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| Planned surgery access policy |
| 2024 |
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| Planned surgery access policy  2024 |
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Acknowledgment of Aboriginal people living in Victoria

The Department of Health acknowledges the strength of Aboriginal people and their power and resilience as members of the world’s oldest living culture.

We acknowledge Aboriginal people as Australia’s First People and recognise the richness and diversity of all Traditional Owners across Victoria.

We recognise that Aboriginal people in Victoria practice their lore, customs and languages. They nurture Country through their deep spiritual and cultural connections and practices to land and water.

We are committed to a future based on equality, truth and justice. We acknowledge Aboriginal people experience entrenched systemic injustices. Victoria’s ongoing treaty and truth-telling processes are a chance to right these wrongs. The Victorian Government’s aim is for Aboriginal people to have the freedom and power to make decisions that affect their communities.

We pay our deepest respect and gratitude to ancestors, Elders and leaders – past and present. They have paved the way, with strength and fortitude, for our future generations.

1. Introduction

Planned surgery is central to Victoria's healthcare system. It provides essential care that improves the quality of life for tens of thousands of Victorians each year.

The Victorian Government wants to maintain and improve equitable access to high-quality planned surgery. We are undertaking local reforms and making broader investments in surgery. We will now focus on ensuring the planned surgery system can withstand ongoing pressures. We want to make sure we can deliver timely and high-quality care into the future.

In 2023, the Victorian Government released a plan for improving the planned surgery system. The [Planned surgery reform blueprint](https://www.health.vic.gov.au/planned-surgery-reform-blueprint)[[1]](#footnote-2) (the Blueprint) sets out a systematic approach to reforming the system. It uses the knowledge of those who have experience with the system to make changes that help everyone in Victoria. The Blueprint aims to make sure that patients receive safe, timely, and fair perioperative care, whether it is surgical or not.

The *Planned surgery access policy 2024* complements the Blueprint. It provides operational guidance to public health services on the delivery of planned surgery and procedures.

This will help create a strong, patient-centred and clear planned surgery system. The policy sets out the foundations we need to facilitate equitable and equal access to clinically appropriate surgical care. It will also support the active management of patients waiting for care.

The Department of Health and the broader system will work together to make these changes happen. Clear governance, communication and ownership among all key stakeholders will help us build a better planned surgery system. This will ensure everyone in Victoria can get the care they need.

# 2. About the policy

The [Planned surgery access policy 2024](https://www.health.vic.gov.au/patient-care/surgical-services-policies-and-guides)[[2]](#footnote-3) sets out the department’s expectations for access to planned surgery and procedures in Victorian public health services.

The policy applies to all planned surgery and procedures delivered by Victorian public health services as identified in the Elective Surgery Information System (ESIS).

This policy applies when a clinician with admitting rights (or a similar agreement with a health service) generates a request for a patient to go on a preparation list. It also applies to referrals from general practitioners through a direct access pathway.

The policy prioritises timely and equitable access to planned surgery and procedures for all Victorians regardless of where they live.

It requires all public health services, regardless of their ESIS reporting status, to:

* support a patient’s timely access to surgery or procedures in a transparent and accessible way
* ensure that surgical referrals are clinically appropriate and reflect the suitable treatment option for the patient
* improve the management of preparation lists to ensure a patient-centred approach
* adhere to policy directions, reporting requirements and mechanisms.

This revised version of the *Planned surgery access policy* builds on previous editions. It incorporates feedback from health services and key stakeholders.

The key changes are:

* the policy applies to all planned surgery and procedures identified in the ESIS manual (section 2.3)
* more advice on treating patients in turn, based on need, within each clinical urgency category (section 4.1)
* new communication timeframes and points of communication between health services and patients (section 5)
* health services must not accept surgical referrals that are incomplete or do not have the required information to assess the referral and take immediate action for category 1 requests (section 7.2.1)
* the head of unit (or their delegate) is responsible for maintaining a single preparation list and managing and overseeing this preparation list for their surgical speciality (section 7)
* health services are responsible for actively managing preparation lists for all surgery and must perform routine administrative and clinical audits (section 7)
* health services are encouraged to develop regionalised preparation lists for improved coordination (section 7.3).

## 2.1 Policy objectives

This policy authorises Victorian public health services to develop relevant local policies, protocols and procedures.

It has five objectives.

1. Promote timely, appropriate and equitable access to planned surgery and procedures so that patients are treated-in-turn, based on their clinical need and considering physical, psychosocial factors and structural disparities in access to care.
2. Promote active management, monitoring and review of planned surgery and procedures preparation lists and patient status.
3. Make sure there is good communication between patients, requesting clinicians and services.
4. Set out the roles and responsibilities of the department, health services, requesting clinicians and patients.
5. Support Victorian public health services to develop and implement local guidelines, protocols and procedures. This includes collaborative and shared service delivery models between health services and improved integration with primary care.

## 2.2 Scope

This policy applies to all Victorian public hospitals, public health services, multipurpose services and denominational hospitals regardless of their ESIS reporting status.

This policy applies to all planned surgery and procedures as identified in the *ESIS manual*.

It applies whether the patient elects to be treated as a public or private patient in a public health service.

## 2.3 Out of scope

The policy does not apply to:

* planned surgeries and procedures that are not ESIS reportable
* planned surgeries such as organ transplants, caesareans and medical inductions of labour where the waiting time cannot be controlled
* emergency surgeries where a patient needs surgical care due to trauma or acute illness after
  + presenting to an emergency department
  + direct emergency admission
  + readmission after leaving hospital
* planned surgery for private patients performed in private health services or facilities.

## 2.4 Policy context

The policy context for the *Planned surgery access policy* includes the key aims and pillars identified in the Blueprint. These support sustainable reform and system improvement to Victoria’s planned surgery system.

The policy also supports the recommendations of the [Review of access to planned surgery in public hospitals](https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/research-and-reports/e/executive-summary---review-of-access-to-elective-surgery-in-public-hospitals.pdf).[[3]](#footnote-4)

It aligns with the findings and recommendations of [Targeting zero: the review of hospital safety and quality assurance in Victoria](https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria).[[4]](#footnote-5) It progresses the Victorian Government’s commitment to zero avoidable harm as described in [Better, safer care: delivering a world-leading healthcare system.[[5]](#footnote-6)](https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria)

The policy reflects the key priority areas of the [Statewide design, service and infrastructure plan for Victoria’s health system 2017–2037](https://www.health.vic.gov.au/health-system-design-planning/statewide-design-service-and-infrastructure-plan).[[6]](#footnote-7) This plan aims to ensure all Victorians receive the best possible health care, no matter who they are, what their condition, or where they are treated.

The policy should be read in conjunction with:

* [Children, Youth and Families Act 2005](https://www.legislation.vic.gov.au/in-force/acts/children-youth-and-families-act-2005/121) [[7]](#footnote-8)
* [Elective Surgery Information System](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) [[8]](#footnote-9)
* [Family Violence Protection Act 2008](https://www.legislation.vic.gov.au/in-force/acts/family-violence-protection-act-2008/053) [[9]](#footnote-10)
* [Health Records Act 2001](https://www.legislation.vic.gov.au/in-force/acts/health-records-act-2001/047) [[10]](#footnote-11)
* [Managing private medical practice in public hospitals](https://www.audit.vic.gov.au/report/managing-private-medical-practice-public-hospitals?section=) [[11]](#footnote-12) (Victorian Auditor-General’s Office 2019)
* [Managing referrals to non-admitted specialist services in Victorian public health services policy](https://www.health.vic.gov.au/publications/managing-referrals-to-non-admitted-specialist-services-in-victorian-public-health) [[12]](#footnote-13)
* [MBS billing policy framework: Victorian public hospitals](https://www.health.vic.gov.au/funding-performance-accountability/mbs-billing-policy-framework-victorian-public-hospitals) [[13]](#footnote-14)
* [National Safety and Quality Health Service Standards: Communicating for Safety Standard](https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard#:~:text=The%20Communicating%20for%20Safety%20Standard,and%20safe%20care%20for%20patients) [[14]](#footnote-15)
* [Performance monitoring framework](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) [[15]](#footnote-16)
* Perioperative service capability framework [[16]](#footnote-17)
* [Policy and funding guidelines for health services](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) [[17]](#footnote-18)
* [Privacy and Data Protection Act 2014](https://www.legislation.vic.gov.au/in-force/acts/privacy-and-data-protection-act-2014/028) [[18]](#footnote-19)
* [Private patient: principles for public health services 2016](https://www.health.vic.gov.au/publications/private-patient-principles-for-public-health-services) [[19]](#footnote-20)
* [Strategic planning guidelines for Victorian health services](https://content.health.vic.gov.au/sites/default/files/migrated/files/collections/policies-and-guidelines/s/strategic-planning-guidelines-for-victorian-health-services.pdf) *[[20]](#footnote-21)*
* [Victorian Colonoscopy Categorisation Guidelines 2017](https://www.health.vic.gov.au/publications/colonoscopy-categorisation-guidelines%3e) [[21]](#footnote-22)
* [Victorian public hospital operating theatre efficiency audit](http://www.audit.vic.gov.au/report/victorian-public-hospital-operating-theatre-efficiency?section=) (Victorian Auditor-General’s Office 2017) [[22]](#footnote-23)
* [Victorian upper-gastrointestinal endoscopy categorisation guidelines for adults 2018](https://www.health.vic.gov.au/publications/upper-gastrointestinal-endoscopy-categorisation-guidelines-for-adults-2018) [[23]](#footnote-24)
* [Why treat in turn works](https://dhhsvicgovau.sharepoint.com/sites/HealthServicesImprovementGroup-GRP/Shared%20Documents/Policy/Access%20to%20surgery%20&%20procedures/Why%20treat%20in%20turn%20works) [[24]](#footnote-25)

# 3. Roles and responsibilities

## 3**.1 The department**

The department is the system steward for government policy directions and priorities for Victorian public health services. It supports links between public health services and community-based services and providers.

Timely, equitable access to planned surgery and procedures affects patient outcomes. This also influences demands on other parts of the health system.

In relation to planned surgery, as the system steward the department is responsible for the following:

* strategic and system stewardship to anticipate and manage
* demand for services
* the length of time that people wait for services
* gaps in service availability
* the approval of proposed new services and the discontinuation of services
* emerging and innovative treatments and technologies
* supporting the provision of planned surgery through investment in services, including allocation of growth funding and reallocating funds
* data collection, performance monitoring and oversight
* quality and safety, pricing and funding frameworks to achieve the policy objectives
* describing and implementing capability frameworks, performance monitoring frameworks, statewide workforce strategies and statewide surgical referral criteria
* describing the rights and responsibilities of health services, requesting clinicians and patients
* providing the authority for health services to develop local policies, protocols and procedures
* describing a statement of priorities for each public health service that is consistent with strategic plans for Victorian public health services and aligned with government policy directions and priorities.

## 3.2 Health services

Victorian public health services are responsible for the following.

### Improving patient-centred access and care

Public health services:

* ensure equitable access by treating each patient in turn, based on:
  + clinical need
  + related physical and psychosocial factors
  + any disparities in access to health care
* use shared decision making and patient-centred access to deliver planned surgery, procedures and other treatment options
* provide culturally safe and respectful services and support for Aboriginal patients, in line with the [Aboriginal and Torres Strait Islander cultural safety framework](https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1)[[25]](#footnote-26)
* provide family violence, linguistic and disability support to patients, families and unpaid carers. This includes liaison services for multicultural communities and people with disability
* offer virtual care options if appropriate and preferred by the patient. Telehealth should align with:
  + [Virtual care operational framework](https://www.health.vic.gov.au/virtual-care-operational-framework)[[26]](#footnote-27)
  + [Victoria’s digital health roadmap](https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap)*[[27]](#footnote-28)*
  + [Victoria’s virtual care strategy](https://dhhsvicgovau.sharepoint.com/sites/HealthServicesImprovementGroup-GRP/Shared%20Documents/Policy/Access%20to%20surgery%20&%20procedures/Approval%20and%20publication/Editor/Victoria’s%20virtual%20care%20strategy)[[28]](#footnote-29)
* identifying groups who encounter disparities in accessing health care in their local community and describing how the health service will address physical, psychological, social or structural barriers, particularly for intersectional groups and Aboriginal communities
* make sure communication with patients, families and unpaid carers is consistent, accessible and in line with people’s needs and preferences
* minimise the inconvenience and cost of attending appointments, including considering:
  + work-friendly appointment times
  + childcare
  + parking fees
  + travel times
  + transport
* provide a shared duty of care for each patient once a surgical referral is accepted. This includes:
* making reasonable efforts to provide services within the agreed timeframes
  + communicating with patients, requesting clinicians and nominated GPs
  + responding to changes in the patient’s condition.

### Managing surgeries and procedures

Public health services:

* manage preparation lists for all surgery and procedures
* maintain a list of clinicians with admitting rights or a similar agreement for surgery and procedures and the scope of surgeries and procedures practiced at the health service
* offering as many perioperative services as possible in:
* outreach locations
* the person’s home (where appropriate and agreed to by the patient)
* in culturally appropriate and safe spaces, including through partnerships with local Aboriginal community-controlled health organisations
* outside normal business hours
* multiple healthcare provider clinics

### Appointment and service optimisation

Public health services:

* manage planned staff absences and conflicting work schedules to minimise postponement and cancellation of surgery
* make sure restrictions unrelated to clinical need (for example, where the patient lives) do not affect access
* maintain the capability and capacity to deliver services. This includes providing suitably credentialled and privileged staff and outlining their scope of practice
* use collaborative and shared service delivery with other Victorian public health services, where appropriate
* improving integration with primary care.

### Governance and planning

Public health services:

* understand and plan to meet demand and minimise gaps in service availability
* have governance policies that guide the allocation of theatre resources between surgical specialities, surgeons and emergency and planned surgery and procedures
* perform routine administrative and clinical audits of all patients on the preparation list.

### Performance monitoring and compliance

Public health services:

* inform the department about significant or long-term reductions to capability or capacity. This must include a proposed management plan to ensure all patients waiting for a procedure receive the required service. It may require transfers to another health service through partnership or collaborative arrangements
* undertake performance monitoring and oversight, including complete and accurate surgical referral management
* comply with the department’s:
  + [Policy and funding guidelines for health services](https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services) [[29]](#footnote-30)
  + [Performance monitoring framework](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) [[30]](#footnote-31)
  + [funding, performance and accountability policies](https://www.health.vic.gov.au/hospitals-and-health-services/funding-performance-and-accountability%3e) [[31]](#footnote-32)
  + workforce strategies.

This includes:

* submitting accurate data and other information
* reporting emerging risks that may affect performance
* collaborating with other health services and health system partners to meet the health needs of communities.

## 3.3 Requesting clinicians

Requesting clinicians those who are both internal and external to the health service. They are responsible for the following.

### Clinical assessment

Requesting clinicians:

* undertake preoperative clinical assessment to ensure patients are fit to undergo surgery and are ready for their procedure. This must be done when patients are registered onto a preparation list
* document clinical categorisations for surgeries.

### Patient communication and decision-making

Requesting clinicians:

* ensure patients understand all their options, including evidence-based alternatives to surgery and optimisation pathways for surgery so that the patient can participate in decision making about their future care and treatments
* give patients the information they need to decide between being treated as a private or public patient, including advice on costs associated with treatment
* document informed consent for the procedure
* ensure patients complete a patient information collection statement before the surgical referral is completed
* give patients a copy of the surgical referral for planned surgery documentation
* identify any supports a patient may need, including factors relating to:
* their reliance on a carers, family members and supporters
* cultural safety
* language or disability support
* changes to clinical condition
* issues that may impact on the suitability of their home for the safe delivery of services
* their reliance on transport and accommodation
* continue to monitor patients’ condition.

### Referral and communication with the health service

Requesting clinicians:

* supply a surgical or procedural request that includes the required information within the appropriate request timeframes outlined in section 6.2
* ensure that referrals for planned surgery and procedures:
  + have the patient’s agreement
  + recognise the content of any advance care directive
  + acknowledge that the patient has agreed that their personal and health information can be shared with the health service
* communicate according to patients’ needs and preferences
* notify the health service of changes in the patient’s condition affecting urgency of treatment or care required.

## 3.4 Patients

Patients and their family and unpaid carers are responsible for:

* participating in shared decision-making processes as much as they can or want to
* consenting to their personal and health information being shared between the health service, requesting clinician, their nominated GP and other health service providers
* providing contact details and telling the health service how they want to receive communication
* responding to correspondence and requests from the health service in a timely manner.
* consenting to services being delivered via virtual care appointments or in their home, where possible
* actively preparing for appointments and/or planned surgery or procedure, for example accessing any required tests and investigations, and being available or attending at the arranged time.
* telling the health service about anything that may affect their care, such as no longer being able to attend for surgery.

# 4. Guiding principles

## 4.1 Treat in turn

Health services are required to meet the performance targets set out in the department’s *Performance monitoring framework*. This means ensuring patients receive their surgery or procedure within the clinically recommended time (section 4.2).

Health services must have the appropriate local policies and procedures in place to treat patients in turn. However, the department acknowledges this is not always clinically appropriate nor practical and may not deliver desired efficiency.[[32]](#footnote-33)

A patient’s personal circumstances should not unfairly disadvantage their position on the preparation list.

To ensure equitable access and outcomes health services should actively identify and offer additional assistance to groups more likely to experience barriers in accessing care. The principle of treat in turn applies to public and private patients. It also applies to patients transferring from one health service to another.

The following reasons **are not** valid rationales for not treating in turn:

* surgical referral by a specific clinician
* a request by a clinician to give precedence to a person for reasons other than clinical urgency
* a patient’s private health insurance status (for patients with private health insurance on public lists) or Medicare eligibility
* demand for the surgery or procedure.

The head of unit (or their delegate) responsible for the procedural or surgical preparation list must ensure each person is treated in turn for the service they oversee.

Individual clinicians are not responsible for managing the preparation list for specialities.

Health services should analyse treat in turn rates as part of normal case review and preparation-list management.

Over the next 12 months, the department will develop a standard methodology to calculate the current treat-in-turn ratio at each health service and share these findings. This will support ongoing service improvement.

## 4.2 Clinical urgency categorisation and registration

Consistent clinical categorisation aims to:

* identify patients suitable for non-surgical options and optimisation pathways
* minimise inappropriate categorisation of clinical urgency
* enable treat in turn
* support equitable access for patients
* facilitate service planning to meet demand.

The requesting clinician must assign a clinical urgency category before a patient is registered on a planned surgery preparation list. This must be documented and recorded.

The head of unit (or their delegate) can choose to review decisions about clinical urgency where there are discrepancies.

Health services should monitor clinical urgency categorisation practices. These practices should align with local policies and procedures, and the [National planned surgery urgency categorisation guidelines](https://www.health.vic.gov.au/publications/national-elective-surgery-urgency-categorisation-guideline-april-2015).[[33]](#footnote-34)

For endoscopy, the categorisation needs to be consistent with the Victorian colonoscopy and upper gastrointestinal endoscopy guidelines.

There are three clinical urgency categories:

* category 1 surgery and procedures are clinically indicated within 30 days
* category 2 surgery and procedures are clinically indicated within 90 days (within 60 days for endoscopy)
* category 3 surgery and procedures are clinically indicated within 365 days (within 180 days for endoscopy).

When a patient is registered on the preparation list, health services must inform the patient, the requesting clinician (and the GP, where appropriate) in writing that they have accepted the referral and registered the patient on the preparation list, and the clinical urgency.

The written notification must include information outlined in section 5.2.1.

Any change in a patient’s clinical urgency category on the preparation list must be authorised by the treating specialist medical practitioner, the head of unit (or their delegate). The health service must record this in the patient’s health record.

Health services must contact the patient and requesting clinician about any change within:

* 3 working days for category 1 patients
* 10 working days for category 2 and 3 patients.

## 4.3 Readiness for surgery status

Health services and requesting clinicians should actively manage and support patients on the preparation list.

This includes identifying patients who are suitable for non-surgical options and optimisation pathways.

Health services should record any change to the patient’s readiness for surgery status in both the preparation list and the patient’s health record.

To be registered on a category 1 preparation list, the patient must be ready for surgery.

There are 2 reasons a person may not be ready for surgery.

1. Something needs to happen so they can be ready for the procedure.
   * They may need further medical care or improvement before they are ready for the procedure. For example, their heart condition may need to improve before they can have surgery.
   * They may need another procedure or treatment first. For example, they may be ready for the first procedure, but they are not ready for a second procedure until the results of the first procedure are known.
2. The person asks to delay the procedure for personal reasons.
   * The person is unavailable on the date the procedure is scheduled for personal or work commitments.

To ensure fairness, there are limits to the total time a patient can be ‘not ready for surgery – deferred for personal reasons’.

Time limits for deferral due to personal reasons are:

* 30 days for category 1 patients
* 90 days category 2 patients
* 180 days for category 3 patients.

Health services must inform patients of these time limits. They must also attempt to contact the patient’s requesting clinician or GP before the deferral time limit passes.

Patients may only request a deferral for personal reasons twice. The maximum number of days set out above applies across the two deferrals.

Sometimes, health services offer to provide surgery at another location, for example through a regionalised preparation list program. If the patient declines this offer, it is not considered a deferral for personal reasons. Their categorisation should not change. They should remain on the preparation list.

Health services must support category 1 patients to resolve any issues preventing them from accessing their care in a timely manner.

A change in a patient’s ready-for-surgery status for any reason must be:

* authorised and documented by a clinician of the health service directly responsible for the patient’s care (for example, treating specialist medical practitioner, senior clinician or the head of unit)
* notified to the patient and the clinician that requested the patient be placed on the preparation list
* notified to the GP (unless the patient does not have a known treating GP).

# 5. Communication with patients

## 5.1 Principles for communication

Health services should record the patient’s preferred method of communication and use this at all times.

All communication with patients must:

* be timely
* use the patient’s (or family/unpaid carer’s) preferred method in their preferred language
* comply with privacy and health record legislation, regulations and standards
* align with *Victoria’s digital health roadmap*
* be documented in the patient’s health record.

## 5.2 Points of communication

Health services should send reminders to patients before procedures or surgeries. This will help to ensure people to attend, reschedule or cancel. It will also remind them to bring appropriate documents on the day.

The department has developed [planned surgery written communication templates](https://www.health.vic.gov.au/patient-care/planned-surgery-access-policy-communication-toolkit).[[34]](#footnote-35) The templates will help to ensure consistent, respectful and clear communication from health services.

Appendix 3 contains a communications checklist for health services. Following the checklist will help to ensure patients understand what they need to do.

Health services must offer verbal and written communication options, including:

* letter
* telephone or video call
* mobile text message
* email
* secure online portal
* fax.

Health services must protect confidential patient health information. This includes complying with data security requirements in accordance with health record legislation, regulations and standards.

Health services should consult with data security experts.

Health services must provide a point of contact and designated staff who can answer all enquiries about planned surgery and procedures, from patients, requesting clinicians and GPs.

Health services’ websites should provide accurate and up-to-date publicly available information about planned surgery and procedures. This includes information about how to access planned surgery.

All communication and engagement with Aboriginal patients must be culturally safe and respectful. This supports Aboriginal self-determination and cultural safety. Health services should train staff in cultural safety for Aboriginal patients.

When communicating with patients on the preparation list, health services must tell the patient:

* their clinical urgency category
* what to do if their condition deteriorates
* how to contact a doctor about health issues that might arise
* other supports available to them, including programs to assist with the costs of patient travel, interpreters, disability support and cultural safety support.

### 5.2.1 Outcome of surgical referral

When a health service accepts a surgical referral, the health service must provide information to the patient (and any authorised medical treatment decision maker or a child’s parent, guardian or another person with parental responsibility) via their preferred communication method.

This should include:

* an acknowledgement of the surgical referral, including:
  + the surgical or procedural unit or team who will be delivering the service requested
  + contact details for the surgical or procedural unit
* tests or investigations that must be completed before surgery
* how many clinic appointments will or could be scheduled, including expected waiting time
* instructions on how to indicate their preferred communication method from those available at the health service
* options for care (for example, outreach, virtual care, home-delivered services and services available outside of normal business hours)
* instructions on how to indicate their preferred method of receiving care
* available support services, such as
  + Aboriginal cultural safety and language supports
  + cultural and linguistic supports
  + disability support
  + transport and accommodation assistance (where eligible)
* patient responsibilities and rights, including
* a ‘collection statement’ about patient rights, including patient advocacy and the process for addressing complaints
  + agreement that their personal and health information will be shared between staff at the health service and with the requesting clinician, their nominated GP, or other health service providers
  + their responsibilities, including the need to notify the health service about changes to their clinical condition, contact details, nominated GP, or next of kin, if they are unable to attend a scheduled appointment, surgery or procedure if they are ‘not ready for care’ or if the appointment, surgery or procedure is no longer needed for any other reason
  + the implications of not responding to or declining communication from the health service, repeatedly rescheduling or not attending a scheduled appointment.

When a surgical referral is not accepted, the health service must

* inform the requesting clinician and the patient, providing the reason for the decision
* refer the patient back to the requesting clinician or the patient’s GP to arrange an alternative treatment plan.

### 5.2.2 Optimisation on the preparation list

Some patients may need education or interventions to optimise their physical and mental health before surgery.

Health services should identify patients on the preparation list who would benefit from optimisation of their condition prior to surgery. For example, this might include multidisciplinary care for patients with comorbidities.

Health services should regularly contact patients to assess their requirements and suitability for non-surgical alternatives and optimisation pathways.

Health services should also educate patients about preparing for surgery. This includes advice or additional interventions they may need while they prepare. This could include:

* tailored education on preparing for surgery
* education about ‘readiness for surgery’ and who to contact if their condition changes
* referral to other health professionals, such as allied health clinicians, nurses or specialist medical practitioners
* communication and collaboration with the patient’s GP while they prepare
* education about non-surgical pathways to optimise their condition before surgery (or as a reasonable alternative to surgery)
* tools or resources to support shared decision making for clinicians, patients, families and unpaid carers.

### 5.2.3 Ready for surgery

Patients must be informed of any change in their ready for surgery status. For example, if it changes from ready for surgery to not ready for surgery, and the reverse. This must occur within:

* 3 working days for category 1
* 10 working days for category 2 and 3.

Section 4.3provides more information.

### 5.2.4 Preadmission information and scheduling

Health services schedule the date of admission for surgery or a procedure. They ensure patients are treated in turn within the timeframe of their clinical urgency category.

When scheduling patients for planned surgery or procedure, health services must:

* confirm the scheduled date and time with the patient using their preferred method of communication
* document this notification in the patient's health record
* take patients’ needs into consideration and provide a choice of admission date
* give sufficient notice of the scheduled admission date, with a minimum of two weeks’ notice for category 2 and 3 patients and as soon as practicable for category 1 patients
* inform the patient of
* name and address of hospital
* information on the physical location of the surgery or procedure, including a map or written instructions
* instructions on what to bring and how to prepare for the surgery or procedure (for example, fasting requirements, Medicare card, medication instructions, list of medications, advance care directive, tests or investigations that must be completed before or on the day of surgery)
* the patient’s rights and responsibilities, including how to notify the health service about changes to their clinical condition, changes to their contact details, if they are ‘not ready for surgery’ or unable to attend a scheduled appointment for any other reason, or if the surgery or procedure is no longer needed
* the expected length of stay after surgery and if intensive care is anticipated
* a health service contact person
* plans for discharge and post-discharge care.

Except when a patient is uncontactable or deceased, health services must:

* notify patients if they are removed from the preparation list without having undertaken the planned surgery or procedure within 10 working days of their removal
* notify the patient by their preferred method of communication of the reason for their removal, date of their removal and details of who the patient should contact if they have any questions or concerns
* notify the patient’s GP within 10 working days.

Health services should exercise discretion when contacting terminally ill patients, their families and unpaid carers to minimise distress.

### 5.2.5 Patient not contactable

If a patient cannot be reached after 2 consecutive invitations sent via their preferred communication method, health services should attempt to acquire updated contact information from:

* the patient’s last known treating specialist medical practitioner:
* the patient’s requesting clinician or nominated GP
* the health service’s health records
* the patient’s listed next of kin.

Section 7.5 sets out guidance for patients no longer needing a procedure and removal from the preparation list.

# 6. Request for planned surgery or procedure

Referrals for planned surgery or procedure must be based on clinical appropriateness and suitability for the patient.

The requesting clinician must conduct a preoperative clinical assessment. This ensures the patient is fit to undergo surgery before they are added to the preparation list.

A referral requesting a patient’s planned surgery or procedure is in part a clinical handover. It involves transferring professional responsibility and accountability for the patient.

The transfer of patient information must comply with the privacy principles defined in the *Privacy and Data Protection Act 2014*,the *Health Records Act 2001* and any other applicable legislation.

## 6.1 Clinical assessment and categorisation

Only clinicians with admitting rights or a similar agreement with a health service can request that a patient be registered on a preparation list at that health service.

Surgical referrals for planned surgery or procedures must be clinically appropriate and suitable for the patient.

Patients, clinicians and health services must work together to discuss options, benefits and harms. This includes cosmetic or aesthetic procedures detailed in Appendix 2.

If there are alternative non-surgical management pathways available, health services should assist shared decision-making between requesting clinicians and patients.

### 6.1.1 Collection statement and information

Requesting clinicians must ensure the patient completes a patient information collection statement. This will ensure compliance with privacy principles for collecting, using and disclosing health information.

Where possible, the requesting clinician should obtain informed consent before referring them for surgery.

Patients, families and unpaid carers have the right to not share their information under the terms of the patient information collection statement.

Before surgical referral, the requesting clinician must inform the patient of:

* the nature of the proposed procedure
* the risks associated with the proposed procedure, including the patient’s age and pre-existing medical conditions
* the reason for surgical referral
* the preparation list process, including clinical urgency categories
* the patient’s clinical urgency category
* the need to obtain consent before referral to the preparation list
* the possibility that surgical care may be delivered at another location (for example, through a Rapid Access Hub (where available) or through a regionalised preparation list)
* the option of being treated as a public or a private patient
* the requirement for public health services to prioritise patients based on clinical need, and without regard to whether a patient elects to be treated as a public or private patient.

The requesting clinician must also:

* explain the health service’s personal information collection statement to the patient
* explain why it is important for their GP to be aware they are to be registered on the preparation list for the proposed procedure (except in the case of direct surgical referral)
* answer any questions the patient has about how the patient’s health information may be used or why it is disclosed
* provide the patient with an electronic copy of the surgical referral for planned surgery or procedure form. They must retain one copy for their records and provide the original to the health service.

### 6.1.2 Financial consent

The requesting clinician must provide the patient with sufficient information to enable them to choose whether to be treated as a private or public patient. This includes advice on the costs associated with treatment.

A patient's choice to be treated as a public or private patient should have no impact on the schedule of the procedure.

Health services must register a patient on the preparation list and schedule them according to the principle of treating patients in turn.

## 6.2 Surgical or procedural request

Health services are strongly recommended to support electronic communication within the health service, between health services and from and with external clinicians.

Requesting clinicians must request that a patient be registered within:

* 3 working days from recommending surgery for category 1
* 10 working days from recommending surgery for category 2 or 3.

The requesting clinician must supply the following information:

* provisional diagnosis or reason for the procedure
* the proposed procedure
* the clinical urgency category or scheduled time or date for the planned surgery
* whether patient is ready or not ready for surgery
* anticipated length of stay for the admission
* anticipated need for a stay in an intensive care or critical unit
* patient demographic information (full name, date of birth, address, contact information)
* whether a person identifies as being of Aboriginal or Torres Strait Islander origin
* language other than English (if applicable), reliance on a carer or family member, reliance on cultural, linguistic or disability support (for example, need for an interpreter)
* reliance on transport or accommodation support
* advance care directive (if any)
* the patient information collection statement
* whether there are barriers to surgical care being delivered at another location (for example, through a Rapid Access Hub or a regionalised preparation list)
* the patient’s intention to be treated as a public or private patient
* consent for the procedure, including patient’s signature
* Medicare number
* name and contact details for the patient’s GP and if the patient has given consent for the health service to communicate with that GP.

Patients must be treated in turn according to clinical need and considering physical, psychosocial factors and structural disparities in access to care.

Health services must schedule in line with transparent local policies and procedures as identified in section 7.

# 7. Preparation list management

Health services must maintain a single preparation list for each surgical or procedural specialty (such as endoscopies).

A single preparation list streamlines surgical care by centralising information, increasing transparency and improving resource management.

Section 4 sets out the principles that guide list management, including treat in turn, categorisation, registration and ready for care.

The head of unit (or their delegate) at the health service is responsible for managing and overseeing the preparation list for their surgical or procedural speciality.

Some health services use regionalised preparation lists. This is where a group of health services manage their preparation lists for the same surgical or procedural speciality collaboratively. Patients on these lists can receive their surgical care by any health service in the group (section 7.3.1).

## 7.1 Capability and capacity

Victorian public health services must only accept surgical referrals if they have the capability and capacity to provide timely, safe and appropriate perioperative care.

Before accepting a surgical referral for a specific surgery or procedure, health services must meet the capability requirements to manage clinical, patient and anaesthetic risks. These are set out in the [Perioperative service capability framework for Victoria](https://www.health.vic.gov.au/health-system-design-planning/perioperative-service-capability-framework-for-victoria).[[35]](#footnote-36)

If a health service has a shared partnership agreement, such as a Health Service Partnership, they can redirect the referral if another health service meets the capability requirements.

If the patient’s clinical condition is approaching a threshold for treatment, the health service should discuss options with the requesting clinician, GP and the patient. This may include managing the patient’s condition or referring them to a more suitable service.

If the request is for a procedure included in Appendix 2or the [Best care: guidance for non-urgent elective surgery](https://www.safercare.vic.gov.au/best-care-guidance-for-non-urgent-elective-surgery),[[36]](#footnote-37) the head of unit (or their delegate) must approve an exemption for the procedure to take place.

The surgical referral must include documentation of a joint discussion between clinician and patient considering:

* the clinical evidence for the procedure
* the individual risks and benefits of the procedure for that patient
* the health outcomes that matter to the patient
* available alternative care options.

Health services must:

* ensure they have the necessary workforce, clinical support services, equipment, infrastructure and clinical governance to deliver safe and appropriate care considering the complexity and care needs of individual patients
* advise the department of any changes to their capability and capacity, whether temporary or permanent, and provide the department with details of a proposed management plan to ensure patients waiting for surgical care are appropriately managed or referred to another provider.

Victorian public health services should have processes in place to manage temporary and long-term changes to the capability and capacity of the health service.

Sometimes, demand may consistently exceed capacity. If this occurs, health services must work with clinicians to manage current and future surgical referrals to better match capacity with demand. This may include increasing the levels of surgical activity, scheduling additional theatre lists or working collaboratively with other health services to manage preparation lists for the same surgical or procedural speciality.

## 7.2 Surgical referral response

The head of unit (or their delegate) is responsible for ensuring surgical referrals are accepted in line with policy requirements.

Health services must check referrals against the policy requirements. They should only accept the surgical referral when:

* the surgical referral is valid and complete
* the aligns with the scope of this *Planned surgery access policy*
* the intended procedure and proposed aftercare are within the capability of the health service at the time of surgical referral
* the surgical referral meets an identified clinical versus aesthetic need to improve the health of the patient
* the clinical threshold for the procedure has been met (if it is an aesthetic procedure).

The following **must not** be used as reasons for not accepting surgical referrals:

* where the patient lives
* to whom the surgical referral is addressed
* the length of the preparation list at the health service.

7.2.1 Incomplete surgical referrals

Health services **must not** accept surgical referrals that are incomplete or do not have the required information.

The health service must notify the requesting clinician in writing of this decision within

* 3 working days of receiving the request for category 1
* 10 working days of receiving the request for category 2 and 3.

If a surgical referral is incomplete but is categorised as category 1, immediately contact the requesting clinician to supply the missing information.

7.2.2 Complete surgical referrals

If the health service accepts the surgical referral, patients must be registered on the preparation list within:

* 3 working days for category 1
* 10 working days for category 2 and 3.

Surgical referrals from medical practitioners’ private rooms for category 2 and 3 patients should be acknowledged in writing within 10 working days.

If a referral cannot be accepted due to capability considerations, health services mustinform the requesting clinician in writing. Health services may refer them to another provider within the Health Service Partnership.

## 7.3 Scheduling management

### 7.3.1 Standby list

Standby lists help to make full use of available procedural sessions and theatre lists. Health services should identify patients who are willing to receive their surgery or procedure at short notice. These patients can be put on a standby list.

Health services must use treat-in-turn principles when offering standby options.

Health services should support all patients to access standby lists. Patients who need support for cultural safety, language or disability should not be excluded from accessing the standby list due to their circumstances.

Health services must confirm and document that the patient:

* agrees to be on a standby list
* agrees to the minimum notice they will be given and that they will attend the service in person or via virtual care options within the agreed level of notice
* can easily be contacted via their preferred method of communication.

It is not considered deferment if the patient declines to go on a standby list. This should not affect their categorisation. They should not be removed from the preparation list.

### 7.3.2 Regionalised preparation lists

Health services should identify patients who are willing to receive their surgery or procedure at another location within a regionalised preparation list.

Health services are encouraged to develop innovative and collaborative agreements to centralise and streamline list management across the Victorian public health system. Health services must use treat-in-turn principles when offering multiple locations.

Health services should support all patients to equitably access surgery or procedures in other locations. They should assist patients as much as possible to overcome barriers such as cultural safety, travel times and transport, missed work and childcare.

If a patient cannot attend another location where there is a regionalised preparation list, this is not a reason for not accepting the referral.

Health services must assign a head of unit (or their delegate) to manage and oversee a regionalised preparation list.

## 7.4 Hospital-initiated postponements

A hospital-initiated postponement is the postponement of a patient’s Scheduled Admission Date that has been initiated by the hospital.

Health services must inform the patient about the postponement as early as possible using the patient’s preferred method of communication. If the postponement occurs at short notice, health services must confirm the patient is notified. This must be documented in the patient’s health record.

Health services should acknowledge the inconvenience that can be caused by hospital-initiated postponements in their communication with patients. This includes the significant inconvenience if there have been multiple postponements. Health services should offer reasonable assistance to inconvenienced patients, families and unpaid carers when surgical care is postponed on the day of admission.

A hospital-initiated delay must not affect a patient’s time to treatment or change their ‘ready for surgery’ status.

Hospital-initiated postponements that occur within two weeks of a patient’s scheduled date of surgery must:

* be approved by the head of unit or relevant executive of the health service
* include the reason for the postponement and the process for rescheduling
* record the name of the clinician authorising the change of scheduled admission date
* include the rescheduled admission date (if known)
* include an offer of a new date for admission to the patient within:
  + 3 working days for category 1
  + 10 working days for category 2 and 3
* inform the requesting clinician, the patient and the patient’s nominated GP of the scheduled or rescheduled date of the procedure no later than:
  + 3 working days for category 1
  + 10 working days for category 2 and 3.

## 7.5 Patients no longer needing a procedure

Health services must perform regular validation of their preparation lists (section 7.6) to identify any patients who no longer need surgery or a procedure.

Health services must remove the request for the surgery or procedure where the patient has confirmed:

* they no longer need the procedure because they have, or plan to, receive the procedure elsewhere
* their presenting problem has resolved
* they no longer consent to treatment or no longer want to pursue treatment.

If the patient does not respond to invitations for appointment, surgery, or procedure or they have not completed required tests or investigations, health services should contact the requesting clinician or GP to find out whether there is another way to contact the patient.

Health services should remove the patient from the preparation list if the patient has:

* not responded to two separate invitations made using their preferred method of communication
* not accessed the tests or investigations that must be completed before the surgery, procedure or appointment, on two consecutive occasions.

Health services should exercise discretion to avoid disadvantaging patients who may be experiencing genuine hardship, misunderstandings or unavoidable circumstances.

Before removing a patient from the preparation list, a clinician of the health service who is directly involved in the patient’s care (for example, treating specialist medical practitioner, senior clinician) or the head of unit should confirm the circumstances. This applies except when:

* the removal is because the patient has had the surgery
* the health service has been advised the patient is deceased.

If a patient is removed from the preparation list, the health servicemust inform the requesting clinician, the patient and the patient’s nominated GP in writing using their preferred method of communication.

## 7.6 Validation of the preparation list

Validating the preparation list helps to detect clinical changes and actively manage patients prepare for surgery.

Health services must keep accurate records of the preparation list and perform regular administrative and clinical audits of all patients.

Health services must complete audits and submit data (including removals from the preparation list) within the reporting timeframes set out in the *Policy and funding guidelines*.

Administrative audits involve contacting patients to confirm:

* the surgery or procedure is still needed (for example, the patient has not already received the surgery or procedure elsewhere)
* the patient’s ability to attend when a time becomes available
* the patient’s current contact details and preferred method of communication.

Clinical audits involve a clinician contacting the patient, and the requesting clinician, to undertake a review of patients on the preparation list. This review is to determine whether:

* the service is still needed, and the patient intends to proceed to surgery
* there is any change in the patient’s clinical condition or clinical urgency
* there has been a change in the patient’s clinical condition, and they are now suitable for non-surgical options and optimisation pathways. If this is the case, complete the required referrals
* there is any reason the patient should be removed from preparation list.

Clinical audits can also identify patients who are able to accept an offer of surgical care delivered at another location (for example through a Rapid Access Hub or a regionalised preparation list).

As a minimum, the head of unit (or their delegate) at the health service must approve regular audits of patients in each clinical category on the preparation list.

* category 1 – there must be a monthly clinical audit for patients waiting more than 30 days without a scheduled admission date
* category 2 – there must be a 3-monthly administrative and clinical audit for patients waiting more than 90 days without a scheduled admission date
* category 3 – there must be an administrative and clinical audit for all patients every 6 months.

Health services must document this audit, including:

* patients contacted
* patients not contactable
* patients who have died, including the name of the person who notified the health service that the patient has died, the cause of death if known, and the date of notification
* follow-up actions (if any)
* names of staff conducting the validation processes.

If a patient is not ready for care for clinical reasons for extended periods of time, clinicians should consider whether it is appropriate for the patient to remain on the preparation list. Consult with treating specialist or GP to confirm the most appropriate treatment pathway.

### 7.6.1 Clinical review

Health services must develop documented operational processes outlining key steps and procedures for preparation list staff and managers.

Internal audits should be conducted annually to:

* assess compliance with department policies
* address local issues affecting service quality
* evaluate data practices
* review the adequacy of policies, procedures and training in alignment with this *Planned surgery access policy*.

Patients who exceed the nationally acceptable time for their clinical categorisation should be reviewed by the head of unit (or their delegate) to assess any clinical changes and potential category adjustments.

### 7.6.2 Patient deceased

Health services must ensure each head of unit (or their delegate) receives 6-monthly reports detailing all removals from the preparation list due to death.

Health services should monitor the type and number of deceased patients removed from the preparation list, including trends over time.

## 7.7 Transfers and contracted services

Health services may transfer the care of patients to another health service or contract another provider (including other public and private hospitals). This supports patients to access the most appropriate care within clinically recommended timeframes.

Health services must:

* ensure the best interests of the patient take precedence over any other interests
* obtain consent from the patient to transfer their care to another service provider.

Local surgical referral and transfer guidelines should set out these arrangements. They should comply with the *ESIS manual* and *Policy and funding guidelines*.

Transfers and contracting of services should capture the total patient waiting time for a procedure. This will help to ensure services occur within clinically recommended times.

## 7.8 Public and private patients

Local policies must not prevent patients from accessing free public hospital surgery or procedures.

The surgeries and procedures provided to private patients in a health service must also be available to public patients.

If a surgeon or procedural specialist is predominately employed to provide public services, a private practice agreement must be in place. This will allow their private patients to be registered on that public health service’s preparation list.

Individual clinicians must not decide or manage who is on the preparation list. The head of unit (or their delegate) manages and oversees the preparation list.

Health services must not direct patients, or their medical treatment decision maker, towards a choice about being treated as a public or private patient.

Patients and consumers may choose to become a public patient at any time. This change in patient status is effective from the date of the change onwards. It should not be retrospectively backdated.

Medicare-eligible patients may elect to be treated as a private patient. This is done using the patient information collection statement. It must be done before or at the time of the request to add them to the preparation list.

Health services must ensure eligible patients who elect to be treated as private patients have done so based on informed financial consent.

Surgeons or other procedural specialists can be granted rights to deliver admitted procedural services to exclusively treat their private patients in a public health service facility.

If the surgeon or procedural specialist is not predominately employed to provide public services, they must have a rental agreement in place. This agreement must include prices that achieve full-cost recovery. It should reflect the commercial value of the resources used. It should be reviewed at least every 3 years.

The principles outlined in *Private patient: principles for public health services*must apply to patients who use their private health insurance in public hospitals.

All arrangements must comply with Commonwealth and Victorian policies, legislation and agreements. This includes the *MBS billing policy framework: Victorian public hospitals*. Arrangements must be available for audit by the department.

The individual surgeon or procedural specialist must keep a list of waiting private patients. Private lists must be held separately from the list of patients on the public health service’s preparation list.

# Appendix 1: Glossary

## Auditing validation

Auditing improves patient care by ensuring that all health service processes and practices conform with policy and legislative requirements. Audits can improve the quality of the preparation list and data collected by health services. A key component of auditing involves regular validation of the number of patients on preparation lists. This validation ensures accuracy, accountability and transparency.

## Administrative audit

Administrative audit of a preparation list verifies non-clinical details (such as if the patient’s surgery or procedure is still needed and their current contact details). Administrative audits can be conducted by text message (SMS), phone call or letter.

## Admitting rights

A formal arrangement granting rights to a clinician to admit patients to a specific health service.

## Advance care directive

This is an instructional document that allows an adult to document their preferences for future medical treatment if they lose decision-making capacity. A person can record general statements about their values and preferences to guide future medical treatment decisions. They can also record instructions consenting to or refusing specific types of treatment.

## Unpaid carer

A carer is someone who provides unpaid care and support to family members and/or friends with a disability, mental illness, chronic health issue or an older person with care needs.

## Clinical audit

Clinical audits of preparation lists are performed by clinical staff. They focus on things such as whether the patient’s categorisation is correct and if their clinical condition has changed. Clinical audits are either direct (by contacting the patient or referrer) or indirect (review of clinical records).

## Clinical prioritisation

The process of assigning a clinical category to a surgical referral based on the timeframe in which a patient needs planned surgery or procedure.

The category is assigned after the requesting clinician makes a clinical assessment.

There are three clinical urgency categories:

* category 1 surgery and procedures are clinically indicated within 30 days
* category 2 surgery and procedures are clinically indicated within 90 days (within 60 days for endoscopy)
* category 3 surgery and procedures are clinically indicated within 365 days (within 180 days for endoscopy).

## Emergency surgery

Emergency surgery is surgery to treat trauma or acute illness following a presentation to an emergency department, or an emergency admission directly to a ward in the hospital.

## Equal access

Equal access assumes all people start from the same point and have the same opportunities to access to services, or they are given equal treatment.

## Equitable access

Equitable access is when all people get fair and reasonable access to the same, or equal, treatment. This requires that barriers to fair and reasonable access are reduced or removed.

## General practitioner

A medical practitioner who holds specialist registration with the Medical Board of Australia and is eligible for fellowship with either the Royal Australian College of General Practitioners or the Australian College of Rural and Remote Medicine.

## Head of unit

The specialist medical practitioner responsible for the surgical or procedural unit at the health service.

## Health service

All Victorian public hospitals and denominational hospitals, public health services and multipurpose services established under the *Health Services Act 1988*. This includes cases where collaborative and shared service delivery models exist between health services, for example Health Service Partnerships.

## Health Service Partnerships

The Health Service Partnership model aims to shift the Victorian health system from competition to collaboration. It mandates health services to collectively address a few strategic system priorities by working together. [The Health Service Partnership policy and guidelines](https://www.health.vic.gov.au/hospitals-and-health-services/health-service-partnerships)[[37]](#footnote-38) outline the framework and expectations for the operation of Health Service Partnerships.

## Health record

A formal record of the patient’s treatment notes and copies of any written and verbal notifications. This record may be kept either electronically or in hard copy and may be a combination of the patient’s medical record and information and management data from the patient administration system.

## Inequities in access to care

Persons in groups that often meet physical, psychosocial and structural inequities to accessing services may include

* Aboriginal communities
* children or young people in residential care
* LGBTIQA+ people
* multicultural communities
* older people
* people experiencing or at risk of homelessness
* people experiencing socioeconomic disadvantage
* people in out-of-home care, foster care or state care
* people living in remote, rural and regional locations
* people living with a life-limiting or terminal illness
* people who are, or have been, incarcerated, including youth justice clients in custodial care
* people with disability
* people with experiences of family violence
* people with mental illness
* refugees and people seeking asylum
* unpaid carers of people with chronic conditions.

## Medical practitioner

A health practitioner who has successfully completed a Bachelor of Medicine, Bachelor of Surgery (MBBS) or equivalent as accredited by the Australian Medical Council and holds registration with the Medical Board of Australia as a medical practitioner.

## Medical specialist

A medical practitioner who holds specialist registration with the Medical Board of Australia.

Specialist registration is available to medical practitioners who have been assessed by an Australian Medical Council–accredited medical specialist college as being eligible for fellowship. Fellowship is not a prerequisite for specialist registration.

## Patient information collection statement

A statement that explains to the patient:

* the reasons why their health information and general practitioner’s contact details are being collected
* that this information will be disclosed to the health service
* that the health service will notify the general practitioner about the proposed procedure.

## Planned surgery

Planned surgery (also known as elective surgery) or procedure that, in the opinion of the treating clinician, is necessary but for which admission can be delayed for at least 24 hours and can be planned in advance.

## Perioperative care

Perioperative care refers to the continuum of multidisciplinary and patient-centred care that is provided before, during and after surgery. Perioperative care begins when surgery is first contemplated and continues through to when an optimal care outcome is achieved.

## Preparation list

The term ‘preparation list’ (also known as a waiting list) acknowledges the importance of engaging patients in active management and education before their surgery. This approach avoids passive waiting. Instead, patients receive support and optimisation before their surgery, improving their experience and outcomes.

## Private lists

Where a surgeon or procedural specialist enacts their right to private practice and has designated operating-theatre time to operate exclusively on private patients within a public health service. A list of waiting private patients must be kept by the individual clinician and must be separate to the health service’s surgical and procedural preparation lists.

## Private patient

Patients who elect to be treated as a private patient in a public health service. Private patients are treated by the specialist medical practitioner of their choice. They may be responsible for hospital accommodation fees, medical and diagnostic services, prosthesis, dental fees and the costs of other related services.

## Public patient

Patients who are eligible for Medicare and who are admitted to a public health service for treatment free of charge. Public patients have their treatment provided by a specialist medical practitioner nominated by the health service, not a specialist medical practitioner of their choice.

Medicare-ineligible asylum seekers are to be provided with health services in public health services in accordance with their clinical urgency. More information about refugee and asylum seeker health, and appropriate billing, is available from the department’s [Refugee Health Program](https://www.health.vic.gov.au/community-health/refugee-health-program).[[38]](#footnote-39)

## Regionalised list

A regionalised preparation list is where two or more health services manage their preparation lists for the same surgical or procedural speciality collaboratively. Patients on these lists can receive their surgical care by any health service in the group.

## Requesting clinician

A clinician who requests a patient to be added to the preparation list for a specific planned surgery or procedure at a health service. Only clinicians with admitting rights or a similar agreement with a health service can request that a patient is registered on that health service’s preparation list.

## Surgical referral

Documented requests (usually in writing) from a requesting clinician to a health service to provide a specific surgery or procedure. Only clinicians with admitting rights or a similar agreement with a health service can request that a patient is registered on that health service’s preparation list.

## Transfer of care

Transfer of care is a part of the discharge process. It occurs when a patient is discharged home following their surgery. Their care may be transferred to their GP, carer, family, community service or care facility.

## Treat in turn

Treat in turn is a key principle of managing patients on each preparation list. It ensures all patients have the shortest waiting time, provides greater certainty to patients and reduces the inappropriate use of more high-priority categories.

## Unplanned surgery

Unscheduled or unexpected surgical procedures, such as emergency surgeries, or surgeries where the time cannot be controlled.

## Verbal communication

Verbal communication involves any type of message that makes use of the spoken communication in English, or any other language preferred by the listener. It includes virtual, telephone and face-to-face conversations.

## Virtual care

Virtual care, or telehealth, involves delivering health services remotely through information and communications technologies (ICT). It uses ICT to connect consumers with clinicians or link clinicians separated by distance. Virtual care is the use of ICT for remote healthcare, not a specific clinical service.

## Written communication

Written communication involves any type of message that makes use of the written word in English, or any other language preferred by the reader. For example, text messages (SMS), phone call, letter, spoken messaging, faxes, websites, patient handouts and brochures.

# Appendix 2: Aesthetic, cosmetic and other procedures that require identified medical indications

Aesthetic or cosmetic procedures are operations, procedures and treatments that revise or change the appearance, colour, texture, structure or position of bodily features. They aim to improve the patient’s appearance or self-esteem.

Aesthetic procedures differ from reconstructive surgery, which is surgery performed on structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumours or disease.

Reconstructive surgery is performed to body parts that are affected aesthetically or functionally.[[39]](#footnote-40)

Cosmetic surgery without medical indications is currently restricted and cannot be performed unless specific medical indications exist. Below are the clinical thresholds that determine whether surgery is necessary for the listed procedures:

## Face/head procedures

### Meloplasty/facelift

Significant deformity and surgery indicated due to disease, trauma or congenital conditions.

Significant deformity following surgery where the initial procedure was not a cosmetic procedure.

### Reduction of upper or lower eyelid (blepharoplasty)

Visual obstruction.

### Rhinoplasty/rhinoseptoplasty

Significant deformity and surgery is indicated due to disease, trauma or congenital conditions.

### Repair of external ear lobes

Significant deformity and surgery is indicated due to disease, trauma or congenital conditions but not as the result of use of a decorative expander or similar device.

### Correction of bat ear(s)

Patient is less than 19 years old.

### Hair transplant

Disfiguring hair loss and surgery is indicated due to disease, trauma or congenital conditions.

## Breast procedures

### Breast reduction (bilateral/unilateral)

Significant clinical symptoms are present (for example, intractable intertrigo and severe gynaecomastia) and body mass index is less than 30.

### Breast augmentation (bilateral/unilateral)

Post-mastectomy reconstruction.

Positive or negative augmentation for contralateral breast Poland syndrome.

Significant deformity, with surgery indicated due to disease, trauma or congenital conditions.

### Mastopexy (breast lift)

Postmorbid obesity treatment where significant clinical symptoms are present, and BMI is less than 30.

Correction of significant breast asymmetry following breast reconstruction.

Correction of asymmetry due to congenital or developmental condition.

### Revision of breast augmentation

As part of treatment for breast cancer and reconstruction following trauma, disease, congenital conditions or infection, not because of previous cosmetic surgery.

### Removal of breast prosthesis

Following rupture, erosion or infection of breast prosthesis.

### Nipple and/or areola reconstruction

When performed as part of a breast reconstruction due to disease or trauma but not as the result of previous cosmetic surgery.

### Nipple eversion (for nipple inversion)

Recurrent infection or ulcerative complications.

## Trunk/limb procedures

### Abdominoplasty, apronectomy, abdominal lipectomy

Postmorbid obesity treatment where significant clinical symptoms are present (for example, intractable intertrigo) and body mass index is less than 30.

### Varicose vein procedures

Venous conditions with the following symptoms:

* chronic leg swelling/oedema
* chronic dermatitis/eczema
* bleeding
* leg ulcers or infections
* superficial thrombophlebitis
* venous disorders in patients less than 16 years old.

Excluded as indications for surgery:

* venous conditions that are likely to lead to the conditions listed above
* cosmetic veins in patients older than 16 years old
* spider veins in patients older than 16 years old.

### Other skin excisions for body contour (for example, buttock, thigh or arm lift)

Postmorbid obesity treatment where significant symptoms are present (for example, intractable intertrigo) and body mass index is less than 30.

### Liposuction

Post-traumatic pseudolipoma.

Lipodystophy.

Gynaecomastia.

Flap reduction.

## Genitourinary procedures

### Genital surgery aimed at improving appearance

Patients requiring surgery for congenital abnormalities.

### Insertion of artificial erection devices

Spinal patients with neurological erectile dysfunction.

Surgery for trauma, disease or infection or as part of a penile reconstructions for congenital abnormalities.

### Testicular prosthesis

Disease, trauma or congenital conditions (for example, following orchidectomy for malignant disease or torsion testes).

### Lengthening of penis

Congenital abnormalities in patients less than 16 years old (for example, severe chordee).

### Reversal of sterilisation

No medical indications.

### Circumcision

For medical indications only – for example, phimosis, recurrent balanoposthitis or paraphimosis. Further information: [Guidelines for male circumcision in the Victorian public health system – information for health professionals](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Guidelines-for-male-circumcision-in-the-Victorian-public-hospital-system---information-for-health-professionals) [[40]](#footnote-41)

## Other aesthetic procedures

### Revision of scar

Scar is disfiguring and extensive and is the result of surgery, disease or trauma but not the result for previous cosmetic surgery.

### Tattoo removal procedures

Patient is less than 16 years old.

# Appendix 3: More effective communications checklist

This checklist outlines tips for health services to make it easier for patients to understand and action reminders.

To support effective communication, health services are strongly recommended to use the [planned surgery written communication templates](https://www.health.vic.gov.au/patient-care/planned-surgery-access-policy-communication-toolkit).[[41]](#footnote-42)

Further information on patient resources can be found on the [Better Health Channel](https://www.betterhealth.vic.gov.au/planned-surgery-elective-surgery).[[42]](#footnote-43)

## Use plain English

This makes it easier for patients to understand the information you are providing and what you want them to do. Explain any medical terms and avoid using jargon and abbreviations.

All communication letter templates provided have a reading level of less than Grade 5 to 6, which is what you should be aiming for.

## Keep it simple

This makes it easier for patients to action your reminder without feeling overwhelmed. Keep the information in your communication (for example SMS or letter) to the essential information about the appointment or procedure.

Generally, communications should:

* be less than one page
* use a plain font (for example, Arial or Calibri) in a font size of at least eleven
* use **bold** words for emphasis but **avoid** using *italics* or underlining or UPPER CASE.
* the key details of the appointment or procedure – where and when – should be clear to the patient immediately. You can do this by creating plenty of white space and drawing attention using
* a table to capture appointment information
* lists (dot points) to break down complex information
* logos and infographics to support text.

Any additional information can be provided in a separate factsheet.

## Use the person’s name

This attracts the attention of the reader and makes it more likely that they will take notice of the reminder.

You should use the patient’s first name at the beginning of the letter or SMS reminder. You should also sign off with the first name of the staff member sending the reminder.

## Make it easy for people to find their way

Hospitals can be confusing places to navigate if you do not know your way around. By providing an easy-to-follow map on the back of any letter reminders, you can help to reduce patients’ potential concerns about finding their way and help them to arrive on time.

## Make it easy for people to confirm, change or cancel their appointment

This makes it most likely that patients will follow through if they need to change or cancel their appointment. Even small hassle factors can have a significant impact on the chances that someone will take an action.

On letter reminders, provide a phone number and office hours.

On SMS reminders, either provide a phone number or the option to reply to cancel or reschedule via return SMS.

## Make it timely

This makes it more likely the patient will receive the reminder when they are most likely to be receptive.

If sending reminders by letter, then you need to factor in enough time for posting. If sending reminders by SMS, then you need to give enough notice for patients to plan to attend or reschedule.

## Consider sending SMS instead of letters

SMS reminders are cheaper and easier to send. You can also offer appointments via SMS rather than letter.

## Make it respectful

This helps to build a positive relationship with the patient. Respectful language presents information positively, checks the wording with patients to make sure it is clear, and translates messages for non-English-speaking patients.

## Make it culturally safe

This increases the likelihood that Aboriginal patients will feel comfortable and receive healthcare free from discrimination and systemic racism.

## Consider options that meet individual preferences

Communicating with patients about how they want to be contacted is essential to patient-centred care. Some patients prefer electronic information like SMS, while others prefer paper-based information.

Sending an initial SMS and following up by letter if there is no response is an effective way to meet the needs of both groups.

1. <https://www.health.vic.gov.au/planned-surgery-reform-blueprint> [↑](#footnote-ref-2)
2. <https://www.health.vic.gov.au/patient-care/surgical-services-policies-and-guides> [↑](#footnote-ref-3)
3. <https://www.health.vic.gov.au/sites/default/files/migrated/files/collections/research-and-reports/e/executive-summary---review-of-access-to-elective-surgery-in-public-hospitals.pdf> [↑](#footnote-ref-4)
4. <https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria> [↑](#footnote-ref-5)
5. <https://www.health.vic.gov.au/publications/targeting-zero-the-review-of-hospital-safety-and-quality-assurance-in-victoria> [↑](#footnote-ref-6)
6. <https://www.health.vic.gov.au/health-system-design-planning/statewide-design-service-and-infrastructure-plan> [↑](#footnote-ref-7)
7. <https://www.legislation.vic.gov.au/in-force/acts/children-youth-and-families-act-2005/121> [↑](#footnote-ref-8)
8. <https://www2.health.vic.gov.au/hospitals-and-health-services/data-reporting/health-data-standards-systems/data-collections/esis> [↑](#footnote-ref-9)
9. <<https://www.legislation.vic.gov.au/in-force/acts/family-violence-protection-act-2008/053>> [↑](#footnote-ref-10)
10. <https://www.legislation.vic.gov.au/in-force/acts/health-records-act-2001/047> [↑](#footnote-ref-11)
11. <https://www.audit.vic.gov.au/report/managing-private-medical-practice-public-hospitals?section=> [↑](#footnote-ref-12)
12. <https://www.health.vic.gov.au/publications/managing referrals-to-non-admitted-specialist-services-in-victorian-public-health> [↑](#footnote-ref-13)
13. <https://www.health.vic.gov.au/funding-performance-accountability/mbs-billing-policy-framework-victorian-public-hospitals> [↑](#footnote-ref-14)
14. <https://www.safetyandquality.gov.au/standards/nsqhs-standards/communicating-safety-standard#:~:text=The%20Communicating%20for%20Safety%20Standard,and%20safe%20care%20for%20patients> [↑](#footnote-ref-15)
15. <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework> [↑](#footnote-ref-16)
16. <https://www.health.vic.gov.au/health-system-design-planning/perioperative-service-capability-framework-for-victoria> [↑](#footnote-ref-17)
17. <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services> [↑](#footnote-ref-18)
18. <https://www.legislation.vic.gov.au/in-force/acts/privacy-and-data-protection-act-2014/028> [↑](#footnote-ref-19)
19. <[www2.health.vic.gov.au/about/publications/policiesandguidelines/private-patient-principles-for-public-health-services](https://www2.health.vic.gov.au/about/publications/policiesandguidelines/private-patient-principles-for-public-health-services)> [↑](#footnote-ref-20)
20. <https://www.health.vic.gov.au/publications/strategic-planning-guidelines-for-victorian-health-services> [↑](#footnote-ref-21)
21. <https://www.health.vic.gov.au/publications/colonoscopy-categorisation-guidelines> [↑](#footnote-ref-22)
22. <https://www.audit.vic.gov.au/report/victorian-public-hospital-operating-theatre-efficiency?section=> [↑](#footnote-ref-23)
23. <https://www.health.vic.gov.au/publications/upper-gastrointestinal-endoscopy-categorisation-guidelines-for-adults-2018> [↑](#footnote-ref-24)
24. <https://www.health.vic.gov.au/publications/why-treat-in-turn-works> [↑](#footnote-ref-25)
25. <https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1> [↑](#footnote-ref-26)
26. <https://www.health.vic.gov.au/virtual-care-operational-framework> [↑](#footnote-ref-27)
27. <https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap> [↑](#footnote-ref-28)
28. <https://www.health.vic.gov.au/victorian-virtual-care-strategy> [↑](#footnote-ref-29)
29. <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services> [↑](#footnote-ref-30)
30. <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework> [↑](#footnote-ref-31)
31. <https://www.health.vic.gov.au/hospitals-and-health-services/funding-performance-and-accountability> [↑](#footnote-ref-32)
32. Refer to [Why treat in turn works](https://www.health.vic.gov.au/publications/why-treat-in-turn-works) <https://www.health.vic.gov.au/publications/why-treat-in-turn-works>. [↑](#footnote-ref-33)
33. <https://www.health.vic.gov.au/publications/national-elective-surgery-urgency-categorisation-guideline-april-2015> [↑](#footnote-ref-34)
34. <https://www.health.vic.gov.au/patient-care/planned-surgery-access-policy-communication-toolkit> [↑](#footnote-ref-35)
35. <https://www.health.vic.gov.au/health-system-design-planning/perioperative-service-capability-framework-for-victoria> [↑](#footnote-ref-36)
36. <https://www.safercare.vic.gov.au/best-care-guidance-for-non-urgent-elective-surgery> [↑](#footnote-ref-37)
37. <https://www.health.vic.gov.au/hospitals-and-health-services/health-service-partnerships> [↑](#footnote-ref-38)
38. <https://www2.health.vic.gov.au/primary-and-community-health/community-health/population-groups/refugee-health-program>. [↑](#footnote-ref-39)
39. <http://www.plasticsurgery.org/> [↑](#footnote-ref-40)
40. <https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Guidelines-for-male-circumcision-in-the-Victorian-public-hospital-system---information-for-health-professionals>. [↑](#footnote-ref-41)
41. <https://www.health.vic.gov.au/patient-care/planned-surgery-access-policy-communication-toolkit> [↑](#footnote-ref-42)
42. <https://www.betterhealth.vic.gov.au/planned-surgery-elective-surgery> [↑](#footnote-ref-43)