Guideline for planning the resumption of elective surgery in NSW public hospitals – as per 15 May 2020 advice from the National Cabinet.

<table>
<thead>
<tr>
<th>Document information</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Version number</td>
<td>1</td>
</tr>
<tr>
<td>Publication date</td>
<td>26 May 2020</td>
</tr>
<tr>
<td>Developed by</td>
<td>Health Service Operations Team – COVID-19 Response, State Health Emergency Operations Centre (SHEOC)</td>
</tr>
<tr>
<td>Endorsed by</td>
<td>COVID-19 Surgery Governance Committee</td>
</tr>
<tr>
<td>For use by</td>
<td>This guideline should be used by NSW Health Districts and Specialty Health Networks to plan for the resumption of elective surgery and procedural activity during the COVID-19 response. This guideline recognises that individual facilities will need to tailor their response to local demand and available resources.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Relevant Policy</th>
<th>To be read in conjunction with</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advice during the COVID-19 Pandemic. Purchasing services from private hospitals under COVID-19 Partnership Agreement.</td>
<td>As this advice is still evolving please contact System Purchasing Branch to request the latest version of the document <a href="mailto:MOH-SPB@health.nsw.gov.au">MOH-SPB@health.nsw.gov.au</a></td>
</tr>
<tr>
<td>LHD and Network Escalation and Management of critical Personal protective Equipment (PPE)</td>
<td>As this advice is still evolving to request the latest version of the document please contact <a href="mailto:MOH-JamesCovid19Support@health.nsw.gov.au">MOH-JamesCovid19Support@health.nsw.gov.au</a></td>
</tr>
</tbody>
</table>
1. BACKGROUND ........................................................................................................................................... 3
2. CURRENT STATE ........................................................................................................................................ 3
3. CONSIDERATIONS ...................................................................................................................................... 4
4. REQUIREMENTS ......................................................................................................................................... 5
5. OBJECTIVE .................................................................................................................................................. 6
   5.1 Guiding Ethical Principles ......................................................................................................................... 6
   5.2 Assumptions .............................................................................................................................................. 7
6. RECOMMENDATIONS ................................................................................................................................. 7
   6.1 Roles and responsibilities of NSW Ministry of Health, Local Health Districts/Specialty Health Networks and Hospitals .................................................................................................................... 8
   6.2 COVID-19 Elective surgery and procedural capability assessment for hospitals .................................. 12
   6.2.1 Capability Assessment .......................................................................................................................... 13
       Table 1 Capability Assessment for increasing elective surgery and procedural activity in hospitals during the COVID-19 Pandemic ........................................................................................................... 13
   6.2.2 Additional Considerations ..................................................................................................................... 14
       Table 2 Additional considerations when planning for elective surgery and procedural activity in hospitals during the COVID-19 Pandemic ..................................................................................... 14
   6.2.3 Next Steps ........................................................................................................................................... 18
7. PROCESS FOR ELECTIVE SURGERY AND PROCEDURAL CASE PRIORITISATION ................................... 18
   7.1 Principles to guide a fair priority-setting process ....................................................................................... 18
   7.2 Criteria for case prioritisation .................................................................................................................. 19
8. ENSURE ONGOING COMMUNICATION AND FOLLOW-UP WITH PATIENTS ......................................... 19

Appendix A. Data .............................................................................................................................................. 20

1. BACKGROUND

On 25 March 2020, as a result of the National Cabinet announcement and acting on the advice of the Australian Health Protection Principal Committee (AHPPC), NSW public hospitals suspended all non-urgent elective surgery. This action was undertaken to create capacity to care effectively for patients with COVID-19, and to preserve resources including personal protective equipment (PPE). Urgent surgery procedures, Clinical Priority Category (CPC) 1 and some exceptional semi-urgent (CPC 2) elective surgery procedures were permitted to continue. The National Cabinet agreed to extend the deadline for the introduction of the changes at private hospitals to 1 April 2020.

On 21 April 2020, National Cabinet provided updated advice that as of 27 April 2020, within the context of the need to maintain PPE stocks, Intensive Care Unit (ICU) capacity and COVID-19 preparedness, additional elective surgery procedures and activity were permitted. The additional activity was restricted to 25% of the capacity that had been closed during the previous restriction period. Permitted procedures continue to include CPC 1 and CPC 2 procedures, with some CPC 3 procedures.

Approved procedures included:
- In vitro fertilisation (IVF)
- Screening programs (for cancer and other diseases)
- Post cancer reconstruction procedures (such as breast reconstruction)
- Procedures for children under 18 years of age
- Joint replacements (including knees, hips, shoulders)
- Cataracts and eye procedures
- Endoscopy and colonoscopy procedures
- Critical dental procedures.

It was acknowledged that the selection of patients to undergo elective surgery was a clinical one. However, the guiding principles recommended procedures that represented low risk, high value care as determined by specialist societies and patients who were at low risk of post-operative deterioration. Individual facilities were advised to tailor their responses to local demand and available resources, whilst bearing in mind that the volume of additional surgical activity was restricted to 25% of the capacity that had been closed, with consideration given to PPE stocks and ICU capacity.

2. CURRENT STATE

On 15 May 2020, National Cabinet advised that all governments had been monitoring public and private hospital activity, and had reviewed the current situation in light of the restoration of elective surgeries and found:
- The spread of the COVID-19 outbreak has slowed, with new cases decreasing nationally since the restoration of elective surgeries;
• There is currently hospital capacity in all jurisdictions across both public and private sectors, and harm to patients can be reduced by taking further steps to restore elective surgery; and
• PPE supplies need to be carefully managed and while there is a need to continue to actively monitor this and manage availability, supply lines are firming.

Given the current situation and Australia’s response to COVID-19, it is now considered safe to reopen elective surgery activity in an incremental and cautious way, while maintaining necessary ICU capacity for any localised outbreaks of COVID-19.

National Cabinet agreed to reopen elective surgery, by removing restrictions and restoring hospital activity involving 3 stages. It is a decision of each jurisdiction to determine which stage applies to its circumstances, the timeline for implementation and the level of normal surgical activity is safely restored in line with the agreed principles. The stages are:

Stage 1 – up to 50 per cent of normal surgical activity levels;
Stage 2 – up to 75 per cent of normal surgical activity levels;
Stage 3 – up to 100 per cent of normal surgical activity levels or as close to normal activity levels as is safely possible.

Private Hospitals should mirror their own state’s approach to surgical activity unless agreed otherwise with the relevant state.

The level of elective surgery will be reviewed monthly from May 2020 by the Australian Health Ministers’ Advisory Council (AHMAC), to ensure that it remains safe and sustainable, and in line with the agreed principles.

In accordance with the National Cabinet decision of 15 May 2020, NSW Health will work with local health districts and specialty health networks to increase the availability of elective surgery in a safe and equitable way on a nationally consistent basis.

3. CONSIDERATIONS

When planning for the resumption of elective surgery and procedures in NSW whilst maintaining COVID-19 preparedness, it is important to consider the impact on patient outcomes of the elective surgery procedures that were postponed. As the pandemic continues to evolve, the objective must be to ensure a measured, and responsive approach to planning decisions for expanding and contracting elective surgery procedures in NSW. Quality and safety are integral parts of healthcare and as such, should be recognised and taken into account during the planning process. Throughout all phases of the pandemic, the priority must be the health and well-being of NSW health care workers and patients.

The reintroduction of activity in a staged manner will balance the ongoing need for acute care capacity to treat COVID-19 patients, while also allowing patients to have their elective surgery and other procedures completed.
This document provides the basis for the staged resumption of surgery. It includes criteria for the reintroduction of elective surgery and procedural work, as well as the basis on which this work should be prioritised. The approach considers ethical principles, the roles of NSW Ministry of Health, Local Health Districts, Specialty Health Networks and individual hospitals. It provides a framework for service resumption.

4. REQUIREMENTS

Detailed below is a set of expectations for Local Health Districts, Specialty Health Networks and individual hospitals. It is expected that each hospital will have acute care capacity reserved or have the ability to immediately create additional capacity when needed, subject to any alternate agreement at the LHD/SHN level for securing sufficient capacity.

The resumption of elective surgery and procedures at any hospital must only take place when:

- Sufficient space is available to provide care, and this space has been evaluated in the context of physical distancing for both inpatient and outpatient activity
- Critical supplies, including PPE and medications, exceed both current usage and projected requirements for planned elective surgery and procedural work given current stock levels and incoming supplies. The target for PPE is for NSW Health to maintain a balance of 30-days’ worth of stock-on-hand, based on the current usage rate and predicted additional requirements. Stock of critical supplies must be confirmed with your LHD/SHN weekly and escalation pathways established and adhered to in order to fulfil ongoing requirements.
- Sufficient human resources are available to provide urgent and emergency surgery/procedures. This includes consideration of overall workforce availability and the requirement for safe working hours.
- The LHD/SHN and the hospital have jointly signed-off on the hospital’s plan to resume elective surgery and procedures.

Local Health Districts and Specialty Healthy Networks are expected to:

- Develop a LHD/SHN approach to managing surge capacity and the resumption of elective surgery and procedures. This may include transferring elective surgery activity out of tertiary hospitals to other hospitals within the District or Network (if applicable).
- Collaborate across hospitals to arrive at coordinated and committed plans
- Monitor surgical and procedural activity across the LHD/SHN, working to balance:
  - Elective surgery and procedural waiting lists
  - Equitable access to care
  - Excess demand on tertiary hospitals with that of other hospitals in the LHD/SHN
  - Resource availability for primary care, home and community care and rehabilitation.
5. OBJECTIVE

This Guideline recognises:

- The need to minimise risk and maximise benefits of the health system for all people in NSW
- The evolving nature of the pandemic and the need for a proportionate response
- The need to have a patient-centred approach that ensures patients and families are supported across the full continuum of care
- The need for equitable access for patients
- The existence of differences between LHD/SHN’s and the need to balance appropriate human resources and scarce resources such as PPE and medications
- The need to make data-informed decisions
- The need to weigh the therapeutic benefit of treatment against the potential risk for COVID-19 transmission to both patients and health care workers associated with the provision of elective surgery and procedural care
- The resumption of elective surgery and procedures will impact multiple departments within each hospital
- That public hospitals must act according to PD2012_011, NSW Health Waiting Time and Elective Surgery Policy.

5.1 Guiding Ethical Principles

The following principles have been adapted from Ontario Health\(^1\) to guide the decision to increase surgical and procedural activities during the COVID-19 pandemic.

- **Proportionality:** Any decisions to increase elective surgical or procedural activity should be proportionate to the real or anticipated capacity to provide those services
- **Non-maleficence:** Decisions should strive to limit harm wherever possible. Activities that have higher implications for morbidity/mortality if delayed too long should be prioritised over those with fewer implications for morbidity/mortality if delayed too long. This requires considering the differential benefits and burdens to patients and patient populations as well as available alternatives to relieve pain and suffering
- **Equity:** Equity requires that all persons in the same clinical priority categories be treated in the same way unless relevant differences exist, and that special attention is paid to actions that might further disadvantage the already disadvantaged or vulnerable. Decision-makers should strive to consider the interests between the needs of COVID-19 patients and patients who need time-sensitive treatment for other diseases and conditions

---

• Reciprocity: Certain patients and populations will have been particularly impacted by service changes that have been made due to the pandemic. Consequently, our health system has a reciprocal obligation to ensure that those impacted by these decisions continue to have their health monitored, receive appropriate care, and can be re-evaluated and receive emergency treatment should they require this.

5.2 Assumptions

The following assumptions have been made:

• The pandemic and its impacts may last many months to years
• Emergency surgery and procedures have been continuing during the pandemic
• Urgent surgery and procedures have been continuing at slightly reduced volumes during the pandemic
• Capacity has been created in hospitals, and this capacity should be considered for use when planning to increase elective surgery and procedural activity
• Changes to surgical and procedural activity will be different between hospitals and LHD/SHN’s based on their local context
• Some hospital staff may be redeployed to other units, and this may impact the planning to increase surgical and procedural activity
• The need for emergency or urgent surgery or procedures for patients with COVID-19 is determined on a case-by-case basis, weighing the risk of further delay of treatment against the risk of proceeding and the risk of virus transmission
• Plans for increasing elective surgery and procedural activity include addressing patients that have already exceeded their clinically recommended waiting time as well as cases that have been delayed since 25 March 2020
• In addition to those patients already waiting, it is anticipated there will be increased cases presenting for surgical care this year due to:
  o Patients not presenting during COVID-19
  o A reduction in rates of private health insurance may result in more people seeking care in the public system.

6. RECOMMENDATIONS

LHD/SHN’s and hospitals must consider that the impact of the COVID-19 pandemic may be experienced differently across LHD/SHN’s and across different health care settings (e.g., hospitals, residential aged care facilities, rehabilitation centres, home and community care, primary care); as such, LHD/SHN’s and hospitals may increase or decrease elective surgery and procedural activity at differing rates.
The following five recommendations for elective surgery and procedural planning ensure that these considerations have been addressed:

1. Use the existing LHD/SHN COVID-19 Steering Committee (or equivalent) to provide oversight in partnership with the hospital Elective Surgery and Procedural Committee (or equivalent) and attain joint sign-off from both the committees before any increase in elective surgery and procedural activity is commenced.

2. Conduct a capability assessment at the hospital level to ensure the following nine factors have been assessed and communicate the results to the LHD/SHN Executive before increasing elective surgery or procedural activity in a hospital:
   - The LHD/SHN has a manageable level of disease burden
   - The hospital has a stable rate of COVID-19 cases
   - The hospital and LHD/SHN have a stable supply of PPE
   - The hospital and LHD/SHN have a stable supply of medications
   - The hospital and LHD/SHN have adequate capacity of inpatient and ICU beds
   - The hospital and LHD/SHN have adequate capacity of human resources
   - The hospital has a plan for addressing the pre-operative assessment of patients
   - The hospital has confirmed that post-acute care outside the hospital is available and can be coordinated in a timely manner (e.g., home care, primary care, rehabilitation, clinic care)
   - The hospital and LHD/SHN has elective surgery and procedural wait list management processes in place to support the ethical prioritisation of cases at a hospital and LHD/SHN level.

3. Review and re-conduct the capability assessment on a weekly basis to identify changes and recognise when a change in direction is required.

4. Follow a fair process for case prioritisation that is grounded by a set of ethical principles as part of the implementation plan.

5. Consider how to leverage opportunities to redesign care, such as making use of virtual care, and extending operating room hours.

6.1 Roles and responsibilities of NSW Ministry of Health, Local Health Districts/Specialty Health Networks and Hospitals

A coordinated effort between NSW Ministry of Health, Local Health Districts/Specialty Health Networks and hospitals is required during planning for the resumption of elective surgery and procedural activity, to ensure the ongoing safety of NSW communities, patients and health care workers. The requirements are described in the table below.
### NSW Ministry of Health Role

- Provide recommendations that enable hospitals and LHD/SHN’s to optimise elective surgery and procedural care in an equitable, measured, gradual, and responsive manner.
- System management role including oversight of elective surgery and procedural waitlists, monitoring of on time performance and overdue patient numbers including requesting surgical and procedural resumption plans from LHD/SHN’s if required.
- Work with the LHD/SHN’s as needed to remove barriers.

### Local Health Districts/Specialty Health Networks

#### Oversight

The LHD/SHN COVID-19 Steering Committee (or equivalent) will:
- Collaborate across hospitals in the LHD/SHN to arrive at a local plan with commitment from leadership at each hospital
- Ensure representation from key clinical and administrative stakeholders on the committee
- Balance the need to be inclusive of many different health system perspectives and keep the committee a manageable size for clear decision-making.

#### Data/Monitoring

Use available data and reports (Appendix A) to monitor:
- COVID-19 pressures at the LHD/SHN level
- Elective surgery and procedural demand and activity (e.g. balancing waiting lists and equitable access to care)
- Resource availability (e.g., capacity in hospitals, primary care, home/community care, rehabilitation; PPE and medical supplies).

Provide reports and information regarding surgical and procedural activity to the MoH as requested.

#### Ongoing Activities

On a weekly basis, collaborate with hospitals that are planning to increase surgical and procedural activity
- Ensure equity across the LHD/SHN through management of imbalances between hospitals
- Foresee and mitigate any unintended adverse consequences that may arise across the LHD/SHN
- Provide clear communication to and negotiate with clinicians as required
- Collaborate with hospitals to mitigate the barriers that arise (e.g., address any barriers identified in the hospital’s weekly capability assessment)
**Local Health Districts/Specialty Health Networks**

- Escalate issues or concerns that cannot be resolved locally to NSW Health for advice or assistance
- Continually assess health care utilisation impacts of COVID-19 community mitigation measures (e.g., tightening and loosening of social distancing) and communicate these impacts to hospitals. Smaller and regional hospitals may be more significantly impacted by this including reduced recovery capacity (including outpatients) and reduced patient transport capacity
- Develop a plan for rapid ramp-down of booked elective surgery and/or procedural activity, should future circumstances warrant (e.g., increasing rate of COVID-19 cases, depleted supply of PPE and medications).

**Hospital Role**

**Oversight**

- Establish a hospital COVID-19 Elective Surgery and Procedural Committee (or equivalent), with representation from key stakeholders
- The function and accountabilities may lie within the existing leadership structure (e.g., senior leadership team, Clinical Council, Medical Advisory Committee, COVID-19 response committees)
- Balance the need to be inclusive of many different health system perspectives whilst keeping the committee a manageable size for clear decision-making
- This committee will oversee development of the elective surgery and procedural plan as a part of the hospital’s overall COVID-19 response
- Consider including a shared clinical and administrative leadership and the following representatives on the committee: a surgeon; a clinical operations lead, an anaesthetist; a radiologist; an executive sponsor; and representation from ethics (if available), administrative leadership (e.g., operating room, procedural spaces), nursing leadership, relevant physician groups, medical laboratory, and persons with lived experience (patients or caregivers).
<table>
<thead>
<tr>
<th>Hospital Role</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accountability</td>
<td>Confirm with the LHD/SHN COVID-19 Steering Committee when it is appropriate to increase elective surgery and procedural activity.</td>
</tr>
</tbody>
</table>
| Data/Monitoring | Begin hospital-level monitoring. Use available data and reports (Appendix A) to monitor:  
  - COVID-19 pressures in your hospital (including hospital testing capacity and turn-around time)  
  - Hospital elective surgery and procedural demand and activity  
  - Resource availability (e.g., hospital bed capacity, PPE and medication supply). |
| Ongoing Activities | Complete a weekly capability assessment (Table 1) and communicate these results to your LHD/SHN  
  - Using the list of additional considerations (Table 2), develop a plan for surgical and procedural activity  
    - Outline a gradual, incremental approach to increasing elective surgery and procedures that is agile enough to quickly ramp down, if needed, and includes contingency capacity for COVID-19 patients  
  - Establish a fair process for case prioritisation and consider using a staged approach in the resumption of services (Section 7).  
  - Develop a plan for rapid ramp-down of booked elective surgery and/or procedural activity, should future circumstances warrant (e.g., increasing rate of COVID-19 cases, depleted supply of PPE and medications)  
  - Collaborate with LHD/SHN executive team and other system partners (e.g., primary care, home and community care, rehabilitation) in the design and implementation of the plan  
  - Continued focus on communication and safety of patients  
  - Continue to focus on ensuring the health and safety of the health care workforce  
  - Continue to manage resources responsibly, including PPE and medication supply  
  - Consider infection prevention and control protocols for the management of COVID-19 in operating room and procedural spaces that factor in recommended PPE  
  - Leverage opportunities to improve care delivery (e.g., expand virtual care options, consider extended operating room hours).  
  - Escalate issues or concerns that cannot be resolved locally to the LHD/SHN for advice or assistance. |
6.2 COVID-19 Elective surgery and procedural capability assessment for hospitals

All hospitals should complete the capability assessment (Table 1) to ensure key criteria have been considered. Once the assessment is complete, hospitals may move on to review the list of additional considerations (Table 2) or follow the recommendations for next steps (Table 3).

The results of these should be shared with the LHD/SHN executive team and inform planning for the resumption of elective surgery and procedural activity. The relevant data should be monitored daily and the capability assessment completed on a weekly basis to confirm criteria are met or if discussion with the LHD/SHN is required. This is an iterative process of decision-making based on the changing environment. The flow chart in Figure 2 illustrates these steps.

**Figure 2 Resumption of Elective Surgery – Flow Chart**
### 6.2.1 Capability Assessment

Complete the capability assessment to ensure that the critical criteria are considered before moving forward with planning to increase elective surgery and procedural activity. Where barriers exist, they must be discussed and the risks mitigated before moving forward.

**Table 1 Capability Assessment for increasing elective surgery and procedural activity in hospitals during the COVID-19 Pandemic**

<table>
<thead>
<tr>
<th>Criteria Met</th>
<th>Discussion Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Has your LHD/SHN had a manageable level of disease burden or a sustained decline in the rate of COVID-19 cases over the past 14 days?</td>
<td></td>
</tr>
<tr>
<td>2. Has your hospital had a stable rate of COVID-19 cases? (e.g., there are no new COVID-19 outbreaks at your organisation)</td>
<td></td>
</tr>
<tr>
<td>3. Does your hospital and LHD/SHN have a stable supply of PPE to allocate to additional elective surgery and procedures as well as to respond to any increases in pandemic activity?</td>
<td></td>
</tr>
<tr>
<td>4. Does your hospital and LHD/SHN have a stable supply of medication to allocate to additional elective surgery and procedures as well as to respond to any increases in pandemic activity?</td>
<td></td>
</tr>
<tr>
<td>5. Does your hospital and LHD/SHN have adequate capacity of inpatient and ICU beds for additional elective surgery and procedures as well as to respond to any increases in pandemic activity?</td>
<td></td>
</tr>
<tr>
<td>6. Does your hospital and LHD/SHN have adequate capacity of human resources to allocate to additional elective surgery and procedures as well as to respond to any increases in pandemic activity?</td>
<td></td>
</tr>
<tr>
<td>7. Does your hospital have a plan for addressing pre-operative assessment of elective surgery and procedural patients?</td>
<td></td>
</tr>
<tr>
<td>8. Has your hospital confirmed the availability of post-acute care outside the hospital that would be required to support patients after discharge? (e.g., coordination of care in primary care, home and community care, and rehabilitation)</td>
<td></td>
</tr>
<tr>
<td>9. Are there elective surgery and procedural wait list management processes in place to support the ethical prioritisation of cases at a hospital and LHD/SHN level?</td>
<td></td>
</tr>
</tbody>
</table>
If you marked “Criteria Met” for all the items in the capability assessment:

• You are ready to move forward with planning for an increase in elective surgery and procedural activity

• Proceed to Table 2 to review the list of additional considerations

• Continue to complete this assessment on a weekly basis

If you marked “Discussion Required” for any item in the capability assessment:

• Where barriers exist, they are discussed, and risks are mitigated before moving forward with planning

• Discuss the possibility of starting with low-resource intensity surgeries and/or procedures (e.g., short stay inpatient, outpatient, day surgery)

• Proceed to Table 3 to review the next steps in collaboration with your LHD/SHN

6.2.2 Additional Considerations

If you have marked “Criteria Met” for all the items in the capability assessment, review this list of additional considerations to inform the planning for increasing elective surgery and procedural activity. Where barriers exist, they must be discussed, and the risks mitigated before moving forward with implementation.

This list should be reassessed on a weekly basis for ongoing monitoring for continued activity and to inform the need to ramp-down.

Table 2 Additional considerations when planning for elective surgery and procedural activity in hospitals during the COVID-19 Pandemic

<table>
<thead>
<tr>
<th>Local Health District/Specialty Health Network status</th>
<th>Item is not a barrier</th>
<th>Item for discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Are there active COVID-19 outbreaks at any residential aged care facilities or other similar settings in your LHD/SHN?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Have you redeployed staff to other facilities or other wards/units that may impact your ability to increase elective surgery and procedural activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Are the outpatient and inpatient rehabilitation programs in the LHD/SHN able to accept patients after surgery?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Have you assessed the availability of home and community care in your LHD/SHN? (e.g., have the required capacity, staff, and PPE)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Have you assessed the availability of primary care follow-up in your LHD/SHN? (e.g., have the required capacity, staff, and PPE, or can provide virtual care, where appropriate)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COVID-19 cases</td>
<td>Item is not a barrier</td>
<td>Item for discussion</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>6. Capability and access to local COVID-19 diagnostic testing (e.g., community testing, testing for health care workers, consideration of false negative test rates, supply of swabs and reagents, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Have you defined a specific criteria and/or threshold COVID-19 incidence rate to trigger ramping down?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Capacity</th>
<th>Item is not a barrier</th>
<th>Item for discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>8. Does your site have acute care capacity reserved for COVID-19 care or the ability to immediately create additional capacity if needed?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Do you have a surge plan to support rapid increases in capacity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Does the physical space at your site allow physical distancing for both inpatient and outpatient activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Does your ICU have capacity for both COVID-19 patients and the potential increased requirements for post-operative patients?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Is there availability in operating room and/or procedure suite spaces to support the proposed increase in elective surgery and procedural activity? (e.g., spaces may be repurposed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. Is there availability in pre-operative and follow-up clinic spaces available to support the proposed incremental surgical and procedural services? (e.g., spaces may be repurposed)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. Does your site have capacity to care for patients if repatriation is not possible?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. Is there availability of the diagnostic and supporting services required for surgical and procedural services? (e.g., diagnostic imaging, pathology, blood bank, sterile processing, clinical laboratory etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16. Do you have appropriate facility cleaning policies in place for all areas? (e.g., clinic, pre-operative spaces, operating room, workrooms, recovery room, ICUs, ventilators, scopes, etc.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Human Resources</td>
<td>Item is not a barrier</td>
<td>Item for discussion</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>17. Do you have an adequate number of clinicians available to accommodate a potential COVID-19 surge?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>18. Do you have an adequate number of clinicians available to support the proposed increase in activity within the constraints of safe working hours? (e.g., staff redeployed to other areas of your organisation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Pre-operatively (e.g. Preadmission Clinic, Imaging)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Intra-operatively (Operating Theatre Team)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Post-operatively (Recovery room and Inpatient ward)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>19. Do you have appropriate policies in place to support the health and well-being of health care workers during the COVID-19 pandemic? (e.g., stress and fatigue, childcare needs, contingency for newly diagnosed workers)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Supply chain</th>
<th>Item is not a barrier</th>
<th>Item for discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>20. Do you have a stable supply of PPE* appropriate for the proposed increase in elective surgery and procedural care and for other areas of the organisation? (Rolling 30-day target of stock on-hand) (*There must be no dependence on emergency escalation to source PPE supplies while providing planned elective surgery or procedures).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Does your organisation adhere to the recommended practices for PPE for COVID-19?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Do you have adequate supply of medications required to support the proposed increase in elective surgery and/or procedural activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Do you have adequate supply of ventilators required to support the proposed increase in elective surgery and/or procedural activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>24. Do you have adequate supply of surgical and procedural supplies? (e.g., stents, implants)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
25. Do you have a plan developed for rapid ramp-down of elective surgery and/or procedural activity, should future circumstances warrant? (e.g., increasing rate of COVID-19 rates, depleted supply of PPE and medications)

26. Do you have a plan developed to review all the foregoing considerations on a regular basis to reconfirm that increased elective surgery and/or procedural activity can safely continue?

After you have reviewed the detailed list of considerations, communicate and collaborate with your LHD/SHN executive team to:

- Validate the impact of COVID-19 in your LHD/SHN
- Review and seek support to mitigate the items that are flagged for discussion in your detailed list of considerations
- Confirm that the supply of required PPE and medication is available to support your plan for increased elective surgery and procedural activity
- Obtain confirmation from LHD/SHN executive team on your plan to increase elective surgery and procedural activity
- Review and discuss opportunities to support LHD/SHN planning and equitable access to care (e.g., could your site support patients from another hospital in your LHD/SHN?)

- If there are no barriers to increasing elective surgery or procedural activity, continue with your planning; Section 5 provides ethical principles to guide fair priority setting processes
- If appropriate, review the possibility of elective surgery and procedures that require lower resources (e.g., day surgery/procedures)
- Monitor this list of considerations daily in order to assess the impact of COVID-19 in your community and in your hospital and ensure your plans are adjusted accordingly (i.e., ramped-down if needed)
- As you move forward with an increase in elective surgery and procedural activity, keep your LHD/SHN executive team updated on your assessments and ongoing progress.
6.2.3 Next Steps

If you marked “Discussion Required” for any item of the capability assessment, do not immediately proceed with planning for increasing elective surgery and procedural activity. Where barriers exist, they must be discussed, and risks mitigated before planning can move forward. Communicate and collaborate with your LHD/SHN executive team to complete the following:

Table 3. Next Steps for hospitals that are not ready to resume elective surgery or procedural activity during the COVID-19 Pandemic

| Review the items that are marked “Item for Discussion” and seek LHD/SHN support to mitigate any immediate needs/barriers. |
| Discuss the possibility of starting with low resource intensity elective surgeries and/or procedures types (e.g., short stay inpatient, outpatient, day surgery). Obtain confirmation from LHD/SHN executive team on your plan. |
| If appropriate, seek LHD/SHN support to redistribute your cases to other hospitals in the LHD/SHN. |

7. PROCESS FOR ELECTIVE SURGERY AND PROCEDURAL CASE PRIORITISATION

The prioritisation of elective surgery and procedural cases during the pandemic requires consideration of multiple factors and adherence to a set of ethical principles to guide a fair process.

7.1 Principles to guide a fair priority-setting process

The principles to guide a fair priority-setting process for case prioritisation are as follows:

- **Relevance:** Decisions should be based on reasons (i.e., evidence, principles, values) that fair-minded people can agree are relevant under the circumstances
  - Clearly indicate the aim and scope of your prioritisation approach
  - Identify clear and explicit decision criteria
  - Ensure you collect data related to your decision criteria
  - Develop a rationale for decisions based on your criteria and data
  - Work with varied stakeholders throughout this process (collect multiple perspectives and experiences)

- **Transparency:** Decisions and their rationales should be made publicly accessible
  - Develop a communication plan that includes affected stakeholders and a rationale for your prioritisation approach

- **Revision:** There should be opportunities to revisit and revise decisions and a mechanism to resolve disputes
  - Ensure you have a process in place to review and evaluate your prioritisation approach at regular intervals

- **Engagement:** Efforts should be made to minimise power differences and to ensure effective stakeholder participation
  - Include affected stakeholders in consultation and decision-making
  - Support the prioritisation approach with staff training and a change management strategy.
Using these guiding principles, along with the information collected in the capability assessment and the list of additional considerations for increasing elective surgery and procedural activity (included above in Table 1 and Table 2), hospitals and LHD/SHN’s need to develop a fair process to guide case prioritisation. This process considers patient, disease, and procedure factors, as well as the availability of resources during the COVID-19 pandemic.

Collaboration across hospital and LHD/SHN’s to prioritise cases can support the effort to maximise the most benefit for the greatest number of people when resources are limited. Monitor to ensure that the application of this list of criteria does not disproportionately disadvantage some patient populations relative to others based on disease or disability (see guiding ethical principles in Section 5.1).

### 7.2 Criteria for case prioritisation

Plans should include a process for prioritising elective surgery and procedural care that considers the following criteria:

- Patient factors (e.g., condition, co-morbidities)
- Disease factors (e.g., non-operative treatment options, risk of surgery delay)
- Procedure factors (e.g., inpatient vs. outpatient or day procedures, operating room time, length of stay, anticipated blood loss, intubation probability)
- Use of resources (e.g., PPE, medications, ICU and other postoperative care needs)
- COVID-19 exposure/virus transmission risk.

To use hospital capacity without impacting readiness to respond to a surge in COVID-19 cases, a staged approach allows hospitals to begin the resumption of services gradually, with services that are best suited to their particular context.

A hospital that has one or two resource constraints but otherwise passes the capability assessment may choose to begin by offering services that require a minimal amount of a constrained resource. For example, as well as continuing to prioritise urgent and overdue patients, a hospital may choose to begin with day surgeries, followed by inpatient surgeries as resources become available. By taking this approach, hospitals can ensure there are appropriate measures in place.

### 8. ENSURE ONGOING COMMUNICATION AND FOLLOW-UP WITH PATIENTS

Even in the context of a pandemic, discussions with patients about their wishes and values still have a foundational role in any elective surgery and procedural activity. Continuous follow-up with patients and their families is essential. Every effort should be made to provide clear and transparent communication with patients and their families to ensure patients are supported.
Patients must be provided with relevant information regarding their health condition, not only while waiting for their elective surgery or procedure (when there are increased risks associated with delays in treatment) but also after the surgery, when additional barriers to post-acute support may be present.

Pre-treatment discussions should cover topics such as the patient’s wishes and alternative treatment options (where appropriate), and transparent discussions about any risks in the face of resource scarcity (e.g., timely access or lack of access due to ramp-down of scheduled surgery during the COVID-19 pandemic, any nosocomial risk of contracting COVID-19 in an acute care setting). Discussions should also incorporate vigilant monitoring of the patient’s condition. Post-treatment discussions should address next steps, expectations, and what to do if a problem arises.

It will be up to each hospital to determine how they will communicate to patients during this pandemic. Access to information and transparency in how decisions are being made are paramount. Some patients may require more information than others, and all questions must be answered honestly. A combination of virtual discussions by phone or other means, complemented with written information stating key messages, is recommended.

As per the requirements of the NSW Health Waiting Time and Elective Surgery Policy, Section 6. Record Keeping, any changes made to a patients booking must be validated with documented evidence and reasons, and be signed by the relevant staff member. The documentation must be attached or be part of the Recommendation for Admission (RFA). The electronic waiting list must also be updated to reflect any changes.

**Appendix A. Data**

LHD/SHN and hospital level monitoring of key factors is needed to support a data-driven, responsive approach to planning elective surgery surgical and procedural activity during the COVID-19 pandemic.

<table>
<thead>
<tr>
<th>Metrics to gauge COVID-19 pressures</th>
<th>Metrics to gauge surgery demand and activity</th>
<th>Metrics to gauge resource availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>• COVID-19 hospitalisations</td>
<td>• Current wait list volumes</td>
<td>• Ward bed &amp; ICU occupancy</td>
</tr>
<tr>
<td>• Number of residential aged care /long-term care home outbreaks</td>
<td>• Surgical volume historical trend comparisons</td>
<td>• Emergency Department Treatment performance (ETP)</td>
</tr>
<tr>
<td>• In-hospital outbreaks</td>
<td>• Current waitlist overdue patients</td>
<td>• Drug supply</td>
</tr>
<tr>
<td>• Hospital testing capacity and turn-around time</td>
<td>• Current wait times</td>
<td>• LHD/SHN PPE supply</td>
</tr>
</tbody>
</table>