the list of most often used urgency categories for higher volume procedures and information on comparative urgency categorisation.

2. Simplified, time-based definitions of urgency categories

The definitions of the urgency categories are based simply on the time frame in which the procedure is clinically indicated, as judged by the treating clinician (Table 1).

Table 1: Proposed simplified, time-based definitions of urgency categories

Urgency category	Meaning
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

These national definitions are intended to be used as part of the integrated elective surgery urgency category definitions package. That is, clinician decision-making about urgency categories should be in accordance with the definitions, and should be informed by the national list of the usual urgency categories for higher volume procedures and information on comparative urgency categorisation.

States and territories and hospitals are discouraged from independently developing other materials that may influence treating clinicians in their interpretation of the definitions. Any guidance materials supplied to treating clinicians should be developed and agreed at a national level, be consistent with these definitions and not seek to add layers of detail regarding how quickly a patient requires surgery.

As is noted in the current national definitions, a patient's classification may change if they undergo clinical review during the waiting period. The need for clinical review varies with the patient's condition and is therefore at the discretion of the treating surgeon.

Comments:

Previously, the definitions included references to the potential for the patient's condition to deteriorate to become an emergency, and to the extent to which it was causing pain, dysfunction or disability. The proposed definitions do not include that type of material, because that is only part of the information used by clinicians to make a judgment about how urgently the procedure should be undertaken, it may not be applicable in all circumstances.

In addition, the absence of specific requirements about patient conditions means that they would not distort clinical choices based on clinical assessment of the time by which a procedure is required.

As is currently the case in the national definitions, category 1 is associated with a time frame of 30 days and category 2 with a time frame of 90 days. Category 3 is now also associated with a time frame that differs from the current national definition for category 3 ('admission at some time in the future acceptable'), which is not associated with a time frame.

The categories and timeframes were chosen because they can be intuitively meaningful for clinicians. It is noted that there is no evidence relevant to patient outcomes for or against having three or a different number of categories, nor to the timeframes associated with the three categories.

Stakeholders expressed a wide range of views on how many urgency categories there should be, and what time periods should be associated with them. There was no consensus for change to the numbers of categories or to the timeframes associated with categories 1 and 2.

There was a more uniform view that the current wording for category 3 was problematic, with many stakeholders considering that it was too 'open-ended' to be meaningful. Most nevertheless recognised that an urgency category needed to be assigned for all patients for whom surgery was clinically indicated, even if the surgery was not indicated within either 30 or 90 days.

Locally, a choice could be made to use more than 3 categories. For example, category 2 could be split into a category for patients for whom their surgery is clinically indicated within 60 days, and patients for whom surgery is clinically indicated within 90 days.

As noted above, in the NHA, states and territories have agreed to provide public hospital services on the basis of the Medicare Principles, which include that access to services is to be on the basis of clinical need and within a clinically appropriate period (Clause 4).

The timeframes associated with category 1, category 2 and category 3 proposed here could be regarded as defining a clinically appropriate period for patients assigned to those categories.

It is important to note that the timeframes proposed as part of the definitions of urgency categories are separate from timeframes for delivery of elective surgery incorporated into local or national elective surgery performance agreements.

3. Information on the 'usual' urgency categories for higher volume procedures

As noted above, it is expected that the list of usual urgency categories for higher volume procedures and information on comparative urgency categorisation would be used together by treating clinicians to inform a more uniform approach to urgency categorisation.

A national list of usual urgency categories for higher volume procedures should be developed as a guide to urgency categorisation by treating surgeons.

The list should be developed by the national surgical specialty groups, with each group asked to provide information on the usual urgency category for their higher volume procedures. The list would be expected to relate primarily to procedures, but specialty groups may also decide to include additional guidance relating to particular indications. Existing lists, which are similar but not identical, are in use in two jurisdictions and could form the basis of developing a national list.

The identification of the usual urgency category for each procedure would be made, acknowledging that other urgency categories would be assigned for some patients.

The need to document reasons for assigning an urgency category other than the 'usual' category is a matter for hospitals or jurisdictions to determine. Where clinicians and services are categorising patients in a manner consistent with elsewhere (informed by comparative urgency categorisation reporting), 'justification' may not be necessary.

The national list would ideally be developed for use by the end of 2013.

Comments:
In New South Wales and Western Australia, recommended urgency categories for higher volume procedures for which patients are added to elective surgery urgency categories have been developed (NSW Health 2012; WA Health 2009). Treating clinicians are guided by the recommended urgency categories, with individual patient exceptions needing to be supported by clinical documentation. Stakeholders from many states agreed that consistency in assignment of urgency categories by procedure is desirable and that a guide to the assignment of urgency categories for the most frequently occurring procedures would be useful. However, a range of views about the appropriateness of recommended or suggested urgency categories were expressed. While some considered that they would not be useful, or be at odds with surgeon decision-making based on the patient's clinical situation, most considered that they would be a useful support, particularly for less experienced surgeons, and for surgeons working outside team settings. For most procedures, it would be expected that there would be a range of urgency categories that would be appropriate, dependent on the clinical indication and other circumstances of the patient. However, it would be expected that a majority of patients would be assigned to the identified usual category.

4. Information on comparative urgency categorisation

As noted above, it is expected that the list of usual urgency categories for higher volume procedures and information on comparative urgency categorisation would be used together by treating clinicians to inform a more uniform approach to urgency categorisation.

Arrangements should be established to provide information about comparative urgency categorisation to surgeons, surgical specialty groups, hospitals, local hospital networks and states and territories on a routine basis. Some of the material should also be published, to improve transparency of urgency categorisation.

Urgency category distributions for specific surgical specialties or procedures for the hospital or Local Hospital Network would be presented in comparison with state/territory and national distributions, and/or distributions for peer group hospitals, for which casemixes (and therefore urgency category distributions) would be expected to be similar. To ensure they were meaningful, some presentations could be for specific indications, for example, where urgency category assignment for a particular procedure typically varies with the indication for surgery.

It would be important for provision of this information to be undertaken on a national basis, so that it can foster comparability of urgency categorisation between states and territories, as well as within them. For example:

- Comparative urgency categorisation information could be published for each state and territory and for national hospital peer groups and local hospital networks.
- Comparative urgency categorisation could also be published for each individual hospital within national peer groups.

At the local level, jurisdictional health departments or local health networks could also provide comparative urgency categorisation data confidentially to individual surgeons or surgeon teams (drawing on data available locally). Such information could also be distributed confidentially through the national surgical specialty groups.

The information should be made available in as timely manner as possible. An option for nationally-based dissemination would be to use the data on elective surgery provision currently provided by states and territories under the NPA IPHS. Those data are provided quarterly, one month after the end of each quarter, and could potentially be a source of national comparative urgency categorisation information soon after that.

The exact nature of the comparative information, and the mechanisms through which it would be published and otherwise disseminated, would need to be decided with input from the surgical specialty groups, states and territories and other stakeholders.

It is important to note that such information on urgency category distributions would not be regarded as performance reporting. Instead, it would be regarded as provision of information to understand and manage variation in practice, in the same way as other comparative information is fed back to inform improvement in other areas of clinical practice.

Comments:
Making national information on urgency category distribution available would allow clinical and management groups to review urgency categorisation profiles for individual hospitals or surgical services compared with profiles of others, and inform processes aimed at understanding, managing and reducing variation in distributions of clinical urgency categories. The information could be disseminated in a variety of ways. One option could be an online data repository, with different presentations to suit different audiences, and password-controlled access for 'drilling down', or linking to confidential information about individual surgeons or surgeon teams. Some examples of different formats are in Appendix E. After a period of time, it would be expected that the pattern of urgency categorisation for particular procedures would become more similar between hospitals, and would not change over time. It is noted that some urgency category distribution information is likely to be available in the future, in association with reporting for the NEST (which is defined in terms of urgency categories).

5. ‘Treat in turn’ as a principle for elective surgery management

A principle that can be applied to assist in the management of elective surgery and waiting times, and in the context of appropriate urgency categorisation, is the principle of ‘treat in turn’.

The idea is that patients are treated in accordance with their urgency category but that, *within* each urgency category, most patients are treated in the same order as they are added to the waiting list.

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

Treatment in turn would help standardise urgency categorisation because it provides greater predictability for the time that patients wait. This should help ensure that patients appropriately categorised as category 2 are not assigned to category 1, for example, to ensure that they are treated within 90 days.

There should be provision of comparative information on the proportions of patients treated in turn. As for provision of comparative information on urgency category distributions, this information would not be regarded as performance information; rather, it would be regarded as information useful to understand and manage practice variation.

Consideration could be given to developing national guidelines for ‘treat in turn’ that could, for example, outline factors that should be taken into account when deciding the order in which patients in an urgency category are provided with their surgery. Such guidelines could be based on existing guidelines (outlined in Appendix B) that are currently in use in several jurisdictions.

6. Clarified approaches for patients who are not ready for surgery

The following definitions are proposed for the *ready for care* status of patients waiting for elective surgery (Table 2).

The terminology has been changed to refer to whether the patient is *ready for surgery*. This provides clarification for situations in which patients who are *not ready for surgery* may be receiving medical or other health care.

Table 2: Clarified approaches for patients who are *not ready for surgery*

Patient listing status	Meaning
Ready for surgery	Patients who are prepared to be admitted to hospital or to begin the process leading directly to admission for surgery. The process leading to surgery could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests.
Not ready for surgery—staged patients	Patients who have undergone a procedure or other treatment and are waiting for follow-up elective surgery, where the patient is not in a position to be admitted to hospital or to begin the process leading directly to admission for surgery, because the patient's clinical condition means that the surgery is not indicated until some future, planned period of time. Examples include a patient who has had internal fixation of a fracture who will require removal of the fixation device after 3 months, a patient who requires a 'check' cystoscopy to check for cancer 12 months after surgery to remove a tumour in the bladder, and a patient requiring rectal cancer surgery 6-8 weeks after neoadjuvant chemoradiotherapy for colorectal cancer.
Not ready for surgery—pending improvement of clinical condition	Patients for whom surgery is indicated, but not until their clinical condition is improved, for example, as a result of a clinical intervention. Examples include patients who require a cardiac work-up before a total hip replacement and patients with respiratory insufficiency who require physiotherapy to maximise respiratory function before a hernia repair. For such patients, a decision has already been made that surgery should take place. Patients should not be regarded as 'not ready for surgery—pending improvement of their clinical condition' when they are undergoing routine monitoring or investigations before a decision is made as to whether surgery is required.
Not ready for surgery—deferred for personal reasons	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.

Comments:
Patients who are *not ready for surgery* (staged or deferred for personal reasons) are usefully managed through elective surgery waiting list management systems. This is because the patients need to be recorded as waiting for a procedure, so that allocation of their surgery can be managed. Should the recommendation (noted under 'Other issues') to expand the scope of the urgency categorisation and national reporting to procedures currently not in scope for reporting be accepted, the term *not ready for procedure* may be preferred instead of *not ready for surgery* as proposed here.

Patients should only be added to waiting lists (that is, regarded as *ready for surgery* for the purpose of monitoring waiting times, and for the purpose of allocation of a surgery date) when they are personally and clinically ready for surgery. This means that they should only be regarded as 'in the queue' when they are ready for surgery and waiting times should only be measured for them when they are ready for surgery.

Patients deferred for personal reasons should not be added to waiting lists until they are ready for surgery. They should be suspended from the waiting list if they defer after being initially ready for surgery.

Details of how and when patients move between *ready for surgery* categories are not needed for national or local reporting of the data (as is currently the case). But these definitions of the *ready for surgery* categories should be applied to calculations of times waited and for management of access to elective surgery.

Not ready for surgery—staged patients

Staged patients have undergone surgery or some other treatment and are waiting for follow-up surgery that needs to occur at a particular, known time in the future—usually within a time period ('window') measured in days or weeks, rather than months or years. The follow-up surgery can be:

- part of a 'package' of surgery, for example, removal of the fixation device after an initial surgical episode for internal fixation of a fracture
- checking a patient's status after an initial surgical episode, for example, a check cystoscopy after initial urological cancer surgery
- a surgical episode after non-surgical care, for example, rectal cancer surgery 6–8 weeks after neoadjuvant chemoradiotherapy for colorectal cancer
- a surgical episode for a paediatric patient, indicated at a future developmental stage.

Staged patients should be designated as *ready for surgery* at the beginning of the window of time during which their procedure is indicated. They should be allocated to the urgency category that is appropriate for the size of the window that applies to their clinical condition at that time. For example,

- for the rectal cancer surgery example above, the patient should be added to the waiting list 6 weeks after their neoadjuvant chemoradiotherapy, in urgency category 1. Their waiting time would be measured from the time they are ready for surgery, that is, from the point in time 6 weeks after their chemoradiotherapy.

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

Not ready for surgery—pending improvement of clinical condition

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

An example is patients who have poorly controlled diabetes who need to have their diabetes managed before they are suitable for surgery. Such patients should only be added to waiting lists when they are clinically ready for the surgery (for example, their diabetes is under control).

For example:

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

Comments:
It could be argued that the patient above could be added to the waiting list at the start of the period of medical management of their respiratory function. However, at that stage, the patient is not suitable for surgery—and could not accept an offer of surgery.

Not ready for surgery—deferred for personal reasons

These are patients who are *not ready for surgery*, for personal (non-clinical) reasons, such as work commitments. Deferred patients should not be added to a waiting list until their personal circumstances mean that they are *ready for care*, and their urgency category should be assigned at that time. Once placed on the list, any time subsequently spent deferred should be subtracted from the amount of time recorded as waiting.

For example:

- A patient is assessed as suitable for surgery and as urgency category 2. However, they are unavailable for surgery for the first 2 weeks after the assessment because of work commitments. The patient should be added to the waiting list when they are available for surgery, that is, after the 2 weeks during which they are unavailable. Their waiting time would be measured from the time they are added to the waiting list, that is, from 2 weeks after the initial clinical assessment.

- A patient is assessed as suitable for surgery and as urgency category 3. They are available for surgery for the next 3 months, but not for the following 3 months, because of a booked holiday. The patient should be added to the waiting list at the time of the initial assessment (in case their surgery is provided within the next 3 months), but 'suspended' from it for the following 3 months. That is, for that 3 months, they become ineligible to be offered surgery, and the 3 months are not counted as part of their waiting time. Consideration would be given to reassessing the urgency category of the patient after their 3-month period of being unavailable for surgery.

The length of time and number of times that patients can defer for personal reasons would remain policy issues for hospitals and health authorities. If a patient has deferred for personal reasons for a prolonged period of time, their urgency category should be reassessed at the time that they become available for their surgery.

Implementing the package

The packaged approach to improved definitions of elective surgery urgency categories should be integrated into the management of elective surgery, both locally and nationally. Approaches that could be considered to facilitate that include:

- arrangements for local peer/team leader review of urgency categorisation, supported by the national list of usual urgency categories and feedback of comparative urgency categorisation
- local surgeon ownership and good communication between surgeons and registrars, and between surgeons and waiting list managers
- flexibility to expedite operations within a category according to patient need
- arrangements for audit of urgency categorisation
- clinical review at appropriate times, for example, after waiting for a year, or after extended periods of being *not ready for surgery*
- continuing engagement with the RACS and surgical specialty groups
- strong monitoring of the effectiveness of the package, with a leadership role played by the Expert Panel.

Timeframes and processes

The national elective surgery urgency category definitions package

Implementation of the package should be undertaken through 2013, with the aim that all components are put into effect by 1 January 2014. It is anticipated that that would allow time in 2013 for:

- development of the national list of the usual urgency categories for higher volume procedures by surgical specialty groups
- jurisdictional arrangements to implement the package in local hospital networks and individual hospitals
- development of arrangements for preparation and dissemination of comparative urgency categorisation information and information on the proportions of patients treated in turn
- further consideration of the definition of elective surgery and the inclusion of live donor transplant procedures
- formalisation of the elective surgery, urgency category and *not ready for care* definitions as part of the Elective surgery waiting times National Minimum Data Set (NMDS).

Changes to the data definitions for urgency categories and for *not ready for care* could be agreed for implementation from 1 July 2013, in line with the usual timetable for making changes to national minimum data sets. However, if the rest of the package is not in place until 1 January 2014, data on Elective surgery waiting times would not be regarded as being collected fully in accordance with the new package until then. This may mean that, for some reporting purposes, the data for 2013–14 would need to be regarded as for two non-comparable 6-month periods.

Arrangements for other procedures currently not within scope

Implementing any similar national waiting list arrangements for procedures not currently within scope (see page 20), if agreed, may take some more time. It is likely that additional time and resources would be required for:

- further consultation with relevant clinical and other stakeholder groups (including jurisdictions) to refine the list of procedures to be included
- the development of a national list of usual urgency categories for higher volume procedures by relevant clinical specialty groups
- developing and implementing local and nationally agreed data specifications and reporting arrangements (for urgency category distributions and the proportions of patients treated in turn). Some jurisdictions already collect this type of information but others do not, and it is likely that there is variation in how the data are collected. Such data development could expect to occur throughout 2013, with agreement to methods of reporting arrangements at the end of the year, and national implementation from 1 July 2014.

Other issues

Procedures in scope

Many stakeholders expressed the view that procedures other than those currently in scope for elective surgery management and reporting arrangements should be brought into scope, for:

- urgency categorisation
- management through elective surgery or similar management systems
- local, jurisdictional and national waiting times reporting.

An important principle is that if a patient is on a waiting list, they should be assigned an urgency category.

The list of procedures excluded in the current definition of elective surgery includes organ and tissue transplant procedures, procedures associated with obstetrics (for example, cervical suture), cosmetic surgery (that is, when the procedure will not attract a Medicare rebate), certain biopsies, bronchoscopy, peritoneal and renal dialysis, gastrointestinal endoscopy, colonoscopy, dental procedures, endoscopic retrograde cholangio-pancreatography, in-vitro fertilisation procedures and other diagnostic and non-surgical procedures (that is, procedures frequently done by non-surgical clinicians).

Live donor transplant surgery

Organ and tissue transplant surgery involving live donors should be assigned urgency categories and included in the scope of the national definition of elective surgery and the national arrangements for monitoring and reporting on elective surgery. This is because live donor transplant surgery is commonly managed through elective surgery services.

The approaches to patients *not ready for surgery* outlined above would apply to the donors as for other patients undergoing elective surgery. That is, time spent by the donor and/or recipient as 'staged' patients and time spent awaiting improvement in clinical condition would not be regarded as time spent waiting.

Transplants involving deceased donors should not be included.

The Organ and Tissue Authority should be consulted about this proposal to ensure that it is consistent with data collections it is responsible for. Further consultation with jurisdictions should also be undertaken.

Comments:
Live organ donor procedures constitute a not insignificant amount of elective surgery. For example, there were about 300 live kidney donor episodes each year in Australia between 2006–07 and 2010–11. Patients (both donors and recipients) wait for these procedures, and their access to surgery is often managed through the elective surgery waiting list management arrangements. Access to live donor transplant surgery is affected by, and impacts on, the provision of other elective surgery. Inclusion of the surgery within elective surgery management and reporting arrangements could assist in 'levelling the playing field' in relation to this type of surgery.

Other procedures not currently reported

It is recommended that urgency categorisation should apply to the following procedures for which patients typically wait in public hospitals. Access to the procedures should also be managed through waiting list management arrangements and consideration should be given to including the procedures in local, jurisdictional and national waiting times reporting arrangements.

Further consultation with relevant specialty groups and other stakeholders (including jurisdictions) will be required for some of the procedures.

It is noted that the costs of national reporting of waiting times statistics for such procedures should be assessed against the likely benefits for each type of procedure.

It is also noted that, should these procedures be included in national waiting times statistical reporting, they should be reported in a category separate from that for elective surgery, so that consistency is maintained for the latter and transparency is established for the former.

The procedures to be considered are:

- bronchoscopy
- gastroscopy
- colonoscopy
- endoscopic retrograde cholangiopancreatography
- endoscopic ultrasound
- peripheral vascular interventional procedures
- cardiac interventional procedures
- interventional radiological procedures.

Comments:
Access to such procedures is commonly but not uniformly managed through waiting lists, including assignment of urgency categories. Many stakeholders expressed strong views that such procedures should be the subject of waiting list management and reporting arrangements, and that such waiting list management and reporting would best occur separately from the current waiting lists reported for elective surgery. A commonly-held view was that this would highlight issues relating to access to the procedures. Caesarean section management may vary from hospital to hospital but where the patient is placed on a waiting list before the procedure occurs, the *not ready for surgery*—staged arrangements should apply.

Types of elective surgery provided by public hospitals

The types of elective surgery that are provided by public hospitals is a policy issue for the state and territory managers of public hospitals. This means there is some variation in whether procedures such as varicose vein removal and bariatric surgery are offered. This has the potential to result in reduced comparability of state and territory data on elective surgery access, and should be noted in statements about data comparability, particularly when what is being considered is access to elective surgery as a whole.

Inclusion of 'staged' procedures in nationally reported waiting times information

States and territories vary in how they treat data on check cystoscopy—some exclude records for such episodes in data reported nationally, while others include them. It is recommended that records for such procedures are included, following the principle that all surgery for which patients need to wait should be in scope. Waiting times and urgency categories for staged cystoscopy and other staged procedures should be reported as outlined in the section on staged patients.

Waiting times from referral to surgical services

Many stakeholders expressed strong views that it was important to recognise that patients waited from the time of referral from their general practitioner to the time they were seen by a surgeon in a public hospital outpatient service (or by a private surgeon in their rooms, seeing the patient as a public patient of a public hospital).

This is not an issue that is within the scope of this work. It is noted that, in the NPA IPHS (Clause A54), COAG has agreed that health ministers will 'agree that for future agreements consideration will be given to developing a measure of surgical access time from general practitioner referral to surgical care, to reflect the actual waiting time for patients and demand for elective surgery performance' (COAG 2011).

Detailed scoring systems

Clinical decisions could be informed by detailed scoring systems. The scoring systems could be procedure specific, specialty specific, diagnosis driven (for example, special scoring for cancer), comorbidity driven or driven by factors such as the age of the patient (for example, special scoring for children).

The use of such scoring systems could assist with urgency categorisation for elective surgery. However, any decision to develop or use such scoring systems should be made by individual groups of surgeons, for their own purposes, not as part of the national approach to assignment of urgency categories. They should not be used to replace the simple time-based definitions for the urgency categories.

Comments:
Such scoring systems exist for some higher volume procedures in countries other than Australia, and have been developed for hip and knee replacement procedures in Victoria (Osborne et al. 2006). It is unlikely that scoring systems could be developed in a cost-effective way that would contribute to standardisation of urgency categorisation for the majority of elective surgery. Most stakeholders considered that such scoring systems would not be useful. However, a few groups (including some surgeon groups with experience in using them) regarded them as useful tools to increase standardisation in urgency category assignment. Where such scoring systems are favoured, they can be appropriately used at the local service level but would not be regarded as being nationally valid.

Appendix A: Current data on urgency categorisation and staged patients

The following data are drawn from the AIHW's National Elective surgery waiting times Data Collection for 2011–12. More information about this collection (which is based on the National Minimum Data Set (NMDS) for Elective surgery waiting times), including a comprehensive data quality statement, is available in *Australian hospital statistics: 2011-12: Elective surgery waiting times* (AIHW 2012). Some summary information on the definitions used for urgency categories and patients who are 'staged' is in Appendix B.

The apparent lack of comparability of clinical urgency categories among jurisdictions means that measures based on these categories are also not comparable between jurisdictions.

Apparent variation in clinical urgency categorisation

In 2011–12, the proportion of patients admitted from elective surgery waiting lists who were assigned to clinical urgency category 1 ranged from 23% for Western Australia to 41% for Queensland. The proportion of patients who were category 3 ranged from 14% in Queensland to 43% in New South Wales (Table A.1).

Table A.1: Admissions[(a)] from waiting lists for elective surgery, by clinical urgency category, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Admissions				
Category 1	52,113	46,763	47,046	19,290	17,666	6,148	3,449	2,811	195,286
Category 2	68,028	72,360	51,262	28,709	21,725	6,966	5,515	3,003	257,568
Category 3	91,311	34,956	16,020	34,249	25,795	2,688	2,398	1,436	208,853
Total	**211,452**	**154,079**	**114,328**	**82,248**	**65,186**	**15,802**	**11,362**	**7,250**	**661,707**
					Per cent				
Category 1	25	30	41	23	27	39	30	39	30
Category 2	32	47	45	35	33	44	49	41	39
Category 3	43	23	14	42	40	17	21	20	32
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Some distributions do not add to 100% due to rounding.

Individual procedures

The apparent variation illustrated in Table A.1 could be affected by the mix of patients treated by states and territories in 2011–12. However, there is apparent variation also for each individual procedure (higher volume elective surgery procedures) for which patient mixes would be expected to be relatively uniform.

For example, the proportion of patients admitted for total hip replacement in urgency category 2 was 21% in South Australia and 82% in the Australian Capital Territory (Table A.2). The proportion of patients admitted for myringoplasty in urgency category 3 was 84% in New South Wales and 27% in Queensland.

This type of variation could reflect differing financial arrangements for the provision of elective surgery (such as financial incentives or disincentives for provision of elective surgery within the recommended maximum waiting times), the differences in urgency category definitions used in some jurisdictions, and differing interpretation of the urgency category definitions by clinicians, clinician groups or hospitals.

Data are not reported in Table A.2 where there were fewer than 100 admissions for an individual procedure for a state or territory.

Table A.2: Proportion of admissions[(a)] from waiting lists for elective surgery for individual procedures by clinical urgency category, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Cataract extraction									
Category 1	1	3	3	3	3	5	2	2	2
Category 2	14	24	48	14	10	32	16	38	20
Category 3	84	73	49	83	88	64	82	60	78
Cholecystectomy									
Category 1	13	21	27	14	18	28	16	26	18
Category 2	58	70	68	55	62	66	78	60	63
Category 3	29	9	5	31	19	5	6	14	18
Coronary artery bypass graft									
Category 1	51	55	74	74	79	100	60	. .	66
Category 2	45	45	25	25	21	0	40	. .	33
Category 3	4	0	1	1	0	0	0	. .	1
Cystoscopy									
Category 1	23	41	57	22	30	40	28	42	32
Category 2	41	45	35	43	46	46	58	44	43
Category 3	36	14	9	35	24	14	14	14	25
Haemorrhoidectomy									
Category 1	12	10	16	7	15	n.p.	n.p.	26	12
Category 2	50	64	70	45	59	n.p.	n.p.	70	58
Category 3	39	26	14	48	26	n.p.	n.p.	4	30
Hysterectomy									
Category 1	12	26	20	20	17	26	18	n.p.	21
Category 2	50	57	65	30	41	55	51	n.p.	47
Category 3	39	17	15	51	43	19	31	n.p.	32

(continued)

Table A.2 (continued): Proportion of admissions[(a)] from waiting lists for elective surgery for individual procedures by clinical urgency category, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Inguinal herniorrhaphy									
Category 1	11	15	14	14	12	19	19	18	13
Category 2	41	71	74	74	49	62	70	63	55
Category 3	48	14	12	12	40	19	11	19	32
Myringoplasty									
Category 1	2	1	10	3	2	n.p.	n.p.	4	4
Category 2	14	43	64	34	35	n.p.	n.p.	41	39
Category 3	84	56	27	64	63	n.p.	n.p.	55	58
Myringotomy									
Category 1	13	7	15	7	13	33	8	14	11
Category 2	54	67	79	45	68	42	77	78	65
Category 3	33	26	6	48	20	25	15	8	24
Prostatectomy									
Category 1	20	40	46	34	18	n.p.	n.p.	n.p.	32
Category 2	57	58	52	52	67	n.p.	n.p.	n.p.	56
Category 3	23	3	3	15	15	n.p.	n.p.	n.p.	12
Septoplasty									
Category 1	1	2	3	0	1	17	2	n.p.	2
Category 2	8	32	60	23	21	48	32	n.p.	27
Category 3	90	66	37	76	78	35	66	n.p.	71
Tonsillectomy									
Category 1	4	4	6	3	5	30	3	5	5
Category 2	22	52	72	34	49	45	60	68	44
Category 3	74	43	22	62	46	26	36	27	51
Total hip replacement									
Category 1	4	4	19	7	6	16	8	n.p.	7
Category 2	24	75	56	58	21	68	82	n.p.	47
Category 3	72	21	26	35	74	16	10	n.p.	45
Total knee replacement									
Category 1	2	1	5	4	2	10	3	n.p.	3
Category 2	12	71	59	47	11	62	82	n.p.	37
Category 3	87	28	36	49	87	28	14	n.p.	60
Varicose vein stripping and ligation									
Category 1	6	1	3	9	4	n.p.	4	n.p.	4
Category 2	13	24	57	25	23	n.p.	25	n.p.	24
Category 3	81	75	40	66	73	n.p.	71	n.p.	72

. . not applicable.

n.p. not published, because fewer than 100 admissions were reported.

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Some distributions do not add to 100% due to rounding.

Surgical specialties

The proportion of patients admitted from waiting lists for elective surgery in each clinical urgency category by surgical specialty is in Table A.3.

The data show considerable variation between individual states and territories. For example, 2% of cardiothoracic surgery was urgency category 2 in Tasmania and in the Australian Capital Territory it was 48%. Some of this variation could be due to variation in casemix.

Data are not reported in Table A.3 where there were fewer than 100 admissions for an individual procedure for a state or territory.

Table A.3: Proportion of admissions[(a)] from waiting lists for elective surgery by clinical urgency category and surgical specialty, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Cardiothoracic surgery									
Category 1	52	51	71	70	72	98	52	. .	61
Category 2	38	42	27	21	26	2	48	. .	33
Category 3	11	7	2	9	3	0	1	. .	6
Ear, nose and throat surgery									
Category 1	16	16	33	13	19	34	13	20	19
Category 2	26	48	55	34	43	45	54	53	41
Category 3	58	35	13	52	38	21	33	27	40
General surgery									
Category 1	33	31	45	23	28	42	36	39	33
Category 2	39	51	46	44	43	46	57	46	44
Category 3	29	18	9	33	30	12	7	15	23
Gynaecology									
Category 1	26	33	37	22	37	34	35	62	31
Category 2	44	54	51	30	32	49	47	28	45
Category 3	30	13	12	48	30	17	18	10	24
Neurosurgery									
Category 1	33	30	58	32	41	61	49	. .	38
Category 2	33	62	36	47	46	38	49	. .	44
Category 3	33	8	6	21	13	1	2	. .	18
Ophthalmology									
Category 1	6	12	13	6	9	18	12	6	9
Category 2	18	27	50	16	15	38	20	41	24
Category 3	76	62	37	78	76	44	68	53	67
Orthopaedic surgery									
Category 1	17	19	38	16	14	18	15	37	22
Category 2	19	59	43	44	20	58	70	46	37
Category 3	64	22	19	39	66	24	16	18	41
Plastic surgery									
Category 1	33	49	54	54	39	64	68	50	47
Category 2	31	36	39	32	41	31	28	42	36
Category 3	36	15	7	15	20	5	4	8	18

(continued)

Table A.3 (continued): Proportion of admissions[(a)] from waiting lists for elective surgery by clinical urgency category and surgical specialty, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Urology									
Category 1	25	43	59	27	31	40	32	39	36
Category 2	42	45	36	44	45	43	56	42	43
Category 3	32	11	5	29	24	17	11	19	21
Vascular surgery									
Category 1	55	38	68	35	76	42	49	n.p.	53
Category 2	23	39	29	44	15	44	21	n.p.	29
Category 3	21	23	4	22	9	14	30	n.p.	18
Other									
Category 1	45	25	35	37	26	n.p.	38	58	36
Category 2	34	62	47	29	40	n.p.	49	22	39
Category 3	21	13	18	34	33	n.p.	13	20	26

. . not applicable.

n.p. not published, because fewer than 100 admissions were reported.

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Some distributions do not add to 100% due to rounding.

Apparent variation in recording elective surgery waiting times for staged procedures

The NMDS for Elective surgery waiting times describes 'staged' patients as those 'whose medical condition will not require or be amenable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time'.

The AIHW has noted some apparently atypical recording practices for waiting times for elective surgery for staged patients in some states. For those states, there were a relatively large number of records with a clinical urgency of category 3 and admitted within 5 days for 2011–12 (Figure A.1). It would be expected that patients assigned a clinical urgency of category 3 typically have longer waits than patients assigned clinical urgency category 1 (admission within 30 days desirable) or category 2 (admission within 90 days desirable).

The apparent atypical reporting practices could reflect differing waiting list practices for patients awaiting staged procedures. For most staged patients, it appears that they are put on the waiting list (or reassigned to *ready for care*) when they are clinically *ready for care*, and they then wait for a date to be assigned for their surgery. However, for others, the data appear to reflect patients (once becoming clinically *ready for care*) only being put on the waiting list at the time that a date is assigned for their surgery.

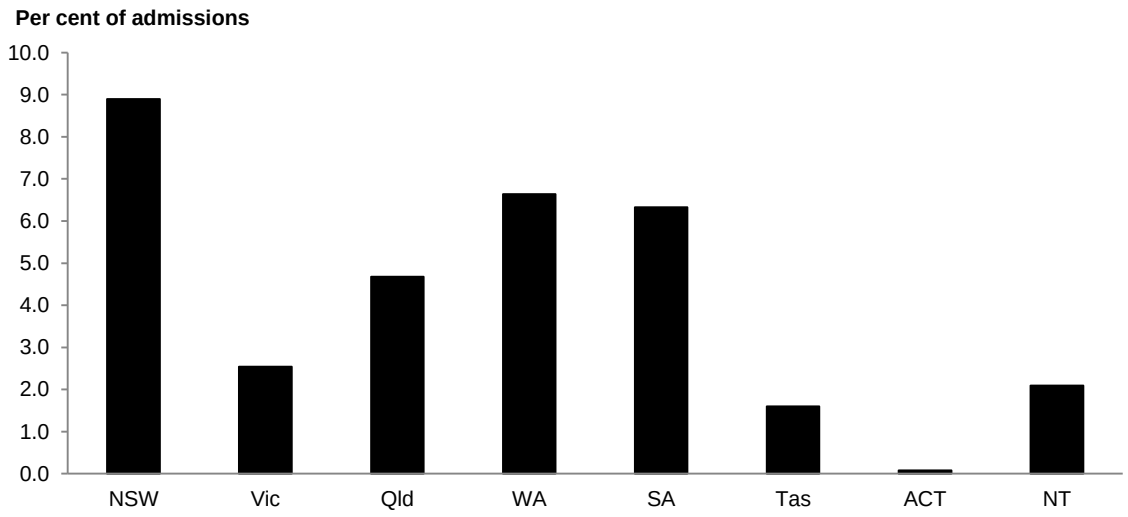
Alternative interpretations are that:

- there may be variation in the urgency category assigned for patients awaiting staged procedures
- some patients awaiting staged procedures are added to the waiting list before they are *ready for care*, whereas others are added only when they are ready for their staged procedure
- some patients awaiting staged procedures may be excluded from the reported data.

The variation in the national data on the lengths of time waited for category 3 is consistent with varying reporting practices as described previously.

Table A.4 presents the difference in the median waiting times for cystoscopy and all admissions when cystoscopy category 3 patients were excluded (for 2011–12). It is expected that the exclusion of cystoscopy category 3 patients would decrease the median waiting time for cystoscopy, and overall. However, the median waiting time for cystoscopy increased for New South Wales, South Australia and for the Australian total. It decreased (or remained the same) for other states and territories when cystoscopy category 3 patients were excluded.

Similarly, the overall median waiting time (for all admissions) increased for New South Wales. It remained the same (or decreased) for other states and territories when cystoscopy category 3 patients were excluded.



(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Figure A.1: Removals[(a)] for clinical urgency category 3 patients that were within 5 days of listing date, states and territories, 2011–12 (per cent)

Table A.4: Median waiting times (days) for elective surgery, for cystoscopy and all procedures, states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Cystoscopy									
All admissions[(a)]	25	21	24	29	32	27	55	48	25
Excluding cystoscopy category 3	30	21	23	28	33	27	47	41	26
All admissions									
All admissions[(a)]	49	36	27	30	34	38	63	39	36
Excluding cystoscopy category 3	51	36	27	30	34	38	62	38	36

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Appendix B: Urgency category definitions variation in Australia

This appendix provides information on the current national definitions for urgency categorisation (and for patients *not ready for care*) and on variation in the definitions used and related practices among the states and territories. More information on the state and territory approaches is available from the referenced documents.

Current national definitions

National data for Elective surgery waiting times are collected as specified in the NHDD as the NMDS for Elective surgery waiting times (removals data) and the NMDS for Elective surgery waiting times (census data).

An NMDS is a minimum set of data elements agreed for mandatory collection and reporting at a national level. All states and territories have agreed to collect data using the NMDSs for Elective surgery waiting times and to report the data for national collation and reporting, such as in the AIHW's *Australian Hospital Statistics: Elective surgery waiting times* report (AIHW 2012).

The NMDSs for Elective surgery waiting times include definitions for elective surgery urgency categories, *not ready for care* patients and other relevant data elements used for reporting of national Elective surgery waiting times. Summary information about these definitions is presented below.

The full specifications for the NMDSs are in METeOR, the AIHW's online registry for national metadata standards for the health, community services and housing assistance sectors. METeOR is available at http://meteor.aihw.gov.au/content/index.phtml/itemId/181162

Clinical urgency

Clinical urgency is defined as a clinical assessment of the urgency with which a patient requires elective hospital care. The categories are defined as:

- Category 1: admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
- Category 2: admission within 90 days desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.
- Category 3: admission at some time in the future acceptable for a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.

Patients who are *not ready for care*

The 'patient listing status' is used as an indicator of the person's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure. The current category definitions are:

- *Ready for care*: patients are those who are prepared to be admitted to hospital or to begin the process leading directly to admission. These could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests.
- *Not ready for care*: patients are those who are not in a position to be admitted to hospital. These patients are either:
  - staged patients whose medical condition will not require or be amendable to surgery until some future date; for example, a patient who has had internal fixation of a fractured bone who will require removal of the fixation device after a suitable time

    or
  - deferred 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 time.

Variation within Australia

The data in Appendix A illustrates that there is apparently considerable variation in urgency categorisation among the states and territories of Australia. There is similar variation apparent among hospitals in recent national data (not shown) and also demonstrated in a study of urgency categorisation for hip replacement and prostatectomy in Victorian hospitals in 2000–01 (Russell et al. 2003).

One reason cited for inconsistency in applying urgency categories is the lack of clinical relevance and evidence-based guidelines for the recommended elective surgery waiting list timeframes attached to the urgency categories (VAGO 2009). As such, it was noted that urgency categories are viewed by the clinical community as primarily a management tool with little relevance to appropriate clinical timeframes for treatment (VAGO 2009).

In comments on the Australian situation, Curtis and others (2009) suggested that the current urgency category definitions comprise clinical terms that are open to subjectivity, however, do not take into consideration other patient factors, for example, severity of condition, comorbidities and social/economic circumstances of the patient.

A review of jurisdictional policy documents indicated that it is not just the current urgency category definitions that could be resulting in non-comparable urgency categorisation within Australia. There are also considerable variations in waiting list management practices, including in the definitions used, between jurisdictions.

The main variations are:

- jurisdictional differences in the definitions used in assigning urgency categories
- the use of procedure-based guidelines for prioritisation in some but not all jurisdictions
- differing approaches to patients who are *not ready for care*
- differing policies related to 'treat in turn' within urgency categories.

The implication of this is that data and performance measures based on clinical urgency categories are not comparable or consistent between jurisdictions.

Jurisdictional differences in definitions used for assigning urgency categories

Some jurisdictions use supplementary material to the current national definitions in their operational policies to provide guidance for assignment of elective surgery urgency categories.

Several states and territories (the Australian Capital Territory, New South Wales, South Australia and Western Australia) have set 365 days as the time frame for category 3 (ACT Health 2011; NSW Health 2009; SA Health 2011; WA Health 2009).

Some states have also amended the definitions of the urgency categories.

- In New South Wales references to 'pain', 'dysfunction' and 'disability' in the urgency category definitions have been removed (Table B.1).
- In South Australia, words have been added to category 1 such that it is described as a 'very early admission' and for conditions including those that are 'life threatening' (Table B.2).
- In Victoria, the guidelines issued by the Victorian Government Department of Human Services indicate that 'urgency categories are to be based on the patient's clinical need'.

Table B.1: New South Wales clinical urgency categories

Urgency category	Meaning	
Category 1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency	**Ready for care**
Category 2	Admission within 90 days desirable for a condition which is not likely to deteriorate quickly or become an emergency	
Category 3	Admission within 365 days acceptable for a condition which is unlikely to deteriorate quickly and which has little potential to become an emergency	
Category 4	Patients who are either clinically not yet ready for admission (staged) and those who have deferred admission for personal reasons (deferred)	**Not ready for care**

Source: NSW Health 2009.

Table B.2: South Australian clinical urgency categories

Urgency category	Meaning	
Category 1 (Urgent)	Very early admission for a condition that has the potential to deteriorate quickly to the point that it may become an emergency or is life threatening (Admission within 30 days desirable).	**Ready for care**
Category 2 (Semi-urgent)	Admission within 90 days for a condition causing some pain, dysfunction or disability which is not likely to deteriorate quickly or become and emergency (Admission within 90 days desirable).	
Category 3 (Not-urgent)	Admission at some time in the future for a condition causing minimal or no pain, dysfunction or disability, that is unlikely to deteriorate quickly and that does not have the potential to become an emergency (Admission within one year desirable).	
Category 4	Staged/Medical Deferred/Patient Deferred: Admission deferred to a time that is medically appropriate, which includes staging surgery whilst the patient waits for periodic treatment or investigation, or deferred to a time move convenient to the patient.	**Not ready for care**

Source: SA Health 2011.

The use of procedure-based guidelines for urgency categorisation

New South Wales and Western Australia have implemented procedure-based guidelines for urgency categorisation to accompany the current elective surgery urgency category definitions. This means a select number of procedures are linked to a recommended clinical urgency category of 1, 2 or 3.

New South Wales' Waiting Time and Elective Surgery Policy is accompanied by an information bulletin, Advice for Referring and Treating Doctors—waiting time and elective patient management. It includes a reference list of recommended clinical priority categories for specific procedures (NSW Health 2012). For example, coronary artery bypass graft has a recommended clinical priority category of 1 (within 30 days), while cochlear implant has a recommended clinical priority of 3 (within 365 days). It is noted that, generally, malignancy will be considered to require treatment within 30 days.

The Department of Health, Western Australia has also developed an extensive list of surgical procedures with corresponding clinical priority category (WA Health 2009). For example, amputation of limb has an accepted clinical priority category of 1 (within 30 days), while a hysterectomy has an accepted clinical priority category of 3 (within 365 days).

While surgeons are still responsible for assigning the urgency category, if deviation from the guidelines occurs clinical documentation and agreement from clinical directors or district/network program directors is required (NSW Health 2012; WA Health 2009).

Jurisdictional differences in approaches to patients who are *not ready for care*

The *not ready for care* data present particular problems, partly due to inconsistent definitions across jurisdictions, but also because patients in the category are not always included in waiting list reporting.

New South Wales and South Australia define patients *not ready for care* as a fourth urgency category (NSW Health 2009; SA Health 2011) (tables B.1 and B.2). For both, the wording used differs slightly from the national definitions.

There appears to be some variation among states and territories in whether some staged patients are included in national waiting times data reports. Victoria reports episodes of 'check cystoscopy' (cystoscopy to follow up surgery for bladder cancer) to the national data collection whereas the Northern Territory and South Australia do not.

In addition, the operational policies of some jurisdictions have maximum cumulative timeframes for *not ready for care* patients to defer for personal reasons. Once the maximum time frame is reached, the patient may be removed from the waiting list. It is possible that this would have some indirect effects on urgency categorisation if categorisation is influenced by there being a maximum period of waiting time 'extension' to be considered.

The time thresholds outlined for New South Wales, Victoria and the Australian Capital Territory (NSW Health 2009; DHS 2009; ACT Health 2011) are in Table B.3.

Table B.3: Maximum cumulative timeframes for *not ready for care* patients to defer for personal reasons in New South Wales, Victoria and Australian Capital Territory

New South Wales	Victoria	Australian Capital Territory
Category 1: 15 days	Category 1: 30 days	Category 1: 30 day
Category 2: 45 days	Category 2: 90 days	Category 2: 90 days
Category 3: 180 days	Category 3: 180 days	Category 3: 180 days

Principle of 'treat in turn'

There is variation among states and territories as to the extent to which they have stated policies of 'treat in turn', or other statements that would influence the order in which patients within clinical urgency categories are treated. This variation is likely to affect the comparability of urgency categorisation among the states and territories, because a policy of 'treat in turn' is considered to provide greater certainty about waiting times and reduce inappropriate assignment of more urgent categories.

The Australian Capital Territory

The Australian Capital Territory's Elective Surgery Access Policy has been developed 'to ensure patients are treated equitably within clinically appropriate timeframes and with priority given to patients with an urgent clinical need'. The following criteria are considered when scheduling patients from the elective surgery waiting list:

- clinical priority
- the length of time the patient has waited in comparison with similar category patients
- previous postponements
- preadmission assessment issues/factors (for example, elderly people living along or those having to travel long distances)
- resource availability (for example, theatre time, staffing, equipment and hospital capacity) (ACT Health 2011).

New South Wales

New South Wales' Waiting Time and Elective Surgery Policy has also outlined criteria that must be considered when choosing patients from the waiting list for admission:

- clinical priority
- the length of time the patient has waited in comparison with similar category patients
- previous delays
- pre-admission assessment issues/factors, for example, elderly people living alone or those having to travel long distances
- resource availability, for example, theatre time, staffing, equipment and hospital capacity (NSW Health 2009).

Queensland

In the Policy Framework for Elective Surgery Services, Queensland Health (2005) states that 'treatment of patients from the elective surgery waiting list will be prioritised primarily on the basis of clinical urgency'. The framework also states that 'within each clinical urgency category, a number of factors should be considered in selecting patients from the waiting list'. These include assigning priority within categories for patients who have waited longer than the recommended time or longer than other patients in the same urgency category. Other factors that may influence selection of patients from the elective surgery waiting list include:

- the type of surgery required
- patient comorbidities
- medication requirements
- patient social and community support
- patient access factors (for example, distance of residence from the treatment centre, availability of transport and accommodation)
- availability and appropriateness of day surgery
- the need for other treatments while awaiting surgery (Queensland Health 2005).

South Australia

South Australia's Elective Surgery Policy Framework and associated procedural guidelines outline a number of factors that should be considered in selecting patients from the booking list:

- waiting time
- previous postponements
- social and geographic circumstances
- other factors that may influence selection of patients from the elective surgery booking list:
  - type of surgery and post-operative care required
  - complexity of case and length of operating time
  - patient comorbidities
  - medication requirements
  - patient social and community support
  - availability and appropriateness of day surgery
  - the need for other treatments while awaiting surgery
  - teaching requirements for junior doctors (SA Health 2011).

Tasmania

Tasmania's Elective Surgery Access Policy requires the scheduling of patients for surgery according to:

- clinical urgency

- the length of time the patient has waited for their surgery in comparison with similar patients
- resource availability (for example, availability of theatre time, the surgeon, equipment and hospital capacity)
- whether the hospital has previously postponed the patient's surgery (DHHS 2009).

Victoria

The Victorian health service policy includes reference to ensuring 'that less urgent patients are treated according to waiting time or 'in turn' within their urgency category, wherever possible' (DHS 2011). Victoria's Elective Surgery Access Policy requires the scheduling of patients for surgery according to:

- clinical urgency
- the length of time the patient has waited for their surgery
- resource availability (for example surgeon, theatre, equipment)
- whether the health service has previously postponed the patient's surgery (DHS 2009).

Western Australia

Western Australia's Elective Surgery Access Policy specifies the selection of patients from the waiting list is based on prioritisation according to clinical need. It also states that 'where no clinical urgency differentiation exists, patients will be treated in order of their registration on to the waiting list (first on, first off)' (WA Health 2009).

Western Australia's policy sets out criteria for prioritisation within clinical urgency categories. They include:

- waiting time
- previous postponements
- factors other than urgency category and relative waiting time:
  - where an opportunity arises to maximise operating theatre utilisation, gaps in theatre lists can be filled with less complex lower priority cases if there is no reasonable prospect of admitting a higher priority case
  - type of surgery required
  - the patient's comorbidities
  - medication requirements
  - the patient's social and community support
  - patient access factors (for example, distance of residence from treatment centre, transport and accommodation)
  - the need for other treatments while awaiting surgery
  - teaching and training needs.

The policy also states 'in cases where factors other than urgency category and relative waiting time influence patient selection for surgery, it must be demonstrated that no patient with similar characteristics has a higher urgency category, or has waited longer for treatment.'

Appendix C: International approaches to urgency categorisation

A number of countries have implemented urgency categorisation for elective surgery patients. This appendix provides an overview of the approaches used in a few of them.

Broadly, two types of approaches are covered:

- Broad categories, in Italy.
- Priority scoring systems, in New Zealand and Canada.

The Organisation for Economic Cooperation and Development (OECD) summarised some other approaches in its comparison of elective surgery policies in 12 OECD countries (Hurst & Siciliani 2003).

Italy

In 2001, the Italian Ministry of Health funded the Surgical Waiting List Information System project to investigate solutions for managing elective surgery waiting lists. It incorporates urgency related groups and corresponding pre-set maximum time before treatment. It drew on the Australian system as part of its development (Valente et al. 2009).

The five urgency categories were adopted based on two criteria: first, fast progression of disease presence and second, the level of pain, dysfunction or disability. They are:

- A1—Evident fast progression of disease affecting outcome by delay—8 days.
- A2—Potential fast progression of disease affecting outcome by delay—30 days.
- B—Severe pain and/or dysfunction and/or disability, but no fast progression of disease affecting outcome by delay—60 days.
- C—Mild pain and/or dysfunction and/or disability, but no fast progression of disease affecting outcome by delay—180 days.
- D—No pain, dysfunction or disability and no fast progression of disease affecting outcome by delay—360 days.

Canada

In Canada, methods of prioritisation have been developed through the work of the Western Canada Waiting List Project (WCWL 2001). The WCWL aimed to improve the fairness of the Canadian health system by prioritising access to medical services based on need and potential benefit.

The methods of prioritisation are based on physician-scored point-based tools to measure patients' priority for five significantly different clinical areas: cataract surgery, general surgery procedures, hip and knee replacement, magnetic resonance imaging, and children's mental health (WCWL 2001). The priority criteria and scoring systems for these five areas were developed through 'extensive clinical input from panel members and several stages of empirical work assessing their validity and reliability' (WCWL 2001).

In developing the priority tools, the panelists selected criteria items that were considered to be appropriate and relevant when assessing a patient's urgency and potential to benefit from surgery or treatment. The final selected criteria items were:

- major clinical factors or criteria relevant to judgments of patients' relative urgency (for example, degree of pain), as well as clinically appropriate levels within each criterion (for example, non, mild, moderate, severe) reflecting difference degrees of severity
- personal and social role measures designed to be physician-scored, such as ability to work, ability to care for self or dependants, and ability to live independently
- a 10-centimetre visual analogue scale and a category rating item, in which a patient's relative urgency was compared with the average in the clinician's practice, were included to serve as indicators of overall clinical urgency
- a point-count scoring system for the tools; that is, maximum weighted scores on the total of all the criteria and were based on the criterion's significance in determining a patient's urgency for treatment, and were therefore different for each of the five clinical areas (WCWL 2001).

The WCWL released a final report in 2005 that discussed the progress and findings in relation to the three aims, including the implementation and evaluation of the priority criteria tools in Western Canada (WCWL 2005). Acceptance of the priority scoring system by clinicians and other staff was identified as a key factor in determining the system's success. This included clinicians understanding and acknowledging that patients needed to be prioritised, and that the priority criteria tools could do this more effectively than the previous system, along with ensuring that the priority tools would not be an additional burden on staff's work (WCWL 2005).

The issue of how to manage patients who were assigned low-priority scores was also recognised in the project's implementation and evaluation phase, which identified the need to formulate maximum acceptable waiting times for all urgency levels (WCWL 2005). Developing maximum waiting times was incorporated into phase two of the project, with the aim of further developing, validating and modifying the maximum times so that they could be applied to all clinical areas in the future.

In 2006, following the WCWL Project, Canadian health ministers issued waiting times benchmarks for seven procedures based on the amount of time that clinical evidence showed as appropriate to wait for a particular procedure. These benchmarks included:

- surgical repair of hip fracture within 48 hours
- cardiac bypass surgery within 2 weeks
- hip replacement within 26 weeks
- knee replacement within 26 weeks
- surgery to remove cataracts within 16 weeks for high-risk patients (CIHI 2006).

WCWL prioritisation tools have now been put into practice in several elective surgery programs in a number of Canadian provinces (Curtis et al. 2010).

The Western Canada Waiting List Project priority criteria tools are at <http://www.wcwl.ca/tools/>.

New Zealand

As part of health reforms in New Zealand, in 1992 the National Advisory Committee on Health and Disability proposed replacing waiting lists with booking systems (Ministry of Health 2000). This led to the formation of the New Zealand Priority Criteria Project, which has as its aim the development of standardised sets of criteria to assess the extent of benefit expected from elective surgery procedures (Hadorn & Holmes 1997).

The project used a number of methods in developing the clinical priority assessment criteria (CPAC). These included a literature review; professional advisory groups for each procedure, selection and weighting of the criteria; and, pilot testing and refinement of weights based on test results (Hadorn & Holmes 1997). As a result, standardised clinical priority criteria were developed for five common elective surgery procedures, to serve the following purposes:

- ensure that the process used to define priority was fair and consistent across New Zealand
- permit the assessment and comparison of need, casemix and severity
- assist the regional health authorities to develop new booking strategies, including target booking times for patients with defined levels of priority
- permit comparison of waiting times across regional health authorities
- ensure that social values were integrated in the decision-making process in an appropriate and transparent manner
- provide the framework for the national health committee to define maximum acceptable waiting times for patients with defined levels of priority, as well as core levels of each service
- make possible national studies on the health outcomes experienced by patients who did and did not receive the services (Hadorn & Holmes 1997).

The assessment criteria varied depending on the factors that influenced the urgency and need for treatment. Similar to the WCWL priority scores, scores could not be compared across the clinical areas due to differences in indicators and weights.

The CPAC played a role in the wider project reforming elective surgery waiting list management in New Zealand. Essentially, this could be seen as a system to create uniformity of urgency assignment for specific procedures, to inform a commitment to treatment within a specific time frame (6 months).

There were more than 30 national CPAC tools for elective surgery prioritisation, including for coronary artery bypass graft surgery, cataract removal, joint replacement and cholecystectomy (Ministry of Health 2000). Patients were assigned a CPAC score according to the criteria that define the urgency of need for the procedure. The CPAC tools were based on evidence-based guidelines and clinical criteria, and were condition specific. They usually comprised a mixture of clinical dimensions (for example, visual acuity, or movement and deformity), patient-experienced dimensions (for example, extent of loss of visual function) and social factors (for example, age, impact on work or social activities, threat to independence and time spent waiting for surgery) (Hadorn & Holmes 1997). CPAC tools are scored according to severity and added to provide a total score ranging from 0 (lowest priority) to 100.

There has been criticism about a range of aspects of the CPAC arrangements (Derrett 2005) and New Zealand clinicians have questioned the effectiveness of the CPACs in prioritising patients (McLeod et al. 2004).

The CPAC tools do not seem to be available on the New Zealand Ministry of Health website. However, they are referred to in the health statistics section of the site at <http://www.health.govt.nz/nz-health-statistics/data-references/code-tables/national-booking-reporting-system-code-tables/cpac-scoring-system-code-table>.

Appendix D: Summary of consultations for this report

This appendix describes the processes used to consult stakeholders for this report and includes a summary of their inputs and feedback.

The consultation process comprised:

- a written public submissions process
- stakeholder workshops in six states and territories
- consultation with RACS-associated surgical specialty and sub-specialty societies.

The process was backed by web pages established as part of the AIHW website. They include background information on the work and on how input could be provided. They also include the draft proposals for were disseminated for comment and copies of all the public submissions.

Public submissions

The AIHW and the RACS invited written submissions from interested parties through letters sent to 55 stakeholder organisations and individuals and an advertisement in *The Australian*. This process ran from 30 March to 27 April 2012, with details, including a submission information paper, posted on the AIHW website.

Twenty written submissions were received, including from state and territory governments, medical and surgical specialty groups and the Consumers' Health Forum (Table D.1).

Table D.1: Written submissions received in the public submission process

Name of organisation making submission
Australian Commission on Safety and Quality in Health Care
Australian and New Zealand College of Anaesthetists
Australian Medical Association
Australian Private Hospitals Association
Colorectal Surgical Society of Australia and New Zealand
Consumers' Health Forum of Australia
Department of Health and Ageing
Department of Health, Northern Territory
Department of Health and Ageing, South Australia
Department of Health and Human Services, Tasmania
Department of Health, Western Australia
Dr Stuart Walker, Head of Department of Vascular and Endovascular Surgery, Royal Hobart Hospital
General Surgeons Australia
Health Directorate, ACT Government
Independent Hospital Pricing Authority

(continued)

Table D.1 (continued): Written submissions received in the public submission process

Name of organisation making submission
NSW Ministry of Health
Queensland Government, Queensland Health
St Vincent's Health Australia Limited
The Royal Australian and New Zealand College of Ophthalmologists

Stakeholder workshops

Stakeholder workshops were held in Melbourne, Sydney, Adelaide, Brisbane and Perth in July–August, to inform development of a draft proposal. In all cities but Brisbane, workshops were held in the afternoon and early evening, to maximise participation.

A final workshop was held in Canberra in September to consider the draft proposal before it was to be finalised for ministers.

For all workshops, draft proposal material was presented, and then participants were encouraged to offer comments in response to a series of questions.

Surgeons and other clinicians, hospital waiting list managers, jurisdictional officers and consumer representatives attended the workshops.

Consultation with surgical specialty and sub-specialty societies

As part of the consultation, the RACS Chair of Professional Development and Standards Board invited written comments and feedback on the draft proposal from 33 surgical specialty and sub-specialty societies, in August–September 2012.

The RACS received written comments and feedback from six surgical specialty and sub-specialty groups (Table D.2).

Table D.2: Surgical specialty and sub-specialty societies providing written comments

Name of society providing comments
Australian Orthopaedic Association
Australian Society of Plastic Surgeons
Australian and New Zealand Society of Cardiac and Thoracic Surgeons
Spine Society of Australia
Obesity Surgery Society of Australia and New Zealand
Colorectal Surgical Society of Australia and New Zealand

Summary of feedback

The following is a summary of the feedback received through the public submission process, stakeholder workshops (both the initial workshops held in July–August and the final workshop in September) and consultation with surgical specialty and sub-specialty societies. Responses have been presented largely against the 10 main topic areas covered at the workshops.

Overarching principles

Initial stakeholder workshop views

There was strong support across all workshops on the proposed overarching principle that 'clinical urgency category should be assigned at the discretion of the treating clinician' and that it would be useful to state the principle as part of the elective surgery urgency category definitions.

The additional principle, 'urgency categories should be assigned dependent on the patients' clinical situation alone and not availability of hospital or surgeon resources' received support across most workshops, but some stakeholders questioned the need for it, as it reaffirmed the first principle.

There was discussion around the need for development of clinical guidelines that would accompanying the urgency category definitions to include a scope statement indicating that the urgency category would be assigned on the basis of all patient needs, including clinical, social factors, functional factors and health outcomes for patients. It was the view that any clinical guidelines developed should be peer-based guidelines and not detract from the overarching principle of clinician discretion.

Some stakeholders questioned the practical application of the second principle, saying that there would always be difficulty in adding people to waiting lists if there was knowledge that resources were limited or not available.

Final stakeholder workshop views

There was strong support for including the overarching principle (revised from the two principles presented at the initial workshops) in the urgency category definitions. It was noted that the secondary part of the overarching principle was always a challenge because of limited hospital resources.

Many stakeholders suggested that the first part of the overarching principle needed strengthening to refer not only to the clinical condition but also patient-centred factors. Also, stakeholders noted that the audience for the urgency category definitions was consumers as well as surgeons.

Surgical specialty and sub-specialty societies' views

There was general consensus that the overarching principles were correct and worth stating explicitly as part of the urgency categories definitions.

Comments were also made that the need to document a consistent regimen of urgency categorisation should be balanced with clinical judgment of the patient and not be constrained by overly prescribed systems. It was noted that national frameworks and

guidelines are useful tools, but must remain intuitive and flexible to retain the authority of clinical judgment and integrity of decisions.

Definitions and timeframes for elective surgery urgency categories

Public submission views

The development of national elective surgery urgency category definitions to enable consistent application across all states and territories received support in-principle from stakeholders. Some stakeholders suggested that a reference to a condition being 'clinical' should be included in the definitions, and some that reference to subjective elements, such as 'pain', 'dysfunction' or 'disability' and 'become an emergency', should be removed from the current definition, as these could be subject to differing interpretations and create inconsistencies in categorisation.

Stakeholders supported that all factors relevant to a patient's requirement for elective surgery be considered as part of the clinical decision-making regarding categorisation. The range of criteria noted for prioritising patients included severity of condition, decay rate of the disease, potential to deteriorate, type of surgery required, expected benefit from surgery, comorbidities and overall health status, measures of functioning/disability or pain, the need for other treatments while waiting for surgery, and social/economic circumstances of the patient. Stakeholders also recognised other factors that needed to be addressed as part of waiting list management included teaching requirements for junior medical officers and hospital resources.

Many stakeholders expressed concerns that the current definitions did not take into consideration all the factors relevant to a patient's need for elective surgery, and should not be limited to the type of procedure the patient required or the volume of procedures.

A few stakeholders expressed concern regarding the current urgency category definitions not having an end time frame for category 3 and hence the potential for the patient being 'forgotten'. Further, stakeholders noted that there was no evidence-based research that provided any clinical or research basis for the use of 30 days, 90 days and 365 days, and that these timeframes were arbitrary.

The need for consultant-led clinical decision-making was noted by some stakeholders, in particular for category 1 patients. It was some stakeholders' opinion that consultants would be in the best position to provide a balanced assessment of urgency for any particular procedure or patient, as they had experience and professional advocacy for the system and the patient.

One stakeholder suggested that evidence-based studies should be used to assign urgency categories and that surgical specialties should be asked to produce evidence when assigning categories.

Initial stakeholder workshop views

There was strong support across all workshops on the use of simple time-based definitions for urgency categorisation; however, support from some stakeholders was qualified by a need for some form of categorisation criteria to accompany the definitions. It was felt that additional criteria would provide a mechanism for clinician accountability and a level of certainty for consumers. It was also noted that any definitions agreed needed to be able to be explained to the consumer.

Concerns were noted that removing the descriptive words, including 'pain', 'dysfunction' and 'disability', from the urgency category definitions may lead to clinician liability. There was some support for the phrase 'clinically indicated' to be replaced with the phrase 'clinically safe to wait'.

Training and education of junior doctors was regarded as a possibly more strategic avenue to reduce variations in assignment of elective surgery urgency categories. It was noted that junior doctors tended to take the lead from senior medical officers when assigning urgency categories. It was acknowledged that a transition and education strategy would need to be used, regardless of which changes were adopted.

Stakeholders at all workshops noted that the timeframes of the current and the proposed urgency category definitions were not evidence-based. Some questioned the need to change timeframes in the absence of evidence that specific timeframes led to better patient health outcomes.

Stakeholders questioned whether the '365 days' time frame was clinically relevant as an end point for urgency categories. Some suggested an end point of 180 days (6 months) may be more 'clinically appropriate'. The 365 days timeframe was also questioned as it was not currently in the definition of clinical urgency.

There was wide support for a policy on the need for a clinical review of a patient after a defined period. Such a review was regarded as especially important for patients assigned to urgency category 3. This review was regarded as necessary to good patient care as patients may have a change in their clinical condition over a period of time.

A recurring theme was the need for data (and hence the underlying definitions) to support both clinical and management requirements, and for alignment of national, state and local key performance indicators with the waiting list data.

Final stakeholder workshop views

There was general support among stakeholder that the urgency category definitions should be simplified and time based. Some stakeholders had concern for the use of the phrase 'clinically indicated', but the addition of the words 'appropriate to the patient and their clinical situation' in the overarching principle was proposed to alleviate this concern.

It was suggested that the simplified, time-based urgency categories definitions should be accepted and implemented using a data feedback mechanism to review the definitions after a period of time.

The potential definition for elective surgery, 'Elective patients are those whose clinical condition requires a procedure that can be managed by placement on a waiting list' was also briefly discussed.

Numbers of urgency categories

Public submission views

The majority of stakeholders agreed that the new national definitions should be simplified and focus on clinically appropriate times to treatment. The timeframes suggested for the urgency category definitions in the public submission process varied from 2 categories (30 days or 6 weeks, and 365 days) to 3 categories (30 days, 90 days and 365 days) and 4 categories (30 days, 60 or 90 days, 120 or 150 or 180 days, and 365 days). One stakeholder suggested that category 3 be defined as beyond 90 days, instead of being 365 days.

Initial stakeholder workshop views

There was mixed support for the proposal to split category 2 (into category 2A and 2B), and no clear agreement to change the timeframes of the current definitions.

There was some support for four urgency categories: category 1 (30 days), category 2 (60 days), category 3 (120 or 150 days), and category 4 (365 days) at the Melbourne and Perth workshops. Stakeholder workshops at Sydney, Brisbane and Adelaide had mixed support for the number of urgency categories, ranging from two categories (urgent—30 days and non-urgent more than 30 days) to six categories (stratification of existing 3 categories into urgent and non-urgent).

The stakeholders provided reasons for both increasing and decreasing or maintaining the number of categories. These included:

- The splitting of category 2 may benefit certain sub-cohorts of patients, particularly in cardiothoracic and neurosurgery. There would also be enhanced confidence in the waiting list management system and therefore eliminate some of the 'up categorising' or gaming that may currently be occurring.
- Increasing the number of categories would have the potential for clinician disengagement, and the need to reclassify patients currently on waiting lists would increase the burden on existing clinical and administrative resources.
- Based on queuing theory, it was suggested that having four or more categories would mean patients would wait longer; it was suggested that consideration should be given to queuing theory as part of the work to develop the proposal.

Stakeholders also raised the need to consider how changes to the number of categories (and their definitions) would affect national reporting requirements. The main reporting target noted was the NEST.

Surgical specialty and sub-specialty societies' views

Stakeholders supported the splitting of urgency category 2 and felt it was sensible and had potential to minimise 'category creep' due to the current large differences between category 1 and category 2 timeframes. One stakeholder suggested the time frame attached to category 3 should be brought forward to 180 days, rather than 365 days. Other stakeholders noted that three categories were sufficient and thought creation of a fourth category may be more confusing for clinicians than helpful.

Feedback about urgency categorisation

Initial stakeholder workshop views

There was support across almost all workshops that providing feedback of data on urgency category distribution to surgeons, surgical specialty groups, hospitals, local hospital networks and states and territories would be useful. A common theme was that all feedback was valuable, if used in the right context and when the information was not used to inform punitive measures. Stakeholders emphasised that for feedback to be useful, the data should be easy to interpret, simple and timely. The benefit in monitoring feedback data over time once definitions were standardised was also noted.

Other themes raised across most workshops included that while feedback may aid in understanding variations in urgency category assignment, it may not directly play a role in reducing variations. Consideration of the types of comparisons provided in any feedback should include similar population, casemixes or hospitals. It was felt that reporting based on procedure by urgency category alone was less meaningful than if it was combined with an indication for procedure or considered with waiting times.

While it was noted that some elective surgery data, such as median waiting times for surgical specialities were published on the *MyHospitals* website, there was a preference at some workshops for at least some feedback data to be limited to the health service level rather than it being provided in the public domain.

Final stakeholder workshop views

There was general agreement that providing feedback information about urgency categorisation should be part of the definitions package. Some stakeholders noted that clinicians would find it useful to see the data. Stakeholders suggested that the use of bar charts and tables would be useful in presenting the feedback data.

There was some discussion about the extent to which the feedback information would be published. Some stakeholders expressed the view that data should be published at the hospital level, whereas others felt that data for hospitals should be distributed confidentially by state and territory health departments.

Some stakeholders asked about the processes proposed to generate and disseminate the feedback data. It was acknowledged that more work would be needed to establish these processes and would include consideration of the frequency and format of the feedback data.

Surgical specialty and sub-specialty societies' views

The majority of stakeholders agreed that providing feedback of urgency distribution information would be useful. Many noted that it would be more valuable at an institutional level, rather than at a national level, and should be presented with information that described the clinical variability of the service provided. Some stakeholders expressed concerns that the feedback information could become a 'stick rather that a carrot' and may encourage manipulation by wait list managers.

Recommended urgency categories for higher volume procedures

Public submission views

Almost all stakeholders supported the need for a nationally recommended agreed list of recommended urgency categories or timeframes for common higher volume procedures to accompany the national definitions, but with the important stipulation that clinical discretion could override the guidelines for assignment.

Some stakeholders noted that it was important to consider the indications for the procedure, their interactions with the patient's comorbidities and many other patient factors, which would make agreement on a procedure list according the urgency difficult. Some also noted that treatment protocols and evidence-based staging or risk algorithms should be considered in assigning urgency categories for the procedures.

A few stakeholders noted that currently there were a significant number of procedures classified as 'non-reportable' and therefore not included in the national data sets. It was also noted that there was a strong focus on the reportable procedures being completed to achieve the NEST targets, such that patients waiting for 'non-reportable' procedures were perceived to be disadvantaged and had reduced opportunities to have their procedure completed in a timely manner.

Initial stakeholder workshop views

There was support across most workshops for a national list of 'recommended' urgency categories for higher volume procedures, to be developed in a clinician-led process. There was some support for using the existing lists, developed by New South Wales and Western Australia.

Stakeholders who supported the use of a national list noted that input from surgical specialties would be essential to develop such a list, that the list should be a tool rather than a prescriptive instrument and that, for the success of such a list, clinicians should have the ability to override a recommended urgency category according to their clinical judgment. There was suggestion that the list should be a recommended list of 'spreads' of urgency categories as this would be more useful than recommending a single number. A national list may also need to consider special sub-groups, such as paediatrics and other patient factors (indications for procedures and health outcomes).

Stakeholders suggested that a combination of a 'recommended' urgency category list and feedback on urgency category distribution data would be useful. A national list could be used to support audits of waiting lists.

There was discussion at a couple of workshops around the apparent poor inter-rater reliability of assigning urgency categories by surgeons compared with the very good inter-rater reliability of nurses assigning triage scores to patients on presentation at hospital emergency departments. The triaging process is supported by guidelines.

Final stakeholder workshop views

Stakeholders strongly supported the use of recommended urgency categories for higher volume procedures as part of the proposed approach to urgency category definitions.

There was concern raised that the word 'recommended' would indicate that the list would be a rule, suggesting use of the phrase 'suggested', 'most common', 'frequently used' or the use of mean or medians should be considered. It was agreed by all stakeholders that input from

surgical specialty groups was needed to develop the suggested list. It was noted that the recommended urgency category list be supported by feedback information and reporting.

Some stakeholders commented that to achieve greater consistency in use of the recommended urgency category list, consideration of clinical indication in addition to procedure would be needed.

Surgical specialty and sub-specialty societies' views

There was some support for the development and use of a national list of recommended urgency categories for higher volume procedures, with suggestions that if a national list was introduced these guidelines should not be 'locked in'.

Some stakeholders commented that a list would be unhelpful in plastic surgery and cardiothoracic surgery and that, for common procedures, for example hernias, gall bladders and colonoscopies, categorisation often depended on patient specific circumstances, so may not be aided by the use of such a list.

Specific guidelines or scoring systems

Public submission views

There was some support for the use of scoring systems or guidelines. Some stakeholders noted that a scoring system or standardised prioritisation tools could be useful where procedures could be placed in more than one category, and that they would be seen to enhance equity of access and reinforce prioritisation. It was suggested that autonomous clinical decision-making by medical practitioners took into account the variability between patients with the same condition, but could be supported by guidelines or tools.

Some stakeholders suggested that scoring systems for specific procedures, similar to those used in the Western Canada Waiting List project and the Victorian Multi-attribute Arthritis Prioritisation Tool (MAPT), could be used, as they allowed inclusion of objective measures of health status and patient factors.

Other stakeholders noted that scoring systems introduced a comparative system with no flexibility and that weighting of various factors would not be easy to develop and achieve agreement by clinicians.

There was consensus that to implement such guidelines, a significant amount of clinician consultation would be required.

Stakeholder workshop views

There was little support for the use of specific guidelines or scoring systems to help reduce variation in urgency categorisation.

Some stakeholders noted that specific guidelines or scoring systems would contribute to objectivity for decision-making for some procedures, while others felt such systems would diminish clinician roles in assigning urgency categories. Stakeholders suggested that the adoption of guidelines and scoring systems had the potential to create a highly resource-intensive, burdensome urgency categorisation process.

While national adoption of specific guidelines and scoring systems was not supported, there was support for optional use (by individual clinicians or clinician groups) of guidelines or scoring systems.

There was acknowledgment that specific guidelines and scoring systems may be helpful within a specific specialty (for example, MAPT in orthopaedic surgery or visual acuity in cataract surgery).

While not supported for use at a national level, stakeholders noted that such specific guidelines or scoring systems (if nationally adopted) would need to be developed by the RACS specialty and sub-specialty groups, be evidence-based, be linked with health outcomes and validated. However, the general consensus was that these guidelines would be hard to write, overly prescriptive in application and resource intensive to develop and apply.

It was acknowledged that such scoring systems could form the basis of an audit tool, be of some assistance for registrars when assigning an urgency category and could be incorporated into information technology systems.

Surgical specialty and sub-specialty societies' views

There was minor support for the development and use of specific guidelines or scoring systems for urgency categorisation. Some stakeholders suggested that the guidelines or scoring systems would be useful as a guide for surgeons, in particular trainee and inexperienced surgeons. One stakeholder expressed that due to a lack of validated scoring systems, at least in bariatric surgery, there would need to be considerable work undertaken to achieve guidelines and scoring systems that were validated before they could be used.

Approaches to patients *not ready for care*

Public submission views

Stakeholders strongly supported that there should be clear procedures for placing patients in the *not ready for care* categories. Many stakeholders expressed that *not ready for care* patients should only be wait-listed and assigned an urgency category once they were *ready for care*. Stakeholders also suggested that there be a mandatory review period for patients in the *not ready for care* category.

Some stakeholders recommended that patients who required treatment periodically (for example, 3-, 6- or 12-month surveillance procedures) or required treatment as part of a staged procedure (for example, removal of pins and plates) should be placed on the waiting list for the procedure when they were *ready for care* with a time interval for the procedure. It was noted that the time intervals for some staged surgical procedures, such as breast reconstruction or cleft lip/palate repairs, could be supported by clinical guidelines.

Some stakeholders noted that the category for patients deferred for personal reasons should have a maximum period of time permitted for deferment, with a suggestion of 30 days, 90 days and 180 days, depending on the assigned urgency category. Exceeding the maximum period would result in the need for clinical reassessment or removal from the waiting list.

Initial stakeholder workshop views

There was general support across all workshops for the proposed approach to *not ready for care* patients and acknowledgment that some states were doing this already to varying degrees. Some stakeholders proposed that a more accurate description for *not ready for care* was *not ready for procedure/surgery*.

There was agreement that *not ready for care* patients should be added to a waiting list at the time they were *ready for care*. This approach supported resource planning and management.

There was some support for patients deferred for clinical reasons being added to the waiting list at the time they were seen, namely at the surgical consultation when the decision for surgery was made.

There were a number of concerns expressed at a number of the workshops about management of patients *not ready for care*:

- A need for monitoring of *not ready for care* patients, for example, having a clinical review date, to ensure all patients waiting for an elective procedure were captured and managed appropriately (and did not 'drop off' the waiting lists).
- The need to accommodate patients who needed elective procedures scheduled after long periods of time, for example, a surveillance cystoscopy in 2 years.
- The need to consider what urgency category a patient should be assigned when the patient became *ready for care*.
- Surgeons taking ownership and managing their waiting list to ensure *not ready for care* patients were appropriately managed.

Final stakeholder workshop views

There was general support among stakeholders for the three *not ready for surgery* categories proposed. The following points were discussed:

- The urgency categories for staged patients should be assigned according to the length of the 'window' during which their procedure was indicated, be evidence based and allocated at the time the patient was placed on the waiting list.
- State and territory policies related to *not ready for care – deferred for personal reasons* imposed maximum cumulative time thresholds and the number of deferrals the patient could have. The time thresholds and/or number of deferrals are jurisdictional or hospital specific issues and will not be part of the national proposal.

Surgical specialty and sub-specialty societies' views

Stakeholders strongly supported the proposed definitions of three *not ready for care* categories. One stakeholder expressed concern that the waiting list system must place importance on staged surgery and the ability to manage staged patients within the correct timeframes associated with the patient's clinical need, for example, after neoadjuvant chemoradiotherapy.

'Treat in turn' principle

Initial stakeholder workshop views

There was general support across all stakeholder workshops for the principle of 'treat in turn' to be included in the elective surgery urgency category definitions and that this principle implied equity. While the principle was supported, it was stressed that flexibility was needed in practice and this principle should be second to the overarching principle of 'clinician discretion'.

Workshop participants agreed that all things being equal the 'treat in turn' principle should apply. However, other imperatives within public hospitals would take priority, for example,

teaching and training requirements of junior surgeons, filling of theatre lists and clinician judgment about priorities based on the clinical condition of the patient.

There was some concern that this principle was difficult to implement as current waiting lists were not combined and the practicalities of applying the principle in situations when demand was much larger than supply.

The Victorian Department of Health has information and research about the use of the 'treat in turn' principle on its website and Queensland has introduced a 'checklist—treat in turn' software reporting tool. The Western Australian Elective Surgery Access Policy (2009) uses the principle 'first on, first off', which is consistent with the principle 'treat in turn' to ensure equity of access. The impact of 'treat in turn' could be informed by data modelling methodologies.

Final stakeholder workshop views

There was general support that the 'treat in turn' principle should be included as part of the urgency category definitions (as it could contribute to improved standardisation of urgency categorisation), noting that this principle applied within categories and that the aim for 'treat in turn' was to treat 60–80% of patients in turn, not all patients. It was noted that the Victorian Department of Health was producing traffic light reporting of 'treat in turn' within hospitals.

Surgical specialty and sub-specialty societies' views

There was minor support for the inclusion of the principle of 'treat in turn' as part of the urgency category definitions package. It was emphasised that patients should be treated according to their clinical priority and clinical need. Concern was expressed about how this principle should be applied, and that individual health services would need to implement it.

Scope of elective surgery waiting lists and urgency categorisation

Initial stakeholder workshop views

There was general support across all stakeholder workshops that the scope of elective procedures should be expanded to include procedures not currently in scope for categorisation and waiting times monitoring. There was support for the expansion to include procedures such as cardiovascular interventional procedures, peripheral vascular interventional procedures, bronchoscopy, gastroscopy, endoscopic retrograde cholangiopancreatography, colonoscopy and living donor organ transplant procedures.

Stakeholders across most workshops raised the importance of monitoring all hospital activity, as it was important for resource allocation. The large demand for colonoscopies and the importance of them being effectively managed was repeatedly raised, with issues around supply not meeting demand and the resultant patient safety and health outcomes risks.

There was a suggestion that the list proposed might be too restrictive and should be broadened to include more diagnostic procedures, interventional radiological procedures, insertions of lines, magnetic resonance imaging, some obstetrics procedures and cardiac 'structural heart' implantation devices. Relevant surgical and physician specialty groups would need to be consulted if the scope was expanded to include such additional elective procedures.

Some stakeholder workshops supported expansion of this list in principle, however, it was suggested that these procedures would be best managed on a waiting list separate from the elective surgery waiting list. Pooling of a surgical list with a procedure list would result in a very large volume of patients on the list, which could increase the complexity of trying to manage the workload at the health service level. Most stakeholders considered that statistics on the waiting times for the additional procedures should be collected separately from those for elective surgery.

Final stakeholder workshop views

There was support that the scope of urgency categorisation and monitoring of waiting times should be broadened to include a range of elective procedures, with further consultation needed with specialty groups. Procedures to be considered would include live donor transplant surgery, bronchoscopy, gastroscopy, colonoscopy, endoscopic retrograde cholangiopancreatography, endoscopic ultrasound, cardiac interventional and pacemaker procedures, peripheral vascular interventional procedures, and interventional radiological procedures.

Surgical specialty and sub-specialty societies' views

There was some support for the inclusion of some elective procedures in urgency categorisation. There was some strong support for including colonoscopies in a 'visible' official waiting list, and support for including endobronchial ultrasound and pacemakers.

Other comments

Access to elective surgery waiting lists

The effects of national variations in approaches to how patients are added to elective surgery waiting lists were raised at a number of workshops. Patient access to waiting lists and the urgency categorisation assigned may be via a hospital outpatient service (which can have long waiting lists) or directly from specialists' private rooms (with possibly shorter waiting lists).

There was a strong view that the entire system needed to support equity of access for patients, not just the urgency categorisation process. The issue of 'hidden waiting lists' or the 'waiting list to get on the waiting list' was also raised. In that context, it was noted that, in the NPA IPHS (Clause A54), COAG had agreed that health ministers would 'agree that for future agreements consideration will be given to developing a measure of surgical access time from general practitioner referral to surgical care, to reflect the actual waiting time for patients and demand for elective surgery performance'(COAG 2011).

Local management of waiting lists

Across all workshops, emphasis was placed on the crucial role that local management had in successfully managing waiting lists and positive patient outcomes. Local clinical ownership and open and positive communication between waiting list managers and clinicians were considered to be very important by many stakeholders.

Procedures provided by public hospitals

There was some discussion about the practice of clinicians and health-care providers adding patients to waiting lists for procedures generally not provided in public hospitals, for

example, breast reduction and breast reconstruction after mastectomy. The need to have a nationally agreed list of procedures which would not be done as elective surgery in public hospitals was raised. There was some suggestion that this would support equity of service provision in an environment where supply did not always equal demand and rationing of services was a reality.

Appendix E: Examples of feedback material on comparative urgency categorisation

The national definitions for elective surgery urgency categories definitions package includes a proposal that arrangements are established to feed back information about comparative urgency categorisation to surgical specialty groups and/or hospitals and local hospital networks on a routine basis.

The following tables and graphs provide examples of the types of presentations that could form the basis of feedback material.

Tonsillectomy

Example 1: Data in tables

Table E.1: Tonsillectomy admissions[(a)] from waiting lists by urgency category (per cent), states and territories, 2011–12

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Category 1	4	4	6	3	5	30	3	5	5
Category 2	22	52	72	34	49	45	60	68	44
Category 3	74	43	22	62	46	26	36	27	51

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Percentages may not add up exactly to 100.0 due to rounding.

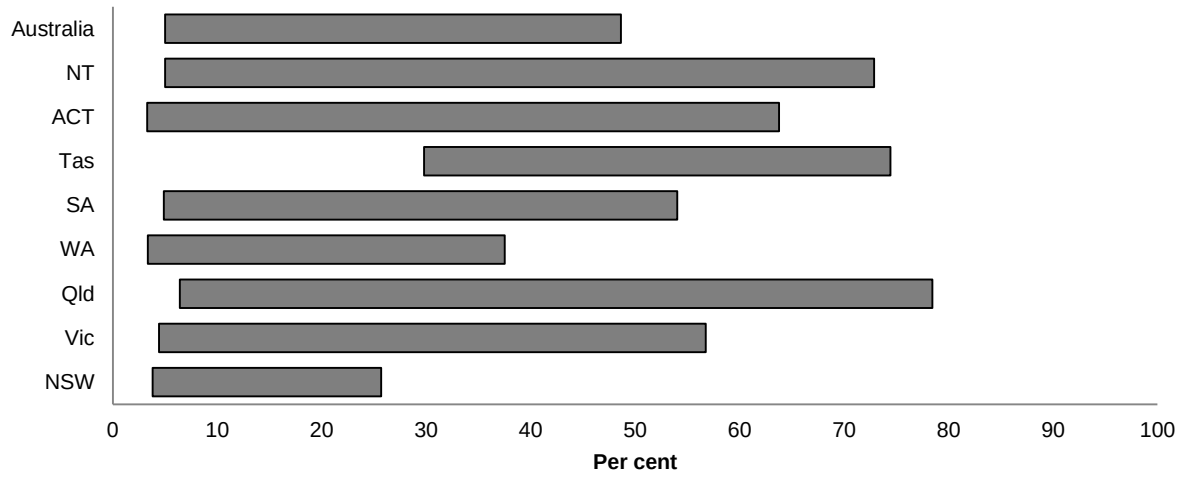
Table E.2: Tonsillectomy admissions[(a)] from waiting lists by urgency category (per cent), peer group A hospitals, 2011–12

	Hospital A	Hospital B	Hospital C	Hospital D	All peer group A hospitals	All hospitals in Australia
Category 1	7	2	7	57	9	5
Category 2	71	19	65	22	61	44
Category 3	22	79	28	22	30	51

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Percentages may not add up exactly to 100.0 due to rounding.

Example 2: Reporting emphasising urgency category 2

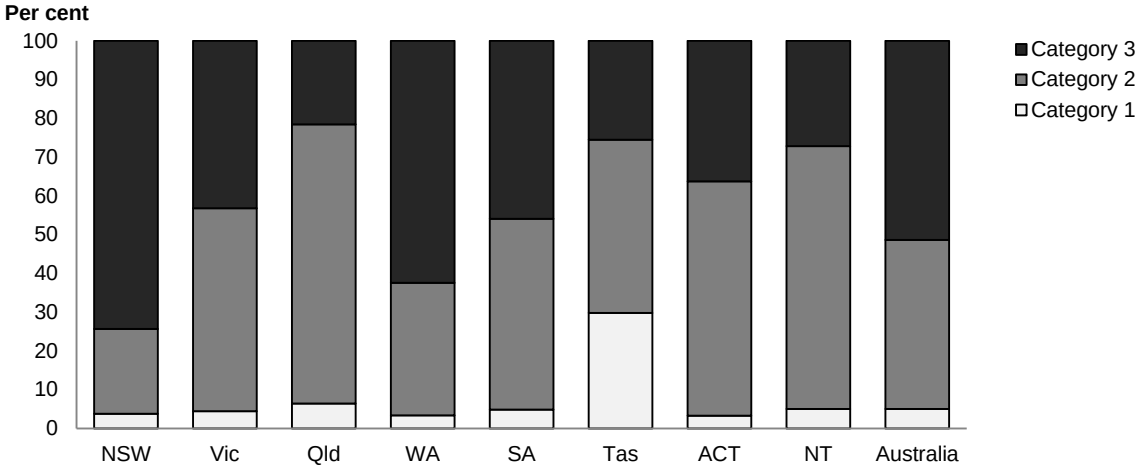


(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: The space between 0% and the grey bar represents the proportion of urgency category 1 patients and the space between the grey bar and 100% represents the proportion of urgency category 3 patients.

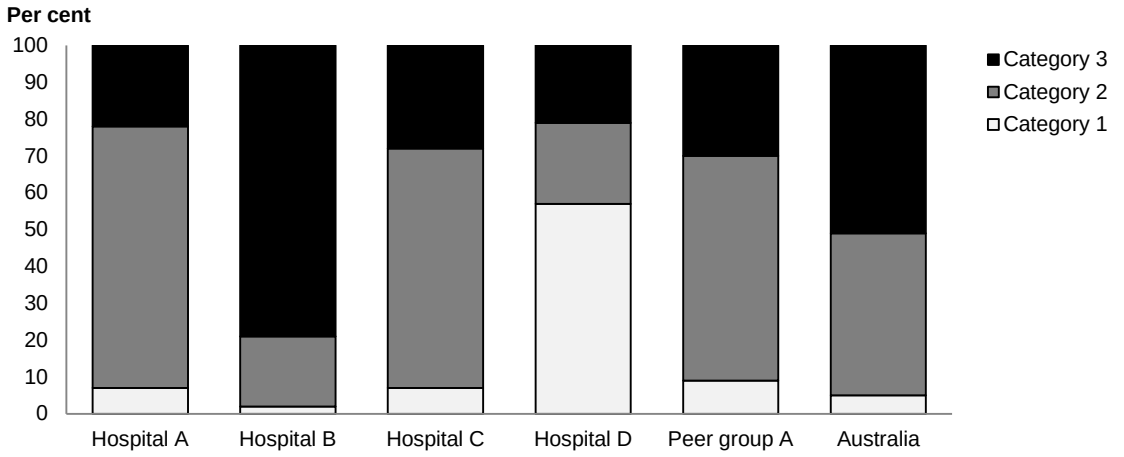
Figure E.1: Tonsillectomy admissions[(a)] from waiting lists, for urgency category 2, states and territories, 2011–12

Example 3: Bar charts



(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Figure E.2: Tonsillectomy admissions[(a)] from waiting lists by urgency category, states and territories, 2011–12



(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Figure E.3: Tonsillectomy admissions[(a)] from waiting lists by urgency category, peer group A hospitals, 2011–12

Cholecystectomy

Example 1: Data in tables

Table E.3: Cholecystectomy admissions[(a)] from waiting lists by urgency category (per cent), states and territories, 2010–11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Category 1	13	21	27	14	18	28	16	26	18
Category 2	58	70	68	55	62	66	78	60	63
Category 3	29	9	5	31	19	5	6	14	18

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Percentages may not add up exactly to 100.0 due to rounding.

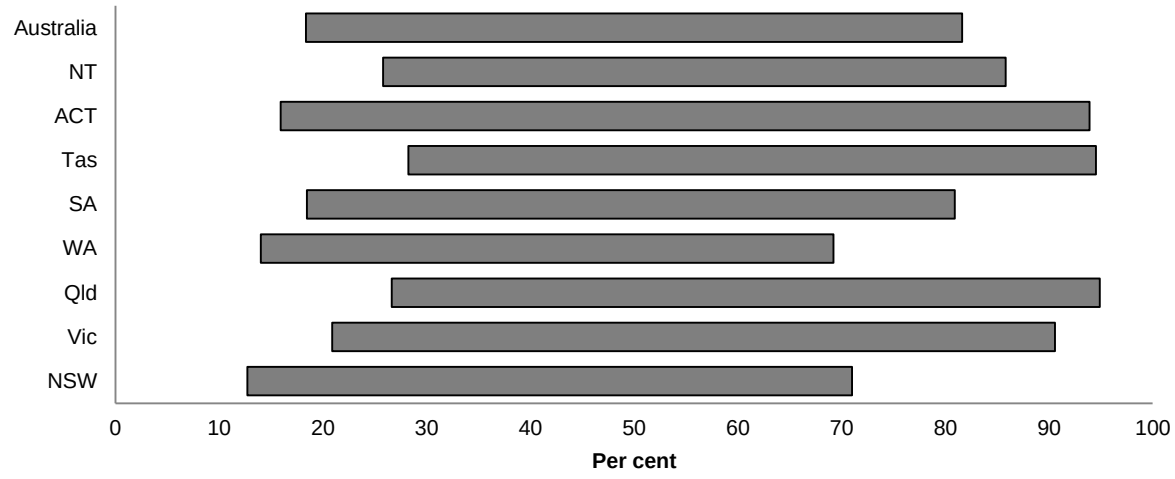
Table E.4: Cholecystectomy admissions[(a)] from waiting lists by urgency category (per cent), peer group A hospitals, 2010–11

	Hospital A	Hospital B	Hospital C	Hospital D	All peer group A hospitals	All hospitals in Australia
Category 1	19	14	26	27	18	**18**
Category 2	60	77	67	67	65	**63**
Category 3	21	9	7	6	17	**18**

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Percentages may not add up exactly to 100.0 due to rounding.

Example 2: Reporting emphasising urgency category 2

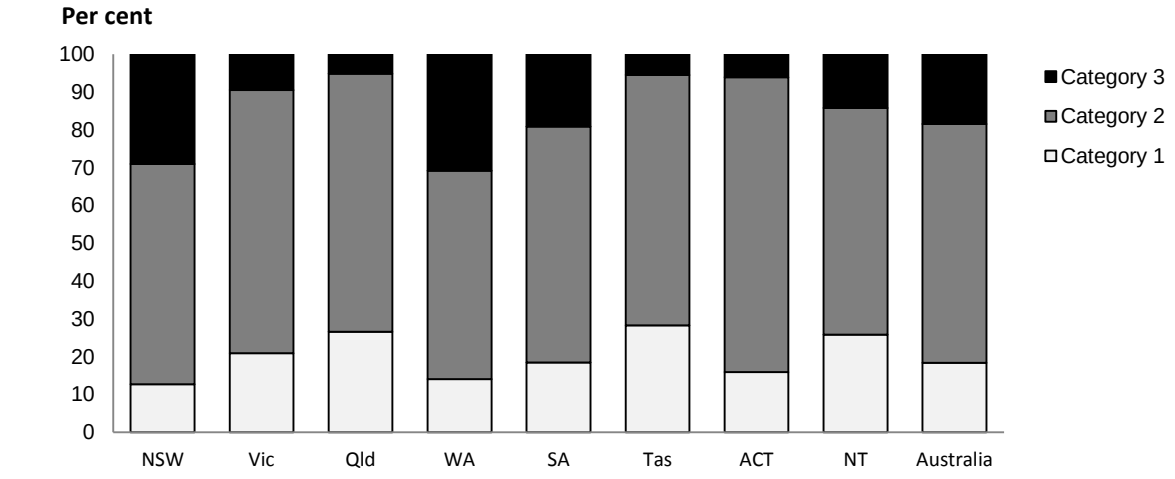


(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: The space between 0% and the grey bar represents the proportion of urgency category 1 patients and the space between the grey bar and 100% represents the proportion of urgency category 3 patients.

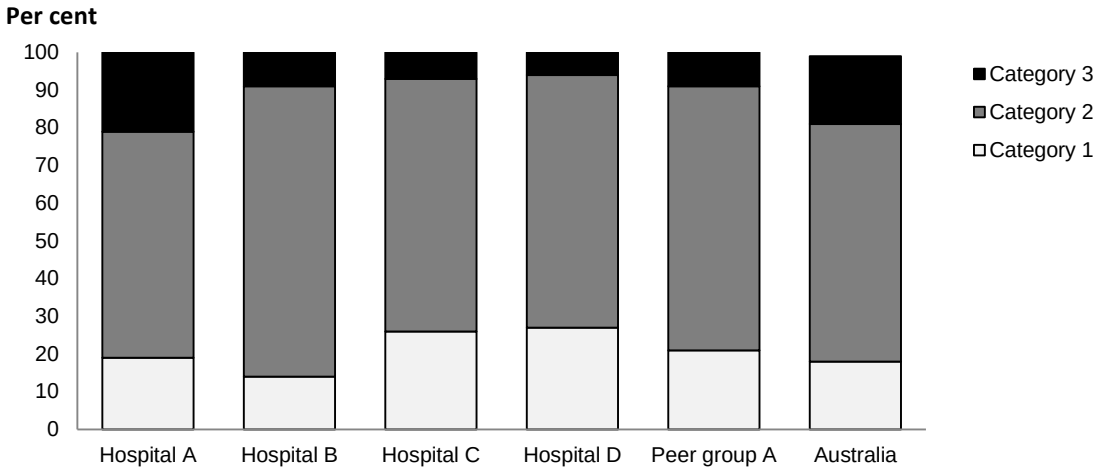
Figure E.4: Cholecystectomy admissions[(a)] from waiting lists, for urgency category 2, states and territories, 2011–12

Example 3: Bar charts



(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Figure E.5: Cholecystectomy admissions[(a)] from waiting lists by urgency category, states and territories, 2011–12



(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Figure E.6: Cholecystectomy admissions[(a)] from waiting lists by urgency category, peer group A hospitals, 2011–12

Total knee replacement

Example 1: Data in tables

Table E.5: Total knee replacement admissions[(a)] from waiting lists by urgency category (per cent), states and territories, 2010–11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Category 1	2	1	5	4	2	10	3	3	3
Category 2	12	71	59	47	11	62	82	59	37
Category 3	87	28	36	49	87	28	14	38	60

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Percentages may not add up exactly to 100.0 due to rounding.

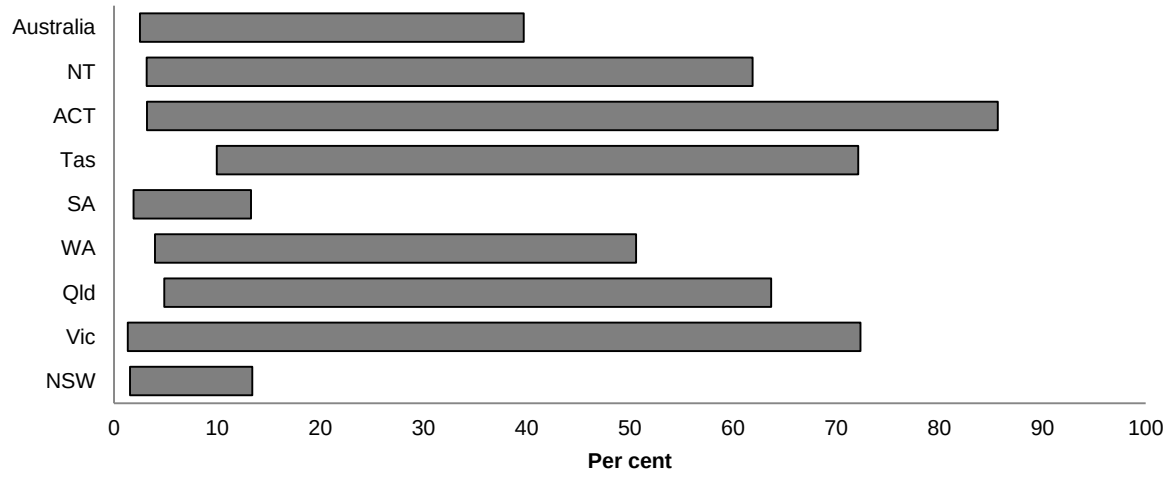
Table E.6: Total knee replacement admissions[(a)] from waiting lists by urgency category (per cent), peer group A hospitals, 2010–11

	Hospital A	Hospital B	Hospital C	Hospital D	All peer group A hospitals	All hospitals in Australia
Category 1	1	10	0	3	4	3
Category 2	66	36	44	80	60	37
Category 3	33	54	56	18	36	60

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Percentages may not add up exactly to 100.0 due to rounding.

Example 2: Reporting emphasising urgency category 2

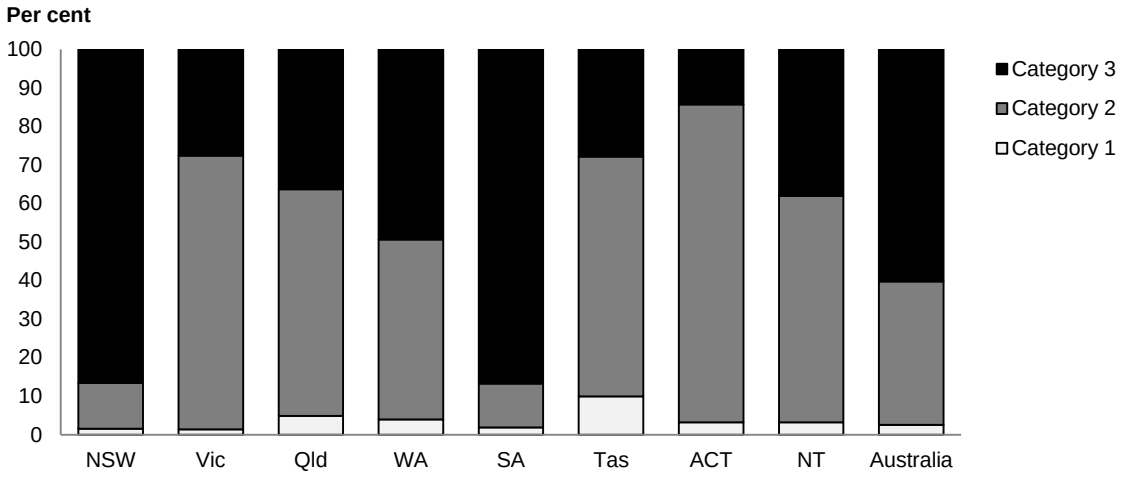


(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: The space between 0% and the grey bar represents the proportion of urgency category 1 patients and the space between the grey bar and 100% represents the proportion of urgency category 3 patients.

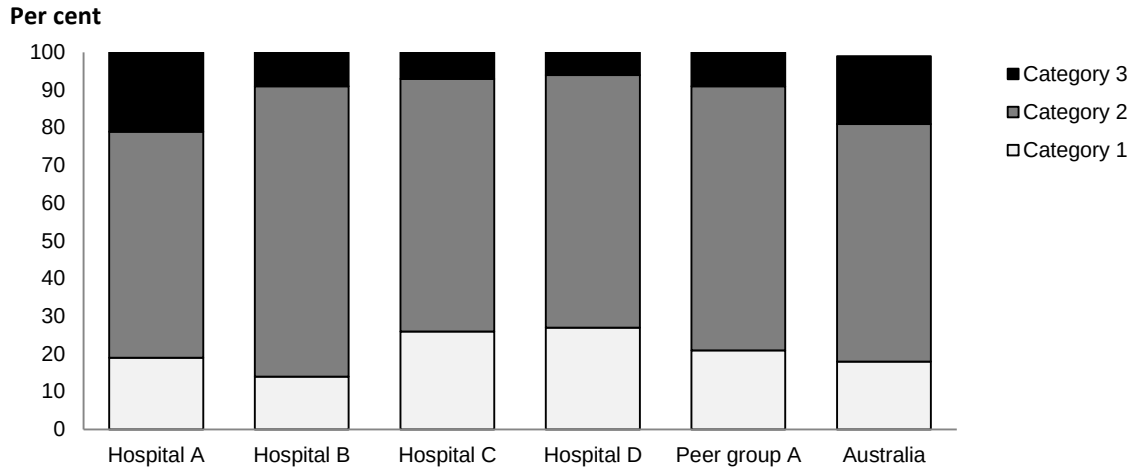
Figure E.7: Total knee replacement admissions[(a)] from waiting lists, for urgency category 2, states and territories, 2011–12

Example 3: Bar charts



(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Figure E.8: Total knee replacement admissions[(a)] from waiting lists by urgency category, states and territories, 2011–12



(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Figure E.9: Total knee replacement admissions[(a)] from waiting lists by urgency category, peer group A hospitals, 2011–12

Total hip replacement

Example 1: Data in tables

Table E.7: Total hip replacement admissions[(a)] from waiting lists by urgency category (per cent), states and territories, 2010–11

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Category 1	4	4	19	7	6	16	8	3	**7**
Category 2	24	75	56	58	21	68	82	79	**47**
Category 3	72	21	26	35	74	16	10	18	**45**

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Percentages may not add up exactly to 100.0 due to rounding.

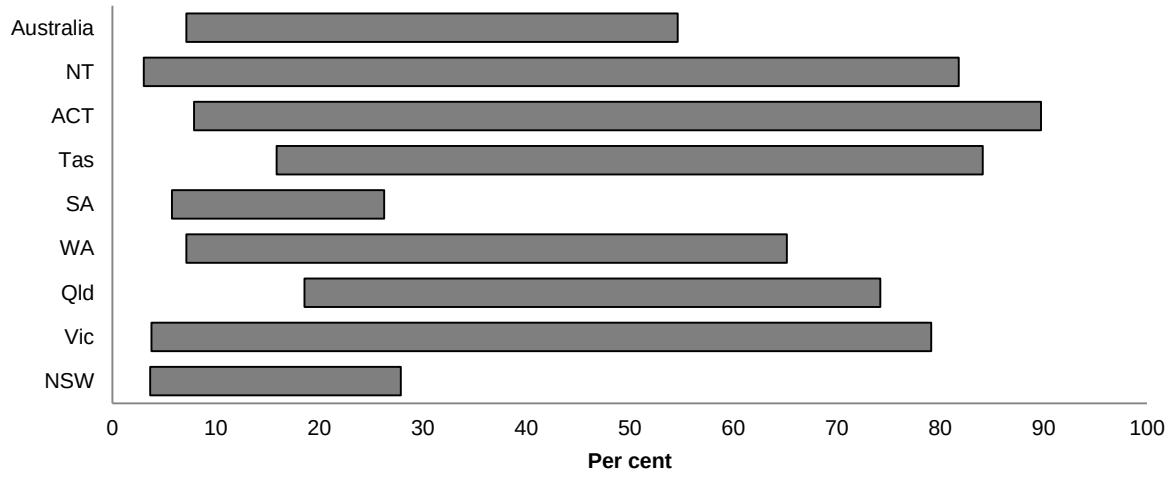
Table E.8: Total hip replacement admissions[(a)] from waiting lists by urgency category (per cent), peer group A hospital, 2010–11

	Hospital A	Hospital B	Hospital C	Hospital D	All peer group A hospitals	All hospitals in Australia
Category 1	4	3	8	1	4	**7**
Category 2	60	23	58	64	51	**47**
Category 3	36	74	34	35	45	**45**

(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: Percentages may not add up exactly to 100.0 due to rounding.

Example 2: Reporting emphasising urgency category 2

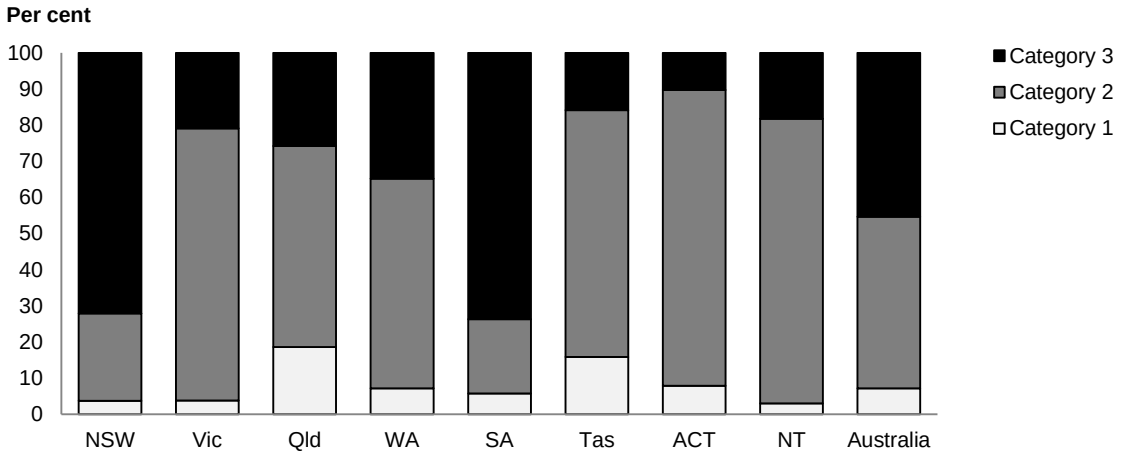


(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Note: The space between 0% and the grey bar represents the proportion of urgency category 1 patients and the space between the grey bar and 100% represents the proportion of urgency category 3 patients.

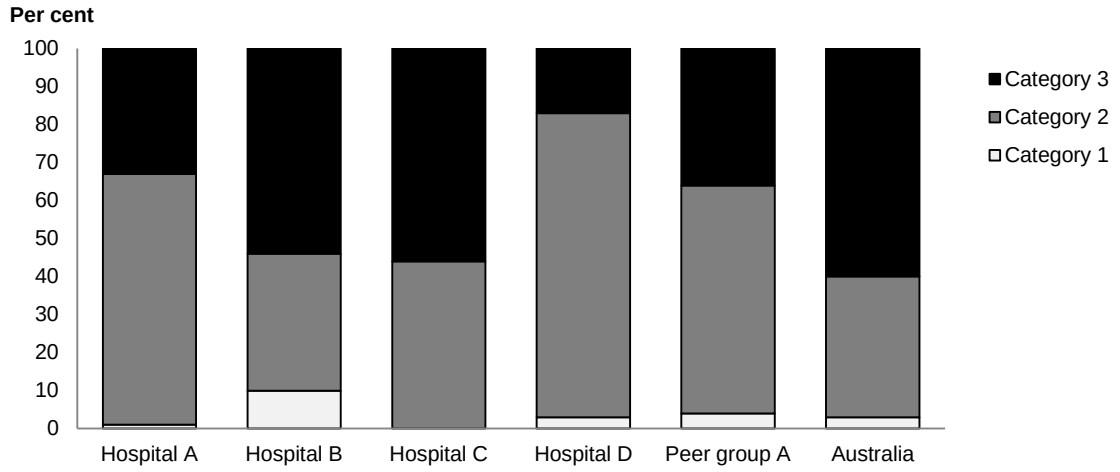
Figure E.10: Total hip replacement admissions[(a)] from waiting lists, for urgency category 2, states and territories, 2011–12

Example 3: Bar charts



(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Figure E.11: Total hip replacement admissions[(a)] from waiting lists by urgency category, states and territories, 2011–12



(a) Records with a reason for removal of Admitted as an elective patient for the awaited procedure by or on behalf of this hospital or state/territory or Admitted as an emergency for the awaited procedure by or on behalf of this hospital or state/territory.

Figure E.12: Total hip replacement admissions[(a)] from waiting lists by urgency category, peer group A hospitals, 2011–12

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List of tables

List of figures

In 2012, the Australian Institute of Health and Welfare and the Royal Australasian College of Surgeons worked together to develop national definitions for elective surgery urgency categories, at the request of the Standing Council on Health. The development of the national definitions resulted in a package of six integrated components proposed for adoption. This report presents the proposed definitions and components.