

## Planned Surgery Access

**Summary** This Policy Directive provides procedures to NSW public hospital teams managing elective surgery services, ensuring clinically appropriate, consistent and equitable management of access for patients across the state.

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## Planned Surgery Access

### Policy Statement

NSW Health organisations that manage planned surgery 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 their ability to pay, regardless of where they live in the country.

### Summary of Policy Requirements

To ensure timely access to planned surgery, NSW public health organisations with surgical services must have local procedures in place that are consistent with the principles and requirements identified in this Policy Directive.

The treating doctor refers patients to the planned surgery wait list by submitting the Recommendation for Admission (RFA) form within 5 working days of the patient consenting to the proposed surgery or procedure.

Requirements to accept a Recommendation for Admission form, including a complete and legible data set, must be met. When the information on the RFA is not legible or complete, the process for seeking clarification from the treating doctor must be followed.

Clinical urgency categories (CUCs) and discharge intent are to be assigned in accordance with recommended categories in this Policy Directive, and any variance or reclassification must be validated by the treating doctor with documented evidence.

Before accepting an RFA, special considerations for cosmetic and discretionary surgery, value-based surgery, or new procedures must be made.

Public health organisations must establish a Clinical Review Panel for Surgical Activity, or equivalent, to support Directors of Surgery to review and make clinical adjudications when assessing appropriateness of RFAs, variations to assignment from the recommended clinical urgency category and default discharge intention.

A patient must be added to the wait list within 3 working days of receiving the completed RFA.

Patients and their General Practitioners must be notified in writing, within 3 working days of the patient being added to the wait list, of the patient's addition to the elective surgery list, their clinical urgency category, estimated timeframe for their surgery and contacts in the event of a change in the patients' clinical condition or circumstances.

All patients on the planned surgery or procedure wait list are to be managed according to their clinical urgency category and treated in turn.

Clinical review should occur when the patient's condition changes or if they have been on the wait list 1.5 times their maximum category wait time.

Requirements for record keeping, approval and notification for changes to CUC, procedure, patient condition or availability, hospital-initiated delays and doctors' leave must be met.

It is the joint responsibility of the treating doctor, senior managers and executives to ensure that patients added to the wait list are treated within their clinical urgency category timeframe through proactive surgical service demand and capacity management. This includes use of guidelines to establish safe high-volume low-complexity theatre case numbers.

The planned surgery/procedure list must be 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

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PD2025_036 September-2025	Deputy Secretary, System Sustainability and Performance	Replaces PD2022_011. Updated to reflect amendments to current policy. Incorporates information from IB2023_004 which will be rescinded on release of this policy.
IB2023_004 February-2023	Executive Director, System Purchasing and Performance	
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## 1. Background

Each year more than 235,000 patients have planned/elective surgery or procedures in operating theatres at NSW public hospitals. People who need these procedures are placed on a wait list according to the urgency of their clinical need and in accordance with [Section 68 of the Health Services Act 1997](#) (NSW).

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

Planned surgery/procedure 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 wait lists with transparent and patient-focused processes for:

- Referring patients for surgery and procedures
- Assigning patients to the appropriate Clinical Urgency Category (CUC)
- Accepting referrals for surgery and procedures
- Registering patients onto the planned procedure list
- Compiling and maintaining the planned procedure list
- Booking patients for procedures under the principles of treating patients in turn and treating patients within clinically appropriate timeframes
- Ensuring patients have timely and effective communication about their planned surgery or procedure
- Removal of patients from the planned procedure 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

This Policy Directive provides requirements for all public hospital staff involved in the delivery of planned surgeries and procedures, including treating doctors, nurses, administrative and management staff. It outlines the steps managing surgery and procedure lists, and sets the standards that must be followed.

Key responsibilities are summarised in [Appendix D](#).

### 1.2. What must be added to the surgical / procedural wait list

All surgical procedures must be added to the surgical/planned wait list. The business rules and processes outlined in the Planned Surgery Access policy should be used as a guide for

managing medical procedures including bronchoscopy, interventional cardiology, endoscopy, and pulmonology services (including transoesophageal echocardiogram) unless covered by another guideline or standard.

### 1.3. Key definitions

<b>Admission</b>	<p>The admission process involves the hospital accepting responsibility for a patient's care and/or treatment. Admission is based on a clinical decision that the patient requires same-day or overnight care and treatment, following specific criteria.</p> <p>For the purposes of this Policy Directive, admission includes both inpatient and non-admitted patient care.</p>
<b>Admission date</b>	Date the patient attends the hospital to commence an episode of care.
<b>Clinical review</b>	A review of a patient on the wait list to ensure that their waiting time remains appropriate for their clinical condition. This should be a clinician led review of the patient.
<b>Clinical Review Panel</b>	<p>Also called a "Clinical review panel for surgical activity". It is a group established within Local Health Districts and Specialty Health Networks to oversee and approve Cosmetic surgery, Discretionary surgery, identified value-based surgical procedures and any locally agreed topics pertaining to patients being added to the surgical/procedural wait list.</p> <p>Their role is to ensure that surgeries are performed for the right reasons and at the right time, based on current peer-reviewed evidence and clinical guidelines.</p>
<b>Clinical Urgency Category (CUC)</b>	A clinical assessment of the timeframe in which a patient requires planned admission.
<b>Cosmetic surgery</b>	Procedure performed to reshape normal structures of the body, or to adorn parts of the body with the aim of improving the patient's appearance and self-esteem. These procedures do not attract a Medicare rebate.
<b>Day of Surgery Admit (DOSA)</b>	<p>These are patients whose Discharge Intention is "overnight", and who are intended to be admitted on the day of their planned surgery.</p> <p>Planned Admission Date / To Come In = Planned Procedure Date.</p>
<b>Day only (DO)</b>	<p>Admission and discharge will occur on the same calendar day.</p> <p>Planned Admission Date = Discharge Date.</p>

<b>Decline</b>	A Planned Admission / Planned Procedure Date outcome where the offer is not accepted by the patient due to non-clinical personal reasons.
<b>Deferred patient</b>	Patients that are not yet prepared to be admitted to hospital for non-clinical reasons; for example, patients with work or other commitments which preclude their being admitted to hospital for a time.
<b>Discharge Intention</b>	It identifies whether the treating doctor expects that the patient will be admitted and discharged on the same day (day only) or will stay overnight.  It is recorded when the patient is added to the surgical/procedural wait list.
<b>Discretionary surgery</b>	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 and will require Clinical Review Panel approval to be added to the surgical/procedural wait list.
<b>Emergency surgery</b>	Surgery to treat trauma or acute illness within 72 hours of an emergency department 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 a planned procedure (for example, in cases of acute deterioration of an existing condition).
<b>Indicator Procedure Code (IPC)</b>	This is an administrative coding used for the procedure or treatment the patient is planned to undergo when admitted. All patients on the wait list will have their intended procedure identified using an IPC, regardless of the patients planned admission status.
<b>Listing date</b>	The date the Recommendation for Admission form was initially received by the first accepting hospital. The calculation of waiting time starts from this date.
<b>Listing status</b>	Indicates the status of the patient on the planned procedure list if a patient is ready and available for admission. This may change while the patient is on the surgical/procedural wait list for example, after a clinical review.

<b>Non-admitted patient</b>	A patient who does not undergo a hospital's formal admission process when receiving their planned procedure.
<b>Not Ready for Care (NRFC)</b>	Patients who are not able to be admitted to hospital. These patients are suspended as either Staged (clinical reasons) or Deferred (non-clinical reasons).
<b>Other surgery</b>	The procedure cannot be defined as either emergency surgery or planned surgery, for example, transplant surgery and obstetrics procedures.
<b>Planned Admission Date (PAD)</b>	The date on which it is proposed that a patient on the planned procedure list will be admitted for an episode of care. This is sometimes also known as a "To Come In" (TCI) date.
<b>Planned procedure</b>	<p>Planned procedures, also known as elective procedures, are necessary surgical or medical interventions that can be scheduled in advance following a specialist's clinical assessment. This assessment results in the patient being placed on a planned procedure list.</p> <p>Planned procedures include, but are not limited to, surgical operations, colonoscopies, gastroscopies, and interventional vascular and cardiac procedures.</p>
<b>Planned procedure date</b>	The date on which it is proposed that a patient on the planned procedure list will have their procedure completed.
<b>Pre-admission</b>	Patients may be assessed before admission to the hospital for their suitability to undergo the intended procedure/treatment, including associated anaesthetic and discharge plans.
<b>Ready for Care (RFC)</b>	A patient who is prepared to be admitted to hospital or to begin the process leading directly to admission and surgery/procedure. The process leading to surgery/procedure could include investigations/procedures or other preoperative preparation.
<b>Specialty</b>	<p>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).</p> <p>Hospitals may have many more specific clinical areas identified, but these must be categorised under the main specialty headings for central reporting.</p>

<b>Staged</b>	A suspension period applied where the patient is clinically not Ready for Care. This may be indicated by either the doctor or the patient.
<b>Status Review Date</b>	This is the date determined for an assessment (clinical or administrative) as to whether a Deferred or Staged patient (specifically Not Ready for Care) will become ready for admission to the hospital from the suspension end date (specifically Ready for Care).
<b>Surgery</b>	<p>Procedures listed in the surgical operations section of the <a href="#">Australian Government Medicare Benefits Schedule</a>.</p> <p>Surgery is classified as either emergency surgery, planned surgery or other surgery based on a patient's presentation and subsequent care, not by time periods to surgery.</p>
<b>Suspension End Date</b>	The date a suspension is due to end. This date is confirmed, or updated, when the status review is undertaken.
<b>Wait list</b>	Also called planned surgery list or procedure list. A list that contains the names and details of all patients who have submitted a Recommendation for Admission form and have been added to the wait list contained in the Patient Administration System (PAS) at a hospital.
<b>Waiting Time</b>	The time a patient spends on the wait list. Waiting time is used to plan care for patients that aligns to their Clinical Urgency Category. Patients must be treated within their Clinical Urgency Category wait time regardless of if they have a medical or surgical IPC.

## 2. Adding a patient to the wait list

Placing a patient on a wait list requires:

- Patient consent ([Section 2.1](#))
- Completion of a Recommendation for Admission form ([Section 2.2](#))
- Submission of a Recommendation for Admission form ([Section 2.3](#))
- Allocation of a Clinical Urgency Category ([Section 2.4](#))
- Special considerations ([Section 2.6](#))
- Acceptance of RFA ([Section 2.5](#))
- Notifications ([Section 2.7](#)).

### 2.1. Patient consent

The treating doctor must have fully informed the patient about the risks and benefits of the proposed surgery/procedure and obtained their written consent in line with NSW Health Policy and Procedure Manual [Consent to Medical and Healthcare Treatment Manual](#).

Written consent should be obtained at the time the patient agrees to be added to the wait list. In instances where signed consent cannot be obtained (for example, when a telehealth consultation has occurred), the consent should be completed as soon as possible after verbal agreement for the procedure is received.

### 2.2. Completion of the Recommendation for Admission (RFA) form

The treating doctor must complete a RFA form legibly and accurately.

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

#### Treating doctor must provide:

- |   |   |
|---|---|
| <ul style="list-style-type: none"> <li>• Patient's full name</li> <li>• Patient's address</li> <li>• Patient's email address, where provided</li> <li>• Patient's contact information (home, mobile and/or work telephone)</li> <li>• Patient's gender</li> <li>• Patient's date of birth</li> <li>• Patient's Medicare number</li> <li>• Planned hospital for admission</li> <li>• Presenting problem/diagnosis and indicator for surgery/procedure</li> </ul> | <ul style="list-style-type: none"> <li>• Discharge intention (that is day only, or indication of number of nights in hospital) and planned length of stay</li> <li>• Clinical rationale for nonstandard Clinical Urgency Category (CUC), non-standard length of stay, discretionary or value-based care procedure</li> <li>• Significant medical history (including allergies, infection risk and disability)</li> <li>• Treating doctor (if different)</li> <li>• Date the RFA is completed (signed by referring clinician)</li> </ul> |
|---|---|

<b>Treating doctor must provide:</b>	
<ul style="list-style-type: none"> <li>Planned Procedure</li> <li>Clinical Urgency Category (if classified as Staged (<a href="#">Section 3.4.1</a>), the time interval when the patient will be Ready for Care must be indicated)</li> </ul>	<ul style="list-style-type: none"> <li>General Practitioner's name and address</li> <li>Interpreter requirements</li> <li>Estimated operating time, including anaesthetic</li> <li>Specific preadmission requirements</li> <li>Special operating theatre equipment</li> <li>Requirement for an intensive care or high dependency bed post-procedure</li> <li>Planned procedure/treatment</li> </ul>
<b>Admissions / Booking Office staff at the receiving hospital must provide:</b>	
<ul style="list-style-type: none"> <li>Planned admission date/Planned procedure date (if allocated)</li> <li>Short notice/standby offers</li> </ul>	<ul style="list-style-type: none"> <li>Aboriginal and Torres Strait Islander Origin</li> <li>Status Review Date (for Staged patients see <a href="#">Section 3.4.1</a>)</li> <li>Anticipated election status, such as Medicare/public or private</li> </ul>

### **2.2.1. Information to be provided to the patient**

Treating doctors must explain the wait list, including:

- a. Reason for referral to the wait list.
- b. Any alternatives to surgery that should be considered by the patient prior to them consenting to being added to the wait list.
- c. Wait list process, including clinical urgency categories and [treat in turn principles](#).
- d. Prioritisation for surgery/procedures is based on clinical need, and without regard to whether a patient chooses to be treated as a public or private patient.
- e. If a public patient, the surgery/procedure may be conducted by an alternative doctor or at an alternate hospital to expediate patient access to care.
- f. 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.
- g. 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.
- h. In keeping with the principle of providing the earliest access and optimal care, surgery/procedures may be performed by another treating doctor or hospital if this would result in the patient receiving an earlier date for care.

- i. When a patient chooses to be treated as a private patient, they can elect the treating doctor and public hospital. However, the patient must receive care as per the treat in turn principles. The treating doctor must also ensure the private patient is advised of the associated costs of treatment and that priority of treatment will be based on clinical need regardless of insurance status.

### 2.3. Submission of the Recommendation for Admission (RFA) Form

At the time of submission of the RFA form, a patient must be Ready for Care and be able to accept an assigned planned admission or planned procedure date, with the following exceptions:

- a. For patients who are Staged ([Section 3.4.1](#)) for planned surveillance according to clinical guidelines, for example, for colonoscopy and cystoscopy, RFAs may be accepted, and the patient added to the wait list and Staged for a maximum of 12 months.
- b. Where a patient is required to be Staged for a prolonged period (more than 45 days for Category 2 and more than 6 months for Category 3) to achieve a desired outcome for their surgery/procedure to occur, the patient must not be placed on the wait list.

An exemption to this rule may be requested by the treating doctor and is subject to agreement by the Director of Surgery or Clinical Review Panel (see [Appendix C](#)). This exemption must be approved prior to the patient being added to the wait list.

- c. Patients requiring an intervention such as weight loss, smoking cessation or diabetes management for the surgery/procedure to proceed, RFAs may be accepted if the treating doctor and the patient agree:
  - i. that the required clinical improvement can be completed within a 6-month period
  - ii. to a documented plan to achieve the required outcome and how this plan will be reviewed within the 6-month timeframe.

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

Facsimiles (fax) of an RFA form or scanned copies 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, where an approved eRFA system is used, must follow as soon as possible. The hard copy should be attached with the faxed/scanned copy.

The treating doctor must forward the completed RFA form to the hospital within 5 working days of the patient agreeing to the proposed procedure or treatment.

## **2.4. Allocation of clinical urgency categories (CUC)**

### **2.4.1. General principles**

Categorisation of planned surgery patients by Clinical Urgency Category is required to ensure they receive care in a timely, equitable and clinically appropriate manner.

- a. When allocating a Clinical Urgency Category, the [NSW Recommended Clinical Urgency Categories](#) must be used until confirmation is received from the treating doctor and approved by the Director of Surgery and/or Clinical Review Panel for surgical activity or equivalent.
- b. The Clinical Urgency Category must be assigned by the treating doctor and must 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 doctor resources.
- c. To enable patient preparation and for them to receive care within the clinically required timeframe, a planned admission date (PAD) should be agreed with the patient within the following timelines.

<b>Clinical Urgency Category</b>	<b>Procedures that are clinically indicated within</b>	<b>PAD to be assigned</b>
<b>Category 1 – Urgent</b>	30 days	As part of the RFA receipt process
<b>Category 2 – Semi-urgent</b>	90 days	By 45 Ready for Care days
<b>Category 3 – Non-urgent</b>	365 days	By 270 Ready for Care days

### **2.4.2. Allocation of a timeframe outside the recommended Clinical Urgency Category**

- a. A departure from the recommended Clinical Urgency Category, the default Discharge Intention (see [Appendix A](#)) or a non-standard allocation of an “urgent within category” (for example, Category 3 within 6 months) may be warranted for sound clinical reasons, including in circumstances where the procedure is for diagnosis or treatment of a proven or suspected malignancy.
- b. For individual patient exceptions to the recommended Clinical Urgency Category, the treating doctor must supply supporting documentation and discuss this with the local health district (District)/specialty health network (Network) Director of Surgery or the equivalent.
- c. If there is no supporting clinical information supplied, the Admissions/Booking Office staff must contact the treating doctor to provide the required information to support the selected Clinical Urgency Category. The patient must then be added to the wait list within 3 working days from receipt of the RFA.

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**2.4.3. Allocation of a Clinical Urgency Category for procedures not included in the *NSW Recommended Clinical Urgency Categories* list**

- a. Where the procedure is not in the [NSW Recommended Clinical Urgency Categories](#) treating doctors must follow the principles in [Section 2.4](#).
- b. There must be a review and escalation process at each hospital for the Director of Surgery or equivalent, and/or the Clinical Review Panel to review all variations from the recommended Clinical Urgency Category to ensure appropriate prioritisation of patients.

**2.4.4. Allocating the correct Indicator Procedure Code (IPC)**

- a. The primary procedure from the consent form should be selected when choosing the IPC.
- b. If there is doubt what the primary procedure is, the treating doctor who referred the patient must be contacted for confirmation.
- c. Where there is a combination of surgical and medical/other categories of IPCs, the surgical IPC must be recorded as the primary intended service activity.

For example:

If the RFA is for both a surgical and medical IPC, the surgical IPC is to be listed as the primary procedure. For instance, colonoscopy + haemorrhoid banding would be listed under the IPC for haemorrhoid banding.

If the RFA is for a medical procedure and/or a surgical procedure, the medical procedure is used as the primary procedure as it has not yet been confirmed the surgical procedure will occur. For instance, colonoscopy +/- haemorrhoid banding would be listed under the IPC for colonoscopy.

**2.4.5. Inclusions and exclusion criteria for Category 1 – urgent surgery / procedure**

- a. 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.
- b. This category is not to be used to advance the date for planned surgery/procedural 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.
- c. For procedures which do not have a recommended Clinical Urgency Category 1 (see [Appendix A](#)) and are submitted to the wait list as a Clinical Urgency Category 1, the treating doctor must provide supporting clinical information with the RFA. The case is then reviewed by the Director of Surgery and/or Clinical Review Panel for surgical activity for approval to be listed with the Clinical Urgency Category requested by the treating doctor.

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- d. Failure of the treating doctor to submit the additional evidence to the booking office will result in the patient being added to the list in the default recommended category.

#### **2.4.6. Reclassification of Clinical Urgency Category after approval**

- a. Only the treating doctor or a delegate from their medical team (following documented discussion with the treating doctor) or the hospital clinical directors of surgical services or equivalent (following documented discussion with the treating doctor) may undertake reclassification of patients between categories once the Clinical Urgency Category has been confirmed.
- b. To reclassify a patient, the amending doctor must ensure documented evidence is available to clinically validate any changes to a patient's Clinical Urgency Category.
- c. Documentation of a Clinical Urgency Category change must be attached to form part of the RFA and will become part of the patient's medical record. Documentation must include:
- i. the name and signature of the relevant staff member documenting the change
  - ii. the date and time of notification of the category change
  - iii. the person notifying the category change
  - iv. the reason for the category urgency category change.

#### **2.4.7. Calculation of Ready for Care Days following reclassification**

- a. 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.
- b. 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.
- c. If a patient has multiple changes in clinical urgency categories, the history is also considered for prior periods served at a higher category. For example, if a patient was a Category 1 for 20 days and then recategorised to Category 2 for 5 days, and then recategorised to Category 1 again, the previous wait time at the same level will count, so the patient count will restart at 20 days.

#### **2.4.8. 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](#) website.

## 2.5. Acceptance of a Recommendation for Admission Form

### 2.5.1. Standard bookings

Admissions/Booking Office staff must:

- a. Date stamp RFA forms upon receipt from the treating doctor. A date stamp must be present in the hard copy form or documented on the electronic form.
- b. Ensure that the RFA form is legible, and the minimum data set ([Section 2.2](#)) is included before acceptance of the form. For further information, refer to the NSW Health Policy Directive *Client Registration Policy* ([PD2007\\_094](#)) for the process to manage incomplete forms. This process should be documented and endorsed by the senior manager or theatre management group.
- c. Where information is missing on the RFA form or the form is not legible, the Admissions/Booking Office staff must contact the treating doctor by telephone or in writing as soon as possible to provide the required information.

If the RFA form is to be returned to the doctor, then the original form must remain in the booking office after acceptance and a copy of the form must be returned to the treating doctor for missing information. An example of a letter regarding an incomplete RFA form is available on the NSW Health [Planned Surgery Program Resources](#) webpage.

- d. Return the RFA form to the treating doctor if the patient's surgery/procedure indicated on the form is required beyond 12 months.
- e. A review of the patient's clinical condition may be required before the RFA form is accepted if a form is not presented to the Admissions/Booking Office within the following timeline for each Clinical Urgency Category:

Clinical Urgency Category	Time from the date the RFA was signed before a clinical review is required
<b>Category 1 – Urgent</b>	Within 14 days
<b>Category 2 – Semi-urgent</b>	Within 30 days
<b>Category 3 – Non-urgent</b>	Within 3 months

- f. Admissions/Booking Office staff must use the date that is stamped on the RFA as the listing date and add the patient to the wait list within 3 working days of receiving the RFA form.
- g. At the time of addition to the wait 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 ([Section 3.4.1](#)).

## **2.5.2. Variations from standard bookings**

### **2.5.2.1. 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.

Examples of bilateral procedures include, right and left cataract extractions, right and left hip replacements.

### **2.5.2.2. Multiple admission forms received for one patient**

Multiple RFA forms 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 ([Section 2.4](#)). 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.

### **2.5.2.3. Duplicate bookings**

An RFA form 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 by the treating doctor or Admissions/Booking Office to decide which wait list they wish to remain on.

## **2.6. Special considerations for acceptance of an RFA**

### **2.6.1. Cosmetic and discretionary surgery**

Every District/Network at either District or hospital level, as appropriate, must have a Clinical Review Panel for surgical activity in accordance with the Agency for Clinical Innovation Clinical Practice Guide [Value-based surgery](#) and [Appendix C](#). This is to ensure a timely, transparent and standardised response to RFAs submitted for procedures that may be either cosmetic, discretionary or there are other queries about the value to the patient of the procedure requested.

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 Clinical Review Panel and/or Director of Surgery or equivalent.

<b>Cosmetic/discretionary procedure</b>	<b>Exception</b>
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

<b>Cosmetic/discretionary procedure</b>	<b>Exception</b>
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 (in people over 16 years old)	Nil
Tattoo removal procedure	Nil
Removal of benign moles	Nil
Candela laser	Congenital abnormality – in people under 17 years old
Varicose veins	CEAP Grade > C3 <a href="#">CEAP Classification System</a>
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, recurrent culture proven urinary tract infection
Temporomandibular joint arthrocentesis	Nil
Labioplasty	Congenital abnormality in people under < 17 years old
Knee arthroscopy when the main indication is osteoarthritis, and the patient is 50 years or older	Only after approval by District/Network Director of Surgery (or equivalent) and local selection criteria has been met

Cosmetic/discretionary procedure	Exception
Knee replacement surgery for a patient who has not undertaken optimal non-surgical management, such as 12 weeks of optimal physical activity and exercise, for example, the Osteoarthritis Chronic Care Program	Patients with severe degenerative disease
Weight loss surgery (where hospital designation and appropriate credentialing is in place)	Patient has a documented multidisciplinary team review by an approved District/Network weight loss clinic/service which includes a recommendation including evidence of exhaustion of non-surgical options

Process:

- a. The treating doctor must provide evidence to obtain approval from the District/Hospital Clinical Review Panel and/or Director of Surgery or equivalent.
- b. Objective medical criteria supporting the decision for surgery for all procedures that may be considered cosmetic or discretionary must be documented on the RFA form at the time patient is referred. This requirement supports appropriate documentation of clinical decision making and the review process.
- c. For procedures not appearing in the cosmetic/discretionary surgery list above, or where there is doubt about the nature of the proposed surgery/procedure, the request must be referred to the District/Hospital Clinical Review Panel and/or Director of Surgery for review prior to the patient being added to the wait list.
- d. 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.

**2.6.2. Value-based surgery / procedures**

The Agency for Clinical Innovation identifies through its clinical networks, procedures that, in certain patient cohorts or clinical presentations, offer little to no benefit to the patient.

Patients referred for any of the conditions below and that meet the specific clinical exclusions criteria of the Agency for Clinical Innovation Clinical Practice Guide [Value-based surgery](#) must be approved by the District/Hospital Clinical Review Panel and/or Director of Surgery before the patient is added to the wait list.

Value-based surgery / procedure
Asymptomatic hernia repair
Cholecystectomy – asymptomatic stone
Colonoscopy: <ul style="list-style-type: none"> <li>• Cancer/Polyp surveillance outside of <a href="#">Clinical practice guidelines</a></li> <li>• Constipation</li> </ul>
Hysterectomy outside of accepted criteria
Knee arthroscopy outside accepted criteria

**Value-based surgery / procedure**

Lumbar spinal fusion for back pain alone

Tonsillectomy outside accepted criteria

Myringotomy without insertion of grommets

Knee replacement surgery for a patient who has not undertaken optimal non-surgical management, such as 12 weeks of optimal physical activity and exercise - for example, the Osteoarthritis Chronic Care Program as described in the Australian Commission on Safety and Quality in Health Care [Osteoarthritis of the Knee Clinical Care Standard](#)

The treating doctor must provide supporting clinical documentation with the RFA form to enable assessment by the hospital Director of Surgery and/or Clinical Review Panel for surgical activity or equivalent.

District/Network staff must follow the review panel process ([Appendix C](#)).

**2.6.3. Dental and oral surgery**

For oral health operating lists, patients must be eligible for public dental services as outlined in NSW Health Policy Directive *Eligibility for Public Dental Services* ([PD2025\\_030](#)) and have been either triaged and prioritised for care through the Priority Oral Health Program outlined in the NSW Health Policy Directive Oral Health Access ([PD2024\\_034](#)) or referred for specialist care as outlined in NSW Health Policy Directive *Oral Health Specialist Referral Protocols* ([PD2011\\_071](#)).

**2.6.4. 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, in line with NSW Health Guideline *New Health Technologies and Specialised Services* ([GL2024\\_008](#)).

The treating doctor must be appropriately credentialed by a relevant committee and have privileges to undertake the procedure before the patient is added to the wait list.

For additional information, refer to:

- [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.](#)

**2.6.5. 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 by the Admissions/Booking Office that the RFA is not accepted and make alternative arrangements for the patient.

## 2.7. Notification

### 2.7.1. Notification to the patient

Admissions/Booking Office staff must inform the patient in writing within 3 working days of them being added to the wait list, of their addition to the list, their Clinical Urgency Category timeframe and any other relevant information of their hospitalisation. This may include the anticipated length of stay, discharge procedures and post-operative follow up and 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 form as appropriate

### 2.7.2. Notification to the patient's general practitioner

The Admissions/Booking Office staff must provide a notification letter to the patient's referring general practitioner (if known), within 3 working days of the patient being added to the list, advising them that the patient has been added to the list as a result of their referral.

The notification letter must include the patient's:

- full name and address
- placement on the wait list
- the date of placement on the wait 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 Office 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 [Planned Surgery Program Resources](#) webpage.

## 3. Managing patients on the wait list

### 3.1. Admission process for timely access to planned surgery / procedures

To ensure equity and priority of access and utilisation of wait lists to their full capacity, when choosing patients from a 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 wait list ([Treat in Turn principle](#)).

Staff must consider:

- Resource availability, such as theatre time, staffing, post-operative bed requirements, equipment and hospital capacity.
- Previous delays.
- Pre-admission assessment issues and factors (for example, 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
- anaesthetist
- operating theatres manager
- admissions
- pre-admission clinic
- wait list coordinator
- other departments if relevant, such as 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.

### **3.1.1. Allocating a date for surgery / procedure**

When a patient is selected from the wait list for care, 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 will usually be the same as the planned procedure date, or it may be different in cases where a hospital admission is required before the procedure date.

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. In these circumstances, the date that the patient is made Ready for Care is to be based on the patient condition and not the Planned Admission Date allocated.

For patients allocated a 30-day Clinical Urgency Category, treating doctors should propose a planned admission date as part of the Recommendation for Admission (RFA) completion process. This date should, if known, be confirmed and agreed with the patient as part of the wait list registration process.

For an example patient letter allocating a date for surgery/procedure to patients, please see the [Planned Surgery Program Resources](#) webpage.

### 3.1.2. 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/procedure. This optimises and supports management of the patient's perioperative risks associated with their planned surgery/procedure.

Senior managers must ensure there is a process in place for patients to complete the patient health questionnaire (PHQ) and authority to obtain medical records in a manner that ensures there is enough time for pre-admission assessment and planning. Ideally, patient health questionnaires should be completed upon RFA submission, however, there may be circumstances where this is not possible (for example, needing general practitioner input).

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/procedure remains undetermined. Any decision to go ahead with the surgery/procedure must be discussed with the treating doctor prior to rescheduling the appointment and surgery/procedure.

For further information on pre-admission clinics, please see the Agency for Clinical Innovation [Perioperative Toolkit](#).

### 3.1.3. Short-notice list

When offering dates at short notice (within one week of the planned admission date), Admissions/Booking Office 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. If a patient has accepted a short notice offer 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.

## 3.2. Procedures provided as non-admitted activity

Patients undergoing their planned procedure as a non-admitted patient must be managed in accordance with this Policy Directive. Treat in turn principles apply to this patient cohort in the same way they do to all patients on the wait list.

For further information on wait list reporting requirements see the NSW Health [Waiting Times Data Collection](#).

## 3.3. Delayed and declined patient outcomes

A delayed or declined outcome must be applied against a planned admission/planned procedure date where the procedure was not performed. However, the patient remains on the wait list unless the patient is removed for other reasons.

### 3.3.1. 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, equipment or bed.

The final approval for cancellation rests with the senior hospital manager (such as the General Manager) only after all possible options have been exhausted.

Admissions/Booking Office staff must:

- a. Keep the patient on the wait list as being Ready for Care and a suspension must not be applied.
- b. Record the reason the patient is being delayed on the patient administration system and paper RFA form (if paper RFA form in use).
- c. A new planned admission/planned procedure date should be communicated to the patient within 5 working days of the delay.

### 3.3.2. 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. A reasonable offer is at least 2 weeks prior to the procedure date, however, this may be shorter due to operational issues.

Admissions/Booking Office staff must:

- a. Record the reason the patient is declining the planned admission or procedure date on the patient administration system and on the RFA form.
- b. Review the reason for a declined planned admission/planned procedure date to determine:
  - i. if a new date is to be offered
  - ii. if a Deferred suspension should be applied ([Section 3.4.2](#))
  - iii. if the patient is to be removed from the wait list ([Section 3.9](#)).
- c. Not apply a Deferred suspension where a patient declines a planned admission/planned procedure date offer with an alternate doctor or at an alternate hospital.
- d. Inform patients who decline 2 reasonable offers that they will be removed from the wait list in consultation with their treating doctor and the hospital clinical directors of surgical services or equivalent.

An offer of an alternate hospital within 100km of the original hospital, or up to 200km where no closer alternate hospital can provide the required care, is considered a genuine offer when assessing access options for a "declined patient". Extenuating personal circumstances, (such as when a patient or carer does not have their own transport) should be considered in the decision making.

### **3.3.3. Requirement to escalate to Chief Executive for public patients who decline to be treated by another surgeon / hospital**

In accordance with [Section 2.2.1](#) and [Section 3.10](#), public patients on the wait list are allocated to a doctor by the hospital. This may mean that in order for the patient to have surgery as soon as clinically recommended, the surgery will be completed by another doctor or hospital.

Patients that decline 2 “reasonable” offers or to have their surgery with another hospital or doctor must have their status on the wait list reviewed in accordance with [Section 3.9](#).

If the decision is made for the patient to remain on the surgery list after review by the treating doctor, the Chief Executive (or a delegate) must be advised of the reason, and will make the final decision on the patient remaining on the wait list.

### **3.4. Suspension**

A patient on the wait list who experiences a period where they are clinically Not Ready for Care (Staged [Section 3.4.1](#)) or personally unavailable (Deferred [Section 3.4.2](#)) must have a suspension applied for that period. This suspension applies when they are expected to become Ready for Care or available in the future.

Admissions/Booking Office staff must record the reason for staging or deferring a patient on both the electronic Patient Administration System and the RFA form.

The maximum suspension period for any patient on the wait list is half of their urgency wait time:

<b>Clinical Urgency Category</b>	<b>Maximum cumulative days <i>Combined Staged and Deferred</i></b>
<b>Category 1 – Urgent</b>	15 days
<b>Category 2 – Semi-urgent</b>	45 days
<b>Category 3 – Non-urgent</b>	180 days

Patients exceeding the maximum days require:

- a. A physical clinical review by the treating doctor regarding appropriateness of procedure and any change to clinical condition.
- b. A written recommendation by the treating doctor must be provided to clinical directors of surgical services or equivalent for approval to remain on the list.
- c. Approval or outcome of review documented on the RFA form.
- d. Removal from the planned wait list in consultation with the treating doctor and referred to a service to support their immediate health need.

Patients with current suspensions must be regularly reviewed to ensure they become Ready for Care (available) or are removed from the wait list ([Section 3.9](#)).

If a patient is unavailable on 2 occasions or exceeds the maximum cumulative number of unavailable/suspension days, the patient should be removed from the wait list ([Section 3.9](#)) following notification of the treating surgeon by the Admissions/Booking Office.

#### **3.4.1. Staged – clinically Not Ready for Care**

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

The treating doctor must first determine the patient's Clinical Urgency Category, and this must be recorded effective from the listing date. The treating doctor must then determine the 'Not Ready for Care' period. This must also be recorded with a start date equal to the listing date.

Admissions/Booking Office staff must first register the patient in their intended Clinical Urgency Category, then record the 'Staged' suspension period.

For further information, please refer to [Waiting Times Data Collection](#).

#### **3.4.2. 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 but is unavailable for surgery/procedure due to personal reasons, Admissions/Booking Office staff must record the unavailable period in the wait list 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.

#### **3.4.3. 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.

#### **3.4.4. Status review report**

Admissions/Booking Office 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:

- a. Be assigned another status review date.
- b. Be returned to Ready for Care with the appropriate Clinical Urgency Category.
- c. Have a planned admission date scheduled ([Section 3.1.1](#)).
- d. Be removed from the wait list ([Section 3.9](#)).

### 3.5. Clinical review

The condition of the patient may change while they are awaiting treatment. Patients and general practitioners can initiate a review to ensure that the waiting time is appropriate for their clinical condition. Clinical review should occur when the patient’s condition changes or if they have been on the wait list 1.5 times their maximum Clinical Urgency Category timeframe ([Section 2.4.1](#)).

Clinical Urgency Category	Maximum days on list until clinical review <i>Cumulative RFC and NRFC days</i>
<b>Category 1 - Urgent</b>	45 days
<b>Category 2 - Semi-urgent</b>	135 days
<b>Category 3 - Non-urgent</b>	547 days

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 delegate.

Examination may result in the patient being assigned a different Clinical Urgency Category from the initial category that was assigned ([Section 2.4.6](#)), with appropriate clinical documentation. An authorised change in the Clinical Urgency Category must be documented in the patient administration system and on the RFA form. 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 Office staff must discuss the patient’s status on the wait list and potential removal with the treating doctor or their delegate and senior management.

### 3.6. 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 retain documented evidence from the treating doctor 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 patient 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), consent ([Section 2.1](#)) must be updated by the treating doctor or delegate as required and the Admissions/Booking Office must:

- edit the procedure description field of the wait list entry screen
- make a notation regarding the changes in the comments field.

Where the principal procedure changes, Admissions/Booking Office staff must remove the original wait list entry as “no longer required” and the treating doctor must submit a new RFA form for the new procedure, including a new signed consent. As this is a new procedure, the listing date is the date on the new RFA form.

### **3.7. Hospital-initiated delays**

- a. Postponements or delays to surgery/procedures 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 wait list manager and senior hospital management.
- b. A senior manager, for example, an Executive Director of Operations or a General Manager, must make the final decision if a patient is to be cancelled on day of surgery.
- c. The decision must consider the:
  - i. reason for the delay
  - ii. Clinical Urgency Category
  - iii. patient’s delay history
  - iv. patient’s length of time on the wait list
  - v. medical input from treating doctor or delegate
  - vi. patient’s proximity to the hospital.
- d. The hospital-initiated delay of a Clinical Urgency Category 1 patient who will not be treated on time or who is being delayed after admission must be approved by a senior manager and reported to the Chief Executive. A new planned admission date for the patient must be scheduled as part of the delay process, with the delay and updated treatment plan, including any clinical impacts, reported to the Chief Executive.
- e. 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.
- f. Non-urgent patients must be advised of a new planned admission date, ideally within 5 working days of the delay.
- g. When possible, delayed patients must be prioritised on the procedure/treatment list to minimise the chance of further delay, for example, placed first on list.
- h. If a patient has been delayed 2 or more times and cannot be treated within the appropriate Clinical Urgency Category timeframe, Admissions/Booking Office staff must escalate to local health district (District)/specialty health network (Network) senior management and a plan made to treat the patient within their clinical timeframe ([Section 3.10](#)).
- i. For an example of a patient delay letter, please see the [Planned Surgery Program Resources](#) webpage.

### **3.7.1. Delay on the day of surgery / procedure or after admission**

When communicating the surgery/procedure delay, Admissions/Booking Office staff must be notified of their delay by a senior member of the surgical/medical team or senior hospital manager.

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
- Arranging and paying for transport home, accommodation, food etc
- Social Worker support.

Admissions/Booking Office staff must:

- Admit and discharge the patient
- Record the reason for the delay
- Return the patients record to the wait 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 planned admission date (PAD) within 5 working days of the delay.

An example letter informing a patient of a necessary delay is available on the [Planned Surgery Program Resources](#) webpage.

## **3.8. Patient-initiated deferral**

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

- A new date is to be offered.
- A Deferred suspension needs to be applied.
- The patient is to be removed from the wait list.

Patients are only permitted to defer a maximum of 2 times for personal or social reasons.

### **3.8.1. 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/procedure with the patient.

If the surgery/procedure is still clinically required and the patient agrees, the patient's wait list record must be returned to the list (rebooked) with the original listing date and history, including urgency categories, delays and other relevant details.

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

### **3.9. Removing patients from the wait list**

Patients may be removed from the wait 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 wait list if they decline an offer that was made at short notice. A reasonable offer is 2 weeks prior to the procedure date; however, this may be shorter due to operational issues.

An example letter for informing a patient that they have been removed from the wait list is available on the [Planned Surgery Program Resources](#) webpage.

<b>Reason</b>	<b>Admissions / Booking Office staff must</b>
Patient declines treatment (including pre-admission assessment)/clinical review or requests removal for other reasons, for example, patient has surgery elsewhere.	<ul style="list-style-type: none"> <li>Obtain authority from the treating doctor or delegate for Clinical Urgency Category 1 patients prior to removal from the wait list</li> </ul> <p>Once the decision is made to remove a patient from the wait list:</p>
Patient defers treatment on 2 occasions (including genuine offers of another doctor/hospital) or exceeds the maximum number of Not Ready for Care / Suspended days: <ul style="list-style-type: none"> <li>Category 1 &gt; 15 days</li> <li>Category 2 &gt; 45 days</li> <li>Category 3 &gt; 180 days</li> </ul>	<ul style="list-style-type: none"> <li>Document discussions with the patient and treating doctor on the RFA form</li> <li>Remove the patient from the wait list on the PAS</li> <li>Document the reason for the removal and date of removal</li> <li>Advise the treating doctor within 24 hours of notification of the removal of the patient from the wait list</li> </ul>
Patient fails to arrive for treatment on > 1 occasion without giving prior notice and with no extenuating circumstances.	<ul style="list-style-type: none"> <li>Advise the general practitioner that the patient has been removed</li> <li>Inform patient if they have any further questions on their healthcare needs to contact the treating doctor/ general practitioner</li> </ul>
Patient not contactable on 2 occasions (one by telephone and one by letter or email with secure code)	<ul style="list-style-type: none"> <li>Obtain, where possible, the patient's correct contact details via treating doctor, general practitioner, medical records, next of kin, patient responsible and telephone directory search</li> </ul>

Reason	Admissions / Booking Office staff must
	<ul style="list-style-type: none"> <li>• Allow 10 business days for response to a letter with the patient remaining Ready for Care for this period</li> <li>• Record any evidence, such as patient letters returned to sender</li> <li>• Remove patient from the wait list</li> <li>• Document the reason for the removal and date of removal</li> <li>• Advise treating doctor and general practitioner that the patient has been removed</li> <li>• Document actions on RFA form and the PAS</li> </ul>
Patient deceased	<ul style="list-style-type: none"> <li>• Obtain verification (usually verbally from the patient's relative, general practitioner or treating doctor)</li> <li>• Record the name of the patient who has notified the hospital that the patient is deceased</li> <li>• Remove patient from the wait list</li> <li>• Document the reason for the removal and date of removal</li> <li>• Document action on the RFA form</li> </ul>
Treating doctor advises surgery no longer required	<ul style="list-style-type: none"> <li>• Once the decision is made to remove a patient from the wait surgery list:               <ul style="list-style-type: none"> <li>○ Document discussions with the patient and treating doctor on the RFA form</li> <li>○ Remove the patient from the wait list on the PAS</li> <li>○ Document the reason for the removal and date of removal</li> <li>○ Advise the treating doctor within 24 hours of notification of the removal of the patient from the wait list</li> <li>○ Advise general practitioner that the patient has been removed</li> <li>○ Inform patient of the potential risks to their health and advise them to contact the treating doctor/general practitioner to discuss</li> </ul> </li> </ul>

Hospitals must have a documented process for removing patients from the wait list. RFA form for removed patients must be handled as per the [State Records Authority General Retention & Disposal Authority](#).

### 3.9.1. Adding a recently removed patient to the wait list

If a patient was removed from the wait list, and in the following 30 days, the wait 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. The patient can have a Deferred suspension added for the period they were removed from the list.

Admissions/Booking Office staff must consult the treating doctor for confirmation before returning the patient to the list.

### 3.10. Demand management to treat patients on time

- a. It is the joint responsibility of the treating surgeon, senior managers and executives to ensure that patients added to the wait list must be treated within their Clinical Urgency Category timeframe through proactive surgical service demand and capacity management.
- b. At a minimum, the strategies below should be implemented when patients are not able to be allocated a plan of care in accordance with the timeframes set out in [Section 2.2](#).
- c. Admissions/Booking Office staff must review the wait list weekly and identify patients that are likely to exceed or have already exceeded their Clinical Urgency Category timeframes ([Section 5.1.1](#)).
- d. Treating doctors must ensure that they are available to perform procedures within the assigned Clinical Urgency Category timeframes.
- e. If a treating doctor is not available to perform the required procedure within the assigned Clinical Urgency Category timeframes, they must notify the hospital. The hospital and the treating doctor must work together to arrange for another clinician to perform the procedure within the assigned Clinical Urgency Category timeframe. This may include the treating doctor providing a clinical handover to a treating doctor in the same or another hospital or District.
- f. Treating doctors must manage the wait list in line with their theatre allocations and proactively escalate mismatch in demand and capacity.
- g. Treating doctors who will not have sufficient theatre time to care for referred patients within the clinically recommended timeframes must engage the theatre manager, wait list manager and senior manager. They must determine whether it is possible to secure additional theatre time before submitting additional RFA forms.
- h. With their treating doctors, clinical teams, senior managers and hospital clinical directors of surgical services or equivalent, must maximise access to planned surgery/procedures through the implementation of current best practice strategies that:
  - minimise length of stay
  - maximise the use of safe same day surgery
  - match value-based care protocols
  - provide evidence based non-surgical alternatives to suitable patients
  - maintain surgical access that considers seasonal hospital demands

- use guidelines ([Appendix B](#)) to establish safe high-volume low-complexity theatre case numbers
  - monitor the volume of each treating doctor's wait list, including rates of addition to the wait list to ensure that there is capacity to undertake required surgery/procedures.
- j. 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:
- The treating doctor should make themselves available to accept additional theatre time where it is available at same or other hospital within the District/ Network. This may include vacant lists due to other doctor leave.
  - Pooled or high-volume short stay 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.
  - Dedicated long wait list sessions which are consultant led.
  - Transfer patients to another treating doctor with a shorter wait list at the same hospital ([Section 3.10.1](#)).
  - Transfer patients to another treating doctor with a shorter wait list at another hospital ([Sections 3.10.1](#) and [3.10.2](#)).
  - Private sector options where the District or Network is responsible for expenses incurred ([Section 3.10.5](#)).

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

### **3.10.1. Transfer of patients to doctors with a shorter waiting time**

The new treating doctor will determine the requirement to consult the patient prior to surgery, procedure, or treatment. If a consult 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. If planned admission date is not available, 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 2 genuine offers of treatment (excluding offers made at short notice (within one week) but including an offer with another doctor or at another hospital), the patient must be advised that they may be removed from the wait list.

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

### **3.10.2. Transferring patients to another hospital 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 wait 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 [Waiting Times Data Collection](#).

### **3.10.3. Transferring patients to another District or Network**

Where an agreement exists with another District or Network to undertake public patient surgery/procedures, the new hospital/receiving hospital Admissions/Booking Office staff must add the patient to the wait list with the new listing date and advise the original hospital when the procedure is undertaken.

Original hospital Admissions/Booking Office staff must send the original RFA form to the new hospital and keep a copy for auditing purposes. Staff must keep the patient on the wait list until advised that the patient has had their procedure and then remove the patient using the relevant reason.

### **3.10.4. Patients who decline offers with alternative surgeon/hospital within 100 kms**

Public patients who decline surgery/procedures within an alternative surgeon/doctor within 100km of the original hospital, or up to 200km where no closer alternate hospital can provide the required care, should have the decline recorded on their wait list.

Where a patient declines 2 offers of surgery/care, the patient should be removed from the wait list, unless in extenuating circumstances which can be agreed locally and are supported by the Chief Executive or delegate.

### **3.10.5. Contracts with private hospitals**

Where a contract exists with a private hospital to undertake planned surgery, treatment or procedures for the District or Network, the contracted hospital must manage public cases as per the requirements of the Contract in place. The public hospital must be advised when the procedure is undertaken.

Admissions/Booking Office staff of the original hospital must send the original RFA form to the new hospital and keep a copy for auditing purposes. The patient is to remain on the wait list until advised that the patient completed their procedure. The patient should then be removed using the relevant reason.

The date of the removal from the public hospital wait list is the date of the admission at the contracted private hospital.

## **4. Record keeping and reporting**

Hospitals must keep accurate records of wait 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 Recommendation for Admission (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 or equivalent must generate and review a weekly report to identify overdue patients ([Section 5.1.1](#)).

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 previous month.
- Patients on the list who have had 2 or more delays to their admission.
- All delayed patients who have not had a rescheduled planned admission date allocated within 5 days.

## **5. Auditing the wait list**

### **5.1. Clerical audit**

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

Hospitals must identify a person suitable and responsible for conducting clerical audits of the wait list and reporting the outcome of the audit to a senior manager. Records related to clerical audits are to be kept for a minimum 3 years.

At a local health district (District)/specialty health network (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 any issues that arise.

Clerical audit is important in identifying opportunities and issues early to support the decision-making process by the surgical services team.

### **5.1.1. Weekly clerical audit**

A clerical audit must be conducted weekly which includes:

- Checking for duplicate bookings.
- Ensuring a Clinical Urgency Category is appropriately assigned and clinician responses/assessments for reclassification are approved and retained with the medical record.
- Reviewing the listing status of patients whose suspension end date falls within the next week. Where possible Clinical Urgency Category 1 patients must be allocated a planned admission date as part of the suspension planning process.
- 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 wait list admitted through the emergency department for the same procedure.
- The number of patients removed from the wait list and the reason for removal.
- Identifying overdue patients.

### **5.1.2. Clerical audit report**

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

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

### **5.1.3. Quarterly evaluation**

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

- Reviewing compliance with weekly and monthly audits.
- Weekly and monthly audit reports ([Section 4](#)) are tabled at the relevant committee.
- Availability of clerical audit records.

#### **5.1.4. Not Ready for Care / Suspended patient audit**

A Not Ready for Care / Suspended patient audit must be conducted when a patient exceeds, or is planned to exceed, the maximum Not Ready for Care period. The audit will include a review of the RFA and supporting documentation by the clinical team +/- a clinical consultation where the patient is present at the frequency set out in the table below.

The aim of the audit is to determine if the planned procedure remains the most appropriate care for the patient. Patients exceeding the “Initial audit at” number of Not Ready for Care days requires hospital clinical directors of surgical services or equivalent approval to remain on the list. The documented outcome of the audit must be retained with the RFA form, and the patients wait list updated following the audit.

<b>Clinical Urgency Category</b>	<b>Initial Audit at</b>	<b>Follow up audit every</b>	<b>Administrative team to initiate audit</b>
<b>Category 1 – Urgent</b>	15 NRFC* days	7 days	Weekly
<b>Category 2 – Semi-urgent</b>	45 NRFC days	30 days	Monthly
<b>Category 3 – Non-urgent</b>	180 NRFC days	90 days	Monthly

\* Not Ready for Care

#### **5.2. 6 monthly audits**

- a. Every 6 months, an audit of all patients on the wait list who have a listing date prior to 18 months from date of audit must be undertaken.
- b. Two contacts must be attempted with a patient, one by letter/email and if no response is received, a follow up telephone call to determine the patient’s status on the wait list.

Correspondence must include:

- i. Information on alternative options, where available, as advised by the treating doctor.
- ii. Advice for clinical reassessment by the treating doctor or general practitioner.
- iii. Hospital and District/Network contact details.
- c. This includes patients who are both Ready for Care and Not Ready for Care / Suspended.
- d. Results must be shared with the Chief Executive and discussed at the District or Network theatre management committee meetings.
- e. The number of patients removed as a result of the audit and plan for patients remaining on the list (for example, face to face clinical review to be arranged, allocation of a planned admission date) must be sent to the NSW Ministry of Health via [moh-surgery@health.nsw.gov.au](mailto:moh-surgery@health.nsw.gov.au).
- f. Any face to face or telehealth clinical reviews of patients to ascertain if they should remain on the list or another care pathway is preferred as part of the audit process should be conducted at no cost to the patient.

- g. Patients who have been audited as part of the Not Ready for Care audit (see section 5.1.4 for more information) within the last 90 days do not need to be contacted as part of the 6 monthly audit.

### **5.3. Review of wait list by treating doctor**

Admissions/Booking Office staff must provide each treating doctor with a comprehensive list of their patients on a monthly basis, or more frequently as requested.

Treating doctors or their rooms must confirm receipt of this wait list with planned surgery/procedure coordinators and advise any changes required.

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

## **6. Doctors' 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. Operating theatre sessions should not be vacated until the doctor's leave has been approved by the senior manager or hospital clinical directors of surgical services or equivalent.

Treating doctors must develop a management plan with the Admissions/Booking Office for all patients who, during the leave period already had a planned admission/procedure date or will exceed their Clinical Urgency Category timeframe due to the planned leave by the treating doctor.

During the doctors' leave period, senior managers and hospital clinical directors of surgical services or equivalent must have processes in place to ensure sessions available are reallocated in accordance with priority and need. This is to ensure access to surgeries/procedures is maximised.

### **6.1. Types of leave**

<b>Type of leave</b>	<b>Action</b>
<b>Planned Leave</b> Such as annual, study, extended and parental leave	Treating doctors must: <ul style="list-style-type: none"> <li>• Provide at least 6 weeks' notice of intended leave to the hospital clinical directors of surgical services or equivalent for approval.</li> <li>• With the Admissions/Booking Office, develop management plan for affected patients.</li> <li>• Not add any patients to their wait list during the leave period, unless approved by the local health district (District)/specialty health network (Network) Director of Surgery or equivalent.</li> </ul>

Type of leave	Action
	<ul style="list-style-type: none"> <li>Establish a plan to ensure any Clinical Urgency Category 1 patients identified prior to the commencement of leave, receive care within the required timeframe.</li> </ul> <p>Admissions/Booking Office staff must:</p> <ul style="list-style-type: none"> <li>With the treating doctor, develop management plans for affected patients.</li> <li>Consult with relevant personnel including Head of Unit or specialty, Medical Administrator, Clinical Director, Divisional Manager, Operating Theatre Manager, Wait list coordinator, Hospital Executive Officer and District/Network Chief Executive or delegate.</li> <li>Not add any patients to the doctor's wait list during the leave period, unless approved by the District/Network Director of Surgery or equivalent.</li> </ul>
<p><b>Unplanned leave</b> Such as sick leave, bereavement leave</p>	<p>Admissions/Booking Office staff must:</p> <ul style="list-style-type: none"> <li>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, wait list coordinator, hospital executive officer and/or District/Network Chief Executive or delegate.</li> <li>Not add any patients to the doctor's wait list during the leave period, unless approved by the District/Network Director of Surgery or equivalent.</li> </ul>
<p><b>Planned resignation</b> Such as resignation from hospital or retirement</p>	<p>Treating doctors must:</p> <ul style="list-style-type: none"> <li>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, wait list coordinator, hospital executive officer and/or District/Network Chief Executive or delegate.</li> <li>A Visiting Medical Officer (VMO) on a sessional contract must provide notice in accordance with the <a href="#">Public Hospitals (Visiting Medical Officers Sessional Contracts) Determination 2014</a></li> </ul> <p>Admissions/Booking Office staff must:</p> <ul style="list-style-type: none"> <li>Transfer patients to a replacement treating doctor's wait list (<a href="#">Section 3.10</a>) and maintain the treat in turn principle. Maintain patients on the resigning doctor's list if they are not immediately transferred.</li> <li>With the treating doctor, develop management plans for affected patients including taking part in clinical hand overs to other doctors within the hospital, District/Network or other</li> </ul>

Type of leave	Action
	<p>public or private hospital as determined by the management plan.</p> <ul style="list-style-type: none"> <li>Notify affected patients of the doctor's intention to leave and provide information about the patient's management plan.</li> <li>Not add any patients to the doctor's wait list upon notification of planned resignation unless there is capacity or for an urgent case. This must be approved by the District/Network Director of Surgery or equivalent.</li> </ul> <p>Hospital executive must:</p> <ul style="list-style-type: none"> <li>Ensure appropriate arrangements are made to either locate replacement treating doctor or transfer patients to another doctor in consultation with senior clinicians and management.</li> <li>Organise clinical review, as required, for patients remaining on the departing doctor's wait list.</li> <li>Determine if departing doctor is willing to treat additional patients and has capacity to undertake the procedure/treatment to decrease the wait list.</li> </ul>
<p><b>Unplanned resignation or death</b></p>	<p>Admissions/Booking Office staff must:</p> <ul style="list-style-type: none"> <li>Transfer patients to a replacement treating doctor's wait list (<a href="#">Section 3.10</a>) and maintain the treat in turn principle. If they are not immediately transferred, place patients on a list for an appropriate doctor or specialty.</li> <li>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, wait list coordinator, hospital executive officer and/or District/Network Chief Executive or delegate.</li> <li>Not add any patients to the doctor's wait list.</li> <li>Notify relevant general practitioners of the resignation/death.</li> </ul> <p>Hospital executive must:</p> <ul style="list-style-type: none"> <li>Locate replacement for the treating doctor in consultation with senior clinicians and management.</li> </ul> <p>Clinical review is at the discretion of the accepting treating doctor.</p>

An example of a notification to a general practitioner of resignation/death letter is available on the [Planned Surgery Program Resources](#) webpage.

## **6.2. Patient management plan for treating doctor's leave**

Admissions/Booking Office staff must inform patients:

- Their position on the wait 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 Recommendation for Admission (RFA) form.

## **7. Appendices**

1. Appendix A – Recommended Clinical Urgency Category and default Discharge Intention reference list
2. Appendix B – Public hospital high-volume low-complexity list guide
3. Appendix C – Clinical Review Panel for surgical activity - Suggested membership, frequency and format
4. Appendix D – Key responsibilities

## 7.1. Appendix A – Recommended Clinical Urgency Category and default Discharge Intention reference list

The table below identifies the recommended Clinical Urgency Category(CUC), which align with the [Australian National Elective Surgery Urgency Categorisation](#), and default Discharge Intention for each Indicator Procedure Code (IPC).

### Default Discharge Intention

- DO (Day Only)
- DOSA (Day of Surgery Admit)
- DO/DOSA. These patients may be DO or DOSA as clinically assessed by the Admitting Medical Officer (AMO).

**Note** IPC changes are made yearly and communicated publicly via the NSW Health [Policy Distribution System](#) and available internal to NSW Health via the [Waiting Times Data Collection](#) intranet page.

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Acromioplasty	124	3	DO/DOSA
Adenoidectomy	67	3	DO
Amputation digit (toe/finger)	197	2	DO
Amputation of limb	85	1	DOSA
Angioplasty - carotid artery / with stent	232	1	DO/DOSA
Angioplasty / with stent	233	1	DO/DOSA
Anal fissure (any treatment)	80	2	DO
Aortic bifurcation graft	175	1 or 2	DOSA
Apicectomy	155	3	DO
Appendicectomy	97	3	DO
Arthrodesis	122	3	DOSA
Arthroplasty- hip (Total Hip Replacement)	13	3	DO/DOSA
Arthroplasty- knee (Total Knee Replacement)	14	3	DO/DOSA
Arthroplasty- other (shoulder)	199	3	DO/DOSA
Arthroplasty- revision of	282	2	DOSA
Arthroscopy	42	3	DO
Arthroscopy shoulder/sub acromial decompression	42	3	DO
Arthrotomy	200	3	DO/DOSA
Axillary node dissection	283	1	DO/DOSA
Bartholin's abscess drainage	103	1	DO

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Bartholin's cyst removal	103	3	DO
Biopsy - muscle	178	1	DO
Biopsy of breast (excluding excision)	27	1	DO
Biopsy/conization of cervix/Large loop excision of transformation zone (LLETZ)	46	2	DO
Bladder neck incision	137	3	DO/DOSA
Blepharoplasty (see Cosmetic and discretionary surgery <a href="#">Section 2.6.1</a> )	184	3	DO
Bone graft	234	As per AMO	DO/DOSA
Botox injection (excluding anal fissure)	235	As per AMO	DO
Breast reconstruction	284	3	DOSA
Breast reduction (see Cosmetic and discretionary surgery <a href="#">Section 2.6.1</a> )	285	3	DO/DOSA
Bronchoscopy	19	1 or 2	DO
Bursa - excision	192	3	DO
Cardiac catheterisation	16	1 or 2	DO
Cataract extraction - 1st eye	292	3	DO
Cataract extraction - 2nd eye	293	2	DO
Change of muscle or tendon length	128	3	DO
Change of plaster (GA)	120	4 (Staged)	DO
Cholecystectomy for biliary colic	2	3	DO
Cholecystectomy for proven acute cholecystitis	2	2	DO
Cholecystectomy for pancreatitis	2	1 or 2	DO
Circumcision	54	3	DO
Closed reduction/internal fixation of fracture	202	1	DO/DOSA
Closure colostomy/ileostomy	176	2 or 3	DOSA
Cochlear implant	75	3	DO
Coeliac plexus block	87	As per AMO	DO
Colectomy/Anterior Resection/Large Bowel Resection (malignant)	25	1	DOSA
Colectomy/large bowel resection (benign)	25	2	DOSA
Colonoscopy (see <a href="#">NHMRC</a> and <a href="#">ACI Clinical Practice Guide</a> )	20	1,2,3 or 4 (Staged)	DO
Colposcopy	101	2	DO
Cone biopsy	286	1	DO

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Corneal graft	113	3	DO
Coronary angioplasty	17	2	DOSA
Coronary artery bypass graft	3	2	DOSA
Correction of bat ears	68	3	DO
Correction of cleft lip/palate	74	3	DOSA
Correction of ectropion	111	3	DO
Correction of uretero-pelvic junction	151	2	DOSA
Craniectomy	108	2	DOSA
Cranioplasty	287	3	DOSA
Craniotomy for removal benign tumour (with no neurological deficit)	104	3	DOSA
Craniotomy for removal of tumour (neurological deficit)	104	1	DOSA
Cystectomy	143	1 or 2	DOSA
Cystoscopy	4	3	DO
Cystoscopy check / flexible	236	3 or 4 (Staged)	DO
Dacryocystorhinostomy	118	3	DO
Dental extractions	156	3	DO
Dermoid cyst - removal of	288	2	DO
Diagnostic laparoscopy	43	3	DO
Diathermy bladder tumour	237	1 or 2	DO
Diathermy of warts	93	3	DO
Dilatation and curettage	100	2	DO
Dilatation of oesophagus	26	2	DO
Dilatation of urethra/bladder biopsy	55	2	DO
Discectomy	39	3	DO/DOSA
Discectomy with foot drop	39	1	DO/DOSA
Drainage of sub-dural haematoma	105	2	DOSA
EBUS (Endobronchial Ultrasound and Trans-bronchial needle aspiration)	279	1 or 2	DO
ECOG-IMPEBAP -electro-cochleography-implant evoked brain auditory procedure	186	As per AMO	DO
Endarterectomy	57	1 or 2	DOSA
Endometrial ablation/biopsy	49	3	DO
Endoscopy - Endoscopic Retrograde Cholangiopancreatography (ERCP)	88	1 or 2	DO

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Endoscopy - small intestine	22	2	DO
Ethmoidectomy	63	3	DO
Examination of eye under anaesthesia	116	2	DO
Examination under Anaesthesia (not including eyes)	204	3	DO
Excision lesion of pharynx	77	2	DO
Excision of Melanoma/SCC/BCC/ +/- Grafting	207	1	DO/DOSA
Excision of anal fissure	80	2	DO
Excision of breast lump	84	1 or 2	DO
Excision of chalazion	119	3	DO
Excision of cholesteatoma	239	3	DO
Excision of ganglion	86	3	DO
Excision of benign lesion or tissue of rectum or anus	238	3	DO
Excision of Lipoma +/- Grafting	208	3	DO
Excision of pituitary tumour	241	1	DOSA
Excision of pterygium	112	3	DO
Female sterilisation	45	3	DO
Femoral herniorrhaphy	28	3	DO
Femoro-popliteal bypass graft (open or endovascular)	154	1 or 2	DOSA
Fistulotomy / Fistulectomy	243	3	DO/DOSA
Flexible sigmoidoscopy	244	3	DO
Foraminotomy	245	3	DOSA
Foreign body - removal	179	3	DO
Freeing abdominal adhesions	31	3	DO/DOSA
Frenuloplasty	246	3	DO/DOSA
Functional endoscopic sinus surgery (FESS)	185	3	DO
Fundoplication	89	3	DOSA
Gastrectomy (malignant)	210	1	DOSA
Gastrectomy (other)	210	2 or 3	DOSA
Gastroscopy (haemorrhage or cancer)	210	1	DO
Gastroscopy (other)	21	2 or 3	DO
Gastroscopy (surveillance)	21	4 (Staged)	DO
Haemorrhoidectomy/Banding of Haemorrhoids	5	3	DO
Hammer toe - correction/repair	198	3	DO

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Hartmann's procedure	247	As per AMO	DOSA
Heart valve replacement (any type including endovascular)	18	2	DOSA
Hypospadias repair	174	3	DO/DOSA
Hysterectomy (laparoscopic/open) malignant	6	1	DO/DOSA
Hysterectomy (laparoscopic/open) benign	6	3	DO/DOSA
Hysterectomy (vaginal) malignant	276	1	DO/DOSA
Hysterectomy (vaginal) benign	276	3	DO/DOSA
Hysteroscopy	44	2	DO
Incision / excision of pilonidal sinus	81	3	DO
Inguinal herniorrhaphy	7	3	DO
Insertion / removal of Levonorgestrel intra uterine system (contraceptive device)	213	3	DO
Insertion / removal Pressure Equalisation (P.E.) tubes (grommets)	66	3	DO
Insertion / replacement / removal of ureteric stent	142	1 or 2	DO
Insertion of access device for dialysis or chemotherapy	211	As per AMO	DO
Insertion of artificial urinary sphincter	212	As per AMO	DOSA
Insertion of cervical suture	248	As per AMO	DO
Insertion of hepatic artery catheter	96	1	DOSA
Insertion of suprapubic catheter	249	1 or 2	DO
Insertion of tension free vaginal tape	250	3	DO/DOSA
Insertion of ventricular shunt	109	2	DOSA
Insertion/change of Pacemaker/Implantable Defibrillator	214	As per AMO	DO
Insertion/removal of inferior Vena Cava Filter	252	1	DO/DOSA
Insufflation of fallopian tube (Rubin's test)	48	3	DO
Interdental wiring	134	As per AMO	DOSA
Intranasal antrostomy	254	3	DO
Laminectomy/Other Spinal Surgery (excluding fusion and discectomy)	38	3	DOSA
Laparotomy	83	2 or 3	DOSA
Laryngectomy	72	1	DOSA
Laryngoscopy	255	1	DO
Litholapaxy	256	1	DO/DOSA
Lithotripsy / laser	56	2	DO/DOSA

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Liver biopsy	82	2	DO
Lobectomy/wedge resection/pneumonectomy	216	1	DOSA
Lymph node - excision	181	1 or 2	DO/DOSA
Lymph node biopsy	257	1 or 2	DO
Mandibulectomy/hemi-mandibulectomy	135	2	DOSA
Manipulation under anaesthetic	195	3	DO
Mastectomy (malignant)	30	1	DO/DOSA
Mastectomy (benign)	30	3	DO/DOSA
Mastoidectomy	70	2	DO/DOSA
Meatoplasty (ear)	258	3	DO/DOSA
Meniscectomy (knee)	126	3	DO
Microlaryngoscopy	64	2	DO
Myomectomy	50	3	DO/DOSA
Myringoplasty/Tympanoplasty	8	3	DO
Myringotomy	9	3	DO
Nasal cautery	69	3	DO
Nasal polypectomy	32	3	DO
Nasendoscopy	217	2	DO
Nephrectomy	141	1 or 2	DOSA
Nerve block (anaesthesia/pain management)	259	As per AMO	DO
Nerve decompression/release	191	3	DO/DOSA
Oesophagoscopy	260	1,2, or 3	DO
Open reduction and internal fixation (ORIF) of fracture	203	1	DO/DOSA
Orchidectomy (benign)	139	2 or 3	DO
Orchidectomy (malignant)	139	1	DO
Orchidopexy	138	2	DO
Osteotomy - ankle/foot/arm/facial	193	3	DO/DOSA
Osteotomy - hip/femur/tibia/shoulder	194	3	DO/DOSA
Ovarian cystectomy	52	3	DO
Panendoscopy (see <a href="#">ACI Clinical Practice Guide</a> )	262	1,2, or 3	DO
Parathyroidectomy	289	2 or 3	DO/DOSA
Parotidectomy/Submandibular gland - excision	180	2 or 3	DO/DOSA
Pelvic lymph node excision	263	1	DOSA

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Peritonectomy	277	As per AMO	DOSA
Pharyngoplasty	187	3	DOSA
Pleurodesis	58	2	DOSA
Positive Faecal Occult Blood Test (FOBT) Colonoscopy	278	See <a href="#">ACI Clinical Practice Guide</a>	DO
Probing of naso-lacrimal duct	117	3	DO
Proctoscopy	264	As per AMO	DO
Prostatectomy/open/Transurethral Resection of Prostate (TURP)	10	2 or 3	DO/DOSA
Prostatic biopsy	147	1	DO
Ptosis - repair, correction	183	3	DO
Pulmonary artery shunt	59	1	DOSA
Pyeloplasty	145	2	DOSA
Pyeloscopy	265	As per AMO	DO/DOSA
Pylorotomy	152	3	DOSA
Radical neck dissection	133	1	DOSA
Reconstruction of shoulder	201	3	DO/DOSA
Reduction of fractured orbit	131	3	DO
Reduction of fractured zygoma	130	3	DO/DOSA
Reimplantation of ureters	149	2	DOSA
Release of carpal tunnel	36	3	DO
Release of clubfoot	127	2	DO
Release of tongue tie	76	3	DO
Removal of Access Device for Dialysis or Chemotherapy	215	As per AMO	DO
Removal of breast implants	132	3	DO
Removal of bunion (hallux valgus; hallux abducto valgus)	41	3	DO
Removal of epididymal cyst	219	3	DO
Removal of ingrown toenail	24	3	DO
Removal of intracranial lesion	290	1	DOSA
Removal of pins and plates	40	4 Staged	DO
Removal of skin lesion (benign)	23	3	DO
Removal of stone from urinary tract	148	1	DO
Renal biopsy	206	1	DO
Repair abdominal hernia	266	3	DO

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Repair atrial-septal defect	61	1	DOSA
Repair incisional hernia	78	3	DO/DOSA
Repair of cystocele, rectocele	47	3	DOSA
Repair of Dupuytren's contracture/Fasciectomy/Palmar Fasciectomy	121	3	DO
Repair of epigastric hernia	177	3	DO
Repair of exostosis	114	3	DO
Repair of hiatus hernia	94	3	DO/DOSA
Repair of hydrocele	150	3	DO
Repair of knee cartilage/Repair of knee ligament/Anterior Cruciate (or Collateral) Ligament (ACL) Reconstruction	34	3	DO
Repair of rotator cuff	123	3	DO
Repair of squint	115	3	DO
Repair of umbilical hernia	29	3	DO
Repair of ventral hernia	267	3	DO
Repair parastomal hernia	269	3	DO/DOSA
Repair patent ductus arteriosus	62	1	DO/DOSA
Repair ventricular-septal defect	60	1	DOSA
Replacement/removal of ventricular shunt	110	As per AMO	DOSA
Resection of abdo-aortic aneurysm	153	1 or 2	DOSA
Resection of bladder lesion/ tumour	270	1	DO/DOSA
Resection small bowel	272	1 or 2	DOSA
Retrograde pyelogram	144	1	DO
Revision of scar	136	4 (Staged)	DO
Rhinoplasty (see Cosmetic and discretionary surgery <a href="#">Section 2.6.1</a> )	33	3	DO
Salpingo-oophorectomy/oophorectomy (benign)	173	3	DO/DOSA
Septoplasty	11	3	DO
Skin Grafts, including Split Skin Graft	209	4 (Staged)	DO/DOSA
Sphincterotomy	95	2	DO
Spinal fusion	37	3	DOSA
Stapedectomy	71	3	DO/DOSA
Sub-mucosal resection/Nasal	65	2	DO
Sympathectomy	90	3	DOSA

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Tendon release/repair	190	3	DO
Tenotomy of hip	129	2	DO
Thoracoscopy	218	1	DO/DOSA
Thyroglossal remnant - removal of	291	2	DO/DOSA
Thyroidectomy/hemi-thyroidectomy	79	2 or 3	DO/DOSA
Tonsillectomy	12	3	DO
Trabeculectomy	182	2	DO
Tracheostomy	73	1	DOSA
Transcatheter Aortic Valve Implantation (TAVI) - High risk	280	2	DOSA
Transcatheter Aortic Valve Implantation (TAVI) - Low to Medium risk	281	2	DOSA
Trigger finger/thumb - repair, release	196	3	DO
Tubal reanastomosis	102	As per AMO	DO/DOSA
Turbinectomy	189	3	DO
Ureterotomy	273	As per AMO	DOSA
Urethrotomy/ optical for urethral stricture	275	As per AMO	DO/DOSA
Urinary Meatoplasty	140	3	DO
Uvulopalatopharyngoplasty (UPPP)	188	3	DO/DOSA
Vaginal repair	51	3	DOSA
Varicose veins stripping and ligation (see <a href="#">Discretionary surgery section 2.6.1</a> )	15	3	DO
Vasectomy	53	3	DO
Vitrectomy (including buckling/cryotherapy)	220	2	DO

The IPC Description below must be used only when there is no IPC available for the primary procedure and after seeking advice from the treating surgeon. Use the 'other' IPC of the specialty and avoid using "other surgical" or "other medical".

The Clinical Urgency Category and Discharge Intention assigned to these procedures must be approved by the Director of Surgery or the Clinical Review Panel for surgical activity.

Other - Cardiothoracic	221		
Other - Ear, Nose and Throat (ENT)	222		
Other - Gastroenterology	231		
Other - General	223		
Other - Gynaecology	224		

IPC description	IPC code	Recommended CUC	Default Discharge Intention
Other - Neurosurgery	225		
Other - Ophthalmology	226		
Other - Orthopaedic	227		
Other - Plastics	228		
Other - Urology	229		
Other - Vascular	230		
Other - dental procedures, e.g. fillings	172		
Other - medical	999		
Other - surgical	998		

Reference:

[British Association of Day Surgery](#)

## 7.2. Appendix B – Public hospital high-volume low-complexity list guide

The implementation of the Getting It Right First Time (GIRFT) standards will help optimise surgical capacity within our facilities.

The GIRFT programme is a national NHS England programme designed to improve the treatment and care of patients through in-depth review of services, benchmarking, and presenting a data-driven evidence base to support change. These benchmarks were developed and endorsed by the relevant clinical colleges within UK. They are to be used in NSW as a guide to help facilities manage their demand and capacity.

Specialty	Pathway	Number of cases per four-hour list
<b>ENT</b>	Endo sinus surgery	2-3
	Nasal airway surgery	4-5
	Myringoplasty	3
	Tonsillectomy	4-5
<b>General surgery</b>	Inguinal hernia	4
	Laparoscopic cholecystectomy	3
	Paraumbilical hernia	4
	Anorectal surgery	5
<b>Gynaecology</b>	Operative laparoscopy	3
	Endometrial ablation	5
	Hysteroscopy	5
	Laparoscopic hysterectomy (with or without removal of ovaries)	2
	Vaginal hysterectomy (anterior/posterior vaginal wall repair)	2
<b>Urology</b>	TURP (transurethral resection of the prostate)	3
	TURBT (transurethral resection of bladder tumour)	4
	Hydrocele	5
	Epididymal cyst excision	4
	Ureteroscopy and laser	3-4
	Vasectomy	5
	Cystoscopy and stent change	5
	Cystoscopy plus biopsy	4
	Cystolitholapaxy	4

Specialty	Pathway	Number of cases per four-hour list
	Circumcision	5
<b>Ophthalmology</b>	Cataract - with junior trainee	8*
	Cataract - high flow	10*
<b>Orthopaedics (limbs)</b>	Anterior cruciate ligament reconstruction	2
	Bunions	3
	Therapeutic shoulder arthroscopy	3
	Total hip replacement	2
	Total knee replacement	2
	Uni knee replacement	2
<b>Orthopaedics (spines)</b>	One or two level microdiscectomy decompression (bilateral/unilateral)	2
	One or two level ACDF/posterior cervical decompression	1.5
	Injections	8
	One or two level posterior lumbar intertransverse fusion	1.5
	One or two level posterior lumbar interbody fusion	1

\* NSW Ophthalmology Network has advised that 6 cataract cases in 4-hour list have been agreed for NSW as of March 2025.

Reference:

- [Getting it Right First Time Elective Care Improvement](#)
- [Elective Recovery High-volume Low-complexity \(HVLC\) – Guide for Systems](#)

### **7.3. Appendix C – Clinical Review Panel for surgical activity - Suggested membership, frequency and format**

The final decision must be made locally regarding the Clinical Review Panel's scope, remit, governance and membership.

*The below exemplar is based on the South Western Sydney Local Health District Clinical Review Panel Terms of Reference.*

#### **7.3.1. Role and Scope of the Clinical Review Panel**

The panel will provide support to the Director of Surgery to review and make clinical adjudications for patients who are referred to the local health district (District or Network) for surgery or procedures in the following areas:

- a. Procedures that are in the list of cosmetic and discretionary surgery in [Section 2.6.1](#).
- b. Procedures that are in the Clinical Practice Guide [Value-based surgery](#) or are identified in future value-based care documents as suitable for the review process ([Section 2.6.2](#))
- c. That are listed as targeted for “same day” admission and the referring doctor requests an overnight admission ([Appendix A](#)).
- d. Where the assigned Clinical Urgency Category varies from the recommended Clinical Urgency Category in [Appendix A](#).
- e. Where it is identified that the referring doctor does not have the capacity to complete the surgery within the recommended timeframe, implement the strategies in [Section 3.10](#) to ensure timely care.

#### **7.3.2. Role of Director of Surgery**

The Director of Surgery is responsible for the following:

- a. Oversight of the Clinical Review Panel process at each hospital.
- b. Providing education and raising awareness among stakeholders about the purpose and importance of the Clinical Review Panel in promoting patient safety, optimising healthcare resources and supporting the implementation of value-based care.

#### **7.3.3. Role of Clinical Review Panel Member**

Clinical Review Panel members are responsible for the following:

- a. Supporting appropriate, safe and effective decision making on referrals that meet the criteria of this Policy Directive.
- b. Participate in clinical adjudications regarding RFA forms through committee meetings.

#### **7.3.4. Frequency of meetings**

The meetings should be held as dictated by the remit of the panel and the volume of RFA forms received that meet the requirement of demand.

### 7.3.5. Review Process

#### 7.3.5.1. Cosmetic / Discretionary procedures and value-based surgery

For the procedure to be approved, there must be a demonstrated clear clinical need to improve a patient's physical health.

The current list of cosmetic and discretionary procedures is outlined [Section 2.6.1](#), value-based surgery in [Section 2.6.2](#) and the Clinical Practice Guide [Value-based surgery](#).

The following outlines the process for submitting and assessing a RFA form for procedures that may be considered cosmetic, discretionary, or fall under value-based surgery:

- a. At the time of consultation, the treating doctor must advise the patient that the procedure requires approval and will go through a review process.
- b. Prior to submitting the RFA for consideration, the treating doctor must obtain approval from the Director of Surgery or equivalent.
- c. The RFA submitted for consideration must have clear documentation of the objective medical criteria supporting the decision for a procedure that may be considered cosmetic or discretionary.
- d. All Admission/Booking Offices must have a list of cosmetic and discretionary procedures and value-based surgery at the location where RFAs are received and where wait list data entry is undertaken.
- e. The RFA form is sent to the Director of Surgery for assessment of its suitability for review by the Clinical Review Panel for surgical activity.
- f. The Clinical Review Panel is to meet and assess the RFA against the policy requirements to determine:
  - Medical Necessity:
    - Will the patient have a clear physical benefit to their health?
  - Risk-Benefit Analysis:
    - Assess the potential risks and benefits of the surgery.
  - Scope of Clinical Practice of the clinician:
    - Assess whether the procedure falls with the approved scope of clinical practice according to training and recency of practice.
  - Alternative Treatments:
    - Consider alternative treatments and their effectiveness compared to surgery.
  - Patient's Condition:
    - Evaluate the patient's overall health condition and how it relates to the surgery.
  - Resource Allocation:
    - Consider the availability of resources such as hospital beds, medical staff, and equipment.

- Procedure is suitable for the hospital:
  - Ensure that this is not a new procedure or health technology for the hospital.
  - Ensure that the procedure is consistent with the role delineation of the hospital.
- g. A decision is to be made by the panel whether to accept the RFA or to decline and refer the RFA back to the treating doctor.
- h. The treating doctor is to be informed in writing of the outcome using the letter template in the [Planned Surgery Program Resources](#).
- i. If the RFA is accepted, the patient is added to the wait list and notified in accordance with [Section 2.7.1](#) of this Policy Directive.
- j. If the RFA is declined, it is the responsibility of the treating doctor to contact the patient and discuss alternative treatment options.

### **7.3.5.2. Variations in the recommended Clinical Urgency Category and default Discharge Intention**

The current list of the recommended Clinical Urgency Category and default Discharge Intention is outlined in [Appendix A](#).

The steps in managing variations in the recommended Clinical Urgency Category and default Discharge Intention is outlined in [Section 2.4.2](#).

### **7.3.6. Monitoring and Evaluation**

#### **7.3.6.1. Outcome Tracking**

On a quarterly basis, the Clinical Review Panel for surgical activity for each hospital will provide a report to the Surgery Management Committee which outlines:

- a. The number of RFAs reviewed by the Director of Surgery and panel for cosmetic, discretionary, new procedures, clinical urgency categorisation and overnight admission for same day procedures.
- b. The number of RFAs accepted, declined or altered, broken down by specialty and referring doctor.

#### **7.3.6.2. Continuous Improvement**

On an annual basis the Surgery Management Committee will review and evaluate the effectiveness of the review process and update guidelines and protocols as needed in consultation with each hospital's Clinical Review Panel for surgical activity.

The review will seek feedback from General Managers, referring doctors, wait list managers, panel members and other stakeholders to identify areas for improvement.

#### **7.3.6.3. Compliance Monitoring**

Compliance will be monitored through the following measures:

- 
- a. Ensure compliance with the established guidelines and protocols through regular audits and reviews.
  - b. Quarterly submissions to the Surgery Management Committee will be reviewed for compliance with this Policy Directive.

#### **7.3.6.4. Disputes and Appeals**

The following process outlines how disagreements and appeals related to Clinical Review Panel decisions are to be managed:

- a. Where there is disagreement, the panel will vote, with the decision determined by majority ruling. The chair reserves the casting vote.
- b. In the event of a dispute on a decision made by the Clinical Review Panel, the referring doctor may request an appeal of the decision.
- c. At the discretion of the Director of Surgery, a review may be undertaken with consultation from the Director of Medical Services, the Executive Director of Operations and the Chair of the local Clinical Review Panel where the RFA was reviewed. A final decision will be made and the referring doctor notified of the outcome.

## 7.4. Appendix D – Key responsibilities

### 7.4.1. Admissions / Booking Office staff

Admissions/Booking Office staff must:

- a. Enter required data on the wait list system within 3 working days of receipt of the completed RFA.
- b. Check allocated clinical urgency categories and default Discharge Intention against [Appendix A](#) of this Policy Directive, escalating any variation.
- c. Ensure all documentation and electronic data input is accurate, legible and complete.
- d. Keep the patient administration system updated with a summary of any changes to the patient's wait list information. The detailed information and supporting clinical evidence should be kept with the RFA form and included in the patient's medical record.

### 7.4.2. Wait list coordinators

Wait list coordinators must:

- a. Have efficient oversight and management of patients requiring a planned procedure.
- b. Ensure that all relevant audits are completed and reported to senior management for noting/action as required.
- c. Provide operational advice on the achievement of planned surgery performance.
- d. Have processes in place to ensure treat in turn principles are applied for all lists.
- e. Have agreed and documented escalation pathways to senior management and Directors of Surgery (or equivalent) to address demand and capacity challenges.

### 7.4.3. Senior manager

Senior managers involved with the coordination of surgical and medical procedural services have responsibility in ensuring the appropriate application of this Policy Directive and ensuring that patients have timely access to care. Senior managers may include General Managers, Directors of Operations and Executive Directors of Operations of both single facilities or the local health district (District) or network.

These senior managers must:

- a. Ensure that services offered within the hospital/District meet the needs of the local population either through the hospital, within the District or with agreed and documented intra-District/specialty health network (Network) relationships.
- b. Manage wait lists so that all patients receive clinically appropriate, timely access to care.
- c. Where it is unavoidable for an urgent case/Clinical Urgency Category 1 patient to receive care on time, inform the Chief Executive of the cause of the delay and mitigation strategies in place to prevent future recurrence.

- d. Have a monitoring process to ensure patient health questionnaires are complete and authority to access medical records are signed to enable clinically appropriate pre-admission planning.
- e. Have a monitoring process to ensure same-day surgical patients receive a documented follow up phone call from a clinical staff member after the patient is discharged. As a minimum requirement all patients who are discharged on the same day as their procedure will receive a follow up phone call.
- f. Ensure all new consultants and rotating junior doctors performing surgical/procedural care are provided a copy of this Policy Directive and informed of the responsibilities of surgical/procedural teams as outlined in this Policy Directive.

Hospital specialty heads of department, clinical directors of surgical services or equivalent, and senior managers must:

- a. Agree to regular operating theatre and procedure time allocation processes.
- b. Reach agreement with treating doctors on the volume and complexity of cases that can be cared for on the allocated operating theatre lists and review the agreed volume regularly (at a minimum once a year). [Appendix B](#) contains an indication of cases numbers for high-volume low-complexity public lists.
- c. Reach agreement with treating doctors on hospital expectations as to how training requirements, theatre throughput and patient care will be balanced.
- d. Regularly review and update theatre schedules based on community needs (at least once a year).
- e. Develop local operational plans to ensure patients receive timely access to care in line with [Section 3.10](#) of this Policy Directive.
- f. Implement strategies to minimise length of stay and maximise the use of safe same day surgery and value-based care protocols.
- g. Develop plans to maintain surgical/procedural access that consider seasonal hospital demands.
- h. Utilise analytics to forecast surgery demand to help develop data driven decisions.
- i. Assess emergency surgery volumes and establish plans to minimise the cancellation of planned surgery to provide emergency care.

#### 7.4.4. Treating doctors

Treating doctors must:

- a. Provide a surgical option to patients when it is in their best interests and when conservative measures are not applicable or have been exhausted, based on the latest evidence and best practices.
- b. Only refer patients for surgery within the capabilities and role delineation of the hospital where the procedure will be performed to ensure the right care and necessary support (like imaging or intensive care) are available.

- c. Provide care they are contracted and credentialed to provide with the relevant District, Network, or hospital.
- d. Use the available clinical networks for patient transfer if a higher level of care is needed.
- e. Adhere to an agreed volume of cases per list. See [Appendix B](#) for an example of cases numbers per session for high-volume low-complexity public lists.
- f. If their wait list demands exceed their current theatre session capacity, they must either agree to take additional sessions offered by the hospital or District or collaborate with the hospital/District to facilitate treatment of the patient by another doctor or District. This includes taking part in clinical handovers to ensure safe transfer of care.
- g. They should obtain written consent from the patient that includes details about the surgery/procedure, potential complications, and expected hospital stay.
- h. Inform patients that, under [Medicare Principles](#), public patients are allocated to doctors by the hospital. and their procedure might be performed by a different doctor or at a different public hospital to ensure they receive treatment within clinically recommended timeframes.
- i. Advise patients that surgery/procedural prioritisation is based on clinical need, not whether they elect to be treated as a public or private patient.
- j. RFA forms submitted to the hospital must contain the complete minimum data set as set out in [Section 2.2](#). Failure to do so may result in delays in patients being added to the wait list.
- k. RFA forms must be complete, legible and submitted within 5 working days of the patient agreeing to the proposed procedure/treatment. This agreement may be in writing.
- l. RFA forms must include a proposed surgery/procedure date for Clinical Urgency Category 1 and other urgent patients.
- m. Provide clinical evidence if the urgency category or length of stay is not consistent with [Appendix A](#), for review and approval by the Director of Surgery and Clinical Review Panel for surgical activity or equivalent review group.
- n. Seek approval from the Director of Surgery and/or Clinical Review Panel for surgical activity or equivalent before a patient is added to the wait list for a discretionary procedure or procedure that does not meet the value-based care criteria for procedures as set out in the [Clinical Practice Guide Value-base surgery](#).
- o. Proactively manage their waiting list to ensure patients receive care within the clinically recommended timeframe.

In conjunction with senior managers, Heads of Department and Directors of surgery or equivalent, treating doctors must:

- a. Manage wait lists in line with their theatre allocations and proactively escalate mismatch in demand and capacity.
- b. Understand the regular operating theatre list and additional list allocation processes.

- c. Agree on the volume and complexity of cases that can be cared for on the allocated lists being guided by the recommended case volumes in [Appendix B](#).
- d. Agree to hospital expectations as to how training requirements, theatre throughput and patient care will be balanced.
- e. In the event patients are unable to receive care within the clinically recommended timeframe, develop a plan in line with [Section 3.10](#) of this Policy Directive before continuing to refer patients. Arrange for another clinician to perform the procedure within the patient's Clinical Urgency Category, including the provision of all consultation notes and investigations to facilitate safe clinical handover.
- f. Mitigate the delays occurring to other patients when prioritising more urgent patients at short notice (such as Clinical Urgency Category 1) and ensure that patients affected by delays for urgent cases also receive their care within the clinical timeframes recommended.
- g. Request planned leave and advise unavailability a minimum of 6 weeks in advance as per [Section 6](#) of this Policy Directive.
- h. With senior managers and heads of department, ensure timely access to care for patients is not impacted by planned leave.
- i. Not cancel planned sessions until the leave has been approved by the designated approver.
- j. Ensure registrars and junior doctors working in their team are aware of and comply with the admitting doctor responsibilities when planning care for patients.
- k. Follow "treat in turn" principles and use local strategies to minimise hospital length of stay, maximise safe same-day surgery and utilise value-based care protocols.
- l. Participate in quality improvement initiatives, including morbidity and mortality reviews.
- m. Review their wait list monthly and maintain up-to-date clinical records.

#### **7.4.5. Hospital clinical directors of surgical services or equivalent**

This position must promote safe, efficient and effective list management by clinicians within their hospital and liaise with the District/Network Director of Surgery or equivalent, for escalation of any issues.

Based on the clinical documentation provided by the admitting doctor the hospital clinical directors of surgical services and/or Clinical Review Panel for surgical activity or equivalent must:

- a. Assess and approve or decline the assignment of clinical urgency categories and/or planned length of stay not in accordance with [Appendix A](#).
- b. Review and approve or decline RFA forms to perform cosmetic and discretionary procedures or exceptions in accordance with this policy in conjunction with the District/Network Clinical Review Panel.

With senior managers, treating doctors, heads of departments and the Director of Surgery they must:

- a. Ensure patients on pooled wait lists or for pooled procedures receive access to care within the clinically recommended timeframe.
- b. Clearly articulate regular operating theatre and procedure room allocation processes with treating doctors.
- c. Reach agreement with treating doctors on the volume and complexity of cases that can be cared for on the allocated lists using the recommendations outlined in [Appendix B](#).
- d. Reach agreement with treating doctors on hospital expectation regarding training requirements, theatre case throughput and the need to balance these with patient care.
- e. Regularly review and update theatre schedules based on community needs (at least once a year).
- f. Develop local operational plans to ensure patients receive timely access to care in line with [Section 3.10](#) of this Policy Directive.
- g. Implement strategies to minimise length of stay and maximise the use of safe same day surgery (admission date = discharge date) and value-based care protocols.
- h. Develop plans to maintain surgical/procedural access that consider seasonal hospital demands.
- i. Assess emergency surgery volumes and establish plans to minimise the cancellation of planned surgery to provide emergency care.

For smaller sites that may not have a hospital clinical Director of Surgery or equivalent, these responsibilities should be undertaken by the District/Network Director of Surgery, the hospital Director of Medical Services or another clearly defined senior medical officer.

#### **7.4.6. District / Network Director of Surgery or equivalent**

The District/Network Director of Surgery or equivalent must:

- a. Ensure that clear administrative and clinical procedures/protocols, are in place to implement this Policy Directive and promote efficient, equitable and effective list management within all levels of hospital management.
- b. Ensure the provision of adequate facilities/staff/work environment to facilitate the surgical management of patients referred to the hospital.
- c. Address issues arising with the management of the patient with the treating doctor and general practitioner, as required. For example, if the general practitioner asks for a patient to be clinically reviewed due to a change in condition.
- d. Work with senior managers, clinical directors of surgery and Chief Executives to fulfil the responsibilities outlined in this Policy Directive.

#### **7.4.7. Chief Executives**

The Chief Executive must:

- a. Regularly review planned surgery/procedural performance across individual hospitals and engage relevant clinicians to ensure consistent application of policy requirements across the organisation.
- b. Ensure that there is training and education programs for staff involved in managing wait lists.

With senior managers and the District/Network Director of Surgery or equivalent, Chief Executives must:

- a. Allocate budget to the priority clinical areas and improvement strategies to ensure access to planned procedures occurs within the clinically required timeframe. This may include the allocation of funds to increase access to appropriate conservative management services such as Osteoarthritis Chronic Care Programs (OACCP) which can reduce the need for planned surgery.
- b. Ensure processes are in place to be informed of any Clinical Urgency Category 1 patient that will not receive care within the clinically recommended timeframe or that if delayed on the day of surgery. Reporting must include the cause of the delay and mitigation strategies in place to prevent future recurrence.
- c. Ensure processes are in place to be informed of patients unable to receive timely access to care but declining care by an alternate admitting doctor. Following consultation with the treating doctor, they have the final decision if a patient is to stay on the waiting list if they have exceeded their number of declines of offers.

#### **7.4.8. Patients**

The partnership with patients in their own care is crucial in the delivery of timely access to planned surgery/procedure. Patients should be informed of their responsibilities and that they may be removed from the list if they do not adhere to the following:

- a. Agree to the procedure and ideally provide written consent after being fully informed of the benefit and potential risks of the procedure.
- b. Be available for pre-procedure assessment appointments, as required.
- c. Be available to receive the care they have consented to from another treating doctor, hospital or District if they are a public patient under Medicare principles.
- d. Provide as much notice as possible if needed to cancel a pre-procedure assessment appointment or planned procedure date.
- e. Provide accurate information to assist the hospital in organising timely access to care.
- f. Update the Admissions/Booking Office when information changes occur (such as contact number, address, GP details and other relevant details).

If a patient declines a planned surgery date on 2 occasions, they may be removed from the planned wait list ([Section 3.9](#)).