Report of the Task Team on Surgical Waiting Lists

LETTER OF TRANSMITTAL

March 10, 1999

The Honourable Pat Atkinson
Minister of Health
Province of Saskatchewan

The Honourable Judy Junor
Associate Minister of Health
Province of Saskatchewan

Your Honours,

On behalf of my colleagues, I am pleased to present to you the Report of the Task Team on Surgical Waiting Lists.

I would like to express the appreciation of the Task Team for the assistance and advice afforded the Team by all those that met with us.

Respectfully submitted,

Dr. J. Stewart McMillan
Chairman
Task Team on Surgical Waiting Lists

Cc Dr. Barry Maber
Dr. Mark Ogrady

The Task Team on Surgical Waiting Lists was appointed by the Minister of Health in early December 1998 in response to public concern that Saskatchewan residents may not be getting access to surgical services in the province in a timely fashion.

The membership of the Task Team was:

- Dr. J. Stewart McMillan, Family Physician,
  Medical Consultant to the Department of Health
- Dr. Mark Ogrady, Otolaryngologist, Chief of Surgery, Regina Health District
- Dr. Barry Maber, Physician Vice President, Saskatoon District Health

The mission of the Task Team was to recommend a waiting list system for surgery that ensures that patients with similar need get access to the system at the same time and to make recommendations regarding resources necessary to achieve such a system. It was further the mission of the Task Team to make recommendations regarding resource allocations to improve patient access for surgical procedures.

Activities of the Task Team

The Task Team has met with representatives of health districts, particularly Regina and Saskatoon where the problems are most acute and with health service professionals concerned with the delivery of surgical care. The definitions currently used to indicate the urgency of surgical need and the application of those definitions have also been reviewed.

The Task Team has also reviewed the systems currently in place for the allocation of operating room times in Regina and Saskatoon and has reviewed the definitions currently used to indicate the urgency of surgical need and the application of those definitions.

We have had the opportunity to liase with working groups established in Regina and Saskatoon who have been charged with outlining perceived barriers to access to care in those districts.

This report outlines the findings of this Task Team. In making recommendations we have appended our sense of whether they can be achieved in the short term (3 to 6 months) medium term (6 to 15 months) or long term (15 to 24 months).

The reader of this report should also note that the Task Team has only concerned itself with issues relating to waits for surgery after a decision has been made between a surgeon and his/her patient to book an operation. The Task Team did not examine to what extent waiting times are influenced by waits for specialist appointments or specialist tests. This in itself is a very complex and difficult issue to study. The Task Team suggests that this issue should be further explored in the future.

The System – How are Patients Prioritized

To all intents and purposes waiting lists for surgery exist in Regina and Saskatoon where approximately 70 percent of the surgery in the province is performed.

In these cities patients needing surgery are categorized according to their assessed urgency of surgical need. Patients are either classified as being emergent, urgent or elective with target time lines for each service attached to the emergent and urgent classifications. All patients who have a diagnosis of cancer or possible cancer are classified as urgent. A description of the classification categories appears in the appendix.

The information obtained by the Task Team was that in both districts, patients in the categories of emergent and urgent were having their surgery within the time frame imposed by the classification. In particular, patients with a diagnosis of cancer or possible cancer are receiving access to surgical procedures within 3 weeks of being booked.

It is apparent, however, from the number of urgent procedures being performed outside regular working hours that the ability to meet these guidelines has become more difficult for some time. The Task Team also understands that the recent surgical slow down in Regina has meant that the time targets have not always been achieved most recently. This has been identified and addressed by the district. It is intended to make extra operating room time available at the Regina General Hospital on the Fridays that the operating rooms would be closed for surgeries other than emergencies. This plan will be implemented in March 1999 with a strategy to have further operating room time available commencing May 9th. as staffing levels improve and permit.

While noting that patients identified as being urgent and emergent have been accessing the operating room within the time frames specified in the definitions of urgency, the Task Team has observed that often the management of the operating room schedule does not leave open time during the day for inpatients who are classified as urgent or for some emergency cases that meet the classification of E3.

The result of this is that these patients may often go to the operating room at some period of time after hours. Often the operating room is used on weekends to catch up on the surgical backlog. This policy of not having scheduled times within the operating room to meet the needs of these patients during the day has a significant impact on hospital budgets in terms of overtime, on human resources and staff morale. For many reasons, including patient safety, medical and other personnel do not wish to work too late in the day. This is particularly true if the operation proposed may be a long and difficult one. There is clear evidence that nursing staff and others are tired and feel less willing to continue to provide the present volume of after hours service. We believe that this has also caused serious difficulties in recruitment and retention of operating room personnel and that these problems will become more acute if this matter is not addressed in the near future. We are strongly of the opinion that when surgical times are allocated that provision be made on a daily basis, during regular hours, for the performance of surgery that would currently be considered in the categories of E3 or urgent.

The implementation of this will have implications for allocation of operating room resources and will mean that more operating rooms are necessary if the system is still going to address the needs of patients who have been classified as stable enough to have their surgical needs met electively. We will address this later in this report.

With respect to the provision of services to those patients who are considered elective there exists a difference in addressing their needs in Saskatoon and Regina. Patients in this category in Saskatoon are placed on a waiting list that is organized chronologically – first on first off. In Regina, surgeons are able to move patients up the list if they feel that their condition is worse or has the potential to become worse. The elective patients are therefore prioritized according to surgical judgement. We believe that this method results in some patients in Saskatoon being classified as urgent because the surgeon feels that they cannot wait at the bottom of the elective waiting list as this may result in a wait of a year or longer. It would appear, therefore that at least some of the non-malignant urgent list in Saskatoon corresponds to prioritized elective cases in Regina. Nevertheless, allowing the individual surgeon to exercise clinical judgement in the prioritization of cases without necessarily needing to seek prospective approval would appear to allow better flexibility and efficiency in meeting specific patient need. However, over the longer term, effort must be made to develop more standardized provincial criteria for prioritization of all surgical cases. The Task Team favours a system that employs prioritization for all patients on the elective waiting lists. We feel that this ensures that patients whose needs are not urgent but are still quite pressing can be accommodated in a planned way without having to be classified on the urgent list and without being required to wait for a long period, perhaps while their condition deteriorates.

To be sure that adequate information can be collected and operating room times allocated based on urgency of need and patient priority the health districts of Regina and Saskatoon will need to ensure that they have an information and data collection system with trained personnel to support this. They must utilize the information obtained in resource planning and allocation. This system could also be used to support the collection of access data and information to be used to monitor the system on an ongoing basis.

The Task Team has noted that the wording of the definitions of urgency of surgical need is similar between Regina and Saskatoon. However we do believe that there is some difference in interpretation of these definitions between the two districts, particularly as it relates to some patients who are classified as urgent. This is difficult for the public and some practitioners to understand. It also makes it difficult, in a provincial sense, to assess the amount of surgery being done and how well surgical priorities are being addressed in the province.

Recommendations

1. That the departments of surgery in Regina and Saskatoon in co-operation with the Department of Health develop consistent definitions of surgical needs and that the system be tracked to ensure consistent application of these definitions (short term).

2. That the surgeon responsible for the patient have the ability to prioritize patients within his/her waiting list and that where chronological systems are currently in place they be modified to permit other than chronological prioritization (short term).

3. When the allocation of surgical times in Saskatoon and Regina is undertaken, that provision be made for the allocation of urgent time to be assigned during regular operating time based on a regular analysis of operating room utilization (short term).

4. That the Regina and Saskatoon district health boards have an operating room information system that ensures sufficient information is available to support a surgical times allocation system as envisaged above. This system, staffed with appropriately trained personnel, should support the collection, analysis and reporting of information that will be required to monitor access to surgery on an ongoing basis (short term) (see also recommendations on a provincial surgery advisory committee).

The System – Time Allocation

The Task Team has noted that the Regina hospitals, St. Paul's Hospital and City Hospital in Saskatoon participate in a district system that allocates operating room time to surgeons based on their waiting list. (A description of the system in point is found in the appendix.) The Regina district health board therefore has knowledge of the waiting times for services at the Regina hospitals and the Saskatoon district health board has knowledge of waiting times at St. Paul's Hospital and City Hospital.

The allocation of surgical times at Royal University Hospital does not follow this system. Surgeons are allocated blocks of time by the Academic Head, Department of Surgery, and maintain their own waiting list. While these time allocations may have been occasionally reviewed in the past, there is no indication that consideration is given to patients waiting times or patient needs when reviewing how these blocks of time are allocated.

The district, therefore, despite its responsibility for the funding of these services, cannot optimally manage the resources it applies to surgical services at the Royal University Hospital site. The public also cannot be assured that priorities are being met uniformly in the surgical services in Saskatoon.

The Task Team fully recognizes that in a teaching institution there are requirements of faculty other than purely providing needed medical services. We are nevertheless of the opinion that when these institutions receive resources from the district it is important that the district ensure those resources are effectively managed and meet the goals of the district.

Recommendations

5. The Saskatoon district health board's, Surgical Operations Committee be given the responsibility of maintaining a centralized surgical waiting list for the district for all acute care facilities in the city. They will be responsible for the allocation of operating time throughout the system (short term).

6. The Task Team strongly recommends that any additional funds for surgical services in Saskatoon not be allocated or expended until the above recommendation is implemented (short term).

7. The Task Team recognizes that the academic faculty practising at the Royal University Hospital has considerable responsibilities to teaching as well as patient care and that it is important to ensure that surgical allocations adequately support the various training programs. We would encourage that any allocations consider the input of the Academic Head, Department of Surgery and the College of Medicine but that such considerations not overshadow the need to ensure appropriate access for patients and appropriate management of the district's resources (short term).

The System – Efficiencies and Resources

In meeting with our colleagues during this review we frequently heard that there are no more opportunities for further efficiencies within the system. Any observer of health care would certainly be impressed with the pace of change in the surgical services in the past few years. Many of these changes would not have occurred without the co-operation of many in the system and their willingness to try to make change work. The admission of patients on the day of surgery, improved surgical techniques and home care enhancements have all made it possible to increase the efficiency of in-hospital services. The Task Team does however believe that there are still some opportunities that, if utilized, would improve access of patients to services.

We believe that there are still opportunities to perform more procedures outside of the operating room in a more efficient ambulatory care surgical setting. We understand that if an appropriate facility was available procedures like breast biopsies, carpal tunnel releases, dental procedures and cataracts to mention a few could be moved to an ambulatory care setting thus allowing more work to be done in the traditional operating room setting. This will improve efficiency and throughput while freeing up operating room space for other procedures that can only be done in the operating room setting.

It is our understanding that the Regina district health board has planned an ambulatory care unit to exist outside of the operating room facilities at the Regina General Hospital, which should be in use in October 1999. The decanting of ophthalmology procedures to ambulatory care (at the Pasqua Hospital) would free up a very substantial amount of operating room time, probably to the extent of about one and one half operating rooms per day. The movement of procedures like breast biopsies and ophthalmology at the Pasqua Hospital to ambulatory care cannot be effected however without some capital funding for changes to the facility and for funding to ensure the availability of extra instruments and equipment. We are of the opinion that this and the maintenance of an enhanced post-operative recuperative facility are very worthwhile initiatives.

The Task Team feels that it is important at this point to indicate one of the implications of implementing the aforementioned and to sound a note of caution. If the Regina District health board is able to make these changes at the Pasqua Hospital site it will create an operating room availability that can only be appropriately utilized if the district re-examines the current configuration of services within the district. In order to obtain these efficiencies in a timely

manner, such a review would need to be undertaken with some urgency and with the knowledge that some additional capital expenditure will be necessary.

In Saskatoon we understand that the situation is somewhat different. Both City Hospital and St. Paul's Hospital have high capacity day surgery units which could possibly still handle an increase in case loads. The day surgery unit at the Royal University Hospital is less capable of an increased workload because it is small and not in close proximity to operating room facilities.

Post surgical recovery facilities are open sufficiently late in the evening to permit patients to recover adequately without the need for overnight admission.

The Task Team suggests that the Saskatoon health district's surgical operations committee should review the utilization of day surgery at all three facilities to determine what further capacity can be used. Thereafter, utilizing information from the centralized booking system, times should be allocated to surgeons throughout the Saskatoon district in a manner that ensures maximal efficiency of the day surgery units.

During our meetings with health care professionals and in asking about perceived barriers to effective management of their surgical caseloads we were frequently told that the practice of closing surgical facilities on some Fridays reduced the efficiency of the system. We were also told that the lack of capital for equipment further reduced the efficiencies of the system and slowed turn around times.

The Task Team is of the opinion that as soon as possible the so-called 5-5-4 systems should be stopped. The reader of this report should recognize however that this is not a simple task. For operating rooms to function five days per week all the resources that back up the operating room and patient recovery have to function as well. It will take some time to return staffing and schedules of all the necessary departments to a level that would support a 5-5-5 system in Regina and Saskatoon. The projected cost of this in Regina is three quarters of a million dollars.

With respect to the provision of capital equipment, health districts maintain that they have insufficient funding for the purchase of equipment. This creates inefficiencies in the operating room in that duplicate sets for some procedures are not available and therefore hold-ups and delays are experienced. Concern was also expressed that some equipment is now quite old and in need of replacement and that strategies have not been adequate to ensure that these needs may be addressed. This is likely to have a greater impact on access as time marches on.

It is also accurate to note that if ambulatory surgical facilities are to be enhanced that equipment will be needed to ensure that realizable efficiencies do in fact occur. In addressing access issues in the short term funds for equipment will need to be made available.

The Task Team notes that with the funding changes that occurred within the system during 1992 when Needs Based Funding was implemented the previously allocated line items for capital equipment were folded into the total budget, thus making them not an identifiable item. For the future management of the system, the issue of capital funding needs to be addressed, particularly in regard to the distinct separation of capital and operating funds.

The Task Team received information that it is possible to further improve the efficiency of the system by facilitating the inter-district transferring of patients.

A review in the Regina health district has shown that patients who come from outside the district have a surgical length of stay that is 1.3 days longer than patients whose home is within the immediate environs of Regina. This represents a considerable allocation of resources as 40 percent of the surgical caseload in that district comes from outside the immediate environs of Regina. We understand that some of this is due to surgeon's reluctance to discharge patients' without knowing the extent of services available to the patient if they return to their home district. However we were also told that the discharge planning staff of the district frequently encountered difficulty in contacting resource personnel in the patients home district and in ensuring that resources can be made available for the patients on their return home. We do not have quantitative information for Saskatoon but we have been told that similar problems are encountered there. The Task Team is strongly of the view that just as it is important for districts to be able to access tertiary services, so too is it important that districts support the appropriate and efficient use of resources of the tertiary centres. They must therefore do everything possible to facilitate discharge planning for patients returning home.

The System – Capacity

Currently the Regina health district is utilizing 14 of 18 operating rooms. Until recently 16 rooms were being utilized but with the slow downs caused by staffing shortages the number of rooms was reduced to 14. If the suggestion of increased ambulatory care services is achieved in Regina with the implementation of a full workweek the Task Team is confident that surgical needs could be met by utilizing the 16 rooms previously available.

An initial review of operating room after hours utilization would suggest that if the surgical time allocation process recommended in this report is followed, additional daytime operating rooms will need to be opened in Saskatoon. Operating room facilities currently exist at all three sites and if staffing complements were satisfactory could be opened.

The Task Team recognizes that based on present after hours surgical utilization figures, that one more daytime operating room would need to be staffed and opened at both St. Paul's and City hospitals in Saskatoon. This will require additional financial resources to meet the human resource implications of this decision. Insufficient information is available to the Task Team to make conclusions about the impact of this recommendation on the Royal University Hospital site.

The Task Team recognizes that the Saskatoon health district has established a task force to examine improved access to elective surgery, similar to the task force recently formed in Regina. We would recommend that the Saskatoon task force study the implications of the Task Teams report with respect to the number of day time operating rooms at the Royal University Hospital site and that they report their recommendations and supporting rationale to the provincial Task Team.

It is noted that surgical capabilities exist outside of Regina and Saskatoon in that qualified surgeons currently work in other centres.

There would appear to be opportunities, particularly in Prince Albert and Moose Jaw because of their present infrastructure and human resources to supplement and compliment services currently provided in the adjacent major urban centres. This would further develop their capacities to provide sustainable secondary level surgical care. This will require attention to developing more mutually supportive rather than competitive teams, peer review and professional development. Telehealth will be a tool for enabling this type of relationship. Such a model is currently being developed between Saskatoon and Prince Albert.

We also recognize that a number of factors influence surgical referrals. Factors such as patient preference and the relationship of trust and respect that has been built between referring physicians and consultant surgeons play a role in the choice of referral centre. We also understand that when new physicians come to a community, referral practices may continue because of the history of a good working relationship. The new doctor may not be aware of services that may be available elsewhere and perhaps closer to home.

The Task Team also notes that while surgical expertise may exist outside Regina and Saskatoon the necessary back-up may not exist to support higher volumes or surgical cases that may require investigations and back-up procedures (for example laparoscopic nephrectomies, laparoscopic hysterectomies) that can only be performed in tertiary care centres.

Coupled with this, when there is a small number of specialists in any one discipline it may be difficult to ensure the public that peer review and assessment is of the depth that would be expected.

Any increase in services outside Regina and Saskatoon must be mindful therefore of the requirements of support for services undertaken and adequate peer review.

Recommendations

8. That the Regina and Saskatoon district health boards urgently explore the capability to move certain surgical procedures out of the operating room to an ambulatory care setting and to ensure that day surgery facilities are maximally utlized (short term).

9. That the districts regularly and consistently report the number of procedures performed as in-patient that would not normally require hospitalization (medium term).

10. That the Regina district health board review the current surgical service mix between the two acute care facilities to ensure that efficiencies gained with increased ambulatory care surgery can be fully optimized (short term).

11. That the Saskatoon and Regina district health boards plan to implement a working schedule that does not include one week of shortened operation (i.e. the 5-5-4 rotation) as soon as staffing complements permit.

12. That the Department of Health provides capital funding for equipment necessary to implement greater efficiencies in the operating room and ambulatory care (short term).

13. That in the future the Department of Health reviews with the districts the mechanism used to allocate funds for capital equipment and to show this in a transparent fashion in district allocations (medium term).

14. That the Department of Health mandate as a provincial standard that all health districts have available a 24 hour resource that ensures patients can be returned to the most appropriate service in their home district when medically appropriate and without delay (short term).

15. That districts outside Regina and Saskatoon that have qualified surgical personnel and available capacity develop a strategy to inform referring physicians of the services available (short to medium term).

16. That a peer review network be established to ensure that any surgical workload increases outside Regina and Saskatoon are done in an environment that ensures appropriate peer review and that the type of service does not exceed the capacity of a facility to support it (medium term).

17. That the Saskatoon district health task force on access to elective surgery study the implications of the Task Teams report with respect to the required number of day time operating rooms a the Royal University Hospital site and provide a report with supporting rationale to the provincial task team on the capacity required (short-term)

The System – Appropriateness

In recent years there has been much discussion and some study on identifying which patients would benefit from surgery and how they should be prioritized. There has been some national and international work on this topic, particularly in the area of cardiac surgery. There is now considerable interest in this research and it is likely that interest will increase as there is increasing need to assure the public that health funds are appropriately targeted. A large research project is underway in Western Canada with funding from the Health Transition Fund that may assist in the development of systems that aid the prioritization of patients for surgery.

Recommendation

18. That research into the appropriateness for surgery be closely followed critically appraised and incorporated into the surgical management systems in Saskatchewan (short, medium and long term).

The System – Human Resources

In January, after the Task Team had commenced its work the Regina district health board indicated that they would be closing some operating rooms because of a critical shortage of

nurses throughout the hospital system. Saskatoon district health board has also had some difficulty in filling nursing staff vacancies. This event has highlighted very powerfully that the system will not work without adequate human resources. It also highlights that any solution envisaged can only be implemented if there are human resources to support the solutions proposed.

The Task Team did not have the time to examine in depth this very complex issue, nor do we profess to have that expertise. There are however some very significant human resource issues that will require careful examination to ensure the viability of the system. We did not do a detailed examination of medical manpower but understand that there are significant medical human resource issues in neurosurgery in Saskatoon. There may be difficulty in the future in recruiting anaesthetists to Saskatoon, particularly to the Royal University Hospital site unless the present daytime and after hours work load issues are addressed.

If services are expanded rapidly in Regina it is possible that the anaesthetist complement will need to be increased to support it.

We also learned that it might be possible to more effectively utilize some of the human resources in the system (i.e. nurses) by reassigning some duties and responsibilities though this may require an examination of professional scope of practice.

Recommendations

19. The Department of Health in conjunction with the district health boards and relevant professional regulatory organizations develop a comprehensive human resource policy to address the need for recruitment, retention, training and retraining of health personnel.

20. That a mechanism be developed to study the scope of practice of health disciplines to determine if an alternative deployment of human resources would benefit the system.

The System – The Public

Whenever concerns are expressed about health care and the ability of the system to meet the public need, this results in great concern amongst the citizens of the province. People who are on waiting lists express concern that their wait may be lengthened and their condition or quality of life may worsen as a result. People who are not on waiting lists and currently feel well express concern that the system may not be there for them when they need it.

Waiting lists are not new, nor is the concern that they engender. In a publicly funded system however the waiting lists can be used to more efficiently manage resources. The alternative to waiting lists is to have a system that allows immediate access to service for all patients. This would only be achievable if a system was developed that had excess capacity with a resultant substantial increase in costs.

There is also some research evidence that indicates that some waiting times for elective surgery may be desirable for patients. Some delay allows for the optimal physiological and

psychological preparation of the patient for surgery. Some patients, on reflection, can reconsider the need for surgery and decide to cancel the proposed procedure.

Having said this however the present system is not very "public friendly". The public is seldom able to find out where they are on the waiting list or when they might expect to be admitted. They seldom know what they can or should do if they feel that their condition is deteriorating. Anecdotally they hear of patients who are "not as sick" as them but who get in ahead of them.

In an ideal system, waiting times for the same procedure should be equal between districts and surgeons. Given some of the current challenges, the public should have the ability to be informed by the attending physician or the district, of specialist and district specific waiting times.

Recommendation

21. That the districts of Regina and Saskatoon develop a central resource that allows patients and physicians to be advised on wait times and projected waits for surgery (short to medium).

22. That the Department of Health in conjunction with the districts develop a patient information brochure that explains the surgical booking system, the categories of surgery prioritization and advises them of the steps that they may take should they feel that their condition has deteriorated since the time of booking (short to medium).

The System – The Future

The health system is going to continue to be challenged to meet patient need. There is much to be done to develop management tools to ensure that we are truly meeting the needs of our patients at the time that is most beneficial to them. Research needs to be done locally and nationally to determine the correlation between length of time on wait lists and surgical outcomes. It is only then that we will know if waiting times are indeed appropriate.

Research also needs to be done on patient factors that affect cancellation and surgical rescheduling.

In order to address waiting times and effective use of resources mechanisms such as Clinical Practice Guidelines, Case Management and timely admission and discharge planning will need to become part of the process of care.

Lastly we feel that the public will need to be assured on an ongoing basis that the system is working and that they can feel confident in its ability to serve them. In conjunction with standard definitions of surgical priorities and consistent applications of these it should be possible to have an understanding of the provincial system and an ability to monitor it. We strongly believe that there is a need to establish a permanent advisory committee to monitor access to surgery in the province.

Recommendation

23. That a permanent advisory committee with representation from the Department of Health, the Saskatoon and Regina health districts and the public be formed to monitor access to surgery in the province and monitor the implementation of the recommendations contained within this report. The advisory committee should receive and review regular performance reports relating to access to surgery in the province. The committee should be chaired by the Assistant Deputy Minister responsible for Acute and Emergency Services Branch, Saskatchewan Health, and a report should be issued annually to the Deputy Minister of Health. Included in the appendix is a description of the functions that we would expect the advisory committee to discharge.

Conclusion

The Task Team has welcomed the opportunity to review and comment on access to surgery in the province of Saskatchewan.

We have been impressed, that where waiting lists exist in Regina and Saskatoon, the prioritization of patients has ensured that those with the most urgent needs and those with a diagnosis of cancer or suspect cancer get access to the system within a fairly short time frame.

We note that the recent surgical slow down in Regina has the potential to cause increased difficulty in achieving access within previously specified time frames and it certainly has the capacity to lengthen the waiting times of patients waiting for elective procedures. Moreover, available data would point to growth in waiting lists and times for elective surgery in both Regina and Saskatoon.

The solutions will take time to implement and involve a number of strategies aimed at recruitment and retention of human resources, appropriate deployment of those resources throughout the system and appropriate use of facilities.

We have identified in this report a number of areas where efficiencies could further be applied to the system to ensure increased throughput of cases and to ensure that the operating rooms are used only when ambulatory care services are not appropriate. We are of the opinion that there is a need to apply more financial resources to achieve the recommendations cited in this report. We would caution however that these resources need to be targeted toward specific resolutions that would allow increased access for patients and that a short term quick infusion of funds, because of the human resource issues, would have no immediate benefit on access to surgery and surgical waiting lists. We also caution that if a decision is made to implement these recommendations this system will only continue to be maintained if provincial funding is sustained past this period of concern.

As mentioned in the text of the report we have recommended the establishment of an advisory committee to monitor access to surgery. This committee would have certain indicators, against which it could measure and monitor access to surgery in the province. We believe that this type of reporting mechanism is necessary. It will reassure the public, particularly if it reports publicly

and regularly. If access is maintained as we expect it should be, this will be a valuable resource in diminishing public concern when issues related to access are raised.

Acknowledgements

In the appendix we have listed the people and organizations that we have met with in reviewing this complex issue.

The Task Team wishes to acknowledge their input and their thoughtfulness in often meeting with us at very short notice.

We also wish to express our appreciation to Mr. Scott Livingstone and Mr. John Mowbray of the Department of Health who facilitated our meetings and were tireless in their efforts to provide us with information when requested.

This report is respectfully submitted.

J. Stewart McMillan
Barry Maber
Mark Ogrady

APPENDICES

Definition of Surgical Case Priorities*

	Saskatoon Health District		
Category	**Sub-category**	**Description**	**Target Timing for Surgery**
Emergent	Emergent E1	Surgical conditions posing immediate threat to life or limb	Within 1 hour
	Emergent E2	Surgical conditions with a likelihood of irreversible worsening, if not operated on within a "short" time frame.	Within 4 to 6 hours
	Emergent E3	Surgical condition which should proceed to definitive treatment at the earliest possible OR available during the present admission.	Usually within 24 hours
Urgent	Urgent In-house	Patients admitted to an inpatient bed for treatment of an acute condition, treated non-surgically with resolution or stabilization of the problem, but whose discharge and subsequent delay in definitive treatment would be inappropriate as determined by attending physician.	
	Urgent Malignant	Patients with a proven malignant diagnosis or situation suspicious of malignancy.	Within 3 weeks.
	Urgent Non-malignant	Patients with a non-malignant diagnosis whose condition has become exacerbated or there is likelihood of irreversible worsening.	Within 6 weeks.
Elective		Surgical patients with conditions that can be chronologically accommodated with other similar patients.	

Regina Health District			
Category	**Sub-category**	**Description**	**Target Timing for Surgery**
Emergent	Emergent E1	Case to be done stat or in first available room (e.g. ruptured aneurysm).	Immediate
	Emergent E2	Case to be done on day booked (e.g. appendectomy).	Within 24 hours.
	Emergent E3	Case to be done within 2 days (e.g. hip pinning).	Within 48 hours.
Urgent	Urgent In-house	Patients admitted to an inpatient bed for treatment of an acute condition, treated non-surgically with resolution or stabilization of the problem, but whose discharge and subsequent delay in definitive treatment would be inappropriate as determined by attending physician.	
	Urgent Malignant	Patients with a proven malignant diagnosis or situation suspicious of malignancy.	Within 2 weeks.
	Urgent Non-malignant	Patients with a non-malignant diagnosis whose condition has become exacerbated.	Within 6 weeks.
Elective		Surgeons have the ability to prioritize electives based on their assessment of patient need.	

*** The reader is cautioned that although the definitions between districts appear quite similar, in practice there are differences in their application between the two districts primarily due to: differences in the way each district assigns operating room time, the ability of Regina surgeons to prioritize electives, and the protected surgical time in Regina for cardiac surgery and emergent orthopaedics (Saskatoon does not have protected surgical time).**

Regina Health District

Surgical Scheduling Process

- RHD has a central booking office. Booking clerks are assigned to each site.

- **RHD has a new Ominiserver/Surgiserver computerized waitlist and operating room scheduling system. It is the same system that the Saskatoon District Health Board uses.**

- The Regina Health District has one booking process for all operating theatres in the district. The process is based on block booking by physician - blocks of O.R. time are assigned to each service or specialty, and are further divided into blocks assigned to individual physicians. The physicians can priorize scheduling of their urgent and elective patients on the waitlist. The District defines maximum acceptable waits for cases which physicians decide are emergent or urgent.

- Emergent cases (immediate to 48 hours) are handled outside of the block booking process.

- Urgent and Elective cases are handled within each physician's allocated block of OR time. Physicians may priorize urgent and elective cases within their blocks. In practice, different physicians handle this priorization differently. Some surgeons perform surgery in chronological order from the time the booking slip is submitted (i.e. within their urgent and elective slates); some override the chronological order for some cases; while others submit their own slate entirely (i.e. provide the District with the order in which they will perform their surgery).

- The District contacts patients only when the actual surgery date is booked and arrangements have to be made for pre-operative tests and preparation. Prior to this point it is the responsibility of the physician to keep patients informed about waits.

- **The allocation of block time to surgeons is handled by an OR Management Committee.**

- The allocation of OR time to surgeons is adjusted 3 times a year (February, July and September).

- A new surgeon receives a minimum allocation / block of OR time of 2 hours per week.

- OR time is allocated based on an assessment of the surgeon's caseload, taking into account the hours of surgery required to clear the surgeon's elective list and the surgeon's historical utilization of urgent time. Physicians are given 1:1 time for urgent cases. Additional time is based on the surgeon's percentage of the waiting list

measured in terms of OR time required - a surgeon with 10% of the list receive 10% of the hours up to a maximum of 20 hours per week. Elective surgery time is allocated following the allocation of urgent and any other "protected surgical time" is removed from the pool (i.e. cardiovascular surgery, urgent orthopaedic time, etc.)

- An Urgent Booking Committee composed of 3 surgeons, acts as a gatekeeper for the urgent surgery. Physicians are required to write a letter of support for all urgent patients. The Committee retrospectively reviews the letters of support and approves or disapproves the classification. This is then used in subsequent allocation of urgent OR time to surgeons.

- Surgeons may raise concerns about allocations of OR time, or other matters, to the OR Management Committee. The physicians have agreed to this process.

- The district does occasional audits of the waitlist. The district also tracks cancellations.

Saskatoon District Health

Surgical Scheduling Process

- Saskatoon has a centralized district-wide waiting list/operating room scheduling system. The district uses a computerized OR booking/scheduling system (OMNISERVER). There is, however, a separate booking system for academic surgeons at the Royal University Hospital, which operates within the larger district system.

- **The district's central booking process is based on block booking by service - that is blocks of O.R. time are assigned to each service (e.g. orthopaedics, general surgery), and waitlists and scheduling are managed at the service level.** There are no blocks set-aside for specific surgeons and surgeons are not assigned urgent OR time in addition to their elective surgery time. OR time is first allocated to the urgent procedures and therefore displaces elective time. Unlike Regina, urgent time is not incremental.

- Each service has its own booking clerk - one person responsible for bookings for the service for all sites. They know which surgeons are available on which days and times. Once the booking clerk knows what times / blocks are allocated to the service, she contacts the available surgeons to fill these time slots. Cases are slotted in according to priority. Urgent cancer and urgent other cases are scheduled within district-specified target waiting times. Elective cases are scheduled into the remaining time in chronological order, though in some cases an elective case may be moved up to fill a gap (e.g. to fill a half-hour time slot between two urgent surgeries.

- When scheduling OR time the scheduler will try to group cases into a “block “ of time for a surgeon in order to achieve efficiency. However there is no predetermined definition of that block of time.

- The District Surgical Operations Committee assigns blocks of time to each service. The scheduling office then assigns theatres and times to individual surgeons based on the criteria that have been established.

- The district notifies the surgeons of the scheduled times for their patients' surgery. The surgeon's office notifies the patients and subsequently confirms the booking with central scheduling.

- **A separate booking system, within the larger district system is used at the Royal University Hospital for the academic surgeons.** There are blocks set aside at the RUH for academic surgeons. The Academic Chief of Surgery allocates time for academic surgeons so that they know exactly when they will be in surgery. The surgeons decide which cases to do when. If there is time that remains unscheduled the District is to be informed and the time is allocated to another surgeon. The

academic surgeon's office may submit the booking slip to the District's central scheduling system when the patient is first assessed, or may hold it until the patient's booking is confirmed or submit the slip following the completion of the procedure. Cancellations / openings must be indicated prior to 36 hours before OR time so that central scheduling can book another patient according to priority from their waitlist.

- Urgent surgical procedure requests are reviewed by specialty/department heads or their designate prior to the procedure being performed. Each surgical specialty/department applies its own criteria for urgent procedures.

- Surgical cancellations are tracked regularly.

- The system distinguished between active and pending cases. Pending cases are those that are rescheduled for any of facility, surgeon or patient reasons.

- In Saskatoon, the surgeon's request for operating time is based on the surgeon's "skin to skin" time. The district then adds 15% more time to account for the "turn-around-time" for the operating room. Total time is therefore the sum of both. In Regina, the surgeon's request for time includes turn-around time and therefore equals the total time required.

Provincial Waitlist Advisory Committee

While it is likely to take some time for the Provincial Waitlist Advisory Committee to achieve effective monitoring of the system, the introduction of such a Committee at this time would move this Province forward in this regard and put it in a position to take advantage of new research already begun through the Western Province's Health Transition Fund Waitlist Project.

The committee will have the authority to examine any areas of specific concern associated with extended waits for surgery in the province. This may involve the formation of specific subgroups to examine different surgical specialties where concerns may arise if deemed necessary by the advisory committee.

The committee should meet regularly to discuss data and reporting regarding access to surgical/medical procedures provincially.

The proposed Provincial Advisory Committee should determine for itself what information / indicators it needs to monitor access to surgery.

The Committee will have to keep in mind that:

- The use of waitlist information to monitor access remains a relatively new field with few established indicators. Indicators will have to be identified over time by monitoring research (e.g. Western Provinces Health Transition Fund Waitlist Project) and changes in practice patterns.

- The availability and comparability of current information is limited by existing information systems and by differences in the way that waitlists are managed in the Province's two major surgical centres. Some time will be required to revise the information reported to the Department (short term) and to implement recommendations of the Task Team which will make waitlist management in the districts more similar and the information they report more comparable.

Any national or international research on waiting times and waiting lists for surgical/medical procedures that may be applied to provincial systems should also be considered. This is especially applicable in regards to the application of clinical practice guidelines; appropriateness measures and benchmarks around waiting times.

Meetings with Organizations and Individuals

Organizations/Committees

Saskatchewan Medical Association
- Dr. Briane Scharfstein
- Dr. Thirza Smith
- Mr. Ed Hobday

College of Physicians and Surgeons
- Dr. Dennis Kendel

Saskatchewan Union of Nurses
- Ms. Bev Crossman
- Ms. Rosalie Longmore

Surgical Operations Committee, Saskatoon District Health

Executive of Surgery, Regina District Health
- Dr. J. Bevridge, Plastic Surgeon
- Dr. J. Fritz, Otolarynologist
- Dr. L. Hunter, General Surgeon
- Dr. K. Kumar, Neurosurgeon
- Dr. Mark Ogrady, Chief of Surgery
- Dr. F. de Yeager, Orthopaedic Surgeon
- Dr. A. Courtney, Ophthalmologist

Individuals

Regina

Ms. Eleanor Fink, Regina Health District
Ms. Darlene Hozempa, Regina Health District
Ms. Leanne Carr, Regina Health District
Ms. Dawn Davis, Director, Medical Administration, Regina Health District
Ms. Michelle Volk, Regina Health District
Ms. Linda Bird, Regina Health District
Dr. Joy Dobson, Head of Anaesthesiology, Regina Health District
Dr. Glenn Bartlett, CEO and President, Regina Health District

Saskatoon

Dr. Len Rivers, Head, Department of Surgery, Saskatoon District Health
Dr. Roger Keith, Academic Head Department of Surgery, College of Medicine
Dr. Peter MacDougall, Clinical Head, Anaesthesia, Royal University Hospital
Ms. Jackie Mann, General Manager, Surgery, Saskatoon District Health
Dr. E. Berenbaum, Former Chief of Anaesthesia, SDH
Dr. Joan Stephenson, Anaesthesia, Saskatoon City Hospital
Dr. David Popkin, Dean, College of Medicine
Dr. Barney Lawlor, Agency Head, Department of Surgery, St. Paul's Hospital
Dr. Roger Turnell, Head, Department of Ob/Gyn, SDH
Dr. Jim Underhill, Ophthalmologist, Saskatoon City Hospital
Dr. David Burris, Agency Head, Department of Anaesthesia, St. Paul's Hospital

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