Elective Surgery Access

Summary	This Policy Directive 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.
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Secretary, NSW Health

This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is mandatory for NSW Health and is a condition of subsidy for public health organisations.

NSW GOVERNMENT

ELECTIVE SURGERY ACCESS

POLICY STATEMENT

NSW Health organisations that manage elective surgery services must ensure clinically appropriate, consistent and equitable management of access for patients across the state.

Arrangements must be in place to provide all Australians with timely access to quality health services based on their needs, not ability to pay, regardless of where they live in the country.

SUMMARY OF POLICY REQUIREMENTS

All local health districts and speciality health networks with surgical services must have local procedures in place that are consistent with the principles and requirements identified in this Policy.

Referring patients to the elective surgery list occurs with receipt of the Recommendation for Admission (RFA) form in a timely manner by the treating doctor.

Clinical urgency categories (CUCs) are to be assigned in accordance to this policy, and any variance or reclassification validated by the surgeon with documented evidence. The procedures part of this policy also provides the management process for colonoscopy, cosmetic and discretionary procedures and new procedures and interventions.

The acceptance of a Recommendation for Admission (RFA) form and variations to normal bookings, including bilateral procedures and duplicate bookings are also included together with the importance of ensuring that the minimum data is set and legible. When the information on the RFA is not legible there is instruction on how to proceed and an example letter that is to be sent to the surgeon requesting clarity.

Once the RFA has been reviewed for completion and appropriate category allocation, timely registration on the elective surgery list is required. Patients and their General Practitioners should also be aware of the patient’s addition to the elective surgery list, clinical urgency category and estimated timeframe for their surgery. It is also important that both patients and their general practitioners are aware and how to contact the hospital in the event of a change in the patients’ clinical condition or circumstances.

In the event that a patient’s clinical condition changes and a clinical review is required, the procedures part of this policy explains the process to instigate a clinical review. It also explains how the patient’s booking is to be managed, when changes are made to the original listing procedure and when there are hospital-initiated delays. This includes if a patient is to be removed from the elective surgery list for reasons other than surgery including who is required to be informed and consulted when this occurs.

All patients on the elective surgery list are to be managed according to their clinical urgency category and treated in turn. Surgical services must keep accurate records of hospital delays and patient deferrals. The clinical staging of procedures and the importance of accurate recording of these events when a patient is ‘not ready for care’ should also be recorded and monitored.

Finally, it is essential that the elective surgery list is regularly audited to ensure accurate information is available for patients, clinicians and administrators. Succession planning of key auditing processes should be in place to ensure this practice continues in the event of annual leave or a staff member resigns.

REVISION HISTORY

Version	Approved by	Amendment notes
January-2022 (PD2022_001)	Deputy Secretary Patient Experience and System Performance	Updated to reflect amendments to current policy. Incorporates information from IB2012_004 which will be rescinded on release of this policy.
February 2012 (PD2012_011)	Director- General	Updated to reflect amendments to current policy
April 2009 (PD2009_018)	Director- General	Updated and replaced PD2006_020
March 2006 (PD2006_020)	Director- General	Policy released

ATTACHMENTS

1. Elective Surgery Access: Procedures

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1 BACKGROUND

Each year more than 220,000 patients have elective surgery or procedures in NSW public hospitals. People who need surgery are placed on an elective surgery list according to the urgency of their clinical need.

Managing patients on elective surgery lists is a key priority for the NSW Government and NSW Health so that the community has timely access to high-quality and patient-centred surgical services.

Elective surgery management is a challenging, dynamic and complex process requiring input from and coordination by a multidisciplinary team.

Public hospitals across NSW must actively manage all aspects of elective surgery lists with transparent and patient-focused processes for:

- Referring patients for surgery
- Assigning to patients the appropriate clinical urgency category (CUC)
- Accepting referrals for surgery
- Registering patients onto the elective surgery list
- Compiling and maintaining the elective surgery list
- Booking patients for surgery under the principals of treating patients in turn and treating patients within clinically appropriate timeframes
- Ensuring patients have timely and effective communication about their elective surgery
- Removal of patients from the elective surgery list
- Accurate data collection documentation, auditing and reporting
- Regular system evaluation, monitoring and improvement
- Well-informed patients and staff (clinical and non-clinical) who understand the process and their roles and responsibilities

1.1 About this document

The elective surgery access Policy Directive is the reference guide for facilities to manage elective surgery lists. The Policy covers the procedures that facilities are required to follow and adequately manage surgery lists.

All medical and surgical procedures that are performed within operating theatres, procedure rooms and endoscopy suites, must be added to the elective surgery list.

1.2 Key definitions

Admission

The process whereby the hospital accepts responsibility for the patient's care and/or treatment. Admission follows a clinical decision based upon specific criteria that a patient requires same day or overnight care and treatment.

Admission date

Date on which an admitted patient commences an episode of care.

Clinical review

A review of a patient on the elective surgery list to ensure that their waiting time remains appropriate for their clinical condition.

Clinical urgency category

A clinical assessment of the timeframe in which a patient requires elective admission. Urgency categories 1, 2 and 3 referred to in this document align with clinical urgency categories.

Cosmetic surgery

Procedure performed to reshape normal structures of the body, or to adorn parts of the body with the aim of improving the consumer's appearance and self-esteem. These procedures do not attract a Medicare rebate.

Decline

A Planned Admission/Planned Procedure Date outcome where the offer is not accepted by the patient due to non-clinical personal reasons.

Deferred patient

Patients that are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.

Discharge Intention

Recorded when the person is added to the elective surgery list. It identifies whether the treating doctor expects that the person will be admitted and discharged on the same day (i.e. day patient) or will stay overnight.

Discretionary surgery

Surgical procedures that must not be undertaken in public hospitals in NSW unless essential. They must meet an identified clinical need to improve the physical health of the patient.

Elective surgery list

A list that contains the names and details of all patients who have submitted a Recommendation for Admission (RFA) and have been added to the elective surgery list contained in the Patient Administration System (PAS) at a hospital. The term elective surgery list in this policy will include both surgical and medical lists.

Indicator Procedure Code (IPC)

This is an administrative coding used for the procedure or treatment the patient is to undergo when admitted.

Listing date

The date the Recommendation for Admission Form was received. Calculation of waiting time starts from this date.

Listing status

Indicates the status of the person on the elective surgery list that is the extent to which a patient is ready and available for admission. This may change while the patient is on the elective surgery list for example, after a clinical review.

Non-admitted patient

A patient who does not undergo a hospital's formal admission process.

Not ready for care

Patients who are not able to be admitted to hospital. These patients are either staged patients or deferred patients.

Planned Admission Date (PAD)

The date on which it is proposed that a patient on the elective surgery list will be admitted for an episode of care.

Planned procedure

The procedure or treatment the patient is to undergo when admitted.

Planned procedure date

The date on which it is proposed that a patient on the elective surgery list will have their procedure completed.

Pre-admission

Patients are assessed before admission to the hospital for their suitability to undergo the intended procedure/treatment, associated anaesthetic and discharge plans.

Ready for care

A patient who is prepared to be admitted to hospital or to begin the process leading directly to admission and surgery. The process leading to surgery could include investigations/procedures or other preoperative preparation.

Specialty

Treating doctor's area of clinical expertise. Where the doctor undertakes surgical procedures, which can be classified into different specialities. The doctor will have a different list for each specialty (for example, Obstetrics/Gynaecology).

Hospitals may have many more specific clinical areas identified, but these must be categorised under the main specialty headings for central reporting.

Staged

A suspension period applied where the patient is clinically not ready for care. This may be indicated by either the doctor or the patient.

Status Review Date

This is the date determined for an assessment (clinical or administrative) as to whether a deferred or staged person (i.e. Not Ready for Care) has become ready for admission to the hospital at the first available opportunity (i.e. Ready for Care).

Surgery

Procedures listed in the surgical operations section of the Commonwealth Medical Benefits Schedule.

Surgery is classified as either emergency surgery, elective surgery or other surgery based on a patient's presentation and subsequent care, not by time periods to surgery.

Emergency surgery

Surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery later following this unplanned presentation. This includes where the patient leaves hospital and returns for a subsequent admission.

Emergency surgery includes unplanned surgery for admitted patients and unplanned surgery for patients already awaiting an elective surgery procedure (for example, in cases of acute deterioration of an existing condition).

Elective surgery

Planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery list.

Other surgery

The procedure cannot be defined as either emergency surgery or elective surgery, for example, transplant surgery and planned obstetrics procedures.

Waiting Time

The total time a patient spends on the elective surgery list.

2 SUMMARY OF KEY RESPONSIBILITIES

2.1 Admissions / booking staff

Admissions / Booking Clerks are expected to enter required data on the elective surgery list 'system' within three working days of receipt of the completed RFA. They need to check allocated clinical urgency categories against the list of recommended clinical urgency categories and ensure all documentation and electronic data input is accurate, legible and complete.

2.2 Elective surgery list coordinators

Elective surgery list coordinators have efficient oversight and management of patients requiring elective surgery to ensure that all relevant audits are completed and provide operational advice on the achievement of elective surgery performance.

2.3 Senior manager

Senior managers who are involved with coordination of surgical services and have decision-making responsibility in ensuring the appropriate application of this policy and ensuring that patients have timely access to care. Surgical services are administered according to local need at Local Health Districts and Specialty Health Networks across NSW.

Not all positions will be the same across NSW, individual facilities need to establish processes and points of escalation to ensure safe, clinically appropriate and equitable access of elective surgery programs.

2.4 Treating doctors

Treating doctors will provide clinical care in the best interests of patients informed by current evidence and best practice. They will have a clear understanding of the clinical capability of the service where the procedure is to be undertaken to ensure the right care is available and occurs in a setting with access to the necessary supportive care for example; imaging, pathology or access to intensive care.

They will only conduct procedures in keeping with the role delineation of the service and the credentials the doctor holds for surgical or other invasive procedures. They must be contracted and appropriately credentialed with the district, network or facility and have a clear understanding of the clinical networks available should the patient require transfer to a higher level of care.

Written informed consent from the patient must be obtained after fully informing the patient of the proposed surgery, procedure or treatment, any potential complications and expected length of hospital stay. The treating doctor must also inform the patient that under Medicare principles, public patients are allocated to a doctor by the hospital and that if the patient elects to be a public patient, their surgery may be performed by another surgeon or hospital. The treating doctor must also inform the patient that they are prioritised for surgery based on clinical need, and without regard to whether a patient chooses to be treated as a public or private patient.

A fully completed and legible RFA must be submitted to the hospital within five working days of the patient agreeing to the proposed procedure/treatment. If the treating doctor is unable to perform the procedure within the clinical urgency category timeframe, they must in conjunction with the hospital, make arrangements for another clinician to perform the procedure within the patient's clinical urgency category.

The treating doctor must also review their elective surgery list provided by the hospital at least monthly and maintain timely clinical record keeping and record sharing and comply with mandatory reporting requirements. They must also participate in quality improvement initiatives including morbidity and mortality reviews and organise ongoing clinical care for patients in their absence.

2.5 Hospital clinical directors of surgical services or equivalent

This position must promote efficient and effective elective surgery list management by clinicians within their hospital and liaise with the district/network program director of surgical services or equivalent, for escalation of any issues. Specific responsibilities

include the management of assigned clinical urgency categories not in accordance with the list of recommended clinical urgency categories and where insufficient evidence has been provided by the treating doctor and in the review and management of applications to perform cosmetic and discretionary procedures or exceptions to the policy.

For smaller sites that may not have a hospital clinical director of surgical services or equivalent, these responsibilities should be undertaken by the district/network Program Directors of Surgical Services or equivalent.

2.6 District / Network program directors of surgical services or equivalent

This position must ensure that clear administrative and clinical procedures/protocols, are in place to implement this policy and promote efficient, equitable and effective list management within all levels of hospital management. This includes the provision of adequate facilities/staff/work environment to facilitate the surgical management of patients referred to the hospital. They are also required to address issues arising with the management of the patient with the treating doctor and General Practitioner as required.

2.7 Chief executives

The chief executive is required to regularly review elective surgery performance across individual hospitals and engage relevant clinicians to ensure consistent application of policy requirements across the organisation. They would also ensure that there is provision for training and education programs for staff involved in managing elective patients and lists

3 ELECTIVE SURGERY LIST

To place a patient on an elective surgery list, the treating doctor must have fully informed the patient about the planned surgery or procedure/treatment and obtained their written consent in line with NSW Health Consent to Medical and Healthcare Treatment Manual.

The treating doctor must complete a Recommendation for Admission form (RFA) legibly and accurately and forward the completed RFA form to the facility within five working days of the patient agreeing to the proposed procedure or treatment.

To ensure that patient information is protected and secure, the RFA must be submitted to the facility in the most appropriate way for example, mail, hand delivery by the treating doctor, patient or carer or electronically if there is an approved system in place. Unsecure or unencrypted transfer of RFA forms through email is not permitted.

Facsimiles (fax) of an RFA form must not routinely be used and must only be accepted for urgent admissions for example, patients in clinical urgency category 1 where there is limited time to send a hard copy. A hard copy or an electronic version (if approved eRFA system is used) must follow as soon as possible.

At the time of lodgement of the RFA form, a patient must be ready for care and be able to accept an assigned planned admission or planned procedure date (excluding staged procedures).

3.1 Completion of the Recommendation for Admission (RFA) form

The following minimum data set on the RFA must be completed.

Treating Doctor must provide:	
• Patient's full name • Patient's address • Patient's email address where provided • Patient's contact information (home, mobile and/or work telephone) • Patient's gender • Patient's date of birth • Patient's Medicare number • Clinical urgency category • If classified as staged, the time interval when the patient will be ready for care must be indicated • Discharge intention (i.e. day only, or indication of number of nights in hospital) • Presenting problem/diagnosis	• Significant medical history (including allergies, infection risk and disability) • Treating doctor (if different) • Date the RFA is completed • General Practitioner's name and address • Interpreter requirements • Estimated operating time, including anaesthetic • Specific preadmission requirements. • Special operating theatre equipment. • Requirement for an intensive care or high dependency bed post-procedure • Planned procedure/treatment
Admission/booking staff must provide:	
• Planned Admission Date / Planned Procedure Date (if allocated) • Short notice / Standby offers	• Aboriginal and Torres Strait Islander Origin • Status Review Date (for staged patients) • Anticipated election status e.g. Medicare/public or private

3.2 Clinical urgency categories

Categorisation of elective patients by clinical urgency category is required to ensure they receive care in a timely, equitable and clinically appropriate manner.

A clinical urgency category must be assigned by the treating doctor and be based on the patient's clinical need, regardless of their health insurance status. It must be appropriate to the patient and their clinical condition and not influenced by the availability of hospital or surgeon resources.

When allocating a clinical urgency category, reference must be made to the *NSW Recommended Clinical Urgency Categories*.

	Procedures that are clinically indicated within
Category 1 - Urgent	30 days
Category 2 - Semi-urgent	90 days
Category 3 - Non-urgent	365 days

	Procedures that are clinically indicated within
Category 4 - Not ready for care or patient suspension	Patient not currently available for surgery • Staged – section 6.4.1 • Deferred – section 6.4.2

A departure from the recommended clinical urgency category may be warranted for sound clinical reasons, including in circumstances where the procedure is for diagnosis or treatment of a proven or suspected malignancy.

For individual patient exceptions to the recommended clinical urgency category, the treating doctor must supply supporting documentation and discuss this with the district/network program director of surgical services or the equivalent.

If there is no supporting clinical information supplied, the admissions/booking staff must contact the treating doctor to provide the required information to support the selected change in clinical urgency category and ensure that the patient is added to the elective surgery list within three working days from receipt of the RFA.

The NSW Recommended Clinical Urgency Categories must be used until clarification is sought from the treating doctor.

Where the procedure is not within the NSW Recommended Clinical Urgency Categories treating doctors must follow the principles outlined in this policy when assigning the clinical urgency category.

There must be a review and escalation process at each facility for hospital clinical directors of surgical services or equivalent to review all variations from the recommended clinical urgency category to ensure appropriate prioritisation of patients

3.2.1 Inclusions and exclusion criteria for category 1 – urgent surgery

The allocation of clinical urgency category 1 is specifically reserved for those patients whose clinical condition has been assessed as requiring the procedure or treatment within 30 days.

This category is not to be used to advance the date for elective surgery patients whose clinical condition does not require the procedure or treatment to be completed within 30 days for example, vasectomy, joint replacement surgery, routine cataract surgery, routine tonsillectomy.

3.2.2 Reclassification of clinical urgency category

Only the treating doctor or their delegate may undertake reclassification of patients between categories. To reclassify a patient, the treating doctor must ensure documented evidence is readily available to validate any changes to a patient's clinical urgency category.

Documentation is to include the name and signature of the relevant staff member documenting the change, the date and time of notification of the category change, the person notifying the category change and the reason for the category urgency category change. The documentation is to be attached to or form part of the RFA and will become part of the patient's medical record.

If a patient is reclassified to a higher clinical urgency category, for example from a category 3 to a category 2, the count of days waiting will restart from the date the change was made.

If a patient is reclassified to a lower clinical urgency category, the waiting days will continue from the listing date, for example from a category 2 to a category 3.

The elective surgery list is to be updated with any changes and the treating doctor advised of the changes in writing to confirm completion of the change in patient category.

3.2.3 NSW colonoscopy categorisation

High quality, timely colonoscopy is critical to the early detection and treatment of bowel cancer and other gastrointestinal conditions.

For detailed information on criteria for the categorisation and prioritisation of patients presenting to NSW public hospital colonoscopy services please refer to the Agency for Clinical Innovation's *NSW Colonoscopy Categorisation Clinical Practice Guide*.

3.3 Cosmetic and discretionary surgery

The following list of surgical procedures must not routinely be performed in public hospitals in NSW unless there is a clear clinical need to improve a patient's physical health and the procedure has been approved by the district/network program director of surgical services or equivalent.

Cosmetic/Discretionary Procedure	Exception
Bilateral breast reduction	Severe disability due to breast size Gross breast asymmetry in patients under 21 years old Virginal Hyperplasia/Hypertrophy
Bilateral breast augmentation	Nil
Replacement breast prosthesis	Replacement for post-cancer patients only
Bilateral mastectomy	Genetic risk such as BRCA1, BRCA2, TP53 or PTEN Cancer in the other breast
Breast reconstruction	Post cancer and genetic risk patients
Hair transplant	Disfiguring hair loss due to severe burns
Blepharoplasty/reduction of upper or lower eyelid	Documented severe visual impairment/obstruction
Total rhinoplasty	Nasal fracture/major facial trauma Congenital abnormality due to a documented syndrome as referred from a Consultant Paediatrician (paediatrics only)
Liposuction	Nil
Abdominal lipectomy (abdominoplasty)	Nil
Meloplasty/facelifts	Nil
Correction of bat ear (>16 years old)	Nil

Cosmetic/Discretionary Procedure	Exception
Tattoo removal procedure	Nil
Removal of benign moles	Nil
Candela laser	Congenital abnormality – paediatrics < 17 years old
Varicose veins	CEAP Grade > C3 [CEAP Classification System]
Laser photocoagulation	Nil
Gender affirming surgery	Congenital abnormalities in children
Lengthening of penis procedure	Congenital abnormalities in children
Insertion of artificial penile prosthetic devices	Post cancer, major trauma and severe burns Patients with neurological erectile dysfunction
Reversal of sterilization	Nil
Circumcision	Phimosis, paraphimosis, balanitis
Temporomandibular joint arthrocentesis	Nil
Labiaplasty	Congenital abnormality in paediatrics < 17 years
Knee arthroscopy when the main indication is osteoarthritis and the patient is 50 years or older.	Only after approval by district/network program director of surgical services (or equivalent) and local selection criteria has been met

The treating doctor must obtain approval from the program director of surgical services or equivalent, in consultation with senior management before submitting the RFA.

They must document on the RFA form at the time a patient is referred objective medical criteria supporting the decision for surgery for all procedures that may be considered cosmetic or discretionary. This requirement supports appropriate documentation of clinical decision making and the review process.

For procedures not appearing in section 3.3, or where there is doubt about the nature of the proposed surgery, the request must be referred to the program director of surgical services or equivalent for review prior to the patient being added to the elective surgery list.

The patient must be advised by the treating doctor when the RFA form is going through the approval process together with an estimated time for review.

Clinical directors of surgical services or equivalent, must review the addition of cosmetic and discretionary procedures to the elective surgery list to ensure their addition was in accordance with this Policy.

3.4 Dental surgery

For operating lists that are dedicated to the Priority Oral Health Program – patients must be eligible for treatment as identified in the NSW Health Policy Directive *Priority Oral Health Program and Elective Surgery List Management* (PD2017_023).

3.5 Introduction of new procedures and technologies

Each district or network must have a process in place to formally approve new procedures not previously undertaken at the hospital. The clinician must be appropriately credentialed by a relevant committee and have privileges to undertake the procedure before the patient is added to the elective surgery list.

For additional information, refer to:

- NSW Health Guideline *NSW Framework for New Health Technologies and Specialised Services* (GL2018_023)
- Australian Safety and Efficacy Register of New Interventional Procedures – Surgical – RACS/ASERNIP-S
- RACS General Guidelines for Assessing, Approving & Introducing New Surgical Procedures into a Hospital or Health Service.

3.6 Planned procedure / treatment not available at the hospital

An RFA form must not be accepted and must be returned to the treating doctor if the procedure or treatment is not provided at the nominated hospital.

The treating doctor must be informed that the RFA is not accepted and make alternative arrangements for the patient.

3.7 Patient consent and communication

Patients must be fully informed about the risks and benefits of the proposed surgery by the treating doctor, procedure/treatment and have consented to the treatment offered.

Consent must be obtained in accordance with the requirements outlined in the NSW Health *Consent to Medical and Healthcare Treatment Manual*.

3.7.1 Information to be provided to the patient

Treating doctors must explain the elective surgery list, including:

- Reason for referral to the elective surgery list
- Elective surgery list process, including clinical urgency categories
- That prioritisation for surgery is based on clinical need, and without regard to whether a patient chooses to be treated as a public or private patient.

Treating doctors must also explain the difference between admission as a public or private patient and provide the patient with information to enable them to elect to be treated as a private or public patient.

When a patient chooses to be treated as a public patient, treating doctors must explain the circumstances in which care might be provided by another doctor or health service.

Under the Medicare principles, public patients are allocated to a doctor by the hospital. While in most instances public patients will be admitted under the care of the original treating doctor, this is not always guaranteed.

In keeping with the principle of providing the earliest access and optimal care, surgery may be performed by another treating doctor if this would result in the patient receiving an earlier date for surgery.

When a patient chooses to be treated as a private patient, the treating doctor must also ensure the patient is advised of the associated costs of treatment and that priority of treatment will be based on clinical need regardless of insurance status.

4 ACCEPTANCE OF RECOMMENDATION FOR ADMISSION FORM

4.1 Standard bookings

When RFA forms are received from the treating doctor, elective surgery admissions/ booking office staff must date stamp the hard copy form or document on electronic RFA.

They must ensure that the form is legible and the minimum data set (see section 3.1) is included before acceptance of the RFA form. For further information, refer to the NSW Policy Directive *Health Client Registration* (PD2007_094).

A locally agreed process must be in place to manage incomplete forms. Where information is missing on the RFA or the form is not legible, the treating doctor must be contacted by telephone or in writing as soon as possible to provide the required information. If the RFA is to be returned to the doctor, then the original RFA must remain in the booking office after acceptance and a copy of the RFA must be used to return to the treating doctor for missing information.

RFA forms are to be returned to the treating doctor if the RFA states the patient's surgery is required beyond 12 months.

If an RFA is not presented to the elective surgery booking office within three months of the date the RFA was signed, acceptance of the form must be discussed with the treating doctor to ensure the patient's clinical condition has not changed. A review of the patient's clinical condition may be required before the form is accepted.

An example of a letter regarding an incomplete RFA is available on the Elective Surgery Program Resources webpage.

4.2 Variations from standard bookings

4.2.1 Bilateral procedures

An RFA must only be accepted for one procedure unless the bilateral procedure is occurring in the same admission. This is to ensure that the patient has been reviewed and that they are clinically ready to undergo the subsequent procedure.

Bilateral procedures include, right and left cataract extractions, right and left hip replacements.

4.2.2 Multiple admission forms received for one patient

Multiple RFAs can be accepted if the treatments/procedures are independent of each other for example, cholecystectomy and tonsillectomy.

The treating doctor must assign a clinical urgency category for each procedure. Where categories differ, the procedure with the more urgent category takes precedence. Where categories are the same, the treating doctor/s must specify the priority.

4.2.3 Duplicate bookings

An RFA for the same procedure with different treating doctors at the same hospital; or for the same procedure at a different hospital must not be accepted. The patient must be asked to decide which elective surgery list they wish to remain on.

5 NOTIFICATION

Admissions/booking staff must use the date that is stamped on the RFA as the listing date and add the patient to the elective surgery list within three working days of receiving the RFA.

5.1 Notification to the patient

Admissions/booking office staff must inform the patient in writing within three working days of them being added to the elective surgery list and of their clinical urgency category timeframe. They must also be advised of any other relevant information of their hospitalisation, which may include the anticipated length of stay, discharge procedures and post-operative follow up. The patient must also be informed of how to advise the hospital of any changes to their contact details or condition.

Any additional information for the patient's admission should be attached to the RFA as appropriate

5.2 Notification to the patient's general practitioner

The treating doctor or hospital must provide a notification letter to the patient's referring general practitioner advising them that the patient has been added to the elective surgery list as a result of their referral. The notification letter is to be sent within three working days of the patient being added to the list and is to include the patient's:

- full name and address
- placement on the elective surgery list
- the date of placement on the elective surgery list
- the proposed procedure
- the clinical urgency category and definition
- hospital contact information, including who to contact if the patient's condition changes

A copy of this notification letter must be sent to the treating doctor or hospital. Admissions/booking staff are to add this letter to the patient's medical record.

An example letter of notification to the general practitioner is available on the Elective Surgery Program Resources webpage.

6 MANAGING PATIENTS

6.1 Access to elective surgery

Access to elective surgery in NSW public hospitals must be managed according to clinical urgency, resource availability and time of a patient's placement on the elective surgery list (treat in turn principle).

6.2 Privately referred non-admitted patients

All medical and elective surgical procedures that are performed within operating theatres, procedure rooms and endoscopy suites must be added to the elective surgery list regardless of admission type.

Privately referred non-admitted patients are also to be managed as per this policy and added to the elective surgery list in the Patient Administration System.

For further information on elective surgery list reporting requirements see the Data Dictionary Wait List Data Stream EDWARD Version: 2021

6.3 Delayed and declined patient outcomes

A delayed or declined outcome can be applied against a planned admission/planned procedure date where the procedure was not performed; however, the patient remains on the elective surgery list.

6.3.1 Delayed patient

A delayed outcome must be reported where a patient's planned admission/planned procedure has been delayed to a later date by reasons initiated by the hospital, for example, unavailability of doctor or unavailability of bed.

The patient must remain on the elective surgery list as being ready for care and a suspension must not be applied.

Admissions/booking office staff must record the reason the patient is being delayed on the patient administration system and RFA and offer the patient a new planned admission/planned procedure date within five working days of the delay.

6.3.2 Declined patient

A declined outcome must be reported where a patient has not accepted a planned admission/planned procedure date for reasons due to their own choice or unavailability, for example, they do not accept an alternate surgeon, or they are unavailable at that time.

Admissions/booking office staff must record the reason the patient is declining the planned admission or procedure date on the patient administration system and on the RFA. They must also review the reason for a declined planned admission/planned procedure date to determine:

- If a new date is to be offered
- If a 'deferred' suspension should to be applied (see section 6.4.2)

- If the patient is to be removed from the elective surgery list

A 'deferred' suspension must not be applied where a patient declines a planned admission/planned procedure date offer with an alternate surgeon or at an alternate hospital. Patients who decline two genuine offers are to be informed that they may be removed from the elective surgery list in consultation with their treating doctor.

6.4 Suspension

A person on the elective surgery list who experiences a period of time where they are clinically not ready for care ('**staged**') or personally unavailable ('**deferred**') but is expected to become ready for care or available in the future must have a suspension applied for the period they are not ready for care or unavailable.

At the time of registration on the elective surgery list all patients must be available to be admitted to hospital or begin the process leading directly to admission, except for patients who are 'staged' (see section 6.4.1).

Where a patient is required to be 'staged' for a prolonged period of time to achieve a desired outcome for surgery to occur for example, significant weight loss, the patient must not be placed on the elective surgery list, or they must be removed from the elective surgery list in consultation with the treating doctor.

Admissions/booking office staff must record the reason for staging or deferring a patient on both the electronic Patient Administration System and the RFA. Patients with current suspensions must be regularly reviewed to ensure they become 'ready for care/available' or are removed from the elective surgery list (see section 6.12).

6.4.1 Staged (Clinically 'not ready for care')

A person on the elective surgery list who is not presently available for treatment due to clinical reasons, or patients whose medical condition will not require or be amenable to surgery until some future date is Staged. An example of a Staged patient is a patient who has had internal fixation of a fractured bone and who will require removal of the fixation device after a suitable time.

The treating doctor must identify the 'not ready for care' timeframe and a 'ready for care' clinical urgency category must be indicated for admission on the RFA.

Admissions/booking staff must first register the patient in their intended clinical urgency category, then record the Staged suspension period.

For further information please refer to the Data Dictionary Wait List Data Stream EDWARD Version: 2021

6.4.2 Deferred (patient unavailable for non-clinical reasons)

A suspension may only be applied where the period of unavailability is greater than one day.

Where a patient is clinically ready for treatment, however they are unavailable for surgery due to personal reasons, admissions/booking staff must record the unavailable period in the waitlist record as a deferred suspension. Any clinical urgency category 1 patient who requests deferral must be brought to the attention of the treating doctor.

The patient listing status should be returned to ‘ready for care’ once the unavailable/suspension timeframe is complete.

If a patient is unavailable on more than two occasions or exceeds the maximum cumulative number of unavailable/suspension days, consider removing the patient from the elective surgery list (see section 6.12).

The maximum cumulative of unavailable/Suspension days does not include days accrued as staged.

Clinical urgency category	Maximum cumulative days
Category 1 - Urgent	15
Category 2 - Semi-urgent	45
Category 3 - Non-urgent	180

6.5 Status review date

Admissions/booking office staff must set the status review date each time a patient’s status changes from ‘ready for care’ to ‘not ready for care/suspended’ or where their status remains ‘not ready for care/suspended’ after assessment.

6.5.1 Status review report

Admissions/booking staff must, at least weekly, generate a report listing the details of each patient whose status review date will become due in the following month. During this review, patients can:

- Be assigned another status review date
- Be returned to ready for care with the appropriate clinical urgency category
- Have a planned admission date scheduled (see section 6.8.1)
- Be removed from the elective surgery list (see section 6.12)

6.6 Clinical review

The condition of the patient may change while the patient is awaiting treatment. Patients and general practitioners can initiate a review to ensure that the waiting time is appropriate for their clinical condition.

Patient listing status must remain in their current clinical urgency category while undergoing a clinical review and must not be moved into ‘not ready for care’.

The clinical review must be arranged by the hospital at no cost to the patient and conducted by the treating doctor, a specialist consultant, or their delegates.

Examination may result in the patient being assigned a different clinical urgency category from the initial category that was assigned (see section 3.2.2). An authorised change in the clinical urgency category must be documented in the patient administration system and on the RFA. The name and signature of the relevant staff member who documented the change is also to be included.

If a patient declines an appointment or fails to attend a clinical review the admissions/booking staff must discuss the patient's status on the elective surgery list with the treating doctor or their delegate and senior management.

6.7 Changes to the patient's planned procedure

When changes are made to the originally listed procedure for the treatment of the same condition, admissions/booking office staff must document evidence to validate any change to a patient's listed procedure including:

- Name and signature of the relevant staff member
- Date and time of notification of the change
- Name of the person notifying of the change to the originally listed procedure
- Reason for the change

Where the changes are minor, and the principal procedure remains the same (for example a left total knee replacement replaces a right total knee replacement) the admissions/booking office must edit the procedure description field of the elective surgery list entry screen and a notation regarding the changes are to be made in the comments field.

Where the principal procedure changes, admissions/booking office must remove the original elective surgery list entry as "no longer required" and the treating doctor must submit new RFA for the new procedure. As this is a new procedure the listing date is the date as on the new RFA.

6.8 Admission process

To ensure equity and priority of access, when choosing patients from an elective surgery list for admission, admissions/booking office staff must treat all patients in accordance with the clinical urgency categories and in the order as they are added to the elective surgery list.

Staff must consider:

- Resource availability e.g. theatre time, staffing, post-operative bed requirements, equipment and hospital capacity
- Previous delays
- Pre-admission assessment issues and factors e.g. elderly people living alone or those having to travel long distances

Staff must also consult with relevant staff to meet individual patient needs including:

- Treating doctor
- Operating Theatres Manager
- Admissions
- Pre-admission clinic
- Elective surgery list coordinator

- Other departments if relevant e.g. medicine or radiology
- Community care and post discharge services for an effective communication to handover patient care to their general practitioner or other relevant community services as required
- Aboriginal liaison officer
- Interpreter

6.8.1 Allocating a date for surgery

When a patient is selected from the elective surgery list for surgery, admissions/ booking office staff must determine a planned admission date on which it is proposed that a patient will be admitted for their planned procedure. This may be the same as the planned procedure date, or it may be different.

The patient must be contacted by phone or patient's preferred contact method to determine acceptance of admission. Once a date is accepted, an admission letter must be sent to the patient.

A planned admission date can be arranged when a patient is in the 'not ready for care/suspended' category. The patient must be returned to 'ready for care' status prior to admission.

For patients allocated a 30-day clinical urgency category, a planned admission date must be given to the patient on registration.

For an example patient letter allocating a date for surgery to patients, please see the Elective Surgery Program Resources webpage.

6.8.2 Pre-admission assessment

All RFA forms must be reviewed for the need for a pre-admission clinic appointment to confirm the patient's suitability and safety to undergo the intended surgery. This optimises and supports management of the patient's perioperative risks associated with their planned surgery.

If the patient meets the local criteria that they are required to attend a pre-admission appointment and then fail to attend, their risk for surgery remains undetermined. Any decision to go ahead with the surgery must be discussed with the treating doctor prior to rescheduling the appointment and surgery.

For further information on pre-admission clinics please see the Agency for Clinical Innovation's Perioperative Toolkit.

6.8.3 Short-notice list

When offering dates at a short notice, admission/booking staff must consider the need for a pre-admission clinic appointment and be managed "in turn" within clinical urgency category as much as possible.

Patients must be given as much notice as possible about their proposed advancement on the list. Once a patient has been called in as a 'short-notice' list patient and their

procedure has not gone ahead, a definite planned admission date must be made to ensure the patient is not inconvenienced further.

A patient must not be marked as 'deferred' if they are unable to make a short notice offer.

6.9 Hospital-initiated delays

Postponements or delays to surgery must be avoided and only occur when all alternative options are exhausted. Decisions to delay a patient must involve relevant medical and operating theatre staff, bed manager, the elective surgery list manager and senior hospital management. The decision must consider the:

- Reason for the delay
- Clinical urgency category
- Patient's delay history
- Patient's length of time on the elective surgery list
- Medical input from treating doctor or delegate
- Patient's proximity to the facility

When a patient's planned admission date is delayed and needs to be rescheduled, administration/ booking office staff must record the reason for the delay and reschedule the patient on the next available list according to their clinical urgency category. The record is to include the original listing date and history of any previous admission dates and delays.

The patient must be advised of a new planned admission date within five working days of the delay.

Where possible, delayed patients must be prioritised on the procedure/treatment list to minimise the chance of further delay for example, placed first on list.

If a patient has been delayed twice and cannot be treated within the appropriate clinical urgency category timeframe, admissions/booking office staff must escalate to district/network senior management and a plan made to treat the patient within their clinical timeframe (see section 6.11).

For an example of a patient delay letter, please see the Elective Surgery Program Resources webpage.

6.9.1 Informing patients of delays

When communicating the surgery delay, admissions/booking office staff must provide the patient with the maximum possible notice. Category 1 patients must be notified of their delay by a senior member of the surgical/medical team or senior hospital manager.

6.9.2 Delay on the day of surgery or after admission

When a patient's surgery, procedure or treatment is delayed by the hospital on the day of their planned admission or their planned procedure date the patient must be informed by a senior member of hospital or district management and/or treating doctor or their delegate.

Offers of support that can be offered to the patient include	
Contacting a family member or friend	Counselling services
Aboriginal Liaison Officer support	Access to a complaint service
Social Worker support	Arranging and paying for transport home, accommodation, food etc

Admission / Booking Office staff must	
Admit and discharge the patient	Record the reason for the delay
Return the patients record to the elective surgery list with the original listing date and history	Reschedule the patient on the next available list according to their clinical urgency category
Advise the patient of a new PAD within 5 working days of the delay	

An example letter informing a patient of a necessary delay is available on the Elective Surgery Program Resources webpage.

6.10 Patient-initiated deferral

When a patient defers an agreed date for surgery or procedure for personal or social reasons, admissions/booking staff must record the reason the patient is declining the planned admission or procedure date on the elective surgery list and on the RFA. They must also review the reason for a declined admission date to determine whether:

- A new date is to be offered
- The patient is to be categorised as ‘not ready for care/suspended’ deferred
- The patient is to be removed from the elective surgery list

Patients are only permitted to defer maximum of two times for personal or social reasons.

6.10.1 Patient deferral after admission

If a patient arrives for surgery, treatment/procedure and decides to defer after admission, admissions/booking office staff must advise the treating doctor, admit and discharge the patient, then record the reason for deferral

The treating doctor or delegate must discuss the requirement for surgery with the patient.

If the surgery is still clinically required and the patient agrees, the patient’s elective surgery list record must be returned to the list (rebooked) with the original listing date and history, including urgency categories and delays etc.

If the patient does not agree to have surgery after discussion with the treating doctor, then the patient’s elective surgery list record must be reinstated with the original listing date and history, including urgency categories and delays. The record is then removed from the elective surgery list using the appropriate reason.

6.11 Demand management to treat patients on time

Patients added to the elective surgery list must be treated within their clinical urgency category timeframe through proactive surgical service demand and capacity management.

Admissions/booking office staff must review the elective surgery list weekly and identify patients that are likely to exceed or have already exceeded their clinical urgency category timeframes (see section 7).

Treating doctors must ensure that they are available to perform procedures within the assigned clinical urgency category timeframes or in consultation with the hospital, arrange for another clinician to perform the procedure within the assigned clinical urgency category timeframe.

Hospital clinical directors of surgical services or equivalent must monitor the volume of each treating doctor's elective surgery list plus additions to the elective surgery list to ensure that there is capacity to undertake required surgery. If the treating doctor has insufficient capacity and/or a patient is identified as having exceeded or likely to exceed their clinical urgency category timeframes the hospital clinical directors of surgical services or equivalent should consider the following solutions in conjunction with the treating doctor, patient, and senior management:

- 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).

The patient must be informed of any change of surgeon or hospital and this contact must be recorded on the RFA form.

All patients requiring elective surgery/procedure (with an allocated surgical indicator procedure code) regardless of admission type are recorded on the inpatient patient administration system which holds the elective surgery list.

6.11.1 Transfer of patients to doctors with a shorter waiting time

The new treating doctor will determine the requirement to review the patient prior to surgery, procedure or treatment. If a review is required, it must be facilitated by the hospital at no cost to the patient.

The patient's listing date and history must be that of the original booking. The patient's current clinical urgency category must be maintained, unless altered after clinical review by the new treating doctor.

The planned admission offer to the patient must be considered 'reasonable'. This must be determined for each patient and consider the circumstances of the patient for example, age, available support, public transport, physical condition and the required procedure.

The offer must be specific and include the name of the clinician, hospital and planned admission date or an estimate of the likely waiting period must be provided to the patient.

The offer must also be a credible alternative and be available if the patient decides to accept the offer.

Where the patient does not accept two genuine offers of treatment (excluding offers made at short notice (within 24hrs) but including an offer with another doctor or at another hospital), the patient must be advised that they may be removed from the elective surgery list.

Hospital clinical directors of surgical services or equivalent must review the patient's status on the elective surgery list in consultation with the original treating doctor prior to the patient being removed from the elective surgery list.

6.11.2 Transferring patients to another facility in the same district or network

When a patient is booked at one hospital and subsequently has the procedure carried out at a different hospital within the same district or network, admissions/booking office staff at the receiving hospital must enter the booking with the same listing date, history and current clinical urgency category as the original hospital booking.

They must also inform the original hospital admissions/booking office staff that the booking has been accepted and added to the receiving hospitals elective surgery list

Admissions/booking office staff at the original hospital must send the original RFA form to the receiving hospital and retain a copy for auditing at the original hospital. The booking at the original hospital must be removed using the relevant reason code on receiving confirmation of the patient's booking at the receiving hospital

For further information please refer to the Data Dictionary Wait List Data Stream EDWARD Version: 2021.

6.11.3 Transferring patients to another district or network

Where an agreement exists with another district or network to undertake public patient surgery, the new facility/receiving hospital admissions/booking office staff must add the patient to the elective surgery list with the new listing date and advise the original hospital when the procedure is undertaken.

Original facility admissions/booking office staff must send the original RFA form to the new facility and keep a copy for auditing purposes. Staff must keep the patient on the elective surgery list until advised that the patient has had their procedure and then remove the patient using the relevant reason.

6.11.4 Contracts with private hospitals

Where a contract exists with a private hospital to undertake elective surgery, treatment or procedures for the district or network, the contracted hospital must be managed as per

the requirements of this Policy. The public hospital must be advised when the procedure is undertaken.

Admissions/booking staff of the original facility must send the original RFA form to the new facility and keep a copy for auditing purposes. The patient is to remain on the elective surgery list until advised that the patient has had their procedure and then remove the patient using the relevant reason.

The date of the removal from the public hospital elective surgery list is the date of the admission at the contracted private facility.

For further information on the reporting requirements for the elective surgery list please see the Data Dictionary Wait List Data Stream EDWARD Version: 2021.

6.12 Removing patients from the elective surgery list

Patients may be removed from the elective surgery list for reasons other than admission.

Hospitals must exercise discretion on a case by case basis to avoid disadvantaging patients in the case of genuine hardship, misunderstanding and other unavoidable circumstances.

Patients must not be removed from the elective surgery list if they decline an offer that was made at short notice.

An example letter for informing a patient that they have been removed from the elective surgery list is available on the Elective Surgery Program Resources webpage.

<table>
<tr><th>Reason</th><th>Admissions / Booking Office staff must</th></tr>
<tr><td>Patient declines treatment/clinical review or requests removal for other reasons for example patient has surgery elsewhere.</td><td rowspan="3">Obtain authority from the treating doctor or delegate for clinical urgency category 1 patients prior to removal from the elective surgery list
Once the decision is made to remove a patient from the elective surgery list:
Document discussions with the patient and treating doctor on the RFA
Remove the patient from the elective surgery list on the PAS
Document the reason for the removal and date of removal
Advise the treating doctor within 24 hours of notification of the removal of the patient from the elective surgery list
Advise the general practitioner that the patient has been removed
Inform patient if they have any further questions on their healthcare needs to contact the treating doctor / GP</td></tr>
<tr><td>Patient defers treatment on 2 occasions (including genuine offers of another doctor/hospital) or in deferring exceeds the maximum number of Not Ready for Care/Suspended days:
Category 1 > 15 days
Category 2 > 45 days
Category 3 > 180 days</td></tr>
<tr><td>Patient fails to arrive for treatment on > 1 occasion without giving prior notice and with no extenuating circumstances.</td></tr>
</table>

Reason	Admissions / Booking Office staff must
Patient not contactable on 2 occasions (one by telephone and one by letter)	• Obtain, where possible, the patient's correct contact details via treating doctor; general practitioner; medical records; next of kin; person responsible; and telephone directory search • Record any evidence such as patient letters returned to sender • Remove patient from the elective surgery list • Document the reason for the removal and date of removal • Advise treating doctor and general practitioner that the patient has been removed • Document actions on RFA and electronic record
Patient deceased	• Obtain verification (usually verbally from the patient's relative, general practitioner or treating doctor) • Record the name of the person who has notified the hospital that the patient is deceased • Remove patient from the elective surgery list • Document the reason for the removal and date of removal • Document action on the RFA
Treating doctor advises surgery no longer required	• Once the decision is made to remove a patient from the elective surgery list: • Document discussions with the patient and treating doctor on the RFA • Remove the patient from the elective surgery list on the PAS • Document the reason for the removal and date of removal • Advise the treating doctor within 24 hours of notification of the removal of the patient from the elective surgery list. • Advise GP that the patient has been removed • Inform patient of the potential risks to their health and advise them to contact the treating doctor / GP to discuss

Hospitals must have a documented process for removing patients from the elective surgery list and retain the RFA form in the medical record of the patient.

6.12.1 Adding a patient to the elective surgery list who was recently removed

If a patient was removed from the elective surgery list, and in the following thirty days the elective surgery list record for the patient is to be re-activated for the same procedure, the patient must be re-booked with the original listing date and history, including clinical urgency category.

Admissions/booking office staff must consult the treating doctor for confirmation before adding the patient to the list.

7 RECORD KEEPING AND REPORTING

Hospitals must keep accurate records of elective surgery list information. Any changes made to a patient's booking must be validated with documented evidence, reason for change and be signed by the relevant staff member. Changes may include planned admission dates or planned procedure dates and treating doctor or hospital.

Accurate records are to be maintained for patient delays and deferrals and include the reason on both the Patient Administration System and the RFA form. RFA forms must have a dedicated section to record all changes and/or a designated form attached to the RFA.

Admissions/booking office staff must generate and review a weekly report to identify overdue patients (see section 8.1.1).

They must also provide monthly reports to the hospital general manager or their delegate with the following information:

- Patients who incurred a delay during the month (previous month)
- Patients on the list who have had two or more delays to their admission
- All delayed patients who have not had a rescheduled planned admission date allocated within five days

8 AUDITING THE ELECTIVE SURGERY LIST

8.1 Clerical audit

Clerical audit of the elective surgery list ensures that accurate information is provided to patients, clinicians and administrators when required.

Hospitals must identify a person responsible for conducting clerical audits of the elective surgery list and reporting the outcome of the audit to a senior manager. Records related to clerical audits are to be kept for a minimum three years.

At a district/network level, a person must be nominated to be responsible for monitoring the clerical audit program across all hospitals, maintaining clerical audit standards and addressing issues arising from the audits within their district/network.

8.1.1 Weekly clerical audit

A clerical audit must be conducted weekly which includes:

- Checking for duplicate bookings
- Ensuring a clinical urgency category is appropriately assigned
- Reviewing listing status of patients whose status review date will become due in the next week
- Reviewing exceeded planned admission and planned procedure date,
- Ensuring a delayed patient has been rescheduled for the next available theatre session in consultation with the treating doctor

- Identifying patients on elective surgery list admitted through the emergency department for the same procedure
- The number of patients removed from the elective surgery list and the reason for removal
- Identifying overdue patients

8.1.2 Clerical audit report

On completion of clerical audits, a report signed by the person responsible for conducting the audit must be sent to a senior manager and tabled at an appropriate surgery committee meeting.

This report must include the type of audit conducted, problems identified and recommendations for improvement.

8.1.3 Quarterly evaluation

Elective surgery list managers and coordinators must evaluate the local audit process quarterly including:

- Reviewing compliance with weekly and monthly audits
- Weekly and monthly audit reports are tabled at the relevant committee
- Availability of clerical audit records

8.1.4 Not ready for care / suspended patient audit

A 'not ready for care/suspended' patient audit must be conducted twice a year. A report must be provided to the NSW Ministry of Health's Systems Purchasing Branch for review.

8.2 Review of elective surgery list by treating doctor

Admissions/booking staff must provide a comprehensive list of their patients monthly to each treating doctor, or more frequently as requested**.**

Treating doctors must confirm this elective surgery list with elective surgery coordinators and make any changes required.

Where a district or network uses pooled lists, the hospital must nominate a medical officer to confirm patients on list and make any changes required as above.

8.3 Patient follow up audit

All patients on the elective surgery list for greater than six months from their listing date with no planned admission date or planned procedure date, must be contacted to ascertain if they still require admission.

Two contacts must be attempted, one by letter/email and if no response is received, a follow up telephone call to determine the patient's status on the elective surgery list. Correspondence must include:

- Information on alternative options where available
- Advice for clinical reassessment by treating doctor or general practitioner

- Hospital and district/network contact details

Patient responses must be documented in the patient 's medical record.

An example of a patient audit letter is available on the Elective Surgery Program Resources webpage.

9 DOCTOR'S LEAVE

A patient's clinical urgency category and listing date does not change because of doctor's leave. To ensure appropriate theatre scheduling, doctors must provide notice of intended leave.

A management plan must be implemented for all patients who, during the leave period already had a planned admission/planned procedure date or will exceed their clinical urgency category timeframe.

9.1 Types of leave

Type of leave	Action
Planned Leave e.g. Annual, Study, Extended Leave and parental Leave	Treating doctors must: • Provide at least six weeks' notice of intended leave • Develop management plan for affected patients. • Not add any patients to their elective surgery list during the leave period, unless approved by the District/Network Program Director of Surgical Services or equivalent. Admissions/booking office staff must: • With the treating doctor, develop management plans for affected patients • Consult with relevant personnel including Head of Unit or specialty, Medical Administrator, Clinical Director, Divisional Manager, Operating Theatre Manager, Elective surgery list coordinator, Hospital Executive Officer and District/Network Chief Executive or delegate. • Not add any patients to the doctor's elective surgery list during the leave period, unless approved by the District/Network Program Director of Surgical Services or equivalent.
Unplanned leave e.g. sick leave, bereavement leave	Admissions/booking office staff must: • Develop management plans for affected patients in conjunction with relevant personnel including head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate. • Not add any patients to the doctor's elective surgery list during the leave period, unless approved by the District/Network Program Director of Surgical Services or equivalent.
Planned resignation e.g. resignation from hospital or retirement	Treating doctors must: • Develop management plan for affected patients with relevant personnel, such as head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager,

<table>
<tr><th>Type of leave</th><th>Action</th></tr>
<tr><td></td><td>Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate.
Admissions/booking office staff must:
Transfer patients to a replacement treating doctor’s elective surgery list (see section 6.11.1) and maintain the treat in turn principle. Maintain patients on the resigning doctor’s list if they are not immediately transferred.
With the treating doctor, develop management plans for affected patients
Notify affected patients of the doctor’s intention to leave and provide information about the patient’s management plan
Not add any patients to the doctor’s elective surgery list upon notification of planned resignation unless there is capacity or for an urgent case. This must be approved by the district/network program director of surgical services or equivalent.
Hospital executive must:
Ensure appropriate arrangements are made to either locate replacement treating doctor or transfer patients to another surgeon in consultation with senior clinicians and management.
Organise clinical review as required for patients remaining on the departing doctor’s elective surgery list.
Determine if departing doctor is willing to treat additional patients and has capacity to undertake the procedure/treatment to decrease the elective surgery list.</td></tr>
<tr><td>Unplanned resignation or death</td><td>Admissions/booking office staff must:
Transfer patients to a replacement treating doctor’s elective surgery list (see section 6.11.1) and maintain the treat in turn principle. If they are not immediately transferred, place patients on a list for an appropriate doctor or specialty.
Develop management plans for affected patient with relevant personnel, such as head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, Elective surgery list coordinator, hospital executive officer and/or district/network chief executive or delegate.
Not add any patients to the doctor’s elective surgery list
Notify relevant general practitioners of the resignation/death
Hospital executive must:
Locate replacement of treating doctor in consultation with senior clinicians and management.
Clinical review is at the discretion of the accepting treating doctor.</td></tr>
</table>

An example of a notification to a general practitioner of resignation/death letter is available on the Elective Surgery Program Resources webpage.

9.2 Patient management plan for treating doctor’s leave

Admissions / booking office staff must inform patients:

- Their position on the elective surgery list will not be affected

- The name of the replacement doctor (if available)
- If a clinical review is required
- About their expected waiting time
- Who to contact for more information

All contact with patients must be documented and be part of, or attached to, the patient's RFA form

10 APPENDIX

Clinical urgency categories reference list

Please note that IPC changes are made yearly. For an up to date searchable list please see the NSW Health Elective Surgery Program Resources webpage.

IPC	Procedure*	Recommended Clinical urgency category
124	Acromioplasty	3
67	Adenoidectomy	3
197	Amputation digit (toe/finger)	2
85	Amputation of limb	1
175	Aortic bifurcation graft	1
97	Appendicectomy (non-emergency)	3
122	Arthrodesis	3
42	Arthroscopy	3
178	Biopsy – muscle	1 or 2
27	Biopsy of breast	1 or 2
46	Biopsy/conization of cervix/LLETZ	2
137	Bladder neck incision	2
184	Blepharoplasty	3
284	Breast reconstruction	3
285	Breast reduction (with supporting evidence)	3
19	Bronchoscopy	1
192	Bursa – excision	3
16	Cardiac catheterisation	1
292	Cataract extraction first eye	3
293	Cataract extraction second eye	3
128	Change of muscle or tendon length	3
120	Change of plaster (GA)	4 (staged)
2	Cholecystectomy (including laparoscopic) - Acute Cholecystitis	1 or 2
54	Circumcision (clinical conditions only)	3
176	Closure colostomy/ileostomy	4 (staged)
75	Cochlear implant	3

IPC	Procedure*	Recommended Clinical urgency category
25	Colectomy/anterior resection/large bowel resection	1 or 2
101	Colposcopy	2
286	Cone biopsy	Under review
113	Corneal graft	3
17	Coronary angioplasty/Stent Balloon dilatation	1
3	Coronary artery bypass graft	1
68	Correction of bat ears	3
74	Correction of cleft lip/palate	3
111	Correction of ectropian	3
151	Correction of uretero-pelvic junction	2
108	Craniectomy	2
287	Cranioplasty	2
104	Craniotomy	2
143	Cystectomy	1 or 2
4	Cystoscopy	3 or 4 (staged)
118	Dacrocystorhinostomy	3
288	Dermoid cyst – removal of	Under review
43	Diagnostic laparoscopy	3
93	Diathermy of warts	3
100	Dilatation and curettage	2
26	Dilation of oesophagus	2
55	Dilation of urethra	2
39	Discectomy	3
103	Drainage of Bartholin's cyst	3
105	Drainage of sub-dural haematoma	2
57	Endarterectomy	1
49	Endometrial ablation	3
88	Endoscopy - ERCP	1 or 2
22	Endoscopy - small intestine	2
63	Ethmoidectomy	3

IPC	Procedure*	Recommended Clinical urgency category
116	Examination of eye under anaesthesia	2
77	Excision lesion of pharynx	2
80	Excision of anal fissure	2 or 3
84	Excision of breast lump	1 or 2
119	Excision of chalazion	3
86	Excision of ganglion	3
208	Excision of Lipoma +/-Grafting	3
207	Excision of Melanoma +/- Grafting	1
207	Excision of SCC +/- Grafting	1
207	Excision of BCC +/- Grafting	1 or 2
52	Excision of ovarian cyst	3
112	Excision of pterygium	3
45	Female sterilisation	3
28	Femoral herniorrhaphy	3
154	Femoro-popliteal bypass graft	1 or 2
179	Foreign body – removal (non- emergency)	3
31	Freeing abdominal adhesions	3
185	Functional Endoscopic sinus surgery (FESS)	3
89	Fundoplication	3
210	Gastrectomy	2
21	Gastroscopy (Haemorrhage or Upper GI Cancer)	1
21	Gastroscopy (other)	3 or 4 (staged)
5	Haemorrhoidectomy/Banding of Haemorrhoids	3
198	Hammertoe – correction/repair	3
18	Heart valve replacement	1
177	Hernia – epigastric, repair	3
174	Hypospadias repair	3
6	Hysterectomy	3
44	Hysteroscopy	2
7	Inguinal herniorrhaphy	3
213	Insertion of levonorgestrel intra uterine system	3

IPC	Procedure*	Recommended Clinical urgency category
96	Insertion of hepatic artery catheter	1
142	Insertion of ureteric stent	1
109	Insertion of ventricular shunt	2
66	Insertion P.E, tubes (grommets)	3
48	Insufflation of fallopian tube (Rubin's test)	3
199	Joint replacement e.g. shoulder (other than hip & knee)	3
38	Laminectomy/Other Spinal Surgery (excluding discectomy)	3
83	Laparotomy	2
72	Laryngectomy	1
56	Lithotripsy	2
82	Liver biopsy	2 or 3
216	Lobectomy any organ/lung	2
181	Lymph node – excision	1
135	Mandibulectomy/hemi- mandibulectomy	2
195	Manipulation under Anaesthetic	3
30	Mastectomy	1 or 2
70	Mastoidectomy	2
140	Meatoplasty (urinary)	3
126	Meniscectomy (knee)	3
64	Microlaryngoscopy	2
50	Myomectomy	3
8	Myringoplasty/Tympanoplasty	3
9	Myringotomy	3
217	Nasendoscopy	2
69	Nasal cautery	3
32	Nasal polypectomy	3
141	Nephrectomy	1 or 2
191	Nerve decompression/release	3
139	Orchidectomy	2 or 3
138	Orchidopexy	2

IPC	Procedure*	Recommended Clinical urgency category
193	Osteotomy – ankle/foot/arm/facial	3
194	Osteotomy – hip/femur/tibia/shoulder	3
289	Parathyroidectomy	2 or 3
180	Parotidectomy/Submandibular gland - excision	2
187	Pharyngoplasty	3
81	Pilonidal sinus	2 or 3
58	Pleurodesis	1
117	Probing of naso/lacrimal duct	3
10	Prostatectomy (TURP or open prostatectomy)	2
147	Prostatic biopsy	1
183	Ptosis – repair, correction	3
59	Pulmonary artery shunt	1
145	Pyeloplasty	2
152	Pylorotomy	3
133	Radical neck dissection	1
201	Reconstruction of shoulder	3
131	Reduction of fractured orbit	3
130	Reduction of fractured zygoma	3
149	Reimplantation of ureters	2
290	Removal of intracranial lesion	Under review
36	Release of carpal tunnel	3
127	Release of clubfoot	2 or 4 (staged)
76	Release of tongue tie	3
132	Removal of breast implants	3
41	Removal of bunion (hallux valgus; hallux abducto valgus)	3
219	Removal of epididymal cyst	3
24	Removal of ingrown toenail	3
290	Removal of intracranial lesion	Under review
40	Removal of pins and plates	4 (staged)
23	Removal of skin lesions	1

IPC	Procedure*	Recommended Clinical urgency category
23	Removal of skin lesions (other)	3
148	Removal of stone from urinary tract	1
61	Repair atrial-septal defect	1
78	Repair incisional hernia	3
47	Repair of cystocele, rectocele	3
121	Repair of Dupuytren's contracture/Palmar fasciectomy	3
114	Repair of exostosis	3
94	Repair of hiatus hernia	3
150	Repair of hydrocele	3
34	Repair of knee cartilage/Repair of knee ligament/ACL reconstruction	3
123	Repair of rotator cuff	3
115	Repair of squint	3
29	Repair of umbilical hernia	3
62	Patent ductus arteriosus	1
60	Repair ventricular-septal defect	1
110	Replacement/removal of ventricular shunt	4 (staged)
153	Resection of abdo-aortic aneurysm	1 or 2
144	Retrograde pyelogram	1 or 2
136	Revision of scar (Non-cosmetic e.g. Burns)	4 (staged)
33	Rhinoplasty	3
173	Salpingo-oopherectomy/Oopherectomy	3
11	Septoplasty	3
209	Skin Grafts, including split skin graft	4 (staged)
95	Sphincterotomy	2
37	Spinal fusion	3
161	Stapedectomy	3
65	Sub-mucosal resection/Nasal	2
190	Tendon release	3
129	Tenotomy of hip	2 or 4 (staged)
291	Thyroglossal remnant – removal of	Under review

IPC	Procedure*	Recommended Clinical urgency category
79	Thyroidectomy/hemi-thyroidectomy	2 or 3
12	Tonsillectomy (+/- adenoidectomy)	3
13	Total hip replacement	3
14	Total knee replacement	3
182	Trabeculectomy	2
73	Tracheostomy	1 or 2
146	Trial of voiding	2
196	Trigger finger/thumb – repair, release	3
15	Varicose veins stripping and ligation (CEAP Grade >C3)	3
53	Vasectomy	3
220	Vitrectomy (including buckling/cryotherapy)	2