ACT Auditor-General’s Office

Performance Audit Report

Waiting Lists for Elective Surgery and Medical Treatment

January 2011
Dear Mr Speaker

I am pleased to forward to you a Performance Audit Report titled ‘Waiting Lists for Elective Surgery and Medical Treatment’, for tabling in the Legislative Assembly, pursuant to Section 17(5) of the Auditor-General Act 1996.

Yours sincerely

Tu Pham
Auditor-General
17 January 2010
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# LIST OF ABBREVIATIONS AND GLOSSARY

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Australian Capital Territory</td>
</tr>
<tr>
<td>ACTPAS</td>
<td>ACT Patient Admission System (or known as i.patient manager)</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
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<td>AMA</td>
<td>Australian Medical Association</td>
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<tr>
<td>CPH</td>
<td>Calvary Public Hospital</td>
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<tr>
<td>CRIS</td>
<td>Clinical Records Information System</td>
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<tr>
<td>ENT</td>
<td>Ear/Nose/Throat</td>
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<tr>
<td>GE</td>
<td>Gastroenterology</td>
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<tr>
<td>IBA</td>
<td>Waiting List Module of the Patient Administration System used by the Calvary Public Hospital</td>
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<tr>
<td>KPI</td>
<td>Key Performance Indicator</td>
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<tr>
<td>NESWTDC</td>
<td>National Elective Surgery Waiting Times Data Collection</td>
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<tr>
<td>NHDD</td>
<td>National Health Data Dictionary</td>
</tr>
<tr>
<td>NHDS</td>
<td>National Health Data Set</td>
</tr>
<tr>
<td>OPD</td>
<td>Out-Patient Department</td>
</tr>
<tr>
<td>RFA</td>
<td>Request for Admission</td>
</tr>
<tr>
<td>TCH</td>
<td>The Canberra Hospital</td>
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<tr>
<td>VMO</td>
<td>Visiting Medical Officer</td>
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1. REPORT SUMMARY AND AUDIT CONCLUSIONS

INTRODUCTION

1.1 This report presents the results of a performance audit that reviewed ACT Health’s management of the waiting lists for elective surgery and medical treatment (non-emergency medical procedures) across the ACT public hospitals.

1.2 The aim of ACT Health is to achieve good health for all residents of the Australian Capital Territory (ACT) by:

- planning, purchasing and providing quality community based health services, hospital and extended care services;
- managing public health risks; and
- promoting health and early care interventions.  

1.3 ACT Health operates in a complex environment, which reflects the diversity of activities for which it is responsible, as well as its key role in providing the best possible healthcare and health-related services throughout all areas of ACT Health.

1.4 In the ACT, there are two public hospitals, namely, The Canberra Hospital (TCH) at Garran, Woden and the Calvary Public Hospital (CPH) at Bruce, Belconnen. The CPH is funded by ACT Health and, through a contractual arrangement with the Territory, managed by the Calvary Health Care ACT. These two public hospitals provide acute and specialist health services to the residents of ACT and the surrounding region of New South Wales (NSW). Canberra is the major health referral centre for the residents of the surrounding southern region of NSW.

1.5 The resident population of the ACT was 324,034 based on the Census in 2006 and projected to grow to 353,190 by 2016. Approximately 481,180 people live in Canberra and the surrounding region of NSW. The anticipated growth in population in this region, particularly the older age groups, has put pressure on the public hospitals’ services.

BACKGROUND

1.6 On 23 June 2010, the Legislative Assembly passed a resolution to request:

…the Auditor-General to conduct an audit of ‘Waiting Lists for Elective Surgery and Medical Treatment’ and consider as part of the audit concerns raised about the management of the elective surgery waiting list.

1.7 The Assembly’s resolution of 23 June 2010 also noted that the Australian Hospital Statistics for 2008-09 published by the Australian Institute of Health and Welfare

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1 ACT Health, Annual Report 2009-10, Section A page 3.
(AIHW) showed that the elective surgery waiting times had worsened in the Australian Capital Territory (ACT). The Assembly also noted that allegations have been made about possible manipulation or mismanagement of the elective surgery waiting list and that some patients have been downgraded to lower categories.

1.8 In response to the request from the Legislative Assembly, the Auditor-General decided, in accordance with the Auditor-General Act 1996, to conduct a performance audit on patients’ waiting lists for elective surgery and medical treatment procedures.

AUDIT OBJECTIVE AND SCOPE

1.9 The objective of this audit was to provide an independent opinion to the Legislative Assembly on whether:

- information on waiting lists published by ACT Health was complete, reliable and timely;
- ACT Health effectively managed the elective surgery policy and related systems and procedures to promote clinically appropriate, consistent and equitable treatment of patients in public hospitals; and
- access to medical services (non-surgical) was effectively managed and timely.

1.10 The scope of this audit was primarily limited to elective surgery and medical treatment procedures conducted in the public hospitals in the ACT. It did not deal with waiting for emergency services or waiting as an in-patient for additional surgery or procedures. Waiting for procedures that were performed outside the public hospital system or outside the ACT were not reviewed.

1.11 Appendix A outlines the audit criteria, approach and methodology.

1.12 Audit appreciates the valuable input to the audit and assistance provided by various key stakeholders including representatives of the Australian Medical Association, the Visiting Medical Officers Association, surgeons, general practitioners and the Health Care Consumers Association of the ACT.

AUDIT CONCLUSIONS

1.13 Audit acknowledges that management of the waiting lists for elective surgery and medical treatments is a complex process that can be influenced by practices of various parties within the system, including doctors, and by a number of factors, some of which are outside the control of ACT Health.

1.14 Audit also notes that Canberra’s public hospitals provide emergency and elective surgery to ACT residents and those in surrounding areas. Most emergency surgery is conducted at TCH, and consequently the pressure of delivering emergency surgery has also impacted on the delivery of elective surgery.
1.15 The audit conclusions drawn against the audit objective are set out below.

- Overall, elective surgery waiting lists are administered in the ACT within a sound framework of policies, guidelines and procedures. However, ACT Health’s implementation and monitoring processes were not managed well to deliver the intended outcomes.

- Current practices in compiling the waiting lists have compromised the policy intention of promoting clinically appropriate, consistent and equitable management of elective surgery waiting lists. In particular, downgrades of patients’ urgency category, often without documented clinical reasons, raised considerable doubts about the reliability and appropriateness of the clinical classifications for patients on the waiting lists.

- The strategies implemented by ACT Heath have not been adequate to address increased demand, and reduce the waiting lists for elective surgery. Recent reviews commissioned by the Department indicate significant issues concerning the delivery of surgical services and management of operating theatres, which have contributed to the long waiting lists.

- ACT Health is implementing the Elective Surgery Access Plan 2010-13 to meet the immediate needs of increasing demand for elective surgery, and introducing changes in elective surgery management. The success of this Plan depends on its effective implementation, which requires adequate resources, engagement of hospital staff and improved communication with, and cooperation from surgeons and other medical professions.

- There were significant delays in assessing appointments in areas reviewed by Audit, namely the Urology and Gastroenterology units at the Central Outpatients Department (OPD) in TCH. There is scope to improve the effective management of waiting lists for medical treatment (non-surgical) by improving strategic management of the OPDs at The Canberra Hospital, and adopting consistent systems and operational procedures across the various units within the OPD.

**KEY FINDINGS**

1.16 The audit conclusions are supported by the following findings:

**Elective surgery processing systems, performance and accountability framework**

- The Canberra Hospital (TCH) and the Calvary Public Hospital (CPH) manage waiting lists independently, largely because the hospitals use different electronic record systems to process patients’ details.

- The lack of an integrated database between TCH and the CPH and the absence of a single waiting list across the ACT have adversely impacted on the efficiency and effectiveness in the management of the waiting lists, including the transfer of patients between these two hospitals. ACT Health plans to implement the same electronic system (ACTPAS) currently used in TCH at the CPH within the next eighteen months.
There have been significant increases to base funding allocated to elective surgery in the ACT:

- the funding provided by the ACT Government increased from $68.8 million in 2007-08 to $78.3 million in 2009-10;
- the Commonwealth Government provided $6.6 million in 2008-09 to fund the building of two theatres at TCH and one at the CPH;
- the Commonwealth Government has committed $17.5 million over three stages from January 2008 to December 2011 under the National Partnership Program for Reduction of Elective Surgery Waiting List; and
- the Commonwealth Government will also provide additional funding of $5.2 million during 2010-11 under the National Access Program, of which $4.8 million will be used for funding additional 700 elective surgery services and $0.4 million for capital equipment.

Notwithstanding increased funding by the Commonwealth and ACT Governments in the recent years, the elective surgery waiting lists have not shown improvements, and the ACT compared unfavourably to other jurisdictions. In 2008-09:

- the median wait was 75 days in the ACT (the Australia median was 34 days);
- only 66 percent of total admissions in the ACT were seen within the recommended time (the Australia median was 86 percent); and
- more than ten percent of ACT public patients had to wait more than a year for admissions (three percent in most other jurisdictions).

More recent statistics in 2009-10 indicated a general worsening situation, compared to 2008-09:

- a total of 9 778 patients had elective surgery at ACT public hospitals during 2009-10, a reduction by three percent from 10 104 in 2008-09;
- there were more patients on waiting list for all categories. The total number of patients waiting for elective surgery at June 2010 was 5 327; an increase of nine percent from June 2009;
- 65 percent of all elective surgery public patients were admitted within the recommended time for their clinical urgency category; and
- the median waiting time for Categories 2 and 3 patients on waiting lists were both increased from the previous year.

Reliability of elective surgery waiting list

ACT Health collected and compiled significant data on waiting lists for elective surgery, which are comprehensive and mostly accurate. However, the classification of clinical urgency categories did not always reflect ACT Health’s policy and procedures, and therefore raised doubts on the reliability and appropriateness of the clinical classifications for patients within the waiting list.
• In the absence of required documents, Audit was unable to form a view on the validity of the clinical reclassifications. In particular, Audit found that:
  – in 2009-10, 250 patients in Category 1 were reclassified and a significant number of these reclassifications (97 percent) occurred without documented clinical reasons;
  – unusual movements of patients’ priority changes occurred; for examples, reclassifications (usually a downgrade) of a number of patients’ classification in one day and several changes of a patient’s clinical urgency category within a short period of time; and
  – consistent practice by some doctors to ‘stage’ (downgrade) patients’ clinical urgency category close to the clinical recommended timeframes for these patients. This often followed a request for review by the hospitals.
• Currently, some surgeons managed their own waiting lists instead of using public hospitals’ waiting lists. This, combined with the lack of documented clinical reasons for patient priority reclassifications, can compromise safeguards that ensure patients are treated in accordance with the priority order they presented and within the level of urgency of their respective case in public hospitals’ waiting lists.
• ACT Health’s current Policy does not require patients to be notified of any priority changes nor to be advised of the impact of the changes. It would appear that reclassifications often resulted from internal waiting list management procedures with no or limited involvement from patients.
• There were deficiencies in processing patients on to the elective surgery waiting list. These included:
  – many patients’ consent forms were partially completed by patients, and did not meet the requirement to demonstrate that patients fully understood the information provided by doctors about the nature of the operation, and the material risks inherent in the treatment;
  – the consent forms did not always have a witness’s signature. This may expose ACT Health and the medical practitioners to risks, including potential legal risks and adverse outcomes for patients; and
  – Request for Admission (RFA) forms were sometimes kept in the surgeons’ private rooms and not forwarded to the hospital for processing in a timely manner.
• The Surgical Booking team at TCH and the CPH did not routinely review waiting list transactions on a monthly basis as required by the Waiting List Policy. This non-compliance increases the risk of the hospitals not detecting and correcting processing errors on patient information in a timely manner, which may in turn compromise the accuracy of the waiting lists.

Analysis of elective surgery waiting times
• Analysis of the waiting lists of four specialties selected for review and of selected surgeons for these specialties indicated that the estimated waiting times for all patients, except most Category 1 patients, would continue to be
well beyond the recommended timeframe and target set by ACT Health and, where relevant, the Commonwealth Government for each category.

**Management of elective surgery waiting lists**

- There was a strong consistent view expressed by key stakeholders consulted by Audit, including various medical professions, that the management of waiting lists by the hospitals was not effective in ensuring patients receive surgery within their clinical urgency timeframes. Overall inadequate resources, such as beds, equipment and operating theatre times and some current inefficient practices, had impacted on the effectiveness of patient throughput, and contributed to the delays experienced by patients.

- Implementation of strategies by ACT Health to improve the waiting list to-date has been slow. Other than progress made in the outsourcing of various surgical procedures to private providers in the 2010-11 financial year, there has been limited progress or improvements on other options such as:
  - transfer of patients to other doctors with a shorter waiting list;
  - transfer of patients to another hospital; and
  - increases in theatre utilisation.

- Clinical review of long-wait patients was not conducted within the recommended timeframes. Patients or their GP’s often needed to request the hospitals to review their cases after long waits.

- There was a high level of postponement and cancellation of elective surgery (335 in 2009-10 for four selected specialities in the TCH), due to various reasons, some avoidable. The main reasons included substitutions of surgical sessions by higher priority Category 1 and 2 patients and emergency surgery. Other postponements or cancellations that could have been avoided by better planning and management by TCH were due to doctors’ leave (with or without sufficient notice) and the unavailability of equipment.

- Many leave applications from doctors (about 32 percent in TCH and 14 percent in CPH) did not comply with the existing Policy to provide a minimum of four weeks’ notice. Insufficient notice to hospitals makes reallocation of available surgical sessions to other surgeons difficult and sometimes impractical. There were no records of patients’ management plans being developed and implemented to minimise the impact on the patients affected by the treating surgeons who took leave.

- Consultants commissioned by ACT Health recently to review surgical services in the ACT (April 2010) and the operations of TCH operating theatres (June 2010) identified many deficiencies in the management of TCH operating theatres that require immediate attention and rectification. ACT Health has commenced actions to address the matters identified, but needs to formalise implementation plans and an appropriate governance and accountability framework to monitor progress and report on outcomes.

- ACT Health has also commenced implementing a new Elective Surgery Access Plan 2010-13 to meet the immediate needs of increasing demand for
access to elective surgery and improve elective surgery management. The new plan has set a performance target for each public hospital and an overall target of 10 711 admissions for 2010-11.

Management of medical treatment waiting lists

- The OPDs in TCH provided almost 118,000 services in 2009-10, an increase of 13 percent from 2008-09 and about 13,000 over target. Funding for the OPDs in public hospitals in 2009-10 totalled $79.8 million, an increase of 3.4 percent over the previous year.

- ACT Health conducted an internal review of the outpatient services at TCH and a draft report in October 2010 found deficiencies in strategic planning, inconsistent application of policies and procedures across the OPDs, ad hoc processes for managing the waiting lists, and poor and inefficient communications with clinicians, consumers and staff. The review report included 35 recommendations to address strategic and immediate operational needs.

- Audit examination of a selection of patient records on the Urology unit waiting list at TCH showed that more than 85 percent failed to meet the timeframes for referral, triaging and booking processes included in the relevant policy.
  - The Standard Operating Procedures for the OPD state that the appointment scheduling system will facilitate the booking of appointments within five days of accepting the referral. The average timeframe between receiving the referral and booking the patient’s appointment in the Urology unit in June 2010 was 71.9 days, and in September 2010 it was 25.5 days.
  - Further, for the selected samples, there was significant delay in the average time between the referral being received in the Urology unit and the clinical appointment, 217.9 days in June 2010 and 158.4 days in September 2010.

- Audit examination of a selection of patient records on the Gastroenterology unit’s waiting list at TCH showed that although the average wait for Category 1 patients fell from 48 days in February 2010 to 39 days in July 2010, the waiting time for only one month in the reviewed period (February 2010 to July 2010) was within the clinical target of 30 days.
  - There was a reduction in the average waiting time for Category 2 patients, with the average wait falling to 108 days in July 2010. Nevertheless, the average wait was outside the clinical target of 90 days. Category 2a waiting times were mostly within the clinical target for the period under review, and have also shown a substantial improvement over the six months from February to July 2010.
  - The average wait for patients in Category 3 was within the clinical timeline target of 365 days, and waiting times have demonstrated a significant improvement (from 177 days in February 2010 to 93 days in July 2010). Category 3a waiting times, however, were well outside
the clinical target of 180 days (times ranged from a high of 239 days in March 2010 to 203 days in July 2010).

- An internal audit of the Gastroenterology unit’s waiting list, which commenced in February 2010 (reported in July 2010), identified numerous data errors including multiple RFAs for the same patient, unregistered RFAs, registrations under the incorrect specialist, and registrations for deceased patients.

- Most referrals tested by Audit were complete and accurately entered onto the waiting list. Only half of the selected entries were processed within the required timeframe and several instances were noted where the specialist doctor had not assigned a clinical urgency category, or the assigned category was varied by staff at the clinic.

- The Canberra Hospital has been implementing improvement strategies in all TCH clinics and this is expected to improve the waiting list over time.

**RECOMMENDATIONS AND RESPONSE TO THE REPORT**

1.17 The audit made eleven recommendations to address the audit findings detailed in this report.

1.18 In accordance with section 18 of the Auditor-General Act 1996, a Proposed Report was provided to the Acting Chief Executive of ACT Health for consideration and comments. The Acting Chief Executive’s overall response is shown below:

> ACT Health welcomes the Auditor-General’s performance audit of waiting lists for elective surgery and medical treatment. Demand for elective surgery and medical treatment has grown rapidly over recent years and has been the subject of internal review by ACT Health to identify approaches to improve access for the ACT community and people in the surrounding region of NSW to these services. ACT Health is committed to continuing the work to improve the management of elective surgery and outpatient services in the ACT.

> ACT Health is increasing capacity to provide elective surgery. Over the first five months of 2010-11, a total of 1,625 people with extended waiting times have been admitted for surgery, 16.5 percent above the figure reported for the same period last year. In January 2010, there were 2,549 people on the ACT public hospitals elective surgery waiting lists with longer than recommended waiting times. At the end of November 2010 (latest available published data), this figure had fallen to 1,992 people, a drop of 22 percent. While ACT Health recognises this figure remains too high, continuing reductions in the number of people waiting longer than recommended waiting times are expected.

> Outpatient services have grown by 23 percent over the three years to 2009-10, and this has resulted in pressure on staffing and space in areas of The Canberra Hospital. In recognition, ACT Health has increased staffing and created space for additional clinics.

> While welcoming the report, ACT Health believes that the report has not provided sufficient recognition of some key factors that impact on the management of elective surgery.

> Perhaps the most significant of these factors is the impact that demand for emergency surgery has on management of elective surgery. In the ACT, as in other
health services, responding to the demand for emergency surgery is the highest priority, and increases in demand for emergency surgery will inevitably impact on the capacity to manage and deliver elective surgery because to a large degree emergency surgery involves the same staff, operating theatres and beds as elective surgery. Over the period audited emergency surgical activity increased overall by 18.4 percent and at The Canberra Hospital by 20.9 percent.

The ACT Government provided significant additional investment to respond to this demand, with increased funding, additional doctors and nurses, four new operating theatres, and 64 additional beds. Despite this additional investment, the significantly increased emergency surgical activity inevitably impacted on the capacity to manage elective surgery in the ACT. Even with this impact ACT Health was still able to provide 5.1 percent more elective surgery in 2009-10 compared to 2006-07.

In relation to reclassifications of patients between urgency categories, it is important to emphasise that reclassifications are an essential feature of elective surgery waiting list management, and is used across all jurisdictions. The key criterion in ACT Health policy that governs reclassification of patients is that all reclassifications are done with the agreement of the treating surgeon.

Notwithstanding that there are process and documentation issues that ACT Health is working on to improve, the report did not confirm a single case where the reclassification occurred without the agreement from the surgeon.

Further Audit comments:

ACT Health has stated that the Audit report ‘did not confirm a single case where the reclassification occurred without the agreement from the surgeon’. Audit notes that during the review of ACT Health’s 2009-10 Statement of Performance, Audit examined 259 records of all Category 1 patients whose clinical urgency category had been reclassified from Category 1 to Category 2. Audit identified 55 reclassifications (or 32 percent) that had no evidence of having been approved by a doctor. This is discussed in Paragraph 3.51 of the Report.

1.19 In addition, the Acting Chief Executive provided responses to each recommendation, as shown below.

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<thead>
<tr>
<th>Recommendation 1 (Chapter 3)</th>
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<td>ACT Health should progress the development of a single waiting list by integrating the two hospitals’ databases to better manage the waiting list across the ACT.</td>
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**ACT Health’s Response:**

**Agreed in principle**

*ACT Health has been working to establish a single waiting list for access to public elective surgery in the ACT. A single waiting list will assist in ensuring that patients are provided with access surgery according to clinical priority across the Territory.*

As identified in the report, this is contingent on establishing a single patient administration system across both public hospitals, and work is underway to implement this and is estimated to be finalised in October 2012.
However, ACT Health does not have operational control of Calvary Public Hospital. The establishment of a single ACT waiting list will remove some control of access to elective surgery at the Calvary site from Calvary Public Hospital, by placing that control within ACT Health. Accordingly, any agreement will require changes to the operation of Calvary Public Hospital and agreement from the Little Company of Mary Health Care.

**Recommendation 2  (Chapter 3)**

ACT Health should:

(a) review and revise the hospitals’ Request for Admission (RFA) forms and patient’s consent form to ensure that standardised forms are used by both public hospitals;

(b) provide additional guidelines to medical staff to ensure that patients’ consent forms are properly completed and witnessed; and

(c) provide additional information to, and seek commitment from, doctors and surgeons, for improvements in the timeliness of lodging RFAs to the hospitals.

**ACT Health’s Response:**

*Agreed*

The Request for Admission (RFA) form for access to elective surgery is often completed within surgeons’ private rooms, by surgeons operating as contractors to ACT Health (not ACT Health employees). This limits ACT Health capacity to ensure that RFAs are completed as required prior to submission to ACT Health, but ACT Health continues to work with surgeons to improve the documentation. Where information is missing on an RFA prepared in private rooms, correcting the information requires that the hospital sends the form back to the rooms. This takes time and can delay the listing of a patient on the waiting list, and the impact of any delays on patients needs to be taken into account when deciding whether the forms should be returned to the private rooms to correct them or to provide further information.

**Recommendation 3  (Chapter 3)**

ACT Health should, in consultation with each hospital, implement and monitor the regular conduct of clerical reviews by surgical booking staff to mitigate the risks of processing errors in the electronic waiting lists.

**ACT Health’s Response:**

*Agreed*

ACT Health conducts a regular clerical audit of the waiting list at a Territory wide level which includes contact with all patients on the waiting list but ACT Health agrees that processes for clerical audit by surgical bookings staff at each Hospital should be improved.

Both public hospitals are developing new Standard Operating Procedures for the management of elective surgery that include processes to ensure that every record
is audited and that all aspects of the ACT Health waiting list policy are being implemented.

**Recommendation 4 (Chapter 3)**

ACT Health should, in consultation with each hospital:

(a) develop a comprehensive procedural manual for surgical bookings in line with ACT Health policy; and

(b) provide adequate training to booking staff to ensure consistent and correct practices and procedures are being adopted.

**ACT Health’s Response:**

**Agreed**

*ACT Health is developing a new procedure manual for surgical booking clerks at both public hospitals, which include a range of Standard Operating Procedures for each aspect of the waiting list policy. These manuals provide clear direction for administrative staff on the procedures that need to be followed. These will be completed early in 2011 and will be able to be utilised at Calvary and Canberra Hospitals.*

*In addition to the development of the manuals, all staff will be trained in the use of the Standard Operating Procedures with a quarterly audit of performance of staff against the procedures. All staff will undertake individual training sessions. This training is to be repeated every three months for the first twelve months and reviewed regularly to ensure that the information is conveyed in an appropriate manner.*

**Recommendation 5 (Chapter 3)**

ACT Health should:

(a) ensure that all reclassifications of patients’ clinical urgency category are properly documented by an authorised doctor based on sound medical reasons;

(b) enhance controls and procedures in recording reclassifications on the electronic waiting lists and the RFA forms; and

(c) improve accountability and transparency in the priority change processes by advising patients of any category reclassification.

**ACT Health’s Response:**

**Agreed**

*It is important to emphasise that patients reclassified from Category 1 to Category 2 represent 2.5 percent of all elective surgery patients in 2009-10.*

*The audit found no evidence that surgical booking clerks or any other administrative officer made any changes to the reclassification of patient without the direction of the treating surgeon.*
Further Audit comments:

Audit identified 55 patients’ reclassifications in 2009-10 from Category 1 to Category 2 (or 32 percent) that had no evidence of having been approved by a doctor. This is discussed in Paragraph 3.51 of the Report.

**Recommendation 6 (Chapter 5)**

ACT Health should:

(a) clarify the circumstances that warrant a clinical review of patients on elective surgery waiting lists; and

(b) ensure The Canberra Hospital and Calvary Public Hospital conduct regular clinical reviews of patients on elective surgery waiting lists within the recommended timeframes.

**ACT Health’s Response:**

*Agreed in part*

The purpose of clinical review is to identify whether a patient’s condition has changed and would require a change to a patient’s urgency category. ACT Health encourages all patients to stay in regular contact with their GPs and for the patient or their GP to contact ACT Health if they believe their condition has changed and whether they need a clinical review. This provides flexibility to organise a timely clinical review rather than waiting for a set time period.

(a) **Agreed** - ACT Health agrees that there are times that it is appropriate for the hospital to initiate clinical review of patients, and clear guidance about the circumstances in which this should occur will be included in the revised ACT Elective Surgery Access Policy which is currently under development.

(b) **Not agreed** - ACT Health does not believe that the recommendation accurately represents ACT Health policy. ACT Health policy does not recommend that all patients who wait longer than the recommended waiting times be clinically reviewed, and if all patients were reviewed it would mean diverting ACT Health resources from caring for other patients to review patients for whom the review may provide no benefit.

**Recommendation 7 (Chapter 5)**

ACT Health should, in consultation with the doctors, implement strategies as outlined in its Policy to avoid elective surgery patients waiting longer than their clinical urgency timeframes. This includes the options of transferring patients to other doctors with a shorter waiting list, transferring patients to another hospital and increasing theatre utilisation.

**ACT Health’s Response:**

*Agreed*
ACT Health agrees with this recommendation, but notes that it appears to be based on the Audit finding that there has been limited progress or improvements in transferring patients between surgeons and hospitals or increasing theatre utilisations.

ACT Health does not believe the finding accurately recognises the progress made in this area. In 2009-10 theatre utilisation was 10.1 percent higher than in 2006-07, the year immediately prior to the audited period, and in the 2009 calendar year, 516 patients were transferred between hospital waiting lists to improve access to elective surgery, increasing to 695 in the 2010 calendar year.

**Recommendation 8  (Chapter 5)**

ACT Health, in conjunction with the doctors, should develop and implement systems and procedures to manage more effectively doctors’ leave and patients’ management plans, to ensure that surgical needs of affected patients have not been compromised.

**ACT Health’s Response:**

*Agreed*

ACT Health agrees with this recommendation but notes that postponements due to surgeon unavailability (surgeons being on leave with less than four weeks’ notice) comprises 18.5 percent of total postponements and one quarter of this total relates to surgeons being away due to illness. The 148 postponements relating to a surgeon being away without sufficient notice (due to illness or other reasons) comprises just 1.4 percent of total planned elective surgery over 2009-10.

**Recommendation 9  (Chapter 5)**

ACT Health should establish appropriate systems to monitor and manage ‘avoidable’ factors to minimise the number of postponements and cancellations of surgery initiated by hospitals.

**ACT Health Response:**

*Agreed*

Half of all hospital initiated postponements (49.9 percent) are due to substitution by a patient with more urgent needs. As the majority of surgeons working in our public hospitals are Visiting Medical Officers with busy private practices, it is not always possible to provide access to alternative surgeons where a surgeon has to postpone a patient’s surgery due to the urgent needs of another patient.

Notwithstanding this, over the three years to 2009-10, the proportion of patients who had their elective surgery postponed dropped from 11.9 percent to 7.6 percent. This result was driven by improvements at The Canberra Hospital with postponements there dropping from 17.0 percent to 7.1 percent over the same period.

This drop is a result of systems being put in place to monitor and manage postponements, but ACT Health is continuing to work to improve these systems and reduce the rate of postponements further.
Recommendation 10 (Chapter 6)

The Canberra Hospital should implement processes for routine data integrity audits of all Outpatient Department waiting lists to ensure all data is valid, complete and accurate. All waiting lists should be subject to a detailed audit at least annually.

ACT Health’s Response:

Agreed

A national minimum data set for outpatient services has been developed recently and ACT Health has worked with both hospitals over the last two years to ensure that outpatient collections meet the new national requirements. A thorough process related to the management of the endoscopy waiting list was completed in April 2010. This process included the development of clear procedures manuals to ensure that data entered into the system is timely and accurate. ACT Health will conduct similar processes across all outpatient services.

In addition, as part of the review of the outpatient service at The Canberra Hospital, ACT Health is implementing additional data validation and reporting processes. Senior managers will be responsible for a range of waiting time performance measures and the collection and collation of data will be subject to regular reviews and audits.

Recommendation 11 (Chapter 6)

ACT Health should develop an appropriate governance and accountability framework to monitor, review and report on the progress of implementation of agreed recommendations arising from the Review of The Canberra Hospital Outpatients Service Redesign Project. Particular attention should be paid to:

(a) implementing a strategy to manage increased demand for outpatient services; and

(b) implementing consistent policies, practices and procedures for managing the waiting lists for individual OPD units.

ACT Health’s Response:

Agreed

The redesign project is being governed by The Canberra Hospital Outpatient Services Governance Committee, which reports to the General Manager of The Canberra Hospital. Development of recommendations and implementation plans arising from the review is well underway and are expected to be completed in February 2011.

Provision of outpatient services continues to grow, and year to date in 2010-11, has increased by 7.0 percent over the same period last year. This increased demand is being managed by the provision of additional staffing and clinics at the Hospital.
OTHER AUDIT COMMENT

1.20 In providing the response to the proposed report, and responses against each recommendation, ACT Health has provided some additional data that has not been subject to audit by this Office.
2. ELECTIVE SURGERY PROCESSING SYSTEMS, PERFORMANCE AND REPORTING FRAMEWORK

INTRODUCTION

2.1 This Chapter provides an overview of the elective surgery processing systems, including prioritisation of patients’ urgency category, and the reporting of ACT public hospitals’ performance against key performance indicators.

KEY FINDINGS

- The Canberra Hospital (TCH) and the Calvary Public Hospital (CPH) manage waiting lists independently, largely because the hospitals use different electronic record systems to process patients’ details.

- The lack of an integrated database between TCH and the CPH and the absence of a single waiting list across the ACT have adversely impacted on the efficiency and effectiveness in the management of the waiting lists, including the transfer of patients between these two hospitals. ACT Health plans to implement the same electronic system (ACTPAS) currently used in TCH at the CPH within the next eighteen months.

- There have been significant increases to base funding allocated to elective surgery in the ACT:
  - the funding provided by the ACT Government increased from $68.8 million in 2007-08 to $78.3 million in 2009-10;
  - the Commonwealth Government provided $6.6 million in 2008 09 to fund the building of two theatres at TCH and one at the CPH;
  - the Commonwealth Government has committed $17.5 million over three stages from January 2008 to December 2011 under the National Partnership Program for Reduction of Elective Surgery Waiting List; and
  - the Commonwealth Government will also provide additional funding of $5.2 million during 2010-11 under the National Access Program, of which $4.8 million will be used for funding additional 700 elective surgery services and $0.4 million for capital equipment.

- Notwithstanding increased funding by the Commonwealth and ACT Governments in recent years, the elective surgery waiting lists have not shown improvements, and the ACT compared unfavourably to other jurisdictions. In 2008-09:
  - the median wait was 75 days in the ACT (the Australia median was 34 days);
  - only 66 percent of total admissions in the ACT were seen within the recommended time (the Australia median was 86 percent); and
  - more than ten percent of ACT public patients had to wait more than a year for admissions (three percent in most other jurisdictions).
More recent statistics in 2009-10 indicated a general worsening situation, compared to 2008-09:

- a total of 9,778 patients had elective surgery at ACT public hospitals during 2009-10, a reduction by three percent from 10,104 in 2008-09;
- there were more patients on waiting list for all categories. The total number of patients waiting for elective surgery at June 2010 was 5,327; an increase of nine percent from June 2009;
- 65 percent of all elective surgery public patients were admitted within the recommended time for their clinical urgency category; and
- the median waiting time for Categories 2 and 3 patients on waiting lists were both increased from the previous year.

BACKGROUND

2.2 Elective surgery is defined as non-emergency surgery that can typically be delayed for at least 24 hours. Demand and admissions for elective surgery have increased in Australia in the recent years. In 2008-09, there were 566,000 admissions for elective surgery in Australian public hospitals, indicating an increase of an additional 29,500 surgical admissions (or 5.2 percent) over the previous year.3

2.3 Consistent with the national trends, admissions for elective surgery have increased in ACT public hospitals in the recent years, except in 2009-10, as illustrated in Table 2.1.

Table 2.1: Elective surgery admissions in the ACT public hospitals 2006-07 to 2009-10

<table>
<thead>
<tr>
<th>Years</th>
<th>2006-07</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of admissions</td>
<td>9,305</td>
<td>9,595</td>
<td>10,107</td>
<td>9,778</td>
</tr>
<tr>
<td>Increase (+)/ decrease (-) compared to previous year (in %)</td>
<td>-</td>
<td>+3.1</td>
<td>+5.3</td>
<td>-3.3</td>
</tr>
</tbody>
</table>

Source: Audit Office based on ACT Health data.

2.4 The drop in the number of admissions in 2009-10 was due to:

- planned reductions in elective surgery as a response to H1N1 flu outbreak; and
- a lower target for 2009-10, pending the outcome of private sector tender arrangements and new Commonwealth programs.

2.5 ACT Health reported that the number of admissions in 2009-10 was still above the target of 9,667 as agreed with the Commonwealth under Stage Three of the Elective Surgery Waiting List Reduction Plan.

Waiting time and waiting lists

2.6 The capacity of the public health systems to respond to increased demand for services is limited by funding and resource availability, such as availability of surgeons, operating theatres, beds and nurses, and also by the efficiency with which these factors are integrated and managed to provide elective surgery.

2.7 Elective surgery waiting time is used as a rationing device to deal with the high demand for a limited resource. The waiting lists are used to manage access to public hospital elective surgery services and give priority to those in most urgent need of care.

2.8 When a public patient's elective surgery is booked, it is registered on a public hospital’s waiting list. Waiting time for elective surgery is defined as the time elapsed between the physician’s decision to admit a patient for elective surgery following clinical assessment and subsequent admission to hospital for surgery. Days on which a patient is ‘not ready for care’ are excluded.4

2.9 Most patients are admitted after waiting. However, some patients are removed from waiting lists because they:
- have been admitted as an emergency patient for the awaited procedure;
- are transferred to another hospital’s waiting list;
- have been treated elsewhere;
- are not contactable;
- have declined surgery or die.5

Patient urgency categories

2.10 Before a patient is placed on an elective surgery waiting list, the patient has to go through a lengthy process of referral, specialist assessment and investigation. Patients placed on waiting list have been assessed to have a clinical need for surgery and are expected to benefit from that surgery. Currently, patients are classified as one of the three clinical urgency categories that take into consideration the likelihood of deterioration and are aligned with recommended waiting time for surgery, agreed nationally by all States and Territories.

2.11 All States and Territories are required to provide elective surgery waiting times data to the Australian Institute of Health and Welfare (AIHW) and Commonwealth Department of Health and Ageing by clinical urgency category (refer Table 2.2). This National Elective Surgery Waiting Times Data Collection (NESWTDC) is based on public acute care hospitals only.

2.12 The three-tiered clinical urgency categories are defined in the National Health Data Dictionary (NHDD) and are outlined in Table 2.2.6

---

Table 2.2: Clinical urgency categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Admission</th>
<th>Clinical condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Within 30 days</td>
<td>Desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.</td>
</tr>
<tr>
<td>2</td>
<td>Within 90 days</td>
<td>Desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.</td>
</tr>
<tr>
<td>3</td>
<td>Within 365 days</td>
<td>For a condition causing minimal or no pain, dysfunction or disability, which is unlikely to deteriorate quickly and which does not have the potential to become an emergency.</td>
</tr>
</tbody>
</table>

Source: AIHW’s National Health Data Dictionary.

2.13 In the ACT, ACT Health has added two new categories to provide some flexibility in waiting times. Additional clinical urgency categories are:

- Category 2a - admission within 60 days, desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency; and
- Category 3a - admission within 120 days, desirable for a condition causing some pain, dysfunction or disability but which is not likely to deteriorate quickly or become an emergency.7

2.14 Other jurisdictions have also made specific variations to meet the internal requirements and policies for clinical category data collection. For example, New South Wales has used Category 4 for patients who are either clinically not ready for admission (staged) or those who have deferred admission for personal reasons (deferred).

2.15 AIHW considers that different clinical urgency category guidelines and policies within jurisdictions may contribute to variations at the national reporting level.8

2.16 AIHW also commented that measures based on clinical urgency categories (including the proportion of patients who are treated ‘on time’) are not meaningful or comparable among jurisdictions, and therefore have limited application for national elective surgery waiting times statistics. The measures may be more useful for comparisons within jurisdictions overtime, or for use at the hospital or other local level.9

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Policy and procedures

2.17 ACT Health has developed the following policies in the management of elective surgery waiting lists in ACT public hospitals:

- *Waiting Time and Elective Patient Management Policy* issued in October 2007 and implemented since January 2008 (Waiting list Policy); and
- *Advice for Referring and Treatment Doctors*, a reference list of recommended clinical urgency categories for each specialty (Reference List).

2.18 The Waiting List Policy has been developed ‘to promote clinically appropriate, consistent and equitable management of elective patients and waiting lists in public hospitals in the ACT’. ACT Health requires the public hospitals to actively manage the waiting lists in compliance with the Policy.10

2.19 The Reference List provides guidance to doctors to:

- allocate the clinical urgency category for patients based on clinical needs;
- ensure that patients with similar conditions are prioritised in a similar way; and
- select categorised patients for surgery in chronological order of their listing date.11

2.20 The Reference List records 125 procedures of which only four fall within Category 2a (within 60 days). No procedure for Category 3a is included in the Reference List, so the clinical relevance of Category 3a is not clear.

2.21 ACT Health advised Audit that the Waiting List Policy has been reviewed and a draft policy is being circulated to all key stakeholders for comments and that the three clinical urgency categories specified in the NHDD (refer Table 2.2) will be adopted in the draft policy to replace the existing five categories. Matters in relation to the existing Policy and the implementation of the relevant policies are discussed in Chapter 3.

NATIONAL HEALTHCARE AGREEMENT AND FUNDING

National Health Care Agreement

2.22 In July 2009, the National Healthcare Agreement (the Agreement) was endorsed by the Commonwealth Government and States and Territories governments to replace the Australian Health Care Agreements, which expired in 2007-08 but were extended by one year to 2008-09, to allow for renegotiation of a new healthcare agreement. The new Agreement commits all governments to improving the efficiency of public hospital services.12

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Commonwealth funding under elective surgery waiting list reduction plan

2.23 In January 2008, the Commonwealth committed $600 million to the Elective Surgery Waiting List Reduction Plan to fund the States and Territories over four years by providing more elective surgery and reducing waiting times. The funding to the States and Territories is provided in three stages.

2.24 Under the Elective Surgery Waiting List Reduction Program National Partnership, the Commonwealth has committed $17.5 million to the ACT over three stages. The Commonwealth also provides the ACT a total funding of $5.2 million during 2010-11 under the National Partnership Agreement on Improving Public Hospital Services (National Access Program). Table 2.3 outlines total funding from the Commonwealth.

Table 2.3: Total Commonwealth funding for Elective Surgery Waiting List Reduction Program and National Access Program

<table>
<thead>
<tr>
<th>Stage</th>
<th>Year</th>
<th>Amount ($ m)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>January to December 2008</td>
<td>2.5</td>
<td>Funding to deliver 250 procedures.</td>
</tr>
<tr>
<td>2</td>
<td>2008-09 financial year</td>
<td>6.6</td>
<td>Capital funding for additional two theatres at TCH and one at the CPH.</td>
</tr>
<tr>
<td>3</td>
<td>2009-10 financial year</td>
<td>4.2</td>
<td>Incentive reward payment that meets agreed targets to reduce waiting times and provide more elective surgery.</td>
</tr>
<tr>
<td>3</td>
<td>July 2010 to December 2011</td>
<td>4.2</td>
<td>As above.</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>17.5</td>
<td></td>
</tr>
</tbody>
</table>

National Access Program

<table>
<thead>
<tr>
<th>Year</th>
<th>Amount ($ m)</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010-11 financial year</td>
<td>5.2</td>
<td>Funding of $4.8 m to deliver 700 elective surgery procedures and $0.4 m for capital equipment.</td>
</tr>
</tbody>
</table>

Source: ACT Health.

2.25 ACT Health advised Audit that not all the funding under the National Partnership Agreement has been allocated yet.

ACT Government funding

2.26 Table 2.4 lists total expenditure estimates funded by the ACT Government on elective surgery.
2.27 Total expenditure on elective surgery in 2008-09 increased by $7.6 million (or 11.1 percent) compared to 2007-08. ACT Health advised that the increase was due to the Commonwealth funding for additional elective surgery procedures under stage 1 of the Elective Surgery Waiting List Reduction Program. The expenditure further increased in 2009-10 by $1.9 million (or 2.5 percent) compared to 2008-09, reflecting CPI indexation.

WAITING LIST PERFORMANCE

Assessment of ACT performance against other jurisdictions

2.28 The Commonwealth Department of Health and Ageing recently released a report on the state of public hospitals titled *The State of Our Public Hospitals June 2010 Report*. Table 2.5 outlines the performance of the ACT public hospitals compared with other jurisdictions and Australia-wide.

Table 2.5: Elective surgery waiting time statistics for public hospitals’ patients 2008-09

<table>
<thead>
<tr>
<th>State</th>
<th>Admissions (Number)</th>
<th>Median wait (Days)</th>
<th>Patients seen within recommended time (% of patients)</th>
<th>Patients waiting more than one year (% of patients)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New South Wales</td>
<td>199 384</td>
<td>39</td>
<td>91.0</td>
<td>2.5</td>
</tr>
<tr>
<td>Victoria</td>
<td>147 690</td>
<td>31</td>
<td>85.4</td>
<td>2.9</td>
</tr>
<tr>
<td>Queensland</td>
<td>109 940</td>
<td>27</td>
<td>84.7</td>
<td>1.8</td>
</tr>
<tr>
<td>Western Australia</td>
<td>60 398</td>
<td>31</td>
<td>85.6</td>
<td>2.0</td>
</tr>
<tr>
<td>South Australia</td>
<td>44 152</td>
<td>36</td>
<td>86.8</td>
<td>2.7</td>
</tr>
<tr>
<td>Tasmania</td>
<td>16 931</td>
<td>44</td>
<td>65.4</td>
<td>13.1</td>
</tr>
<tr>
<td>Northern Territory</td>
<td>6 410</td>
<td>40</td>
<td>70.3</td>
<td>5.6</td>
</tr>
<tr>
<td>ACT</td>
<td>10 104</td>
<td>75</td>
<td>65.5</td>
<td>10.6</td>
</tr>
<tr>
<td>Australia</td>
<td><strong>595 009</strong></td>
<td><strong>34</strong></td>
<td><strong>86.2</strong></td>
<td><strong>2.9</strong></td>
</tr>
</tbody>
</table>

Source: Commonwealth Department of Health and Ageing.\(^{13}\)

2.29 Table 2.5 shows:
- median wait (days);\(^{14}\)
- percentage of patients seen within the recommended time of the clinical urgency categories (Categories 1, 2 and 3); and
- percentage of patients who have been waiting for more than one year.

2.30 In 2008-09, there were 10 104 patients from the elective surgery waiting lists admitted in ACT public hospitals.

2.31 As can be seen from Table 2.5, the ACT public hospitals did not perform well compared to other jurisdictions, in all indicators, except Tasmania.

2.32 The length of time a patient waits for elective surgery is determined by the treating surgeon based on clinical assessment. The clinical urgency category assigned to a patient can be used to measure patient access to timely surgery. Table 2.6 compares the distribution of elective surgery admissions by clinical urgency category in the ACT with Australia’s median results.

Table 2.6: Percentage distribution of elective surgery admissions by clinical urgency category, public hospitals, 2008-09

<table>
<thead>
<tr>
<th>State</th>
<th>Category 1 (%)</th>
<th>Category 2 (%)</th>
<th>Category 3 (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>28</td>
<td>50</td>
<td>22</td>
</tr>
<tr>
<td>Australia (median)</td>
<td>30</td>
<td>38</td>
<td>31</td>
</tr>
</tbody>
</table>

Note: percentages do not add to 100% due to rounding.

Source: Commonwealth Department of Health and Ageing.\(^{15}\)

2.33 In the ACT, the combined Categories 2a and 2 have the largest percentage of patients, and this may contribute to long delay to access to surgery for these patients.

2.34 The percentage of elective surgery admissions within the recommended time by clinical urgency category is a useful performance indicator for accessibility and timeliness of services. The ACT performance compared to Australia median in 2008-09 is outlined in Table 2.7.

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\(^{14}\) Australian Bureau of Statistics (ABS) defines ‘median’ as ‘one of the three measures of central tendency. A median is the middle score that separates the higher half of a data set from the lower half. It looks at the mid point of a set of data when the numbers are ordered numerically.’ (ABS website 1332.0.55.002 – Statistics Language!, 2008)

\(^{15}\) Commonwealth Department of Health and Ageing, The State of Our Public Hospital June 2010 Report, page 77. Reference is made to page 77 of this Report for other jurisdictions’ data.
Table 2.7: Percentage of elective surgery admissions seen within the recommended time by clinical urgency category, public hospitals, 2008-09

<table>
<thead>
<tr>
<th>State</th>
<th>Category 1 (%)</th>
<th>Category 2 (%)</th>
<th>Category 3 (%)</th>
<th>Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT</td>
<td>94</td>
<td>45</td>
<td>75</td>
<td>65</td>
</tr>
<tr>
<td>Australia (median)</td>
<td>90</td>
<td>78</td>
<td>93</td>
<td>86</td>
</tr>
</tbody>
</table>

Source: Commonwealth Department of Health and Ageing.16

2.35 Although in the ACT in 2008-09 the number of Category 1 patients admitted within the recommended time was better than other jurisdictions, ACT’s overall performance was significantly below other jurisdictions, especially for Categories 2 and 3.

Analysis of ACT Health’s performance from 2007-08 to 2009-10

Number of people waiting for elective surgery

2.36 Table 2.8 shows the number of people waiting on the public hospitals’ elective surgery waiting lists at the end of the financial years from 2007-08 to 2009-10. The share of patients on elective surgery waiting lists between TCH and the CPH was stable at about 60 and 40 percent respectively in the recent years.

2.37 The number of patients on the elective surgery waiting list at 30 June 2010 increased by 9 percent over the same time in 2009, and by 11 percent since 2008. The significant increases in Commonwealth and ACT Government funding for elective surgery have not led to any reduction in the number of patients on the waiting list, nor the waiting time for most categories.

Table 2.8: Number of people waiting for elective surgery

| Hospital | 30 June 2008 | | 30 June 2009 | | 30 June 2010 | |
|----------|--------------|----------------|----------------|----------------|----------------|
|          | Number | %  | Number | %  | Number | %  |
| TCH      | 2 856 | 60 | 3 019 | 62 | 3 192 | 60 |
| CPH      | 1 935 | 40 | 1 987 | 38 | 2 135 | 40 |
| ACT Total| 4 791 | 100| 4 906 | 100| 5 327 | 100|
| Increase (in number and %) compared to previous year | -- | -- | 115 | 2 | 421 | 9 |

Source: Audit Office based on ACT Health data.

2.38 The number of patients of each clinical urgency category (Categories 1, 2 and 3) at 30 June of 2008, 2009 and 2010 is shown in Table 2.9.

Table 2.9: Number of patients waiting for elective surgery by clinical urgency category

<table>
<thead>
<tr>
<th>Hospital</th>
<th>30 June 2008</th>
<th>30 June 2009</th>
<th>30 June 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cat 1</td>
<td>Cat 2</td>
<td>Cat 3</td>
</tr>
<tr>
<td>TCH (Number)</td>
<td>123</td>
<td>1 863</td>
<td>870</td>
</tr>
<tr>
<td>CPH (Number)</td>
<td>31</td>
<td>803</td>
<td>1 101</td>
</tr>
<tr>
<td>ACT Total (Number)</td>
<td>154</td>
<td>2 666</td>
<td>1 971</td>
</tr>
<tr>
<td>ACT Total (%)</td>
<td>3%</td>
<td>56%</td>
<td>41%</td>
</tr>
</tbody>
</table>

Source: Audit Office based on ACT Health’s data.

2.39 At 30 June 2010, there were more patients waiting for elective surgery in all categories. ACT Health stated in its June 2010 Monthly Report that:

- a total of 9 778 people had elective surgery at ACT public hospitals over 2009-10 and this was three percent below the total for the same period in 2008-09 (10 107 people);
- the 2009-10 total was 162 above the target of 9 667 agreed with the Commonwealth Government under the Stage Three of the Elective Surgery Waiting List Reduction Plan; and
- the total number of surgery provided in 2009-10 exceeded the annual target of 9 648 due to additional activity at TCH and CPH over May and June 2010.17

2.40 ACT Health stated that the growth in number of Category 1 patients in the early part of 2009-10 was related to:

- the slowdown in elective surgery in the first part of the year due to planned response to the H1N1 outbreaks; and
- a lower target set for 2009-10, pending the outcome of contract out arrangements to the private sector and new Commonwealth programs.18

**Elective surgery throughput**

2.41 The number of patients (all clinical urgency categories) who had elective surgery at ACT public hospitals in recent years is summarised in Table 2.10.

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17 ACT Health’s *June 2010 Monthly Report* to the Minister page 4.
18 ACT Health’s *June 2010 Monthly Report* to the Minister page 4.
Table 2.10: Elective surgery throughput and removals from the waiting lists

<table>
<thead>
<tr>
<th>Hospital</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCH</td>
<td>5 336</td>
<td>5 914</td>
<td>5 690</td>
</tr>
<tr>
<td>CPH</td>
<td>4 259</td>
<td>4 193</td>
<td>4 088</td>
</tr>
<tr>
<td>ACT Total</td>
<td>9 595</td>
<td>10 107</td>
<td>9 778</td>
</tr>
<tr>
<td>Increase (+)/decrease (-) in ACT Total from previous year</td>
<td>--</td>
<td>+ 5%</td>
<td>- 3%</td>
</tr>
</tbody>
</table>

Source: Audit Office based on ACT Health’s data.

2.42 ACT Health reported that the increase in access to elective surgery by five percent during 2008-09 compared to 2007-08 was due to:
- additional funding by the ACT and Commonwealth Governments to reduce the number of people waiting for elective surgery (357 operations) through public hospital operating theatres; and
- a total of 155 public patients received surgery in private hospitals under a contract arrangement with ACT Health.  

2.43 The improvement was reversed in 2009-10, with a total of 9 778 patients having had elective surgery at ACT public hospitals, 3 percent below the total in 2008-09. However, the 2009-10 result was above the annual target of 9 667 agreed with the Commonwealth under Stage Three of the Elective Surgery Waiting List Reduction Plan.

2.44 Since the audit, ACT Health advised that over the first five months of 2010-11, total surgical activity at TCH increased by 9.5 percent compared with the 2009-10. This increase in access to surgery is due to the Government’s increased investment in surgical services as part of the National Access Program, with additional theatre resources and additional medical and nursing staff. ACT Health further advised that there was a 22 percent drop in the number of extended wait elective surgery patients from 2 549 to 1 992 in January 2010 to 1 992 in November 2010.

Timeliness of admission of patients

2.45 As shown in Figure 2.1, 65 percent of total patients in ACT public hospitals were admitted within the standard timeframe for their urgency category in 2009-10:
- 93 percent of all Category 1 patients within 30 days (target of 95 percent). However, the 2009-10 result following review by the Audit Office was 88 percent instead of 93 percent reported by ACT Health (details are discussed in next Chapter);
- 44 percent of all Category 2 patients within 90 days; and
- 78 percent of all Category 3 patients within a year.

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20 ACT Health’s June 2010 Monthly Report to the Minister page 4
2.46 There was not any significant trend in the percentage of elective surgery patients admitted within the recommended time in different categories across recent years. Improvement was made in Category 3 but there were declining results in Category 1.

**Median waiting time for all ACT elective surgery patients**

2.47 The median elective surgery waiting times are presented as the number of days within which 50 percent of patients are admitted. It is used to measure the effectiveness of the elective surgery managed by the public hospitals to provide accessible services. Figure 2.2 shows the median waiting time for each category of patients, and the ACT total from 2007-08 to 2009-10.

2.48 The growth in demand for elective surgery in the recent years has made access to surgery in the ACT public hospitals more difficult as indicated by longer waiting time particularly for Categories 2 and 3 patients. This situation is likely to continue until the backlog of long wait patients has been addressed.
**Figure 2.2:** Median waiting time of all categories for 2007-08, 2008-09 and 2009-10

<table>
<thead>
<tr>
<th>Category</th>
<th>2007-08</th>
<th>2008-09</th>
<th>2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>14</td>
<td>14</td>
<td>13</td>
</tr>
<tr>
<td>Category 2</td>
<td>98</td>
<td>101</td>
<td>106</td>
</tr>
<tr>
<td>Category 3</td>
<td>203</td>
<td>172</td>
<td>200</td>
</tr>
<tr>
<td>Total ACT</td>
<td>72</td>
<td>75</td>
<td>73</td>
</tr>
</tbody>
</table>

Source: Audit Office based on ACT Health data.

**GOVERNANCE AND ACCOUNTABILITY FRAMEWORK**

**Governance**

2.49 The Chief Executive of ACT Health has overall responsibility for ensuring regular review of individual hospital performance and compliance with ACT Health’s policies. The performance of surgical services of both public hospitals is managed through the Deputy Chief Executive. TCH’s General Manager and Chief Executive Officer of the CPH or their delegates are responsible for managing surgical services and report to the Deputy Chief Executive.

**Surgical Service Task Force (SSTF)**

2.50 The Terms of Reference (ToR) of the SSTF (October 2006) was to ‘provide strategic direction and clinical leadership for ACT surgical services to achieve highly integrated services, which reflect best national and international standards’. Its ToR (May 2010) states that its functions, among other things, include:

- the development of a network for surgical services to optimise the effectiveness of surgical services;
- the provision of strategic direction and leadership for ACT surgical services to reflect best national and international standards;
- the provision of input into the development and implementation of surgical services plans, policies, processes and related initiatives; and
- coordination with various surgical service committees.
2.51 Other than the senior executives of ACT Health, including the Chief Executive and Deputy Chief Executive, membership of the SSTF comprises of the hospital senior management of TCH and the CPH and Unit Directors of specialties. The SSTF is required to provide reports to the Clinical Council Executive, Clinical Council and Portfolio Executive.

2.52 Audit reviewed the meeting minutes of the SSTF from the period of February 2008 to July 2010 and noted that the SSTF had discussed various issues affecting the management of elective surgery in the ACT, including efficiency of theatres, bed management, inadequate theatre time and staff resources. In recent years, the SSTF provided feedbacks into the development and implementation of policies and management plans for surgical services, such as:

- the proposed policy for management of waiting lists of surgeons who have resigned in January 2010;
- the draft proposal for managing Category 1 RFA forms at TCH issued in February 2010;
- the exiting elective surgery management policy; and

**Reporting framework**

2.53 ACT Health produces the following reports for internal and external performance reporting on elective surgery waiting lists and management purposes:

- weekly elective surgery reports to the Deputy Chief Executive, which are then transmitted to the General Manager of TCH, the Executive Director of Surgical Services and the Chief Executive Officer of Calvary Health Care;
- monthly reports to the Minister on access to elective surgery of ACT public hospitals;
- monthly activity and performance reports to the Executive Finance and Performance Committee, including performance data for elective surgery; and
- quarterly reports on ACT Health Public Performance Report, including performance on elective surgery.  

2.54 Audit considered the performance management reports for elective surgery provide adequate information for managing elective surgery waiting lists.

**CONCLUSION**

2.55 The performance of ACT Health in the management of elective surgery waiting lists in the recent years is below other jurisdictions, and no improvement was recorded for most key performance indicators over time.

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2.56 Significant increases in funding have been provided in the last three years from the Commonwealth and ACT Governments, and total expenses on elective surgery having increased from $68.8 million in 2007-08 to $78.3 million in 2009-10. This led to a five percent increase in the number of patients (10 107) admitted in 2008-09, but fell back to 9 778 in 2009-10 (10 711 planned for 2010-11).

2.57 The current numbers of patient admission for elective surgery were not sufficient to address demand, which is expected to continue to increase. Indeed, as at June 2010, the number of patients waiting for elective surgery was higher for all clinical urgency categories than previous years.

2.58 ACT Health has commenced implementing the new Elective Surgery Access Plan 2010-13. ACT advised that over the first five months of 2010-11 there was an increase in investment in surgical activity (elective and emergency) and that there was an improvement in the number of long waiting elective surgery patients during 2010.
3. RELIABILITY OF ELECTIVE SURGERY WAITING LISTS

INTRODUCTION

3.1 This Chapter examines the ACT Health’s processes in compiling information for elective surgery waiting lists and assesses the reliability of the waiting lists.

KEY FINDINGS

- ACT Health collected and compiled significant data on waiting lists for elective surgery, which are comprehensive and mostly accurate. However, the classification of clinical urgency categories did not always reflect ACT Health’s policy and procedures, and therefore raised doubts on the reliability and appropriateness of the clinical classifications for patients within the waiting list.

- In the absence of required documents, Audit was unable to form a view on the validity of the clinical reclassifications. In particular, Audit found that:
  - in 2009-10, 250 patients in Category 1 were reclassified and a significant number of these reclassifications (97 percent) occurred without documented clinical reasons;
  - unusual movements of patients’ priority changes occurred; for examples, reclassifications (usually a downgrade) of a number of patients’ classification in one day and several changes of a patient’s clinical urgency category within a short period of time; and
  - consistent practice by some doctors to ‘stage’ (downgrade) patients’ clinical urgency category close to the clinical recommended timeframes for these patients. This often followed a request for review by the hospitals.

- Currently, some surgeons manage their own waiting lists instead of using public hospitals’ waiting lists. This, combined with the lack of documented clinical reasons for patient priority reclassifications, can compromise safeguards that ensure patients are treated in accordance with the priority order they presented and within the level of urgency of their respective case in public hospitals’ waiting lists.

- ACT Health’s current Policy does not require patients to be notified of any priority changes nor to be advised of the impact of the changes. It would appear that reclassifications often resulted from internal waiting list management procedures with no or limited involvement from patients.

- There were deficiencies in processing patients on to the elective surgery waiting list. These included:
  - many patients’ consent forms were partially completed by patients, and did not meet the requirement to demonstrate that patients fully understood the information provided by doctors about the nature of the operation, and the material risks inherent in the treatment;
Reliability of elective surgery waiting lists

- the consent forms did not always have a witness’s signature. This may expose ACT Health and the medical practitioners to risks, including potential legal risks and adverse outcomes for patients; and
- Request for Admission (RFA) forms were sometimes kept in the surgeons’ private rooms and not forwarded to the hospital for processing in a timely manner.

- The Surgical Booking team at TCH and the CPH did not routinely review waiting list transactions on a monthly basis as required by the Waiting List Policy. This non-compliance increases the risk of the hospitals not detecting and correcting processing errors on patient information in a timely manner, which may in turn compromise the accuracy of the waiting lists.

ELECTIVE SURGERY PROCESSING SYSTEM

Waiting list processing systems

3.2 From an overall health system perspective, the total time a patient waits for treatment is from the date the General Practitioner (GP) refers the patient to a specialist, until the date the patient is admitted to hospital. It generally comprises three main elements:

- waiting to see the specialist - the patient may be seen in the specialist’s private room or in the hospital’s Outpatient Departments (OPDs);
- establishing whether treatment is required. In some cases, a specialist might require tests or diagnostic procedures to be carried out before determining what treatment, if any, is required; and
- waiting for elective surgery – the time the patient waits from being placed in the elective surgery waiting lists for treatment until he/she is admitted to hospital.

3.3 Information on the waiting time for a patient to see a specialist in the specialist’s private room was not available. This waiting time is outside the control of ACT Health and does not impact on the allocation of clinical categories which are based on the clinical status of the patient when they are seen by the specialist. Audit was advised that this time can be substantial, (in the order of a few months or more), unless the GP seeks priority consideration for more seriously ill patients. The waiting time between GP referrals and a consultation at an outpatient clinic in the hospitals and the management of the Central OPD waiting lists are discussed in Chapter 6.

3.4 The Central OPD is located in The Canberra Hospital (TCH) and includes the surgical and medical (non-surgical) specialties.

3.5 Figure 3.1 outlines the processes for listing a patient in the ACT public hospitals’ elective surgery waiting lists.
3.6 If a surgeon recommends an elective surgical procedure to a patient, this specialist sends a Recommendation for Admission (RFA) form to a public hospital with a clinical urgency category assigned by the surgeon. This clinical urgency category is required to be based on the seriousness of the patient’s condition. At the patient’s choice, the RFA form can be sent to TCH or the Calvary Public Hospital (CPH) for processing. Counting of elective surgery waiting time of a patient starts when the RFA form, duly prepared and approved by the surgeon, has been
received and registered by the hospital’s bookings office. Calculation of elective surgery waiting time starts on the date when the patient is added to the hospital’s waiting list (listing date).

3.7 The Waiting List Policy (section 1.5) requires the referring doctors to forward the RFA form direct to the hospital within three working days of seeing the patient.

3.8 Each hospital’s booking staff members are required to comply with ACT Health’s Waiting List Policy to record and process patients’ details and waiting lists. The Policy states:

- the RFA form must be complete, accurate, legible and date stamped. The hospital is not obliged to add a patient to the waiting list if information is incomplete;
- patients should be added to the waiting list within one working day upon receipt of the form;
- patients must be fully informed and have consented to the treatment offered. The patient’s consent should be obtained in writing by the referring doctor prior to placing the patient on the waiting list and not deferred to the time of admission or pre-admission clinic; and
- a RFA form will not be accepted if at the time of lodgement the patient is ‘Not Ready for Care’ for personal reasons.

3.9 Each hospital uses a different electronic record system to process patients’ details and manages its own elective surgery waiting lists. TCH uses the ACTPatient Administration System (ACTPAS) to record elective surgery waiting lists. ACTPAS can generate surgeons’ waiting lists for all patients in five clinical urgency categories (Categories 1, 2a, 2, 3a and 3). The CPH uses the Waiting List Module of the Patient Administration System (IBA) to record patient details and waiting lists. The CPH’s IBA can only produce reports on waiting lists in three clinical urgency categories (Categories 1, 2 and 3).

3.10 The CPH has developed a procedural manual to assist its surgical booking staff in their daily work processes. There is no written procedural manual for TCH booking staff.

Communications with patients and GPs

3.11 Each hospital has an Elective Surgery Coordinator who is responsible for coordinating with patients and their GPs. When patients are included on the waiting lists, they are informed by a standard letter, accompanied by a pamphlet titled Access to Elective Surgery – Information for consumers on ACT elective Surgery Waiting List. The Policy requires this notification to be sent to the patient within ten working days of receipt of the RFA form.

3.12 The standard letter provides patients with information on their clinical urgency category and other general information regarding the choice between being a public or private patient in a public hospital. Even though public patients do not have the right to choose their doctor, they would have a choice to wait for surgery with a specific surgeon. However, private patients in a public hospital could have
their surgery performed by their chosen surgeon subject to fees charged by their surgeon and other specialist doctors. Under the Australian Health Care (Medicare) Agreement with the Commonwealth Government, access to public hospital facilities must be based solely on the clinical urgency of the patient, not whether the patient elects to be admitted as a private patient.

3.13 Patients (or their GPs) could contact the Elective Surgery Coordinator enquiring about their status of waiting time for surgery and other matters, such as a request for transfer to another surgeon if their clinical condition deteriorates or they have been waiting too long for surgery. In such circumstances, patients are advised to consult with their GP who will refer them to another surgeon or specialist, seeking an upgrade in priority.

3.14 ACT Health has posted the latest information on surgeon waiting times and operating sessions for all surgeons operating at TCH and the CPH on its website. Searches can be made by specialty or individual surgeon.

**Pre-admission clinic and admission**

3.15 When a patient’s surgery date has been allocated, each hospital’s Surgical Bookings Team informs the patient when they should come to the hospital to attend the Pre-Admission Clinic and for admission for surgery, and manages any unexpected postponements by the patient or the hospital. The Team also liaises with the surgeons seeking their approval of the surgical lists and with the theatres regarding any special equipment needed for certain patients.

‘Not Ready for Care’ Patients

3.16 Patients could be placed as ‘Not Ready for Care’ (NRFC) at any point in their waiting period. ACT Health’s Waiting List Policy defines a NRFC patient as a patient who is not available to be admitted to hospital until some future date, and is either:

- staged (not ready for clinical reasons); or
- deferred (not ready for personal reasons).

3.17 The Surgical Bookings Team is required by the Waiting List Policy to actively manage patients’ NRFC status to ensure they become ‘Ready for Care’ or are removed from the waiting list. The reasons for staging and deferring a patient must be recorded on the patient’s electronic waiting list and on the RFA form.

**Transfer of patients between TCH and the CPH**

3.18 The two hospitals independently manage their waiting lists due to incompatibility of the electronic waiting list systems. If a patient requests a transfer between the two hospitals, each hospital’s Elective Surgery Coordinator coordinates to physically transfer the patient’s RFA form and other related documents to the receiving hospital. This practice makes the transfer of patients between the two hospitals less efficient.

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3.19 The lack of an integrated database between the two hospitals combined with the absence of a single waiting list across the ACT, can impact on the efficiency and effectiveness of management of surgical waiting lists. ACT Health advised Audit that the CPH plans to implement ACTPAS within the next eighteen months to establish a single waiting list across the ACT.

**Recommendation 1**

ACT Health should progress the development of a single waiting list by integrating the two hospitals’ databases to better manage the waiting list across the ACT.

**EFFECTIVENESS OF IMPLEMENTATION OF WAITING LIST POLICY**

**Implementation of waiting list policy**

3.20 In accordance with ACT Health’s current *Waiting Time and elective Patient Management Policy* issued in October 2007 (Waiting List Policy), processing patient records on the electronic system is required to ensure that (sections 1 to 3):

- a patient’s Request for Admission (RFA) form is complete, accurate, legible and date stamped. The RFA form should be completed by the referring doctor who is currently contracted with ACT Health and appropriately credentialed with the Clinical Privileges Committee;
- any requirements for variations from standard bookings are met;
- a patient is listed on the electronic record system within one working day of receipt of the RFA form;
- data is accurately entered on the electronic waiting list; and
- the patient’s written consent is obtained, preferably prior to placing the patient on the waiting list and not deferred to time of admission or pre-admission. The patient must be fully informed and has consented to the treatment offered.

**Examination of selected patient cases**

3.21 Audit tested the implementation of the ACT Health’s Policy by examining hospital records for a number of patients at The Canberra Hospital (TCH) and the Calvary Public Hospital (CPH). In total, 68 patients selected from four specialties, including General Surgery, Ear, Nose and Throat (ENT), Orthopaedics and Urology because of their long waiting times for elective surgery. Audit’s examination of these patients’ records focused on whether:

- the patient’s information was accurate, correct and timely; and
- the reclassification of patient’s clinical urgency category was made in accordance with the Policy.

**Accuracy, correctness and timeliness of processing**

3.22 Of the 68 patients’ records examined, Audit noted:
63 percent of RFA forms were not accompanied by a properly completed patient consent form;

35 percent of patients’ consent forms did not have witness signature;

ten percent of the RFA forms were not dated or did not include the treating doctors’ signature or date;

six percent of the forms were incomplete or illegible;

three percent RFA forms were not processed within the required timeframe by the booking Office and the Surgical Booking Team; and

three percent of the RFA forms were not forwarded to the hospital within the timeframe required by the Waiting List Policy (within three working days).

**Timeliness of submission of patient’s RFA form by the referring doctor**

3.23 Examples where the patients’ RFA forms were kept in the surgeons’ private rooms and not forwarded to the hospital for processing in a timely manner are outlined below.

**Examples of delays in submission of the RFA forms by doctors**

**Case One**

A patient rang the hospital’s Bookings Office on 28 January 2010 seeking information regarding the waiting time status since the patient went to see a surgeon (in the surgeon’s private room) in January 2009. The Bookings Office found that the patient’s RFA form was received by the hospital on 11 January 2010, about one year after the visit to the surgeon. The surgeon reclassified the patient’s clinical urgency category from a Category 2a to Category 1 in March 2010 on medical reasons. The patient was admitted to hospital in May 2010.

**Case Two**

A patient went to see an Orthopaedic surgeon in November 2009 in the surgeon’s private room. The patient’s RFA form was received by the hospital and listed in March 2010. To be fair to the patient, the hospital had back-dated the listing date to December 2009.

3.24 Delays by surgeons in forwarding the appropriate paperwork to the hospital within a reasonable time had adversely impacted on the patients’ waiting time for elective surgery. This could have adverse impact to patients’ health outcome. Although in some circumstances, as in Case 2 above, the hospitals can make reasonable decisions to back-date the patient’s listing date to correct the delays, this approach also impacts on other people who had been on the waiting lists earlier than the patient in question and their expected surgery date would be delayed to allow priority to this patient.

**Completeness and legibility of the RFA forms**

3.25 RFA forms used by TCH and the CPH differ in design and format. The use of standardised form by both hospitals would encourage consistent completion of required information and facilitate transfer of patients between hospitals.
Patients’ consent

3.26 ACT Health’s Consent to Treatment Policy and related Procedure states that a valid informed consent should satisfy four elements:

- the patient is competent to give consent;
- full information on risks, benefits and alternatives has been provided to the patient;
- patient consent is freely given; and
- the patient’s consent is specific to the procedure.  

3.27 Generally, the law requires medical practitioners to exercise their duty of care in relation to their patients. Better practice suggests that patients must be provided with sufficient and material information to have a genuine understanding of the nature of operation, procedure or treatment. Failure to warn a patient about the material risks inherent in a proposed procedure is a breach of the medical practitioner’s duty of care to the patient and could give rise to a legal action for negligence.

3.28 A failure by the patients (unless there is an emergency) to clearly indicate their consent may expose ACT Health and medical practitioners to legal challenge regarding whether the patients’ consent was valid and informed. There may also be legal risks if the consent forms were not properly signed by a witness. Additional guidelines to medical staff may assist them to understand the process.

Audit comment

3.29 Notwithstanding the weaknesses discussed at paragraphs 3.22 to paragraph 3.28, Audit considered that patients’ information contained in the RFAs and recorded in the hospitals’ systems was generally accurate and complete.

3.30 Audit understands that RFA and patients’ consent forms are being under review by ACT Health.

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Recommendation 2

ACT Health should:

(a) review and revise the hospitals’ Request for Admission (RFAs) forms and patient’s consent form to ensure that standardised forms are used by both public hospitals;

(b) provide additional guidelines to medical staff to ensure that patients’ consent forms are properly completed and witnessed; and

(c) provide additional information to, and seek commitment from, doctors and surgeons, for improvements in the timeliness of lodging RFAs to the hospitals.

PROCESSING CONTROLS AND CLERICAL AUDITS

Elective surgery policy

3.31 The Waiting List Policy (section 6) requires each hospital to conduct clerical reviews of the waiting lists. The Waiting List Policy requires:

- a monthly review by the surgical booking staff to review the electronic waiting list against the RFA forms;
- a monthly audit by each hospital’s Elective Surgery Coordinator on a selected specialty; and
- an annual review of the audit process should be conducted by ‘the staff responsible for waiting list management’.

Review by surgical booking staff

3.32 The monthly clerical review aims to ensure the waiting list is accurate, valid and complete by:

- ascertaining whether patients have already had their procedure or treatment;
- checking for duplicate bookings;
- ensuring the correctness of assigned clinical urgency category;
- updating ‘Status Review Date’ for ‘Not Ready for Care’ and deferred patients within six months; and
- ensuring postponed or cancelled patients are re-scheduled for next available theatre session in consultation with treating doctors.

3.33 The Waiting List Policy requires surgical booking staff to maintain adequate documentation and provide a clear audit trail for validation of any changes made to a patient’s booking on the electronic system and the RFA form or relevant designated form. The result of the monthly review by the surgical booking staff must be provided to the unit manager.
3.34 Audit noted monthly review by the surgical booking staff had not been conducted in recent years in either hospital. TCH and CPH Surgical Bookings Office staff advised that resources had not been available to conduct the reviews.

**Audit by Elective Surgery Coordinators**

3.35 Each hospital’s Elective Surgery Coordinator selects a specialty or several specialties for the monthly audit of the elective surgery waiting lists in order to cover all specialties twice in a year. The audits were conducted by sending letters to selected long waiting patients on waiting lists and followed up by phone contact. The results of the monthly audits were reported to ACT Health Elective Surgery Access Manager outlining the timing of the audits, number of patients contacted (by letters and phone contacts), and total number of patients removed from the waiting lists. The reasons for removals included ‘no longer required surgery’, ‘had operations elsewhere’ and ‘un-contactable or deceased’.

3.36 Table 3.1 includes a summary of the results of the audits performed by the Elective Surgery Coordinators in 2008, 2009 and 2010 (January to July), the number of patients removed from the waiting lists decreased from 523 (16.5 percent of total patients audited) in 2008 to 366 (11.8 percent) in 2009. For the first seven months of 2010, the number of patients removed from the waiting lists already reached 388, suggesting that the waiting lists require regular monitoring to ensure their accuracy. The main reasons cited for removals were ‘no longer required by patients’ and ‘had operations elsewhere’.

**Table 3.1**: Results of audits by Elective Surgery Coordinators 2008 to July 2010

<table>
<thead>
<tr>
<th>Year</th>
<th>Total number of patients audited</th>
<th>Total number of patients removed from the waiting lists</th>
<th>Removal reasons</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>No longer required</td>
</tr>
<tr>
<td>2008</td>
<td>3 171</td>
<td>523</td>
<td>280</td>
</tr>
<tr>
<td>% of removals to total patients audited</td>
<td>--</td>
<td>16.5</td>
<td>8.8</td>
</tr>
<tr>
<td>2009</td>
<td>3 102</td>
<td>366</td>
<td>204</td>
</tr>
<tr>
<td>% of removals to total patients audited</td>
<td>--</td>
<td>11.8</td>
<td>6.6</td>
</tr>
<tr>
<td>2010 (Jan. to July)</td>
<td>3 913</td>
<td>388</td>
<td>202</td>
</tr>
<tr>
<td>% of removals to total patients audited</td>
<td>--</td>
<td>9.9</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Note: * Reasons for ‘Other’ was not captured in the audit results and would relate to patients’ surgery performed as emergency surgery or system errors found during the audits.

Source: Audit Office based on ACT Health data.
Audit comment

3.37 The audits conducted by the Elective Surgery Coordinators were an effective way to update the elective surgery waiting lists and patients’ status.

3.38 However, as only selected specialties are audited each month, the Elective Surgery Coordinators’ audits were not able to rectify errors to other (non-audited) specialties. A routine clerical review by surgical booking staff on regular interval would reduce the risk of processing errors such as those found in the Audit’s sampling tests (discussed in paragraph 3.22) and hence reducing the risks of having incorrect and incomplete information in the waiting lists.

Recommendation 3

ACT Health should, in consultation with each hospital, implement and monitor the regular conduct of clerical reviews by surgical booking staff to mitigate the risks of processing errors in the electronic waiting lists.

RECLASSIFICATION OF CLINICAL URGENCY CATEGORY

Policy

3.39 The initial RFA form submitted by a treating doctor to TCH or the CPH is required to have a clinical urgency (or priority) category assigned by the doctor based on the doctor’s clinical assessment. The ‘Advice for Referring and Treatment Doctors’ provides a reference list to all treating doctors of recommended clinical urgency categories for each specialty.

3.40 Reclassification of a patient’s clinical urgency category is subject to ACT Health’s Waiting List Policy (section 1.2). In particular:

- documentary evidence must be readily available to validate any changes to priority category and must be part of the RFA form and patient’s medical record;
- documentation must be signed by the relevant staff member (in the Surgical Bookings Office) and include date and time of notification of priority change;
- the person notifying priority change and reason for priority change must be shown;
- an authorised doctor should only undertake reclassification of patients between Categories 1, 2 and 3; and
- the electronic waiting list must be updated with any changes.

3.41 Audit considers that the Policy concerning reclassification of patients’ clinical priority is sound. Some aspects of the above Policy, however, were not well defined and subject to various interpretations. For example, ‘the person notifying priority change’ may refer to a person other than the treating doctor and the ‘reason’ for change may include any reason other than ‘clinical related’ reason. The Waiting List Policy (section 4.2) refers to clinical review of patients on the
waiting lists by doctors to ensure that their waiting time is appropriate for their clinical condition and to determine any change in clinical urgency category.

3.42 Audit considered that the following key requirements needed to be met for a valid reclassification of a patient’s clinical urgency category:

- only doctors can approve a priority change;
- reclassification must be supported by documentary evidence and a ‘clinical’ reason; and
- the change must be documented in the electronic system and on the relevant RFA form which will become part of the patient’s medical record.

Communication with surgeons regarding category reclassifications

3.43 The current Waiting List Policy, among other things, requires that:

- surgeons who add a Category 1 patient to the waiting list must ensure they are available to perform the surgery within the 30-day period. Alternatively, the surgeon should make arrangements for another surgeon to perform the surgery within the appropriate timeframe; and
- the Executive Director, Surgical Services should communicate with the referring doctor to discuss other options if the procedure/treatment cannot be undertaken within clinical priority timeframes.

3.44 One option available is to downgrade the patient’s urgency category with a later scheduled surgical booking date, if clinically appropriate.

3.45 Audit was advised that the following practices are adopted by the surgical booking staff when more Category 1 patients are received from a particular surgeon than can be accommodated in the surgeon’s scheduled operating time:

- the surgeon is asked to advise of his/her availability to take up extra operation sessions to accommodate these patients;
- the surgeon is requested to clinically prioritise his/her Category 1 patients in order of clinical urgency so the patients could be booked as such;
- if the hospital is still unable to book the Category 1 patients for elective surgery within 30 days, the referring surgeons or registrars would be consulted regarding the earliest possible date they could be accommodated in the surgeon’s scheduled operating time; and
- if the surgeon approves the proposed date without clinically compromising the patients, and if the proposed surgical day is outside the 30 day timeframe, the surgeon or registrar would be asked to approve the procedure as a ‘staged’ procedure. This means the hospital would guarantee this proposed surgical date, and the patient is reclassified, generally as a Category 2a clinical urgency priority.

3.46 Many surgeons would agree to the above process. In other cases, without the approval of the referring surgeons, the patients will not be re-categorised and remain as Category 1 patients.
In early 2010, The Canberra Hospital developed a draft proposal to managing Category 1 patients in TCH to address situations where ACT Health believed that surgeons resisted or refused requests to downgrade the category even when it was obvious that the condition had been inappropriately categorised. Under this proposal:

The surgeon will be asked to re-categorise patients that cannot be accommodated within 30 days in their routine sessions as a ‘staged 2a’ procedure that will be performed on an agreed date within the 60 day period. If the referring surgeon refuses to rank patients then the Clinical Director will do so.

Audit understands this draft proposal has not been finalised due to a lack of support from surgeons.

**Review of ACT Health’s accountability indicator on Category 1 patients**

ACT Health reports its performance regarding elective surgery in its annual Statement of Performance. Accountability indicator 1.1c, under Output Class 1.1 Acute Services, is ‘Percentage of Category 1 elective surgery patients who receive surgery within 30 days of listing’. The target for 2009-10 was set at 95 percent which was the national benchmark standards for waiting times for access to elective surgery for Category 1 patients.26

In 2009-10, ACT Health reported that it had achieved 93 percent against the indicator.

As part of the review of ACT Health’s 2009-10 Statement of Performance, Audit reviewed all Category 1 patients from all specialties whose clinical urgency category had been reclassified from Category 1 to Category 2 during 2009-10. In all, 259 Category 1 patients’ reclassifications were examined. Audit found that:

- nearly all patients’ priority changes (252 out of 259 patients’ records examined or 97 percent) were not supported by any documented reasons; and
- only 177 reclassifications (or 68 percent) were evidenced as having been approved by a doctor (i.e. 55 reclassifications – or 32 percent - had no evidence of having been approved by a doctor).

Consequently, the reviewed result against the accountability indicator is summarised in Table 3.2.

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26 ACT Health, 2009-10 Annual Report, pages 93 and 94.
Table 3.2: Reported results of accountability indicator 1.1c in ACT Health’s Annual Report for 2009-10 (Percentage of Category 1 patients who receive surgery within 30 days)

<table>
<thead>
<tr>
<th>Accountability indicator 1.1c</th>
<th>Original target 2009-10</th>
<th>Actual results 2009-11</th>
<th>Variance from original target</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACT Health’s reported result</td>
<td>95%</td>
<td>93%</td>
<td>2% less than the target</td>
<td>(1)</td>
</tr>
<tr>
<td>Result reviewed by Audit Office</td>
<td>95%</td>
<td>88%</td>
<td>7% less than the target</td>
<td>(2)</td>
</tr>
</tbody>
</table>

Notes: (1) This result is based on the total number of Category 1 patients, excluding patients reclassified to a lower category with the authority of the doctor.
(2) This result is based on the total number of Category 1 patients, excluding patients reclassified to a lower category with the authority of the doctor (but without a written reason provided by the doctor for the reclassification other than the doctor’s decision).

Source: ACT Health Annual Report 2009-10.27

Review of category changes

3.53 Audit’s discussion with the hospitals’ Surgical Bookings Teams indicated that the following operational practices were generally adopted in the processing of priority changes:

- upon receipt of advice from doctors or doctors’ rooms for reclassifications (usually by email, letter or phone contact), the changes were recorded in the electronic systems and the RFA forms. For TCH patients, the RFA forms were sent to the Medical Record Department for scanning on TCH’s electronic medical record system; and
- if doctors visited the Surgical Bookings Team and gave an instruction to change patients’ clinical urgency priority, the booking staff usually asked the doctors to initial the RFA forms adjacent to the new re-assigned category.

3.54 The result of the examination of selected patients’ reclassifications discussed in paragraph 3.21 revealed that the majority of the priority changes did not comply with the current Waiting List Policy since there was no documented (clinical) reason to support the reclassifications.

3.55 Audit’s discussion with the Surgical Bookings Teams identified that some doctors preferred to manage their own waiting list instead of using the public hospitals’ waiting lists. They would determine their surgical list and advise the Surgical Bookings Office to follow up with the pre-admission and admission procedures.

3.56 Such practices adopted by some surgeons do not comply with ACT Health’s procedures. This could remove safeguards that aim to ensure patients are treated in the priority order in accordance with the order they presented and within the level of urgency of their respective case in public hospitals’ waiting lists. In

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particular, such practices allow surgeons to change priority or add new patients on the operating list without the need for clinical justification.

3.57 Until ACT Health implements a new arrangement agreed with surgeons regarding classification and recategorisation of clinical urgency category, it is unlikely that the policy intention of ACT Health’s Waiting List Policy to promote ‘clinically appropriate, consistent and equitable management of elective surgery waiting lists’ will be achieved.

Inconsistent practices in processing priority changes

3.58 There were shortcomings in the current practices of processing changes in patient priorities on the waiting list. These included:

- the procedures adopted by the booking staff in making changes to patients’ clinical urgency category did not always comply with the Waiting List Policy;
- inconsistent practices being adopted by different booking staff in each hospital and between TCH and the CPH. For example, some staff recorded the changes in the electronic system and the RFA form but some staff only recorded the changes in the electronic system;
- a lack of designated form for the doctors to authorise the priority change and document the reason of change. This may contribute to inconsistent practices in managing and processing priority changes;
- insufficient procedural guidance for booking staff. A manual had been developed for the CPH, but there was no equivalent document for TCH; and
- on-the-job training for new staff at TCH reflected current practices, rather than procedures required by the Policy.

3.59 Audit noted that ACT Health has recently developed a draft form for doctors to document reclassification of patients’ clinical urgency category.

3.60 Audit also was advised that the CPH will adopt the same electronic system (ACTPAS) currently used in TCH within the next eighteen months. A procedural manual will facilitate uniform practices between the public hospitals.

Recommendation 4

ACT Health should, in consultation with each hospital:

(a) develop a comprehensive procedural manual for surgical bookings in line with ACT Health policy; and

(b) provide adequate training to booking staff to ensure consistent and correct practices and procedures are being adopted.
Unusual movements of patients’ clinical urgency category

3.61 Audit analysed data for March and June 2010 and found instances of unusual movements of patients’ clinical urgency category. For example, doctors from the Urology unit in TCH had reclassified several patients’ clinical urgency category in one day. Examples of these changes are outlined in Table 3.3.

Table 3.3: Examples of unusual movements of patients’ clinical urgency category

<table>
<thead>
<tr>
<th>Department</th>
<th>Date of reclassification</th>
<th>Number of patients reclassified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urology</td>
<td>10 March 2010</td>
<td>25</td>
</tr>
<tr>
<td>Urology</td>
<td>19 March 2010</td>
<td>5</td>
</tr>
<tr>
<td>Urology</td>
<td>2 June 2010</td>
<td>7</td>
</tr>
<tr>
<td>Urology</td>
<td>24 June 2010</td>
<td>3</td>
</tr>
</tbody>
</table>

Source: Audit Office.

3.62 Audit noted that the most patients were downgraded either from Category 1 to Category 2a or from Category 2a to Category 2. The reasons for these reclassifications were not documented. However, Audit noted that the priority changes were made when the patients’ waiting time had reached recommended surgery time of their initial clinical urgency category or close to the reporting period (census date).

3.63 Audit review of several patients’ priority changes showed that their clinical urgency category was reclassified within a short period of time sometimes more than once. Examples are outlined below.

Examples of patients’ frequent movements of priority changes

**Patient 1**

On 17 March 2010, a Urologist ‘upgraded’ the patient as a Category 1. On 22 March 2010, the patient’s clinical urgency category was downgraded to Category 2a with no record of who authorised the change or the reason for the change.

**Patients 2, 3 and 4**

On 2 March 2010, a Urologist upgraded these three patients to Category 1 with no reason provided in the Urologist’s letter. On 10 March 2010, a doctor in the Urology Department ‘staged’ these patients to Category 2a with no written reason provided.

**Patient 5**

On 25 February 2010, the patient’s clinical urgency category was upgraded by a Urologist from Category 2a to Category 1 with no reason given. On 10 March 2010, a doctor in the Urology Department ‘staged’ the patient to Category 2a with no documented reason provided.
Patient 6

Patient 6 was listed as a Category 2a patient on 8 December 2009. On 21 May 2010, a specialist reclassified the patient’s clinical urgency category to Category 1 on a second RFA form with the same operation description. On 2 June 2010, a doctor in the Urologist Department downgraded the patient to Category 2a without any documented reason. On 25 August 2010, the patient was reclassified to Category 1 again. However, there was no record in the electronic system or the RFA form to indicate who authorised the change or the reason for the change.

Patient 7

A General Surgery patient was listed on 14 May 2010 as a Category 1 patient. A surgeon ‘staged’ the patient to Category 2a on 1 June 2010 for a planned surgery date on 23 June 2010. Due to other urgent cases, the patient’s surgery was again postponed to 21 July 2010.

3.64 In response to the proposed report, ACT Health commented that:

Of all patients reclassified, 48 percent were from Urology, although Urology comprised only 10 percent of total elective surgery activity. All but one of the specific examples cited above relate to urology patients.

Urology was a specialty area under significant pressure following the resignation of one of the four urologists in April 2009 and difficulties in recruiting replacement Urologists. Given this pressure it is understandable that there was a need to review the categorisation of patients regularly. Since March 2010, ACT Health has recruited three more Urologists, and as a consequence this has seen the number of urology patients with extended waiting times drop from 592 patients in March 2010 to 245 patients by the end of November 2010, a drop of almost 60 percent.

The report, however, does not provide this context, and consequently risks creating the impression that the experience in one speciality at a time of particular pressure can be generalised to the experience of elective surgery waiting list management overall.

Audit comment

3.65 The reason for reclassification of priority category for the patients was often not documented. Audit was therefore unable to form a view on the validity of these changes.

3.66 However, the urgency category changes examined by Audit suggest that some doctors adopt the practice of staging (downgrading) patients’ clinical urgency category close to the recommended timeframes for the patients. Such practices were also confirmed by advice to Audit from some surgeons. Given the long delay in other categories, some surgeons have allocated their patients to Category 1 as a means to get the patient ‘onto the system’ for more timely treatment.

3.67 Audit notes that ‘staging’ is accommodated in the Policy under the ‘NRFC’ provision (sections 4.8 to 4.10). A patient is ‘Not Ready for Care’ if he/she is not available to be admitted to hospital until some future time. ‘Not Ready for Care’ patient is either ‘staged’ (not ready for clinical reasons) or ‘deferred’ (not ready for personal reasons).
3.68 The reasons for staging and deferring patients must be recorded on the electronic waiting list and patient’s RFA form (section 4.9 of Waiting List Policy). The valid reasons for ‘Not Ready for Care’ staged patient may be:

- a co-mobility exists, which until resolved, means the patient is unfit for the proposed treatment;
- a patient requiring treatment as part of periodic treatment, or a staged procedure; or
- a planned re-admission for a patient with a predictable morbid process, requiring periodic treatment of the on-going disease process.

3.69 The Policy specifies that ‘Not Ready for Care’ status is not intended as a method for managing waiting times to meet targets.

3.70 Audit further noted that the Waiting List Policy did not have a requirement for treating doctors or hospital Surgical Bookings Office to advise patients about a change to their priority when the doctors had made a decision to reclassify the patients’ clinical urgency category. The patients’ electronic records examined by Audit showed that the patients had not been notified of the priority change and the impact of the changes. It would appear that the reclassifications often resulted from internal waiting list management procedures with no or limited involvement from patients.

3.71 Although there is no requirement in the Policy to inform the patients, Audit believes appropriate communication with the patients about their priority change may improve transparency and accountability of the process of reclassification. Audit understood that this issue was suggested by doctors in the recent Chief Executive Forum.

**Recommendation 5**

ACT Health should:

(a) ensure that all reclassification of patients’ clinical urgency category are properly documented by an authorised doctor based on sound medical reasons;

(b) enhance controls and procedures in recording reclassifications on the electronic waiting lists and the RFA forms; and

(c) improve accountability and transparency in the priority change processes by advising patients of any category reclassification.
4. ANALYSIS OF ELECTIVE SURGERY WAITING TIMES

INTRODUCTION

4.1 This Chapter examines patients’ waiting times of the four specialties selected for audit.

KEY FINDINGS

- Analysis of the waiting lists of four specialties selected for review and of selected surgeons for these specialties indicated that the estimated waiting times for all patients, except the majority of Category 1 patients, would continue to be well beyond the recommended timeframe and target set by ACT Health and, where relevant, the Commonwealth Government for each category.

ANALYSIS OF WAITING TIME

4.2 Audit performed an analysis of waiting lists for selected specialties and surgeons to determine the estimated waiting time for current patients, and to provide some indicative information on the management of the waiting lists.

4.3 Audit analysis of the estimated waiting times for patients of all categories was based on the assumptions that all surgeons would take up their allocated surgical time and that there would be no postponement of patients’ surgery on the waiting lists. Further, the analysis did not take into consideration other unknown factors, such as availability of theatre time and beds, doctors’ leave, complexity of individual patients’ surgical time, and other resources (human and equipment). Finally, Audit estimates assumed that no more new patients would be added onto the waiting lists.

4.4 Even under these optimum assumptions, there will be extended waiting times for elective surgery patients in most specialties and for most surgeons. The challenges in implementing appropriate strategies to reduce the waiting list and to meet the recommended timeframes for all categories are significant for ACT Health.

4.5 It is essential for ACT Health to enhance its waiting list management and effectively implement its recently developed Elective Surgery Access Plan, if it is to make any significant improvement to the waiting times as discussed below.

Waiting time for selected specialties

4.6 To ascertain how long the patients of the four specialties selected for audit (including General Surgery, Ear/Nose/Throat, Orthopaedics and Urology) are expected to wait to have their surgery, Audit undertaken analysis of patients of these specialties on the waiting lists of all public hospitals as at 31 August 2010. The results of the analysis are summarised in Table 4.1.
Table 4.1: Estimated waiting time for all public patients in each Category as at 31 August 2010

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Number of patients</th>
<th>Total surgical session Note 1</th>
<th>Total number of patients treated Note 2</th>
<th>Estimated additional wait time from 31 August 2010 (Recommended time frame for each category)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Cat 1</td>
<td>Cat 2</td>
<td>Cat 3</td>
<td>Cat 1 (30 days)</td>
</tr>
<tr>
<td>General Surgery</td>
<td>28</td>
<td>343</td>
<td>123</td>
<td>332</td>
</tr>
<tr>
<td>ENT</td>
<td>11</td>
<td>463</td>
<td>569</td>
<td>120</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>8</td>
<td>973</td>
<td>316</td>
<td>65</td>
</tr>
<tr>
<td>Urology</td>
<td>69</td>
<td>397</td>
<td>164</td>
<td>164</td>
</tr>
</tbody>
</table>

Note 1: Total surgical sessions for each specialty were based on the latest information on the allocation of surgical sessions by individual doctors per month from hospitals’ Surgical Bookings Office.

Note 2: Total number of patients treated was based on total surgical sessions multiplied by four (an average of four patients per surgical session).

Source: Audit Office based on ACT Health data.

4.7 Audit also analysed the waiting time for each category of patients of each public hospital (TCH and the CPH). The estimated waiting time for the patients in TCH would be longer compared to the CPH, because of higher number of patients waiting on TCH waiting lists. For example:

- at TCH, ENT Category 2 patients would have to wait 5 months and Category 3 patients for 9.5 months; and
- at the CPH, ENT Category 2 patients would need to wait for 1.2 months and Category 3 patients for 6.6 months.

**Waiting time for selected surgeons**

*Median waiting time*

4.8 Audit also performed similar analysis for selected surgeons from each of the four selected specialties working at TCH.

4.9 Table 4.2 outlines the number of patients in each category and the median waiting times for selected surgeons. The median waiting time (number of days) indicated how long the patients in their relevant clinical urgency priority had been listed on the waiting list of their selected surgeons at 15 October 2010.
Table 4.2: Patients’ median waiting days of selected surgeons at 15 October 2010

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Category 1 (30 days)</th>
<th>Category 2a (60 days)</th>
<th>Category 2 (90 days)</th>
<th>Category 3a (120 days)</th>
<th>Category 3 (365 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Surgeon 1</td>
<td>4 (13 days)</td>
<td>14 (119 days)</td>
<td>6 (80 days)</td>
<td>No patients</td>
<td>No patients</td>
</tr>
<tr>
<td>General Surgeon 2</td>
<td>1 (1 day)</td>
<td>4 (51 days)</td>
<td>36 (153 days)</td>
<td>2 (307 days)</td>
<td>No patients</td>
</tr>
<tr>
<td>Urologist 1</td>
<td>30 (45 days)</td>
<td>56 (359 days)</td>
<td>22 (300 days)</td>
<td>14 (243 days)</td>
<td>5 (382 days)</td>
</tr>
<tr>
<td>Urologist 2</td>
<td>16 (24 days)</td>
<td>92 (347 days)</td>
<td>25 (458 days)</td>
<td>14 (85 days)</td>
<td>9 (108 days)</td>
</tr>
<tr>
<td>Orthopaedics Surgeon 1</td>
<td>2 (13 days)</td>
<td>14 (16 days)</td>
<td>7 (156 days)</td>
<td>6 (102 days)</td>
<td>3 (87 days)</td>
</tr>
<tr>
<td>Orthopaedics Surgeon 2</td>
<td>No patients</td>
<td>24 (93 days)</td>
<td>43 (163 days)</td>
<td>3 (133 days)</td>
<td>8 (317 days)</td>
</tr>
<tr>
<td>ENT Surgeon 1</td>
<td>3 (16 days)</td>
<td>22 (74 days)</td>
<td>192 (157 days)</td>
<td>61 (198 days)</td>
<td>5 (200 days)</td>
</tr>
<tr>
<td>ENT Surgeon 2</td>
<td>No patients</td>
<td>7 (49 days)</td>
<td>12 (186 days)</td>
<td>9 (367 days)</td>
<td>84 (494 days)</td>
</tr>
</tbody>
</table>

* Median waiting days shown was to indicate the middle value of waiting time for each category of patients as per 15 October 2010 waiting list.

Source: Audit Office based on ACT Health data.

4.10 The median waiting time for Categories 2a, 2, 3a and 3 patients was generally well beyond the recommended timeframes of ACT Health and, where applicable, Commonwealth policies. The Categories 2a and 3a are unique to the ACT and not part of the Commonwealth data set.

Estimated waiting time for surgery

4.11 Table 4.3 summarises the results of the analysis of patients’ additional waiting times from 15 October 2010 based on selected surgeons’ waiting lists. The estimated waiting time for each category was calculated based on the same assumption used in Table 4.1.
Table 4.3: Patients’ estimated additional waiting times for surgery by selected surgeons at 15 October 2010

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total number of patients</th>
<th>Total number of patients treated</th>
<th>Estimated additional waiting time from 15 October 2010</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Note 1</td>
<td>Cat 1 (30 days)</td>
</tr>
<tr>
<td>General Surgeon 1</td>
<td>24</td>
<td>16</td>
<td>Within 1 month</td>
</tr>
<tr>
<td>General Surgeon 2</td>
<td>43</td>
<td>16</td>
<td>Within 1 month</td>
</tr>
<tr>
<td>Urologist 1</td>
<td>127</td>
<td>28</td>
<td>Within 1.5 months</td>
</tr>
<tr>
<td>Urologist 2</td>
<td>156</td>
<td>32</td>
<td>Within 1 month</td>
</tr>
<tr>
<td>Orthopaedics Surgeon 1</td>
<td>32</td>
<td>4</td>
<td>Within 1 month</td>
</tr>
<tr>
<td>Orthopaedics Surgeon 2</td>
<td>78</td>
<td>12</td>
<td>No patient</td>
</tr>
<tr>
<td>ENT Surgeon 1</td>
<td>283</td>
<td>32</td>
<td>Within 1 month</td>
</tr>
<tr>
<td>ENT Surgeon 2</td>
<td>112</td>
<td>4</td>
<td>No patient</td>
</tr>
</tbody>
</table>

Note 1  Total number of patients treated was based on the latest information of individual surgeon’s allocated surgical session per month multiplied by four (an average of four patients per surgical session).

Source: Audit Office based on ACT Health data.

4.12 Except for most Category 1 patients, the waiting times for surgery by other category patients of some specialties, such as Urologists, Orthopaedics and ENT surgeons will be unacceptable long, and well beyond the recommended timeframes.
5. MANAGEMENT OF ELECTIVE SURGERY WAITING LISTS

INTRODUCTION

5.1 This Chapter assesses the management of elective surgery waiting lists, in particularly, the implementation of the ACT Health’s Waiting Time and Elective Patient Management Policy issued in 2007 (the Waiting List Policy). The Chapter outlines issues and constraints that impact on the effectiveness of waiting list management, and identifies areas for improvement.

5.2 Audit’s emphasis has been on the operation of The Canberra Hospital (TCH), in view of its greater flow of patients compared to the Calvary Public Hospital (CPH), and greater control and management within the ACT Government’s system.

KEY FINDINGS

- There was a strong consistent view expressed by key stakeholders consulted by Audit, including various medical professions, that the management of waiting lists by the hospitals was not effective in ensuring patients receive surgery within their clinical urgency timeframes. Overall inadequate resources, such as beds, equipment and operating theatre times and some current inefficient practices, had impacted on the effectiveness of patient throughput, and contributed to the delays experienced by patients.

- Implementation of strategies by ACT Health to improve the waiting list to-date has been slow. Other than progress made in the outsourcing of various surgical procedures to private providers in the 2010-11 financial year, there has been limited progress or improvements on other options such as:
  - transfer of patients to other doctors with a shorter waiting list;
  - transfer of patients to another hospital; and
  - increases in theatre utilisation.

- Clinical review of long wait patients was not conducted within the recommended timeframes. Patients or their GP’s often needed to request the hospitals to review their cases after long waits.

- There was a high level of postponement and cancellation of elective surgery (335 in 2009-10 for four selected specialities in the TCH), due to various reasons, some avoidable. The main reasons included substitutions of surgical sessions by higher priority Category 1 and 2 patients and emergency surgery. Other postponements or cancellations that could have been avoided by better planning and management by TCH were due to doctors’ leave (with or without sufficient notice) and the unavailability of equipment.

- Many leave applications from doctors (about 32 percent in TCH and 14 percent in CPH) did not comply with the existing Policy to provide a minimum of four weeks’ notice. Insufficient notice to hospitals makes reallocation of available surgical
sessions to other surgeons difficult and at times impractical. There were no records of patients’ management plans being developed and implemented to minimise the impact on the patients affected by the treating surgeons who took leave.

- Consultants commissioned by ACT Health recently to review surgical services in the ACT (April 2010) and the operations of TCH operating theatres (June 2010) identified many deficiencies in the management of TCH operating theatres that require immediate attention and rectification. ACT Health has commenced actions to address the matters identified, but needs to formalise implementation plans and an appropriate governance and accountability framework to monitor progress and report on outcomes.

- ACT Health has also commenced implementing a new Elective Surgery Access Plan 2010-13 to meet the immediate needs of increasing demand for access to elective surgery and improve elective surgery management. The new plan has set a performance target for each public hospital and an overall target of 10,711 admissions for 2010-11.

EFFECTIVENESS OF POLICY IMPLEMENTATION

Managing patients on the waiting list

5.3 The Waiting List Policy (section 4.19) outlines options for managing the elective surgery waiting lists and these include:

- clinical review;
- transferring patients to another doctor with a shorter waiting list;
- transferring the patient to another hospital;
- increasing theatre utilisation; and
- other options including contracting out to the private sector.

5.4 During discussions and consultation with various key stakeholders, including the representatives from the Australian Medical Association (AMA), Visiting Medical Officers (VMOs) Association and other specialty groups, Audit was advised of their views that there was a lack of overall resources including theatre times, medical staff, and beds in the ACT public hospital system to meet the increasing demand for surgical services. Stakeholders considered a lack of resources and inefficient practices had impacted on the effectiveness of waiting lists management and expressed their concerns about the correctness and reliability of elective surgery waiting lists. Matters identified by these stakeholders included:

- a lack of co-ordinated approach in the management of the operating theatres led to under-utilisation of the theatres and overrun of some surgical sessions that led to cancellation of subsequent surgical sessions;
- late starting and finishing times within the operating theatre units;
- inadequate beds, in particular in the recovery area;
• inadequate equipment and staff, such as availability of trolleys and supporting workers to transport patients, which would cause delays in managing patient throughput, and availability of specialised equipment;
• a lack of flexibility to allocate additional sessions to some surgeons even though they would be willing to operate in the night shifts or during weekends. It was considered that the CPH was more flexible than TCH;
• a shortage in surgeons in some specialities and some surgeons did not want to work in the public hospital system;
• insufficient medical staff, in particular the junior doctors and registrars;
• a lack of communication and planning between hospitals and surgeons, and
• a lack of willingness to learn from, and implement more efficient practices in the private hospitals.

5.5 ACT Health advised that the Government has funded additional resources for the public hospital system over the recent years, including:
• the number of medical officers (including interns, registered medical officers, registrar and senior registrars) increased by 38 percent over the four years to 2009-10, from 276 to 381; and
• additional 19 beds in the public hospitals in 2010-11 on top of the 223 added to the public hospital system over the previous seven years.

Clinical review

Policy

5.6 Clinical review is defined as ‘review of a patient on the waiting list to ensure that their waiting time is appropriate for their clinical condition’. The major objectives of clinical review are to determine whether any change in priority for the procedure has occurred with the resulting need to revise the patient’s clinical urgency category, and whether admission is still required. A clinical review may be initiated by a patient or a GP. A review will be organised by the hospital and conducted by an appropriate clinician, being the treating doctor or delegate, a GP, or a Specialist Consultant or delegate such as a registrar or resident.

5.7 The Policy outlines circumstances that trigger a clinical review. For Category 1 patients, a clinical review is required when a Category 1 patient’s waiting time is greater than 30 days. The hospital should request a clinical review by an appropriate clinician within five working days, which includes a documented ‘Ready for Care’ date and, if necessary, reclassification. The patient and the patient’s GP are to be advised of the outcome of the review.

5.8 A clinical review for Category 2 and 3 patients is triggered after 90 days or 270 days, respectively, or if the patient requests deferment as ‘not ready for care’ for a significant period. The policy provides a preferable timeframe for the conduct of the reviews in each case, but a clinical review is not compulsory. The policy offers no guidance on circumstances regarding whether a clinical review should be conducted once these trigger points have been reached.
Patient review

5.9 Audit testing of patients’ electronic records found several examples where clinical reviews were conducted well outside the timeframes recommended by ACT Health’s Waiting List Policy. For example:

- a patient was listed as a Category 2a on 17 February 2009. The patient’s clinical urgency category was reclassified to Category 1 for the same procedure on 8 June 2010. A clinical review for Category 2 may be triggered when total waiting times exceed 90 days (i.e. 17 May 2009), and preferably the review should occur within 30 days, i.e. by 17 June 2009. It occurred some 11 months later;

- a patient was initially classified as a Category 3 patient on 29 April 2009 and then upgraded to Category 2a on 28 May 2010 after doctor’s clinical review. A clinical review for Category 3 may be triggered at 270 days if the patient has no planned admission date within that timeframe. The preferred timeframe for a review is ‘within 15 working days, but not exceeding 30 days’, i.e. by 23 February 2010. For this patient, the review was conducted 14 months after the initial classification; and

- clinical reviews were often initiated by patients, instead of the hospitals. Audit noted cases where patients contacted Surgical Bookings Office regarding their waiting list status after a long wait and arranged for clinical review. Details are summarised in Table 5.1.

Table 5.1: Examples of clinical reviews initiated by patients

<table>
<thead>
<tr>
<th>Patient</th>
<th>Initial category</th>
<th>Number of total days waiting</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
<td>204</td>
<td>Initial RFA form was listed on 23 November 2009. The patient called Surgical Bookings Office on 22 April 2010 and was advised to seek GP referral to another surgeon for review. The patient was seen by another surgeon and reclassified to Category 2a on 30 June 2010.</td>
</tr>
<tr>
<td>2</td>
<td>3</td>
<td>570</td>
<td>Initial RFA form was listed on 28 November 2008. The patient’s mother rang Surgical Bookings Office on 3 June 2010 and was then advised to seek the treating doctor or GP referral to another surgeon for review. On 25 June 2010, a new RFA form from another surgeon reclassified the patient to Category 2.</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>280</td>
<td>The patient was classified as Category 3 on 26 August 2009 and was then upgraded to Category 2 on 2 June 2010 after clinical review instigated by the patient.</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
<td>436</td>
<td>The patient was listed as Category 3 on 30 March 2009. On 25 February 2010, the patient’s GP rang and was advised to contact the treating doctor or refer to another surgeon for review. On 6 September 2010, a new RFA form from another surgeon classified the patient as Category 2.</td>
</tr>
</tbody>
</table>

Source: Audit Office.
5.10 Audit found insufficient evidence to demonstrate that TCH conducted a clinical review of long wait patients in each clinical urgency category, once the patients’ waiting times passed the relevant trigger point. The above examples indicated that the clinical reviews were, in most cases, initiated by the patients or their GP.

5.11 Audit considers that clinical reviews are a significant aspect of the management of elective surgery waiting lists. It is important that the hospitals take a proactive approach to consider the need to conduct a clinical review of long-wait patients once they have passed the relevant trigger point.

**Recommendation 6**

ACT Health should

(a) clarify the circumstances that warrant a clinical review of patients on elective surgery waiting lists; and

(b) ensure The Canberra Hospital and Calvary Public Hospital conduct regular clinical reviews of patients on elective surgery waiting lists within the recommended timeframes.

**Transferring patients to another doctor with a shorter waiting list**

5.12 The Waiting List Policy (section 4.20) states that the offer to transfer a patient to another doctor with a shorter waiting list has to be:

- determined based on the patient’s individual circumstances (for example, age, available support, physical condition and the required procedure);
- specific with the name of the clinician, hospital and an estimate of the likely waiting period for the new surgeon given; and
- a credible alternative and available if the patient decides to accept the offer.

5.13 The Surgical Service Task Force (SSTF)\(^28\) discussed the pooling or sharing public patients in its October 2008 meeting. The SSTF supported an approach to sharing of long-wait patients by mutual agreement between surgeons (consultants and specialists) but not pooling.

5.14 Audit was advised that the sharing of patients had not been implemented as intended due to a lack of support by surgeons and some other practical issues, for example, the patients’ records were kept in the surgeons’ offices and not in the hospitals if the patients went through the surgeon’s private rooms.

5.15 However, Audit noted that the Surgical Bookings Team usually advised patients to seek their GP referral to another surgeon with a shorter waiting list when patients raised their concerns regarding their long waiting time. Examples of these transfers (or referrals) were discussed in Table 5.1. In these cases, the patients may have to wait for another few months to be seen by another surgeon.

\(^{28}\) The SSTF Terms of Reference and functions were discussed in Chapter 2 (refer paragraph 2.50).
Increasing theatre utilisation

5.16 TCH operates 13 operating theatres to provide elective and emergency surgical services between 8.00 am and 5.00 pm Monday to Friday. TCH is required to balance the competing demands of elective and emergency surgery across its 13 operating theatres. The CPH has seven operating theatres, of which four and half theatres are for public use.

5.17 Audit was advised that there have been some improvements in elective surgery waiting lists as a result of the availability of additional theatres in the recent years. Audit reviewed the operating theatres lists of TCH and the CPH and noted that each specialty was allocated certain spots (in particular days during a week). The Surgical Bookings Teams would allocate sessions that were not taken up by the usual surgeon to other members of the same specialty. However, the Surgical Bookings Teams advised Audit that there was a lack of flexibility to move vacant surgery sessions to other specialties due to resistance by some surgeons. Audit considers the ability and flexibility to reassign free surgery sessions as considered appropriate by the hospitals, when the usual surgeon is unavailable, is an effective management tool to improve waiting list management in elective surgery. This matter needs to be actively pursued and negotiated with the surgeons.

5.18 Further, similar to the practices in other jurisdictions, some operating theatres had been closed down in April and July school holidays in 2009 as ‘part of ACT Health’s management plan to adopt a more measured approach to managing elective surgery activity in 2009-10’. This was in response to higher activity in 2008-09, staff excessive leave as well as budgetary reasons.29 Since not all surgeons took leave in these shut down periods, the unavailability of theatres affected the capacity of some surgeons to perform normal elective surgical sessions and the hospitals to reduce the elective surgery waiting lists. The performance of TCH operating theatres are further discussed later in this Chapter.

Transferring patients to another facility

5.19 Audit noted that ACT Health had negotiated with Queanbeyan Hospital (New South Wales) since April 2008 regarding plans to use its facilities to establish an orthopaedic service at the hospital. Negotiations stalled in early 2009 as the Queanbeyan Hospital had to apply for funding from New South Wales Department of Health.

5.20 ACT Health entered into contract arrangements with private providers to undertake Urological Surgery in March 2009. Due to additional funding from the Commonwealth for elective surgeries to be performed by private hospitals under the Elective Surgery Waiting List Reduction Program, ACT Health has sought expressions of interest from the private providers to provide a range of services in various surgical specialties, when required by ACT Health.

5.21 ACT Health advised Audit that the contract arrangements with two suitable private providers had recently been finalised. One private provider had been

offered work orders in November 2010 to perform 92 surgical procedures for Ear/Nose/Throat (ENT), Urology and Plastic. ACT Health has recently completed negotiation with another provider to include orthopaedic joint work to be commenced in 2011. Procurement for a third private provider is being processed and is expected to commence contracted surgical work on General Surgery and ENT.

**Audit comment**

5.22 Audit noted that in recent times ACT Health has made good progress in engaging private sector providers to undertake elective surgery procedures in order to reduce long waiting patients. However, the implementation of other policies outlined in paragraph 5.3 to prevent patients from having to wait past clinical priority timeframes, have not been managed effectively.

5.23 Audit understands that effective implementation of these options relies on cooperation from surgeons. It is therefore important that ACT Health has robust and effective process in place for regular, on-going communications, discussions and negotiations with surgeons to achieve better outcomes for patients.

**Recommendation 7**

ACT Health should, in consultation with the doctors, implement strategies as outlined in its Policy to avoid elective surgery patients waiting longer than their clinical urgency timeframes. This includes the options of transferring patients to other doctors with a shorter waiting list, transferring patients to another hospital and increasing theatre utilisation.

**Absence on leave of Medical Officers**

5.24 Audit reviewed a sample of Visiting Medical Officers’ contracts and noted that all contracted medical officers would be eligible for twelve weeks annual leave and two weeks conference leave.

5.25 ACT Health’s Waiting List Policy (section 7) requires doctors to provide as much notice of intended leave as possible (minimum four weeks), (the exception is for unplanned leave such as sick leave). Doctors are also required to develop and implement an appropriate patient’s management plan for affected patients (those who already had a planned admission or their clinical urgency category has exceeded the recommended timeframe during the leaving period).

5.26 Audit reviewed 91 leave applications from doctors from the four specialties selected for audit (including General Surgery, ENT, Orthopaedics and Urology), who worked at TCH and the CPH for the periods from early 2009 to September 2010. Audit found that 24 percent of total selected leave applications did not comply with the Waiting List Policy to be submitted with a minimum of four weeks’ notice. The results are summarised in Table 5.2.
**Table 5.2: Non-compliance of doctors’ leave applications with ACT Health’s Policy**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Number of leave applications reviewed</th>
<th>Number of leave applications without four weeks’ notice</th>
<th>Percentage of non-compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>TCH</td>
<td>47</td>
<td>15</td>
<td>32%</td>
</tr>
<tr>
<td>CPH</td>
<td>44</td>
<td>6</td>
<td>14%</td>
</tr>
<tr>
<td>Total</td>
<td>91</td>
<td>21</td>
<td>23%</td>
</tr>
</tbody>
</table>

Source: Audit Office.

5.27 Overall, 23 percent of doctors’ leave application forms examined did not satisfy the minimum requirement of four weeks’ notice in accordance with the Waiting List Policy. Results at CPH were much better than TCH because CPH had a system in place to send quarterly reminders to doctors for submission of leave applications, if leave was planned. Audit understands that patients’ management plans were not usually developed when the treating surgeons were on leave. There was no follow-up process or strategies to improve the current situation.

**Recommendation 8**

ACT Health, in conjunction with the doctors, should develop and implement systems and procedures to manage more effectively doctors’ leave and patients’ management plans, to ensure that surgical needs of affected patients have not been compromised.

**Postponement and cancellation of surgery**

5.28 Audit analysed TCH data for the 2009-10 financial year and examined the reasons for the 336 postponements and cancellations of surgery for the four selected specialties.

5.29 Other than doctors’ leave, Audit identified other reasons for postponement or cancellation of patients’ treatments or admissions. The reasons were broadly classified by Audit as ‘avoidable’ and ‘unavoidable’ and the results are outlined in Table 5.3. (For the purposes of this audit, ‘avoidable’ means that more effective management by the hospitals, including better planning, coordination, communication with the doctors, could avoid these postponements and cancellations).
Table 5.3: Reasons for postponement and cancellation of patients’ surgeries during 2009-10

<table>
<thead>
<tr>
<th>Reasons</th>
<th>General Surgery</th>
<th>ENT</th>
<th>Orthopaedics</th>
<th>Urology</th>
<th>Percentage to Total (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avoidable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>List overrun</td>
<td>9</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>3.8</td>
</tr>
<tr>
<td>Surgeon absent with sufficient notice</td>
<td>21</td>
<td>1</td>
<td>9</td>
<td>20</td>
<td>15.1</td>
</tr>
<tr>
<td>Surgeon absent without sufficient notice</td>
<td>11</td>
<td>4</td>
<td>11</td>
<td>19</td>
<td>13.3</td>
</tr>
<tr>
<td>Equipment not available</td>
<td>2</td>
<td>0</td>
<td>5</td>
<td>16</td>
<td>6.8</td>
</tr>
<tr>
<td>Anaesthetist not available</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0.3</td>
</tr>
<tr>
<td>Overbooked</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0.6</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>44</td>
<td>7</td>
<td>28</td>
<td>56</td>
<td>39.9</td>
</tr>
<tr>
<td><strong>Unavoidable</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Substituted by Category 1 and 2 patients</td>
<td>40</td>
<td>44</td>
<td>13</td>
<td>77</td>
<td>51.5</td>
</tr>
<tr>
<td>Substituted by emergency surgery</td>
<td>7</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>3.8</td>
</tr>
<tr>
<td>Cancelled by Surgical Bookings Team</td>
<td>0</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>1.2</td>
</tr>
<tr>
<td>No beds</td>
<td>1</td>
<td>2</td>
<td>4</td>
<td>0</td>
<td>2.1</td>
</tr>
<tr>
<td>No intensive care beds</td>
<td>4</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1.5</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>52</td>
<td>46</td>
<td>25</td>
<td>80</td>
<td>60.1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>96</td>
<td>53</td>
<td>53</td>
<td>136</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: Audit Office based on TCH data.

5.30 The Audit’s examination showed that:

- 40 percent of postponements or cancellations were considered ‘avoidable’;
- about 52 percent of total postponements or cancellations was due to substitutions by Category 1 and 2 patients;
- Urology had the highest postponements or cancellations (136 out of total 338 or 40 percent); and
- as a result of doctors’ leave, 28 percent of total scheduled admissions were postponed or cancelled (nearly half of which was without sufficient notice).

5.31 A recent consultant’s report commissioned by ACT Health indicated that the rate of hospital initiated postponements was approximately 10 percent in both TCH
and the CPH. Audit considers that there is scope to minimise the postponements and cancellations of planned admissions, unless due to unexpected circumstances, with better planning by the hospitals, improved communication with, and cooperation from, the doctors.

5.32 The current rate of postponements and cancellations can compromise patients’ clinical care, cause undue anxiety and disappointments for patients (and their carers and families). This would also increase inefficiencies and costs to the hospitals as postponed patients have to be re-admitted for surgery, with flow-on impacts on others on the waiting lists.

**Recommendation 9**

ACT Health should establish appropriate systems to monitor and manage ‘avoidable’ factors to minimise the number of postponements and cancellations of surgery initiated by hospitals.

**REVIEWS OF SURGICAL SERVICES AND MANAGEMENT OF TCH OPERATING THEATRES**

5.33 Audit did not review the management and operations of both hospitals’ operating theatres (OT) in details since Audit was aware that ACT Health had engaged two consultants to review the operations of the OT. The following comments are based on Audit’s discussions with hospitals’ management and medical specialist groups and Audit’s review of the consultants’ reports. In the main, Audit’s discussions with stakeholders identified similar issues to those raised by the consultants.

**Review of surgical services**

5.34 KM Health Consulting, undertook a review of ACT Health’s surgical services in April 2010. The report, titled *Review of Surgical Services*, covered a review of ACT Health’s current policies and practices in the management of the surgical program and focused on the performance of surgical services, including operating theatre management at both public hospitals.

5.35 The consultant’s report highlighted a number of issues that would impact on the performance of surgical services and made 22 recommendations to reform and streamline the current performance of surgical services. Areas that require improvement include:

- the surgical services structure and governance structure, with a single ACT Division of Surgery to be established responsible for managing policies, procedures and guidelines relating to surgical services;
- accountability arrangements for the new position of the Director of ACT Division of Surgery and performance and accountability framework for surgical services;

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• elective surgical waiting list management; and
• operating theatre management.  

5.36 In relating to operating theatre management, KM Health Consulting reveals that:
• theatre management at TCH and CPH is unclear or ineffective;
• there is a lack of flexibility in allocation of theatre sessions which hampers management of waiting times; and
• management information on theatre utilisation is inadequate to provide useful data for routine management.

5.37 ACT Health advised that the implementation of a cross Territory services recommended by the consultants’ reports will be reliant on the cooperation of Calvary Public Hospital.

Review of TCH operating theatres

5.38 ACT Health also commissioned other consultants, Cogent Business Solutions, to undertake a review of TCH operating theatres. The final report, titled Review of Operating Theatres at The Canberra Hospital, was completed in June 2010 (Cogent Report).

5.39 The Cogent Report covers organisational structure and management, operational practices and staff and resources. The Report identifies the following key findings: 

• …What is mostly lacking are good systems and decision making process that will inevitably lead to significant improvements in the efficient and effective functionality of the operating suite.

• Within the operating Suite there exists a consistent theme of tension and conflict regarding the provision of a safe, effective and efficient peri-operative service. It was a common view that the Suite is in a constant state of crisis management, with staff overwhelmed by the need to solve each day’s problems. It was a widely held view that surgeons, anaesthetists and nursing staff were working in isolation from each other with no effective processes to support day to day operational communication or problems solving mechanisms.

• The Suite is plagued by frequent delays in commencing operating lists, and once the operating lists are underway, there are a number of factors that conspire against the efficient and effective throughput of patients on those lists.

• The organisational structure and management arrangements within the Operating Suite are not conducive to the effective functioning of the unit.

• Engagement of the clinical staff seems disjointed and not approached in any methodical way. The frustration of the clinicians is evident as they state they don’t have any clear way of knowing where to take issues or concerns,

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32 Cogent Business Solutions, Review of Operating Theatres at The Canberra Hospital, June 2010, pages 2 and 3.
and neither are they actively sought or consulted on issues that directly affect them. As a result, the clinicians attempt to find alternate ways to get decisions made, equipment purchased, or to bring about service enhancements.

- The provision of a safe, effective and seamless perioperative service is hindered by a business model that displays inadequate systems, processes, workflows and communication channels.

- There are numerous factors at play that combine to conspire against an efficient unit. These perhaps stem from the way in which the theatre lists are compiled and managed; the lack of meaningful data that could assist with their construction; and the finalisation of the list prior to publication and promulgation.

- …there are regular delays caused to the flow of the theatre lines due to difficulties in the way the theatre lists are scheduled with inherent conflict for equipment and resources built into the program; a lack of an appropriate number of patient trolleys; delays in the commencement of lists on time; and delays in Paediatric Admission Care Unit which impact the ability of the theatre staff to clear recovery beds. Clearly the business model used within the Operating Suite at TCH requires significant ‘upgrading’ and enhancement.

- Staff education, training and skills development was one such area of concern…noting that the perioperative educational framework is inadequate to support practice development for the nurses of the unit.

- Also of the concern is the Suite is the rostering practices used. These practices result in very large overlaps of shifts in the early afternoon, and insufficient staff rostered on to match the scheduled operating list finishing time each day.

5.40 The Cogent Report made a total of 83 recommendations and included a draft implementation plan. More than 70 of the recommendations were rated the highest or high priority by the consultant, who recommended they be implemented before December 2010.

5.41 The matters identified in the consultants’ reports were similar to the representations made by various stakeholders (refer paragraph 5.4) to Audit.

5.42 Audit acknowledges that the effective management of the waiting lists is a complex process that can be influenced by parties within the system, including the surgeons. Further, there were many factors within and outside the control of ACT Health, that impact on the management of waiting lists.

5.43 Among the key factors, the inefficient practices of the operating theatres in the hospital systems have been consistently identified by surgeons and medical staff as having adverse impact on the ability of the ACT public hospitals to manage the waiting list for elective surgery.

5.44 Accordingly, Audit considers that significant improvement in the efficient and effective management and operations of the operating theatres would lead to better management of elective surgery waiting lists.
5.45 Given the significant list of recommendations by recent consultants’ reports, it is important that ACT Health have in place sound governance and accountability framework to promptly consider the merits of recommendations, plan and assign adequate resources for its timely implementations of the agreed recommendations. The implementation plans should clearly:

- assign responsibility for implementation of accepted recommendations to a single person or business unit;
- include a timetable for implementation;
- include monitoring and review mechanisms;
- allocate resources as required; and
- regularly report progress to the Legislative Assembly and community.

5.46 In response to the proposed report, ACT Health advised:

ACT Health already has well established governance arrangements that are used to monitor progress against the reviews, as well as the plans already established by ACT Health to meet government objectives in relation to increased access to surgery in the ACT. The Surgical Services Taskforce, which comprises membership including the Chief Executive of ACT Health and senior surgeon and anaesthetists, will be the body with the primary responsibility to ensure that recommendations are fully explored and implemented. This body reports directly to the ACT Health Portfolio Executive, the major decision making and direction-setting body for ACT Health.

In addition, The Canberra Hospital has established a Steering Committee to manage the local implementation of the review. This Committee is required to report progress against recommendations to the Surgical Services Taskforce.

ACT Health has also established the National Access Program to drive initiatives associated with the agreement by Government to the National Health Reform Program. A major part of this program deals with initiatives related to improving access to elective surgery. As part of their role, this Committee is responsible for ensuring that ACT Health meets its responsibilities under the ACT Health Elective Surgery Access Plan 2010-13. This Committee is also responsible for reporting progress to the Surgical Services Taskforce.

**ACT ELECTIVE SURGERY ACCESS PLAN**

5.47 Prior to 2010, ACT Health developed and implemented the following strategies and plans, including:

- Elective Surgery Plan 2007-08 in February 2008;
- Surgical Services Plan (draft) 2008-12 in May 2008; and

5.48 ACT Health has recently developed the ACT Elective Surgery Access Plan 2010-13 (the Plan) to improve access to elective surgery under the Commonwealth’s Elective Surgery Waiting List Reduction Program National Partnership. The Plan aims to meet the immediate needs of increasing demand for access to elective surgery and set the foundation for the changes in elective surgery management. An additional funding of $14.7 million, over four years
from 2010-11 to 2013-14, will be allocated to improve access to elective surgery and improve waiting times.

5.49 The Deputy Chief Executive is responsible for the implementation of the Plan. Table 5.4 outlines the key steps and initiatives to the delivery of the Plan:

**Table 5.4: Summary of the ACT Elective Surgery Access Plan 2010-13**

<table>
<thead>
<tr>
<th>Steps</th>
<th>Initiatives</th>
</tr>
</thead>
</table>
| 1. Capacity building | – Maintain the same level of elective surgery in 2010-11 as in 2009-10  
– Expand the capacity of public hospitals  
– Establish partnerships with private hospitals  
– Explore innovative options in both the public and private sectors, e.g. use of private services to provide full surgical teams for public patients and referral of patients with specific high acuity needs to specialist private hospitals interstate (e.g. Neurosurgery) |
| 2. Improved management of elective surgery | – Establish the role of a clinical director of surgery  
– Review elective surgery waiting list policy  
– Establish one single waiting list for the ACT across TCH and the CPH  
– Establish better coordination of waiting list management across the ACT  
– Better categorisation of patients by eliminating Category 2a and 3a. |
| 3. Service re-design | – Clarify the roles of each public hospital in relation to emergency and elective surgery  
– Establish a more appropriate categorisation policy (based on national definitions)  
– Review operating theatre utilisation and allocation for maximum efficiency  
– Implement a new theatre management system |
| 4. Continual performance monitoring, reporting and auditing | – Establish a process for regular reporting, and constant reporting of the elective surgery process, both administrative and clinical  
– Initiate new processes for auditing the waiting list  
– Develop new and comprehensive elective surgery reports  
– Work with the SSTF to ensure that waiting lists policies and practices have clear accountabilities and responsibilities |

Source: ACT Health
5.50 Individual hospital management is responsible for achieving specific hospital targets and the 2010-11 performance targets have been set for each of the ACT public hospitals. A target of 10,711 admissions is planned for 2010-11, compared to actual results of 10,107 in 2008-09 and 9,778 in 2009-10.

5.51 ACT Health advised that progress has been made in increasing access to elective surgery, with a commitment by ACT public hospitals to provide over 800 more elective surgery operations over 2010-11 compared with 2009-10. Activities undertaken included:

- establishing a tender process to provide elective surgery in the private sector;
- developing a new elective surgery waiting list management policy for consultation with stakeholders in early 2011; and
- developing a tender for consultancy services for redesigning surgery services.

5.52 The successful implementation of the ACT Elective Surgery Access Plan 2010-13 should address a number of issues and deficiencies identified by Audit and by internal and external reviews recently commissioned by ACT Health.
6. MANAGEMENT OF MEDICAL TREATMENT WAITING LISTS

INTRODUCTION

6.1 This Chapter discusses the policies, procedures and practices implemented by the Central Outpatient Department (Central OPD) at The Canberra Hospital (TCH) to manage the waiting lists for medical treatments. It also outlines results of an audit of waiting list management at the Gastroenterology and Urology Units at TCH.

KEY FINDINGS

- The OPDs in TCH provided almost 118 000 services in 2009-10, an increase of 13 percent from 2008-09 and about 13 000 over target. Funding for the OPDs in public hospitals in 2009-10 totalled $79.8 million, an increase of 3.4 percent over the previous year.

- ACT Health conducted an internal review of the outpatient services at TCH and a draft report in October 2010 found deficiencies in strategic planning, inconsistent application of policies and procedures across the OPDs, ad hoc processes for managing the waiting lists, and poor and inefficient communications with clinicians, consumers and staff. The review report included 35 recommendations to address strategic and immediate operational needs.

- Audit examination of a selection of patient records on the Urology unit’s waiting list at TCH showed that more than 85 percent failed to meet the timeframes for referral, triaging and booking processes included in the relevant policy.
  - The Standard Operating Procedures for the OPD state that the appointment scheduling system will facilitate the booking of appointments within five days of accepting the referral. The average timeframe between receiving the referral and booking the patient’s appointment in the Urology unit in June 2010 was 71.9 days, and in September 2010 it was 25.5 days.
  - Further, for the selected samples, there was significant delay in the average time between the referral being received in the Urology unit and the clinical appointment, 217.9 days in June 2010 and 158.4 days in September 2010.

- Audit examination of a selection of patient records on the Gastroenterology unit waiting list at TCH shows that although the average wait for Category 1 patients fell from 48 days in February 2010 to 39 days in July 2010; the waiting time for only one month in the reviewed period (February 2010 to July 2010) was within the clinical target of 30 days.
  - There has been a reduction in the average waiting time for Category 2 patients, with the average wait falling to 108 days in July 2010. Nevertheless, the average wait is outside the clinical target of 90 days. Category 2a wait times are mostly within the clinical target for the period under review, and have also shown a substantial improvement over the six months from February to July 2010.
– The average wait for patients in Category 3 was within the clinical timeline target of 365 days, and waiting times have demonstrated a significant improvement (from 177 days in February 2010 to 93 days in July 2010). Category 3a waiting times, however, were well outside the clinical target of 180 days (times ranged from a high of 239 days in March 2010 to 203 days in July 2010).

- An internal audit of the Gastroenterology unit’s waiting list, which commenced in February 2010 (reported in July 2010), identified numerous data errors including multiple RFAs for the same patient, unregistered RFAs, registrations under the incorrect specialist, and registrations for deceased patients.

- Most referrals tested by Audit were complete and accurately entered onto the waiting list. Only half of the selected entries were processed within the required timeframe and several instances were noted where the specialist doctor had not assigned a clinical urgency category, or the assigned category was varied by staff at the clinic.

- The Canberra Hospital has been implementing improvement strategies in all TCH clinics and this reform process is expected to improve the waiting list over time.

### CENTRAL OUTPATIENT DEPARTMENT (CENTRAL OPD)

6.2 The Central Outpatient Department (Central OPD) is part of the Ambulatory Care Unit and is an important point of entry for patients who require non-emergency treatment or services, but who are not currently admitted to the hospital.

6.3 The services provided within Central OPD reflect all the surgical specialties and some medical specialists within the hospital system. Central OPD provides two options for patients to receive their required treatment; either as an outpatient where treatment is performed in Central OPD, or referred to the hospital’s elective surgery waiting lists. The functions of Central OPD are discussed in Table 6.1. There are other outpatient clinics within the Ambulatory Care Services at TCH, including Gastroenterology, Renal, Cardiology, Pain Management Unit, Paediatrics, Gynaecology and Canberra Sexual Health Clinics.

**Table 6.1: Lists of Central Outpatient clinics at TCH**

<table>
<thead>
<tr>
<th>Surgical</th>
<th>Medical (Non-surgical)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear/Nose/Throat (ENT)</td>
<td>Dermatology</td>
</tr>
<tr>
<td>Facia-maxillary</td>
<td>Diabetes/Endocrinology</td>
</tr>
<tr>
<td>General Surgery</td>
<td>General Medicine</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>Infectious Diseases</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Neurology</td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>Neuropsychology</td>
</tr>
<tr>
<td>Plastics</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td></td>
</tr>
<tr>
<td>Vascular</td>
<td></td>
</tr>
</tbody>
</table>

Source: ACT Health.
6.4 Figure 6.1 outlines the appointment processes within the Central OPD. The processes are detailed in the Procedure Manual for Outpatient Service Administration and the Standard Operating Procedure for Administrative Consultant/Specialist Outpatient (issued in May 2009).

Figure 6.1: Central Outpatient Department appointment system

6.5 The Procedure Manual identifies the following key procedures:

- referrals to outpatient medical specialist;
- waiting list management;
- triaging of referrals;
- appointment system process;
- cancellation of clinical appointments; and
- managing cancellations and failures to attend.

**Referrals**

6.6 Central OPD clinics in TCH normally only accept referrals from medical practitioners, including:

- General Practitioner (GP);
- Medical Officer within the hospital (emergency department, other specialist outpatient clinics, inpatient units);
- Medical Officer’s private rooms; or
- Medical Officers in other hospitals.

6.7 The referral process must contain enough information to permit triaging the patient, including the patient’s demographic information, information about the patient’s condition and the need for a medical specialist appointment, recent investigations undertaken, current medications and the patient’s status. Incomplete referrals are returned to the medical practitioner without registration.

**Waiting list management**

6.8 All Central OPD clinics are required to maintain an outpatient database that functions as a waiting list system (Concerto or ACTPAS) and registers essential details about all patients requiring an appointment with a medical specialist in Central OPD. Audit observed some inconsistency in management practices; for example, the Gastroenterology Unit uses ACTPAS, supported by medical records and other relevant documents, whereas the Urology and Central OPD units use ACTPAS and Concerto.

**Triaging of referrals**

6.9 All patients are assigned a clinical urgency category within five working days of accepting the referral for an appointment with the Outpatient clinic consultant. The clinical urgency categories in Central OPD are defined in Table 6.2.
## Table 6.2: Triage category of OPD patients

<table>
<thead>
<tr>
<th>Category</th>
<th>Urgency</th>
<th>Appointment within</th>
<th>Condition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Semi-urgent</td>
<td>30 days</td>
<td>Potential to require more complex or emergent care if the consultation is delayed. Potential to have significant impact on quality of life if care is delayed.</td>
</tr>
<tr>
<td>2</td>
<td>Semi-elective</td>
<td>90 days</td>
<td>Unlikely to require more complex or emergent care if assessment is delayed. Potential to have some impact on quality of life if care is delayed.</td>
</tr>
<tr>
<td>3</td>
<td>Elective</td>
<td>Over 90 days</td>
<td>Unlikely to deteriorate quickly and to require more complex care if assessment is delayed.</td>
</tr>
</tbody>
</table>

Source: OPD (TCH) manual.

6.10 Any urgent referrals (those that must be seen in two days or less) will either need to be seen in the emergency department or by some arrangement made directly with specialists or their treating team.

### Appointment or booking system

6.11 The appointment scheduling or booking system allows patients to be allocated an appointment in the specialist outpatient waiting list. The appointment scheduling or booking system will facilitate the booking of appointments within five days of accepting the referral.

### Managing cancellation of appointments

6.12 Cancellation can be initiated by patients or hospital clinics. To minimise the number of patient cancellations, patients are advised of their responsibilities and the effect of late cancellation on service provision when an appointment is offered. A patient who fails to attend a scheduled appointment will generally be contacted and a new appointment made. A failure to attend two consecutive appointments will trigger a review of the patient’s clinical records by the Outpatient Clinic Consultant, after which the patient may be removed from the Outpatient Clinic waiting list.

6.13 If a cancellation is initiated by the hospital due to unforeseen circumstances, such as urgent need for the specialist to attend emergency surgery, or other factors relating to staff issues, equipment or facilities, the clinics will notify the patient as soon as possible and reschedule the next available appointment.

### OPD EXPENDITURE AND SERVICE DELIVERY

6.14 Table 6.3 shows that the expenditure for all OPD services in ACT public hospitals increased from $64.5 million in 2007-08 to $79.8 million in 2009-10.
Table 6.3: Total expenditure of all OPD services funded by ACT Government

<table>
<thead>
<tr>
<th>Funding</th>
<th>2007-08 $m</th>
<th>2008-09 $m</th>
<th>2009-10 $m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total expenditure for the year</td>
<td>64.5</td>
<td>77.1</td>
<td>79.8</td>
</tr>
<tr>
<td>Variance (percent) compared to previous year</td>
<td>--</td>
<td>19.5</td>
<td>3.5</td>
</tr>
</tbody>
</table>

Source: ACT Health.

6.15 There is no performance indicator to compare performance of outpatient services across all jurisdictions. *The State of Our Public Hospitals Report* issued by the Commonwealth Department of Health and Ageing in June 2010 provides information of outpatient services for all public hospitals in Australia, but mainly related to the total number of services. The Report also states that there is no consistent method by which to count outpatient services. Under the National Partnership Agreement between the Commonwealth and States and Territories, there was an agreement to develop information for nationally consistent activity based funding, including better information for outpatients.33

6.16 Table 6.4 compares the performance of OPD at TCH for 2008-09 and 2009-10. The actual number of services provided by OPD in 2009-10 increased by 13 percent compared to 2008-09.

Table 6.4: Comparison of all OPD performance at TCH

<table>
<thead>
<tr>
<th>OPD</th>
<th>2008-09</th>
<th>2009-10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target</td>
<td>Actual</td>
</tr>
<tr>
<td>Total OPD number of services</td>
<td>88 172</td>
<td>104 563</td>
</tr>
<tr>
<td>Variance (percent) actual compared to target</td>
<td>--</td>
<td>19%</td>
</tr>
</tbody>
</table>

Source: TCH data.

INTERNAL REVIEW OF THE OPD

6.17 ACT Health has completed a comprehensive internal review of the OPD in October 2010. The *Review of The Canberra Hospital Outpatients Service Redesign Project* identified a range of findings that impacted the effective delivery of services within the OPD of TCH. These included:

- the lack of an overarching strategic framework including a comprehensive mission statement, strategic goals and performance measure;
- the absence of a formal capacity management plan related to OPD services or a workforce management strategy;

no evidence the data generated by the data reporting system within the OPD was used to inform strategic planning and decision making;

no formal planning for the development, implementation and review of new information technologies;

policies and protocols were not always followed and were inconsistent;

ad hoc processes for managing the waiting lists, inefficient waiting room processes, and an absence of processes for auditing the waiting list; and

poor and ineffective communications between the OPD and General Practitioners, consumers and hospital executive.

6.18 The review report included 25 recommendations to address strategic and communications deficiencies, and a further ten recommendations to address immediate operational needs.

6.19 ACT Health advised that:

- an implementation plan has been developed to address the recommendations;
- the ten recommendations to address the immediate operational needs are currently being implemented; and
- the remaining recommendations will be considered by the Outpatient Services Governance Steering Committee in early 2011.

WAITING LISTS FOR MEDICAL TREATMENTS

6.20 Audit examined waiting list management in two units within the OPD, namely Urology and Gastroenterology. Selection of these units for review recognised that both were particularly busy areas, and that while most Urology patients seen within OPD will become in-patients, Gastroenterology patients will usually remain as outpatients.

6.21 Audit notes that the Gastroenterology unit has been part of an Access Improvement Plan developed by ACT Health and TCH, to improve waiting times for patients in the OPD unit of TCH.\(^{34}\) A project officer was appointed as part of the business improvement program in February 2010. The Urology unit has not undergone a similar improvement process.

6.22 Audit reviewed a sample of patients from each speciality against the following policy and procedural documents:

- Waiting Time and Elective Patient Management Policy;
- Ambulatory and Medical Services Process;

\(^{34}\) Canberra Hospital Outpatients Services Redesign Project v2 25 October 2010
Management of medical treatment waiting lists

- Procedure for Management of Endoscopy Waiting Lists Standard Operating Lists Procedures;
- OPD Standard Operating Procedures (SOP); and
- Ambulatory Care Outpatient Services Administration Procedure Manual.

**Waiting Lists in the Urology unit (OPD)**

6.23 At the time of audit, the Urology unit in the Central OPD consists of four surgeons supported by junior medical staff.

6.24 During the period from July 2009 to April 2010 (Table 6.5), the unit processed 1 353 patients including new patients, reviewed patients and walk in. The average was 135.3 patients per month for the period.\(^{35}\)

**Table 6.5: Urology patients (July 2009 to April 2010)**

<table>
<thead>
<tr>
<th></th>
<th>New</th>
<th>Review</th>
<th>Walk In</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total patients number and percentage</td>
<td>227 (17%)</td>
<td>1 105 (82%)</td>
<td>21 (1%)</td>
</tr>
<tr>
<td>Average patients per month</td>
<td>22.7</td>
<td>110.5</td>
<td>2</td>
</tr>
<tr>
<td>Average patients per month per doctor</td>
<td>5.7</td>
<td>27.6</td>
<td>0.5</td>
</tr>
</tbody>
</table>

Source: TCH Data.

6.25 Audit reviewed a selection of patient records in June 2010 and September 2010, with a focus on effective management of the wait lists and compliance with relevant policies and procedures.

6.26 In both sampling periods, the details provided by the referring practitioner generally conformed to the requirements of the guidelines, and were input to the waiting lists correctly.

6.27 For the selected referrals in the Urology unit, however, more than 85 percent failed to meet the timeframes for referral, triaging and booking processes included in the relevant policy. Audit observed that:

- the Standard Operating Procedures for the OPD state that patients should be assigned a clinical urgency category within five working days of accepting the referral for an outpatient appointment with a medical specialist. The average timeframe between receiving the referral and triaging the patient in June 2010 was 15.2 days, and in September 2010 it was 18.8 days;

- the Standard Operating Procedures for the OPD state that the appointment scheduling system will facilitate the booking of appointments within five days of accepting the referral. The average timeframe between receiving the referral and booking the patient’s appointment in June 2010 was 71.9 days, and in September 2010 it was 25.5 days.

\(^{35}\) Urology Report 2010
Further, there were significant delays to receiving medical appointments in the Urology unit. For the selected samples, the average time between the referral being received in the OPD and the clinical appointment was 217.9 days in June 2010 and 158.4 days in September 2010.

Figures 6.2 and 6.3 illustrate the average waiting times from receipt of a referral to Central OPD to the date of an appointment for the selected samples.

**Figure 6.2:** Average waiting time in Urology unit – June 2010

Source: Audit Office

**Figure 6.3:** Average waiting time in Urology unit – September 2010

Source: Audit Office

With the significant delays in the triaging and booking appointment time, there is a very high risk that patients could not access to the required services and care appropriate for their medical conditions.
6.31 The Central OPD should ensure both the triage and the booking processes in the Urology unit are compliant with the relevant timeframe. This may require additional resources, a business process reengineering or an assessment of the guidelines to ascertain if the required timeframes are still relevant and achievable within current resources.

**Waiting Lists in the Gastroenterology unit (Central OPD) in TCH**

6.32 The Gastroenterology unit uses similar processes to the elective surgery waiting list unit. Patients seen in Gastroenterology are classified as outpatients and procedures are carried out within the unit, rather than patient being referred to the elective surgical waiting list as is the case with urology patients.

6.33 The Gastroenterology unit in the Central OPD consists of four staff specialists in Gastroenterology, and six VMOs.

6.34 Table 6.6 shows the number of patients on the waiting lists as at July 2010.

**Table 6.6: Gastroenterology (endoscopy) patients- July 2010**

<table>
<thead>
<tr>
<th>Clinical urgency category</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Category 1</td>
<td>143</td>
</tr>
<tr>
<td>Category 2A</td>
<td>260</td>
</tr>
<tr>
<td>Category 2</td>
<td>324</td>
</tr>
<tr>
<td>Category 3A</td>
<td>280</td>
</tr>
<tr>
<td>Category 3</td>
<td>648</td>
</tr>
<tr>
<td>Total</td>
<td>1655</td>
</tr>
</tbody>
</table>


6.35 One method of identifying the effective management of the waiting lists is to analyse the average waiting time by categories.

**Table 6.7: Gastroenterology (endoscopy) waiting list - average waiting time by clinical urgency category**

<table>
<thead>
<tr>
<th>Clinical urgency category</th>
<th>CAT 1</th>
<th>CAT 2A</th>
<th>CAT 2</th>
<th>CAT 3A</th>
<th>CAT 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average wait – Feb 2010</td>
<td>48</td>
<td>96</td>
<td>190</td>
<td>214</td>
<td>177</td>
</tr>
<tr>
<td>Average wait - March 2010</td>
<td>28</td>
<td>76</td>
<td>145</td>
<td>239</td>
<td>165</td>
</tr>
<tr>
<td>Average wait – April 2010</td>
<td>34</td>
<td>83</td>
<td>139</td>
<td>235</td>
<td>160</td>
</tr>
<tr>
<td>Average wait – May 2010</td>
<td>36</td>
<td>84</td>
<td>114</td>
<td>232</td>
<td>132</td>
</tr>
<tr>
<td>Average wait – June 2010</td>
<td>44</td>
<td>82</td>
<td>103</td>
<td>227</td>
<td>98</td>
</tr>
<tr>
<td>Average wait – July 2010</td>
<td>39</td>
<td>73</td>
<td>108</td>
<td>203</td>
<td>93</td>
</tr>
<tr>
<td>Clinical Target</td>
<td>30</td>
<td>60</td>
<td>90</td>
<td>180</td>
<td>365</td>
</tr>
</tbody>
</table>

Table 6.7 shows that although the average wait for Category 1 patients fell from 48 days in February 2010 to 39 days in July 2010 - waiting time for only one month in the reviewed period (March 2010) was within the clinical target.

There has been a continuous reduction in the average waiting time for Category 2 patients, with the average wait falling to 108 days in July. Nevertheless, the average wait is outside the clinical target of 90 days. Category 2a wait times are also outside the clinical target for the period under review (60 days), and have also shown a gradual improvement over the six months.

The average wait for all months in Category 3 were within the clinical timeline target of 365 days, and have demonstrated a very significant improvement. Category 3a waiting times, however, were outside the clinical target of 180 days.

Audit noted a project was conducted by TCH to audit the Gastroenterology waiting lists early in 2010 and reported in July 2010. At the time the internal audit project commenced, there were 1,655 patients on the waiting lists. This internal audit identified numerous data errors including:

- multiple RFAs for the same patient / different specialist;
- 39 RFAs not registered;
- 21 RFAs registered under incorrect specialist;
- 136 entries where the original clinical urgency was missing or not a valid code;
- 76 entries where the planned procedure code was missing or invalid;
- 1,393 entries that had a removal date but no procedure date;
- 66 entries with a total waiting time exceeding 500 days;
- patient generated postponements were not being recorded correctly within the system, impacting on average waiting times; and
- 16 RFAs were located that related to deceased patients.

Similar to testing for the Urology unit, Audit reviewed a selection of patient records in the Gastroenterology unit for March 2010 and September 2010. This period of time was to determine whether there had been improvements in the administration of the waiting list with the implementation of the reform program in the Gastroenterology unit. The result showed that most referrals were complete and accurately entered onto the waiting list. Only half of the selected entries were processed within the required timeframe (one day) and several instances were noted where the specialist doctor had not assigned a clinical urgency category, or the assigned category was varied by staff at the clinic.

Audit testing indicates that overall improvement in the management of waiting list in the Gastroenterology unit following the reform program has been limited, but
Audit recognises it may take some more time for the data to reflect the overall outcomes of this program.

Conclusion

6.42 The Central OPD is a complex and busy area. A sound strategic framework that supports the decision making processes is essential for effective management of the Department. A recent internal review of the OPD identified the need to introduce a cohesive framework that identifies and supports the overall requirements of Central OPD.

6.43 Significant data is available within the Central OPD regarding patient throughput, and reports are routinely prepared. The accuracy and completeness of some datasets need to improve, as evidenced by the recent internal audit of the Gastroenterology waiting lists. Attention to addressing data inaccuracies is important, and should be accompanied by the development of a data and reporting strategy that defines the nature of the data to be collected, who will use the data and the cost effectiveness of the reporting process.

6.44 There was scope for improving the performance of Central OPD as a cohesive unit, through the introduction of consistent and agreed systems, procedures and processes to share better practices and assist in the effective management of all areas within the Central OPD.

**Recommendation 10**

The Canberra Hospital should implement processes for routine data integrity audits of all Outpatient Department waiting lists to ensure that all data is valid, complete and accurate. All waiting lists should be subject to a detailed audit at least annually.

**Recommendation 11**

ACT Health should develop appropriate governance and accountability framework to monitor, review and report on the progress of the implementation of the agreed recommendations arising from the *Review of The Canberra Hospital Outpatients Service Redesign Project*. Particular attention should be paid to:

- implementing a strategy to manage increased demand for outpatient services; and
- implementing consistent policies, practices and procedures for managing the waiting lists for individual OPD units.
APPENDIX A: AUDIT CRITERIA, APPROACH AND METHODOLOGY

AUDIT CRITERIA

Audit assessed the reliability and completeness of the waiting list data for elective surgery and non-emergency medical treatment and ACT Health’s management of waiting lists based on the following audit criteria:

- the availability of comprehensive and up-to-date waiting time information for all doctors, hospitals, and surgical procedures;
- the reliability of collection systems;
- the consistency of application of clinical priority:
  - documented evidence is readily available to validate any changes to a patient’s clinical urgency category;
- the monitoring of patients with extended waiting times to ensure clinically appropriate and timely treatment:
  - patient priorities are subject to review by qualified persons and changed where necessary;
- the implementation of ACT Health’s relevant policy and guidelines; and
- the monitoring by senior management and of performance measures relevant to waiting lists, including the use of performance standards and targets.

AUDIT APPROACH AND METHODOLOGY

The audit approach and methodology consisted of:

- review of the appropriateness of ACT Health and its hospitals systems and procedures to compile and manage waiting lists;
- analysis of the completeness, reliability, and timeliness of the waiting list data;
- review of ACT Health and hospital files;
- review of data provided by ACT Health and other bodies such as the Australian Institute of Health and Welfare, the Productivity Commission and the Australian Bureau of Statistics;
- interviews and discussions with key stakeholders on the effectiveness of the waiting list information and the extent to which it is used. These stakeholders include:
  - management and staff at ACT Health, The Canberra Hospital and the Calvary Public Hospital;
  - representatives of surgeons, General Practitioners and patients including the Australian Medical Association, Visiting Medical...
Officers Association, and the Health Care Consumers Association of the ACT; and

- research other audit reports and publications issued by the Audit Offices of other jurisdictions on the related audit topics.
## AUDIT REPORTS

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<td>1 / 2011</td>
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