

# Elective surgery access policy

July 2015





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# Glossary

Term	Definition
Aesthetic procedures	Operations, procedures and treatments 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.
Clinical prioritisation	The process of assigning urgency categories based on clinical need for surgery. The categories are: <ul style="list-style-type: none"> <li>• Category 1: Admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it might become an emergency.</li> <li>• Category 2: Admission within 90 days is desirable due to the clinical condition of the patient.</li> <li>• Category 3: Admission within 365 days is desirable due to the clinical condition of the patient.</li> </ul>
Collection statement	A statement which explains to the patient the reasons why their health information and general practitioner's contact details are being collected, that this information will be disclosed to the health service, and that the health service will notify the general practitioner about the proposed procedure.
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. This includes instances where the patient leaves hospital and returns for a subsequent admission. Emergency surgery includes unplanned surgery for admitted patients and unplanned surgery for patients already awaiting an elective procedure (for example, in cases of acute deterioration of an existing condition).
Head of unit	The specialist medical practitioner responsible for the surgical unit or department.
Hospital-initiated postponements	Any surgical procedure that is postponed by the health service.
Medical record	A formal record of the patient's treatment notes and copies of any written and verbal notifications. This record may be kept either electronically or in hard copy, and may be a combination of the patient's medical record and information and management data from the Patient Administration System.
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 that preclude them from being admitted to hospital for a time.
Not ready for surgery – pending improvement of clinical condition	Patients for whom surgery is indicated, but not until their clinical condition is improved. For example, as a result of a clinical intervention, such as patients who require a cardiac work-up before a total hip replacement.

Term	Definition
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 hospital 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 after neoadjuvant chemoradiotherapy for colorectal cancer.
Other surgery	Where the procedure cannot be defined as either emergency surgery or elective surgery. For example, transplant surgery and planned obstetric procedures.
Pooled lists	Unit-based elective surgery waiting lists which allow specialist medical practitioners to include their patients on a combined list for their speciality. Patients on pooled lists can be expected to be treated in turn by any of the surgeons within the group.
Pre-admission process	Care received prior to hospital 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 patients	Patients who are admitted to a public health service and elect to be treated as private patients. Private patients are treated by the specialist medical practitioner of their choice, and may be responsible for payment of hospital accommodation fees, medical and diagnostic services, prosthesis, dental fees and other related services.
Public health services	All public hospitals and denominational hospitals, public health services and multi-purpose services established under the <i>Health Services Act 1988</i> .
Public patients	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 hospital, not a specialist medical practitioner of their choice.
Ready for surgery patients	Patients who are 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 or procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests, where the decision for surgery has already been made.
Reconstructive procedures	Surgeries performed on abnormal 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.
Referring specialist medical practitioners	Specialist medical practitioners who refer patients onto the elective surgery waiting list.
Senior clinicians	Senior medical staff such as the director of surgery or the director of medical services.

Term	Definition
Specialist medical practitioners	Medical practitioners who possess higher qualifications (usually a fellowship of one of the learned colleges) appropriate to the specialty in which they are employed, or who have sufficient experience in their specialty to meet the credentialing requirements of the health service at which they are appointed.
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.
Verbal communication	Communication that may occur over the telephone, face-to-face or via teleconference.
Victorian Patient Transport Assistance Scheme	A Victorian Government initiative which provides financial subsidies to eligible patients living in rural and regional Victoria who need to travel long distances to access medical specialist services, including surgery.
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.
Working days	Days that fall between Monday and Friday inclusively (excluding public holidays).
Written communication	Communication that may occur via letter, email, text message or fax.



# 1. Introduction

Approximately 170,000 Victorians have elective surgery in the public health system each year. Elective surgery encompasses a range of procedures from urgent cancer investigations and coronary bypass surgery, through to less time-critical interventions that can significantly improve patients' quality of life, such as cataract surgery or knee reconstructions.

Timely access to elective surgery is critical to the successful functioning of the public health system and is a high priority for the community and governments.

The Department of Health and Human Services (the department) first published the *Elective surgery access policy* in 2005 to guide health services on the management of elective surgery. A revised edition was released in 2009, followed by a number of amendments.

This latest edition of the *Elective surgery access policy 2015*, builds on previous versions and incorporates feedback and suggestions from health services and stakeholders to strengthen the policy. The policy provides guidance to the managers, administrative and clinical staff of Victorian public health services who provide elective surgery.

Elective surgery performance is monitored through a range of indicators that are reported at health service, state and national level. Each year the department negotiates performance targets with health services as part of their Statements of Priorities. Progress against defined indicators is published on the Victorian Health Service Performance website<sup>1</sup> and in State Budget papers.

Benchmarking of Victoria's elective surgery performance with that of other states and territories occurs in the Commonwealth Government's *State of our public hospitals report*, the Australian Institute of Health and Welfare's *Australian hospital statistics* and the Productivity Commission's *Report on government services*. Elective surgery performance is also reported publicly on the Commonwealth Government's *MyHospitals* <[www.myhospitals.gov.au](http://www.myhospitals.gov.au)> website.

The *Elective surgery access policy 2015* is a comprehensive document that retains a strong focus on the active management of elective surgery patients. It is designed to be read in conjunction with other key documents, including:

- *Australian Charter of Healthcare Rights in Victoria*
- *Language Services Policy*
- *Credentiaing and defining the scope of clinical practice for medical practitioners in Victorian health services*
- *Improving Care for Aboriginal and Torres Strait Islander Patients*
- *Cultural responsiveness framework – guideline for Australian health facilities*
- *Specialist clinics in Victorian public hospitals: Access policy*
- *National Safety and Quality Health Service Standards*
- *High performing health services: Victorian health service performance monitoring framework.*

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<sup>1</sup> <<http://www.health.vic.gov.au/>>

## 2. Policy objectives

The policy seeks to:

- support the active management of elective surgery patients
- support best practice in elective surgery management
- identify the rights and responsibilities of health services, referring specialist medical practitioners and patients
- improve communication among patients, health services, referring specialist medical practitioners, general practitioners and community providers
- support meaningful reporting to the public by health services and the government
- provide scope and authority for local policy and procedure development.

## 3. Policy principles

The following principles underpin the policy:

- Referrals for elective surgery are clinically appropriate and represent the most suitable treatment for the patient's condition.
- Patients waiting for elective surgery are the shared responsibility of the health service, the referring specialist medical practitioner and the general practitioner.
- Health 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.
- Patients waiting for elective surgery are fully informed about the procedure, and have given their consent.
- Patients are informed about their status on the elective surgery waiting list.
- Elective surgery management practices are transparent, efficient and patient-focused.
- Elective surgery is managed to ensure patients are treated equitably within clinically appropriate timeframes. Priority is given to patients with an urgent clinical need.
- Health services minimise the time patients are not ready for surgery through early and active management of comorbidities and fitness for surgery.
- Health services minimise the impact and inconvenience to patients whose surgeries they postpone.
- Health services exercise discretion to avoid disadvantaging patients in the case of hardship, misunderstanding and other extenuating circumstances.
- There is valid and reliable reporting of access to elective surgery to the community and to patients.
- Health services consider the principles and requirements of the *Elective surgery access policy 2015* when entering into collaborative arrangements with private elective surgery providers.

## 4. Scope

The *Elective surgery access policy 2015* applies to all elective surgery patients, whether public or private, who are waiting for elective surgery at a Victorian public health service. The definition of a public health service for this purpose is all public hospitals and denominational hospitals, public health services and multi-purpose services established under the *Health Services Act 1988*. The term 'elective surgery' means 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.

This document provides policy direction for all public health services in Victoria. It should be read in conjunction with the current *Elective Surgery Information System Manual*<sup>2</sup>, which provides data items, definitions and codes relevant to collecting data for submission to the Elective Surgery Information System.

Health services are responsible for compliance with the policy, ensuring that there are processes in place to:

- implement the policy
- identify health service staff who fulfil the roles and carry out the tasks required by the policy
- validate the accuracy and integrity of reported data
- regularly review individual health service performance
- provide training and education programs for staff managing elective surgery.

A visual summary of a patient's elective surgery journey mapped against the requirements of the *Elective surgery access policy 2015* is provided in Appendix 3.

Health services are encouraged to develop their own local policies and guidelines which comply with the *Elective surgery access policy 2015*. Each section of the policy includes guidelines to support implementation. A range of relevant resources, including examples of written notifications, forms and patient information sheets, are available on the department's website <[www.health.vic.gov.au/surgery](http://www.health.vic.gov.au/surgery)>.

This policy replaces the *Elective surgery access policy: Managing elective surgery patients and treatment times in Victoria's public health services 2009* and subsequent amendments including *Circular: Section 5 – Referring patients for elective surgery (2012)*; *Circular: Section 7 – Clinical prioritisation (2013)*; *Circular: Section 9 – Scheduling patients for surgery (2011)*; and *Circular: Section 13 – Communicating with patients, general practitioners and referring medical practitioners (2013)*.

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<sup>2</sup> *Elective Surgery Information System manual* and subsequent updates can be found online at <[www.health.vic.gov.au/hdss/esis/](http://www.health.vic.gov.au/hdss/esis/)>.

# 5. Communicating with patients, referring specialist medical practitioners and general practitioners

## Principles:

- Patients waiting for elective surgery are the shared responsibility of the health service, the referring specialist medical practitioner and the general practitioner.
- Patients are informed about their status on the elective surgery waiting list.
- Health 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.
- There is valid and reliable reporting of access to elective surgery to the community and to patients.

## Policy

- 5.1 Health services must communicate with patients, referring specialist medical practitioners and general practitioners by the means (verbal or written) specified in each section of this policy (summarised in Appendix 4).
- 5.2 Verbal communication with patients, referring specialist medical practitioners and general practitioners can occur over the telephone, face-to-face or via teleconference.
- 5.3 Written communication with patients, referring specialist medical practitioners and general practitioners can occur via letter, email, text message or fax.
- 5.4 Where health services have systems in place to be able to send written notifications by a range of mechanisms, patients should be given an opportunity to nominate how they wish to receive the written notifications.
- 5.5 Health services must document all communication (verbal and written) with patients, referring specialist medical practitioners and general practitioners in the patient's medical record, as required by this policy. Documenting the use of a template letter is acceptable for this purpose (as described in Section 13: Validation and record keeping).
- 5.6 Health services should have a clear point of contact for enquiries about elective surgery, with designated staff available to respond to queries from patients, referring specialist medical practitioners and general practitioners.
- 5.7 Health services should provide a clear point of contact for patients who believe that their clinical condition has changed while they have been waiting for elective surgery.

## Implementation guidelines

- Health services 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.

# 6. 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

- 6.1 Patients may be referred for elective surgery from a specialist clinic of a public health service or a specialist medical practitioner's private consulting rooms.
- 6.2 Patients should be referred for surgery only when it meets an identified clinical need to improve the health of the patient.
- 6.3 Before referral, the referring specialist medical practitioner must inform the patient of:
  - the nature of the proposed surgical procedure
  - the risks associated with the proposed procedure
  - the reason for referral to the waiting list
  - the waiting list process, including clinical urgency categories
  - their clinical urgency category
  - the need for consent to perform the procedure, prior to referral to the elective surgery waiting list
  - the option of being treated either as a public or a private patient
  - the requirement for public health services to prioritise patients for surgery based on clinical need, and without regard to whether a patient elects to be treated as a public or private patient.
- 6.4 If the patient's clinical condition is approaching a threshold for treatment at the health service (for example, thresholds for comorbidities which make treatment clinically unsuitable at that site), the health service should discuss strategies with the referring specialist medical practitioner, the general practitioner and the patient to manage the patient's condition. This may include discussion about whether referral to an alternative health service would be appropriate, or advice on strategies that the patient may take in order to reduce the risks of surgery and satisfy criteria for appropriate treatment at that site.
- 6.5 Referral for elective surgery must occur within three working days of the specialist consultation at which surgery is recommended.<sup>3</sup>

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<sup>3</sup> For Elective Surgery Information System reporting health services, the date that the referral is made should be coded as the Clinical Registration Date.

6.6 The referral/consent form should record all relevant information required by the health service in order to manage the patient's waiting list episode, including:

- the patient's full name
- date of birth
- sex
- full address
- contact telephone numbers such as home, work and mobile numbers
- Medicare number
- interpreter requirements
- proposed procedure
- provisional diagnosis
- clinical urgency category
- ready for surgery status
- anticipated hospital length of stay
- anticipated need for stay in an Intensive Care Unit or Critical Care Unit
- general practitioner's name, address and contact number (if the patient gives permission for the health service to communicate with the general practitioner)
- consent for the procedure
- patient's signature
- referring specialist medical practitioner's signature
- collection statement (refer to guidelines below).

## Implementation guidelines

- A 'collection statement' is needed to ensure compliance with privacy principles governing the collection, use and disclosure of health information. This statement explains to the patient the reasons why their health information and general practitioner's contact details are being collected, that this information will be disclosed to the health service, and that the health service will notify the general practitioner about the proposed procedure.
- The referring specialist medical practitioner should use this opportunity to fully explain to the patient why their health information and general practitioner contact details are being collected, and to answer any questions the patient might have about how their health information may be used or why it is disclosed. Confirming the general practitioner's contact details with the patient also gives the patient a chance to understand why it is important for their general practitioner to be aware that they are to be placed on the elective surgery waiting list for the proposed procedure.
- Referring specialist medical practitioners should actively manage patients where appropriate, so that whenever possible, patients are ready for surgery at the time they are referred onto the elective surgery waiting list.
- When a patient is transferred from the elective surgery waiting list at one health service to that of another health service to receive appropriate care, all documentation relating to the patient's waiting list episode should be transferred with the referral. This is to ensure that the receiving health service is able to take into account the patient's individual circumstances and recognise the time they have already waited for surgery.
- Where the patient is transferred to another health service for treatment and the referring health service's consent process does not satisfy the requirements of the receiving health service, the receiving health service should reobtain consent from the patient. The time the patient has already waited at the referring health service should be recognised by the receiving health service.

- It may be appropriate to reobtain consent where the risks or benefits associated with surgery are impacted by a change in a patient's clinical condition, by new diagnostic information obtained during the patient's wait for admission, or by a change in the type of surgery to be performed.
- Thresholds for comorbidity levels are in place at health services to protect the health and safety of patients and staff. Patients should be kept fully informed about their status on the elective surgery waiting list and this includes being advised as soon as possible if they are at risk of surpassing thresholds at the health service to which they are referred, and that this may result in them being unable to undergo surgery at the planned date and location.
- To facilitate the early identification of patients approaching thresholds for treatment, health services should explore ways for critical patient information to be received at the same time as the referral/consent form, for example via a combined referral/consent and patient questionnaire booklet.

### Referring public patients from private rooms

- Specialist medical practitioners can only refer patients directly onto the elective surgery waiting list at health services to which they have admitting rights.
- Specialist medical practitioners referring from private rooms should provide the patient with a copy of the referral/consent for surgery form, retain one copy for their records and provide the original to the health service.
- In addition to obtaining the patient's consent for the proposed procedure, the referring specialist medical practitioner should ensure that the patient is provided with sufficient information to enable them to choose whether to be treated as a private or public patient. This should include advice on the costs associated with treatment, and that access to surgery will be based on clinical urgency regardless of insurance status.
- Health services should work with specialist medical practitioners who refer patients from private consultation rooms, to obtain all relevant clinical information about the patient prior to, or shortly after the patient being registered on the public elective surgery waiting list.

### Provision of indemnity cover

- Referring specialist medical practitioners should refer to the coverage provided by the current Victorian Managed Insurance Authority *Medical Indemnity Policy* available at [www.vmia.vic.gov.au](http://www.vmia.vic.gov.au).

### Aesthetic procedures

- Aesthetic procedures are defined as operations, procedures and treatments 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.<sup>4</sup>
- Aesthetic procedures differ from reconstructive surgery, which is defined as surgery performed on abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumours or disease. Reconstructive surgery is usually done to improve functions, but may also be done to approximate a normal appearance.<sup>5</sup>
- Aesthetic procedures should not be performed in Victorian public hospitals unless there is a clear clinical need to improve a patient's physical health. Appendix 1 provides a definitive list of conditions that if present, would indicate that surgery is clinically needed and appropriate for the patient in a public hospital.

<sup>4</sup> Medical Council of New Zealand, *Statement on Cosmetic Procedures* October 2011.

<sup>5</sup> American Society of Plastic Surgeons [www.plasticsurgery.org](http://www.plasticsurgery.org) (website accessed March 2014).



# 7. Registering patients on the elective surgery waiting list

## Principle:

- Elective surgery management practices are transparent, efficient and patient-focused.

## Policy

- 7.1 All referrals for elective surgery must be actioned (accepted or rejected) within three working days of the health service receiving the completed and signed referral/consent form.
- 7.2 If a referral is accepted, patients must be registered on the elective surgery waiting list within three working days of the health service receiving the completed and signed referral/consent form.<sup>6</sup>
- 7.3 Health services are required to advise patients in writing that they have been placed on the elective surgery waiting list within three working days of registration. The written notification must include:
  - date of placement on the waiting list
  - surgical unit responsible for care
  - proposed procedure
  - urgency category and definition
  - ready for surgery status
  - health service contact for information about the elective surgery waiting list
  - what to do and who to contact if the patient's clinical condition changes
  - patients' rights and responsibilities.
- 7.4 If a referral is not accepted, health services must advise the referring specialist medical practitioner and the patient in writing within three working days of the health service receiving the completed and signed referral/consent form.
- 7.5 If the referral/consent form is incomplete, health services must advise the referring specialist medical practitioner verbally or in writing, and request the missing information within three working days of receiving the referral.

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<sup>6</sup> For Elective Surgery Information System reporting health services, the date that the referral is registered should be coded as the Administrative Registration Date.

7.6 Health services are required to acknowledge in writing, receipt and registration of a referral originating from a specialist medical practitioner's private rooms within 10 working days of registration. The notification to the referring specialist medical practitioner must include:

- date the patient was placed on the waiting list
- provisional diagnosis as stated on the referral/consent form
- proposed procedure as stated on the referral/consent form
- patient's urgency category
- patient's ready for surgery status.

7.7 Where the patient has provided consent for communication with their general practitioner, a copy of the written patient notification must be sent to their general practitioner within 10 working days of registration.

## Implementation guidelines

- Before accepting a referral onto the elective surgery waiting list, health services 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 health service capacity to provide treatment to patients within appropriate timeframes, health services should work with referring specialist medical practitioners to explore options to manage current and future referrals. Options may include: increased levels of activity, clinical review of listed patients, pooling of listed patients among surgeons, or referral pathways to other health services.
- As soon as health services become aware that a patient's condition may preclude safe and appropriate treatment at the health service, they should contact the referring specialist medical practitioner and the patient to discuss possible referral to another health service.
- If a patient is referred to another health service and the patient has provided consent for communication with their general practitioner, their general practitioner should be notified, verbally or in writing, of this change.
- Some patients may choose to be listed for the same procedure at more than one health service. It is essential that patients are aware of their responsibility to notify health services when they no longer require a procedure.

## 8. Clinical prioritisation

### Principles:

- Elective surgery is managed to ensure patients are treated equitably 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.

### Policy

8.1 Urgency categories are to be based on the patient's clinical need.

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

#### Category 1

Admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it might become an emergency.

#### Category 2

Admission within 90 days is desirable due to the clinical condition of the patient.

#### Category 3

Admission within 365 days is desirable due to the clinical condition of the patient.

8.3 The assignment of urgency categories must be made with reference to the *Recommended guide on the assignment of clinical urgency categories* (Appendix 2) and the patient's clinical condition.

8.4 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
- sound clinical reasons.

8.5 Where the procedure is not listed in the *Recommended guide on the assignment of clinical urgency categories*, specialist medical practitioners are expected to follow the principles outlined in this policy.

8.6 A change in a patient's urgency category must be authorised by the treating specialist medical practitioner or the head of unit.

8.7 Patients must be advised in writing or verbally within three working days of any change in their clinical urgency category and documentation of this notification must be kept in the patient's medical record.

## Implementation guidelines

- Patients experience the shortest overall waiting times when there are the fewest number of queues. The more queues there are, the higher the chance that the patients at the back of the queues will wait longer for surgery. In reality, a single queue to elective surgery is not appropriate as a proportion of patients need 'urgent' care and require treatment sooner than more 'routine' cases.
- There is currently considerable variation between specialist medical practitioners and health services in the proportion of patients assigned to the three urgency categories. Variation in the categorisation of patients might result in two patients being assigned different urgency categories and experiencing very different waiting periods despite having similar clinical conditions. More consistent categorisation practices will enable health services to better plan capacity to meet demand, treat patients in turn, and more effectively manage patients requiring surgery.
- The department does not support the creation or use of additional categories or subcategories in health services for the purpose of wait list management.
- Insurance status or willingness to pay should not result in preferential treatment or access to services within public health services.

## 9. Managing patient status

### Principles:

- Health services minimise the time patients are not ready for surgery through early and active management of comorbidities and fitness for surgery.
- Patients waiting for elective surgery are the shared responsibility of the health service, the referring specialist medical practitioner and the general practitioner.
- Patients are informed about their status on the elective surgery waiting list.

### Policy

- 9.1 A patient on the elective surgery waiting list must be identified as being ready for surgery or not ready for surgery.<sup>7</sup>
- 9.2 *Ready for surgery* patients are those who are 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 or procedures done on an outpatient basis, such as autologous blood collection, pre-operative diagnostic imaging or blood tests, where the decision for surgery has already been made.
- 9.3 *Not ready for surgery* patients are those who are not prepared to be admitted to hospital or 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 not until their clinical condition is improved. For example, as a result of a clinical intervention, such as patients who require a cardiac work-up before a total hip replacement.
- 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 hospital or to begin the process leading directly to admission for surgery, because the patient's clinical condition means that surgery is not indicated until some future, planned period of time.

#### Personal:

- 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 that preclude them from being admitted to hospital for a time.
- 9.4 Health services must actively manage patients who are not ready for surgery for clinical reasons.

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<sup>7</sup> As of 1 July 2014, all elective surgery patients are assigned a 'ready for surgery' status. This replaces the 'ready for care' status described in previous editions of the *Elective surgery access policy*.

- 9.5 A change in a patient's ready for surgery status for clinical reasons must be authorised by the treating specialist medical practitioner, head of unit or a senior clinician of the health service. The reason for the change and any substantiating evidence must be documented in the patient's medical record. Where the senior clinician provides authority for the change in status, the treating specialist medical practitioner or head of unit must be notified of the change.
- 9.6 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.
- 9.7 The following time limits apply to patients who are not ready for surgery – deferred for personal reasons:
- 30 days for Category 1 patients
  - 90 days for Category 2 patients
  - 180 days for Category 3 patients.
- 9.8 Patients who advise the health service that they are not ready for surgery for personal reasons must be informed of the time limits for their urgency category and advised that the health service will contact them before they exceed the time limit.
- 9.9 Health services must contact a patient before they exceed a time limit for not ready for surgery – deferred for personal reasons, and may remove a patient from the elective surgery waiting list if they exceed a time limit, in accordance with Section 12: Removing patients from the elective surgery waiting list.
- 9.10 Patients must be advised 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) when deferred for personal reasons.
- 9.11 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.
- 9.12 A copy or record of the patient notification must be added to the patient's medical record.
- 9.13 Where the patient has provided consent for communication with their general practitioner, health services should notify the general practitioner, 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.

## Implementation guidelines

- Not ready for surgery patients should not be confused with patients whose operations are postponed for reasons other than their own unavailability; for example, the unavailability of a surgeon or operating theatre time due to emergency workload. These patients are still ready for surgery.
- Patients who are not ready for surgery – pending improvement of clinical condition, should have their care actively managed by the treating health service. Active management may reduce the time a patient is not ready for surgery and optimises fitness for surgery. Active management also improves the accuracy of waiting lists by ensuring that patients 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 validation and record keeping activities, as described in Section 13.
- Changes to a patient's status to not ready for surgery – pending improvement of clinical condition, require authorisation from a senior clinician and involves multiple clinicians in both the decision and the responsibility to monitor the patient.
- Health services should ensure that their authorisation practices, including process and timing, are appropriate for the particular circumstances. This may include having different authorisation practices for different types of decisions.
- Changes to a patient's status to not ready for surgery – deferred for personal reasons, potentially involve only the patient and a health service staff member. In this case, providing a written notification to the patient acts as a data integrity control by confirming what the patient has told the health service, and also reminds the patient of the time limits for being not ready for surgery – deferred for personal reasons.
- Health services are encouraged to notify the treating specialist medical practitioner or head of unit of all patients who have notified that they are not ready for surgery – deferred for personal reasons, particularly Category 1 patients.
- The following examples may assist with policy implementation:
  - A patient has poor respiratory function that needs to be improved before open abdominal surgery. They are managed medically until their clinical condition improves, and during this time the patient is not ready for surgery – pending improvement of clinical condition.
  - A patient is assessed as suitable for surgery and as Category 3. They are available for surgery for the next three months, but not the following three months because of a booked holiday. The patient is ready for surgery for the first three months, but must then be changed to not ready for surgery – deferred for personal reasons for the period of the holiday.
  - A patient requires rectal cancer surgery 6–8 weeks after neoadjuvant chemoradiotherapy for colorectal cancer. The patient is not ready for surgery – staged patient for the rectal cancer surgery for the first six weeks after their neoadjuvant chemoradiotherapy. After that time, the patient should be added to the waiting list as a Category 1 patient. Their waiting time would be measured from the time they are ready for surgery, that is, from the point in time six weeks after their chemoradiotherapy.

# 10. Scheduling patients 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.

## Policy

- 10.1 Health services must schedule patients for surgery within each urgency category according to waiting time, except in specific circumstances.
- 10.2 The only circumstances which may prevent patients being scheduled for surgery according to waiting time are:
- a patient's condition has deteriorated
  - the health service has previously postponed the patient's surgery
  - patient availability
  - resource availability (availability of theatre time, staff, equipment and hospital capacity)
  - sound clinical reasons
  - teaching and training needs.
- 10.3 When scheduling patients for surgery, health services are required to negotiate with the patient to agree on a mutually acceptable admission date.
- 10.4 Health 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

- Health services' normal case review practices and waiting list management activities should include an analysis of treatment in turn.
- Health services should have appropriate local policies and procedures in place to actively support the implementation of treatment in turn. For example, health services should explore the use of pooled lists.
- Any variations to treatment in turn should be for appropriate reasons, as stipulated in Section 10.2.
- When scheduling a patient for surgery to meet the training needs of staff, health services must ensure that no other patients with similar characteristics have a higher clinical need, or have waited longer for treatment.



- When scheduling patients for surgery, health services should:
  - provide sufficient notice to the patient (a minimum of two weeks except for Category 1 patients)
  - advise the patient of the risk that surgery may be postponed
  - confirm the patient's:
    - full name
    - medical record number
    - date of birth
    - proposed procedure
  - inform the patient of:
    - the admission date and time
    - any instructions for admission and pre-operative preparation
    - the anticipated length of stay
    - a health service contact
    - their rights and responsibilities, including the possibility of being removed from the waiting list if they fail to attend for admission without notice.
- Wherever possible, health services should offer patients a choice of admission date. Where a patient chooses a later date over an earlier one because they are unavailable before the later date, a patient may be made not ready for surgery – deferred for personal reasons.
- Surgery scheduling should take into account the patient's personal circumstances. For example, it may be difficult for a patient living outside the metropolitan area to get to the earliest appointment in the morning at a metropolitan health service.
- The Victorian Patient Transport Assistance Scheme provides financial subsidies to eligible patients living in rural and regional Victoria who need to travel long distances to access medical specialist services, including surgery. Patients residing in rural or regional areas who have to travel to a metropolitan health service should be provided with information on the scheme. Information is available at [www.health.vic.gov.au/ruralhealth/patient-transport-assistance.htm](http://www.health.vic.gov.au/ruralhealth/patient-transport-assistance.htm).
- Insurance status or willingness to pay must not result in preferential treatment or access to services within public health service facilities. Under the National Healthcare Agreement between the Commonwealth of Australia and the State of Victoria, the state will provide public patients with access to all services provided to private patients in public hospitals.<sup>8</sup>
- Eligible patients have the right to elect to be treated as either a public or private patient. Full and open information should be provided to allow patients to make informed choices about financing their care. Information is available at [www.health.vic.gov.au/hospitalcirculars/circ04/circ2504.htm](http://www.health.vic.gov.au/hospitalcirculars/circ04/circ2504.htm).

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<sup>8</sup> For further information refer to the National Healthcare Agreement (2012 and subsequent updates) between the Commonwealth of Australia and the State of Victoria.

# 11. Postponement of surgery

## Principle:

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

## Policy

- 11.1 All hospital-initiated postponements that occur within two weeks of a patient's scheduled date of surgery must be approved by the head of unit or a senior clinician of the health service.
- 11.2 Patients must be informed in writing of any postponement as early as possible, and advised of the circumstances that resulted in the need to reschedule surgery. Written notification is not required when surgery is rescheduled for 10 working days' time or less.
- 11.3 Patients must be offered an appropriate level of assistance to manage the inconvenience caused by the postponement. Health services should tailor written notifications to patients who have been deferred more than once to acknowledge the significant inconvenience of multiple postponements.
- 11.4 When hospital-initiated postponements occur within two weeks of a patient's scheduled date of surgery, an offer of a new date for admission must occur within five working days.
- 11.5 Where the patient has provided consent to communicate with their general practitioner, health services should notify the general practitioner, either verbally or in writing, of any specific assistance they require to care for the patient while their surgery has been deferred. This notification must occur within three working days of the postponement and be recorded in the patient's medical record.

## Implementation guidelines

- Definitions relating to hospital initiated postponements are available in the *Elective Surgery Information System manual* at [www.health.vic.gov.au/hdss/esis/index](http://www.health.vic.gov.au/hdss/esis/index).
- When communicating the postponement to the patient, the patient should be advised of:
  - the reason for the postponement
  - the rescheduled admission date, if known
  - what they should do if their condition deteriorates
  - the option to speak with a doctor about medical issues that might arise as a result of the postponement
  - the Victorian Patient Transport Assistance Scheme (for those who have travelled long distances to the health service)
  - the name and contact details of a health service staff member, should they require further information.
- Where reasons for a postponement warrant a change to a patient's status or their removal from the waiting list, the relevant clauses in Section 9: Managing patient status and Section 12: Removing patients from the elective surgery waiting list, should be followed.

# 12. Removing patients from the elective surgery waiting list

## Principle:

- Health services exercise discretion to avoid disadvantaging patients in the case of hardship, misunderstanding and other extenuating circumstances.

## Policy

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

- have undergone the surgical procedure for which they were referred onto the elective surgery waiting list
- are deceased
- are not contactable
- decline surgery
- no longer require surgery
- fail to attend for admission without prior notice
- defer treatment on two occasions
- are not ready for surgery – deferred for personal reasons for a period exceeding the following number of days:
  - 30 days for Category 1 patients
  - 90 days for Category 2 patients
  - 180 days for Category 3 patients.

12.2 Removals from the elective surgery waiting list, other than as a result of the patient having undergone surgery or being deceased, must be authorised by the treating specialist medical practitioner, head of unit or a senior clinician.

12.3 All patients who are removed from the elective surgery waiting list without surgery must receive written advice within three working days of their removal by the health service, including:

- the reason for their removal from the elective surgery waiting list
- the date of their removal from the elective surgery waiting list
- details of who the patient should contact if they have any queries or concerns.

12.4 Written notification is not required for terminally ill patients when it is likely to cause distress.

12.5 Where the patient's consent for communication with their general practitioner has been provided, a copy of the written notification must also be provided to the general practitioner within 10 working days of the patient's removal from the elective surgery waiting list.

## Implementation guidelines

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

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

- Health 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 health service and therefore may be removed from the elective surgery waiting list.

- In line with Section 12.2, removals from the elective surgery waiting list due to the patient having received their surgery (in this case, at another health service), are not required to be authorised by the treating specialist medical practitioner, head of unit or a senior clinician.

### **Patient deceased**

- The medical records department should be notified of any patient deaths so the record can be stored appropriately.
- The head of unit should receive a six-monthly report detailing all removals from the elective surgery waiting list due to death and monitor the type and number of deceased patients being removed from the waiting list and trends over time.
- Health services should develop appropriate processes to regularly undertake case review of patients who have been removed from the elective surgery waiting list due to death (for example, health services may focus on particular procedures or patient cohorts).

### **Patient not contactable**

- Health services should make reasonable attempts to contact patients before removing them from the elective surgery waiting list. Health services are required, at a minimum, to attempt to obtain contact details from:
  - the patient's treating specialist medical practitioner
  - the patient's referring specialist medical practitioner, or nominated general practitioner
  - the health service's medical records
  - the patient's next of kin.

### **Patient declines surgery or it is no longer required**

- Some patients choose to be listed for the same procedure at more than one health service. Patients should be advised of their responsibility to notify health services 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 health service's elective surgery waiting list at their own request (without having undergone surgery at another health service) should be advised to contact their referring specialist medical practitioner or 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. This may be at the health service where the patient is listed, or a health service to which they have been referred for treatment.<sup>9</sup>

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

- Health 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 a prolonged period (for example, due to overseas travel).

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<sup>9</sup> This may include patients who are treated under a specific government initiative.

# 13. Validation and record keeping

## Principle:

- There is valid and reliable reporting of access to elective surgery to the community and to patients.

## Policy

- 13.1 Health services must keep accurate records of elective surgery waiting list information including any change to a patient's clinical urgency category, 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.
- 13.2 Health services must validate each registration on their elective surgery waiting list at least every six months to ensure accurate representation of the number of patients waiting and available for surgery.

## Implementation guidelines

- Validating the elective surgery waiting list is not only an administrative exercise, but also an opportunity to detect clinical changes and actively manage patients who are waiting for elective surgery. The use of clinical staff to undertake validation can be important for some patient cohorts.
- Guidance on the collection and storage of patient information is available from the Public Record Office Victoria <[www.prov.vic.gov.au](http://www.prov.vic.gov.au)>. Health services should refer to the *Retention & Disposal Authority for Patient Information Records* (2011) available at <[www.prov.vic.gov.au/wp-content/uploads/2012/05/PORS11-06PatientInformationRDA-WebVersion20120507.pdf](http://www.prov.vic.gov.au/wp-content/uploads/2012/05/PORS11-06PatientInformationRDA-WebVersion20120507.pdf)>, or any subsequent updates of this authority.
- Copies of the following should be included in the patient's medical record, or on the patient administration system, in electronic or hard copy format:
  - the elective surgery waiting list referral/consent 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 medical record including:
  - a change to the patient's ready for surgery status
  - a change to the patient's clinical urgency category
  - removal of a patient from the health service's waiting list.

- Where verbal notifications have taken place, a record of the conversation should be made in the medical record and include:
  - date and time of the notification
  - names of the people involved in the conversation
  - key points of discussion.
- When it is not practical to file copies of written correspondence due to technical or resource constraints, and where those written notifications do not vary significantly from a template, evidence of the type of written notification and date sent will be adequate to meet the requirements of the policy. Where the content of a written notification varies significantly from a template, a copy of the written notification should be retained and placed on the patient's medical record.
- Health services should have a system in place to identify patients who are approaching thresholds for treatment due to the presence of comorbidities.
- Health services should have a system in place to identify patients who are approaching time limits for not ready for surgery – deferred for personal reasons.
- At the time of the validation, health 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 health 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.
- Health services must follow relevant sections of this policy in carrying out appropriate actions following validation, including changes to patients' ready for surgery status or clinical urgency category, and removals from the elective surgery waiting list.

# Appendix 1: Aesthetic procedures and indications for surgery in Victorian public health services

Face and head	
Procedure	Indications for surgery in public health services
Meloplasty/facelift	<ul style="list-style-type: none"> <li>• Patient has significant deformity and surgery is indicated due to disease, trauma or congenital conditions</li> <li>• To correct significant deformity following surgery where the initial procedure was not a cosmetic procedure</li> </ul>
Reduction of upper or lower eyelid (blepharoplasty)	<ul style="list-style-type: none"> <li>• Visual obstruction</li> </ul>
Rhinoplasty/rhinoseptoplasty	<ul style="list-style-type: none"> <li>• Patient has significant deformity and surgery is indicated due to disease, trauma or congenital conditions</li> </ul>
Repair of external ear lobes	<ul style="list-style-type: none"> <li>• Patient has significant deformity and surgery is indicated due to disease, trauma or congenital conditions, but not as the result of use of a decorative expander or similar device</li> </ul>
Correction of bat ear(s)	<ul style="list-style-type: none"> <li>• Patient is less than 19 years old</li> </ul>
Hair transplant	<ul style="list-style-type: none"> <li>• Patient has disfiguring hair loss and surgery is indicated due to disease, trauma or congenital conditions</li> </ul>
Breast	
Procedure	Indications for surgery in public health services
Breast reduction (bilateral/unilateral)	<ul style="list-style-type: none"> <li>• Where significant clinical symptoms are present (for example intractable intertigo and severe gynaecomastia) and body mass index (BMI) is less than 30</li> </ul>
Breast augmentation (bilateral/unilateral)	<ul style="list-style-type: none"> <li>• Post mastectomy reconstruction</li> <li>• +/- Augmentation for contra lateral breast Poland syndrome</li> <li>• Patient has significant deformity and surgery is indicated due to disease, trauma or congenital conditions</li> </ul>
Mastopexy (breast lift)	<ul style="list-style-type: none"> <li>• Post morbid obesity treatment where significant clinical symptoms are present and BMI is less than 30</li> <li>• Correction of significant breast asymmetry following breast reconstruction</li> <li>• Correction of asymmetry due to congenital or developmental conditions</li> </ul>
Revision of breast augmentation	<ul style="list-style-type: none"> <li>• As part of treatment for breast cancer, and reconstruction following trauma, disease, congenital conditions or infection not as a result of previous cosmetic surgery</li> </ul>
Removal of breast prosthesis	<ul style="list-style-type: none"> <li>• Following rupture, erosion or infection of breast prosthesis</li> </ul>
Nipple and/or areola reconstruction	<ul style="list-style-type: none"> <li>• When performed as part of a breast reconstruction due to disease or trauma, but not as the result of previous cosmetic surgery</li> </ul>
Nipple eversion (for nipple inversions)	<ul style="list-style-type: none"> <li>• Recurrent infection or ulcerative complications</li> </ul>

## Trunk and limbs

Procedure	Indications for surgery in public health services
Abdominoplasty/ Apronectomy/ Abdominal lipectomy	<ul style="list-style-type: none"> <li>• Post morbid obesity treatment where significant clinical symptoms are present (for example intractable intertrigo) and BMI is less than 30</li> </ul>
Varicose vein procedures	<ul style="list-style-type: none"> <li>• Venous conditions with the following symptoms: <ul style="list-style-type: none"> <li>– chronic leg swelling/oedema</li> <li>– chronic dermatitis/eczema</li> <li>– bleeding</li> <li>– leg ulcers or infections</li> <li>– superficial thrombophlebitis</li> </ul> </li> <li>• Venous disorders in patients less than 16 years old</li> <li>• <b>Excluded as indications for surgery are:</b> <ul style="list-style-type: none"> <li>– venous conditions which are unlikely to lead to the conditions listed above</li> <li>– cosmetic veins in patients greater than 16 years old</li> <li>– spider veins in patients greater than 16 years old</li> </ul> </li> </ul>
Other skin excisions for body contour, for example, buttock, thigh or arm lift	<ul style="list-style-type: none"> <li>• Post morbid obesity treatment where significant clinical symptoms are present (for example, intractable intertrigo) and BMI is less than 30</li> </ul>
Liposuction	<ul style="list-style-type: none"> <li>• Post traumatic pseudolipoma</li> <li>• Lipodystrophy</li> <li>• Gynaecomastia</li> <li>• Lymphoedema</li> <li>• Flap reduction</li> </ul>

## Genitourinary

Procedure	Indications for surgery in public health services
Genital surgery aimed at improving appearance	<ul style="list-style-type: none"> <li>• Patients requiring surgery for congenital abnormalities</li> </ul>
Insertion of artificial erection devices	<ul style="list-style-type: none"> <li>• Spinal patients with neurological erectile dysfunction</li> <li>• Surgery for trauma, disease or infection or as part of a penile reconstruction for congenital abnormalities</li> </ul>
Testicular prosthesis	<ul style="list-style-type: none"> <li>• Surgery is indicated due to disease, trauma or congenital conditions (for example, following orchidectomy for malignant disease, torsion testes or as a result of a congenital abnormality)</li> </ul>
Lengthening of penis procedure	<ul style="list-style-type: none"> <li>• Congenital abnormalities in patients less than 16 years old (for example, severe chordee)</li> </ul>



Genitourinary (cont.)	
Procedure	Indications for surgery in public health services
Reversal of sterilisation	<ul style="list-style-type: none"> <li>• Nil medical indications</li> </ul>
Circumcision	<ul style="list-style-type: none"> <li>• For medical indications only (for example, phimosis, recurrent balanoposthitis or paraphimosis) <ul style="list-style-type: none"> <li>– For more information, refer to the department's website at <a href="http://www.health.vic.gov.au/surgery">www.health.vic.gov.au/surgery</a>.</li> </ul> </li> </ul>
Other	
Procedure	Indications for surgery in public health services
Revision of scar	<ul style="list-style-type: none"> <li>• Where scar is disfiguring and extensive and is the result of surgery, disease or trauma but not as the result of previous cosmetic surgery</li> </ul>
Tattoo removal procedures	<ul style="list-style-type: none"> <li>• Patients less than 16 years old</li> </ul>

## Appendix 2: Recommended guide on the assignment of clinical urgency categories

It is recognised that the assignment of urgency categories is a clinical decision. To guide that decision, the following table shows recommended urgency categories for common procedures in Victoria. This guidance is based on the usual urgency category listed in the National Elective Surgery Urgency Categorisation Guideline mapped to Victorian Principal Prescribed Procedure codes.<sup>10</sup>

To access advice on recommended categorisation for other less common procedures, please refer to the National Elective Surgery Urgency Categorisation Guideline <[www.health.vic.gov.au/surgery](http://www.health.vic.gov.au/surgery)>.

Principal Prescribed Procedure code	Procedure	Usual specialty	Recommended urgency category*
1	Coronary artery bypass graft	Cardio-thoracic	2
2	Replacement of heart valve	Cardio-thoracic	2
11	Tonsillectomy/Tonsillectomy & Adenoidectomy	Ear, nose and throat	3
12	Myringotomy	Ear, nose and throat	3
13	Septoplasty	Ear, nose and throat	3
23	Functional Endoscopic Sinus Surgery (FESS)	Ear, nose and throat	3
39	Thyroidectomy	General surgery	2
33	Local excision of lesion/lump of breast	General surgery	1
38	Mastectomy	General surgery	1
34	Release of carpal tunnel	General surgery	3
32	Cholecystectomy^	General surgery	2
196	Inguinal herniorrhaphy	General surgery	3
197	Other herniorrhaphy	General surgery	3
41	Colectomy	General surgery	1
37	Procedures for haemorrhoids	General surgery	3
205	Repair/closure of anal fistula#	General surgery	2
225	Rectal resection	General surgery	1
35	Ligation and stripping of varicose veins of legs	General surgery	3
52	Dilation and Curettage	Gynaecology	2
206	Gynaecological laparoscopy	Gynaecology	3
54	Hysterectomy	Gynaecology	3
55	Excision/destruction of lesion/tissue of cervix	Gynaecology	2

<sup>10</sup> National Elective Surgery Urgency Categorisation Guideline April 2015 <[www.health.vic.gov.au/surgery](http://www.health.vic.gov.au/surgery)> <<http://www.coaghealthcouncil.gov.au/Publications/Reports/ArtMID/514/ArticleID/57/National-Elective-Surgery-Urgency-Categorisation-Guideline-April-2015>>.

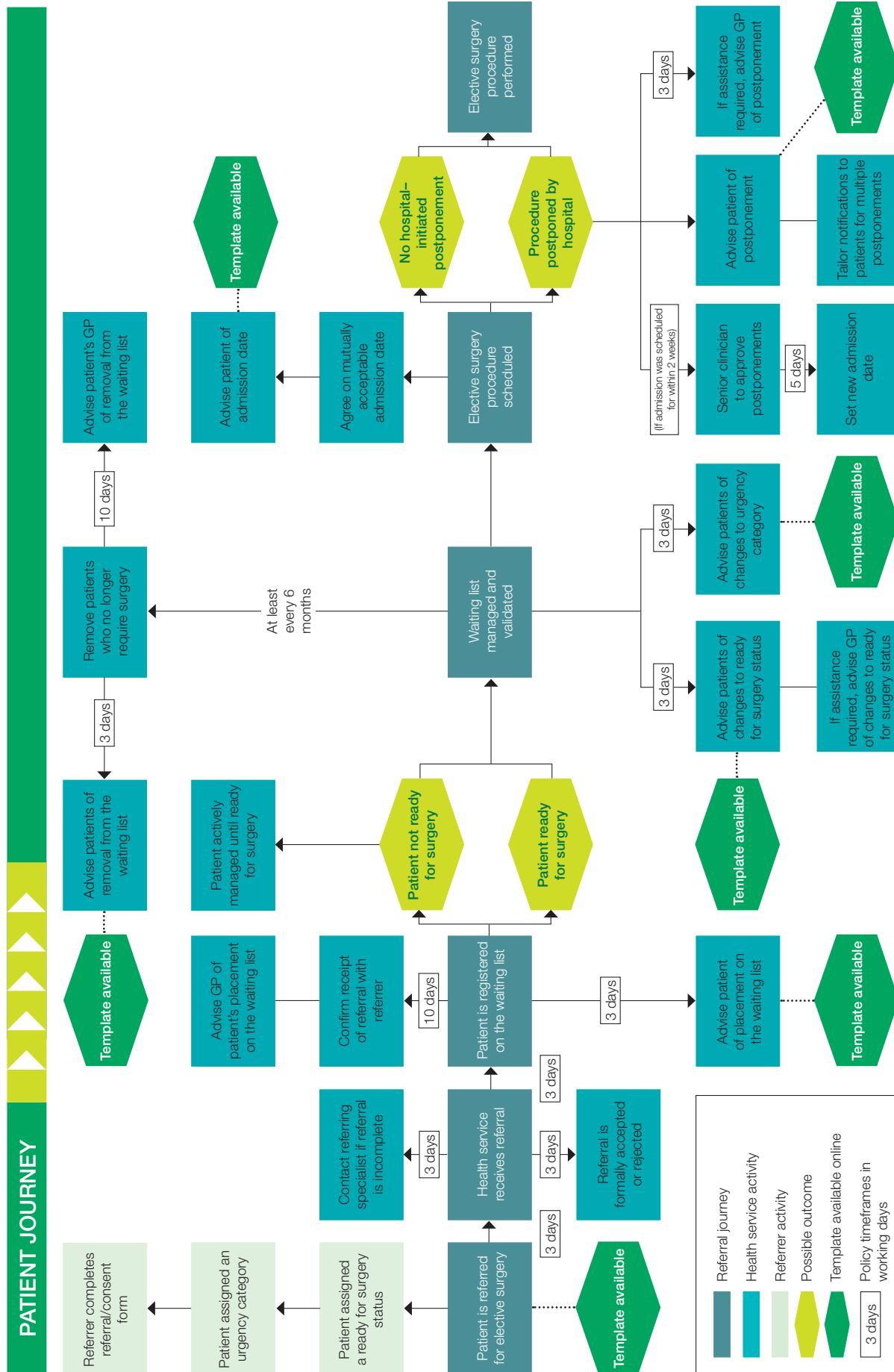
Principal Prescribed Procedure code	Procedure	Usual speciality	Recommended urgency category*
59	Excision/destruction of lesion/tissue of uterus	Gynaecology	3
58	Vaginal repair – anterior and/or posterior	Gynaecology	3
73	Incision, division, excision and decompression of spinal canal and spinal cord structures	Neurosurgery	2
86	Craniotomy and/or craniectomy^	Neurosurgery	1 or 2
91	Repair of cataract^	Ophthalmology	3
97	Procedures on vitreous^	Ophthalmology	2
92	Excision/destruction of lesion/tissue of eyelid	Ophthalmology	3
117	Repair procedures on shoulder and elbow	Orthopaedics	3
134	Reduction of fracture with internal fixation#	Orthopaedics	1 or 2
111	Removal of internal fixation device of bone#	Orthopaedics	2 or 3
113	Total hip replacement	Orthopaedics	3
116	Arthroscopy of knee	Orthopaedics	3
120	Repair of cruciate ligaments	Orthopaedics	3
114	Total knee replacement	Orthopaedics	3
115	Excision/repair of bunion and other toe deformities	Orthopaedics	3
150	Local excision/destruction of lesion/tissue of skin and subcutaneous tissue	Plastic surgery	3
212	Excisional debridement of skin and soft tissue wound, infection or burn #	Plastic surgery	1
170	Cystoscopy	Urology	3
161	Prostatectomy	Urology	2
171	Transurethral removal of obstruction from ureter and renal pelvis^	Urology	1 or 2
162	Excision/destruction of lesion/tissue of bladder^	Urology	1 or 2
166	Nephrectomy	Urology	2

\* Generally, malignancy and conditions that have the potential to deteriorate quickly to the point that they might become an emergency require an urgency Category of 1.

# Not included in national guideline. Victorian recommended category applies.

^ Multiple listings included in national guideline. Victorian recommended category listed.

# Appendix 3: Elective surgery pathway and timeframes



This diagram must be read in conjunction with the Elective Surgery Access Policy 2015.

## Appendix 4: Summary of appropriate notification methods

Notification content	Notification can be made verbally or in writing			Written notification must be provided		
	Patients	GPs	Referrer	Patients	GPs	Referrer
Acknowledgement of referral originating from a private room						•
Referral received is incomplete and requires further information			•			
Referral has not been accepted				•		•
The patient has been placed on the elective surgery waiting list				•	•	• <sup>11</sup>
The patient's clinical urgency has been changed	•					
The patient's ready for surgery status has been changed for clinical reasons	•					
Notice of specific assistance required to manage the patient's condition after a change to their clinical urgency category		•				
The patient's ready for surgery status has been changed for personal reasons				•		
Notice of specific assistance required to manage the patient's condition while they are not ready for surgery for clinical reasons		•				
Time limits for not ready for surgery – deferred for personal reasons				•		
Confirmation of surgery date (for procedures more than 10 working days away)				•		
Confirmation of surgery date (for procedures in less than 10 working days)	•					
Notice of hospital initiated postponement (for procedures more than 10 working days away)				•		
Notice of hospital initiated postponement (for procedures less than 10 working days away)	•					
Notice of specific assistance required to manage the patient's condition during a hospital initiated postponement		•				
The patient has been removed from the elective surgery waiting list				• <sup>12</sup>	•	

<sup>11</sup> Written notification must be provided to the referrer if the referral originates from a specialist medical practitioner's private rooms. Written notification to the referrer is not required if the referral originates from the public hospital's specialist clinic.

<sup>12</sup> Written notification is not required for terminally ill patients when it is likely to cause distress.

