Elective Surgery Access Policy

Treat in Turn Principle in Practice

Aim

- For patients to receive their elective surgery in a safe and timely manner.
- To match surgery capacity with demand within NSW.
- To facilitate waitlist managers in conjunction with the treating surgeon to safely maximise theatre time available.
- To facilitate discussion between waitlist managers and hospital executive.

NOTE: This document is focusing on one element of theatre scheduling only as a result of feedback as to confusion over this principle. For further information on safely maximising theatre efficiency please see resources at the end of this document.

Surgery Access Policy "Treat in Turn" Principle

The Elective Surgery Access Policy provides procedures to NSW public hospital teams that manage elective surgery services so that there is clinically appropriate, consistent and equitable management of access for patients across the state.

A key part of providing equitable access for patients is a "Treat in Turn" principle with a clinical urgency category.

For example:

Mr Sharma is waiting for a Total Hip Replacement as a category 3 patient with a listing date of 21/06/21 with 0 days Not Ready For Care (NRFC)/Suspension time.

Ms Smith is waiting for an arthroscopy for meniscal repair as a category 3 patient with a listing date of 18/07/21 with 0 days Not Ready For Care (NRFC)/Suspension time.

Ms Danbury is waiting for a Total Knee replacement as a category 3 patient with a listing date of 1/11/21 with 0 days Not Ready For Care (NRFC)/Suspension time.

Following the principle "treat in turn" Mr Sharma should have his surgery before Ms Smith and Ms Danbury as Mr Sharma was added to the waitlist first and had the most "Ready for Care" days.

Variation to "Treat in Turn" Principle

Perioperative Services are one of the most expensive, labour and carbon intensive areas of a hospital to run (REF) and as such It is also vital that theatre time is maximalised.

This may mean that in order to safely maximise a theatre list capacity, patients may need to be admitted from the Elective Surgery waitlist out of category/treat in time order.

Below are the scenarios where the "Treat in turn" principle may not be appropriate:

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1. Scheduling by length of procedure

For more detailed information on scheduling theatre lists, including the relevance of the factors of surgical, anaesthetic and nursing training on building a theatre list please see the Agency for Clinical Innovation's [Theatre Efficiency Guidelines] and consult your local performance unit for more detailed data.

The example below is simplified to explain the principle behind this variable.

Using your Surginet/theatre data, you can see that Dr Jones takes on average 2 hours to complete a Total Hip Replacement, however he only has a 1-hour gap in his theatre time allocated to him.

Checking the waitlist, you can see that the next patient on the waitlist, Mr Sharma is also waiting for a total hip replacement, and Ms Smith is waiting for an Arthroscopy for meniscal repair. You check the Surginet/theatre data and Dr Jones takes an average of 45 minutes to complete this procedure.

In this scenario, it will be appropriate to book Ms Smith before Mr Sharma to maximise available theatre time without overbooking a theatre list.

2. Scheduling to reduce turn around time in theatres

When booking a theatre list, reducing turnaround time between cases can also improve throughput of patients.

For example, if booking a Cataract Surgery list, consider booking an all-left eye list to reduce movement of the Microscope and other equipment. This approach can also help reduce surgical errors through reducing variation (REF).

3. Bed availability

To ensure effective patient flow the daily bed requirements for surgery should be discussed regularly and agreed to reduce patient cancellations due to bed availability. Models of Care that reduce bed need where clinically safe to do so should also be implemented to allow elective surgery to continue even in periods of high demand.

Despite efforts to reduce bed variation in the number of beds required for surgery patients each day and implementing safe models of care; there may still be a scenario where bed availability may prevent the "treat in turn" policy being implemented to ensure that theatre time is maximised.

For example:

XX hospital has recently implemented a model of care where routine joint replacement surgery is conducted on a same day basis.

When booking for a theatre list, Dr Jones has flagged that Ms Danbury meets the criteria for a Day only joint replacement however, Dr Jones has indicated that she will have a length of stay of 2-4 days post hus total hip replacement.

The waitlist manager at XX hospital has been advised that due to planned refurbishment work, all specialties including surgery are having their available beds reduced by 10%.

It may be appropriate to maximise theatre time, to book Ms Danbury for her total knee replacement despite having accumulated less "Ready for Care' days than Mr Sharma.

4. Patient availability – use of "standby lists"

Especially in the current COVID-19 climate, standby lists should be utilised to reduce scheduling gaps due to late cancellations by patients.

In line with the Elective Surgery Access Policy, patients should only be added to their standby if they understand and are able to attend their surgery within short notice, which may be within 24 hours. They should also have been screened for likely preadmission clinic needs and need no further assessments, tests or consultation.

In this instance, the "standby list" for a specialty/surgeon should adhere to the "Treat in Turn" principle where possible whilst also considering the points as discussed in 1-3. Noting that patients on the standby list may have their surgery ahead of patients on a standard or pooled list, due to their short notice availability.

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Additional strategies for meeting Demand and Capacity Management

The Elective Surgery Access Policy also contains demand management strategies to proactive management of surgical services demand and capacity.

These include:

- Additional theatre time at same or other facility
- Pooled lists where it is clinically appropriate for doctors in the same specialty to agree to include their public patients on a combined list for that specialty. Patients may be treated by any one of the doctors belonging to the group
- Transfer of patients to another treating doctor with a shorter elective surgery list at the same facility (see section 6.11.1).
- Transfer of patients to another treating doctor with a shorter elective surgery list at another facility (see sections 6.11.2 and 6.11.3).
- Private sector options where the district or network is responsible for expenses incurred (see section 6.11.4)

Additional resources

- NSW Agency for Clinical Innovation Operating Theatre Efficiency Guidelines
- NSW Health Patient Flow Systems Framework

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