

|  |
| --- |
| Implementation tracker |
| Planned Surgery Access Policy |
|  |

Contents

[About this implementation tracker 1](#_Toc169700431)

[Policy requirements that should already be in place or implemented 3](#_Toc169700432)

[Policy requirements that should be implemented by June 2025 24](#_Toc169700433)

[Policy requirements that should be implemented by June 2026 27](#_Toc169700434)

The Department of Health (the department) has developed a readiness assessment tool and this implementation tracker to support health services with implementation in order to meet all the requirements of the policy by June 2026. These tools aim to support the identification of good practice in action, areas needing improvement and actions that will be undertaken to meet expectations of the policy. If you have any questions about these tools please contact [healthservicesimprovement@health.vic.gov.au](mailto:healthservicesimprovement@health.vic.gov.au).

# About this implementation tracker

The [Planned surgery access policy 2024](https://www.health.vic.gov.au/patient-care/surgical-services-policies-and-guides) <<https://www.health.vic.gov.au/patient-care/surgical-services-policies-and-guides>> outlines the department’s expectations regarding access to planned surgery and procedures. To implement the policy health services should:

* develop local policies, protocols and procedures that align with the requirements of this policy
* identify the health service staff responsible for performing the tasks required by the policy
* provide training and education programs for staff who manage the access to planned surgery
* monitor the health service’s performance against the policy, particularly new policy requirements.

This implementation tracker tool has been developed to support health services to track a health service’s performance against the policy and planning how to achieve the **full implementation of the policy by June 2026**.

It is envisaged that each health service will nominate a lead group or committee to identify the health service’s performance against the policy and identify gaps in implementation. There are three tables listing:

* the key requirements that health services should already be meeting
* requirements health services must meet by June 2025
* requirements health services must meet by June 2026.

Health services may have explored or implemented business intelligence applications to automate preparation list management and validation and communication processes. The development or use of such tools should be included in this appraisal.

Note: in the policy the use of the term ‘must’ denote actions that are obligations to be met by the health service within a specified timeframe. The use of the term ‘should’ refer to a practices that a health service should be aiming to do with increasing frequency.

### Proposed rating scale

|  |  |
| --- | --- |
| **The following rating scale can be used to rate how the organisation is performing against each statement or requirement:**   1. **just beginning, self-assessment and planning** 2. **some progress, implementation of some aspects evident** 3. **most but not all aspects implemented** 4. **all aspects implemented** 5. **all aspects implemented, and regularly reviewed** | The following questions can be asked to inform the rating:   * To what extent is the requirement implemented? * Do all surgical specialities or services meet requirements to the same extent? * What information is available to the public/patient? * If asked, what would people say about how the service meets each requirement or the policy as a whole? |

# Policy requirements that should already be in place or implemented

### Headline updated requirements

**The policy requirements** **in both** the Elective surgery access policy 2015 and Planned surgery access policy 2024

**Treat in turn**.

* The policy requires a treat-in turn approach to each surgical or procedural specialty to ensure each patient on a preparation list is treated based on their clinical need.
* 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. The analysis will be used to support ongoing service improvement.

**Requests for planned 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. The requesting clinician must provide essential information such as proposed clinical categorisation, if the patient is ready for surgery, anticipated length of stay in hospital etc.
* Health services must not accept surgical referrals from requesting clinicians that are incomplete or do not have the required information to assess the surgical referral and take immediate action for category 1 requests.

**Regionalised preparation lists**

* The Elective surgery access policy 2015 included the concept of pooled waiting lists. Health services are encouraged to build on this concept to develop innovative and collaborative agreements, including regionalised or Health Service Partnership-wide preparation lists as outlined in the Planned Surgery Reform Blueprint 2023 through using regionalised preparation lists where applicable, or as required.
* If regionalised preparation lists are used for a surgical or procedural speciality, health services must assign a head of unit responsible for managing and overseeing these pooled preparation lists.

**Responsibilities of the head of unit**

* The head of unit is responsible for managing and overseeing preparation list for their surgical or procedural specialty.
* This includes ensuring surgical referrals are accepted in line with policy requirements, ensuring that each person is treated in turn and changes to the categorisation of patients on preparation lists etc.

Table 1 Policy requirements from previous and current policy that should already have been implemented

| Obligations / requirements to be met: | Rating (1-5) | Gaps still to be addressed | Comments / issues |
| --- | --- | --- | --- |
| **Section 3 Roles and responsibilities** | | | |
| Delivery of care is informed by shared-decision making and patient-centred access to high-quality 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)[[1]](#footnote-2) |  |  |  |
| Providing family violence, linguistic or disability support to patients, family and unpaid carer(s), including liaison services to support multicultural communities and people with a disability. |  |  |  |
| Offer virtual care options if appropriate and preferred by the patient. Virtual care should align with:   * + [Virtual care operational framework](https://www.health.vic.gov.au/virtual-care-operational-framework)[[2]](#footnote-3)   + [Victoria’s digital health roadmap](https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap)[[3]](#footnote-4)   + [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)[[4]](#footnote-5) |  |  |  |
| 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. |  |  |  |
| Recognising and, where possible, minimising the inconvenience and cost of attending appointments, including considering:   * work-friendly appointment times * childcare * parking fees * travel times * transport |  |  |  |
| Maintaining 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 of normal business hours * multiple healthcare provider clinics. |  |  |  |
| Appointment and service optimisation   * 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. |  |  |  |
| Understand and plan to meet demand and minimise gaps in service availability. |  |  |  |
| Having governance policies that guide the allocation of theatre resources between surgical specialities, surgeons and emergency and planned surgery and procedures. |  |  |  |
| Performance monitoring and compliance   * informing 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 * undertaking 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) [[5]](#footnote-6)   + [Performance monitoring framework](https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework) [[6]](#footnote-7)   + [funding, performance and accountability policies](https://www.health.vic.gov.au/hospitals-and-health-services/funding-performance-and-accountability%3e) [[7]](#footnote-8)   + 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. |  |  |  |
| **Section 4 Guiding principles** | | | |
| Health services must have the appropriate local policies and procedures in place to treat patients in turn.  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 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. |  |  |  |
| 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 record any change to the patient’s readiness for surgery status in both the preparation list and the patient’s health record. |  |  |  |
| 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).[[8]](#footnote-9). |  |  |  |
| To be registered on a category 1 preparation list, the patient must be ready for surgery |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |
| When any approval for a change in categorisation is accepted, the 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. |  |  |  |
| 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. |  |  |  |
| If a health service offers to provide surgery at another location, for example through a regionalised preparation list program and 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. |  |  |  |
| 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). |  |  |  |
| **Section 5 Communication with patients** | | | |
| 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. |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |
| 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 6 Request for planned surgery or procedure** | | | |
| 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. |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |
| Before surgical referral, 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. |  |  |  |
| 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. |  |  |  |
| 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.   They must also supply the information listed in Section 6.2 of the policy and document the joint discussion between clinician and patient. |  |  |  |
| 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. |  |  |  |
| Patients must be treated in turn according to clinical need and considering physical, psychosocial factors and structural disparities in access to care. |  |  |  |
| **Section 7 Preparation list management** | | | |
| 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).[[9]](#footnote-10) |  |  |  |
| 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),[[10]](#footnote-11) the head of unit (or their delegate) must approve an exemption for the procedure to take place. |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |
| Health services **must not** accept surgical referrals that are incomplete or do not have the required information.  If a surgical referral is incomplete but is categorised as category 1, immediately contact the requesting clinician to supply the missing information. |  |  |  |
| The health service must notify the requesting clinician in writing that the referral is incomplete and cannot be accepted within:   * three working days of receiving the request for Category 1 * ten working days of receiving the request for Category 2 and 3. |  |  |  |
| If the health service accepts the surgical referral, patients must be registered on the preparation list 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 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. |  |  |  |
| Surgical referrals from medical practitioners’ private rooms for category 2 and 3 patients should be acknowledged in writing within 10 working days. |  |  |  |
| 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. |  |  |  |
| Requirements in Section 7.3.2 apply if regionalised preparation lists are used for a surgical or procedural speciality. |  |  |  |
| Health services must inform the patient about any 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. |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |
| Health services must document preparation list audits, 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. |  |  |  |
| 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, and * obtain consent from the patient to transfer their care from one service provider to another.   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 to ensure these services are provided within clinically recommended times. |  |  |  |
| 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 to allow their private patients to be registered on that public health service’s 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. |  |  |  |
| 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 must be 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 servicesmust 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. |  |  |  |

## Policy requirements that should be implemented by June 2025

### Headline new requirements

**Communication with patients**

* The policy has amended communication timeframes and identified the necessary points of communication between health services and patients to deliver patient-centred, timely and structured communication.
* To improve communication with patients on the preparation list, the policy requires health services to respond to the communication needs and preferences of each patient.

**Validation of preparation lists**

* Health services are responsible for actively managing the preparation lists for all surgery and procedures provided by the health service and performing routine administrative and clinical audits of all patients on the preparation list for planned surgery or procedures.
* Individual clinicians must not decide or manage who is on the preparation list.

Table 2 Policy requirements that must be implemented by June 2025

| Obligations / requirements to be met: | Rating (1-5) | Gaps still to be addressed | Comments / issues |
| --- | --- | --- | --- |
| **Section 5 Communication with patients** | | | |
| 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](https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap).[[11]](#footnote-12) * be documented in the patient’s health record. |  |  |  |
| 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).[[12]](#footnote-13) 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’ 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. |  |  |  |
| **Section 7 Preparation list management** | | | |
| Health services must keep accurate records of the preparation list and perform regular administrative and clinical audits of all patients. |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |
| 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. |  |  |  |

## Policy requirements that should be implemented by June 2026

### Headline new requirements

**Scope of the policy**

* This policy applies to all planned surgery and procedures listed in the [ESIS manual](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) < https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>
* The policy applies to all Victorian public hospitals, public health services, multi-purpose services and denominational hospitals.
* The policy applies to all planned surgery and procedures whether the patient elects to be treated as a public or private patient in a public health service.

**Single preparation list**

* Health services must maintain a single preparation list for each surgical or procedural specialty.
* Individual clinicians must not decide or manage who is on the preparation list. The head of unit at the health service is responsible for managing and overseeing the preparation list for their surgical or procedural speciality.
* A list of waiting private patients must be kept by individual clinicians and must be separate to the health service’s single surgical and procedural preparation lists.

Table 3 Policy requirements that must be implemented by June 2026

| Obligations / requirements to be met: | Rating (1-5) | Gaps still to be addressed | Comments / issues |
| --- | --- | --- | --- |
| **Section 2 About the policy** | | | |
| 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](https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis) < https://www.health.vic.gov.au/data-reporting/elective-surgery-information-system-esis>.   It applies whether the patient elects to be treated as a public or private patient in a public health service.  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. |  |  |  |
| Section 4 Guiding principles |  |  |  |
| Health services should analyse treat in turn rates as part of normal case review and preparation-list management. |  |  |  |
| **Section 7 Preparation list management** | | | |
| Health services must maintain a single preparation list for each surgical or procedural specialty (such as endoscopies). |  |  |  |
| 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.  Individual clinicians must not decide or manage who is on the preparation list. |  |  |  |
| The principles outlined in Private patient: principles for public health servicesmust 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. |  |  |  |

|  |
| --- |
| To receive this document in another format, phone using the National Relay Service 13 36 77 if required, or email <healthservicesimprovement@health.vic.gov.au>.  Authorised and published by the Victorian Government, 1 Treasury Place, Melbourne.  © State of Victoria, Australia, Department of Health, June 2024.  ISBN/ISSN 978-1-76131-599-2 (online/ Word)  Available at [Surgical services policies and guides (health.vic.gov.au)](https://www.health.vic.gov.au/patient-care/surgical-services-policies-and-guides) <https://www.health.vic.gov.au/patient-care/surgical-services-policies-and-guides> |

1. <https://www.health.vic.gov.au/publications/aboriginal-and-torres-strait-islander-cultural-safety-framework-part-1> [↑](#footnote-ref-2)
2. <https://www.health.vic.gov.au/virtual-care-operational-framework> [↑](#footnote-ref-3)
3. <https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap> [↑](#footnote-ref-4)
4. <https://www.health.vic.gov.au/victorian-virtual-care-strategy> [↑](#footnote-ref-5)
5. <https://www.health.vic.gov.au/policy-and-funding-guidelines-for-health-services> [↑](#footnote-ref-6)
6. <https://www.health.vic.gov.au/funding-performance-accountability/performance-monitoring-framework> [↑](#footnote-ref-7)
7. <https://www.health.vic.gov.au/hospitals-and-health-services/funding-performance-and-accountability> [↑](#footnote-ref-8)
8. <https://www.health.vic.gov.au/publications/national-elective-surgery-urgency-categorisation-guideline-april-2015> [↑](#footnote-ref-9)
9. <https://www.health.vic.gov.au/health-system-design-planning/perioperative-service-capability-framework-for-victoria> [↑](#footnote-ref-10)
10. <https://www.safercare.vic.gov.au/best-care-guidance-for-non-urgent-elective-surgery> [↑](#footnote-ref-11)
11. <https://www.health.vic.gov.au/publications/victorias-digital-health-roadmap> [↑](#footnote-ref-12)
12. <https://www.health.vic.gov.au/patient-care/planned-surgery-access-policy-communication-toolkit> [↑](#footnote-ref-13)