NSW Health

A resource guide for effective management of planned surgical lists in NSW public hospitals

November 2025

NSW GOVERNMENT

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Contents

What is this resource guide for?

Each year more than 235,000 patients in NSW public hospitals have planned surgery procedures. NSW Health PD2025_036 *Planned Surgery Access* policy (the Policy) was developed to ensure clinically appropriate, consistent, and equitable management of planned surgery in public hospitals across NSW.

This resource guide provides practical advice on various aspects of the planned surgery policy, examples of processes for decision making, escalation and communications around planned surgery list management.

It is designed to assist surgery managers to implement the Policy. It does not serve as a replacement for the Policy. If there is any perceived discrepancy between the information contained in this resource guide and the *Planned Surgery Access* policy, the Policy will always take priority.

Abbreviations

ACI	Agency for Clinical Innovation
CUC	Clinical Urgency Category
DO	Day Only
DOS	Director of Surgery
DOSA	Day of Surgery Admission
GP	General Practitioner
IPC	Indicated Procedure Code
LHD	Local Health District
NRFC	Not Ready for Care
OT	Operating Theatres
PAD	Planned Admission Date
PAS	Patient Administration System
RFA	Recommendation for Admission
RFC	Ready For Care
SHN	Specialty Health Network
VMO	Visiting Medical Officer

1. Adding the patient to the planned surgery wait list

Acceptance of a Recommendation for Admission form

When an RFA form is received from a doctor, staff must stamp it with the date it has been received by the booking office staff. This may or may not be the same date as the RFA was signed by the treating doctor. For example, if the RFA is dropped off by a patient or doctor on a Saturday or after hours, the date stamp would be the next business day.

RFA forms received that are for procedures not carried out by the hospital must be sent back to the treating doctor for action and not accepted by the booking office.

If the surgery or procedure is scheduled more than 12 months away, the form must be returned to the doctor, and the doctor advised the reason for the return of the RFA. The RFA is not to be accepted by the booking office.

This date must be visible on the paper form or recorded in the electronic version if an approved eRFA system is in place.

The date stamp either electronic or physical is the representation that the hospital has accepted the patient on the planned surgery wait list and forms the listing date for the patient.

Before accepting the RFA form, staff must check that:

- It is legible.
- It includes all the required information/minimum data set (*Section 2.2* of the Policy)
    - **If any information is missing or hard to read**, staff must contact the doctor (by phone or in writing) as soon as possible to get the correct details
    - **If the form needs to be returned to the doctor**, the original stays in the booking office, and a copy is sent back for completion.

Treating doctors must submit the RFA to the hospital within 5 working days of the patient agreeing to the proposed procedure/treatment.

If the RFA form is not submitted within a certain time after the doctor signs it, the patient's condition may need to be reviewed before the form is accepted. The timeframes are:

Category 1 (Urgent)	Within 14 days
Category 2 (Semi-urgent)	Within 30 days
Category 3 (Non-urgent)	Within 3 months

The date on the stamp is used as the official listing date. Staff must add the patient to the wait list within 3 working days of receiving the form with the listing date reflecting the date the RFA was received with the minimum data set (*Section 2.2* of the Policy).

When a patient is added to the wait list, they must be ready to be admitted or start the process that leads to admission—unless they are marked as "Staged" (*Section 3.4.1* of the Policy).

Allocation of Clinical Urgency Category

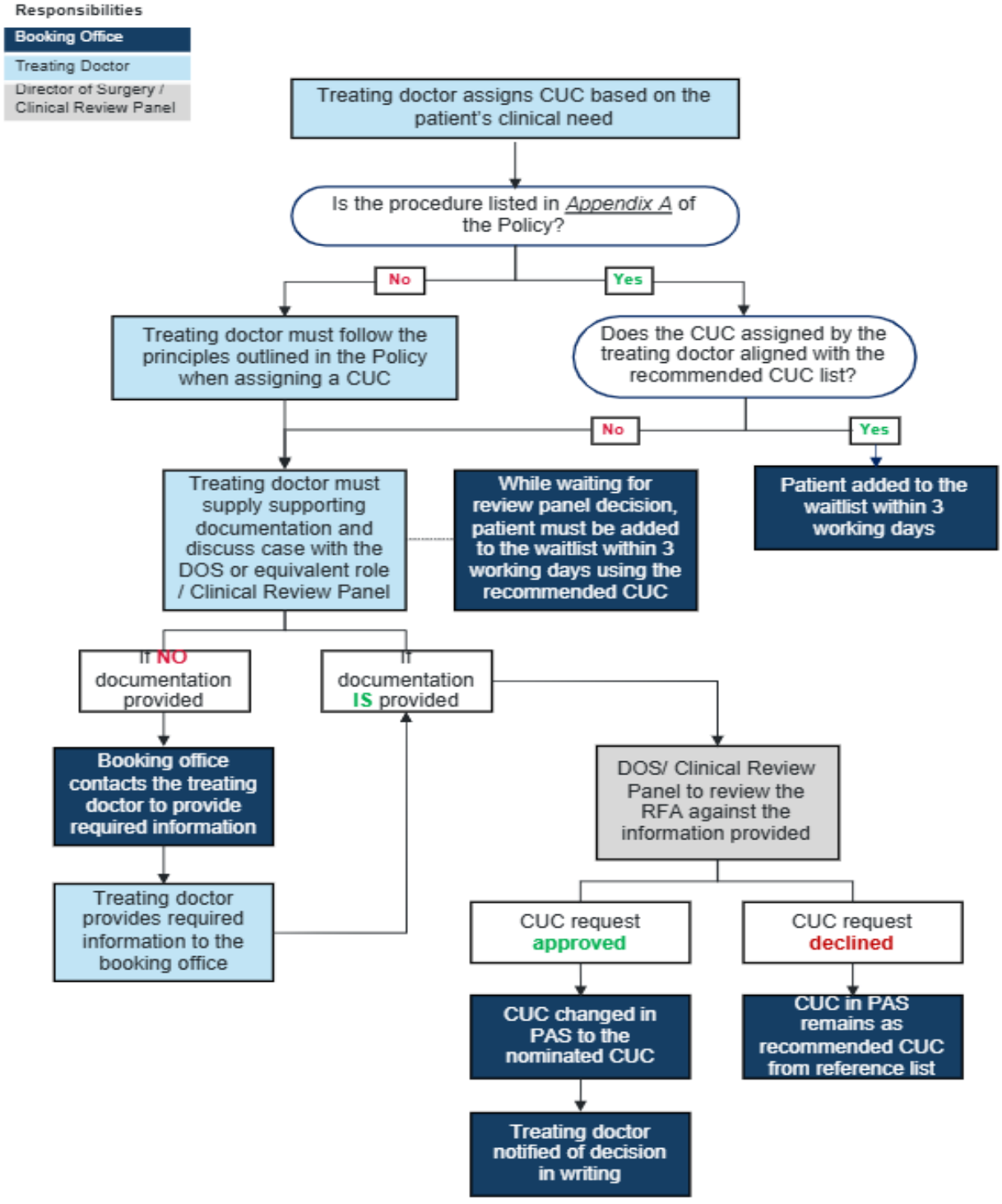
To ensure patients get the care they need at the right time, the treating doctor must assign a Clinical

Urgency Category for their surgery/procedure. This helps ensure treatment is fair, timely, and based on the patient's clinical need.

Only the treating doctor can assign the CUC. It must be based purely on the patient's medical condition regardless of private health insurance status or the availability of hospital resources.

The doctor must provide written evidence to support the nominated urgency category and discuss it with the Director of Surgery or equivalent role or the Clinical Review Panel. The outcome of this review should be attached to the RFA.

Flow chart – CUC Allocation



How do I manage a request for a non-recommended CUC?

Sometimes, a patient might need a different urgency category than the one usually recommended. This can happen for valid medical reasons—like when surgery is needed to diagnose or treat a confirmed or suspected malignancy.

If the treating doctor believes a different urgency category is needed, they must have an appropriate clinical reason for it.

There must be a review and escalation process at each hospital for Director of Surgery or equivalent and/or the Clinical Review Panel (*Appendix C* of the Policy) to review all variations from the recommended CUC to ensure appropriate prioritisation of patients.

The NSW Health Planned Surgery Program Resources webpage has example letters that can be used for communicating with the treating doctor when managing non-recommended CUCs.

How do I manage a request for a procedure not in the NSW Recommended Clinical Urgency Categories List?

Where the procedure is not in the NSW Recommended Clinical Urgency Categories list (*Appendix A* of the Policy) treating doctors must follow the principles in *Section 2.4* of the Policy which requires that an escalation to the Director of Surgery/equivalent delegate and/or the Clinical Review Panel occurs.

Steps:

1. RFA is received by booking office, checked for minimum data set and CUC checked against reference list (*Appendix A* of the Policy).
2. Where there is a query about the appropriateness of the CUC a discussion should occur between the treating doctor and Director of Surgery/equivalent role or Clinical Review Panel to resolve the issue and ensure that the patient is added to the wait list within 3 working days from receipt of the RFA.
3. If clinical information is provided to support the non-recommended CUC – the booking office must send the RFA to the Director of Surgery/Clinical Review Panel for review and a decision is made to accept or not.
4. If no clinical information has been provided to support the non-recommended CUC, request the treating surgeon to supply documentation. This may be via telephone or in the form of a letter. If there is no clinical evidence provided on the RFA then the reference list CUC should be used until clarification is sought from the treating doctor.
5. Once evidence is received, forward to the Director of Surgery/Clinical Review Panel for a decision. To accept or decline the non-recommended CUC.
6. If accepted this should be documented on the RFA and on the PAS system. A letter may be sent back to the treating doctor confirming this.
7. If the non-recommended CUC is declined, the Referring Doctor must be informed in writing and the RFA added to the wait list using the recommended CUC.
8. If following a request to the treating doctor no supporting clinical information is received, a letter can be sent advising that the recommended CUC will be used.
9. If a patient's CUC is changed after they have been added to the wait list, they must be notified in writing of the revised CUC together with the expected waiting time.

How do I manage a request for a wait time outside the three national clinical urgency categories?

In circumstances where a RFA is received which indicates a timeframe for surgery that is not aligned with the three standard national clinical urgency categories (Category 1: within 30 days, Category 2: within 90 days, Category 3: within 365 days), treating doctors must supply supporting documentation and discuss the case with the local health district or specialty health network Director of Surgery or equivalent (*Section 2.4.2* of the Policy).

The patient should be added to the waitlist at the recommended CUC whilst the approval process is occurring (presuming minimum data set is present on the RFA).

If following the review, the alternative wait time is approved then the patient should have their CUC updated (if applicable) to the planned surgery wait list at the closest category consistent with the recommended timeframe. A note needs to be added to the booking that the patient should receive a planned admission date within the agreed number of days of listing.

For example, if a period of 180 days is approved, the patient should be given a category 3 (Surgery within 365 days) with a note added that surgery has been approved to occur within 180 days.

How do I manage non-recommended discharge intention?

The NSW Default Discharge Intention reference list (*Appendix A* of the Policy) provides guidance on the recommended discharge intention of Day Only, DOSA or both for common procedures.

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

Example from the *Recommended Clinical Urgency Category and default Discharge Intention reference list*

The process for managing a non-recommended discharge intention is the same as the steps outlined in the process for management of non-recommended CUC. There must be a review and escalation process at each hospital for Director of Surgery or equivalent delegate, and/or the Clinical Review Panel to review all variations in the discharge intention.

Where the procedure is not in the NSW Default Discharge Intention reference list, the treating doctor must specify the discharge intention on the RFA as part of the minimum data set required for RFA submission.

A local operational decision or a standing rule might apply after an evidenced based consultation process with the specialty department, Director of Surgery, equivalent delegate and/or Clinical Review Panel for certain patient cohorts.

How do I manage introduction of new health technologies?

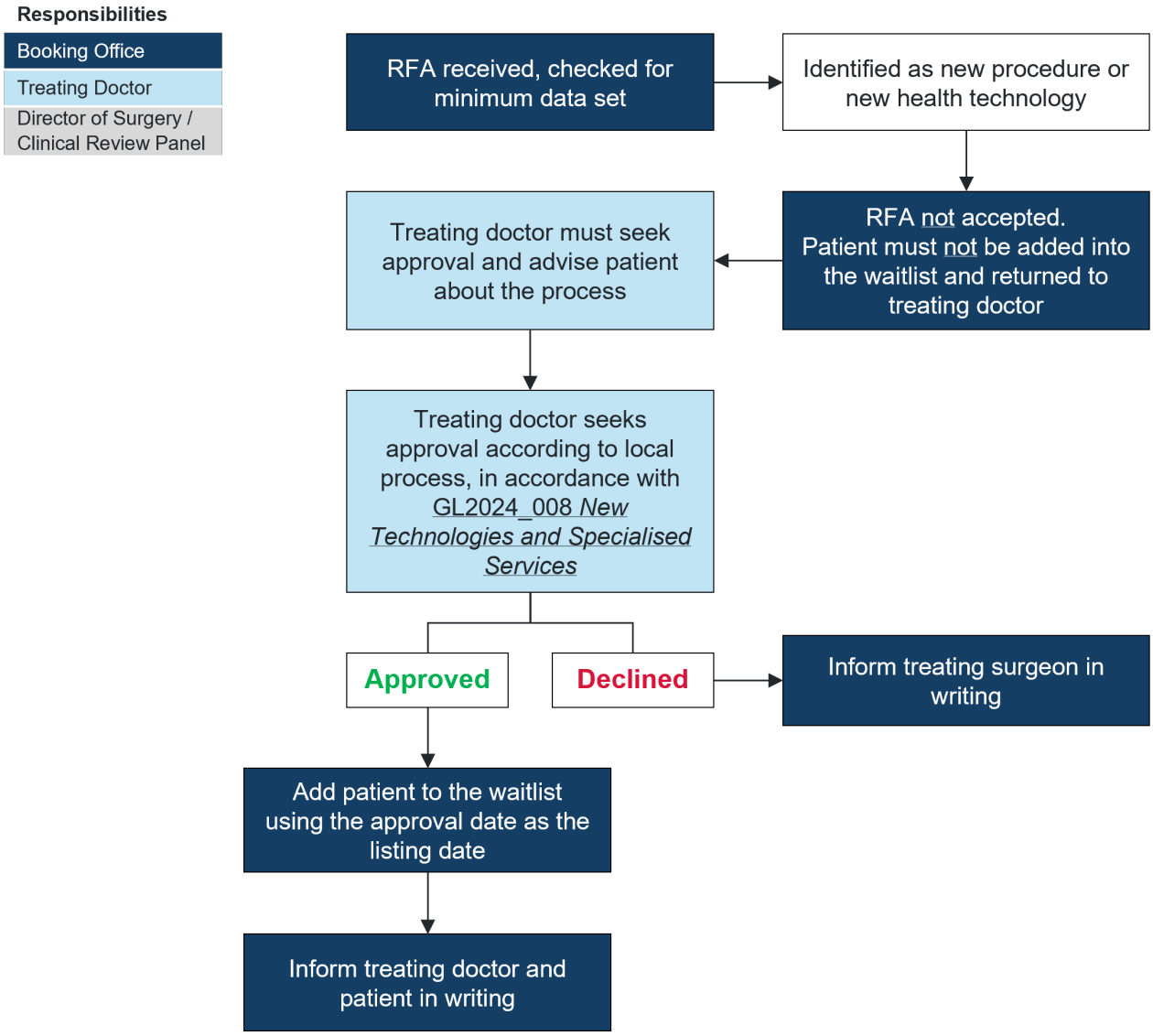
Decisions made regarding the introduction of new procedures, interventions and new health technologies in NSW should be made taking into consideration available evidence, cost implications and the requirement of the health system to provide contemporary high-quality clinical services.

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 GL2024_008 New Health Technologies and Specialised Services. 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.

An RFA for a new procedure/intervention/ technology should not be accepted by the hospital until approval for the procedure has been given. A copy of the decision should be forwarded to the hospital's admissions manager (*Section 2.6.4* of the Policy).

Do not accept the RFA until the procedure +/- treating doctor has been approved by the relevant hospital authorities.

Example of the process to take for new procedures and new health technology



What is value-based surgery?

Getting the most value from surgery involves patients having the right procedures, for the right reasons, at the right time. The Agency for Clinical Innovation *Value-based surgery: Clinical Practice Guide* identifies procedures that, in certain patient cohorts or clinical presentations, offer little to no benefit to

the patient. The procedures were identified using current peer reviewed evidence and guidance and position statements from relevant craft groups.

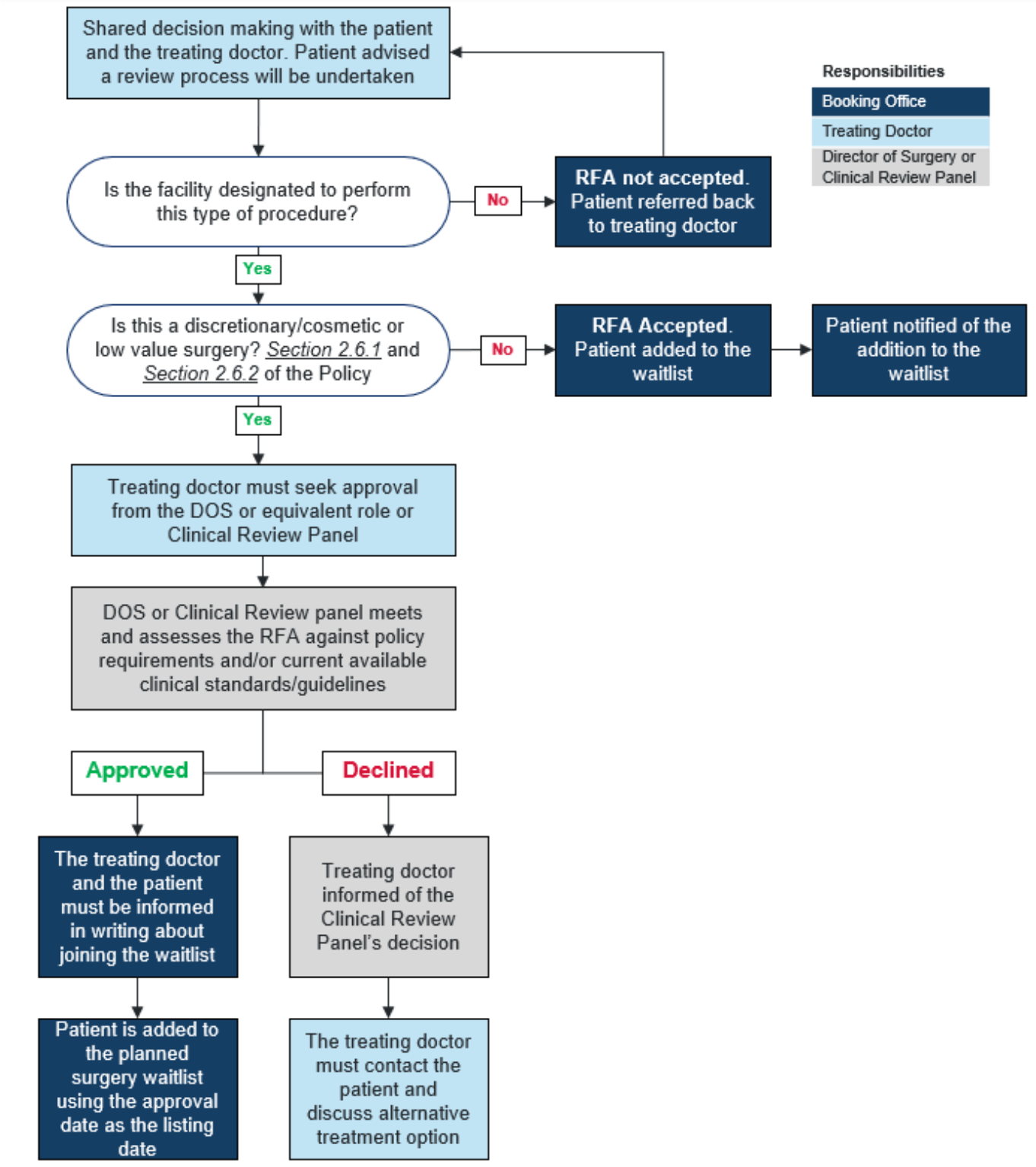
How do I manage cosmetic/discretionary surgery and value-based surgery?

Cosmetic and discretionary procedures (*Section 2.6.1* of the Policy) must not routinely be performed in NSW. Where a procedure on the list has 'nil' exceptions, this procedure must not be performed unless approved by the Director of Surgery or equivalent delegate, and/or Clinical Review Panel.

The remaining procedures on the list outline the conditions in which the procedure may be performed where there is a clear clinical need to improve the patient's physical health. Each hospital must have a local approval process in place to manage patients when their surgery that appears in this list of cosmetic and discretionary procedures.

Do not add an RFA to the wait list if unsure – ask your manager first! If in doubt, follow the appropriate process.

Flow chart – Clinical Review Panel Process



Patients referred for any of the value-based surgery procedures (*Section 2.6.1* of the Policy) that also meet the specific clinical exclusion criteria of the ACI *Value-based surgery: Clinical Practice Guide* must also be approved by the Director of Surgery and/or Clinical Review Panel (or equivalent) before the patient is added to the wait list.

Additional procedures to the cosmetic/discretionary and value-based surgery list

As new clinical evidence and guidance get updated, additional surgeries may be added to the cosmetic/discretionary and value-based surgery list. The Planned Surgery Access Policy cosmetic/discretionary list now includes:

- **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
- **Weight loss or metabolic surgery** to be added to the list if the 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.

RFA submitted for these procedures must be reviewed and approved in accordance with the Clinical Review Panel process.

What is an Indicator Procedure Code?

Indicator Procedure Code 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.

IPCs were created to give a specific indication of performance areas of planned care provision, as a relatively small number of procedures account for the bulk of the planned surgery workload. It was introduced nationally to monitor the volume, median wait and on time performance of frequently performed planned surgeries. NSW uses IPCs for the same purpose. This data can assist in planning and resource allocation, auditing and performance monitoring. Not all procedures have their own IPC however the list is updated each year. The current list is available on the intranet at *Waiting Times Data Collection.*

Which IPC should I use?

The primary procedure from the consent form should always be selected when choosing the IPC. If you are in doubt of what the primary procedure is, the treating doctor who referred the patient should be contacted for clarification.

Where there is a combination of surgical and medical/other categories of IPC's, the surgical IPC must be recorded as the primary intended service activity.

What can I do if the surgical IPC is the primary procedure but has a lower CUC than the medical IPC?

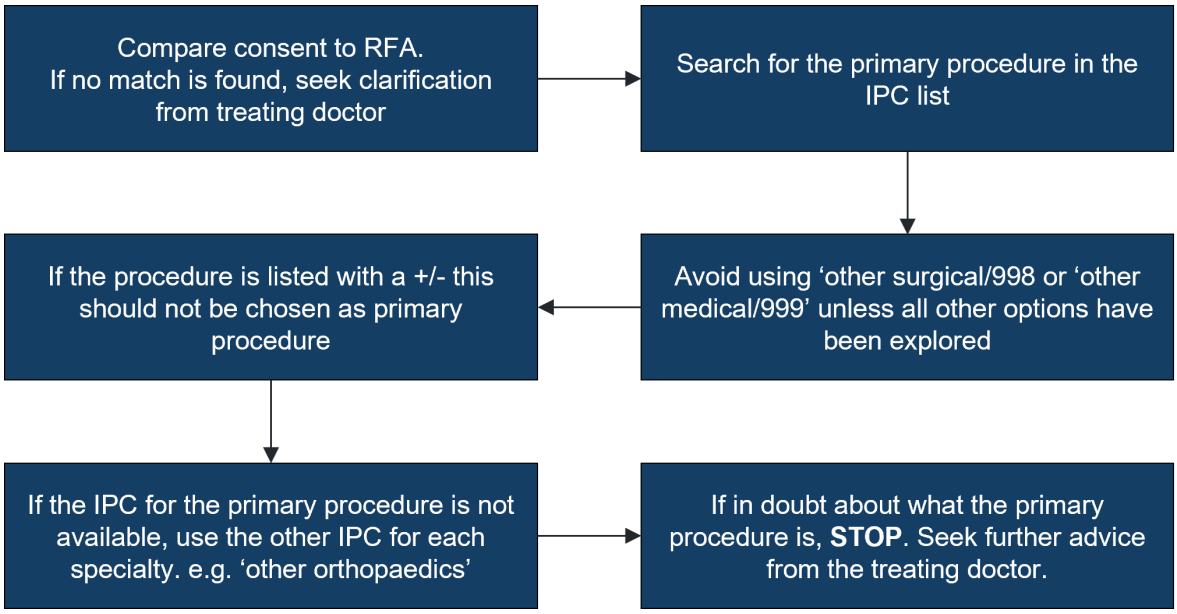
In cases where a combination of surgical and medical IPC has a different CUC, the recommended CUC for the surgical IPC must be applied. If the CUC for the medical IPC is higher than the surgical IPC, clinical evidence must be provided by the treating doctor for the procedure to be waitlisted using the more urgent category.

Scenario: The intended procedure on the RFA is Colonoscopy + Haemorrhoid Banding

The IPC to use must be haemorrhoid banding as it is surgical. The recommended CUC for haemorrhoid banding is Category 3. However, some colonoscopies may be indicated as a Category 1 for certain indications such as Faecal Occult Blood Test (FOBT) positive patients.

Outcome: If the treating doctor provides clinical evidence to perform procedure as a category 1 and has been approved by the Director of Surgery, or equivalent delegate or the clinical review panel, then patient must be waitlisted as a Category 1. This evidence may be that it will save 2 admissions for the patient if these procedures are performed in the same operation.

Summary of process – IPC Selection



A searchable list of IPCs and CUCs is available on the NSW Health Planned Surgery Program Resources webpage.

2. Managing patients on the wait list

How do I reclassify a patient's Clinical Urgency Category?

A reclassification of the CUC may be necessary due to a change in a patient's clinical condition.

Any issues with hospital resourcing such as staffing, theatre time or bed availability must never be a basis for re-classification of CUC.

Who can reclassify the CUC?
☐ Treating doctor
☐ Delegate from the treating doctor's team (following documented discussion with the treating doctor)
☐ Director of Surgery or equivalent delegate (following documented discussion with the treating doctor)
☐ Clinical Review Panel

Doctor checklist for CUC change
☐ There has been a change to a patient's clinical condition that warrants a CUC change
☐ Ensure documented evidence is available to clinically validate any changes to a patient's CUC

Booking staff documentation
☐ Name and signature of the relevant staff member documenting the change
☐ Date and time of notification of the category change
☐ Person notifying the category change
☐ Reason for the CUC change

When can I make a patient Not Ready for Care/Suspended?

Patients can only be made NRFC when they are not available for surgery for either personal or medical reasons. The use of NRFC should not be used if the hospital or treating surgeon is not able to provide care in a timely manner.

- NRFC **deferred** (*Section 3.4.1* of the Policy) is to be used if a patient is unavailable due to personal reason such as work or holidays. On completion of the NRFC period the patient should be moved back to RFC regardless of whether a planned admission date is allocated.
- NRFC **staged** (*Section 3.4.2* of the Policy) is reserved for when a patient is medically unfit for surgery due to another intervention being required first. It is not to be used if a surgeon or operating theatre is

unavailable to provide care for a patient. On completion of the NRFC period the patient should be moved back to RFC regardless of whether a planned admission date is allocated.

What is the maximum suspension period for any patient on the wait list?

The maximum suspension period for any patient is half of their urgency wait time. This can either be staged, deferred or combined.

The table below provides the maximum cumulative suspension days for each category:

Clinical Urgency Category	Maximum cumulative days *Combined Staged and Deferred*
Category 1 - Urgent	15 days
Category 2 – Semi-urgent	45 days
Category 3 – Non-urgent	180 days

What MUST happen if a patient exceeds the maximum days of suspension?

- A physical clinical review by the treating doctor regarding appropriateness of procedure and any change to clinical condition. As a clinical review should be done at no cost to the patient. If a patient refuses to attend the clinical review; the status of the patient on the waitlist should be discussed with the treating doctor to ascertain that surgery is still the best way forward for the patient.
- 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.
- Approval or outcome of review documented on the RFA form.
- 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* of the Policy).
- 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* of the Policy) following notification of the treating surgeon by the Admissions/Booking Office.

Patients in Not Ready for Care status must be returned to Ready for Care as soon as they become available for surgery

Pre-admission Assessment

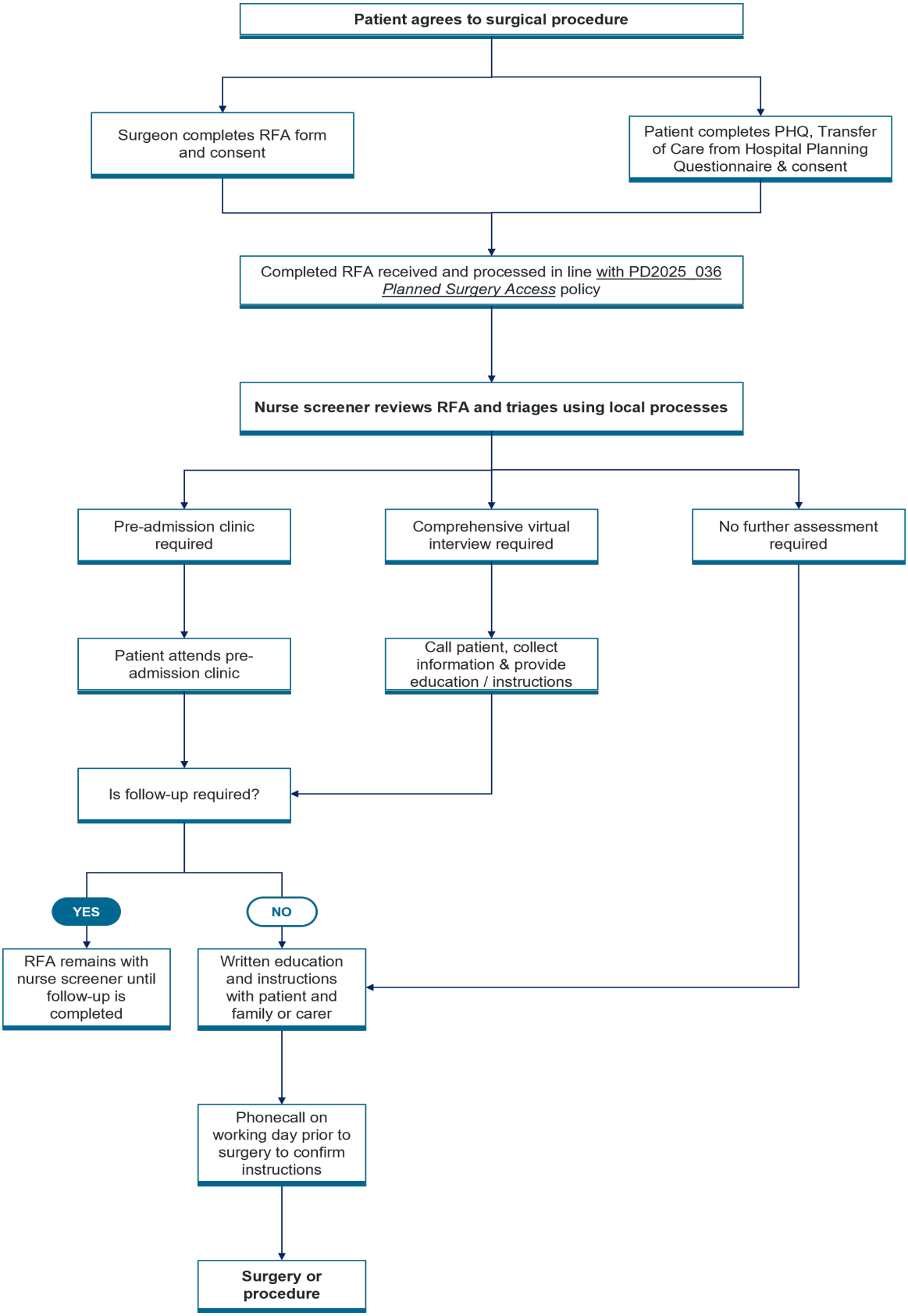
- All RFA forms must be reviewed to assess the need for a pre-admission clinic appointment.
- Senior managers must ensure a process is in place for:
    - Completion of the patient health questionnaire
    - Obtaining authority to access medical records
- Ideally completed at RFA submission, but delays may occur (e.g., needing GP input).

What happens if a patient doesn't attend their pre-admission assessment?

If a patient is required to attend and fails to attend, their surgical risk remains undetermined and any decision to proceed with surgery must be:

- Discussed with the treating doctor
- Rescheduling the appointment and procedure may be necessary

Flow chart - Pre-admission review (adapted from the *ACI Perioperative Toolkit*)



Waitlist management quick reference

Admission Process

Section 3.1

- ☐ Consider theatre availability, staffing, bed needs, and patient-specific factors
- ☐ Consider previous delays
- ☐ Consider the need for pre-admission assessment
- ☐ Coordinate with treating doctors, anaesthetists, theatre managers, and support services
- ☐ Follow Treat in Turn and Clinical Urgency Category principles

Allocating a Surgery Date

Section 3.1.1

- ☐ Determine a planned admission date
- ☐ Contact patient to confirm acceptance
- ☐ Send admission letter once date is accepted

Delayed Patients

Section 3.3.1

- ☐ Delay initiated by hospital e.g. doctor unavailable, bed, equipment or staffing issues
- ☐ Senior manager must approve delays
- ☐ Keep patient on RFC status
- ☐ Record the reason for the delay in PAS and RFA form
- ☐ A new planned admission date should be communicated to the patient within 5 working days of the delay
- ☐ Notify Chief Executive for Category 1 delays

Declined Patients

Section 3.3.2

- ☐ Where a patient declines an offer for personal reasons when given a reasonable offer (at least 2 weeks prior to the procedure date) for a planned admission date
- ☐ Keep patient on RFC status
- ☐ Record the reason for the patient declining on the electronic list and the RFA and assess if:
    - A new date should be offered
    - A deferred suspension applies
    - Patient is removed from list
- ☐ In line with *Section 3.10.1* of the Policy, patients that decline two genuine offers of treatment with another hospital or surgeon must have their status on the wait list reviewed and may be removed from the list unless extenuating circumstances exist
- ☐ If the decision is made for the patient to remain on the wait list after review by the treating doctor, the Chief Executive must be advised of the reason for the patient to remain on the wait list and will have the final decision on the patient remaining on the wait list

Declining Offers Within 100 km

Section 3.10.4

- ☐ Record any declined offers in PAS and RFA
- ☐ If patient declines 2 offers within 100 km (or 200 km if no closer option), escalate for removal
- ☐ Consider extenuating circumstances (e.g. transport issues)

Clinical Review

Section 3.5

- ☐ Triggered by patient condition change or the time on list exceeds 1.5 times the CUC timeframe
- ☐ Must be clinician-led and at NO COST for patients
- ☐ Document changes in PAS and RFA

Changes to Planned Procedure

Section 3.6

- ☐ For Minor changes: update description and comments
- ☐ For Major changes: remove original entry, submit new RFA and consent

Short-Notice List

Section 3.6

- ☐ Offer short-notice dates (within 1 week) only if pre-admission needs are met
- ☐ Follow Treat in Turn and Clinical Urgency Category principles
- ☐ Do not mark patients as 'Deferred' if they decline short notice offers

Removing patients from wait list

Section 3.9

- ☐ A patient may be removed from the list for a range of reasons (*Section 3.9* of the Policy)
- ☐ Before removing a patient from the wait list, the treating doctor must be consulted
- ☐ Document reason and date
- ☐ Notify treating doctor and GP
- ☐ Update PAS and RFA

Re-adding removed patients

Section 3.9.1

- ☐ If re-added within 30 days for same procedure:
    - Use original listing date
    - Add deferred suspension for time off list
    - Confirm with treating doctor

How do I schedule operating theatre lists?

Lists should be booked according to category and treat in turn principle. Operating theatres are a valuable resource. The goal when scheduling operating sessions is to minimise sessions that over-run and minimise sessions that finish early.

The Policy provides guidance on how many high-volume low complexity procedures should be booked in a 4-hour session (*Appendix B* of the Policy). Booking the suggested volume of cases per theatre session is highly recommended to help facilities manage demand and capacity.

Where possible patients should be treated in turn, however, to fill lists it may be necessary to move a patient up the list. For example, in a 4-hour session, the next two patients due may both be 3-hour operations. These would not fit within the session, so it is necessary to book 1 case and then move down the list and select a 1-hour case to ensure that the session is fully utilised but is not overbooked.

Resources to help

- The NSW Health *Treat in Turn Principle* website provides more practical examples
- Talk to your Perioperative Nurse Manager or Data Manager for information on the estimated theatre time for common surgical cases and to access data on the average case length per surgeon
- The Patient Flow Portal Support website has information about access and application of the Patient Flow Portal Surgery Module which includes the Demand and Capacity Dashboard, and waitlist tool which can assist with planning of waitlists

Weekly Theatre Session Review

A weekly meeting should occur where the sessions booked for the next 7-10 days are reviewed. Each session is individually reviewed to ensure that the session is resourced, that the cases booked will fit into the session and any available time can be filled.

This is also the opportunity to flag patients who may require additional care, special equipment or have previously been postponed. Review of the previous week's finish times should also be considered to guide future bookings.

Required attendees:

- Nurse Manager Perioperative Services (Chair)
- Planned Surgery Wait List Manager
- Operating Theatre Nurse Unit Manager
- Staff member responsible for ordering equipment/loan sets

Optional attendees:

- Patient flow/bed manager
- Surgical booking clerk

Operating Theatre Efficiency

When reviewing efficiency, it is important to note that each measure when viewed in isolation does not adequately reflect the efficiency of an operating theatre. When viewing operating theatre efficiency, the following metrics should be considered:

- OT utilisation
- Anaesthetic care time
- First case on time starts
- Postponement on the day of surgery
- Turnover time
- Underrun and overrun times.

For further information on theatre efficiency and session reviews refer to the ACI *Operating theatre efficiency: Clinical practice guide*

3. Capacity and Demand Management

To ensure that patients on the wait list receive their surgery within the clinically recommended timeframe, a range of management strategies can be used (*Section 3.10* of the Policy). The goal of demand and capacity management is to focus on the patient, and to provide access to planned surgery within the assigned clinical urgency timeframe.

Specific responsibilities for managing demand and capacity

Treating surgeon responsibilities

Set patient expectations from the start that surgery may occur a different facility or with a different surgeon to ensure access to surgery as soon as possible for the patient.

It is important that when a patient is registered to the planned surgery list, they are made aware, that while they will generally be admitted under the care of their referring surgeon, this is not guaranteed. The hospital may transfer their care to another surgeon or hospital to provide surgery within the clinically recommended timeframe.

Booking office team responsibilities

- Weekly review of wait lists to identify patients at risk of exceeding their CUC timeframes.
- Coordinate with treating doctors to ensure they can perform procedures on time.
- Ensure patients are moved back to RFC from NRFC as soon as the completion of the NRFC period
- Escalate issues to senior managers if demand exceeds capacity.
- Document all changes (doctor, hospital, admission date) in the PAS and on the RFA form.

Strategies to help increase capacity and manage demand in surgical services

- Transfer of care
    - Transfer to a doctor with a shorter wait time
    - Transfer to another hospital in the same District/Network
    - Transfer to another District/Network
    - Contract with private hospitals
- Variation to Treat in Turn Principle
    - Scheduling by length of procedure
    - Scheduling to reduce turnaround time in theatres
    - Use of standby or short-notice list
- Models of care
    - Same day surgery
    - High volume short stay surgery
    - Pooled list

- Use of Getting it Right First Time (GIRFT) benchmarks for booking high volume low complexity cases

For more information refer to

- Approaches to reduce surgical waiting time and waitlist: Living evidence
- Operating theatre efficiency: clinical practice guide

Transfer to a doctor with a shorter wait time

Section 3.10.1

Steps:

1. The accepting doctor will determine the requirement for consultation prior to surgery (if required, it must be facilitated by the hospital, at no cost to the patient)
2. Offer patient a transfer to a doctor with a shorter wait time
3. Keep original listing date and CUC
4. Ensure the offer includes:
    - Doctor's name
    - Hospital name
    - Planned admission date or estimated wait time
5. Record patient's response
6. If patient declines 2 genuine offers, escalate for possible removal from wait list

Removal from the planned surgery list for deferring or declining a genuine offer with another doctor on two occasions should not be used as a means of coercing the patient into accepting the transfer to an alternate doctor or hospital

Transfer to another hospital in the same district or network

Section 3.10.2

Steps:

1. Receiving hospital adds patient with original listing date and CUC
2. Notify original hospital of acceptance
3. Send original RFA to the receiving hospital
4. Original hospital removes patient from their list using correct reason code

Transfer to another district or network

Section 3.10.3

Steps:

1. Receiving hospital adds patient with new listing date
2. Original hospital sends RFA and keeps copy for audit
3. Patient remains on original list until procedure is completed
4. Remove patient from original list once confirmed

Contracts with private hospitals

Section 3.10.5

Steps:

1. If patient is sent to a contracted private hospital:
    - Keep them on public hospital wait list until procedure is done.
    - Send RFA to private hospital and retain a copy.
2. Remove patient from public list on the date of admission at private hospital.

Communication strategies to patients if a transfer is being considered

In the event that a patient does need to have their surgery moved to a different facility or will be conducted by a different surgeon – the following communication points should be considered

Prior to any contact with the patient, the hospital needs to consider a number of factors to ensure that communications with the patient are clear and consistent and the process is as easy as possible for the patient. These include:

- the circumstances of the patient including their age, available support, transport options including travel distances, the patient's physical condition and what procedure they are having
- an agreement from the referring doctor for the transfer of the patient
- a new treating doctor to accept the care of the patient
- acceptance by the new hospital (if applicable) including consideration of equipment requirements etc.
- a date for surgery or expected waiting time
- clinical review requirements by the nee treating doctor (must be at no cost to the patient)
- a preadmission clinic date if required

Encourage clinical handover from treating doctor to receiving doctor to ensure continuity of clinical care and reassurance to the patient. The Australian Commission on Safety and Quality in Health Care have developed a range of resources to support this practice.

Tools to assist

- Appendix A: Sample script for transfer of patients
- Appendix B: Sample Frequently Asked Questions (FAQ) Template

What do I do if there is disagreement between the referring hospital and the treating doctor on the proposed patient list to be transferred?

- The reason should be documented with the patient's medical record.
- This information should be shared with the Director of Surgery or equivalent delegate for noting and further discussion with the treating doctor if clinically appropriate.
- The wait list booking should continue to be handled in alignment with the *Planned Surgery Access* policy.
- Opportunities to allow the surgery to take place at the referring hospital should be explored including:

- Discussion with the Director of Surgery or equivalent delegate, the Theatre Nurse Manager, Planned Surgery Bookings Manager, the treating doctor and Heads of Department including Anaesthetic representation.
- A clinical review of the patient. Note any clinical review should be at no cost to the patient.
- Increasing theatre utilisation at existing site through the temporary adding additional sessions
- A review of the existing theatre schedule to assure alignment of surgery time with current wait list activity.
- Opportunity for the surgeon to perform the operation in an alternative location within the District or Network if clinically appropriate to do so.
- Opportunities for operating theatre time under an agreed partial outsource model in a private facility under contractual agreement with the District or Network (using the same guidelines for transfer of care as detailed above).

4. Notifying patients, GP and treating doctors

There are several occasions during the patient's planned surgery journey where communication is required with the patient, their general practitioner, and the treating doctor. Template letters for patients, GPs and treating doctors are available on the NSW Health planned surgery resources website.

The table below provides guidance on who to notify and how to notify them, with policy requirements highlighted in blue and highlighted. If both columns are highlighted, it means either form of notification is allowed.

Reason for Notification	Notification in writing			Notification can be made verbally		
	Patient	GP	Treating Doctor	Patient	GP	Treating Doctor
Referral received is incomplete and requires further information			☐			☐
Supporting documentation required for CUC allocation			☐			☐
Referral has not been accepted			☐			
The patient has been placed on the planned surgery list	☐ Within 3 days	☐ Within 3 days	☐ Within 3 days			
Changes have been made to a patient's original CUC by an authorised doctor	☐		☐			
The patient's ready for care status has changed	☐		☐			
The patient's ready for surgery status has been changed for clinical reasons				☐		
The patient's ready for surgery status has been changed for personal reasons	☐			☐		
Time limits for not ready for surgery – deferred for personal and clinical reasons e.g. 15, 45 + 180 days				☐		
Patient declines treatment, fails to arrive or requests removal			☐			
Confirmation of surgery date (for procedures in less than 10 working days)				☐		
Confirmation of surgery date (for procedures in more than 10 working days)	☐	☐				
Notice of hospital-initiated postponement (for procedures > 10 working days away	☐			☐		
The patient has been removed from the planned surgery list other than for admission	☐	☐	☐			
Notification of new PAD following a cancellation				☐ Within 5 days		
Doctor's leave - Temporary and Permanent	☐	☐				

5. Keeping records and auditing the wait list

Both hospital staff and the treating doctor have responsibility to ensure the waitlist is accurate, up-to-date, and patients are treated within their clinical urgency timeframes.

Audit quick reference

For Hospital clerical staff

Clerical audit overview

Section 5.1

- ☐ Conduct regular checks to ensure patient data is correct
- ☐ Identify delays, duplicates, overdue patients, and suspension issues
- ☐ Keep audit records for at least 3 years
- ☐ Assign a responsible staff member to manage and report audit outcomes

Weekly clerical audit tasks

Section 5.1.1

Perform these checks every week:

- ☐ Duplicate bookings
- ☐ Correct Clinical Urgency Category and approvals
- ☐ Suspension end dates approaching
- ☐ Overdue planned admission/procedure dates
- ☐ Rescheduling of delayed patients
- ☐ Emergency department admissions for listed procedures
- ☐ Patients removed from the list and reasons
- ☐ Overdue patients

Clerical audit report

Section 5.1.2

After each audit:

- ☐ Prepare a report with:
    - Type of audit
    - Issues found
    - Recommendations
- ☐ Submit to a senior manager
- ☐ Present at surgery/procedural committee meetings

Quarterly evaluation

Section 5.1.3

Every 3 months:

- ☐ Review compliance with weekly/monthly audits
- ☐ Ensure reports are tabled at relevant committees

- ☐ Confirm availability of audit records

Not Ready for Care / Suspended patient audit

Section 5.1.4

Audit patients who exceed suspension limits:

- ☐ Review RFA and supporting documents
- ☐ Conduct clinical consultation if needed
- ☐ Document outcome and update wait list

Not Ready for Care/Long waitlist audits (MoH conduct every 6 months)

Section 5.2

This audit is to ensure patients listed for over 18 months are still appropriate for surgery and reachable and to identify patients who may have exceeded maximum NRFC timeframes. The MOH will advise of any patients the District/Network may have that meet these categories and provide a template for completion.

- ☐ Audit all patients with a listing date older than 18 months
- ☐ Exclude patients audited in the last 90 days under NRFC audits
- ☐ Attempt two contacts:
    - First by letter/email
    - Follow-up by phone if no response
- ☐ Include in correspondence:
    - Alternative treatment options
    - Advice for clinical reassessment
    - Hospital and District/Network contact details
- ☐ Includes Ready for Care and Not Ready for Care / Suspended patients

Reporting:

- ☐ Share results with the Chief Executive and District/Network theatre management committee
- ☐ Send audit outcomes to NSW Ministry of Health at moh-surgery@health.nsw.gov.au
- ☐ Include:
    - Number of patients removed
    - Plan for remaining patients (e.g. clinical review, admission date allocation)

  Please note any face-to-face or telehealth patient reviews should be at no cost to the patient

Review process by the treating doctor

Section 5.3

This audit is to ensure treating doctors regularly review and update their patient lists.

- ☐ Each month, provide each treating doctor with a list of their patients
- ☐ Doctors or their rooms must:
    - Confirm receipt

- Advise changes (e.g. cancellations, updates)

☐ For pooled lists, nominate a medical officer to manage and confirm patient details

Summary of audits and reports

Minimum required audits:

Audit Type	Frequency	What to Include	Actions to Take
Weekly Clerical Audit	Weekly	Duplicate bookings, correct CUC assignments, suspension end dates (especially CUC 1), exceeded planned admission/procedure dates, delayed patients and rescheduling, ED admissions for same procedure, removals and reasons, overdue patients	Conduct audit weekly, identify issues, update records, allocate PAD for CUC 1 patients, reschedule delayed patients, escalate if delays exceed limits
Clerical Audit Report	After each audit	Type of audit conducted, problems identified, recommendations for improvement	Approve report, table at surgery committee meeting/s
Quarterly Evaluation of Audit Process	Quarterly	Compliance with weekly/monthly audits, audit reports tabled at relevant committees, availability of audit records	Evaluate audit process, ensure compliance, report findings, table at relevant surgery meeting/s
Not Ready for Care (NRFC)/Suspended Audit	As per CUC thresholds	Review of RFA and supporting documentation, clinical consultation if needed, documented outcome retained with RFA, wait list updated accordingly (refer to table 5.1.4)	Conduct initial and follow-up audits based on CUC: CUC 1 - initial at 15 NRFC days, weekly follow-up; CUC 2 - initial at 45 NRFC days, monthly follow-up; CUC 3 - initial at 180 NRFC days, monthly follow-up
6-Monthly Wait List Audit	Every 6 months	Patients listed >18 months Includes RFC and NRFC patients	Complete MoH template; Contact patients (2) attempts, document responses, arrange clinical reviews, report results to Chief Executive, share result to NSW Ministry of Health
Treating Doctor Wait List Review	Monthly or as needed	Comprehensive list of patients per doctor including relevant wait list information	Send list to doctors, confirm receipt, update records as needed

Additional suggested reports:
The use of the below reports should be discussed locally and evaluated for their value add within the local context.

Report Type	Frequency	What to Include	Actions to Take
Monthly Report	Monthly	Patients delayed in the previous month, Patients with ≥2 delays, delayed patients without rescheduled PAD within 5 days	Generate report, escalate unresolved delays, table at relevant surgery meeting/s

Patient follow up	Every 6 months	Patient listed > 6 months with no PAD	Contact patients (2) attempts, document responses, arrange clinical reviews, report results

6. Managing when a doctor takes leave or resigns

General Principles

- Patient's CUC and listing date do not change due to doctor's leave.
- Theatre sessions must not be vacated until leave is approved by senior management.
- Management plans must be developed for patients affected by the leave.

A sample VMO / Staff Specialist form is available to assist

Doctors' leave quick reference

Planned Leave (annual, study, parental)

Section 6.1

Treating doctor must:

- ☐ Give 6 weeks' notice
- ☐ Develop a management plan with Booking Office
- ☐ Not add patients during leave unless approved
- ☐ Ensure Category 1 patients are treated on time

Booking Office must:

- ☐ Collaborate on management plans
- ☐ Consult relevant personnel (e.g. Head of Unit, Theatre Manager)
- ☐ Not add patients during leave unless approved

Unplanned Leave (sickness, bereavement)

Section 6.1

Booking Office must:

- ☐ Develop management plans with relevant personnel
- ☐ Not add patients during leave unless approved

Planned resignation or retirement

Section 6.1

Treating Doctor must:

- ☐ Develop management plan with hospital leadership
- ☐ Notify patients
- ☐ Not add patients unless urgent and approved

Booking Office must:

- ☐ Transfer patients to new doctor's list (once identified)
- ☐ Maintain treat-in-turn principle
- ☐ Notify patients and general practitioners

Hospital Executive must:

- ☐ Arrange replacement doctor
- ☐ Organise clinical reviews if needed

Unplanned resignation or death

Section 6.1

Booking Office must:

- ☐ Transfer patients to new doctor or appropriate specialty
- ☐ Notify general practitioners
- ☐ Not add patients to the departed doctor's list
- ☐ Communicate with patients, informing them:
    - Their wait list position remains unchanged
    - The name of the replacement doctor (if known)
    - If a clinical review is required
    - Their expected waiting time
    - Who to contact for more information
- ☐ All communication must be documented and attached to the RFA

Hospital Executive must:

- ☐ Locate replacement doctor

7. Appendices

Appendix A - Sample Script for transfer of patients

Appendix B - Sample Frequently Asked Questions template

Appendix C - Sample VMO/Staff Specialist leave form

Appendix D - Additional resources

Appendix A- Sample script for transfer of patients

It is important that when a patient is registered to the planned surgery wait list, they are made aware, that while they will generally be admitted under the care of their referring surgeon, this is not guaranteed. The hospital may transfer their care to another surgeon or hospital in order to provide surgery within the clinically recommended timeframe.

Before you call

- Consider the need for a translator
- Before you contact the patient ensure you have the full details of the patient, details of the offer and answers to any likely questions that you will be asked.
- Consider completing the FAQ sheet in Appendix B for your use at your site so you have specific answers on hand to address any patient questions or concerns.
- Make sure you have enough time to make the call, understanding that some patients may take longer than others. If possible, make the call in a quiet place with minimal distractions.
- Calls should be made by the Planned Surgery Bookings manager or senior administration staff.

Greet the person and introduce yourself

Good morning/afternoon <patient's name> my name is <staff's name>, and I am calling from <facility name> hospital. I am calling in relation to your wait list booking for under Dr <doctor's name>.

Ascertain that this is a good time to call. If not, ascertain when a preferred time to call is.

Is now a good time to discuss your surgery booking?

I am sorry to have disturbed you, when would be a better time for me to call you <note details>? Thank you <Patient's name>. I will call you back on this number then.

- make note of time/day and call the patient back
- document encounter in the waitlist booking and on the RFA.

Explain purpose of the call

Here at <facility name> we are aware that your surgery has been delayed due <reason> to the and to ensure that you receive your surgery as soon as possible Dr <doctor's name> has advised that your surgery is suitable for you to undergo at <hospital name> under the care of <receiving doctor's name>.

I am pleased to say we have a date for your surgery on <date> OR <hospital name> have said that you will have a date for your surgery in <timeframe>. Can I give you more information on this?

- Allow time for the patient to process/react to the information

Answer the patient's questions

- Refer to your hospital's FAQ information sheet for site specific information
- Advise the patient that they will also receive confirmation of the offer and additional information in the mail including a person to contact for further information.

If there is a question asked that you do not have an answer to

Advise the patient that you will find out and get back to them.

<Patient's name> I will find out the answer to that question for you and call you back. <Depending on the question> it may take me X time to find that out for you. When is a good day/time to call you back?

- Take a note of the question and day/time.

- Once clarified – consider adding the question to your site's FAQ if applicable to other patients.

If the patient is hesitant - offer the patient time to consider the option

"I understand that I have given you a lot of information which you may want to discuss with your family and GP before accepting your surgery date. Is it ok if I call you back on <date/time nominated by patient> to confirm?

Thank the patient for their time and advise next steps

"Thank you for your time <patient's name>. The <receiving hospital/we> will be in contact to confirm this information for you in writing and this will include a contact number for you to call for further information if you have any further questions".

Summary table of reasons and suggested responses:

Reason for decline	Suggested response
X hospital is too far to travel	I understand that X hospital is further than <hospital currently listed>, however this is your opportunity to have your surgery earlier on the X of X. Currently we estimate your wait time at <current hospital> would be <insert time frame>. To support your surgery at X, travel and accommodation costs are covered up to X.
I know Dr X (treating doctor) and I don't know Dr Y (receiving surgeon).	Dr X has reviewed your surgery and approved your surgical care to be transferred to Dr Y. Dr Y will have the opportunity to talk to Dr X and <if indicated> Dr Y has asked to meet you prior to your surgery to review your condition and answer any questions you may have. I understand that you may have concerns as you have not met the Dr before. I can give you time to discuss this with your family and GP. Can I call you back on <insert date>?
What about my follow up care/what happens if I have a question after my surgery?	After your surgery you will be required to see Dr Y for a follow up appointment at no cost to you. Travel assistance of X is covered as part of the surgery. OR Dr X and/or <referring hospital> will be providing any follow up care. You will receive a discharge letter from Dr Y that can be sent to your GP also.
I am happy to wait	The doctor has indicated that you should have your surgery within <insert clinical timeframe>. Currently we estimate your wait time at <insert hospital name> would be a further X.

Appendix B- Sample Frequently Asked Questions Template

Purpose: To provide answers to typically asked questions from patients who are being given a date to have their surgery in another district.

Questions <add in other questions that your patients ask>

Finance

Will my transport costs be covered?

A:

I will need to go down the night before my surgery. Who will pay my hotel costs?

A:

Where do I stay the night before my surgery?

A:

Do I have to pay to see the new surgeon?

A:

You mentioned I will be going to a private hospital – will I have to pay?

Clinical Questions

When can I talk to my new surgeon?

A:

Who can I ask if I have further questions about my surgery at X hospital?

A:

Where will I recover from my operation?

A:

Wait list status

Will I be removed from the wait list if I say no to this offer?

A:

Will my surgery be delayed if I decline this offer?

A:

Miscellaneous

Who do I call if I have further questions?

A:

Appendix C- Sample VMO/Staff Specialist Leave Form

District/Network Logo here

VMO/Staff Specialist Leave Form

I <doctor's name> wish to notify <LHD> that I will be on leave from my position as VMO/Staff Specialist in <hospital/s name> from <leave start date> <leave finish date> (both dates inclusive).

I have arranged the following cover with my colleagues during the above period as follows:

Please tick:

☐ My clinical commitments will be covered by the on-call clinician

☐ My private patients will be cared for by Dr ……..…….....

☐ My hospital patients will be cared for by Dr ……...

☐ My "on call" commitments will be covered by Dr ……..

☐ My outpatient clinics will be covered by Dr ……

☐ My outpatient clinics will be rescheduled, and a plan has been discussed with the Outpatients Manager.

My management plan for planned patients who fall due for treatment under their clinical timeframe is:

☐ Transfer care to Dr……who has agreed to care for the patients and has been given all necessary information

☐ Pool the patients to suitable consultants

☐ I will discuss with Head of Department and/or Director of Surgery

AND

☐ My teaching commitments will be covered by Dr ……

Where applicable:

☐ Dept Head taking leave – General Manager notified. Date: …….....

Signature of AMO notifying leave ……Date: …….

Signed by AMO accepting cover …… Date: …….

(**OR** by Dept Head where cover is shared or rostered) ……...

Confirmed by Director of Surgery…….. Date: ……..

Confirmed by Director Medical Services ……..…….Date: …….

***Personal emergencies excepted, at least 6 weeks' clear notice of leave should be given**

Appendix D- Additional resources

Resource	Description
Approaches to reduce surgical waiting time and waitlist: Living evidence	This living table lists strategies identified in the peer-reviewed and grey-literature with evidence of feasibility and an association with a reduction in waiting times and hospital procedure waiting lists.
High Volume Short Stay Surgery Toolkit	This toolkit supports health facilities in NSW to plan and set up the best way to deliver a high volume of surgeries for patients needing a short hospital stay. The high-volume short stay (HVSS) surgery model is a surgical unit that delivers planned surgery or procedures that require patients to be admitted for up to 72 hours. This includes same day and extended day only cases.
Operating theatre efficiency: Clinical Practice Guide	This document is a resource for all staff who deliver surgical services. It aims to support managers and clinicians to increase the efficiency of operating theatres in NSW.
Osteoarthritis of the Knee: Clinical Care Standard	The Standard describes what each quality statement means for consumers, clinicians, and healthcare services. It provides indicators to support local monitoring and includes information about using clinical care standards.
Perioperative Toolkit	The Perioperative Toolkit supports surgical services in NSW public hospitals to optimise care and outcomes. This includes metropolitan, regional and rural facilities.
Planned Surgery Access policy	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.
Same Day Surgery Admission Model	The model supports quality and safety for patients by establishing consistent care for commonly performed surgical procedures. This model is for all staff involved in the surgical care of patients. It provides the most up to date advice, is validated based on contemporary practice and literature, and is supported by tools to provide direction to NSW Health organisations to effectively implement the model.
Value-based surgery: Clinical Practice Guide	This guide identifies procedures that, in certain patient cohorts or clinical presentations, offer little to no benefit to the patient. The procedures have been identified using current peer reviewed evidence and guidance and position statements

Resource	Description
	from relevant craft groups. The identification was evidence-based. It also permits more clinically appropriate procedures to be performed in public hospitals.
Waiting Times Data Collection	This is a well-established unit record data collection of all patients booked on the public hospital waiting list for planned and planned surgery/clinical care provided on an admitted patient basis. This has traditionally been reported via WLCOS but this will be replaced by reporting via the EDWARD data warehouse over time.

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ISBN: 978-1-74231-319-1

Further copies of this document can be downloaded from the NSW Health website www.health.nsw.gov.au

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