A Resource Guide for Effective Management of Elective Surgical Lists in NSW Public Hospitals

NSW GOVERNMENT Health

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CONTENTS

What is this Resource guide? How do I use it?

Each year more than 220,000 patients in NSW public hospitals have elective surgery procedures. The Elective Surgery Access Policy was developed to ensure clinically appropriate, consistent and equitable management of elective surgery patients in public hospitals across NSW.

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

It is designed to assist surgery managers to administer 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 Elective Surgery Access Policy, the policy will always take priority.

1. Accepting a patient onto the Elective Surgery List

What is an Indicator Procedure Code (IPC)?

Indicator Procedure Codes are a list of codes for common procedures. They were created in order to give a specific indication of performance areas of elective care provision, as a relatively small number of procedures account for the bulk of the elective surgery workload.

IPC's were introduced nationally to monitor the volume, median wait and on time performance of frequently performed elective surgeries. NSW uses IPCs for the same purpose. This data can assist in planning and resource allocation, auditing and performance monitoring.

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.

Steps to select the correct IPC:

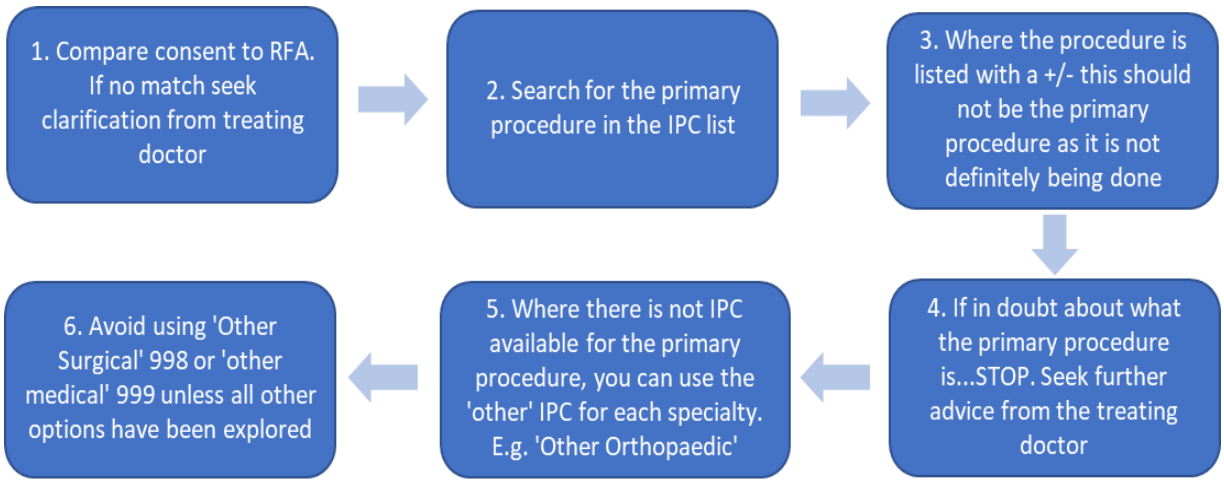
1. Review the procedure on the consent form and compare it to the recommendation for admission (RFA). If there is not a match – seek clarification from treating doctor.
2. Search for the correct IPC for the primary procedure in the searchable list on the NSW Health Elective Surgery Program Resources page.
3. Where a surgery is listed as "+/- "the primary surgery should only be included. This is because the procedure that is "+/-" is not necessarily going to be performed. For example, Diagnostic Laparoscopy +/- excision of Endometriosis, the primary procedure is Diagnostic Laparoscopy, and only the IPC 043 for Diagnostic Laparoscopy should be used.
4. If in doubt of what the primary procedure is, STOP and seek further advice from the treating doctor before allocating.

5. Where there is no IPC available for the primary procedure, use the ‘other’ IPC of the specialty. For example, ‘other orthopaedic’, ‘other plastic’.
6. **Avoid using ‘other surgical” or ‘other medical’ as these IPCs cover a broad range of specialties.** The use of these IPCs limits the ability to inform locally and at a State level numbers of a specific procedure performed, specialty volumes for planning and resource allocation, and auditing and performance monitoring.

A searchable list of IPCs and Clinical Urgency Categories (CUCs) is hosted on the NSW Health Surgery Website: NSW Health Elective Surgery Program Resources

Further documents relating to data collection and reporting requirements including those for COVID-19 can be found at the Planned Service Waiting Times Data Portal:
http://internal.health.nsw.gov.au/data/collections/covid19/index.html#WAITLISTof

Summary of Process



How do I manage a non-recommended Clinical Urgency Category (CUC)?

There must be a review and escalation process at each facility for hospital Clinical Directors of Surgical Services or equivalent to review all variations from the recommended CUC to ensure appropriate prioritisation of patients. Patients need to be added to the list within 3 days of receiving the RFA (Section 4.2 of the Elective Surgery Access Policy).

Where the procedure is not in the NSW Recommended Clinical Urgency Categories, treating doctors must follow the principles outlined in this policy when assigning the Clinical Urgency Category.

With the release of the Elective Surgery Access Policy IB2012_ 004 *Advice for Referring and Treating Doctors* will be rescinded.

Recommended Clinical Urgency Categories can be found on the Elective Surgery Program Resources page.

Process for the management of non-recommended CUC's.

An example process for managing non-recommended Clinical Urgency Categories can be found below.

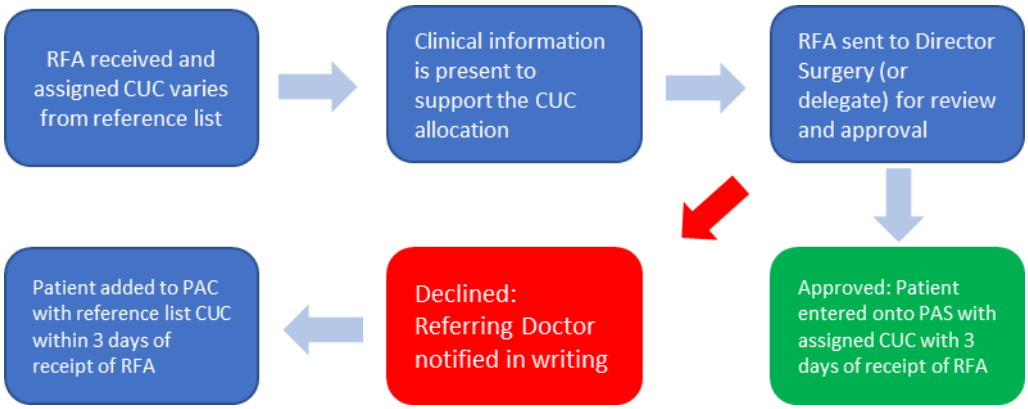
1. RFA received, checked for minimum data set and CUC checked against reference list.
2. Where there is a query about the appropriateness of the CUC a discussion should occur between the treating doctor and senior management to resolve the issue and ensure that the patient is added to the elective surgery list within 3 working days from receipt of the RFA.
3. If clinical information is provided to support the non-recommended CUC – send the RFA to the Director of Surgical Services (or delegate) 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, send the RFA to the Director of Surgical Services (or delegate) who can contact the treating doctor if required. 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 reviewed and a decision made by Director of Surgical Services the non-recommended CUC will either be accepted or declined.
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 should be informed in writing and the RFA added to the elective surgery 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 Clinical Urgency Category will be used
9. If a patient's Clinical Urgency Category is changed after they have been added to the elective surgery list, they must be notified in writing of the revised Clinical Urgency Category and expected waiting time

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

Steps to take when managing Clinical Urgency Categories

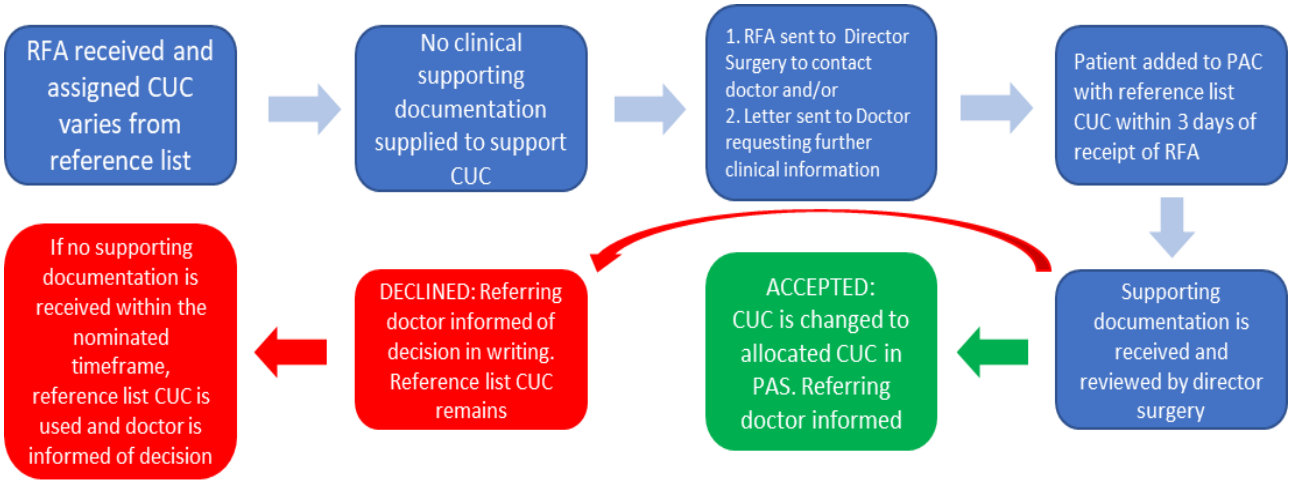
Scenario 1:

Example steps to take when an RFA is received with a Clinical Urgency Category that varies from the reference list and clinical supporting documentation is provided:



Scenario 2:

Example steps to take when an RFA is received with a Clinical Urgency Category that varies from the reference list and no supporting clinical documentation is provided:



Do we do that procedure?

Under the Elective Surgery Access Policy, A doctor may only refer patients to the elective surgery list for procedures for which the doctor has been given privileges by the relevant credentials committee.

If in doubt, stop, don't add the patient to the waitlist and check with the Director of Surgery or equivalent (Section 3.6 of the Elective Surgery Access Policy).

How do I manage the 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.

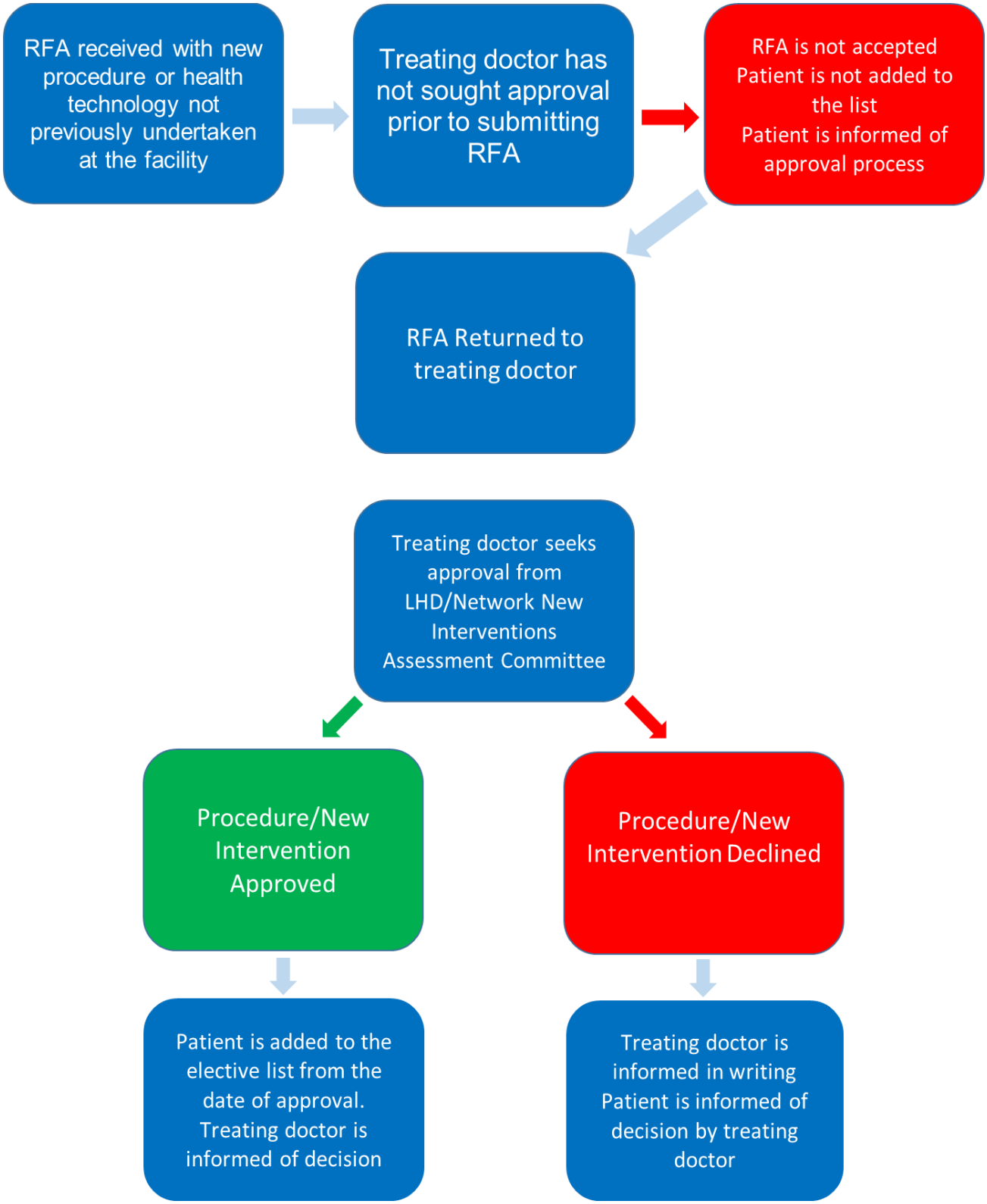
A Local Health District/Network New Interventions Assessment Committee or equivalent must formally approve new procedures not previously undertaken at the hospital.

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 3.5 of the Elective Surgery Access Policy).

An example of how to manage this process would be as follows:

1. RFA received, checked for minimum data set.
2. Identified new procedure or health technology and treating doctor has not sought approval prior to submitting RFA.
3. RFA is **not** accepted – Patient is not added to the list. Patient is informed of the approval process.
4. RFA returned to treating doctor.
5. Treating doctor seeks approval according to the local process for the New Interventions Access Committee. NSW Health has created the NSW Framework for New Health Technologies and Specialised Services, a guide for districts, networks and pillars to support their role in locally evaluating new health technologies.
6. If the procedure is approved the patient is added to the elective list from the date of approval and the treating doctor is informed of decision.
7. If the procedure is declined the treating doctor is informed in writing.
8. The treating doctor is to inform the patient of the decision.

Steps to take when an RFA is received with a procedure or health technology not previously done at your hospital



What about cosmetic and discretionary surgery?

The list of cosmetic and discretionary procedures which must not routinely be performed in NSW can be found in the Elective Surgery Access Policy. Where a procedure on the list has 'nil' exceptions, this procedure should not be performed unless approved by the Program Director of Surgery. 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.

It is the responsibility of the treating doctor to seek approval for cosmetic and discretionary procedures to be completed in any public hospital facility. The approval of the LHD/Network program director of surgery or equivalent should be sought in consultation with senior management.

Objective medical criteria supporting the decision for surgery should be documented on the RFA and used during the clinical decision and review process.

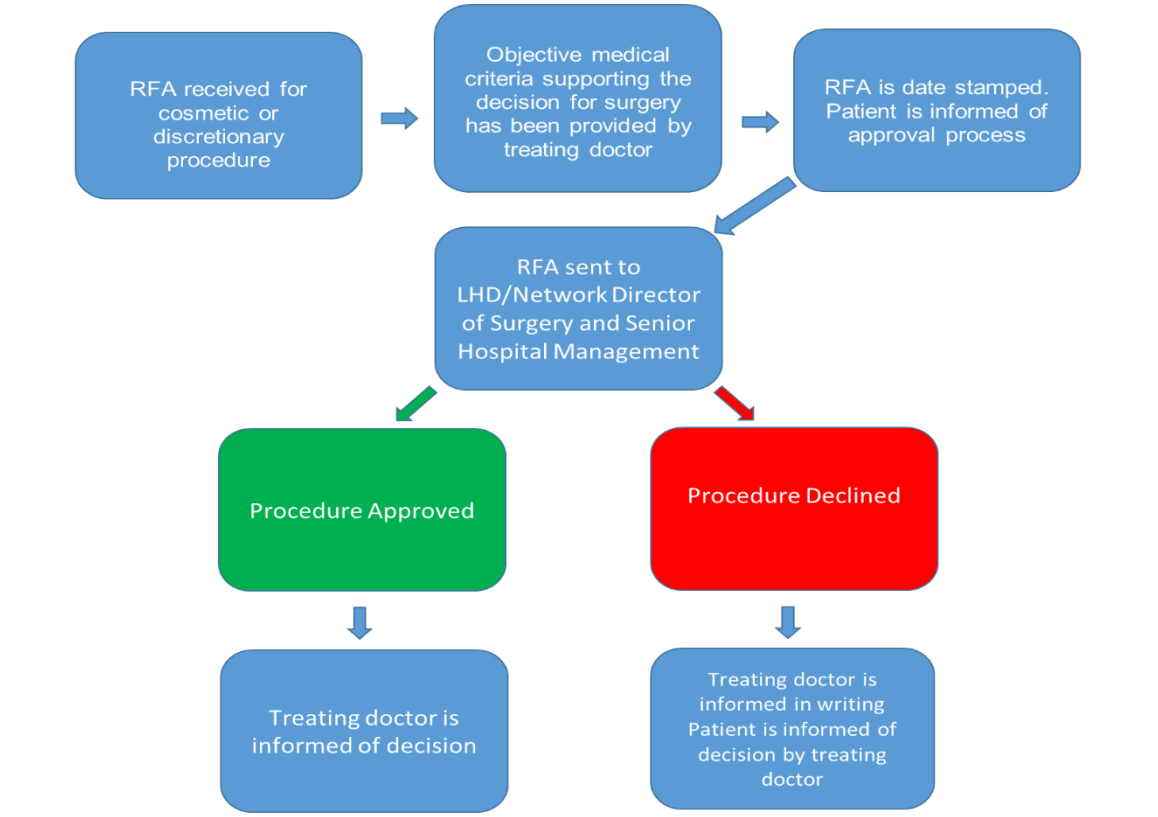
For procedures not appearing on the list or where there is doubt about the nature of the proposed surgery, the request should be referred to the Local Health District/Network Program Director of Surgery or equivalent for review prior to the patient being added to the elective surgery list.

Below is an example of how to manage this process.

Steps to take when managing cosmetic and discretionary surgery:

Scenario 1: RFA received for a cosmetic or discretionary surgery and clinical supporting documentation is provided by the treating doctor:

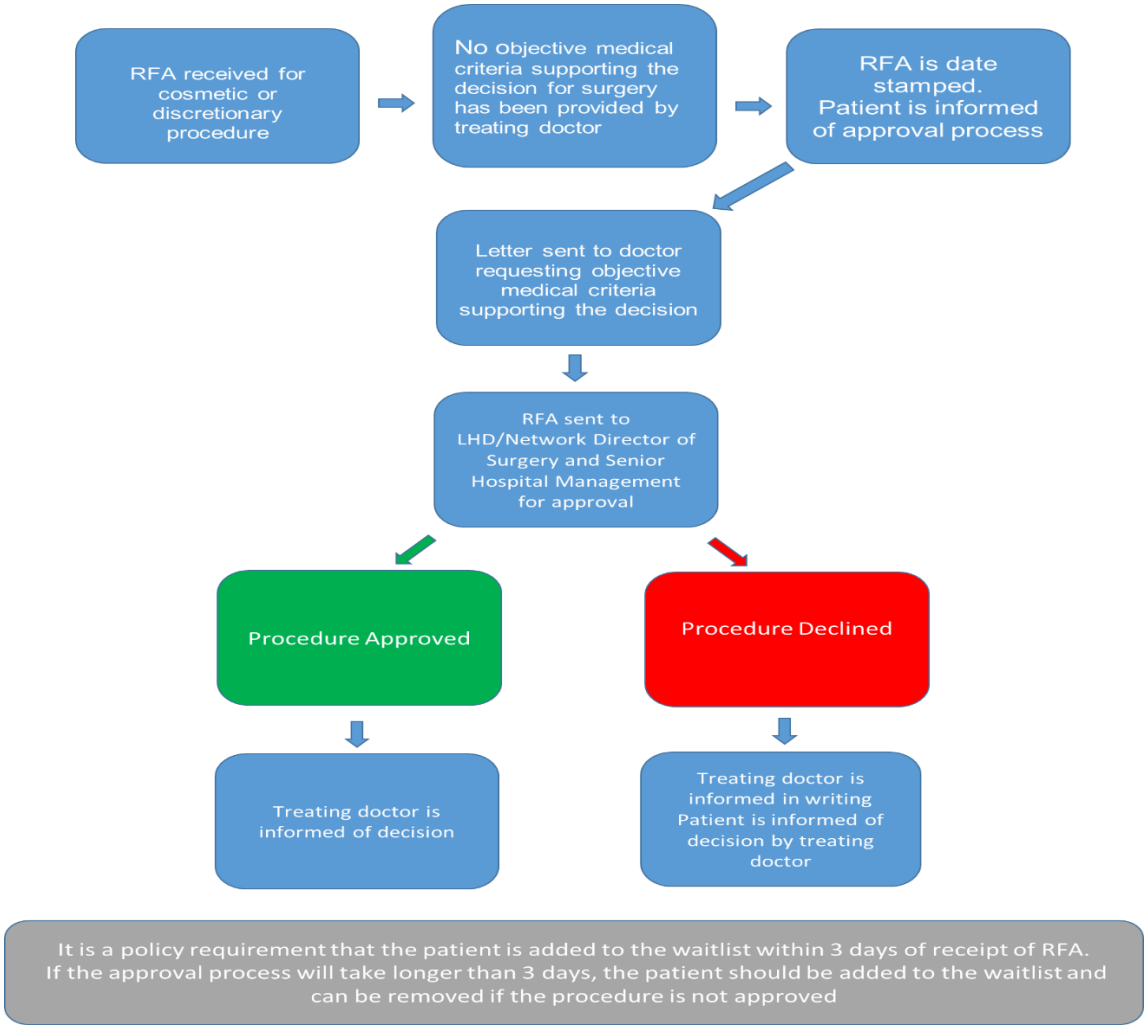
1. RFA received, checked for minimum data set
2. Identified cosmetic or discretionary procedure and supporting clinical documentation has been provided by the treating doctor.
3. RFA is date stamped. Patient is informed of the approval process
4. RFA sent for review and approval of the LHD/Network Director of Surgery and Senior Hospital Management or delegate according to local process
5. If the procedure is approved the patient is added to the elective list from the date of receipt of RFA. Treating doctor is informed of decision
6. If the procedure is declined. The treating doctor is informed in writing.
7. The treating doctor is to inform the patient of the decision.
8. It is a requirement of the policy that the patient is added to the waitlist within 3 days of receipt of RFA.



It is a policy requirement that the patient is added to the waitlist within 3 days of receipt of RFA. If the approval process will take longer than 3 days, the patient should be added to the waitlist and can be removed if the procedure is not approved

Scenario 2: RFA received for a cosmetic or discretionary surgery and clinical supporting documentation has not been provided by the treating doctor:

1. RFA received, checked for minimum data set
2. Identified cosmetic or discretionary procedure and no supporting documentation is provided.
3. RFA is date stamped. Patient is informed of the approval process
4. RFA sent for review and approval of the LHD/Network Director of Surgery and Senior Hospital Management or delegate according to local process.
5. Letter sent to doctor requesting clinical information.
6. If the procedure is approved the patient is added to the elective list from the date of receipt of RFA. Treating doctor is informed of decision.
7. If the procedure is declined. The treating doctor is informed in writing.
8. The treating doctor is to inform the patient of the decision.



2. Managing patients on the Elective Surgery List

How do I book operating lists?

With limited resources and the requirement to complete surgical and medical procedures within the assigned clinical time frame, lists should be booked according to category and treat in turn principals. Operating theatres are one of the most expensive hospital services to run due to high levels of staffing and equipment costs. **The goal when scheduling operating sessions is to minimise sessions that over-run and minimise sessions that finish early**.

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-case 1 and then move down the list and select a 1-hour case to ensure that the session is fully utilised but is not overbooked.

For information on the estimated theatre time for common surgical cases, talk to your Perioperative Nurse Manager or data manager to access average case length per surgeon data.

Short notice patients should be utilised where there is a cancellation at short notice – ensure that the principles outlined in section 6. 8.3 of the Elective Surgery Access Policy are followed.

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 weeks finish times should also be considered to guide future bookings.

Required attendees:	Nurse Manager Perioperative Services (Chair) Elective Surgery list Manager Operating Theatre Nurse Unit Manager Staff member responsible for ordering equipment/loan sets
Optional attendees:	Patient flow/bed manager Surgical booking clerks

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 start
- postponement on the day of surgery
- turnover time

- Underrun and overrun times.

For further information on theatre efficiency and session reviews please refer to The Agency for Clinical Innovation (ACI) Operating Theatre efficiency guidelines which have been developed to improve theatre efficiency in NSW public hospitals.

3. Capacity and Demand Management

Transfer to another surgeon or hospital within the District or Network.

To ensure that patients on the elective surgery list receive their surgery within the clinically recommended timeframe, it may be necessary to put in place additional management strategies. The goal is to focus on the patient, and to provide access to elective surgery within the assigned clinical urgency timeframe.

Section 6.11 of the Elective Surgery Access Policy outlines the options available for avoiding exceeding clinical urgency timeframes.

A fact sheet on *Elective Surgery Transfer of Care Principles* is available on the NSW Surgery COVID-19 and elective surgery webpage on how to manage the transfer of patients.

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

For appropriate patients who have elected to be treated as Medicare patients, there is the option for the patient to be transferred to a surgeon with a shorter waiting time within the hospital or to another hospital.

1. **Setting patient expectations from the start**

It is important that when a patient is registered onto the elective 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 in order to provide surgery within the clinically recommended timeframe.

Suggested correspondence to the patient regarding their addition to the Elective Surgery List surgical care is available on the NSW Health Elective Surgery program resources webpage.

2. **Communication**

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, this includes 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 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 new treating doctor (must be at no cost to the patient)
- a preadmission clinic date if required

When contacting the patient, a genuine offer including a date of surgery (or estimated waiting time) and details of the new surgeon and hospital (if applicable) must be provided.

Note: If a patient declines a genuine offer, the patient must remain 'Ready for Care' and the details of the declined the offer must be recorded. See section 6.3 and 6.3.2 of the Elective Surgery Access Policy for more information.

Removal from the Elective 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.

The key message to the patient should focus on providing access for their surgery, and the commitment of the hospital to provide the surgery within the recommended clinical urgency timeframe.

Tools/points to assist this process include:

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

3. When the patient accepts transfer to a new doctor

- The patient's listing date and history must be that of the original booking. In this way an accurate record of waiting time is maintained.
- The patient's current Clinical Urgency Category must be maintained, unless altered after clinical review by the new treating doctor.

4. When the patient accepts transfer to a new hospital within the District/Network

- Original RFA sent to new hospital
- Copy of RFA kept at original hospital
- The booking at the hospital where the patient will be treated is entered with the same listing date and history as the booking at the original hospital, and with the current Clinical Urgency Category
- When new hospital confirms patient has been added to the Elective Surgery List, the patient can be removed from the list at original hospital using reason code 'treated elsewhere' (at another hospital within LHD).

5. **If the patient declines transfer**

- Ask the patient the reason for the decline. Some suggested responses to common responses are below:

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.

Further information on *increasing take up of services* is available from the Behavioural Insights Unit at the Department of Customer Service.

If the patient continues to decline the surgery offer:

- The hospital must record the reason for patients declining a planned admission date on the electronic list and on the patient's RFA.
- If a patient declines a genuine offer, the patient must remain 'Ready for Care'.
- Where the patient declines two genuine offers of treatment with another doctor or at another hospital, then the patient should be advised that they may be removed from the elective surgery list.
- The Local Health District Program Director of Surgery should review the patient's status on the elective surgery list in consultation with the original treating doctor prior to the patient being removed from the elective surgery list. Capacity and Demand Management: Transfer of care to a hospital outside of the Local Health District or Specialty Health Network
- Any decisions made to remove a patient from the waitlist must be made in line with section 6.12 of the Elective Surgery Access Policy and include consultation with the treating doctor. Authorisation from the Local Health District or Speciality Health

Network Program Director of Surgery or equivalent is required as well as notification to the patient and GP.

Patient's clinical care and waitlist booking should always be managed in accordance with existing NSW Health policy and guidelines

Variances - Transfer of care process

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 Local Health District/Network Program Director of Surgery or equivalent for noting and further discussion with the treating doctor if clinically appropriate.
- The waitlist booking should continue to be handled in alignment with the Elective Surgery Access Policy.
- Opportunities to allow the surgery to take place at the referring hospital should be explored including:
    - Discussion with the Local Health District/Network Director of Surgery or equivalent, the Theatre Nurse Manager, Elective 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 waitlist 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, GPs and treating doctors

There are several occasions during the patient's elective surgery journey where communication is required with the patient, their general practitioner, and the treating doctor.

Below is a table that provides guidance of who to notify and how to notify them.

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 elective 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 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 elective surgery list other than for admission	□	□	□			
Notification of new PAD following a cancellation				□ Within 5 days		
Doctor's leave - Temporary and Permanent	□	□				
Cells filled with this colour indicate a policy requirement						

5. Keeping records and auditing the waitlist

Requirements

Frequent monitoring, auditing, and reporting is essential to ensure that patients are being correctly managed while on the list for elective surgery, that the patients are being treated in turn and the management of the elective surgery list is a fair, clinically appropriate and transparent process.

Each hospital is required to nominate a person responsible for the clerical audit of the hospital elective surgery list. This includes conducting audits and reporting the outcome to the relevant manager (Section 8.1 of the Elective Surgery Access Policy)

There are weekly, monthly, quarterly and twice-yearly auditing and reporting requirements which are outlined in Section 8.1.1, 8.1.2, 8.1.3 and 8.3 of the policy. Below is a table that outlines the weekly clerical audit and monthly audit requirements under the policy.

The table is split by patient administration system CERNER and iPM as they are the two systems with the highest number of users across the state.

iPM Monthly reports

Policy Ref	Requirement	Frequency	Available Report iPM	Extra Information
Policy Ref	**Requirement**	**Frequency**	**Available Report iPM**	**Extra Information**
8.1	Patients who have incurred a delay during the previous month	**Monthly**	**RES_WLIST37** ADMISSION DELAYS	Provide to Hospital General Manager and Table at appropriate Committee
8.1	Patients who have had 2 or more delays	**Monthly**	**WLI013_SBB** PATIENTS WITH 2 OR MORE ADMISSION DELAYS	
8.1	Patients who have been delayed and do not have a rescheduled PAD	**Monthly**	**WLI014_SBB** PATIENT DELAYS WITH NO RESCHEDULED TCI **GS_WLIST37** Admission Delays	
8.2	Provide treating doctor with comprehensive list of patients on waitlist	**Monthly**	**GS or RSE_WLIST34** - WAITLIST SUMMARY BY AMO	Send to each treating doctor. Treating doctor to confirm list with waiting time coordinator
9.3	Review patients on list for > 6 months	**When patient on list > 6 months**	**Batch Review**	Letter and Phone call with alternate treatment options where available, advice for clinical reassessment, hospital/ district/network contact details

iPM weekly reports

Policy Ref	Requirement	Frequency	Available Report iPM	Extra Information
9.1.1	Check for duplicate bookings	**Weekly**	**RSE_WLIST 45** or **WLI007_SBB WSWL04** or **WL 21** DUPLICATE BOOKINGS AT THE SAME FACILITY	Report signed by the responsible person conducting the audit must be sent to the relevant manager and tabled at appropriate committees
9.1.1	Ensure correct Clinical Urgency Category has been assigned	**Weekly**	**RSE_WLIST42** – CATEGORY 1,2,3 WAITLIST REPORT **WS_WL33** Total waitlist	
9.1.1	Review listing status of patients whose status review date will become due in the next week	**Weekly**	**RSE_WLIST12 -** STATUS REVIEW or **RSE_AUDIT04** - WL OPEN SUSPENSION W PRIORITY NOT = 9 **RSE_AUDIT 11** WL PRIORITY =9 AND NO CURRENT SUSPENSION **RSE_AUDIT 12** - WL SUSPENSIONS W.OUT RESUME DATE **WS_WL15** Suspension review date	
9.1.1	Review exceeded planned admission and planned procedure dates	**Weekly**	**WLI008_SBB** PLANNED ADMISSION DATE PASSED or **GS_WLIST19 -** Admission Date Passed **WS_WL 33** Admission Date Passed	
9.1.1	Ensure delayed patient is rescheduled for next available theatres session in consultation with treating doctor	**Weekly**	**WLI014_SBB** PATIENT DELAYS WITH NO RESCHEDULED TCI **GS_WLIST37** Admission Delays	
9.1.1	Identify patients on list admitted through the Emergency Department for the	**Weekly**	**RSE_WLIST39** - EMERGENCY ADMISSION AND HAS ACTIVE WL BOOKING or **WLI004-** Waiting List Entries for Patients Admitted **WS_WL05** Emergency admit and possibly on WL	

	same procedure			
9.1.1	Number of patients removed and reasons for removal from the waiting list	**Weekly**	**RSE_WLIST 40** - REMOVALS FROM THE WAITLIST or **WLI011_SBB** - removals from WL EXCL.DUE TO ADMISSION	
9.1.1	Identify overdue patients on list	**Weekly**	**WS_WLI06** – National Elective Surgery Target **RSE_WLI011** – Inappropriate Waits	

CERNER monthly reports

Policy Ref	Requirement	Frequency	Available Report CERNER	Extra Information
8.1	Patients who have incurred a delay in the last month	**Monthly**	**SWSLHD + SLHD** 952_PM_DELAY_PAT_SSW Waiting Pts – Delayed Report **NSLHD + CCLHD** 855_WR031_DELAY_IN_LAST_MONTH	Provide to Hospital General Manager and Table at appropriate Committee
8.1	Patients who have had 2 or more delays	**Monthly**	**SWSLHD + SLHD** 952_PM_DELAY_PAT_SSW WL – Delayed > Once **SLHD** 855_DELAYED_TWICE_SUMMARY **NSLHD + CCLHD** 855_WR032_WL_DELAY_GREATER	
8.1	Patients who have been delayed and do not have a rescheduled PAD	**Monthly**	**SWSLHD + SLHD** 952_PM_DELAY_PAT_SSW Waiting Pts – Delayed Report **NSLHD + CCLHD** 855_WR008_DELAY_NOT_RESCH	
9.2	Provide treating doctor with comprehensive list of patients on waitlist	**Monthly**	**SWSLHD + SLHD** 952_PM_WL_LIST_SSW **NSLHD + CCLHD** 855_WR022-wl_BY_AMO **NSLHD:** Automated WL Report, executed from WL Mgt App	Send to each treating doctor. Treating doctor to confirm list with waiting time coordinator
9.3	Review patients on list for > 6 months	**When patient on list > 6 months**	**SWSLHD + SLHD** REPORT AUTOMATED – CHEKCLIST OF PATIENTS ON WLIST > 6 MONTHS **NSLHD + CCLHD** 855_WR019_LTR_AUDIT	Letter + and Phone call with alternate treatment options where available, advice for clinical reassessment, hospital/ district/network contact details

CERNER weekly reports

Policy Ref	Requirement	Frequency	Available Report Cerner	Extra Information
9.1	Check for duplicate bookings	**Weekly**	**SWSLHD + SLHD** 952_PM_WL_MULTI_ENTRY_DTL_SSW **NSLHD + CCLHD** 855_WR049_WL_DUP_BOOKING	Report signed by the responsible person conducting the audit must be sent to the relevant manager and tabled at appropriate committees
9.1	Ensure correct Clinical Urgency Category has been assigned	**Weekly**	**SWSLHD + SLHD** **NSLHD + CCLHD** 855_WR005_BOOOKED_PATS_AMO	
9.1	Review listing status of patients whose status review date will become due in the next week	**Weekly**	**SWSLHD + SLHD** WL-Status Review Date **NSLHD + CCLHD** 855_WR017_STATUS_REVIEW	
9.1	Review exceeded planned admission and planned procedure dates	**Weekly**	**SWSLHD + SLHD** 952_PM_BOOK_PASTDATE_SSW WL – Inappropriate Waits Report **NSLHD + CCLHD** 855_WR010_PLANNED_ADM_PASSED	
9.1	Identify patients on list admitted through the Emergency Department for the same procedure	**Weekly**	**SWSLHD + SLHD** 952_PM_WL_ADM_VEGM_SSW **NSLHD + CCLHD** 855_WL_ED_RECLASS	
9.1	Number of patients removed and reasons for removal from the waiting list	**Weekly**	**SWSLHD + SLHD** BK – removals during a period **NSLHD + CCLHD** 855_REMOVALS_FRM_AMO_SPEC_IPC or 855_WR040_WL_PT_REMOVALS	
9.1	Ensure delayed patient is rescheduled for next available theatres session in consultation with treating doctor	**Weekly**	**SWSLHD + SLHD** 952_PM_DELAY_PAT_SSW Waiting Pts – Delayed Report **NSLHD + CCLHD** 855_WR008_DELAY_NOT_RESCH	
9.1	Identify patients on list who are overdue	**Weekly**	**855_WR024** – Waitlist by Clinical Category	

Cerner Waitlist Optimisation Project

In the new build of the Cerner Wait List module (Cerner Waitlist Optimisation project) that is to be implemented for the Sydney Children's Hospitals Network and Northern NSW, Mid North Coast, Sydney, South Western Sydney, Northern Sydney and Central Coast Local Health Districts; there are changes to weekly and monthly audits and reports.

Northern NSW and Mid North Coast Local Health Districts

Northern NSW and Mid North Coast Local Health Districts have completed their implementation as of 1 March 2021.

- The Weekly and Monthly reports have been amended:
- The new reports available are referenced below

Note:

- No report changes to other Cerner sites or Non-Cerner sites (iPM PAS).
- iPM PAS sites will continue to use the current reports.
- Other Cerner sites (Sydney Children's Hospitals Network, Sydney, South Western Sydney, Northern Sydney and Central Coast Local Health Districts) will continue to use the current reports until each District and Network complete their respective implementations of the Cerner Waitlist Optimisation project.

CERNER Waitlist Optimisation sites - Weekly Executive Reporting

Policy Ref.	Requirement	Current	Future
9.1.1	Check for duplicate bookings	855_WR049_WL_DUP_BOOKING	855_WR049_WL_DUP_BOOKING & PM Office Worklist – WL Dup Bookings
9.1.1	Check correct CUC Assigned	855_WR005_BOOOKED_PATS_AMO	855_WR005_BOOOKED_PATS_AMO & PM Office Work Item – List of patients Waiting & Scheduled by AMO
9.1.1	reviewing listing status of patients whose status review date will become due in the next week	855_WR017_STATUS_REVIEW	855_WR052_SUSPEND_REVIEW & PM Office Worklist – WL - 5 days to Suspend Review & PM Office Worklist – WL - Exceeded NRFC KPI
9.1.1	Review exceeded planned admission dates	855_WR010_PLANNED_ADM_PASSED	855_WR10_TCI_DATE_PASSED & PM Office Worklist – Pt Pass Due Date Spec
9.1.1	Identify patients on list admitted through ED for same procedure	855_WL_ED_RECLASS	855_WL_ED_RECLASS
9.1.1	Ensure delayed patient is rescheduled for	855_WR008_DELAY_NOT_RESCH	855_WR008_DELAY_NOT_RESCH &

	next available theatre		PM Office Work Item – Deferred Patients by AMO
9.1.1	Number of patients removed and reasons for removal from the elective surgery list	855_REMOVALS_FRM_AMO_SPEC_IPC or 855_WR040_WL_PT_REMOVALS	855_WR040_WL_PT_REMOVALS
9.1.1	Number of patients on list who are overdue		

CERNER Waitlist Optimisation sites - Monthly Executive Reporting

Policy Ref.	Requirement	Current	Future
8.1	Patients who have incurred a delay (change to patients who have been deferred)	855_WR031_DELAY_IN_LAST_MONTH	855_WR031_DELAY_IN_LAST_MONTH Modified the report to include patients that have been delayed and admitted within same month
8.1	Patients who have had 2 or more delays	855_DELAYED_TWICE_SUMMARY	855_WR032_WL_DELAY_GREATER & PM Office Worklist – WL Pt Enct Deferred Twice PM Office Worklist – WL Hosp Enct Deferred Twice

8.1	Patients who have been delayed (Deferred) and do not have a rescheduled PAD (TCI)	855_WR008_DELAY_NOT_RESCH	855_WR008_DELAY_NOT_RESCH & PM Office Work Item – Waitlist Deferred Pts
9.2	Comprehensive list of patients for each treating doctor	855_WR022-wl_BY_AMO	855_WR022_WL_BY_AMO & PM Office Work Items – List of Pts by AMO (Waiting, Scheduled, Deferred, Suspended)
9.3	Review of patients on list for > 6 months	855_WR019_LTR_AUDIT	855_WR019_LTR_AUDIT

What do I do with the completed Audits and Reports?

Records relating to audits must be kept for three years. Documentation must provide a clear audit trail and must be readily available to validate any changes made to a patient's booking

Reports and Audits should be conducted in accordance with Section 8.1 and 9.1.2 of the Elective Surgery Access Policy.

At the conclusion of the audit, a report is signed by the person running the report which outlines:
the audit conducted, the methodology used, problems identified, recommendations for improvement, number of patients removed and the reason for removal. Location of the audit documents for review if required.

The audit report is sent to the relevant manager for example: Nurse Manager Perioperative services (or equivalent) to be tabled at the next Perioperative governance (or equivalent) meeting. A copy of the audit and the audit letter is stored within the waitlist office for the required 3-year period.

Examples of the audit reports are available on the Elective Surgery Resources page to assist in meeting the requirements of the policy.

Not Ready for Care/Suspended Patient Audit

The NSW Ministry of Health conduct NRFC patient audits periodically to ensure that the Elective Surgery List is an accurate reflection of patients waiting for surgery.

A report signed by the responsible person (usually the District/Network list coordinator) is to be tabled at the appropriate committee and sent to the System Purchasing Branch of the NSW Ministry as directed.

Evaluating compliance and management of the Elective Surgery List

Effective management of the elective surgery list requires strong processes and communication. There are several stakeholders involved with providing care to patients requiring surgery. A regular review of the overall elective surgery list management process is advisable at regular intervals.

The Elective Surgery assessment tool outlines the various policy requirements for managing Elective Surgery Lists in line with the Elective Surgery Access Policy and can be used to review your current practice and align areas that need improvement to meet the requirement of the policy. At the end of completing a self-assessment, surgery managers are invited to contact the NSW Ministry of Health for feedback and where requested, assistance with improving and standardising elective surgery list management.

The Surgery team can be contacted at moh-spb@health.nsw.gov.au

6. Managing when a Doctor takes leave or resigns

It is important that Elective Surgery List managers are given as much notice as possible to minimise the impact and disruption on patients who are affected. Doctors should give 6 weeks' notice of intended leave. A process should be in place at all hospitals whereby doctors leave is managed through medical administration.

Operating theatre sessions should not be vacated by a doctor without an approved leave form. A management plan for affected patients should be developed and implemented for all leave.

Section 8 of the Elective Surgery Access policy documents the process when a doctor takes leave or resigns

An example of an approval and communication process would be as follows:

1. Doctor intends to take leave and completes a leave form which is submitted to the Head of Department or Director Surgical Services (dependent on local process).
2. Leave request is reviewed including the upcoming demand for the doctor to see if additional time may be required to complete upcoming cases within their clinical timeframe.
3. Advice is provided by doctor for management of any patients already booked into the session to be vacated.
4. Notice is provided to waitlist manager and operating theatres.
5. Vacated sessions are filled according to local process.

During the leave period or after a doctor has resigned, no further patients should be added to the doctor's elective surgery list unless approved by the District/Network Program Director of Surgery

If an RFA is received for a doctor that is on leave, the RFA should not be added to the waitlist. The issue should be escalated to the Director of Surgical Services or delegate for assistance.

In cases where a doctor will no longer be working at the hospital through either planned or unplanned resignation a management plan should immediately be developed and implemented. Section 10 of the Elective Surgery Access Policy should be followed.

Committees

Monthly Perioperative Governance meeting

The elective surgery list manager should attend this meeting as it is a forum to highlight upcoming demand and capacity issues or predictions, escalate any concerns and to table and provide feedback from the previous months audits and reports conducted in line with the Elective Surgery Access Policy.

Weekly elective surgery clerical audit reports, monthly executive reports and quarterly clerical audit evaluations should be tabled at this meeting.

For further information on Perioperative Governance meetings please refer to The Agency for Clinical Innovation (ACI) Operating Theatre efficiency guidelines

Appendix A: Sample script for transfer of patients

It is important that when a patient is registered onto the elective 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 in order to provide surgery within the clinically recommended timeframe.

This information is printed on the patient notification letter found in Template 2 of the Elective Surgery Access Policy.

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 quite place with minimal distractions.
- Calls should be made by the Elective Surgery Bookings manager or senior administration staff.

Greet the person and introduce yourself

Good morning/afternoon <Patients Name> my name is <staff's name> and I am calling from <Facility Name> hospital. I am calling in relation to your waitlist booking for <procedure name> 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? <ascertain details> Thank you <patient name>. I or my colleague <name> will call you back on this number then.

- make note of time/day and call back then
- Document in the WL booking and on the RFA.

Explain purpose of the call

Here at <hospital name> we are aware that your surgery has been delayed due to the COVID -19 pandemic and to ensure that you receive your surgery as soon as possible Dr <enter Dr name> has advised that your surgery is suitable for you to undergo at <enter hospital name> under the care of <enter receiving specialist name>. I am pleased to say we have a date for your surgery of <enter date> OR <Hospital name> have said that you will have a date for your surgery in <enter 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 have not got an answer to

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

<patient 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?

- Make a note of the question and time. Day to return the call.
- 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 <day/time? To confirm?

Thank the patient for their time and advise next steps

"Thank you for your time <enter patient 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".

Appendix B: Frequently Asked Questions (FAQ) template for use by Booking Officers

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: **Waitlist status**

Will I be removed from the waitlist 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:

Acknowledgement

NSW Ministry of Health would like to acknowledge the dedication and contribution of the members of the Working Group in the development of the original resource guide.

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For further information:

Elective Surgery Access Policy

Operating Theatre Efficiency Guidelines

Agency for Clinical Innovation Surgical Services Resources

NSW Framework for New Health Technologies and Specialised Services

Documents relating to data collection and reporting requirements can be found at the Planned Service Waiting Times Data Portal.