Government of Western Australia
Department of Health

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Elective Surgery Access and Waiting List Management Policy

1. Purpose

The Elective Surgery Access and Waiting List Management Policy (the Policy) reflects the WA health system's strong commitment to the delivery of quality patient-focused elective surgery services. The purpose of this policy is to:

- Define the responsibilities of Health Service Providers (HSPs), hospitals and key personnel with regards to the delivery of elective surgery services
- Ensure a consistent and structured approach to the efficient management of elective surgery waiting lists (ESWLs)
- Support timely and equitable patient access to elective surgery services in accordance with clinical need
- Support provision of patient-centred elective surgery services

This is a mandatory policy under the Clinical Services Planning and Programs Policy Framework.

It should also be read in conjunction with the following documents:

- WA Health Consent to Treatment Policy (2016)
- WA Health Central Referral Service Policy (2014)
- WA Health Specialist Outpatient Services Access Policy (2014)
- Admission Readmission Discharge and Transfer Policy (2017)
- WA Aboriginal Health and Wellbeing Framework 2015-2030

This Policy supersedes:

- OD 0608/15 Elective Surgery Access and Waiting List Management Policy (2015)
- OD 0402/12 Plan for access to Surgical Procedures for Obesity for Public Patients
- OD 0472/13 Excluded Procedures and
- OD 0375/12 Elective Surgery Access Policy – Maintaining the principle of 'first on first off' for elective surgery cases and minimum waiting periods for Categories 2 and 3.

2. Applicability

This Policy applies to HSPs and their staff members and contracted health entities, where they are involved in the delivery of public elective surgery services. This includes elective surgery services provided by HSPs to patients that elect to be treated as private patients.

Elective surgery refers to planned surgery that can be booked in advance as a result of a specialist assessment resulting in placement on an ESWL. 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, which do not meet the above definition of elective surgery:
    - Gastroscopy
    - Colonoscopy
    - Hepatobiliary endoscopy
    - Endovascular procedures
    - Interventional cardiac procedures
    - Organ/tissue transplant
    - Dental procedures requiring admission.

All elective 'cosmetic' or 'excluded' procedures performed in the public system for approved medical reasons (Section 3.3.8) are within the scope of this policy.

Where HSPs choose to manage additional 'non-reportable' procedure groups via ESWLs, these procedures are to be managed in accordance with the principles outlined in this Policy. Where possible and practical, all other elective procedures requiring admission should be managed via ESWLs.

3. Policy requirements

3.1 Principles

3.1.1 Active Waiting List Management

Waiting lists are actively managed by hospitals to ensure all patients are treated in clinically appropriate timeframes and that ESWL management practices are transparent, efficient and patient-focused.

3.1.2 Access Equity

All patients are to be prioritised based on their assigned clinical urgency category, individual clinical urgency and length of wait. Where no clinical urgency differentiation exists within categories, patients are to be treated in order of their registration onto the waiting list in accordance with the 'first on, first off' principle.

All Medicare-eligible patients receiving public healthcare services in Western Australian hospitals can choose to receive free care as a public patient, or to be treated as a private patient with an associated cost. Regardless of financial status, all patients receiving treatment in a hospital within the WA health system are to receive the same high quality of care and treatment, and access to hospital services.

3.1.3 Timeliness of Surgery

HSPs are to ensure patients are managed and treated within the assigned clinical urgency category timeframe:

- 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.

3.1.4 Safety and Quality

HSPs are responsible for ensuring procedures and processes are in place to optimise the safety and quality of the elective surgery journey. These should be monitored and reviewed via continuous quality improvement and service improvement processes.

3.2 Roles and Responsibilities

In order to facilitate safe and timely patient access to elective surgery services, HSPs and contracted health entities are responsible for:

- ensuring appropriate resources and infrastructure essential to the efficient operation of elective surgery services are available
- nominating, in writing, an Accountable Officer for the elective surgery waiting list at each hospital where elective surgery is offered
- ensuring mechanisms are in place for managing patient load across hospitals
- ensuring processes are in place for optimising utilisation of available theatre resources and minimising hospital-initiated postponements
- developing local policies and guidelines to support operations in alignment with this Policy
- ensuring processes are in place for efficient waitlist management, including regular waitlist audits
- monitoring performance relating to elective surgery access
- implementing initiatives to address identified access or quality issues
- validating data provided to WA Health Inpatient Data Collections
- auditing compliance with this Policy

Further details relating to specific roles and responsibilities in the management of elective surgery waiting lists are available in the supporting document Elective Surgery Waitlist Management Roles and Responsibilities.

3.3 Elective Surgery Waiting List Referral Management

3.3.1 Referral Sources

The responsibility to appropriately refer a patient to the ESWL in accordance with this Policy lies with the treating Specialist.

Before a patient referral can be registered onto the ESWL the patient should have first received a medical Specialist assessment that has determined the patient requires elective surgery from:

- a medical Specialist working in a hospital outpatient clinic
- a medical Specialist working in a private consulting room and who has admitting and operating rights to the hospital (Section 3.3.4).

Where direct access referral pathways have been established, referrals for certain procedures may be accepted without a Specialist assessment.

3.3.2 Mandatory Referral Content

The referring Specialist must submit a request for admission to the hospital waitlist team or equivalent. . Requests must be written or electronic and should include the mandatory patient information listed below.

Requests that do not contain the mandatory information will either be returned to the referring Specialist for completion as soon as possible, or the Specialist and/or patient will be contacted to ascertain the missing details and facilitate the patient's timely access to elective surgery.

Mandatory Referral Content

- Patient's full name (including alias or maiden name where relevant), Patient's residential address (and mailing address if different)
- Patient's telephone number/s
- Patient's date of birth
- Next of kin/carer/guardian/local contact for paediatric referrals
- Contact details for patient's General Practitioner (GP)
- Medicare Number and expiry date (excludes patients from correctional facilities and Medicare ineligible patients)
- Past medical history including details of previous treatment and investigations including radiology, pathology, procedures and other relevant results
- Allergies
- Relevant clinical details
- Co-morbidities
- Weight and/or BMI
- Medication advice (including current medications and any known medication allergies)
- Request date
- Referring clinician
- Source of referral
- Principal procedure
- Clinical urgency category
- Anaesthetic type
- Estimated operation duration

Direct access procedure requests may be accepted without all of the above information, where it would not be clinically appropriate for a referrer external to the WA health system (e.g. GP) to provide this.

3.3.3 Consent for Procedure

Patient consent must be obtained before registration onto the ESWL. The Specialist completing the request for admission is responsible for obtaining the patient's consent. Consent must be confirmed in writing using an approved hospital patient consent form.

Where direct access models of care have been developed to facilitate access to services without a prior Specialist assessment (e.g. diagnostic endoscopy), arrangements for the timing to obtain patient consent may be modified.

A copy of the consent for treatment must be held in the patient's medical record. Further details relating to documentation of consent are available in the WA Health Consent to Treatment Policy (2016).

3.3.4 Patients Referred from Private Consulting Rooms

Requests to register a patient onto the ESWL by a Specialist working from private consulting rooms who has admitting and operating rights at the hospital to which the patient is to be admitted for their elective procedure will:

- Not be referred to a public outpatient clinic for review prior to registration on the ESWL unless further clinical assessment by another specialty is required (e.g. complex patients with co-morbidities)
- Be accompanied by relevant documentation regarding registration on the ESWL (e.g. completed requests for admission, patient notes, and imaging and patient consent form).

Where no clinical urgency differentiation or exceptional circumstances exist, patients referred from private consulting rooms for registration onto the ESWL are to be clinically prioritised and managed in accordance with this Policy and the 'first on, first off' principle.

3.3.5 Clinical Urgency Categorisation

An urgency category must be assigned before the patient is registered onto the ESWL. The treating Specialist is responsible for assigning one of the following urgency categories, as per the National Definitions for Elective Surgery Urgency Categories (2013):

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.

The assigned urgency category should:

- be appropriate to the patient and their clinical condition and
- not be influenced by the availability of the hospital or surgeon resources, or the patient's financial election.

A list of high volume procedures for each specialty with the recommended urgency categorisation are provided in the National Elective Surgery Urgency Categorisation Guideline (2015). A summary of usual urgency categories for common procedures, as advised in the Guideline, is provided in Appendices 3 and 4. Hospitals are responsible for monitoring and

managing compliance with the Guideline.

If clinically indicated, the treating Specialist may change an assigned urgency category to reflect a change in the patient's clinical needs, however approval from hospital Executive or a delegate must be sought and the reason documented on the Patient Administration System (PAS) and the patient's medical record, if available. The patient is also to be notified of the change.

3.3.6 Registering Patients onto the Elective Surgery Waiting List

Procedures that are to be registered onto the ESWL are outlined in Section 2.

Following submission of a request for admission and patient consent form, the receiving hospital must determine whether the request is to be accepted or refused within five (5) working days.

If an admission request is refused, the hospital must inform the referring Specialist of the reason for refusal.

Grounds for refusal include:

- The request for admission has missing information (Section 3.3.2)
- The request for admission is for an excluded procedure without a strong clinical indication (Section 3.3.8)
- The patient has a duplicate waiting list entry (Section 3.3.11)
- The patient is ineligible for the provision of treatment (Refer to WA Health Fees and Charges Manual).

If the decision of refusal is upheld it is the responsibility of the referring Specialist to advise the patient of this. The decision must be documented in the PAS, as well as the patient's medical record, where available.

If a request is accepted, the patient must be registered onto the ESWL within that same period of five (5) working days. The date on which the admission request is first received by the hospital is the date used for ESWL registration.

Patients must be registered on the ESWL at the hospital best matched to their care requirements based on complexity, medical workforce, hospital capacity, location and waiting time. If a patient is allocated to a tertiary hospital, a reason must be specified and recorded on the relevant PAS.

The capacity to admit the patient within the clinically recommended timeframe should be considered when determining the appropriate location for the patient's care. However, this must not delay registration onto the ESWL, which is to occur within five (5) working days irrespective of anticipated waiting times.

Patients who will not be able to undergo surgery within 365 days must not be waitlisted (e.g. where post-operative recovery and rehabilitation prevents further surgery).

Registering Category 1 Patients onto the ESWL

A scheduled admission date is to be provided to all Category 1 patients at time of registration onto the ESWL. If a date is not available within the clinically recommended 30 day timeframe,

the patient must be given the earliest available date. Category 1 patients must be notified of the date once the date for surgery has been allocated. Hospitals must conduct weekly reviews of the waitlist to actively monitor this patient cohort.

3.3.7 Listing Status

When a patient is registered on the ESWL, the patient's readiness to undergo their procedure must be reflected by selecting the appropriate Listing Status:

1. Ready for Surgery
2. Not Ready For Surgery - Pending Improvement of Clinical Condition
3. Not Ready For Surgery - Deferred For Personal Reasons
4. Not Ready For Surgery - Staged Patients

Ready for surgery

As specified in the National Definitions for Elective Surgery Urgency Categories (2013), for the patient to be listed on the ESWL as 'Ready for Surgery', the patient must be "prepared to be admitted to hospital or to begin the process leading directly to admission for surgery. The process leading to surgery could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests."

Only patients listed as Ready for Surgery are included in state-wide elective surgery performance reporting.

Not Ready for Surgery

The three (3) 'Not Ready for Surgery' listing status options are described below. A "Not Ready for Surgery" listing status must be used only if the patient is unable to undergo their procedure due to their individual clinical or personal circumstances. A "Not Ready for Surgery" status should not be used for waitlist management purposes (e.g. indicating surgeon or theatre unavailability) as this results in inaccurate reporting of the patient's overall waiting time on the ESWL.

The relevant date fields in the PAS must be completed to ensure that the time period when the patient is not ready for surgery is accurately recorded.

Patients must be informed that while they are listed as 'not ready for surgery' they are not considered to be waiting for surgery. Hospitals must actively monitor 'not ready for surgery' patients to ensure they become ready for surgery and receive their elective surgery procedure or alternatively, are removed from the ESWL.

Not Ready For Surgery – Pending Improvement of Clinical Condition

This includes patients for whom surgery is indicated, but because of a medical condition, require treatment or management (or simply time to pass) for the patient to be suitable for the surgery.

Examples include patients who require a cardiac 'work-up' before a total hip replacement or

patients with respiratory insufficiency that require physiotherapy to maximise respiratory function before a hernia repair.

For such patients, a decision has already been made that surgery should take place. Patients should not be regarded as 'Not Ready for Surgery - Pending Improvement of Clinical Condition' when they are undergoing assessment to determine the patient's requirement or suitability for surgery.

The patient's nominated GP should be advised if the patient has been listed as 'Not Ready for Surgery – Pending Improvement of Clinical Condition', where a significant delay in care is anticipated and/or for clinical issues potentially requiring management by the GP. Where care is delayed for a short period for minor health complaints (e.g. upper respiratory tract infection, gastroenteritis) GP notification is not required.

Not Ready For Surgery – Deferred For Personal Reasons

This includes patients for whom surgery is indicated but for personal (non-clinical) reasons are not yet prepared to be admitted to hospital. This includes patients with work or other commitments that preclude their being admitted to hospital for a period of time. For example:

- inadequate home support post operatively for self
- caring for another person and unable to secure respite care
- holiday planned
- work commitment.

Category 1 patients should not be deferred for personal reasons if this results in the patient not receiving surgery within 30 days of registration onto the ESWL. If deferral of a Category 1 case is being contemplated and is likely to result in the patient not being treated within 30 days, the treating Specialist must review the case.

The maximum cumulative length of time for a patient deferring their procedure for personal reasons is:

- Category 1 - 15 days
- Category 2 - 45 days
- Category 3 - 120 days.

Patients who have exceeded these timeframes may require clinical advice/management by the treating Specialist or GP, or removal from the ESWL. The hospital must contact patients and review cases that are listed as deferred in excess of the above timeframes to ensure that the patient becomes ready for surgery or is removed from the ESWL.

Patients listed as 'Not Ready for Surgery – Deferred for Personal Reasons' must be advised that:

- they are listed as deferred
- the maximum deferred times (as above) for their urgency category
- each episode of deferred status accumulates towards total deferred time
- exceeding maximum deferred time may result in their removal from the waiting list.

Not Ready For Surgery - Staged Patients

This includes patients who have undergone a procedure or some other treatment and are waiting for follow-up elective surgery that needs to occur at a particular, known time in the future.

Examples include:

- a patient who has had internal fixation of a fracture and will require removal of the fixation device after three months
- a patient who requires a 'check' cystoscopy to check for cancer 12 months after surgery to remove a bladder tumour
- a patient requiring rectal cancer surgery six weeks after neoadjuvant chemo-radiotherapy for colorectal cancer.

3.3.8 Excluded Procedures

All elective procedures performed in the WA health system must meet an identified clinical need to improve the health of the patient. Procedures are not to be performed for cosmetic or other non-medical reasons. A list of specific procedures that are not routinely performed in the WA health system, known as excluded procedures, is provided in Appendix 3.

If a medical practitioner believes that an excluded procedure is clinically indicated, approval is required before the patient can be registered on the ESWL. Requests to register a patient onto the ESWL must not be actioned until a decision is determined, following adherence to the process outlined below:

1. Refer the case to the Director of Medical/Clinical Services, or their appropriately qualified delegate, who will review the circumstances.

    1.1 Information provided must include, at a minimum, the name and practice address of the doctor, the name, medical record number (if allocated), date of birth and sex of the patient, details of the proposed procedure, relevant clinical history and details of any other procedures which are planned at the same time.

    1.2 The review may include examination by an independent clinician or review by another relevant advisor, in which case this is to be arranged by the Director of Medical/ Clinical Services or delegate.

2. The decision of the Director of Medical/Clinical Services is to be communicated in writing to the medical practitioner. A copy of this decision is to be placed in the patient's medical record for review as required.

3. Should the decision of the Director of Medical/Clinical Services be disputed by the medical practitioner, the case should be referred by the Director of Medical/Clinical Services in writing, including all pertinent details, to the Chief Medical Officer who is to review the circumstances.

4. The decision of the Chief Medical Officer is to be communicated in writing to the Director of Medical/Clinical Services, who will communicate this to the medical practitioner. A copy of this decision is to be placed on the patient's medical record, and a copy maintained at the Health Service for review as required.

Since patients cannot undergo a procedure without the willing participation of a hospital and a treating doctor, patients are not permitted to make applications or appeals on their own behalf.

Once a request for an excluded procedure has been approved via the above process, the patient must be registered on the ESWL and subsequently managed as per the principles outlined in this Policy, including the 'first on, first off' principle.

3.3.9 Bariatric Surgery

The WA health system is committed to addressing the health burden caused by obesity and standardising access to publically funded bariatric surgery (i.e. surgery for the purpose of achieving weight loss). Due to the high demand and potential risks involved for this group of surgical procedures, patients must meet strict access criteria, as outlined in Appendix 4.

3.3.10 Multiple Waiting List Entries

Multiple wait list entries are to be accepted if the treatments/procedures are independent of each other (e.g. cataract extraction and joint replacement). The patient's ability to undergo multiple surgical procedures within a short period of time must be considered before registration on ESWL.

If an ESWL entry already exists for the same procedure (duplicate referral), the request must be refused (Section 3.3.11).

With regards to patients being wait listed for multiple procedures:

- bilateral procedures are not both to be listed as Ready for Surgery unless the procedures are being completed on the same day
- procedures that are not planned for completion within 365 days must not be waitlisted
- where a patient is admitted for one of their waitlisted procedures, the ESWL Accountable Officer, in consultation with the relevant treating Specialist/s must determine if the patient is to be deemed 'Not Ready for Surgery' for the other waitlisted procedure(s) while the patient is convalescing.

3.3.11 Duplicate Waiting List Entries

Patients must not be listed for the same procedure at different hospitals. A duplicate waitlist entry for the same procedure poses a serious safety and quality risk as the patient may present at the second hospital for a surgical procedure which has already been performed.

When a duplicate request to register a patient onto the ESWL for the same procedure at a different hospital becomes known, the new request must be refused. If it is identified that a patient has been registered on the ESWL for the same procedure at multiple hospitals, all but one of the waitlist events must be removed following consultation between the relevant hospitals and the patient. In both cases the patient, their GP and the referring Specialist are to be advised of the situation and the duplicate booking policy.

Elective Services Wait List Data Collection provides reports that identify potential duplicate wait list entries, to assist hospitals in appropriately managing duplicate cases.

3.3.12 Transferring Requests for Registration on the ESWL

When a request to register a patient onto the ESWL is received and the hospital determines the current treating Specialist is unable or is unlikely to be able to provide the procedure within the assigned clinical urgency category timeframe the hospital must (where

feasible):

- transfer the patient from one Specialist to another equivalently credentialed Specialist within the same hospital
- transfer the patient to another hospital and Specialist that is equivalently credentialed to perform the procedure where a shorter waiting time to admission is available
- consider theatre utilisation and the option of additional sessions, or
- consider transferring the patient to a private provider.

Public patients who decline transfer to another Specialist or hospital must be considered as declining an offer of treatment (Section 3.4.3).

Patients referred from a Specialist working from private consulting rooms who indicate that they will elect to be admitted as private patients may choose whether to accept the transfer to another Specialist or hospital.

Consent must be obtained from the private patient and the referring Specialist prior to transfer to another Specialist or hospital. Private patients who decline transfer to another Specialist or hospital are not to be considered as declining an offer of treatment.

The hospital is to liaise with the patient, the GP and referring Specialist regarding the transfer arrangement and the patient's registration onto the ESWL at the receiving hospital.

When a procedure request is transferred to another hospital/Specialist and the patient requires further medical assessment there will be no additional cost to the patient. The date on the initial request for registration onto the ESWL must be transferred and maintained with the patient to the receiving hospital ESWL to ensure the waiting time is accurately captured and to ensure equitable patient management.

A record of the patient's decision is to be entered in the PAS for audit and reporting purposes.

3.3.13 Consent to Share Patient Information with GP

Information relevant to the continuing care and management of a patient on the ESWL is to be shared with the patient's nominated GP, unless the patient expressly does not consent. The patient's decision to share information (or not) with their GP is to be documented in the patient medical record and recorded in the PAS.

3.3.14 Communicating Information

Hospitals must communicate timely and meaningful information to patients, carers and GPs, ensuring patients are advised of their rights and responsibilities while waiting for their elective procedure, including information about circumstances that may result in removal from the ESWL. Hospitals may contact patients by telephone, letter or other appropriate methods.

A scheduled admission date is to be provided to all Category 1 patients at time of registration onto the ESWL. If a date is not available within the clinically recommended 30 day timeframe, the patient must be given the earliest available date. Category 2 and 3 patients must be notified in writing within five (5) working days of the request that they have been registered on the ESWL.

Hospitals must ensure that information relevant to a patient's treatment/admission is available in languages other than English, as required. Strategies are also to be in place for providing information for patients with visual impairment, hearing deficit, low literacy and patients from culturally and linguistically diverse backgrounds.

Patients must be notified in writing when their elective surgery is scheduled and of a requirement to attend any pre-admission clinic. In the case of Short Notice patients being contacted to fill vacancies created by cancellations (see Section 3.4.11), this notification may occur by telephone.

Hospitals must notify the patient of any changes to their status on the ESWL either in writing or by telephone.

Hospitals must ensure that an up-to-date record of all communication is maintained in the PAS and in the patient's medical record, where available.

GP Information

The hospital is to notify the patient's nominated GP in writing within five (5) days of the request for registration onto the ESWL unless the patient does not give consent to do this. The letter must include:

- patient's name and address
- proposed procedure
- urgency category and definition
- contact number for information about the waiting list
- who to contact if clinical condition changes.

3.3.15 Patients from Correctional & Forensic Secure Mental Health Facilities

Patients from correctional or forensic secure mental health facilities are afforded the same treatment available as the wider population. However, for security reasons, these patients and their relatives must not be informed of admission details (e.g. booked or expected procedure date). These patients may be advised that at some time in the future they will attend a hospital for surgery.

The details of the dates for admission and surgery must be directly conveyed to the relevant accountable authority at the correctional facility or forensic secure mental health facility.

3.4 Managing the Elective Surgery Waiting List

Hospitals must actively manage their ESWLs to provide patients with timely and appropriate access to elective surgery. This requires a WA health system-wide approach to waitlist management and co-ordinated care, cognisant of the workforce, infrastructure and case complexity considerations incumbent in elective surgery management.

3.4.1 Keeping Fit for Surgery

The responsibility for keeping fit for surgery is a collaborative commitment between the patient, the treating Specialist, the hospital and the GP.

The Specialist / hospital ESWL staff are to work with the patient to ensure that they:

- meet pre-operative health requirements necessary for surgery to proceed
- know what to do if they believe their condition has deteriorated while waiting for surgery
- know how to best manage their condition while waiting for elective surgery
- are able to access services, and are aware of the role of their GP in helping them to maintain general health.

3.4.2 Hospital-Initiated Postponements

A hospital-initiated postponement is defined as any rescheduling of a patient's confirmed admission date due to the inability of the hospital to deliver the required service. The hospital may need to postpone surgery due to unforeseen circumstances (e.g. major trauma, unplanned staff leave), or other factors relating to human resources, equipment or facilities that may compromise the safety and quality care of the patient.

Category 1 patients who have arrived at the hospital for their elective procedure must not be postponed without the approval of the hospital Executive acting under delegation from the Chief Executive.

When a hospital initiates the postponement of a patient's elective procedure, the hospital must:

- give the patient as much notice as possible
- make arrangements for the procedure to be undertaken as soon as possible; or transfer the patient to another Specialist/hospital with a shorter wait time.

The patient must be advised of:

- the reason for the postponement
- the rescheduled admission date (must be provided immediately for Category 1 patients)
- any changes to the intended Specialist/hospital providing the treatment
- what they should do if their condition deteriorates
- the opportunity to discuss with a doctor any medical issues that might arise as a result of the postponement of surgery (as clinically required – e.g. patients requiring advice regarding re-commencement of anti-coagulant medication).

The hospital is to ensure that a record of changes and communication is maintained on the PAS and the patient's medical record, where available.

A patient must not be postponed a second time without the express approval of the Hospital Executive acting under delegation from the Chief Executive. A patient should not under any circumstance be postponed a third time.

3.4.3 Patient-Initiated Postponements

A patient who requires postponement of a confirmed booking for surgery due to personal reasons (i.e. not ready for surgery – deferred for personal reasons) can defer treatment (see Section 3.3.7).

A patient who initiates a second postponement, defers an admission date for surgery a second time, declines an available surgery date on two occasions, or fails to arrive for surgery on the scheduled admission date for a second time without prior notice and without good

cause must be removed from the ESWL. Where good cause is given, ESWL staff are to work with the Specialist and the patient to reschedule their procedure.

In the case of Category 1 patients, a clinical review is required prior to removal from the ESWL. Category 1 patients should not be deferred if this results in the patient not receiving surgery within 30 days from the date of registration onto the ESWL.

The hospital is to exercise discretion to distinguish between patients who negotiate an admission date due to extenuating circumstances and those who declare themselves 'not ready for surgery' for a prolonged period.

The hospital must record patient-initiated postponements on the PAS.

3.4.4 Patients Who Fail To Attend For Treatment

A patient must be removed from the ESWL following the patient's second failure to attend without good cause and without prior notice to the hospital. This includes the failure to attend pre-admission outpatient clinic appointments.

The hospital should exercise discretion on a case-by-case basis to avoid disadvantaging patients in the case of genuine hardship, misunderstanding and other unavoidable circumstances.

The hospital must have robust procedures to administratively and clinically manage patients who fail to attend.

3.4.5 Patients Who Are Not Contactable

Once registered on the ESWL, the patient is to be informed of their responsibility to notify the hospital of any changes to their contact details and the outcome for failing to do so.

Patients who are not contactable by the hospital must be removed from the ESWL, provided the hospital has made reasonable attempts to contact the patient. This includes attempts to identify the patient's correct contact details via:

- the patient's treating Specialist
- the patient's GP
- the hospital's medical records.

Other sources of information may include a telephone directory search and in some circumstances, contact with next of kin (e.g. minors).

3.4.6 Patients Who Request Removal from the ESWL

A patient who indicates that they no longer wish to receive treatment at the hospital is to be removed from the ESWL, subject to the requirements described in Section 3.3.7.

3.4.7 Removing Patients from the ESWL

Category 2 and 3 patients who meet the criteria for removal from the ESWL must be automatically removed, with advice to contact their referring GP or Specialist in the event that they wish to proceed with treatment at a later date, or if their condition deteriorates.

Category 1 patients who request a second postponement, fail to attend a second treatment date

or request removal from the ESWL must be brought to the attention of the treating Specialist and/or relevant Head of Department. Depending on the patient's diagnosis, the treating Specialist or Head of Department may request that the patient attend a clinical review for re-assessment of their condition and to discuss the consequences of not proceeding with surgery.

If the patient's removal from the ESWL is deemed to carry significant risk to the patient's health, the hospital may consider deferring the patient's surgery. This option is to be discussed with the patient at the time of clinical review.

Notification of Removal

Patients who are removed from the ESWL must receive written notification of their removal by the hospital that clearly states:

- the reason for the removal
- who the patient should contact if they have a query or concern.

The hospital must also notify the patient's Specialist and nominated GP within five (5) working days of removal.

Documentation of Removal

The removal of a patient from the ESWL must be documented in the PAS and where available, the patient's medical record. The hospital must ensure that the reason for removal and all attempts to contact the patient to facilitate surgery are clearly documented. Reasons for removal are:

- patient or guardian request
- patient non-contactable
- patient defers treatment on two (2) separate occasions or defers for an excessive time period
- patient fails to arrive for scheduled appointments and/or treatment.
- clinical decision (i.e. procedure is no longer appropriate for the patient)
- patient deceased.

3.4.8 Prioritising Elective Surgery

The prioritisation of patients to be booked from the ESWL is based on the 'first on, first off' principle, which aims to achieve fairness and equity of access to elective surgery services by ensuring that:

- Patients are treated in order of their assigned clinical urgency category
- Within each category patients are treated in the same order as they are registered onto the waiting list unless clinically indicated and/or in exceptional circumstances.

Patient prioritisation may require consultation and negotiation with the referring Specialist, the Head of Department and as required, the relevant Executive/s responsible for surgical services.

When arranging a theatre list, the attending medical officer is to liaise with the personnel responsible for managing the ESWL to ensure full utilisation of available operating theatres

based upon the following considerations:

Waiting Time

Priority for admission is to be given to patients who have waited longer than the recommended time for their assigned urgency category.

When patients are assigned the same urgency category and all other relevant factors are equal, the longest waiting patient is to receive priority.

Previous Postponement

Patients whose surgery has previously been postponed for hospital initiated reasons are to be given priority and rescheduled as soon as possible.

Complexity and Resource Utilisation

A mix of complex and less complex cases are frequently combined in theatre lists to maximise theatre time. It is appropriate where necessary to prioritise less complex cases with shorter waits to fill theatre lists. Where possible the longest waiting of these cases are to be included. The same principle applies to short notice (stand by) cases to replace cancellations (see Section 3.4.11).

Geographic Issues

Consideration is to be given to patients who are required to travel a significant distance (i.e. regional to metropolitan areas) for surgery. Where possible, multiple appointments should be coordinated on the same day/visit, and/or be conducted via Telehealth to minimise travel time and costs.

Geographic location (i.e. distance to be travelled and catchment area) are not to hinder the selection of patients being scheduled for treatment.

Additional Factors for Consideration

- Type of surgery required
- Patient co-morbidities
- Medication requirements
- Patient social and community support
- Availability and appropriateness of day surgery
- The need for other treatments while awaiting surgery.

3.4.9 Premature Admissions

The thresholds below have been established to support the ‘first on, first off’ principle by preventing elective Category 2 and 3 cases being booked prematurely.

Category	Threshold
2	Booked date to be no earlier than 31 days after addition to the ESWL (and no later than 90 days)

3	Booked date to be no earlier than 91 days after addition to the ESWL (and no later than 365 days)

These thresholds must be adhered to unless clinically indicated and/or in exceptional circumstances, including a short waiting list.

3.4.10 Distribution of Elective Surgery Cases

HSPs must ensure that procedures are in place to support equitable distribution of demand for elective surgery across facilities under their jurisdiction.

Patients who do not have a booked date for their procedure and who are approaching the boundary for their urgency category are to be (where feasible):

- transferred from one consultant to another within the same specialty at the same hospital
- transferred to another hospital within the WA health system that performs the procedure and with a shorter waiting time to admission with another appropriately credentialed Specialist, or

These options are to be coordinated in consultation with the patient. Where a patient is transferred to another Specialist or hospital, the ESWL Accountable Officer is to ensure appropriate arrangements are made for:

- notifying the referring Specialist and original treating Specialist
- assessment of the patient by the Specialist who will undertake the surgery, as required
- post-operative care for the patient
- clear documentation of the transfer of the patient in the patient medical record and on the PAS
- transfer of the medical record, as required.

3.4.11 Short Notice Patients

Hospitals must maintain a record of 'standby' patients who have indicated that they are available for admission at short notice, in order to ensure full utilisation of theatre capacity.

In addition:

- patients should be given as much advance notice as possible regarding the date of their procedure
- where feasible, the 'first on, first off' principle should be applied to patients being contacted on short notice. Patients who decline an admission date that is offered at short notice are not recorded as having declined an offer of admission
- if a patient has been called in on short notice and their procedure does not go ahead, a definite planned date of admission should be made to ensure the patient is not further inconvenienced.

3.4.12 Transfers After Registration onto the ESWL

If, after initial registration, it is established that the treating Specialist is unable or unlikely to

be able to provide treatment (e.g. due to resignation or service changes) in the recommended timeframe, the hospital must:

- transfer the patient from one Specialist to another credentialed Specialist within the same hospital; or
- transfer the patient to another credentialed Specialist/hospital to perform the procedure where a shorter waiting time to admission is available.

Patients who decline transfer to an alternative Specialist or hospital are to be deemed to have declined an offer of treatment, which must be recorded in the PAS. Care should be taken not to unfairly disadvantage patients. Extenuating circumstances, such as carer support needs, family requirements or other personal matters, can impact on the patient's ability to accept an alternative ESWL.

Patients must be advised that any refusal of an agreed date or failure to arrive for treatment contributes to the number of occasions a patient can defer surgery before being removed from the waiting list.

3.4.13 Management of Doctor's Absence - Temporary or Permanent

To ensure appropriate theatre scheduling and utilisation, it is recommended that surgeons provide as much notice of intended leave or resignation as possible (minimum of six (6) weeks). A patient's clinical priority category and surgery should not be influenced by the availability of the hospital or surgeon resources.

A management plan should be developed and implemented for all affected patients – i.e. those who:

- already had a scheduled admission date during the period of absence
- will exceed their clinical priority timeframe during the period of absence.

The management plan should ensure affected patients are:

- assured that their position on the waitlist will not be affected
- advised who the replacement treating Specialist will be
- advised if clinical review is required
- provided with information regarding their expected waiting time.

All communication with patients must be documented. Every effort should be made to ensure the patient has their surgery completed in a timely manner by either reallocation to another appropriately credentialed surgeon or hospital, depending on case complexity.

3.5 Monitoring the ESWL

Each hospital is to identify a person responsible for overseeing and monitoring the ESWL. This responsibility includes developing and documenting operational processes, conducting regular reviews of the waitlist, overseeing administrative audits and reporting audit outcomes to relevant management staff.

The ESWL is to be reviewed regularly (minimum of weekly) to identify and prioritise unbooked patients who have exceeded, or are approaching, the clinically recommended timeframe for their urgency category. Where required, the treating Specialist or Head of Department should

be consulted to assist with patient prioritisation.

Other tasks that should be completed regularly include:

- identifying and removing duplicate waitlist entries
- completing missing details in the waitlist record
- reviewing cases with a booked date in the past who remain on the waitlist
- identifying and contacting patients who have not confirmed their availability to attend their pre-admission clinic or booked admission date.

3.5.1 Waitlist Audits

Hospitals must conduct administrative audits of the waiting list at least every 6 months. All patients who have been on the waitlist longer than 6 months should be contacted by letter or telephone to confirm:

- patient and GP contact details are current
- patient still requires surgery (i.e. has not had surgery elsewhere) and wishes to proceed
- patient is not on an ESWL list at another hospital (i.e. duplicate booking)
- patient's short notice availability.

Communication with the patient must include:

- advice regarding clinical reassessment by treating doctor or GP
- hospital contact details.

In the event that a patient cannot be contacted, the principles outlined in Section 3.4.5 must be followed. The hospital must ensure that a record of communication is maintained on the PAS.

An evaluation of the audit process must be conducted regularly by the staff responsible for waiting list management at each hospital.

3.5.2 Clinical Review of ESWL

Hospitals must have processes in place to identify and manage patients on the ESWL who may require a clinical review (e.g. patients who have waited longer than the clinically recommended time for their urgency category, patients waitlisted for multiple procedures). The clinical review process may include a review of the medical records, a telephone interview or clinic appointment with the Specialist or Anaesthetist, or referral to the patient's GP.

3.5.3 Waitlist Data

Elective Services Wait List Data Collection provides a range of reports to support hospitals to manage their waitlists in accordance with this Policy and maintain the data integrity of the ESWL. These reports can be accessed via the Department of Health intranet site

Hospitals are required to maintain their waitlist data in compliance with the requirements specified in the Elective Services Wait List Data Collection: Data Reporting Requirements for Health Service Providers Policy (MP0088/18).

4. Compliance, monitoring and evaluation

The Key Performance Indicator used to monitor and evaluate elective surgery access and waiting list management within the WA health system is the WA Elective Services Target (WEST). This indicator measures the proportion of elective waitlist patients waiting longer than the clinically recommended time for their urgency category, with targets as outlined below.

	2016/17 Target	2017/18 Target	2018/19 Target
Reportable procedures	0%	0%	0%
Non-reportable procedures	15%	8%	0%

Longest over boundary waiting times by urgency category are also reported as a supporting indicator to monitor compliance with the 'first on, first off' principle.

These indicators are reported in the Health Service Performance Report (HSPR), which contains the performance indicators against which HSPs are assessed.

It is the responsibility of the HSPs to ensure that elective surgery access is managed in accordance with this Policy. Where HSPR elective surgery performance targets are not being met, evidence of Policy compliance auditing may be requested by the System Manager as part of the HSP performance review cycle.

5. Related documents

The following documents are required to give affect to this policy (i.e. the documents included are mandatory):

- Appendix 1: Usual urgency categories for common elective surgery procedures, as per National Elective Surgery Urgency Categorisation Guideline 2015 – by specialty
- Appendix 2: Usual urgency categories for common elective surgery procedures, as per National Elective Surgery Urgency Categorisation Guideline 2015 – alphabetical
- Appendix 3: Excluded procedures
- Appendix 4: Standardised access criteria for bariatric surgery in public hospitals in Western Australia

6. Supporting Information

The following documents inform this policy (i.e. documents that are not mandatory to the implementation of this policy but may support the implementation of the policy):

- Elective Surgery Waitlist Management Roles and Responsibilities
- Excluded Procedures Code List
- Elective Surgery Patient Information
- Registration on the ESWL – Patient Letter
- Registration on the ESWL – GP letter
- Booked Procedure – Patient Letter
- Booked Procedure – GP Letter

- Missed Booking (not re-booked) – Patient Letter
- Missed Booking (not re-booked) – GP/Specialist
- Removal from the ESWL – Patient Letter
- Removal from the ESWL – GP/Specialist Letter
- Audit Letter – Patient

7. Definitions

Scheduled Admission Date	The admission date for an elective procedure that has been entered into the Patient Administration System (TOPAS, webPAS, HCARe).
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	Review of a patient to consider appropriateness of the elective surgery urgency category, to assess the patient's clinical condition during the waiting period, or after an extended period when classified as not ready for surgery. This process may include a chart review of the medical records, a telephone interview or a clinic appointment with the Specialist, or referral to the patient's GP.
Direct access	Direct access services are those which, by prior agreement, routinely accept requests for registration onto the ESWL from external sources (e.g. GP), without assessment of the patient by a Specialist in an outpatient clinic.
Elective surgery	Elective surgery is planned surgery that can be booked in advance following a Specialist assessment resulting in placement on an elective surgery waiting list. While further details can be found in the Australian Institute of Health and Welfare definition for Elective Care Waiting List Episode – elective care type, it should be noted that the scope of this Policy includes additional procedures as outlined in Section 2.
Excluded Procedure	Any procedure not routinely undertaken in the Western Australian public health system as defined in Appendix 1 of this Policy.
'First on, first off'	The principle by which all patients are to be treated in order of their registration onto the waiting list unless clinically indicated and/or in exceptional circumstances. Also known as the 'treat in turn' principle.

Listing Status	An indicator of the patient's readiness to begin the process leading directly to being admitted to hospital for the awaited procedure i.e. • Ready for Surgery • Not Ready for Surgery – Staged Patients • Not Ready for Surgery – Pending Improvement of Clinical Condition • Not Ready for Surgery – Deferred for Personal Reasons
Not Ready for Surgery - Staged Patients	Patients who have undergone an elective procedure or other treatment and are waiting for a follow-up elective procedure, where the patient is not in a position to be admitted to hospital or to begin the process leading directly to admission or to provision of care on a non-admitted basis, because the patient's clinical condition means that the procedure is not indicated until some future, planned period of time.
Not Ready for Surgery – Pending Improvement of Clinical Condition	Includes patients for whom surgery is indicated, but because of a medical condition, requires treatment or management (or simply time to pass) for the patient to be suitable for the surgery.
Not Ready for Surgery – Deferred for Personal Reasons	Patients who for personal reasons are not yet prepared to be admitted to hospital - for example, patients with work or other commitments which preclude their being admitted to hospital for a period of time.
Over Boundary	Term used to identify cases that have waited longer than the clinically recommended timeframe for their urgency category.
PAS	Patient Administration System (e.g. webPAS, TOPAS, HCARe)
Premature Admission	Category 2 patient scheduled for surgery earlier than 31 days after registration to the elective surgery waiting list. Category 3 patient scheduled for surgery earlier than 91 days after registration to the elective surgery waiting list.
Ready for Surgery	A patient who is prepared to be admitted to hospital or to begin the process leading directly to admission for elective surgery. The process leading to surgery could include investigations/procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests.
Requesting Specialist	The Specialist who has made a request to register a patient onto the elective surgery waiting list.

Short Notice / Stand by Patient	Patients may agree to be available on the 'short notice' list to have their surgery performed if there is a cancelled procedure. The hospital should determine what period of time prior to admission is regarded as short notice and for which procedures this is appropriate.
Treating Specialist/ Surgeon	Credentialed Specialist medical practitioner eligible to request admission of patients to a public hospital and who has operating rights to that public hospital.

8. Policy contact

Enquiries relating to this Policy may be directed to:

Title: Director, System Clinical Support and Innovation Unit

Directorate: Clinical Leadership and Reform

Email: SCSI@health.wa.gov.au

9. Review

This mandatory policy will be reviewed and evaluated as required to ensure relevance and recency. At a minimum it will be reviewed within 2 years after first issue and at least every 3 years thereafter.

Version	Effective from	Effective to	Amendment(s)
MP 0050/17	4 April 2017	14 February 2019	Supersedes OD 0608/15 Elective Surgery Access and Waiting List Management Policy (2015). Inclusion of non-reportable procedure groups in policy scope Updates to Excluded Procedures section and supporting information Inclusion of bariatric surgery access criteria previously outlined in OD 0402/12 Clarification of principles relating to: - use of Not Ready for Care status - waitlist review/audit Other minor amendments to align with new governance framework, or as per advice of relevant stakeholders
MP 0050/17 v.1.1	14 February 2019	16 October 2020	Minor amendment – correction to broken hyperlinks
MP 0050/17 v.1.2	16 October 2020	Current	Minor amendment to update Section 8. Policy contact and fix broken hyperlink

10. Approval

This mandatory policy has been approved and issued by the Director General of the Department of Health.

Approval by	Dr David Russell-Weisz, Director General, Department of Health
Approval date	23 February 2017
Published date	14 February 2019
Dept. File No	F-AA-40622

Appendix 1: Usual urgency categories for common elective surgery procedures, as per National Elective Surgery Urgency Categorisation Guideline 2015 – by specialty

CARDIO-THORACIC PROCEDURES	URGENCY CATEGORISATION
Congenital cardiac defect/s	2
Coronary artery bypass grafting	2
Heart valve replacement	2
Lobectomy / wedge resection / pneumonectomy	1
Pleurodesis	2
GENERAL SURGERY	URGENCY CATEGORISATION
Anal fissure – surgery for	2
Axillary node dissection	1
Breast lump – excision and/or biopsy	1
Cholecystectomy (open/laparoscopic)	3
Cholecystectomy (open/laparoscopic) with biliary pancreatitis	1
Cholecystectomy (open/laparoscopic) with potential common bile duct stone or severe frequent attacks (two within 90 days)	2
Colectomy/anterior resection/large bowel resection	1
Fundoplication for reflux disease	3
Hemorroidectomy	3
Herniorrhaphy – femoral/inguinal/incisional/umbilical	3
Lipoma – excision of	3
Malignant skin lesion – excision of +/- grafting	1
Mastectomy	1

Obstructing hiatus hernia (para-oesophageal hernia)	2
Parotidectomy /submandibular gland – excision of	2
Parathyroidectomy	2
Pilonidal sinus surgery	3
Skin lesions (not malignant) – excision of	3
Thyroidectomy/hemi-thyroidectomy	2

GYNAECOLOGY SURGERY	URGENCY CATEGORISATION
Bartholin's abscess drainage	1
Bartholin's cyst – removal of	3
Curettage and evacuation of uterus	1
Colposcopy	2
Cone biopsy	1
Endometrial ablation	3
Female sterilisation	3
Hysterectomy (abdominal / vaginal / laparoscopic)	3
Hysteroscopy, dilatation and curettage	2
Laparoscopy for dye studies / endometriosis	3
Large loop excision of the transformation zone cervix (LLETZ)	2
Mirena insertion	3
Myomectomy	3
Salpingo-oophorectomy / oophorectomy / ovarian cystectomy	2

Stress incontinence surgery	3
Vaginal repair - anterior / posterior	3
Warts - diathermy of	3
NEUROSURGERY	URGENCY CATEGORISATION
Carpal tunnel release	3
Cerebral haematoma – evacuation of	1
Cervical discectomy and fusion unless neurological deficit	3
Chiari malformation decompression	3
Common peroneal nerve release	2
Craniotomy for removal of tumour (neurological deficit)	1
Craniotomy for removal of benign tumour(no neurological deficit)	3
Craniotomy for ruptured aneurysm	1
Craniotomy for un-ruptured aneurysm	2
Cranioplasty	3
Discectomy with foot drop	1
Intracranial lesion (for example abscess/arteriovenous malformation) – removal of	1
Laminectomy	3
Muscle biopsy/temporal artery biopsy	1
Nerve decompression of spinal cord	2
Pedicle screw fusion	3
Posterior fossa decompression for	

haemorrhage, tumour or syrinx	1
Untethering of spinal cord	2
Ventricular peritoneal shunt for obstructive hydrocephaly	1
Ventricular peritoneal shunt for normal pressure hydrocephaly	2
OPHTHALMOLOGY SURGERY	URGENCY CATEGORISATION
Blepharoplasty (for reasons other than cosmetic)	3
Cataract extraction (+/- intra-ocular lens insertion)	3
Cataract extraction (+/- intra-ocular lens insertion) with angle closure glaucoma	1
Cataract extraction (+/- intra-ocular lens Insertion) with severe disability	2
Chalazion - excision of	3
Corneal graft	3
Dacrocystorhinostomy	3
Ectropion – correction of	3
Examination of eye under anaesthesia	2
Probing of naso-lacrimal Duct	3
Pterygium - excision of	3
Ptosis – repair of	3
Squint - repair of	3
Trabeculectomy	2
Trabeculectomy with high intra ocular pressure	1
Vitrectomy (including buckling/cryotherapy)	2
Victrectomy (including buckling/cryotherapy)	

with retinal detachment or infection)	1
ORTHOPAEDIC SURGERY	URGENCY CATEGORISATION
Anterior cruciate ligament reconstruction	3
Acromioplasty	3
Arthrodesis	3
Arthroplasty – revision of	2
Arthroscopy	3
Arthroscopy shoulder / sub acromial decompression	3
Bunion (hallux valgus) - removal of	3
Dupytrens contracture release	3
Exostosis – excision of	3
Fracture non-union - treatment of	2
Ganglion - excision of	3
Hammer/claw/mallet toe – correction of	3
Meniscectomy	3
Muscle or tendon length – change of	3
Nerve decompression	2
Osteotomy	3
Rotator cuff - repair of	3
Shoulder joint replacement	3
Shoulder reconstruction	3
Tendon release	3
Tenotomy of hip	2
Total hip replacement	3

Total knee replacement	3
OTOLARYNGOLOGY HEAD AND NECK SURGERY	URGENCY CATEGORISATION
Adenoidectomy	3
Ethmoidectomy	3
Functional endoscopic sinus surgery	3
Laryngectomy	1
Mastoidectomy	3
Microlaryngoscopy	2
Myringoplasty/tympanoplasty	3
Myringotomy	3
Nasal cautery	3
Nasal polypectomy	3
Nasendoscopy	2
Panendoscopy	1
Parotidectomy/submandibular gland – excision of	2
Pharyngoplasty	3
Pharynx – excision of	2
Pressure equalising tubes (grommets) - insertion of	3
Radical neck dissection	1
Rhinoplasty (for reasons other than cosmetic)	3
Septoplasty	3
Stapedectomy	3
Sub-mucosal resection	3

Tonsillectomy (+/- adenoidectomy)	3
Turbinectomy	3
PAEDIATRIC SURGERY	URGENCY CATEGORISATION
Branchial apparatus remnant –removal of	2
Circumcision (for reasons other than cosmetic)	3
Congenital pulmonary lesion – removal of	1
Dermoid cyst - removal of	2
Fundoplication	2
Herniorrhaphy - epigastric/umbilical	3
Hydrocele – repair of	3
Hypospadias - repair of	2
Inguinal herniotomy/herniorrhaphy for age < 6 months	1
Inguinal herniotomy/herniorrhaphy for age > 6 months	2
Lingual or maxillary frenulum surgery	3
Neonatal surgery (e.g. hirschsprungs, anorectal, malrotation, oesophageal atresia)	1
Nephrectomy for congenital abnormality	2
Orchidopexy	2
Pectus surgery	3
Pyeloplasty	2
Pyogenic granuloma - removal of	1
Skin lesion- excision of	3
Thyroglosssal remnant –removal of	2

Toenail surgery	3
Ureteric - re-implantation	2
PLASTIC AND RECONSTRUCTIVE SURGERY	URGENCY CATEGORISATION
Breast prosthesis - removal of (for reasons other than cosmetic)	2
Breast reconstruction (for reasons other than cosmetic)	3
Breast reduction (for reasons other than cosmetic)	3
Cleft lip and palate – repair of	3
Dupytrens contracture release	3
Lipoma – excision of +/-grafting	3
Lymphangioma – surgery for	3
Malignant skin lesion – excision of +/- grafting	1
Rhinoplasty (for reasons other than cosmetic)	3
Skin lesions, non-malignant – excision of	3
Scar revision (for reasons other than cosmetic)	3
Trigger finger / thumb release	2
UROLOGICAL SURGERY	URGENCY CATEGORISATION
Bladder neck incision	3
Circumcision (for reasons other than cosmetic)	3
Cystectomy	1
Cystoscopy	3
Epididymal cyst - removal of	3
Hydrocele - repair of	3

Hyposadias – repair of	3
Lithotripsy	2
Meatoplasty	3
Nephrectomy	2
Orchidectomy	1
Orchidopexy	3
Prostatectomy (transurethral or open)	2
Prostate biopsy	1
Pyeloplasty	2
Retrograde pyelogram	2
Stone/s urinary tract – removal of	1
Uretero-pelvic junction - correction of	2
Ureters re-implantation	3
Ureteric stent - insertion of	1
Urethra – dilatation of	2
VASCULAR SURGERY	URGENCY CATEGORISATION
Abdominal or thoracic aortic aneurysm by any means	1
Amputation of limb	1
Bifurcated aortic graft	1
Carotid endarterectomy	1
Dialysis access surgery	2
Femoro-popliteal bypass graft	2
Varicose veins treatment by any means (for reasons other than cosmetic)	3

Appendix 2: Usual urgency categories for common elective surgery procedures, as per National Elective Surgery Urgency Categorisation Guideline 2015 – alphabetical

ALPHABETICAL LISTING OF ELECTIVE SURGICAL PROCEDURE	URGENCY CATEGORISATION
Abdominal or thoracic aortic aneurysm by any means	1
Acromioplasty	3
Adenoidectomy	3
Amputation of limb	1
Anal fissure – surgery for	2
Anterior cruciate ligament reconstruction	3
Arthrodesis	3
Arthroplasty – revision of	2
Arthroscopy	3
Arthroscopy shoulder / sub acromial decompression	3
Axillary node dissection	1
Bartholin's abscess drainage	1
Bartholin's cyst – removal of	3
Bifurcated aortic graft	1
Bladder neck incision	3
Branchial apparatus remnant –removal of	2
Breast lump – excision and/or biopsy	1
Breast prosthesis - removal of (for reasons other than cosmetic)	2
Breast reconstruction (for reasons other than cosmetic)	3
Breast reduction (for reasons other than cosmetic)	3
Bunion (hallux valgus) - removal of	3
Carotid endarterectomy	1

Carpal tunnel release	3
Cataract extraction (+/- intra-ocular lens insertion)	3
Cataract extraction (+/- intra-ocular lens insertion) with angle closure glaucoma	1
Cataract extraction (+/- Intra-Ocular Lens Insertion) with severe disability	2
Cerebral haematoma – evacuation of	1
Cervical discectomy and fusion unless neurological deficit	3
Chalazion - excision of	3
Chiari malformation decompression	3
Cholecystectomy (open/laparoscopic)	3
Cholecystectomy (open/laparoscopic) with biliary pancreatitis	1
Cholecystectomy (open/laparoscopic) with potential common bile duct stone or severe frequent attacks (two within 90 days)	2
Circumcision (for reasons other than cosmetic)	3
Cleft lip and palate – repair of	3
Colectomy/anterior resection/large bowel resection	1
Colposcopy	2
Common peroneal nerve release	2
Cone biopsy	1
Congenital pulmonary lesion – removal of	1
Corneal graft	3
Cranioplasty	3
Craniotomy for removal of tumour (neurological deficit)	1
Craniotomy for removal of benign tumour(no neurological deficit or mass effect)	3
Craniotomy for ruptured aneurysm	1

Craniotomy for un-ruptured aneurysm	2
Curettage and evacuation of uterus	1
Cystectomy	1
Cystoscopy	3
Dacrocystorhinostomy	3
Dermoid cyst- removal of	2
Dialysis access surgery	2
Discectomy with foot drop	1
Dupytrens contracture release	3
Ectropion – correction of	3
Endometrial ablation	3
Epididymal cyst - removal of	3
Ethmoidectomy	3
Examination of eye under anaesthesia	2
Exostosis – excision of	3
Female sterilisation	3
Femoro-popliteal bypass graft	2
Fracture non-union - treatment of	2
Functional endoscopic sinus surgery	3
Fundoplication for reflux disease	3
Fundoplication (paediatrics)	2
Ganglion - excision of	3
Hammer/claw/mallet toe – correction of	3
Heart valve replacement	2
Hemorroidectomy	3

Herniorrhaphy - epigastric/umbilical (paediatrics)	3
Herniorrhaphy – femoral/inguinal/incisional/umbilical	3
Hydrocele - repair of	3
Hyposadias – repair of	3
Hypospadias - repair of (paediatric)	2
Hysterectomy (abdominal / vaginal / laparoscopic)	3
Hysteroscopy, dilatation and curettage	2
Inguinal herniotomy/herniorrhaphy for age < 6 months	1
Inguinal herniotomy/herniorrhaphy for age > 6 months	2
Laminectomy	3
Laryngectomy	1
Laparoscopy for dye studies / endometriosis	3
Large loop excision of the transformation zone cervix (LLETZ)	2
Lingual or maxillary frenulum surgery	3
Lipoma – excision of	3
Lobectomy / wedge resection / pneumonectomy	1
Lymphangioma – surgery for	3
Malignant skin lesion – excision of +/- Grafting	1
Mastectomy	1
Mastoidectomy	3
Meatoplasty	3
Menisectomy	3
Microlaryngoscopy	2
Mirena insertion	3
Myringoplasty/tympanoplasty	3

Myomectomy	3
Myringotomy	3
Muscle biopsy/temporal artery biopsy	1
Muscle or tendon length – change of	3
Nasal cautery	3
Nasal polypectomy	3
Nasendoscopy	2
Neonatal surgery (e.g. hirschsprungs, anorectal, malrotation, oesophageal atresia)	1
Nephrectomy for congenital abnormality	2
Nerve decompression	2
Nerve decompression of spinal cord	2
Nephrectomy	2
Obstructing hiatus hernia (para-oesophageal hernia)	2
Orchidectomy	1
Orchidopexy	3
Orchidopexy (paediatric)	2
Osteotomy	3
Panendoscopy	1
Parathyroidectomy	2
Parotidectomy/submandibular gland – excision of	2
Pectus surgery	3
Pedicle screw fusion	3
Pharyngoplasty	3
Pharynx – excision of	2

Pilonidal sinus surgery	3
Pleurodesis	2
Posterior fossa decompression for haemorrhage, tumour or syrinx	1
Pressure equalising tubes (grommets) - insertion of	3
Probing of naso/lacrimal Duct	3
Pterygium - excision of	3
Ptosis – repair of	3
Pyeloplasty	2
Pyogenic granuloma- removal of	1
Prostatectomy (transurethral or open)	2
Prostate biopsy	1
Pyeloplasty	2
Radical neck dissection	1
Rhinoplasty (for reasons other than cosmetic)	3
Rotator cuff - repair of	3
Retrograde pyelogram	2
Salpingo-oophorectomy / oophorectomy / ovarian cystectomy	2
Scar revision (for reasons other than cosmetic)	3
Septoplasty	3
Shoulder joint replacement	3
Shoulder reconstruction	3
Skin lesions (not malignant) – excision of	3
Squint - repair of	3
Stapedectomy	3
Stone/s urinary tract – removal of	1

Stress incontinence surgery	3
Sub-mucosal resection	3
Tendon release	3
Tenotomy of hip	2
Thyroglosssal remnant –removal of	2
Thyroidectomy/hemi-thyroidectomy	2
Toenail surgery	3
Tonsillectomy (+/- adenoidectomy)	3
Total hip replacement	3
Total knee replacement	3
Trabeculectomy	2
Trabeculectomy with high intra ocular pressure	1
Trigger finger / thumb release	2
Turbinectomy	3
Untethering of spinal cord	2
Uretero-pelvic junction - correction of	2
Ureteric re-implantation (paediatric)	2
Ureteric stent -insertion of	1
Urethra – dilatation of	2
Vaginal repair - anterior / posterior	3
Varicose veins treatment by any means (for reasons other than cosmetic)	3
Ventricular peritoneal shunt for obstructive hydrocephaly	1
Ventricular peritoneal shunt for normal pressure hydrocephaly	2
Victrectomy (including buckling/cryotherapy)	2

Victrectomy (including buckling/cryotherapy) with retinal detachment or infection)	1
Warts – diathermy of	3

Appendix 3: Excluded procedures

The following list of surgical procedures should not routinely be performed in public hospitals in WA unless approval is given by the appropriate Executive/s, as specified in Section 3.3.8.

Procedure	Exceptions/Indications
Abdominal lipectomy (Abdominoplasty)	Nil
Breast reduction (not performed as part of cancer treatment)	Clinically significant and persistent mobility issues Clinically significant and persistent intertrigo
Breast augmentation (not performed following surgical management of breast cancer)	Nil
Removal or Replacement of breast prosthesis	While failed breast implants can be removed to reduce health risks, replacement of prostheses implanted for cosmetic reasons shall not occur within the public health system. This will apply even where the patient seeks to supply the implants. Replacement prostheses for post cancer patients only
Breast lift (mastopexy)	Nil
Browlift	Nil
Blepharoplasty/Reduction of upper or lower eyelid	Clinically significant visual impairment
Correction of bat ear(s)	Nil
Excision of accessory nipple	Nil
Facelift (meloplasty)	Nil
Gender reassignment procedures	Congenital abnormalities in children
Hair transplant	Nil
Insertion/revision of artificial erection device	Patients using urodomes Spinal patients with neurological erectile dysfunction
Lengthening of penis (phalloplasty)	Congenital abnormalities in children
Liposuction	Nil
Lipectomy (other)	Nil
Male circumcision	Phimosis Paraphimosis Balanitis
Necklift	Nil

Penile procedures for sex transformation	Congenital abnormalities in children
Removal of benign moles	Requiring histology to exclude malignancy
Reversal of sterilisation	Nil
Rhinoplasty	Major Facial Trauma Congenital abnormality in children
Tattoo removal	Nil
Vaginoplasty	Nil
Varicose Veins	CEAP Grade > C3*
Vulvoplasty/Labioplasty	Nil
Any other procedure performed for cosmetic reasons (i.e. in the absence of significant functional impairment)	

(*) Refer to CEAP Classification – Table 1

The classification of venous disease is classified according to **C**linical severity, **E**tiology or cause, **A**natomy and **P**athophysiology (CEAP). For the initial assessment of a patient, the clinical severity is the most important and can be made by simple observation and does not need special tests. There are seven grades of increasing clinical severity:

Table 1: CEAP classifications and severity descriptions (Reference: NSW Waiting Time and Elective Surgery Policy p.57, 2012)

Grade	Description
C 0	No evidence of venous disease.
C 1	Superficial spider veins (reticular veins)
C 2	Simple varicose veins
C 3	Ankle oedema of venous origin (not foot oedema).
C 4	Skin pigmentation in the gaiter area
C 5	A healed venous ulcer
C 6	An open venous ulcer

Appendix 4: Standardised access criteria for bariatric surgery in public hospitals in Western Australia

Parameter	Criteria
Age	Age between 16-55 years Pregnancy not anticipated in first two years post-op
Body weight	BMI >= 40, or BMI >=35 with associated obesity illnesses such as Type II Diabetes and Sleep Apnoea Pubertal development ≥ stage 4
Resistant obesity	Failed weight loss techniques including dietary, exercise and behaviour modification programmes supervised within the Bariatric Programme
Morbidity	Obesity related morbidity as follows: diabetes, sleep apnoea, degenerative major weight bearing joint disease (and be candidate for joint replacement) etc. Free of end organ damage Absence of other medical conditions such as Multiple Sclerosis that would increase the morbidity or mortality risk of bariatric surgery Comprehensively assessed as fit for surgery by specialist physician, endocrinologist, anaesthetist and bariatric surgeon
Psychological profile	Undergone comprehensive psychosocial evaluation, and free of psychiatric issues, treatment or drug dependency problems Proven to be able to comply with and adhere to the behavioural changes required after surgery Capacity to understand the associated risks and commitment Well-informed, motivated and with acceptable operative risks

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