**Canberra Health Services**

**Policy**

**Elective Surgery Access**

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| Background |

Surgery is classified as either emergency surgery, elective surgery or other surgery on the basis of a patient’s presentation and subsequent care.

Publicly funded elective surgery is available to eligible patients.

* A medicare *eligible* patient is defined as being a holder of an Australian Medicare card or is from one of the countries that holds a reciprocal healthcare agreement with the Australian government.
* *Non-eligible* patients are those who are not entitled to access an Australian Medicare card.

There is an ongoing commitment to collaborative cross border engagement to ensure all patients accessing ACT Health services receive timely and high-quality care.

Cross-border health management issues will be managed in a spirit of cooperation and mutual support and include genuine community engagement.

The policy provides guidance to managers, clinicians and administrative staff of the ACT Health system who are involved in the provision of public elective surgery.

The Elective Surgery Access policy is a document that retains a focus on the active management of elective surgery across the Territory. It is designed to be read in conjunction with other documents, including:

* Australian Charter of Healthcare Rights
* Credentialing and defining the scope of clinical practice for senior medical and dental practitioners
* Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2016-2026.
* Canberra Health Services Occupational Violence Policy and Procedure.

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| Purpose |

The policy seeks to:

* Support active management of patients waiting for elective surgery
* Support best practice in elective surgery waiting list management
* Identify the rights and responsibilities of healthcare services, referring surgeons and patients
* Improve communication between patients, healthcare services, referring surgeons, general practitioners and non-government organisations.
* Support consistent reporting to the public by healthcare services and the government

The following principles underpin the Policy:

* Referrals for elective surgery are made for eligible patients.
* Referrals for elective surgery are clinically appropriate and are representative of a suitable treatment for the patient’s condition
* Patients are provided with accessible information that ensures they will be able to make informed choices about elective surgery, along with information about their rights and responsibilities
* Public patients are the shared responsibility of the healthcare service, the referring surgeon and the relevant specialty
* All documentation is complete, legible and accurate
* Waiting list management services are provided in an efficient, transparent and patient-centred manner
* The elective surgery waiting list is managed to ensure patients are treated equitably within clinically appropriate timeframes and with priority given to patients with an urgent clinical need
* The elective surgery waiting list is managed to promote the most effective use of available resources.
* Where possible pateints should receive their specialist surgical care at facilities near their place of residence, or at a facilty as close as practicable to their place of residence.

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| Scope |

The *Elective Surgery Access Policy 2020* applies to all healthcare services and their staff members and contracted health entities, where they are involved in the delivery of public elective surgery services.

Elective surgery refers to planned surgery that can be booked in advance as a result of a medical assessment resulting in referral to the elective surgery waiting list. Elective procedures that are within the scope of this policy are:

* All elective surgery procedures with a Commonwealth data reporting requirement (‘reportable procedures’), as defined by the Australian Institute of Health and Welfare (AIHW)
* The following ‘non-reportable’ procedure groups, do not meet the above definition of elective surgery:
* Adult Gastroscopy
* Adult Colonoscopy
* Hepatobiliary endoscopy
* Endovascular procedures
* Interventional cardiac procedures
* Organ/tissue transplant
* Dental procedures requiring admission
* Elective Obstetric procedures (caesareans).

All elective excluded procedures performed in the public system for approved medical reasons (Section 6) are within the scope of this policy. Elective Surgery is defined as planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery waiting list.1 Refer to Attachment 1 for common procedures not considered elective surgery.

Emergency surgery and other surgery are outside the scope of this policy. Emergency surgery is defined as surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery at a later time following this unplanned presentation. This includes where the patient leaves the healthcare service and returns for a subsequent admission within 7 days. Emergency surgery also includes unplanned surgery for admitted patients and unplanned surgery for patients already waiting for an elective surgery procedure (for example, in cases of acute deterioration of an existing condition).1 Other surgeryis where the procedure cannot be defined as either emergency surgery or elective surgery, for example, and planned obstetric procedures.

Elective surgery in the public healthcare system is provided through the mechanism of waiting lists, which are registers of patients who are waiting for elective care. Patients are placed on the ACT Elective Surgery Waiting List and assigned to a clinical priority urgency category depending on the needs of their condition. Refer to Attachment 2 for urgency category guidelines.

Clinical priority urgency categories 1, 2, and 3 referred to in this document are consistent with the National Elective Surgery Urgency Category guideline[[1]](#footnote-1) developed in conjunction with the AIHW and the Royal Australasian College of Surgeons to enable improved consistency and reporting of elective surgery.2

Where a patient is referred from an area where a facility could provide the the same specialist care closer to a persons place of residence, the referral may be declined or redirected to a health care facility as close as practicable to the patients place of residence.

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| Section 1 - Responsibilities |

Each public health facility has a responsibility to regularly monitor their demand and capacity to ensure timely access to services is sustainable. Where it is identified that there is insufficient capacity to treat patients within clinically recommended waiting times, the facility must investigate strategies to align demand and capacity either internally or seek alternative, suitable arrangements to provide surgery in time.

In situations where elective surgery services are provided through a cooperative arrangement between healthcare services, a service agreement between facilities should clearly identify the service with the responsibility for each aspect of clinical service provision.

In addition to the minimum reporting requirements that form part of each facility’s Service Agreements, the Territory Wide Surgical Services Team (TWSS) should seek to undertake regular monitoring, review and analysis of waiting list activity, dynamics and measurement against key performance indicators agreed to by national and local governance bodies.

Regular reporting on waiting list statistics will be made available to clinicians to assist in the management of elective surgery waiting list and to maintain access to surgery within clinically indicated timeframes.

This is to ensure a proactive approach to waiting list management whereby capacity issues can be identified, escalated and acted on early to ensure waiting times remain appropriate and are sustainable.

The following metrics should be reported and monitored to the Territory Wide Surgical Management Committee on a monthly basis:

* number of long waits at census by category and by specialty
* proportion of patients treated in clinically recommended timeframes by category
* number of patients removed from the elective surgery waiting list as having received treatment by specialty
* number of patients added to the elective surgery waiting list by specialty
* number of patients removed from the elective surgery waiting list by specialty including all removal reasons
* healthcare service and patient-initiated cancellation rates (Day of surgery and total cancellations)
* mail audits conducted by TWSS as part of the six-monthly schedule.

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| Section 2 – Referral to the Elective Surgery Waitlist |

## 2.1 Eligible referrals to the elective surgery waitlist

## Principles:

Elective surgery access is managed to ensure eligible patients are treated equitably within clinically appropriate timeframes.

Patients waiting for elective surgery are the shared clinical responsibility of the admitting specialist medical practitioner and patient nominated general practitioner.

**Policy**

2.1.1 Eligible referrals to the ACT public elective surgery waiting list are identified by those patients who hold an Australian Medicare card and who have been referred for a surgical procedure by a specialist medical practitioner.

2.1.2 Specialist medical practitioners can only refer patients directly onto the elective surgery waiting list at health care facility to which they have admitting rights.

2.1.3 All Medicare-eligible patients receiving public healthcare can choose to receive free care as a public patient, or to be treated as a private patient with or without an associated cost.

2.1.4 All eligible referrals to the elective surgery waiting list will be processed following the guidelines set out in Section 2.4 Registering a patient for elective surgery.

2.1.5 All eligible referrals will be assessed for provision of care as close to the place of residence as is possible, this may mean referrals to the ACT waitlist are declined and referral to a closer facility is requested.

2.1.6. All eligible referrals must be ready fo care.

## Implementation Guidelines

Eligible patients have a right to elect to be treated as either public or private. Full and open information should be provided to allow patients to make informed choices about financing their care.

Before accepting a referral onto the Elective Surgery Waiting List, health care facilities should consider their anticipated demand and capacity, and the realistic likelihood that the patient would be treated within the clinically recommended timeframe.

Where demand for a procedure exceeds the capacity of the health care facility to provide treatment to patients within appropriate timeframes, health care facilities should work with referring specialist medical practitioners to explore options to manage current and future referrals.

Patients requiring further clinical assessment and or risk assessment for surgery are not classified as ready for care and therefore may not be accepted to the ACT waiting list. Waitlist management staff will not refer patients for clinical or risk assessment and referrals will be returned to the referring clinician for referral for suitable specialist input.

To be ready for care:

* All patients with excess BMI, or history of sleep apneoa or sleep disturbed breathing must have had suitable assessment to determine suitability of anaesthesia/sedation for the patient.
* Imaging required to determine the manner/technique/prosthetic of surgery is completed.

## 2.2 Non-eligible referrrals for elective surgery

## Principles:

Referrals for elective surgery are clinically appropriate and represent the most suitable treatment for the patient’s condition.

A non-eligible patient receiving access to elective surgery will be clinically prioritised in the same manner as eligible patients.

**Policy**

2.2.1 All non-eligible patients accepted for registration onto the public elective surgery waiting list will be notified of their registration via written notification.

2.2.2 Non-eligible referrals to the public elective surgery waiting list will be discretionary.

2.2.3 Referrals to the elective surgery waiting list for patients identified as outside of the catchment area for the ACT are discretionary and will be assessed based on clinical need.

2.2.3 All non-eligible patients will be provided with the opportunity to fully understand and consent to their financial obligations in relation to their procedure, admission and associated ancillary costs.

**Implementation Guidelines**

All non-eligible patients or parent/carer’s will be provided with an Estimate of Costs and Agreement to Pay (EoCAP) to complete the agreement to pay section, prior to the patient being registered onto the Elective Surgery Waiting List.

The EoCAP will provide a documented estimate of the theatre and accommodation charge costs that the patient/parent/carer may be responsible for as a result of their referral to the elective surgery waiting list based on the operation description and the Medicare Benefits Schedule numbers provided by the treating specialist.

The EoCAP will include the following details:

* Anaesthetic cost estimate
* Procedural cost estimate based on Medicare Benefits Schedule (MBS) codes provided by specialist
* Admission costs, including any costs for High Dependency Unit (HDU)/Intensive Care Unit (ICU)

Pathology, Imaging and Pharmacy costs can be difficult to estimate as these are dependent on each patients’ requirements. Non-eligible patients can be responsible for the payment and surcharges imposed by Canberra Health Services for these specific services.

The EoCAP will be provided to the patient/parent/carer via postal and electronic communication, where available. A copy of the EoCAP and communication will be provided to the referring specialist and the nominated delegate within the healthcare facility.

The patient/parent/carer is required to complete details regarding their private health insurance provider and visa coverage type and return the completed form to the Territory Wide Surgical Services Team. The type of visa and health insurance coverage provided under the terms of the visa can impact on the levels of financial support given to them by their insurance provider.

Following receipt of the completed form and approval from the nominated delegate, the patient will be registered onto the elective surgery waiting list.

All patients who reside outside of the Canberra Health Services catchment area, will be assessed as to whether there are clinical reasons for their referral to the ACT Elective Surgery Waiting List. Referrals received for patients outside of the identified catchment area will be returned to the treating specialist and general practitioner for re-referral to a specialist service within their care jurisdiction or to provide additional clinical justification/reasoning.

Clinical justification will be required for those patients who have been referred by an NSW specialist surgeon to an ACT surgeon for treatment.

## 2.3 Clinical Prioritisation

**Principles:**

Elective surgery is managed to ensure patients are treated equitably and within clinically appropriate timeframes. Priority is given to patients with an urgent clinical need.

Patients are informed about their status on the elective surgery waiting list. Their status includes their assigned urgency category, approximate wait time and any notes within the system relevant to their positon on the elective surgery waiting list.

Categorisation of elective surgery patients is prioritised by clinical urgency and is required to ensure patients receive care in a timely and clinically appropriate manner.

Patients who require elective surgery must be assigned an urgency category by the treating clinician (or an appropriate clinical delegate) prior to registration on the elective surgery waiting list. Where a procedure is listed in the National Elective Surgery Urgency Categorisation Guideline – April 2015 (NESUCG), the recommended urgency category should be assigned unless there is a clinical reason not to do so.

Where a national urgency category recommendation does not exist, the urgency category should be appropriate to the patient and their clinical situation and not influenced by the perceived or actual availability of resources.

**Policy**

2.3.1 All elective surgery patients are assigned to an urgency category by the referring specialist medical practitioner. The three urgency categories are:

Category 1: Procedures that are clinically indicated within 30 days.

Category 2: Procedures that are clinically indicated within 90 days.

Category 3: Procedures that are clinically indicated within 365 days.

2.3.2 The assignment of urgency categories must be made with reference to the National Elective Surgery Urgency Category Guidelines (NESUCG) and the patients’ clinical condition.

2.3.3 The circumstances below may prompt departure from the recommended urgency categories in the guide:

* The procedure is for diagnosis or treatment of a proven or suspected malignancy
* The patient’s condition has the potential to deteriorate quickly to the point that it might become an emergency
* clinical justification.

2.3.4 Category 2 and 3 patients referred with a clinical priority urgency category outside of the national guidelines and with no documentation of a clinically verifiable reason should be added to the elective surgery waiting list in accordance with the NESUCG:

* In all circumstances, public health facilities must ensure robust processes are in place to confirm that the listing surgeon has received notification of the override of the patient’s category and the process and timeframe for appealing the change as described above.
* The assignment of urgency categories must be made with reference to the National Elective Surgery Categorisation guideline (Appendix 2) and the patient’s clinical condition.

2.3.5 Reclassification of a patients assigned clinical urgency category to higher category (e.g. category 2 to category 1) must only occur following a clinical assessment/review of the patient by a medical officer and reflect a change in the patient’s condition that has occurred after the patient has been added to the elective surgery waiting list. This review could be done by phone for some patients, but patients should be offered a face to face assessment if they so desire, and clinically practicable.

**Implementation guidelines**

If a clinically verifiable reason exists for allocation to a higher/lower category, the listing surgeon must submit a re-categorisation form for processing within seven (7) days stating the clinically verifiable reason for change. This does not apply to Category 1 patients.

The listing surgeon must be notified in writing if a Request for Admission and consent to treatment form (RFA) is registered onto the elective surgery waiting list with a higher or lower category than that originally indicated by the treating specialist.

Reclassification to a lower category (e.g. category 1 to category 2) the patient must be directly informed by the treating specialist or delegate, who is involved with patients care, and reasons for the reclassification given to the patient.

Reclassification cannot occur following a review of clinical notes only but can occur following receipt of investigative results that indicate a deteriorating or improving condition.

Authority to reclassify a patient’s clinical priority urgency category may only be undertaken by the treating specialist or delegate, who must complete the reclassification of clinical priority form, stating a clinical reason for the change. The clinical reason for the change may reflect deterioration in the patient’s condition either an improvement or reassessment of the patient’s condition.

The completed reclassification form or formal correspondence, is to be forwarded to the Territory Wide Surgical Services Office, where following a review by the Surgery Access Nurse, the reclassification will be recorded in the patient electronic clinical record giving the reason for the change and using the date reviewed and accepted by the Surgery Access Nurse. Patients must be advised of any change in their clinical priority urgency category and a brief summary of the telephone conversation recorded in the patient’s electronic clinical record. The reclassification will not be processed if a form is incomplete and will be returned to the consultant for amendment.

Should the referring surgeon complete a new request for admission and consent to treatment form assigning a new clinical urgency category, this can only be accepted if the patient has signed the consent form or there is evidence that a clinical review or assessment of the patient has occurred.

If the new request for admission and consent to treatment form has a change to the procedure, i.e. the principal procedure remains the same, the wait listing entry should be amended and the new request for admission attached to the original request.

If the new request for admission and consent to treatment form has a different principal procedure listed, the original waiting list registration should be removed as ‘procedure no longer required’. The new request for admission and consent to treatment form is then logged onto the elective surgery waiting.

Documentation of the changes must be recorded in the patient’s electronic clinical record.

## 2.4 Referring patients for elective surgery

**Principles:**

Referrals for elective surgery are clinically appropriate and represent the most suitable treatment for the patient’s condition.

Patients waiting for elective surgery are fully informed about the procedure, and have given their consent.

**Policy**

2.4.1 All patients referred for an elective surgery procedure must have a request for admission and consent to treatment form completed. The request for admission and consent to treatment forms, located in the Planned Hospital Admission Booklet for Surgical and Medical Care, will only be accepted if completed by Consultant Clinicians or delegate, currently contracted to one of the public healthcare facilities or contracted healthcare providers.

2.4.2 Before referring the patient for surgery, the specialist medical practitioner must:

* Complete an approved request for admission and consent to treatment form ensuring the minimum fields are completed, legible and accurate
* Assign a clinical priority urgency category consistent with the National Elective Surgery guideline and provide a clinically verifiable reason to assign a different category (if required)
* Ensure the request for admission and consent to treatment form is signed and dated on page 2.
* If a request for admission and consent to treatment form is presented for a procedure(s) a surgeon is unable to perform, for any reason, the request for admission and consent to treatment will not to be added to the treating specialists waiting list and will be returned to the treating specialists rooms as soon as possible.

2.4.3 Category 1 requests for admission and consent to treatment form submitted when a treating specialist will be away during the 30 day period, may not be accepted unless accompanied by a date for surgery identified by the treating specialist that falls within the indicator for this category.

2.4.4 The request for admission and consent to treatment should record the minimum fields required by the healthcare service to manage the patient’s waiting list episode, and the elective surgery waiting times data set:

* Patient’s full name
* Patient’s address
* Patient’s contact information (home, work & mobile telephone, email)
* Patient’s gender
* Patient’s date of birth
* Medicare number
* Clinical priority urgency category
* Discharge intention (i.e. day only, or indication of number of nights admitted to the healthcare service)
* Presenting problem
* Planned procedure/treatment
* Estimated operating time
* Treating doctor (if different)
* General practitioner’s name and address
* Treating specialist or delegate to sign and date the request for admission and consent to treatment form on page 2, and other relevant information may include:
* Significant medical history
* Specific preadmission requirements
* Special operating theatre equipment
* Requirement for an ICU/HDU bed, post procedure.

2.4.5 Completed requests for admission and consent to treatment form should be submitted directly to the Territory Wide Surgical Services Team within five working days of request for admission and consent to treatment form being signed and dated on page 2.

**Implementation guidelines for medical practitioners**

Ensure patients are ready for surgery and ready to accept a surgery date.

Ensure that they are able to perform the patient’s surgery within the clinical priority urgency category timeframe that they assign.

If patient is classified as staged, the time interval when the patient will be ready for surgery should be indicated. The category selected should reflect the time window of when the surgery is to be performed.

## 2.5 Registering patients for elective sugery

**Principle:**

Elective surgery management practices are transparent, efficient and patient-focused and directed by the appropriate standards and guidelines that support quality practices.

**Policy**

2.5.1 All referals suitable for elective surgery waitlist must be accepted and placed on the elective surgery waiting list within three working days.

2.5.2 A patients listing date will be the date the request for admission and consent to treatment form is accepted.

“Acceptance” will be deemed when the following are complete:

* The minimum data fields are completed (see Section 2.4.4)
* It is not a procedure that requires prior approval
* It is within national elective surgery urgency category guidelines, or a clinically verifiable rationale is documented supporting the change in category
* The surgeon is available and able to provide the patient with a date for surgery within the clinical priority urgency category timeframe that they assign (excepting patients who may require multimodality therapies as part of their treatment plan e.g. some colorectal surgery).

2.5.3 Requests for admission and consent to treatment forms will not be accepted if it does not meet the criteria above or is received 28 days or more after being signed and dated by the referring surgeon:

* Requests for admission and consent to treatment forms not accepted will be returned to the referring surgeon accompanied by a letter explaining the reason for return
* It is the referring surgeon’s responsibility to progress any further action required and inform the patient should they not be placed on the elective surgery waiting list for a procedure.

2.5.4 Patients must be registered on the elective surgery waiting list at the healthcare service best matched to their care requirements based on complexity, medical workforce, healthcare service capacity, location and waiting time.

2.5.6 Where a decision is made not to acceptable a referral as the surgery could be completed at a facility closer to home and not within the ACT, the patient, referring surgeon, and local GP will be written to, outlining the decision, accept in those circumstance that NSW indicates they can directly accept the referral onto their waitlist for management.

**Implementation guidelines**

All Request for admission and consent to treatment forms for patients requiring registration onto the elective surgery waiting list will be directed to the Territory Wide Surgical Services except for in the following instance:

* *urgent category one patients requiring surgery within 7 days should be submitted directly to the surgical bookings at the healthcare service site selected by the treating specialist.*

Requests for admission and consent to treatment forms for category 2 and 3 patients, will receive written notification of their registration onto the elective surgery waiting list.

A patient health questionnaire will be sent to the patient for completion and return in the reply-paid envelope.

Multiple bookings can only be accepted if the procedures are independent of each other e.g. cataract extraction and joint replacement. The referring doctor must specify which procedures are prioritised. This may be indicated by the clinical priority urgency category assigned to both bookings e.g. if one is category 2 (within 90 days) and the other is category 3 (within 365 days) then the category 2 takes precedence. However, if both request for admissions have the same clinical priority urgency category, the referring doctor should identify on the request for admission and consent to treatment forms which procedure is to be prioritised.

The Surgery Access Nurse will document the agreed priority in the patient’s electronic medical record. The patient should remain ready for surgery for both procedures until a surgery date is assigned to the first procedure, at which time the second procedure is made not ready for surgery. Advice should be received from the doctor or patient when they can become ready for surgery for the second procedure.

The only exception to this is for ongoing regular planned treatment e.g. tissue expansion or change of supra pubic catheters.

If the procedures are dependent on each other (such is the case for patients having multimodality treatments), the patient can be listed for both procedures. The first procedures will be listed as ready for surgery. The secondary procedure will be entered as “not ready for care”.

Duplicate bookings must be investigated as a request for admission and consent to treatment form will not be accepted for the same procedure with different referring doctors at the same healthcare service; or for the same procedure at a different healthcare service. The patient must be advised of the situation and asked to make a decision as to the preferred waiting list they wish to remain on.

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| Section 3 – Managing the Elective Surgery Waiting List |

## 3.1 Communicating with patients, referring specialist medical practitioners and general practitioners

**Principles:**

Patients waiting for elective surgery are the shared responsibility of the health care services, the referring specialist medical practitioner and the general practitioner.

Patients are informed about their status on the elective surgery waiting list. Their status includes their assigned urgency category, approximate wait time and any notes within the system relevant to their positon on the elective surgery waiting list.

Healthcare services communicate with patients, referring specialist medical practitioners and general practitioners in a timely and efficient way and provide easy-to-understand information to facilitate optimum patient treatment.

**Policy**

3.1.1 Healthcare services must communicate with patients, referring specialist medical practitioners and general practitioners.

3.1.2 Verbal communication with patients, referring specialist medical practitioners and general practitioners can occur over the telephone or face-to-face.

3.1.3 Information relevant to the continuing care and management of a patient on the elective surgery waiting list is to be shared with the patients nominated GP, unless the patient expressly does not consent to this occurring. The patient’s decision to decline sharing information with their GP should be documented in the patient’s electronic medical record.

3.1.4 Healthcare services must document all communication (verbal and written) with patients, referring specialist medical practitioners and general practitioners in the patients electronic clinical record as required by this policy.

3.1.5 All facilities performing elective surgery on public patients should have a clear point of contact for patients who are concerned about their waiting time or who believe that their clinical condition has changed while they have been waiting for elective surgery.

**Implementation guidelines**

Healthcare facilities should consider the language and cultural needs of particular patient groups including Aboriginal and Torres Strait Islander patients, those from culturally and linguistically diverse backgrounds, and individuals with disabilities.

Mechanisms should be in place to align the information provided to patients with their capacity to understand, wherever possible.

## 3.2 Scheduling patient for surgery

**Principle:**

Elective surgery is managed to ensure patients are treated equitably within clinically appropriate timeframes.

Priority is given to patients with an urgent clinical need.

The principle of treat in turn is to be applied to all scheduling of patients. This means that patients are treated in order of registration onto the elective surgery waiting list.

**Policy**

3.2.1 Healthcare services must schedule patients for surgery within each urgency category according to waiting time, except in specific circumstances.

3.2.2 The only circumstances which may prevent patients from being scheduled for surgery according to waiting time are:

* a patient’s condition has deteriorated
* the healthcare service has previously postponed the patient’s surgery
* patient availability
* resource availability (availability of theatre time, staff, equipment and healthcare service capacity)
* sound clinical reasons
* surgeon request for clinical reasons

3.2.3 Once a tentative To Come In (TCI) date is confirmed the patient should be contacted by phone to determine acceptance of surgery date followed by a letter from the surgical bookings office. The recommended timeframes for allocation of a TCI date:

Category 1 – within 5 days of registration onto the waiting list

Category 2 – within 45 days of registration onto the waiting list

Category 3 – within 270 days of registration onto the waiting list

3.2.4 Healthcare services must confirm the scheduled surgery date with the patient verbally and in writing. Written notification is not required for patients scheduled at short notice (10 working days or less).

**Implementation guidelines**

Healthcare services will conduct normal case review practices and waiting list management activities which should include an analysis of treatment in turn.

Healthcare services should have appropriate local policies and procedures in place to actively support the implementation of treatment in turn.

When scheduling a patient for surgery, healthcare services must ensure that no other patient with similar characteristics has a higher clinical need, or has waited longer for treatment.

The following criteria must be considered when selecting patient for scheduling:

* Clinical priority urgency category
* The length of time the patient has waited in comparison with similar category patients
* Previous postponements
* Pre-admission assessment issues/factors e.g. elderly people living alone or those having to travel long distances
* Resource availability e.g. theatre time, staffing, equipment and healthcare service capacity.

There should be relevant consultation with staff from:

* treating Doctor
* theatres
* admissions
* pre-admission
* liaison nurses
* other Departments if relevant e.g. Medicine, Radiology.

Surgery scheduling should take into account the patients personal circumstances. For example, it may be difficult for a patient living in an regional area to arrive at the earliest appointment at a healthcare facility.

The NSW Government Isolated Patient Travel Assistance Scheme provides financial subsidies to eligible patients living in rural and regional NSW who need to travel long distances to access medical specialist services, including surgery. Patients who are residing in rural or regional areas who have to travel to the nearest tertiary level health service should be provided with information on the scheme. Information is available at: <http://www.iptaas.health.nsw.gov.au/> .

Aboriginal Liaison Officer - the patient/carer is asked if they would like to request an Aboriginal Liaison Officer to contact them either before their admission or to visit during their admission.

Any tentative or planned dates should be documented in the patients electronic waiting list record.

Any acceptance of an offered date should be recorded within the patients electronic waiting list record.

Insurance status or ability to pay must not result in preferential treatment or access to services within public health facilities. Full and open information should be made available to allow patients to make informed choices about financing their care.

## 3.3 Postponement of surgery

**Principle:**

Healthcare services minimise the impact and inconvenience to patients whose surgeries they postpone.

**Policy**

3.3.1 Patients who receive a notification of their postponement on the day of surgery are advised of the postponement and the reason for postponement.

3.3.2 Where a healthcare service initiated postponement is made, category 1 patients postponed after admission will be contacted by the nominated delegate, who should be a senior member of staff within the Operating Rooms or Surgical Bookings.

3.3.3 For all other day of surgery healthcare service-initiated postponements, the patient will be notified by peri-operative staff.

3.3.4 Patients who receive a healthcare service-initiated postponement on the day of surgery will receive support options from bookings staff or peri-operative staff.

3.3.6 All day of surgery postponements must be approved by the nominated delegate. Peri-Operative staff will advise relevant healthcare service areas of the postponement including the Senior Nursing, Patient Flow Unit and Bookings office.

**Implementation guidelines**

Definitions relating to healthcare service initiated postponements are available in the ACTPAS TheatrePost. Further information is available at Attachment 3.

When communicating the postponement to the patient, the patient should be advised of:

* the reason for the postponement
* surgical bookings will contact the patient when a new surgery date become available
* what they should do if their condition changes or deteriorates
* the option to speak to a doctor about medical issues that might arise as a result of the postponement
* the Isolated Patient Travel Assistance for those who have travelled long distances to the healthcare service
* the contact details of the Surgical Bookings office, should they require further information.
* where reasons for postponement warrant a change to a patient’s status or their removal from the waiting list, the relevant clauses in Section 3.4 Managing patient status and Section 3.5 Removing patients from the elective surgery waiting list, should be followed.

## 3.4 Managing patient status

**Principles:**

Patients waiting for elective surgery are the shared responsibility of the healthcare service, the referring specialist medical practitioner and co-managed from time to time with the general practitioner.

Healthcare services minimise the time patients are not ready for surgery through early and active management of patient comorbidities and fitness for surgery.

Patients are informed about their status on the elective surgery waiting list. Their status includes their assigned urgency category, approximate wait time and any notes within the system relevant to their positon on the elective surgery waiting list.

**Policy**

3.4.1 A patient on the elective surgery waiting list must be identified as being ready for surgery.

3.4.2 Ready for surgery patients are those who are prepared to be admitted to healthcare service or to begin the process leading directly to admission for surgery.

3.4.3 Not Ready for surgery are those patients who are on the waitlist but are unable to begin the process leading directly to admission for surgery. Patients can be not ready for surgery for the following reasons:

Clinical:

*Not ready for surgery – pending improvement of clinical condition.* Patients for whom surgery is indicated, but who’s condition has deteriorated further sinc ethe addition to the waitlist. For example, patients who have a heart attack while on elective waitlist and need to wait for clinical improvement prior to admission.

*Not ready for surgery – staged patients*. Patients who have undergone a procedure or other treatment and are waiting for follow-up elective surgery. The patient is not able to be admitted to the healthcare service or to begin the process leading directly to admission for surgery.

Examples include:

* a patient who has had internal fixation and will require removal of the fixation device after three months
* a patient who requires cystoscopy to check for cancer after initial surgery to remove a bladder tumour
* a patient requiring rectal cancer surgery 6-8 weeks after neoadjuvant chemo- radiotherapy for colorectal cancer
* a surgical episode for a paediatric patient, indicated at a future developmental stage

Personal:

*Not ready for surgery – deferred for personal reasons*. Patients who for personal reasons are not yet prepared to be admitted to the healthcare service. For example, patients with work or other commitments that preclude them from being admitted to healthcare service for a time.

Healthcare services must actively manage patients who are not ready for surgery for clinical reasons and changes in status must be authorised by a senior clinician involved in the patient’s care (e.g. treating specialist, senior nurse) and involve multiple clinicians in both the decision and the responsibility to monitor the patient.

Responsibility lies with the referring clinician,medical teams and relevant health care service.

For example, patients who are waiting for an implant can be made not ready for surgery until a TCI is assigned e.g. EVAR, Orthopaedic patients requiring custom made prosthesis.

A change in the patient’s ready for surgery status for clinical reasons may be authorised by the treating specialist medical practitioner, head of clinical unit or appropriate delegate. The reason for the change and any substantiating evidence must be documented in the patient’s electronic medical record. Where the treating specialist or delegate provides authority for the change in status, the treating specialist / delegate or head of unit may be notified of the change by the individual providing authority.

Patients must be advised verbally or in writing within three working days of any change in their ready for surgery status (from ready for surgery to not ready for surgery, and the reverse) for clinical reasons.

3.4.4 The following time limits apply to patients who are not ready for surgery – deferred for clinical reasons:

* Category 1 - 15 days (discuss with referring doctor)
* Category 2 - 45 days
* Category 3 -180 days.

3.4.5 The following time limits apply to patients who are not ready for surgery – deferred for personal reasons:

* Category 1 - 15 days (discuss with referring doctor)
* Category 2 - 45 days
* Category 3 -180 days.

3.4.6 Patients who advise the healthcare servicel that they are not ready for surgery for personal reasons must be informed of the time limits for their urgency category. This should be documented.

3.4.7 Advice to patients who are made not ready for surgery must include:

* the reason for being made not ready for surgery (clinical or personal)
* an explanation that the time spent as not ready for surgery does not count towards the reported waiting time
* notification of the time limits for not ready for surgery – deferred for personal reasons, and the potential actions arising if they exceed the time limits
* the details of who to contact if the patient has questions or concerns or there is a change in their clinical condition.

3.4.8 The patient’s general practitioner may be notified either verbally or in writing, of any specific assistance they require to care for the patient while they are not ready for surgery for clinical reasons. This notification must occur within three working days of the patient being made not ready for surgery for clinical reasons, and details of this notification must be documented in the patient’s medical record.

3.4.9 If a patient becomes pregnant while waiting for an elective surgical procedure, a clinical review must be undertaken by an appropriate clinical delegate and a determination made as to whether surgery will be performed during the pregnancy. If it is determined that surgery will not proceed, the patient and their referring general practitioner, must be contacted and advised that they are being removed from the waitlist.

The treating specialist must be notified of a category 1 patient who has advised they are not ready for surgery – deferred for personal reasons.

3.4.10 All changes to the patient’s status must be clearly documented in the patients’ electronic clinical record.

**Implementation guidelines**

Patients who are not ready for surgery – pending improvement of clinical condition, should have their care actively managed by the referring clinician, medical team and the relevant healthcare facility. Active management may reduce the time a patient is not ready for surgery and optimises fitness for surgery. It is not the responsibility nor appropriate for waitlist management to manage such patients clinically.

Active management also improves the accuracy of waiting lists by ensuring that patents who become ready for surgery again have their status on the elective surgery waiting list updated as early as possible. This approach links in with the validation and record keeping activities as described in Section 4.

## 3.5 Removing patients from the elective surgery waiting list

**Principle:**

Healthcare services exercise discretion to avoid disadvantaging patients experiencing hardship, misunderstanding and other extenuating circumstances.

**Policy**

**3.5.1 A patient may be removed from the elective surgery waiting list if they:**

* have undergone the surgical procedure for which they were referred
* are deceased
* are not contactable via phone, mail, next of kin, general practitioner and email where available
* no longer require surgery
* fail to respond to a mail audit and are un-contactable via phone, next of kin, general practitioner or email
* fail to attend for admission without prior notice
* decline treatment on two occasions
* are not ready for surgery – deferred for clinical reasons for a period exceeding the following number of days:
* 15 days for Category 1 patients
* 45 days for Category 2 patients
* 180 days for Category 3 patients
* are not ready for surgery – deferred for personal reasons for a period exceeding the following number of days:
* 15 days for Category 1 patients
* 45 days for Category 2 patients
* 180 days for Category 3 patients

3.5.2 Removals from the elective surgery waiting list by healthcare facilities, other than as a result of the patient having undergone surgery or being deceased, must be notified to the referring medical specialist and general practitioner within 10 working days.

3.5.3 Category 1 patients must not be removed without authority from the referring medical specialist.

3.5.4 All patients who are removed from the elective surgery waiting list without surgery must receive written advice within five (5) working days of their removal by the healthcare service.

## Implementation guidelines

Healthcare services should exercise discretion on a case-by-case basis to avoid disadvantaging patients experiencing hardship, a misunderstanding and other extenuating circumstances.

**Patient deceased**

* If notification is received of the death of a patient listed on the ACT elective surgery waiting list the following steps should be followed:
* confirm accuracy of patient death notification
* complete on-line ACTPAS Patient Death Notification Form found at <https://healthhub.act.gov.au/form/actpas-patient-death-notificatio>n
* document all communication and action taken in the patient’s electronic clinical record.

## Patient received surgery at another healthcare service (public or private)

* Healthcare services should ensure that they have appropriate procedures and processes in place to adequately document and confirm with the patient that they have received the awaited procedure at another healthcare service and therefore may be removed from the elective surgery waiting list.

## Patient not contactable

* Healthcare services should make reasonable attempts to contact patients before removing from the elective surgery waiting list. Healthcare services are required at a minimum, two attempts to obtain contact details from:
* the patient’s treating specialist medical practitioner
* the patient’s referring specialist medical practitioner, or nominated general practitioner
* the healthcare services medical records
* the patient’s next of kin.

## Patient declines surgery or it is no longer required

* Patients should be advised of their responsibility to notify the healthcare service when a procedure is no longer required so that they can be removed from the elective surgery waiting list.
* Any patient who is removed from a healthcare services’ elective surgery waiting list at their own request (without having undergone surgery at another facility) should be advised to contact their general practitioner to discuss the potential risks associated with not proceeding with surgery and options for alternative management.

## Failure to attend for treatment

* In consultation with the treating specialist medical practitioner and in the context of individual patient circumstances, a patient may be removed from the elective surgery waiting list if they fail to arrive for admission without providing prior notice.

## Patient repeatedly defers treatment or wishes to defer treatment for a long period

* Healthcare services should exercise discretion to distinguish between patients who are reasonably negotiating an admission date to suit their particular circumstances and those who declare themselves unavailable for treatment for prolonged period (for example, due to overseas travel).

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| Section 4 – Validation and record keeping |

## Principle:

## There is valid and reliable reporting on the performance of the elective surgery waiting list management against strategic objectives and key performance indicators readily available to the community and government.

**Policy**

4.1.2.1 Each healthcare facility should identify a person/team responsible for the oversight and monitoring of the Elective Surgery Waitlist (ESWL). Healthcare services must keep accurate records of elective surgery waiting list information including any change to a patient’s clinical urgency, ready for surgery status or scheduled admission date. The records must also include the reasons for the change, substantiating evidence where appropriate, and the name of the person who authorised the change.

4.1.3.2 Healthcare services must audit each registration on their elective surgery waiting list at least every six (6) months to ensure accurate representation of the number of patients waiting and available for surgery.

**Implementation guidelines**

Develop and document operational processes, conduct regular reviews of the ESWL, oversee administrative audits and reporting audit outcomes to the Territory Wide Surgical Management Team.

Validating the Elective Surgery Waiting List on a regular basis include:

* Identifying and removing duplicate waiting list entries
* Completing missing details in the waiting list entry.
* Reviewing registrations with a booked date in the past that remain on the ESWL.
* Identifying and contacting patients who have not confirmed their availability to attend their pre-admission clinic or booked admission date.

Evaluation of the audit process must be conducted bi-annually by the Territory Wide Surgical Management Team.

Copies of the following should be included in the patient’s electronic medical record, or on the patient’s administration system (ACTPAS):

* the elective surgery request for admission and consent to treatment form
* patient notification of registration on the elective surgery waiting list
* patient notification of a change in ready for surgery status
* each occasion of postponement of surgery and the reason
* patient notification of removal from the elective surgery waiting list
* any communication with the patient’s general practitioner.

Any change to a patient’s booking or waiting list status should be recorded in their electronic medical record including:

* change to the patient’s ready for surgery status
* change to the patient’s clinical urgency category
* removal of a patient from the healthcare service’s waiting list.

Where verbal notifications have taken place, a record of the conversation should be made in the electronic medical record and include:

* date and time of notification
* names of the people involved in the conversation
* key points of discussion.

Healthcare services should use the system in place to identify patients who are approaching time limits for not ready for surgery.

Any change to a patients booking or waiting list status should be recorded in their medical record including:

* A change to the patients ready for surgery status
* A change to the patients’ clinical urgency category
* Removal of the patient from the health service waiting list.

Healthcare services should have a system in place to identify patients who are approaching thresholds not ready for surgery – deferred personal reasons.

At the time of validation, healthcare services should contact patients with whom no communication has taken place in the preceding six months, to determine whether they still require surgery.

Documentary evidence of the elective surgery waiting list validation process should be retained by healthcare services and should include:

* Patients contacted
* Patients not contactable
* Patients who have died, including the name of the person who notified the health service that the patient has died, the cause of death, if known and the date of notification
* follow up actions if any.
* Names of staff conducting the validation process

Healthcare services must follow the relevant sections of this policy in carrying out appropriate action after validation has been undertaken including changes to the patients ready for surgery status or clinical urgency category and removals from the elective surgery waiting list.

Elective surgery waiting list data collection provides a range of reports to support the Territory Wide Surgical Services Team to manage the Territory waiting lists in accordance with this Policy and maintain data integrity of the ESWL.

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| Section 5 – Outsourcing Elective Surgery |

**Principles:**

In order to optimise access to timely elective surgery, ACT Health in consultation with healthcare facilities will develop and maintain partnerships with private providers to assist in the effective management of the territory wide elective surgery waiting list.

Request for Procurement responses for outsourcing public elective surgery will be assessed in according with the Government Procurement Act 2001 to determine best value for money.

**Policy**

* 1. If a healthcare service is unable to treat patients within the clinically recommended timeframe the option of outsourcing patients for public elective surgery via the Private Provider Program should be considered.
  2. A service agreement between ACT Healthor Canberra Health Services and the private provider should clearly identify the service with the responsibility for each aspect of clinical and administrative service provision.
  3. The contracting entity (ACT Health or Canberra Health Services) to establish and monitor the safety, quality and efficiency of service agreements with private providers to enable the transfer of patients in a timely manner.

**Implementation guidelines**

Internal options should include, at minimum:

* Increasing internal capacity at the healthcare service where the patient is waitlisted either by allocating additional operating theatre time or substituting operating theatres sessions with another specialist and/or specialty
* transfer of care from one Health employed surgeon to another within the same specialty and healthcare service. ACT public health facilities have the right to construct a single specialty elective surgery waiting list through combining or pooling waiting lists for specialties or subspecialties
* TWSS may allocate patients to any appropriately credentialed surgeon with the required scope of practice to deliver the surgery. Patients on pooled lists can expect to be treated in turn by any appropriately credentialed surgeon.

Where internal options are not possible, options for transferring patients to other public healthcare services or outsourcing to private providers should be considered as below:

External options:

1. the option for transfer to another public healthcare service that provides the services and where a shorter waiting time for elective surgery is available
2. the option for outsourcing to a private facility with appropriate service capability to deliver the service and where a shorter waiting time for elective surgery is available. It is the responsibility of the contracting entity to establish and monitor the safety, quality and efficiency of agreements with private providers to enable the transfer of patients in a timely manner.

For the purpose of clarity, the following terms are used quite distinctly to differentiate between:

* Transfers: where patients are referred from one public healthcare service to another public healthcare service for treatment
* Outsourcing: where patients are referred from a public healthcare service to a private facility for treatment.

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| Section 6 – Discretionary Funding Pool |

## Principles:

All elective procedures performed in the ACT Public Health system must be listed in the Commonwealth Medical Benefits Schedule and meet an identified clinical need to improve the health of the patient. Procedures are not to be performed for aesthetic or other non-medical reasons.

Aesthetic procedures are defined as operations and other procedures that revise or change the appearance, colour, texture, structure or position of normal bodily features with the sole intention of improving the patient’s appearance or self-esteem.”

Aesthetic procedures differ from reconstructive surgery, which is defined as surgery performed to improve abilities, function and quality of life when structures of the body have been affected by congenital and developmental defects, trauma and disease.

All elective surgical procedures performed in the ACT will follow the recommendations from the Royal Australasian College of Surgeons on hernias, blood transfusion, reflux in gastric band patients and appendicitis Refer Attachment 4.

## Policy:

* 1. All elective procedures performed in the ACT Health system must be listed in the Commonwealth Medical Benefits Schedule and meet an identified clinical need to improve the health of the patient.
  2. This policy does not include gender reassignment procedures for which there are no exceptions (adults).

## Implementation guidelines

A list of specific procedures that are not undertaken in the ACT Health system, known as excluded procedures, is provided in Attachment 5. If a medical practitioner believes that an excluded procedure is clinically indicated, approval from the Director, Territory Wide Surgical Services or nominated delegate is required before the patient can be registered on the elective surgery waiting list. Requests to register a patient onto the elective surgery waiting list must not be actioned until a decision is determined, following adherence to the process outlined below:

* When the Medical Officer wishes to apply for an exemption to the exclusion list or other aesthetic procedure. The Medical Officer must include with this application verifiable clinical evidence to support this application. For example, a patient requesting breast reduction or abdominoplasty for severe intertrigo will need a letter from a dermatologist stating this procedure is clinically required to improve this patient’s health after failure of medical therapy, or documented evidence of two admissions to healthcare service for treatment of cellulitis
* If a patient requests an excluded procedure for alleviation of significant psychiatric symptoms a letter from a Psychiatrist will need to be included with the outpatient department referral stating this procedure is required to improve the patient’s mental state. Similarly, if a patient is requesting an upper or lower eyelid blepharoplasty the Medical Officer must provide the rationale as documented in Attachment 5
* This application must be forwarded to the Director, Territory Wide Surgical Services (TWSS) ([cwls@act.gov.au](mailto:cwls@act.gov.au)) for review and endorsement. If, on the evidence supplied, the Director TWSS endorses the application, the referral/request would then be forwarded to the nominated delegate of the organisation for final endorsement following assessment at the healthcare service site to determine the capacity to undertake the procedure. It must be stressed the occasions for acceptance to undertake an excluded procedure would be rare, and patients should be counselled that there is no guarantee that exception to the excluded criteria provisions would be granted. The Director, Territory Wide Surgical Services will advise the referring treating specialist by letter if the application is not approved
* For procedures not appearing on the list, that could be interpreted as aesthetic in nature, the request should be referred to the Director, Territory Wide Surgical Services for review prior to the patient being added to the elective surgery waiting list.
* Elective surgical services need to be aware of issues that could lead to systemic inequalities of access to services particularly amongst vulnerable people and where possible focus strategies to mitigate those inequalities.

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| Evaluation |

## Outcome

Referrals to the Elective Surgery Waiting List are appropriate and within the identified guidelines.

Registrations occur within specified timeframes.

Access to surgery is equitable across all clinical urgency categories.

## Measures:

* Review of referrals to ensure that the meet the National Guidelines for Urgency Classification.
* Monitoring of registrations onto the elective surgery waiting list to ensure that they achieve key performance indicator targets.
* The principle of treat in turn is applied across all urgency categories to facilitate equitable access to surgery.

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| Related Policies, Procedures, Guidelines and Legislation |

**Policies**

* Informed Consent (Clinical)
* Clinical Records Management

**Procedures**

* Infection Prevention and Control - Healthcare Associated Infections
* Patient Identification and Procedure Matching
* Admission to Discharge
* Patient Debt Write-Off
* Inpatient Revenue Collection
* Clinical Records Management

**Guidelines**

* Fasting Guidelines – Elective and Emergency Surgery
* Pre-admission Clinic – Adutl Elective Surgery Perioperative Medication

**Legislation**

* *Health Records (Privacy and Access) Act* 1997
* *Human Rights Act* 2004
* *Work Health and Safety Act* 2011
* Australian charter of Healthcare Rights

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| References |

1. Victorian Elective Surgery Access Policy (ESAP) 2015. Victorian Department of Health
2. Elective Surgery Services Implementation Standard. Department of Health Standard QH-IMP-342-1-2017. Queensland Health.
3. MP 0050/17 - Elective Surgery Access and Waiting List Management Policy.. Department of Health. Government of Western Australia
4. Elective Surgery Policy Framework and Associated Procedural Guidelines eA507304. SA Health. Government of South Australia.
5. Royal Australian College of Surgeons – Choosing Wisely Australia

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| Definition of Terms |

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| --- | --- |
| Acceptance date | Acceptance of the request for admission will be deemed when the following are complete:   * The minimum request for admission and consent to treatment data set is completed * The request for admission and consent to treatemtn is signed and dated on page 4 * It is not an excluded procedure |
| ACTPAS | ACT Health patient administration system |
| Additions to the waiting list | As soon as a decision is made that a patient is in need of admission to the healthcare service and the admission is not required within 24 hours, the treating doctor should complete a request for admission and consent to treatment form and forward it to the healthcare service within 5 working days. The patient will be added to the electronic waiting list within 3 working days of acceptance of a complete, accurate and legible request for admission and consent to treatment form.  The date the request for admission and consent to treatment form is accepted becomes the patient’s listing date. |
| Clerical Audit | A clerical audit is a regular and routine clerical check that the information the healthcare service has of patients waiting for admission is correct. It will facilitate the identification of patients who no longer require admission or who have duplicate bookings. |
| Clinical prioritisation | The process of assigning urgency categories based on clinical need for surgery. The categories are:   |  |  | | --- | --- | | Category 1 | Procedures that are clinically indicated within 30 days | | Category 2 | Procedures that are clinically indicated within 90 days | | Category 3 | Procedures that are clinically indicated within 365 days | |
| Clinical Review | Clinical Review is the examination of a patient by a clinician after the patient has been added to the elective surgery waiting list. This examination may result in the patient being assigned a different urgency rating from the initial classification. The need for clinical review varies with a patient's condition and is therefore at the discretion of the treating clinician. |
| Elective surgery | Planned surgery that can be booked in advance as a result of a specialist clinical assessment resulting in placement on an elective surgery waiting list |
| Emergency surgery | Surgery to treat trauma or acute illness subsequent to an emergency presentation. The patient may require immediate surgery or present for surgery at a later time following this unplanned presentation. |
| Health service | Refers to public healthcare services and contracted healthcare facilities who provide access to public elective surgery patients through identified waiting list reduction programs. |
| Healthcare service - initiated postponements | Any surgical procedure that is postponed by the health service |
| Isolated Patient Travel Assistance Scheme | A NSW Government initiative which provides financial subsidies to eligible patients. |
| Managing not ready for surgery patient report | This report identifies patients whose suspension review date will become due in the following month and will assist in the active management of not ready for surgery patients. See Section 9 Managing Patient Status. |
| Medicare eligible | Patients must be identified as being eligible (or non- eligible) for treatment under the Medicare agreement for each episode, and a record of the patients Medicare number is to be made at the time of listing. |
| Medicare  Non-eligible | Patients who are not eligible for Medicare |
| Medical Record | A formal record of the patient’s treatment notes and copies of any written and verbal notifications. |
| Minimum Data Fields | Minimum amount of data required for a Request for Admission and consent to treatment form to be accepted. |
| National Elective Surgery Urgency Categorisation Guideline - April 2015 | The Guideline has been developed to promote national consistency and comparability in urgency categorisation and to improve equity of access for patients undergoing elective surgery, and acts as a reference for treating clinicians when assigning an urgency category for elective surgery procedures. The full report can be found at <https://www.aihw.gov.au/reports/hospitals/national-definitions-for-elective-surgery-urgency/contents/summary> |
| National Minimum Data Set (NMDS) | Is a minimum set of data elements agreed for mandatory collection and reporting at a national level. |
| Not ready for surgery - “deferred” for personal reasons | Patients who – for personal reasons – are not yet prepared to be admitted to  Healthcare service. For example, patients with work or other commitments that preclude them from being admitted to a healthcare service for a time |
| Not ready for surgery - “staged” patients | Patients who have undergone a procedure or other treatment and are waiting  for follow-up elective surgery, where the patient is not in a position to be admitted to healthcare service or to begin the process leading directly to admission for surgery, because the patient’s clinical condition means that the surgery is not indicated until some future, planned period of time. For example, patients who require rectal cancer surgery 6–8 weeks before neoadjuvant chemo radiotherapy for colorectal cancer. |
| Objective Connect | A Portal that provides a secure mode of delivery for the submission of requests for admission to Territory Wide Surgical Services office. |
| Outsourced patient | A patient listed on the ACT elective surgery waiting list who receives their surgery at a healthcare service that is a member of the Private Provider Panel |
| Public Patient | Patients who are eligible for Medicare and who are admitted to a public health service for treatment free of charge. Public patients have their treatment provided by a specialist medical practitioner nominated by the healthcare service, not a specialist medical practitioner of their choice. |
| Pre-admission process | Care received prior to healthcare service admission to prepare the patient for surgery.  This includes investigations that can be performed on an outpatient basis within the usual preoperative preparation process |
| Private/Chargeable patients (including DVA & WC etc.) | Patients who are admitted to a public health service and elect to be treated as a private patient. Private patients are treated by the specialist medical practitioner of their choice, and may be responsible for payments of healthcare service accommodation fees, medical and diagnostic services, prosthesis, dental fees and other related services. |
| Private Provider Panel | The Territory partners with a number of private providers who undertake delivery of public elective surgical services when required. |
| Ready for surgery | Ready for surgery is defined as patients who are prepared and able to be admitted to a healthcare service or to begin the process leading directly to admission for surgery. For example; patients are not awaiting further specialist treatment. |
| Reconstructive procedures | Surgeries performed on abdominal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumours or disease. This is usually undertaken to improve function, but may also be undertaken to approximate a normal appearance. |
| Registration on the elective surgery waiting list | The process whereby the patient is added to the ACT elective surgery waiting list to wait for the requested surgical procedure |
| Removing patients from the waiting list, other than for admission | Patients can be removed from the waiting list for reasons other than for admission:   * Patient requests removal * Patient defers treatment on 2 occasions * Patient defers & exceeds the total cumulative maximum number of Not ready for surgery days Cat 1 > 15 days; Cat 2 > 45 days; Cat 3 > 180 days * Patient not ready for surgery >365 days * Patient fails to arrive on 1 occasion, with no notice or extenuating circumstances * Patient not contactable on three separate occasions by three separate means (patient / General Practitioner / Next of Kin) * Patient deceased |
| Status Review Date (SRD) | This is the date determined for an assessment (clinical or administrative) of a deferred or staged person (i.e. not ready for surgery) to determine if the patient has become ready for admission to the healthcare service at the first available opportunity (i.e. ready for surgery). |
| Transferred patient | Is a public patient referred from one public healthcare service to another public healthcare service for treatment e.g. transfer from Calvary Public Hospital to Canberra Hospital |
| Treatment in turn | The process of treating patients with an urgent clinical need as a priority and then treating less urgent patients according to their waiting time or “in turn” within their urgency category, whenever possible. |
| Treating specialist medical practitioners | The specialist medical practitioners who perform the surgical procedures. |
| TWSS patient register | Is used to catalogue patients on ACTPAS, who are awaiting finalisation of their registration onto the elective surgery waiting list (ESWL). |
| Waiting List validation | A process to ensure that the elective surgery waiting list accurately represents the number of patients who are waiting and ready for surgery. |
| Waiting Time | Time a patient is ready for care |
| Working days | Days that fall between Monday and Friday inclusively (excluding public holidays) |

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| Search Terms |

Elective, surgery, waitlist, cancel, referral, categories, cat, 1, 2, 3, urgency *.*

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| Attachments |

Attachment 1: Common procedures not considered elective surgery

Attachment 2: Naitonal elective surgery urgency categorisaiton guideline

Attachment 3: Healthcare Service initiated postponement reasons

Attachment 4: Choosing Wisely Australia – 5 Things Clinicians and Consumers should question

Attachment 5: Excluded procedures and exceptions for surgery

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*Policy Team ONLY to complete the following:*

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| --- | --- | --- | --- |
| *Date Amended* | *Section Amended* | *Divisional Approval* | *Final Approval* |
| *14/04/2021* | *Complete Review* | *Dave Peffer, DECO, Stratergic Policy and Planning* | *CHS Policy Committee* |
| *03/02/2022* | *Amendments to clarify ready for care vs not ready for care* | *Colm Mooney, DCEO* | *Co-Chair CHS Policy Committee* |

*This document supersedes the following:*

|  |  |
| --- | --- |
| *Document Number* | *Document Name* |
| *DGD 16-015* | *Waiting Time and Elective Surgery Access Policy* |
|  |  |

# Attachment 1: Common procedures not considered Elective Surgery

The below procedures, which are taken from the National Health Data Dictionary (NHDD) are not considered to be elective surgery and are therefore not registered onto the territory wide elective surgery waiting list.

Common procedures NOT part of elective surgery:

* Biopsy of:
* Kidney (needle only) 36561-11 (1047)
* Lung (needle only) 38418-08 (550)
* Liver and gall bladder (needle only) 30409-00 (935) 30412-00 (953) 90319-01 (951) 30094-04 (964)
* Bronchoscopy (including fibre-optic bronchoscopy)
* Aesthetic surgery not attracting a Medicare rebate
* Dental procedures not attracting a Medicare rebate
* Endoscopy of:
* Biliary tract and pancreas
* Oesophagus
* Large intestine, rectum and anus
* Endovascular interventional procedures
* In vitro fertilisation
* Miscellaneous cardiac procedures
* Miscellaneous lower urinary tract procedures
* Obstetrics
* Organ or tissue transplant
* Panendoscopy (except when involving the bladder)
* Peritoneal ad renal dialysis
* Procedures associated with obstetrics (eg elective caesarean section, cervical suture)
* Other diagnostic and non-surgical procedures
* Varicose Veins – micro-injections of venular flares, multiple injections of varicose veins, interruption of sapheno-femoral junctional varicose veins, subfascial interruption of perforator veins, endovenous interruption of veins (laser therapy), re-operation of veins.

# Attachment 2: National elective surgery urgency categorisation guideline

In 2012, the Australian Institute of Health and Welfare and the Royal Australian College of Surgeons worked together to develop national definitions for elective surgery categories. The following table shows recommended urgency categories for common procedures performed in Australia. The full report can be found at <https://www.aihw.gov.au/reports/hospitals/national-definitions-for-elective-surgery-urgency/contents/summary>

| Procedure | Usual specialty | Recommended urgency category |
| --- | --- | --- |
| **CARDIO-THORACIC** | | |
| Congenital cardiac defect/s | Cardio-thoracic | 2 |
| Coronary artery bypass grafting | Cardio-thoracic | 2 |
| Heart valve replacement | Cardio-thoracic | 2 |
| Lobectomy / wedge resection / pneumonectomy | Cardio-thoracic | 1 |
| Pleurodesis | Cardio-thoracic | 2 |
| **EAR, NOSE & THROAT - HEAD AND NECK** | | |
| Adenoidectomy | Otolaryngology head & neck | 3 |
| Ethmoidectomy | Otolaryngology head & neck | 3 |
| Functional endoscopic sinus surgery | Otolaryngology head & neck | 3 |
| Grommets – insertion of | Otolaryngology head & neck | 3 |
| Laryngectomy | Otolaryngology head & neck | 1 |
| Mastoidectomy | Otolaryngology head & neck | 3 |
| Microlaryngoscopy | Otolaryngology head & neck | 2 |
| Myringoplasty/tympanoplasty | Otolaryngology head & neck | 3 |
| Myringotomy | Otolaryngology head & neck | 3 |
| Nasal cautery | Otolaryngology head & neck | 3 |
| Nasal polypectomy | Otolaryngology head & neck | 3 |
| Nasendoscopy | Otolaryngology head & neck | 2 |
| Panendoscopy | Otolaryngology head & neck | 1 |
| Parotidectomy/submandibular gland – excision of | Otolaryngology head & neck | 2 |
| Pharyngoplasty | Otolaryngology head & neck | 3 |
| Pharynx – excision of | Otolaryngology head & neck | 2 |
| Radical neck dissection | Otolaryngology head & neck | 3 |
| Rhinoplasty (indication as noted in Excluded Procedures) | Otolaryngology head & neck | 1 |
| Septoplasty | Otolaryngology head & neck | 3 |
| Stapedectomy | Otolaryngology head & neck | 3 |
| Sub-mucosal resection | Otolaryngology head & neck | 3 |
| Tonsillectomy (+/- adenoidectomy) | Otolaryngology head & neck | 3 |
| Turbinectomy | Otolaryngology head & neck | 3 |
| **GENERAL SURGERY** | | |
| Anal fissure – surgery for | General surgery | 2 |
| Axillary node dissection | General surgery | 1 |
| Breast lump – excision and/or biopsy | General surgery | 1 |
| Cholecystectomy (open/laparoscopic) | General surgery | 3 |
| Cholecystectomy (open/laparoscopic) with biliary pancreatitis | General surgery | 1 |
| Cholecystectomy (open/laparoscopic) with potential common bile duct stone or severe frequent attacks (two within 90 days) | General surgery | 2 |
| Colectomy/anterior resection/large bowel resection | General surgery | 1 |
| Fundoplication for reflux disease | General surgery | 3 |
| Haemorroidectomy | General surgery | 3 |
| Herniorrhaphy – femoral/inguinal/incisional/umbilical | General surgery | 3 |
| Lipoma – excision of | General surgery | 3 |
| Malignant skin lesion – excision of +/- grafting | General surgery | 1 |
| Mastectomy | General surgery | 1 |
| Obstructing hiatus hernia (para-oesophageal hernia) | General surgery | 2 |
| Parotidectomy /submandibular gland – excision of | General surgery | 2 |
| Parathyroidectomy | General surgery | 2 |
| Pilonidal sinus surgery | General surgery | 3 |
| Skin lesions (not malignant) – excision of | General surgery | 3 |
| Thyroidectomy/hemi-thyroidectomy | General surgery | 2 |
| **GYNAECOLOGY** | | |
| Bartholin’s abscess drainage | Gynaecology | 1 |
| Bartholin’s cyst – removal of | Gynaecology | 3 |
| Curettage and evacuation of uterus | Gynaecology | 1 |
| Colposcopy | Gynaecology | 2 |
| Cone biopsy | Gynaecology | 1 |
| Endometrial ablation | Gynaecology | 3 |
| Female sterilisation | Gynaecology | 3 |
| Hysterectomy (abdominal / vaginal / laparoscopic) | Gynaecology | 3 |
| Hysteroscopy, dilatation and curettage | Gynaecology | 2 |
| Laparoscopy for dye studies / endometriosis | Gynaecology | 3 |
| Large loop excision of the transformation zone cervix (LLETZ) | Gynaecology | 2 |
| Mirena insertion | Gynaecology | 3 |
| Myomectomy | Gynaecology | 3 |
| Salpingo-oophorectomy / oophorectomy / ovarian cystectomy | Gynaecology | 2 |
| Stress incontinence surgery | Gynaecology | 3 |
| Vaginal repair - anterior / posterior | Gynaecology | 3 |
| Warts - diathermy of | Gynaecology | 3 |
| **NEUROSURGERY** | | |
| Carpal tunnel release | Neurosurgery | 3 |
| Cerebral haematoma – evacuation of | Neurosurgery | 1 |
| Cervical discectomy and fusion unless neurological deficit | Neurosurgery | 3 |
| Chiari malformation decompression | Neurosurgery | 3 |
| Common peroneal nerve release | Neurosurgery | 2 |
| Craniotomy for removal of tumour (neurological deficit) | Neurosurgery | 1 |
| Craniotomy for removal of benign tumour (no neurological deficit) | Neurosurgery | 3 |
| Craniotomy for ruptured aneurysm | Neurosurgery | 1 |
| Craniotomy for un-ruptured aneurysm | Neurosurgery | 2 |
| Cranioplasty | Neurosurgery | 3 |
| Discectomy with foot drop | Neurosurgery | 1 |
| Intracranial lesion (for example abscess/arteriovenous malformation) – removal of | Neurosurgery | 1 |
| Laminectomy | Neurosurgery | 3 |
| Muscle biopsy/temporal artery biopsy | Neurosurgery | 1 |
| Nerve decompression of spinal cord | Neurosurgery | 2 |
| Pedicle screw fusion | Neurosurgery | 3 |
| Posterior fossa decompression for haemorrhage, tumour or syrinx | Neurosurgery | 1 |
| Untethering of spinal cord | Neurosurgery | 2 |
| Ventricular peritoneal shunt for obstructive hydrocephaly | Neurosurgery | 1 |
| Ventricular peritoneal shunt for normal pressure hydrocephaly | Neurosurgery | 2 |
| **OPHTHALMOLOGY** | | |
| Blepharoplasty (indication as noted in Excluded Procedures) | Ophthalmology | 3 |
| Cataract extraction (+/- intra-ocular lens insertion) | Ophthalmology | 3 |
| Cataract extraction (+/- intra-ocular lens insertion) with angle closure glaucoma | Ophthalmology | 1 |
| Cataract extraction (+/- intra-ocular lens Insertion) with severe disability | Ophthalmology | 2 |
| Chalazion - excision of | Ophthalmology | 3 |
| Corneal graft | Ophthalmology | 3 |
| Dacrocystorhinostomy | Ophthalmology | 3 |
| Ectropion – correction of | Ophthalmology | 3 |
| Examination of eye under anaesthesia | Ophthalmology | 2 |
| Probing of naso-lacrimal Duct | Ophthalmology | 3 |
| Pterygium - excision of | Ophthalmology | 3 |
| Ptosis – repair of | Ophthalmology | 3 |
| Squint - repair of | Ophthalmology | 3 |
| Trabeculectomy | Ophthalmology | 2 |
| Trabeculectomy with high intra ocular pressure | Ophthalmology | 1 |
| Vitrectomy (including buckling/cryotherapy) | Ophthalmology | 2 |
| Victrectomy (including buckling/cryotherapy) with retinal detachment or infection) | Ophthalmology | 1 |
| **ORTHOPAEDICS** | | |
| Anterior cruciate ligament reconstruction | Orthopaedics | 3 |
| Acromioplasty | Orthopaedics | 3 |
| Arthrodesis | Orthopaedics | 3 |
| Arthroplasty – revision of | Orthopaedics | 2 |
| Arthroscopy | Orthopaedics | 3 |
| Arthroscopy shoulder / sub acromial decompression | Orthopaedics | 3 |
| Bunion (hallux valgus) - removal of | Orthopaedics | 3 |
| Dupuytren’s contracture release | Orthopaedics | 3 |
| Exostosis – excision of | Orthopaedics | 3 |
| Fracture non-union - treatment of | Orthopaedics | 2 |
| Ganglion - excision of | Orthopaedics | 3 |
| Hammer/claw/mallet toe – correction of | Orthopaedics | 3 |
| Meniscectomy | Orthopaedics | 3 |
| Muscle or tendon length – change of | Orthopaedics | 3 |
| Nerve decompression | Orthopaedics | 2 |
| Osteotomy | Orthopaedics | 3 |
| Rotator cuff - repair of | Orthopaedics | 3 |
| Shoulder joint replacement | Orthopaedics | 3 |
| Shoulder reconstruction | Orthopaedics | 3 |
| Tendon release | Orthopaedics | 3 |
| Tenotomy of hip | Orthopaedics | 2 |
| Total hip replacement | Orthopaedics | 3 |
| Total knee replacement | Orthopaedics | 3 |
| **PAEDIATRICS** | | |
| Branchial apparatus remnant –removal of | Paediatrics | 2 |
| Circumcision (indication as noted in Excluded Procedures) | Paediatrics | 3 |
| Congenital pulmonary lesion – removal of | Paediatrics | 1 |
| Dermoid cyst - removal of | Paediatrics | 2 |
| Fundoplication | Paediatrics | 2 |
| Herniorrhaphy - epigastric/umbilical | Paediatrics | 3 |
| Hydrocoele – repair of | Paediatrics | 3 |
| Hypospadias - repair of | Paediatrics | 2 |
| Inguinal herniotomy/herniorrhaphy for age < 6 months | Paediatrics | 1 |
| Inguinal herniotomy/herniorrhaphy for age > 6 months | Paediatrics | 2 |
| Lingual or maxillary frenulum surgery | Paediatrics | 3 |
| Neonatal surgery (e.g. hirschsprungs, anorectal, malrotation, oesophageal atresia) | Paediatrics | 1 |
| Nephrectomy for congenital abnormality | Paediatrics | 2 |
| Orchidopexy | Paediatrics | 2 |
| Pectus surgery | Paediatrics | 3 |
| Pyeloplasty | Paediatrics | 2 |
| Pyogenic granuloma - removal of | Paediatrics | 1 |
| Skin lesion- excision of | Paediatrics | 3 |
| Thyroglosssal remnant –removal of | Paediatrics | 2 |
| Toenail surgery | Paediatrics | 3 |
| Ureteric - re-implantation | Paediatrics | 2 |
| **PLASTIC SURGERY** | | |
| Breast prosthesis - removal of (indication as noted in Excluded Procedures) | Plastic surgery | 2 |
| Breast reconstruction (indication as noted in Excluded Procedures) | Plastic surgery | 3 |
| Breast reduction (indication as noted in Excluded Procedures) | Plastic surgery | 3 |
| Cleft lip and palate – repair of | Plastic surgery | 3 |
| Dupuytren’s contracture release | Plastic surgery | 3 |
| Lipoma – excision of +/-grafting | Plastic surgery | 3 |
| Lymphangioma – surgery for | Plastic surgery | 3 |
| Malignant skin lesion – excision of +/- grafting | Plastic surgery | 1 |
| Rhinoplasty (indication as noted in Excluded Procedures) | Plastic surgery | 3 |
| Skin lesions, non-malignant – excision of | Plastic surgery | 3 |
| Scar revision (for reasons other than aesthetic) | Plastic surgery | 3 |
| Trigger finger / thumb release | Plastic surgery | 2 |
| **UROLOGY** | | |
| Bladder neck incision | Urology | 3 |
| Circumcision (indication as noted in Excluded Procedures) | Urology | 3 |
| Cystectomy | Urology | 1 |
| Cystoscopy | Urology | 3 |
| Epididymal cyst - removal of | Urology | 3 |
| Hydrocele - repair of | Urology | 3 |
| Hyposadias – repair of | Urology | 3 |
| Lithotripsy | Urology | 2 |
| Meatoplasty | Urology | 3 |
| Nephrectomy | Urology | 1\* |
| Orchidectomy | Urology | 1 |
| Orchidopexy | Urology | 3 |
| Prostatectomy (transurethral or open) for benign disease | Urology | 3\* |
| Prostate biopsy | Urology | 1 |
| Pyeloplasty | Urology | 2 |
| Retrograde pyelogram | Urology | 2 |
| Stone/s urinary tract – removal of | Urology | 2\* |
| Uretero-pelvic junction - correction of | Urology | 2 |
| Ureters re-implantation | Urology | 3 |
| Ureteric stent - insertion of | Urology | 1 |
| Urethra – dilatation of | Urology | 2 |
| **VASCULAR** | | |
| Abdominal or thoracic aortic aneurysm by any means | Vascular | 1 |
| B9Amputation of limb | Vascular | 1 |
| Bifurcated aortic graft | Vascular | 1 |
| Carotid endarterectomy | Vascular | 1 |
| Dialysis access surgery | Vascular | 2 |
| Femoro-popliteal bypass graft | Vascular | 2 |

# Attachment 3: Healthcare service initiated postponement reasons

|  |
| --- |
| SWL Anaesthetist away insufficient notice |
| SWL Anaesthetist away sufficient notice |
| SWL Anaesthetist Sick |
| SWL Anaesthetist Unavailable - HIP |
| SWL Booked in error |
| SWL Brought Forward |
| SWL Cancelled by Anaesthetist |
| SWL Contraindication |
| SWL Deceased |
| SWL Did not arrive |
| SWL Did not attend PAC |
| SWL Elective List Overrun |
| SWL Equipment Unavailable |
| SWL List Overbooked |
| SWL More urgent patient |
| SWL Move to AM/PM list |
| SWL No Bed |
| SWL No ICU Bed |
| SWL Nursing shortage |
| SWL Other |
| SWL Postponement due to list planning |
| SWL Procedure already done |
| SWL Procedure cancelled due to acute medical condition |
| SWL Procedure cancelled due to pre-existing medical condition |
| SWL Procedure no longer required |
| SWL Refused date |
| SWL Session Cancelled by Surgical Bookings |
| SWL Substituted by more urgent Category 1 patient |
| SWL Substituted by more urgent Category 2 patient |
| SWL Substituted by more urgent emergency/non-elective patient |
| SWL Surgeon away insufficient notice |
| SWL Surgeon away sufficient notice |
| SWL Surgeon Sick |
| SWL Transferred |

# Attachment 4: 5 Things Cllinicians and Consumers should question

Developed by the Royal Australian College of Surgeons

|  |  |
| --- | --- |
| Don’t perform repair of minimally symptomatic or asymptomatic inguinal hernias without careful consideration, particularly in patients who have significant co-morbidities | The proportion of patients presenting with ingional hernias who are suffering significant co-morbidities is increasing, In these populations and in the presence of multiple co-morbidities the importance of carefully assessing the risk and benefits of surgical internvention is vital, Stuidies have shown that adoption of a watch and wait approach does not heighten the risk of the patient developing more sever sumptoms. In cases of minimally symptomatic and asymptomatic inguinal hernias, the patients prognosis and long term health may be improved by non-surgical intervention. Ongoing surgical review is required to ensure that an individuals conditions is monitored and that a re-evaluation of their surgical needs is made should their symptoms increase in severity. |
| Do not use ultrasound for the further investigation of clinical apparent groing hernias. Ultrasound should not be used as a justification for repair of hernias that are not clinically apparent. | The role of ultrasound in the diagnosis and treatment of groin hernis is limited, When the clinical diagnosis of a groin hernia is uncertain, any sonographic findings should be interpreted in conjunction with clinical judgements and treated conservatively. The diagnostic accuracy of ultrasound is reduced in the absence of any clinicaly palpable herna. |
| Don’t transfuse more units of blood than absolutely necessary, noting that mny hospitals have developed policies on indications for transfusion with a view to minimisation. | The limited blood resources available within the health system and the lack of evidence to support transfusing more blood than required necessitate the use of appropriate guidelines. Patietns should be carefully evaluated (through use of applicable guidelines) when being assess for blood transfusions and closely monitoried. |
| Don’t use endoscopy for investigation in gastric band patietns with symptoms of reflux. | The treatment of reflux in gastric band patients should be carefully considered, Endoscopy should not be used without consideration of alternative stratetigies. Reflux in gastric band patients is often related to the device. It is best managed by removal of fluid, in consultation with a Bariatric Surgeon or other appropropriately qualified person. |
| Don’t do computed tomography (CT) for the evaluation of suspected appendicitis in children and young adults until after ultrasound has been considered as an option. | Although CT is accurate in the evaluation of suspected appendicitis in the paedicatric population, ultrasound is a good diagnostic tool that will reduce radiation exposure. Ultrasound is the preferred initial consideration for imaging examindation in children and young adults. If the results of the ultrasound exam are equivocal, it may be followed by CT. |

# Attachment 5: Excluded procedures and exceptions for surgery

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| **Face and head** | |
| Procedure | Exception |
| Facelifts / Meloplasty | Nil |
| Correction of bat ear(s)) | Patient is less than 16 years |
| Hair transplant | Nil |
| Reduction of upper or lower eyelids (blepharoplasty) | * Vision obscured as evidenced by upper eyelid skin resting on lashes on straight ahead gaze * Herniation of orbital fat in exophthalmos * Facial nerve palsy or post traumatic scarring * Restoration of symmetry of contralateral eyelid in respect of one of the above conditions |
| Rhinoplasty/rhino septoplasty | Patient has significant deformity and surgery is indicated due to disease, trauma or congenital conditions |
| **Breast** | |
| Procedure | Exception |
| Reduction (mammoplasty) (bilateral/unilateral) | * Gross breast asymmetry in patients under 21 * Virginal Hyperplasia/Hypertrophy |
| Breast augmentation  (bilateral/unilateral) | Post mastectomy reconstruction  +/- Augmentation for contra lateral breast Poland syndrome  Patient has significant deformity and surgery is indicated due to disease, trauma or congenital disorders |
| Replacement breast prosthesis | * Replacement for post cancer patients only |
| Nipple and/or nipple reconstruction | * When performed as part of a breast reconstruction due to disease or trauma, but not as the result of previous surgery |
| **Trunk and Limbs** | |
| Procedure | Exception |
| Abdominoplasty/  Abdominal lipectomy/  Apronectomy | * Post morbid obesity treatment where significant clinical symptoms are present (intractable intertrigo) and BMI is less than 30 |
| Varicose Vein procedures | CEAP Grade 4, 5, and 6 |
| Other skin excisions for body contour, for example, buttock, thigh or arm lift | Post morbid obesity treatment where significant clinical symptoms are present (intractable intertrigo) and BMI is less than 30 |
| Liposuction | Post traumatic pseudolipoma  Lipodystrophy  Gynaecomastia  Lymphoedema  Flap reduction |
| **Genitourinary** | |
| Procedure | Exception |
| Reversal of sterilisation | Nil medical indications |
| Circumcision | For medical indications only (for example. phimosis, paraphimosis, recurrent balanitis, Frenulum breve) |
| Insertion of artificial erection devices | Nil |
| Gender reassignment surgery | Congenital abnormalities in children |
| Phalloplasty | Congenital abnormalities in children |
| Labioplasty | Nil |
| **Other** | |
| Procedure | Exceptions |
| Bariatric Surgery | Referred from the Obesity Management Service |
| Removal of benign moles, skin tags, revision of scar, removal of keloid scarring, removal of sebaceous cyst, or any skin abnormality deemed to be wholly aesthetic in nature | Nil |
| Candela Laser | Congenital abnormality – paediatrics < 17 years |
| Skin laser photocoagulation | Nil |
| Tattoo removal procedures | Nil |

1. 1 METeOR, Metadata Online registry (glossary item) Endorsed by ACT Health July 2018

   2 National Elective Surgery Urgency Categorisation Guideline - April 2015 [↑](#footnote-ref-1)