

Urgency Categorisation and Access Policy for Public Direct Access Adult Gastrointestinal Endoscopy Services

1. Purpose

The *Urgency Categorisation and Access Policy for Public Direct Access Adult Gastrointestinal Endoscopy Services* (the Policy) provides instruction to Health Service Providers (HSPs) and contracted health entities on urgency categorisation and access criteria for adult patients requiring a planned direct access gastrointestinal endoscopy procedure within the WA health system.

By implementing consistent urgency categorisation practices across all HSPs, the Policy aims to contribute to both the timely treatment of individuals, and equitable prioritisation and access to gastrointestinal endoscopy procedures for all patients.

This is a mandatory policy under the Clinical Services Planning and Programs Policy Framework.

It should also be read in conjunction with the following documents:

- WA Health Referral Guidelines, Direct access gastrointestinal endoscopy procedures (2016)
- WA Health Elective Surgery Access and Waiting List Management Policy (2016)
- WA Health Central Referral Service Policy (2014)
- WA Aboriginal Health and Wellbeing Framework 2015-2030
- Relevant hospital guidelines and protocols

This policy supersedes *Assessment and access criteria for public colonoscopy services – OD 0409/12*.

The purpose of this Policy is to:

- support timely and equitable prioritisation and access for patients with a clinical indication for direct access gastrointestinal endoscopy procedures
- provide advice to HSPs and clinicians on urgency categorisation and appropriate surveillance intervals for patients requiring direct access gastrointestinal endoscopy procedures
- support a consistent and structured approach to the efficient management of the waitlist to ensure effective demand management and appropriate prioritisation practices within the applicable patient cohort.

2. Applicability

This Policy applies to all HSPs and contracted health entities that provide public direct access adult gastrointestinal endoscopy services (including gastrointestinal endoscopy services provided under the Ambulatory Surgery Initiative (ASI)). It is to

be utilised by all clinical, administrative and service management staff to guide appropriate and consistent waiting list management and patient prioritisation practices for the provision of direct access gastrointestinal endoscopy procedures.

Sections of the Policy do not apply to direct access endoscopy services within WA Country Health Service (WACHS). The relevant sections will be marked with an explanatory footnote.

Referrals that are within the scope of this Policy are those that are received via direct access for:

- Gastroscopy
- Colonoscopy

3. Policy Requirements

This Policy articulates the rights and responsibilities of Primary Care (General Practitioners) and HSPs in managing direct access adult gastrointestinal endoscopy services.

3.1. Principles

- The provision of public direct access gastrointestinal endoscopy services will be based on clinical need and equity of access.
- Timely service delivery is a priority for all HSPs and patients assessed as requiring a gastrointestinal endoscopy should receive it within the clinically recommended time.
- HSPs will aim for consistency of practice and will actively monitor and manage waiting lists to ensure effective demand management and appropriate prioritisation practices.
- The clinical triage and treatment of patients remains the responsibility of their treating clinicians.

3.2. Roles and Responsibilities

3.2.1. Primary Care (General Practitioners)

The initial assessment of the patient's suitability for direct access gastrointestinal endoscopy services should be led by the patient's General Practitioner with particular regard to:

- the patient's clinical condition and past medical/family history
- the patient's eligibility for a direct access gastrointestinal endoscopy procedure in the public sector as outlined in the referral guidelines (Refer to Section 5)
- the presence of risk factors – which must be clearly stated on the referral form.

Addition to the public Elective Surgical Waiting List (ESWL) for direct access gastrointestinal endoscopy requires the following:

- The referral must meet the access criteria and contain mandatory demographic and clinical information as described in the referral guidelines (Refer to Section 5)

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- The referral must be submitted via the Central Referral Service on the standardised *WA Health Request for Direct Access Gastrointestinal Endoscopy (Adult)* form (Refer to Section 5)¹.

3.2.2. Health Service Providers

HSPs are required to establish local policy arrangements for the management and coordination of gastrointestinal endoscopy services which facilitate patients receiving timely care cognisant of case complexity, care pathways, specialist availability and infrastructure requirements. The HSP is to:

- ensure relevant staff within their organisation are aware of the Policy requirements
- manage ESWLs across the HSP to support patients receiving their care within the clinically recommended time
- monitor and manage performance to support patients receiving their care within the clinically recommended time for their assigned urgency category
- undertake regular ESWL audits as per the *WA Health Elective Surgery Access and Waiting List Management Policy*
- ensure relevant clinicians are familiar with the Policy and the specified access criteria, usual urgency categorisation and surveillance timing
- ensure patients are registered on the ESWL with the correct urgency category assigned by the triaging clinician, and that surveillance patients requiring a procedure in greater than 12 months are managed in line with this Policy.

3.3. Referral Acceptance Criteria

The WA health system has endorsed standardised access criteria for public direct access gastrointestinal endoscopy services to assist in streamlining patients towards the most appropriate care pathways and avoiding unnecessary delay.

Referrals are to be accepted by HSPs if they:

- meet the specified referral guidelines *WA Health Referral Guidelines: Direct access gastrointestinal endoscopy procedures* (Refer to Section 5), as assessed by the triaging clinician; and
- are submitted via the Central Referral Service (CRS) on the *WA Health Request for Direct Access Gastrointestinal Endoscopy (Adult)* form (Refer to Section 5).

Referrals that meet the above criteria are to be accepted by the hospital and assigned the appropriate urgency category (Refer to section 3.4). These patients are to be placed on the ESWL for the assigned procedure(s).

Referrals that are assessed by the triaging clinician as not meeting the access criteria, as defined in the referral guidelines (Refer to Section 5), are to be returned to the referrer with a standardised letter (Refer to Section 6) providing a brief explanation of the reason for return. The CRS will send the letter to the referrer on behalf of the hospital; however hospitals are responsible for managing

¹ Referrals are only submitted via the Central Referral Service, on the standardised referral form for access to **metropolitan** direct access endoscopy services.

communication with the patient regarding the status of their referral². A sample patient letter template is available (Refer to Section 6) for use at the discretion of the HSPs.

Figure 1 illustrates the referral acceptance decision process.

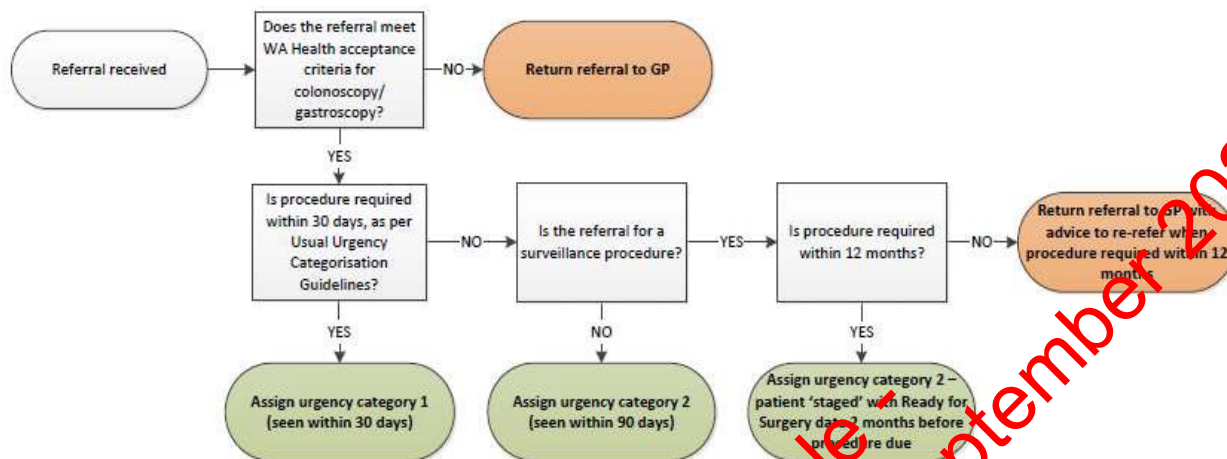


Figure 1: Referral acceptance and urgency categorisation process for direct access referrals

3.4. Recommended Urgency Categorisation

Recommended urgency categories have been defined in order to promote equity of access to public direct access gastrointestinal endoscopy services and to encourage consistency in the prioritisation and treatment of patients with similar symptoms and/or risk factors.

The urgency category for a patient is to be allocated by an appropriately credentialed clinician and based on the patient's clinical indication(s) as specified in the referral form.

While it is anticipated that the recommended urgency categories and surveillance guidelines will be suitable in most circumstances, it is acknowledged that there may be exceptional cases where a different approach will be clinically appropriate.

3.4.1. Urgency categorisation for direct access gastrointestinal endoscopy

Table 1 and Table 2 outline the recommended urgency categories for adult patients with a clinical indication for a direct access gastrointestinal endoscopy procedure within the WA health system.

All referrals that have been assessed by the triaging clinician as meeting the access criteria, as defined by the referral guidelines (Refer to Section 5), are to be assigned an urgency category of 1 or 2. Category 3 should not be assigned to referrals accepted under direct access criteria. Further information regarding assigning a 'staged' status for surveillance procedures is provided in section 3.4.2.

² This only applies to referrals within the metropolitan area that have been submitted via the Central Referral Service. Direct access endoscopy services within WACHS will be responsible for sending return letters to referrers.

Table 1: Recommended urgency categorisation for direct access colonoscopy

| Recommended Urgency Category | Indication(s) |
|------------------------------|---|
| 1 (within 30 days) | <p>Rectal bleeding for >4wks</p> <p>Positive FOBT result</p> <p>Change in bowel habit >6wks with alarm symptoms (rectal bleeding, weight loss, severe pain, anaemia, palpable mass, bloody diarrhoea with negative stool MC&S) at any age</p> <p>Unexplained iron deficiency anaemia in men or non-menstruating women</p> <p>Active inflammatory bowel disease to progress management</p> <p>Bloody diarrhoea with negative stool MC&S</p> |
| 2 (within 90 days) | <p>Change in bowel habits >6wks without alarm symptoms in patients >60yr</p> <p>Abnormal imaging</p> <p>Diarrhoea >6wks where endoscopy is indicated to progress management</p> <p>Surveillance procedures required within 12 months, as per surveillance guidelines (refer to section 3.4.2)*</p> <p>*Surveillance procedures should registered on the ESWL with a listing status of 'Not Ready for Surgery – Staged', with a Ready for Surgery date 2 months prior to procedure due date.</p> <p>Referrals for surveillance procedures that are due in >12 months should be returned to the GP with advice for re-referral closer to the due date</p> |
| N/A - Return to Referrer | <p>Does not meet WA Health direct access criteria for gastrointestinal endoscopy</p> <p>Provide a brief (1-2 sentences) return reason on the referral. This will be included in the standardised letter that the GP receives from Central Referral Service on behalf of the hospital/triaging officer.</p> |

Table 2: Recommended urgency categorisation direct access gastroscopy

| Recommended Urgency Category | Indication(s) |
|------------------------------|--|
| 1 (within 30 days) | <ul style="list-style-type: none"> • Unexplained upper GI bleeding (haematemesis, melaena) • Iron deficiency anaemia in males and post-menopausal females • Unexplained recent dyspepsia in patients <55yr with alarm symptoms • Dysphagia, odynophagia • Unexplained upper abdominal pain and weight loss (>10%) • Persistent vomiting and weight loss • Upper abdominal mass |
| 2 (within 90 days) | <ul style="list-style-type: none"> • Unexplained recent dyspepsia in patients >55yr • Reflux refractory to medical therapy • For duodenal biopsy following positive serology in suspected coeliac disease • Surveillance procedures required within 12 months, as per surveillance guidelines (refer to section 3.4.2)* <p>*Surveillance procedures should registered on the ESWL with a listing status of 'Not Ready for Surgery – Staged', with a Ready for Surgery date 2 months prior to procedure due date.</p> <p>Referrals for surveillance procedures that are due in >12 months should be returned to the GP with advice for re-referral closer to the due date</p> |

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| Recommended Urgency Category | Indication(s) |
|------------------------------|---|
| N/A - Return to Referrer | <p>Does not meet WA Health public endoscopy access criteria.</p> <p>Provide a brief (1-2 sentences) return reason on the referral. This will be included in the standardised letter that the GP receives from Central Referral Service on behalf of the hospital/triaging officer.</p> |

3.4.2. Surveillance Procedures

Patients who are assessed by the triaging clinician as requiring a surveillance endoscopy within 12 months of the HSP receiving the referral (or completion of a previous procedure) are to be registered on the ESWL as Category 2.

Where the procedure is required at an identified interval (e.g. 12 months after an initial endoscopy), a listing status of 'Not Ready for Surgery – Staged' is to be assigned in the Patient Administration System (PAS), with a 'Ready for Care' date that is 2 months prior to the date the procedure is due. This ensures that patients who do not yet require a procedure are not incorrectly reported in ESWL data.

Referrals for surveillance endoscopies that are due more than 12 months after receipt of the referral (or completion of a previous procedure) are to be returned to the referrer, with advice to re-refer the patient when their procedure is due within 12 months.

The following sections outline the recommended indications and timing for surveillance procedures.

3.4.2.1. Surveillance guidelines: Colonoscopy

All patients referred for surveillance colonoscopies after removal of polyps, for family history or following colorectal cancer are triaged according to the guidelines below. These guidelines are based on *Cancer Council Australia Clinical Practice Guidelines for Surveillance Colonoscopy (December 2011)*.

Family History

| Family History | Advice |
|---|---|
| Average Risk <ul style="list-style-type: none"> No family history 1 relative affected >55 | FOBT 1-2 yearly from age 50 |
| Moderate Risk <ul style="list-style-type: none"> 1st degree relative affected with colorectal cancer (CRC) age <55 Two 1st or 2nd degree relatives on same side of family with CRC Serrated/Hyperplastic Polyposis Syndrome | Colonoscopy every 5 years from age 50 (or 10 years younger than youngest affected relative) Colonoscopy every 2 years after polyps have been removed |
| High Risk <i>should be managed by specialist referral centre in collaboration with a genetic diseases service.</i> <ul style="list-style-type: none"> Lynch syndrome (Hereditary Non Polyposis Colorectal Cancer - HNPCC) Familial Adenomatous Polyposis (FAP) | HNPCC: Colonoscopy 1-2 yearly from age 25 (or 5 years younger than youngest affected relative) FAP: sigmoidoscopy or colonoscopy from 12-15 years of age |

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After Polypectomy

| Finding at Colonoscopy | Interval |
|---|--|
| 1 or 2 tubular adenomas <10mms | 5 years |
| Large adenomas ≥ 10mms | |
| Advanced adenoma – high grade dysplasia/villous component | 3 years |
| 3 or more adenomas | |
| 5 or more adenomas | 1 year |
| Malignant polyps | Clinical discretion (recommend within 3-6 months, then 1 year, then 3 years, then 5 years) |
| Piecemeal resection of large sessile polyps (>2cms) | 5 yearly |

After Curative Surgery for Colorectal Cancer

Complete examination of the colon before or within 6 months of surgery
Subsequent colonoscopy at 1 year, then as per adenoma surveillance (see box above) – if no polyps detected then 5 yearly surveillance interval

3.4.2.2. Surveillance guidelines: Gastroscopy

Referrals for patients with the following indications should be accepted and waitlisted for a surveillance gastroscopy

Barrett's Oesophagus

| Finding at Gastroscopy | Interval |
|---|---|
| No dysplasia | |
| Short (<3 cm) segment | 3-5 years |
| Long (>3 cm) segment | 2-3 years |
| 'Indefinite for dysplasia' or 'Confirmed dysplasia' | This should be referred and managed at a tertiary centre. |

Gastric intestinal metaplasia

If this is a finding at gastroscopy the patient should be referred to a tertiary centre for follow-up in a Gastroenterology outpatient clinic and further surveillance booked as clinically indicated.

4. Compliance, monitoring and evaluation

HSPs are responsible for ensuring compliance with this Policy and that elective waitlists for gastrointestinal endoscopy services are managed in line with the *Elective Surgery Access and Waiting List Management Policy*.

HSPs are required to develop a local policy that complies with this Policy, refer to 3.2.2 of this Policy.

Performance will be monitored by the System Manager against the WA Elective Services Target (WEST) for non-reportable procedures.

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The System Manager may audit HSPs to assess compliance with practice and processes as directed in the Policy.

5. Related documents

The following documents inform the implementation of this Policy:

- WA Health Referral Guidelines: [Direct access gastrointestinal endoscopy procedures](#). Accessed via [Central Referral Service website](#).
- WA Health Request for [Direct Access Gastrointestinal Endoscopy \(Adult\) form](#). Accessed via [Central Referral Service website](#).
- [WA Health Elective Surgery Access and Waiting List Management Policy \(2016\)](#).
- [WA Health Central Referral Service Policy \(2014\)](#).
- [Administrative Procedures – Ambulatory Surgery Initiative – OP 1816/04](#).
- Section 904 – [WA Health Financial Management Manual: Ambulatory Surgery Initiative](#).

6. Supporting information

The following non-mandatory documents support the implementation of this Policy:

- [Standardised CRS fax template for referrals that do not meet endorsed access criteria](#).
- [Sample patient letter for referrals that do not meet endorsed access criteria](#).
- [WA Health standardised referral and care pathway for direct access gastrointestinal endoscopy services](#).
- Department of Health and Ageing, Government of South Australia (2016): [Colonoscopy Urgency Categorisation and Surveillance Timing and Policy Guideline](#).
- [Cancer Council Australia Surveillance Colonoscopy Guidelines Working Party. Clinical practice guidelines for Surveillance Colonoscopy. Sydney: Cancer Council Australia](#).

7. Definitions

| | |
|--|--|
| Ambulatory Surgery Initiative (ASI) | Patients can access the ASI via their GPs by opting for a referral to specialists working in a private capacity at one of the participating general hospitals. Patients do not incur any out-of-pocket expenses as medical fees are directly billed to Medicare. This approach is consistent with the Australian Health Care Agreement between the Commonwealth and Western Australia. |
| Category 1 | Procedures that are clinically indicated within 30 days. |
| Category 2 | Procedures that are clinically indicated within 90 days. |
| Direct access | Direct access services are those which, by prior agreement, routinely accept requests for registration onto the elective surgery waitlist from external sources (e.g. GP), without assessment of the patient by a |

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| | |
|--|---|
| | Specialist in an outpatient clinic. |
| Not Ready for Surgery | A patient who is not in a position to be admitted to hospital or to begin the process leading directly to admission for elective surgery until some future date. |
| Not Ready for Surgery – Staged Patients | Patients who have undergone an elective procedure or other treatment and are waiting for a follow-up elective procedure, where the patient is not in a position to be admitted to hospital or to begin the process leading directly to admission or to provision of care on a non-admitted basis, because the patient's clinical condition means that the procedure is not indicated until some future, planned period of time. |
| PAS | Patient Administration System (e.g. webAPS, TOPAS, HCARE). |
| Ready for Surgery | A patient who is prepared to be admitted to hospital or to begin the process leading directly to admission for elective surgery (procedure). |
| System manager | The term used for the Department CEO to reflect his role as being responsible for the overall management of the WA health system. |
| Surveillance endoscopy | An endoscopy performed on a patient who is identified as having specific risk factors for developing malignancy. |
| Triaging clinician | Credentialed Specialist medical practitioner eligible to request admission of patients to a public hospital. |

8. Policy custodian

Clinical Support Directorate

System Policy and Planning Division

Enquiries relating to this mandatory policy may be directed to:

clinicalsupport@health.wa.gov.au

9. Review

This mandatory policy will be reviewed as required to ensure relevance and recency. At a minimum it will be reviewed within 1 year after first issue and at least every 2 years thereafter.

| Version | Effective from | Effective to | Amendment(s) |
|------------------|-----------------|-----------------|--------------------------------------|
| MP 0045/17 v.1.0 | 20 January 2017 | 29 May 2019 | Original version |
| MP 0045/17 v.1.1 | 29 May 2019 | 20 January 2022 | Minor Amendment – Fixed broken links |

The review table indicates previous versions of the mandatory document and any significant changes.

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10. Approval

This mandatory policy has been approved and issued by the Director General of the Department of Health.

| | |
|-----------------------|--|
| Approval by | Dr David Russell-Weisz, Director General, Department of Health |
| Approval date | 21 December 2016 |
| Published date | 29 May 2019 |
| RMR# | F-AA-50210 |

Superseded by MP 0169/21 - 30 September 2021
No Longer Applicable -

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