NATIONAL CLINICAL GUIDANCE FOR ELECTIVE CARE FACILITIES

NOVEMBER 2025

RCSI

Clinical Design & Innovation
Person-centred, co-ordinated care

NCP T&O National Clinical Programme for Trauma & Orthopaedic Surgery

Anaesthesia National Clinical Programme for Anaesthesia

NCPS National Clinical Programme in Surgery

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Note:

This Policy Guidance Document will need to be tailored for each individual Surgical Hub and Elective Hospital particularly in terms of the individual policies, digital systems and procedures in place in the governing Model 3 or 4 hospital.

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Glossary

	Definition
AHD	Advanced Healthcare Directive
AI	Artificial Intelligence
AMRIC	Antimicrobial Resistance and Infection Control
ANP	Advanced Nurse Practitioner
AR	Augmented Reality
ASA	American Society of Anaesthesiologists (Physical Status Classification System)
BADS	British Association of Day Surgery
BGL	Blood Glucose Level
BMI	Body Mass Index
CAI	College of Anaesthesiologist of Ireland
CCO	Chief Clinical Officer
CLD	Criteria Led Discharge
CORU	Regulatory body for Health and Social Care Professions
CPAP	Continuous Positive Airway Pressure
CPC	Clinical Prioritisation Category
CPD	Continuous Professional Development
CPR	Cardio-Pulmonary Resuscitation
CSA	Committee for Surgical Affairs
CVA	Cerebrovascular Accident
DBP	Diastolic blood pressure
DC	Day Case
DMR	Decision Making Representative
DMRO	Decision Making Representative Order
DNAR	DO Not Attempt Resuscitation
EH	Elective Hospital
EHR	Electronic Health Record
EMT	Emergency Medical Technician
EN	Endoscopy
EPOA	Enduring Power of Attorney
EPR	Electronic Patient Record
ERAS	Enhanced Recovery After Surgery
ERS	Endoscopy Reporting System
GI	Gastrointestinal
GIRFT	Getting it Right First Time
HA	Hospital Attire
HB	Haemoglobin
HCRN	Healthcare Record Number
HDU	High Dependency Unit
HIPE	Hospital Inpatient Enquiry
HLOC	Higher Level of Care
HSCP	Health and Social Care Professional
HSE	Health Service Executive
ICD	Implantable Cardioverter Defibrillator
ICU	Intensive Care Unit
INEWS	Irish National Early Warning System
IPC	Infection Prevention and Control
ISBAR	Identify, Situation, Background, Assessment, and Recommendation – Communication Tool
KPI	Key Performance Indicator

LA	Local anaesthesia
MCAN	Managed Clinical and Academic Network
MDRO	Multi Drug Resistant Organism
METS	Metabolic Equivalents
MICAS	Mobile Intensive Care Ambulance Service
MO	Minor Operations
NAS	National Ambulance Service
NCEC	National Clinical Effectiveness Committee
NCG	National Clinical Guideline
NCHD	Non-Consultant Hospital Doctor
NCPS	National Clinical Programme for Surgery
NECCGG	National Elective Care Clinical Guidance Group
NMBI	Nursing and Midwifery Board of Ireland
NOK	Next of Kin
NPPPEP	National Perioperative Patient Enhancement Programme
NQAIS	National Quality Assurance and Improvement System
NSRSC	National Surgical Support Research Centre
NTPF	National Treatment Purchase Fund
OD	Out Patient Diagnostics
OPD	Out Patients Department
OSA	Obstructive Sleep Apnoea
OT	Outpatient Treatment
PACU	Post Anaesthesia Care Unit
PADDS	Post Anaesthesia Discharging Scoring System
PAS	Preoperative Assessment Services
PHN	Public Health Nurse
PIFU	Patient Initiated Follow UP
PIR	Patient Initiated Review
PPDWL	Planned Procedure Day Case Waiting List
QR	Quick Response
RCPI	Royal College of Physicians of Ireland
RCSI	Royal College of Surgeons
RDSC	Reeves Day Surgery Centre
REO	Regional Executive Officer
ROSC	Return of Spontaneous Circulation
SBP	Systolic blood pressure
SC	Street Clothes
SH	Surgical Hub
SMS	Short Message Service
Solus	Web-based endoscopy management and reporting solution
ST	Surgical Training
TIA	Transient Ischaemic Attack
TMM	Theatre Measurement Model
TTOM	Target Theatre Optimisation Model
VTE	Venous Thromboembolism
WL	Waiting List

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1.0 Introduction

This guidance provides practical advice to enable frontline staff, supported by administrative staff, clinical directors, Integrated Healthcare managers and Regional Executive Officers to think ‘day case first’ to maximise surgery in the most efficient way possible while ensuring high quality day surgery and a positive patient experience. This is a dynamic document and will periodically be updated as needed.

Surgical Hubs

Surgical Hubs are being developed in key locations on-site or on sites operated under the governance of Model 3 or 4 hospitals with the intent of having an impact on day-case waiting lists in advance of the development of regional elective hospitals. They will also allow hospitals to focus on other areas of waiting lists as many day-case procedures can be moved to the surgical hubs. The intention with these surgical hubs is that they will have the capacity for four theatres plus minor ops, and be in operation from 8am – 8pm, 6 days per week.

Elective Hospitals

The Government plan for the Elective Hospitals, subject to the necessary Public Spending Code requirements and approvals being met, is to implement a national strategy for elective ambulatory care, initially through the surgical hubs. The elective care scope of service is currently under development but will provide a sustainable and strategic plan to cater for the projected increased demand associated with changing population demographics and the highly dynamic landscape of healthcare policy.

2.0 Rationale

This clinical guidance document has been commissioned by the HSE’s Chief Clinical Officer and developed by the National Elective Care Clinical Guidance Group to support the establishment of the surgical hubs and elective hospitals. The aim of this document is to facilitate safe, effective and high-quality day case surgery across all elective care facilities.

3.0 Scope

This document will address the clinical guidance for the surgical hubs and elective hospitals only. Operational processes, building design and integrated workforce planning are outside the scope of this document and will be addressed by other elective care programme workstreams.

The Office of the CCO under the direction of Professor Risteárd Ó Laoide, have been working on a National Radiology Strategy. A link to this document will be inserted as soon as it is available.

Elective Care Facilities will refer to both surgical hubs and elective hospitals collectively and will be highlighted in the document by the symbol below.

Where guidance specifically relates to either a hub or elective hospital, this will be flagged separately as below:

There are no plans for any paediatric patients to be seen at the elective care facilities i.e., <16 years of age.

This is considered a dynamic document and as the elective care facilities evolve and mature, this will be updated as required.

4.0 Defining Day Surgery

The definition of day surgery is that the patient:

- should be undergoing a planned procedure
- must have an intended management of day surgery
- must be admitted, operated upon and discharged on the same calendar day. (1)

4.1 Intended Management

For an elective procedure it is essential that the patient has been identified for the intended management, for either day case surgery or procedure when entered onto the hospital waiting list. Best outcomes are achieved when the patient is appropriately screened and adequately prepared for day surgery. This process should ensure that the patient and all the staff involved in their care are aware that the intended plan is for day surgery and they follow a clear day case pathway. The process should include multidisciplinary prehabilitation where required.

4.2 Urgent Planned Surgery

Many acute surgical conditions such as acute cholecystitis, appendicitis, fractured mandible and closed fractures can be treated as day cases if a robust pathway exist. These referral pathways will need to be developed for these time sensitive procedures in the future. It will be important to have clear coding which ensures that this activity is correctly captured as day cases if undertaken on an ambulatory basis.

Note: While surgical hubs are focused on managing waiting lists, elective hospitals will aim to meet the demographic demand for elective day case procedures. Introducing urgent planned surgery will be explored once progress has been made to reduce waiting lists and capacity becomes available.

5.0 Infection Prevention and Control

Effective Infection Prevention and Control (IPC) is central to providing high quality healthcare for people who use healthcare services and a safe working environment for those that work in healthcare settings. This guide should be used in conjunction with National Clinical Guideline (NCG), Infection Prevention and Control, No. 30. The principles outlined in this guidance apply to all settings where healthcare is provided.

The following are the basics of IPC in the healthcare setting:

- Infectious microorganisms (also called pathogens) are biological organisms that frequently cause human infection. Infection refers to the invasion of body tissues by a microorganism. Microorganisms may only cause infection in a proportion of people to whom they are transmitted and infection may only cause disease in a proportion of people who are infected.

- Colonisation, in this context, refers to a situation in which a microorganism is established on a person's body (for example on skin, mucous membrane or wound, for example MRSA) but is not causing infection at that time. Although the person who is colonised is not infected, the organism may spread from a colonised person to others and/or subsequently cause infection in the colonised person.

- Infection that does not result in any illness or disease is referred to as asymptomatic infection, (for example asymptomatic COVID infection). Although people who are colonised do not have disease, the organism may spread to others from them.

- Many different infectious microorganisms are present in healthcare settings.

- For infection to spread, 6 elements are required - causative microorganism (pathogen), reservoir, means of transmission, portal of entry, susceptible host, portal of exit. These 6 elements form what is commonly referred to as The Chain of Infection.

- People who use healthcare services and healthcare workers are most likely to be sources of infectious microorganisms and are also the most common susceptible hosts. Other people visiting and working in healthcare settings may also be at risk of infection and may be a source of transmission.

- In healthcare settings, the main ways that infectious microorganisms spread are by contact (direct and indirect) and through the air. Spread through the air is categorised as either droplet or airborne transmission.

A suite of eLearning resources is available on HSeLanD at www.hseland.ie and can be easily accessed through the AMRIC HUB.

Additional AMRIC guidance, poster and webinar resources are available on www.hpsc.ie

5.1 Pre-operative Screening of Patients

Screening for Multi-Drug Resistant Organisms (MDROs) is often guided by both the nature of the clinical procedure and the individual patient's risk profile (individual patient exposure to healthcare and antibiotics). This should be in line with standalone AMRIC guidance for example MRSA and CPE. Some suggested recommendations are outlined below:

If the procedure is considered low risk, high volume, there is no general need to screen or isolate. It is anticipated that as the elective facilities mature, practice will evolve and patients will be more complex than expected, including having significant antibiotic and healthcare exposures, both of which are risks for MDRO carriage. Any such patients should have their microbiological history taken as part of the pre-assessment. A review of the results should influence patient placement on the scheduling list to ensure optimal patient flow and avoid delayed discharge or unplanned admission.

A risk assessment of individual patients should be carried out where there is:

- known MDRO carriage
- exposure to MDRO carrier
- recent hospital admission
- residential care patient
- procedures carried out abroad
- pre-existing conditions and health history
- other concerns informed by risk assessment

Other recommendations include:

1. Standard precautions should be used at all times, for all patients. Transmission based precautions should be used, as appropriate.
2. Focus on cleaning and management of the physical environment as per the National Clinical Guideline (NCG) Infection Prevention and Control, No. 30. (Click here) (2).
3. Recommend adhering to the AMRIC guidance recommendations on the prevention of Surgical Site Infection prevention. (Click here) (3).
4. Adherence to the recommended prescribing practices for Surgical antibiotic prophylaxis and duration (Click here) (4).

Any patient symptomatic with an infectious condition on the day should be risk-assessed and a clinical assessment conducted.

5.2 National Clinical Surveillance Infection Control System

During the response to the COVID-19 pandemic the lack of information sharing between hospitals, unavailability of patient records and the lack of a centralised IT infrastructure and systems became apparent and was added to the HSE's Corporate Risk Register. To address this risk the AMRIC team and eHealth are progressing the national implementation of a comprehensive ICT system (ICNET is the procured system being implemented). AMRIC has resourced the implementation of a National Clinical Surveillance IPC system across both acute and community settings.

This system will assist in the management of clinical, laboratory and administrative information related to IPC aspects of individual patients and outbreaks. It will help prevent and reduce hospital acquired infection and control antibiotic-resistant organisms, generating real-time IPC alerts, which will enable 24/7 management of IPC. For each Health Region, there will be integration of the laboratory and patient information systems into ICNET. Overall, ICNET will support patient contact tracing, monitoring of infections and reporting. The system can also provide a comprehensive suite of management, monitoring and reporting tools, thus replacing paper based and excel sheet-based approaches.

6.0 Suitable Procedures for the Elective Care Facilities

To further encourage the shift to day case surgery and optimal utilisation of theatre, engagement has been carried out across 12 surgical specialties and approximately 625 procedures have been identified as being suitable for the surgical hubs and elective hospitals (Table 1) with an additional 126 being suitable for the elective hospitals only (Table 2).

Work has also been carried out with the specialties to determine the most appropriate treatment room for each procedure, the necessary hospital attire with a move to utilising 'street clothes' for the less complex procedures, chair or bed and an estimated average length of time. These considerations should be considered the default for these elective care facilities.

The following table gives an overview of the procedure numbers per specialty in each of the areas with the detailed list for each being outlined in **Appendix 1a and b**. It is important to note that many procedures can be carried out by more than one specialty and this will vary from region to region, but for the purpose of this document, they have been listed against the specialty that carries out the majority of the procedures according to reported hospital data.

Table 1. Summary of Procedures Suitable for Surgical Hubs and Elective Hospitals

Specialty	Procedure number	
Anaesthesia & Pain Relief	54	
Dermatology	13	
Gastroenterology	5	
General Surgery	98	
Gynaecology	5	
Ophthalmology	46	
OMFS	49	
Orthopaedics	122	
Otolaryngology	78	
Plastic Surgery	68	
Urology	73	
Vascular	14	
TOTAL	625	

Table 2. Summary of Additional Procedures Suitable for Elective Hospitals only

Specialty	Procedure number	
Gastroenterology	18	
General Surgery	32	
Gynaecology	58	
Ophthalmology	5	
Plastic Surgery	5	
Respiratory Medicine	5	
Urology	2	
Vascular	1	
TOTAL	126	

6.1 Planned Urgent Treatment

When the hubs and elective hospitals are established, the focus will be on clearing the current waiting lists that are evident in each health region. However, based on the modelling that has been completed, in time, there will be capacity for planned urgent elective care. This will include procedures from specialties such as Trauma and Orthopaedic Surgery, Urology, General Surgery, Plastic Surgery and OMFS for example. It will be necessary however, to continue to work with the National Clinical Programme for Anaesthesia to determine the Pre-assessment pathway for this cohort. The list of procedures is outlined in **Appendix 1c**.

It is expected that as the elective facilities mature, and with the continual move to day case surgery, there may be scope to review and expand the entire list of procedures with specialty approval. There will be a need to develop referral pathways for these planned, time sensitive procedures in the future.

7.0 The Patient Perspective

Traditionally, many patients were deemed unsuitable for day surgery for a variety of reasons. Experience suggests that the majority of patients are in fact appropriate for day case management, or can be enabled to be so with careful organisation and proactive management.

7.1 Social Factors

• **Adequate housing conditions;** Most patients now have access to inside bathroom facilities and a telephone, so it is unusual to be excluded from day surgery on this basis

• **Distance from hospital**; Ideally, patients should live within approximately 90 minutes drive of a hospital which would be able to provide care resulting from a complication of the surgery*. It is important to note that this may not be the hospital in which the surgery was undertaken. In some scenarios and for appropriate patients, it may be necessary for patients to be accommodated in a local hotel on the first postoperative night before travelling to their final destination the following day. This is still a better and more cost-effective environment than keeping the patient in a hospital bed unnecessarily.

**It is recognised that in certain regions of the country there are established practices in place that allow ambulatory surgery for patients outside of this distance and this based on geographic location and need for surgery. Clinical judgement can be applied in these situations and the balance of risk applied.*

• **Availability of someone to care for the patient overnight**; Standard guidance is that all patients who have had **general anaesthesia or sedation** should be escorted home by a responsible adult, who should remain with them for 24 hours after surgery.

7.2 Diabetes

The effective management of diabetes during the perioperative period is essential, given the increasing prevalence of diabetes mellitus and the subsequent rise in surgical procedures among individuals with diabetes. Maintaining optimal diabetes control before, during, and after any surgical procedure is paramount for preventing complications. In both diabetic and non-diabetic populations, hyperglycaemia during the perioperative period serves as an independent marker of adverse surgical outcomes. In addition, hyperglycaemia elevates morbidity and mortality risks, including delayed wound healing, an increased rate of infection, ICU admissions, prolonged hospital stays, and higher postoperative mortality (5).

The value of day surgery for patients with diabetes is well recognised (6). Patients with diabetes are more likely to maintain good diabetic control if they are in their normal environment with their normal diet and medication. Diabetic patients should be included unless it is poorly controlled, i.e., blood glucose level 0.12mmol/L more than 2 x per week, as outlined in the inclusion criteria in Chapter 8.

The Guidelines for Perioperative Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery can be accessed here (6). Patients with diabetes should be scheduled for surgery early in the day.

7.3 Elderly Patients

There are no upper age limits for day surgery. The elderly in particular benefit from day surgery with minimal disruption to their daily routine and return to their normal environment as soon as possible.

7.4 Sensory Support

Work is underway with the Operation and Design teams to enable the facilities to support patients requiring sensory support in terms of hearing, vision, dementia and neurodiversity. Depending on the needs of the patient a clinical decision should be made as to whether the procedure should be carried out in an elective care facility or their local Model 2, 3 or 4 hospital.

7.5 As A Patient, Who Do I Call If…?

Patients will be discharged with tailored information outlining their treatment plan and post discharge care. There must be a dedicated and staffed 24/7 phone line that patients are able to contact in the event of developing a complication post procedure or having an urgent query. This phone line must be staffed by an individual with the appropriate clinical experience and should have access to the electronic surgical, endoscopy, anaesthesia and nursing records so that they can determine the safest course of action required.

8.0 Patient Selection (Excluding Endoscopy)

Patient safety is a priority for both the surgical hubs and elective hospitals and not every patient will be considered suitable for day surgery for a variety of reasons. However, many patients will be appropriate with careful selection, optimisation, organisation and proactive management which will ensure that any inequalities are reduced. This is for patients undergoing general anaesthesia or sedation.

Based on the American Society of Anaesthesiologists Physical Status Classification system (7), the following **EXCLUSION CRITERIA** have been developed to ensure optimal patient safety for patients undergoing general anaesthesia or sedation:

General

- ***ASA 3 or above** *[1]*
- ***Inability to lie flat***
- ***BMI>35kg/m2***
- ***Previous Hx or family Hx of problems with anaesthesia***
- ***Known or suspected difficult airway***
- ***Previous History/Family Hx of malignant hyperthermia or suxamethonium***
- ***Family history of sudden cardiac death***
- ***History of chronic pain with regular opioid use***
- ***Methadone use***
- ***Under 16 years old***

Respiratory

- ***Obstructive sleep apnoea*** *[2]
- ***Poorly controlled asthma (history within last 6 months of exacerbation requiring hospital admission or systemic steroids)***
- ***Poorly controlled COPD (history of exacerbations within the last 30 days)***
- ***On oxygen therapy or nebulisers at home***
- ***Pulmonary embolism in the last 6 months***
- ***Previous lung transplant***
- ***Moderate to severe pulmonary fibrosis***

Endocrinology

- ***Poorly Controlled Diabetes (Blood Glucose Level > 12mmol/L more than 2 x per week)***
- ***Acromegaly***
- ***Electrolyte disorder***

ENT

- ***Prior radiotherapy to the head/neck***
- ***Inability for cervical flexion/extension***
- ***Head and neck tumours causing airway distortion***
- ***Large goitre***
- ***Impaired swallow***

Rheumatology

- ***Severe scoliosis***
- ***Moderate to severe rheumatoid arthritis***
- ***Moderate to severe ankylosing spondylitis***
- ***Achondroplasia***

Hepatobiliary

- ***Moderate to severe chronic liver disease***

Renal

- **Chronic kidney disease Stage 3 or 4**

Cardiology

- ***Uncontrolled ischaemic heart disease (angina at rest or on minimal effort)***
- ***Myocardial infarction in the last 6 months***
- ***Poorly Controlled hypertension (SBP >160mmHg or DBP > 100mmHg*** ***recorded with GP or in Pre – operative Assessment***
- ***Moderate to severe cardiac failure***
- ***Congenital heart disease***
- ***Moderate to severe valvular heart disease***
- ***Any form of cardiomyopathy***
- ***Effort tolerance/functional status (minimum 4 METS)***
- ***Presence of pacemakers or internal cardiac defibrillators**[*3]*
- ***Symptomatic arrhythmias***
- ***Severe peripheral vascular disease (indicative or cardiac risk) – e.g., intermittent claudication or history of lower limb revascularisation***

Neurology

- ***Epilepsy (seizures within the last 3 months)***
- ***Cerebrovascular Accident (CVA) or Transient Ischaemic attack (TIA) in the past year***
- ***Advanced neuromuscular disorders***
- ***Myasthenia Gravis***
- ***Previous post-operative delirium requiring overnight stay***

Haematology

- ***Bleeding disorder***
- ***HB <11g/dL**** [4]
- ***Platelets <100x10^3/uL***
- ***Sickle cell disease (sickle cell trait is acceptable)***
- ***Porphyria***
- ***Clotting disorder (discuss prior to listing)***

Social

- ***Patients should live within 90mins approximately from a hospital that is capable of providing care resulting from a complication of the surgery which may not necessarily be the hospital where the surgery was carried out.***
- ***Unable to be accompanied by a responsible adult for 24hrs post-surgery if they have had General Anaesthesia or Sedation***
- ***Unable to get an escort to drive or accompany them home in a taxi***

OBGYN

- ***Pregnancy (any gestation)***

*[1] For Phase 1, it has been recommended by the National Clinical Programme for Anaesthesia, that only ASA 1 and ASA 2 are considered for surgery in the surgical hubs/ elective hospitals. However, as experience grows, it may be agreed locally in individual hubs/hospitals to expand the criteria.

*[2] Once the facilities become more mature, consideration may be given to treating patients with Obstructive Sleep Apnoea (OSA) but only if these patients can be scheduled early, are compliant with Continuous Positive Airway Pressure (CPAP), and can bring their own machine into the unit.
*[3] Patients with a pacemaker fitted may not be a contraindication for endoscopy procedures unless cardiology input is required.
*[4] Exceptions to this haemoglobin level may be considered for endoscopy patients as this may be the reason for this investigation and also for a cohort of gynaecology patients. These exceptions will be at the discretion of the Consultant Surgeon and Anaesthesiologist.

Patients who are deemed unsuitable for the hub or elective hospital will be referred back to the Model 2,3 or 4 hospital from which they were referred. This decision may happen at the time of pre-assessment and it should be clear from the referral information as to who this person is referred back to.

9.0 Patient Preassessment

Preassessment for elective surgery is a critical step in ensuring patient safety, optimising surgical outcomes, and minimising risks. This step should be carried out ideally within 6 weeks of the planned surgery. If this step is delayed and the planned surgery is not within 3 months, then each case should be reviewed on an individual basis as per local guidelines to determine if reassessment is required. This is based on the Model of Care for Pre-assessment (8).

Preassessment is a necessary part of the patient flow process for the following reasons:

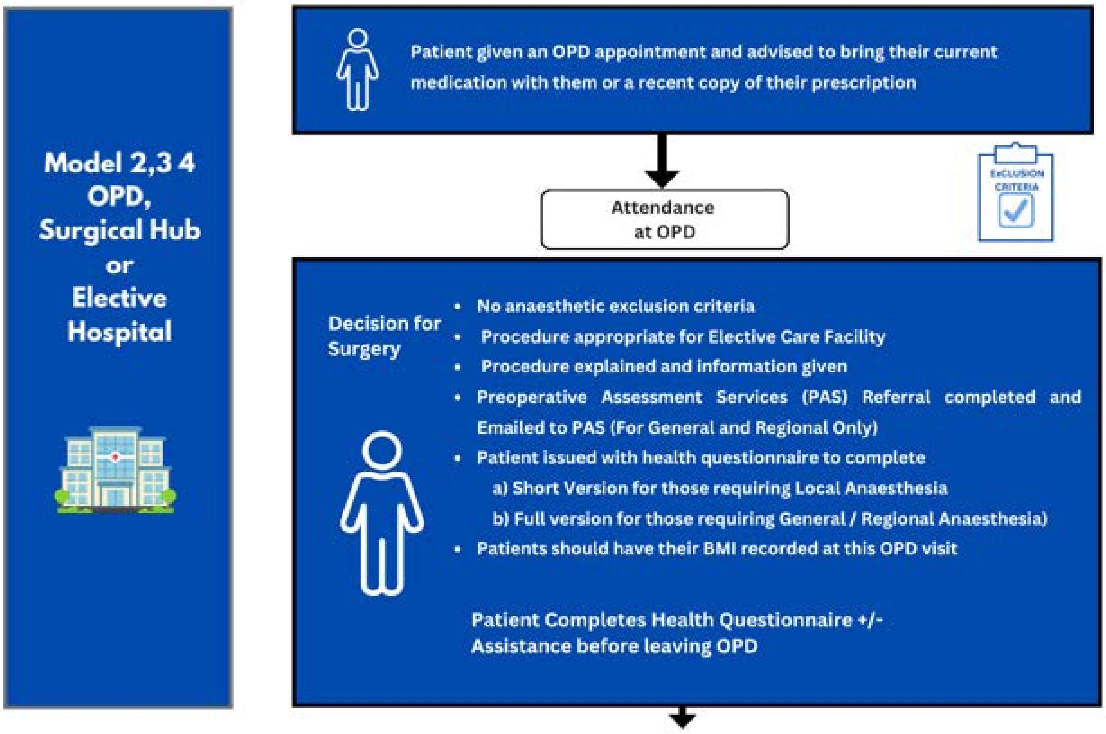
1. Identifying and managing risks
2. Optimising patient health - prehabilitation
3. Reducing surgical delays and cancellations
4. Enhanced anaesthesia planning
5. Enhanced postoperative recovery
6. Educating and preparing the patient

A thorough preassessment leads to safer surgeries, better patient experiences, and improved healthcare efficiency.

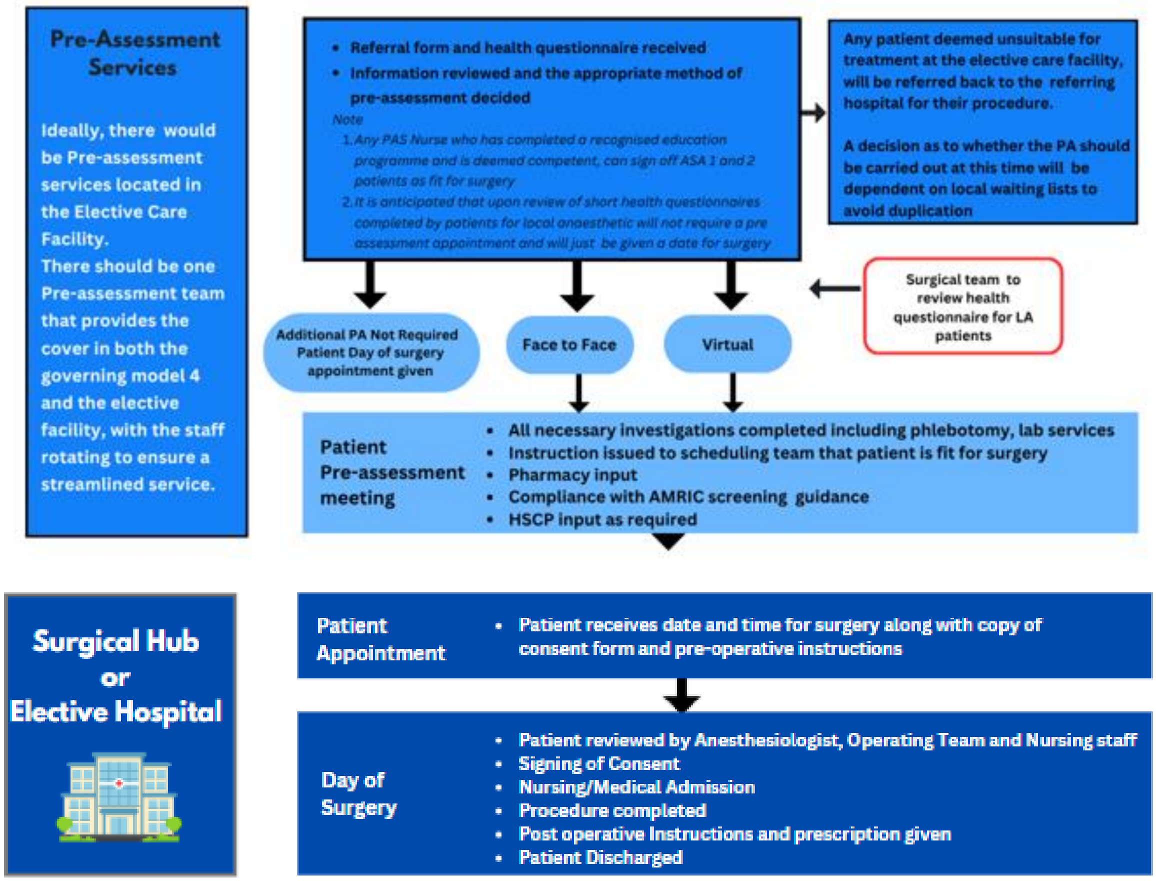
It is hoped that the future state of preassessment should be via an electronic app.

Figure 1 outlines a pathway that has been agreed for preassessment in the elective care facilities.

Figure 1. Preassessment in the Elective Care Facilities (Excluding Endoscopy)



If the patient is unsuitable, the surgery should be carried out in the Model 2, 3 or 4 hospitals per local referral policy



10.0 Endoscopy Patients

The pathway and requirements for endoscopy patients to attend the elective care facilities is not the same as day surgery patients. The following outlines the pathway for endoscopy patients.

10.1 Endoscopy Referrals

Referrals for endoscopy may be completed directly, usually from the primary care setting and may not require an outpatient consultation. A patient with a direct gastrointestinal (GI) endoscopy referral can be added directly to the waiting list without first being seen by a consultant. All direct referrals will be assigned a clinical prioritisation category (CPC). A CPC is the level of urgency assigned to a referral by a clinician or a delegated clinical team member. These patients are clinically prioritised as Priority 1 (P1 or urgent) or Priority 2 (P2 or routine) within five (5) working days of receipt of referral.

The triage and vetting process will determine patient suitability for the elective care facilities. Patients who are deemed unsuitable for the elective hospital will be managed at the Model 2,3 or 4 hospital they were referred to. This decision may happen at the time of triage or at the pre-assessment stage and it should be clear from the referral information as to who the patient is referred back to.

10.2 Preassessment for Endoscopy

The purpose of pre-assessment in advance of an endoscopy procedure is to ensure patients who are scheduled are appropriately prepared and safe to proceed with their procedure. This includes education on bowel preparation, knowledge of co-morbidities and factors which may have an impact of the safety of the endoscopy procedure as well as providing education and advice on sedation.

Risk stratification is an essential component of a pre-procedure evaluation to determine selected patients that should undergo formal pre-assessment prior to endoscopy (9). There are guidelines in relation to the safe management of patients taking anti-platelet or anti-coagulant medications in advance of endoscopy procedures. It is important patients who take these medications are appropriately managed in advance of their procedure to reduce the risk of adverse events both pre and intra procedure. Pre-assessment to reduce the risk of sedation-related complications and to balance the indication and intended aim of the procedure against the physical status of the patient is also important (10).

Inadequate bowel preparation has been associated with significantly lower rates of adenoma detection, caecal intubation failure and poor patient experience (11). Poor bowel preparation is associated with failure to reach the caecum and hinders the detection of lesions (NEQI, 2020). Caecal Intubation Rate (CIR) is one of the key quality indicators (KQI) of colonoscopy. Caecal intubation rates are affected by a number of factors including bowel cleansing. Enhanced patient information regarding bowel preparation is recommended ahead of colonoscopy procedures (NEQI, 2024). Enhanced instructions for bowel preparation also include a telephone service (11).

Patients automatically referred for endoscopy preassessment:

- All patients requiring a colonoscopy

All patients who have the following medical conditions:

- Diabetes
- Implantable Cardioverter Defibrillator (ICD)
- Mobility issues
- Currently taking anti-coagulation and antiplatelet medication
- Respiratory illness

Note: Pre-Assessment for Endoscopy is not limited to the above conditions.

Referral Process to Preassessment

The endoscopy triage nurse or appropriate clinician at the referring hospital will:

- Review the patient's referral form
- Determine if the patient requires a preassessment review at the elective hospital if they have been deemed suitable to have their procedure carried out there

Follow Up

If the preassessment clinic nurse requires any follow-up guidance, they will contact the endoscopy team performing the procedure. This includes follow-up for results of any tests required pre-procedure.

ELECTIVE HOSPITAL ONLY

This following pathway has been developed in conjunction with the Endoscopy Programme and is outlined in Figure 2.

Figure 2. Endoscopy Patient Pathway for Elective Hospitals

Endoscopy Patient Pathway For Elective Hospital

Pre Procedure	Referral	Referral received. Referral logged on patient management system by administration staff.
	Planned procedure waitlist	Part of clinical validation (completed by suitable person), patients on Planned Procedure Daycase Waiting List (PPDWL) could be identified as suitable for elective hospital
	Triage	Referral reviewed by Triage nurse/appropriate clinician and decision made for most appropriate care pathway (scope/OPD/back to GP/alternative test). Patient referred to elective hospital (if this is the Triage decision) and added to GI endoscopy waiting list.
	Scheduling	Patient scheduled in **strict chronological order** as per priority assigned Patient management system in elective hospital should be linked to referring hospital
	Pre Assessment (Virtual)	Pre defined patients from patient selection pre-assessed by nurse prior to procedure to ensure they are adequately prepared and safe to proceed with procedure. Pre assessment completed on pre assessment module on ERS (optional)
Procedure	Registration	Patient's HCR is available (HCR available electronically) Patient attends for procedure and is registered on the patient management system
	Pre-admission	Nursing admission and pre-procedure checklist. Pre-assessment if not already completed.
	Procedure	Endoscopy reporting system in elective hospital linked to referring hospital
	Recovery	Post procedural care, care of sedated patients, management of adverse events, assess fitness for discharge
	Discharge	Nurse led discharge, procedure specific discharge instructions including contact information in event of queries/complications post discharge. Results of procedure and follow up communicated to patient. Results available electronically to source of referral e.g. referring hospital or GP
Post - Procedure	Pathology	Samples taken during scope sent to laboratory for testing and analysis
	Results	Results will be available on the endoscopy reporting system. The operating consultant must be able to access results on the endoscopy reporting system and is responsible for the follow up of results if required with the patient
	Complications	Patient follows instructions given at time of discharge and attends local hospital in the event of any complications Follows up on patient if complications/concerns/queries - person to be identified
	NQAIS	Appropriate delegated clinical manages uploads to NQAIS endoscopy A dedicated clinician - person to be identified

10.3 Endoscopy Reporting System

Solus is the Endoscopy Reporting Systems (ERS) due to be rolled out in HSE hospitals. This electronic platform creates an endoscopy report after each procedure. It is a cloud-based software and has the ability to be integrated with Electronic Health Record's (EHR) as they come on line with later phases of the project.

Solus ERS includes a nursing pre-procedure checklist and a nursing pre-assessment document for GI Endoscopy. The nursing pre-assessment document is designed for patients who require preassessment in advance of their procedure date as well as on day of admission. The nursing pre-procedure checklist will be completed on the day of admission. Additional documents can be uploaded to the patient's ERS record in PDF format. E-Health, in collaboration with the HSE Endoscopy Programme, are working with Solus Endoscopy on this project. These optional modules will be part of Solus when it is rolled out nationally.

11.0 Patient Communication, Education, Shared Care and Consent

11.1 Communication, Education and Shared Care

Reducing the need for unnecessary surgical care can be facilitated by utilising a shared-decision making philosophy which facilitates patient-surgeon dialogue, thus enabling the patient to become a more active participant in decisions surrounding their care. Patients should be advised as to the benefits, risks, alternatives and option of conservative management.

11.1.1 The Role of Primary Care

Communication with patients from the point of GP referral about the nature of day surgery is key in managing patient's expectations. With the move of many procedures from inpatient to day case, the patient experience of the elective care facilities will require collaboration with the GPs to optimise awareness for which procedures can be considered for day case surgery and to ensure that the 'day surgery' message is communicated early on to patients.

Advancements in surgical techniques and perioperative care now allow many procedures that previously required a three-day hospital stay to safely be performed as day cases for suitable patients.

Patients discharged earlier than they anticipate may feel uncertain or worry that their care is being compromised. Consistent communication from the outset is essential to managing expectations and ensuring patient confidence in their care plan.

11.1.2 Prevention

For patients to take a proactive role in their own care, they need to understand their condition and how they may care for themselves to prevent the need for any surgical intervention.

11.1.3 Prehabilitation

Prehabilitation aims to prepare patients physically, psychologically and nutritionally to enhance general health and wellbeing prior to major surgery. By intervening in the preoperative period to modify behavioural and lifestyle risk factors, the 'physiological reserve' of the patient is increased with the aim of avoiding or overcoming complications post-operatively. Importantly, this also promotes and facilitates health behaviour changes not only preoperatively but during the postoperative period and over the long-term (12).

11.1.4 Enhanced Recovery After Surgery

Enhanced Recovery After Surgery (ERAS) can be supported by following guidelines that have been developed for various procedures. These guidelines are multidisciplinary perioperative care pathways designed to achieve early recovery after surgical procedures by maintaining preoperative organ function and by reducing the profound stress response after surgery.

The ERAS® society is a non-profit, multidisciplinary and multi-professional medical society set up in 2010 with the mission of developing perioperative care and to improve recovery through research, education, audit and implementation of evidence-based practice (13). Since its inception, the society has published multiple consensus guidelines for enhanced recovery after surgery which can be accessed here. (14). ERAS protocols offer recommendations for the pre, intra and postoperative management of surgical patients. Preassessment services play a key role in the preoperative element of ERAS protocols.

11.1.5 Procedure/Patient Information

Patients need to understand the surgical intervention proposed along with the risks and benefits and the option of not having the intervention. Recognising that patients may have physical, sensory, intellectual and language differences, the patient information should be standardised and available in various formats and languages. It is not appropriate to hand patients many documents without taking the time to ensure they understand the information and have any questions answered. Involving family members in the education, if supported by the patient, improves the chances that information will be retained and instructions will be followed. Families play a critical role in healthcare management.

Technology has made patient education materials more accessible. Educational resources can be customised and either printed out for patients with the touch of a button or patients are given a Quick Response (QR) code which will allow them to read the information online. Ideally across all the elective care facilities there should be the same access to standardised patient information for procedure types. This could be through a HSE website or an established commercial company that is already in operation within the HSE.

A Preoperative Booking Pack, including the templates for post op instructions, consent and an analgesic plan would support efficiency if completed at OPD booking stage.

11.2 Informed Consent in Practice

Consent involves a process of communication about the proposed intervention in which the person has received sufficient information to enable them to understand the nature, potential risks and benefits of the proposed intervention. Seeking consent should usually occur as an on-going process rather than a one-off event (15).

The HSE developed a National Consent Policy in 2013 which was updated in 2022. Although the core principles underpinning valid informed consent and good practice were unchanged, the revised policy reflects important legislative and policy changes since 2013 and can be found here. The following information has been extracted from this policy and adapted for use in elective care facilities (15).

The NECCGG sought a copy of the current available consent forms in use, including a recently produced form from University Hospital Limerick. These were reviewed in line with the current national consent policy and a standardised consent form was developed that could potentially be used as a template for all elective facilities.

Note – The consent form is currently being reviewed by the HSE National office for Human Rights and Equality (October 2025). Once approved it will be made available to all sites as part of Appendix 8 of this document. Further information on the practicalities of seeking consent will also be found in the updated Appendix 9. This consent serves as a template for sites adapt locally.

12.0 Patient Scheduling

Scheduling patients for day case surgery involves balancing efficiency, safety, and patient experience. The best approach should minimise delays and cancellations, optimise operating theatre utilisation and ensure proper patient selection and preparation. Use of the Theatre Measurement Model (TMM) (Section 17.4) and associated Gantt charts and Target Theatre Optimisation Model (TTOM) could inform schedulers of capacity usage in terms of session utilisation and associated metrics such as underruns and overruns.

The exclusion criteria, agreed list of procedures and pre-assessment, along with the cohorting of patients, will go a significant way in supporting this approach but the following are suggested additional recommendations:

12.1 Staggered Arrival Times and Fasting

Patients can have staggered arrival times with agreed fasting times. This has three major benefits. Firstly, it avoids overcrowding and minimizes fasting times and secondly allowing people to sip water until they are about to undergo surgery means that they are hydrated and more comfortable [i,ii,iii,iv,v,vii], with less nausea, fewer headaches and a lower chance of needing an intravenous drip. It also minimises a delayed discharge post-op.

12.1.1 SipTilSend Policy

This applies to all patients unless a senior clinician has requested an individual "opt out".

No food for 6 hours before surgery and then unlimited clear fluids (water, black tea, black coffee, squash or oral carbohydrate drinks) until 2 hours before surgery, after which the 'Siptilsend' applies. This means sipping water, black tea, black coffee or squash up to 170mls per hour (= one cup) until the operating team send for the patient.

12.1.2 Contraindications

- Significant history of symptomatic gastro-oesophageal reflux disease or hiatus hernia
- Class-3 obesity (BMI >40)
- Documented history of gastric immobility e.g., autonomic dysfunction related to diabetes
- Admission for gastrointestinal surgery where the patient has a known obstructing lesion
- Significant dementia or learning difficulties where a patient is unable to limit/manage their own water consumption
- Any patient on thickened fluids
- Patients who have had a stroke affecting swallowing
- Patients who have a bowel obstruction or ileus

12.1.3 Advice to Patients

- You may drink clear fluids before your surgery
- Clear fluids include water, black coffee, black tea, or diluted squash
- Do not eat any solid food, milky drinks, fizzy drinks, or sweets (including chewing gum) 6 hours before your surgery

- You may drink unlimited amounts of clear fluids until 2 hours before the intended start time of your operation. After that, you will be encouraged to sip up to 1 glass (170mls) of clear fluids every hour

12.2 Diabetes

Patients with diabetes are more likely to maintain good diabetic control if they are in their normal environment with their normal diet and medication. The Guidelines for Perioperative Care for People with Diabetes Mellitus Undergoing Elective and Emergency Surgery can be accessed here. Patients with diabetes should be scheduled for surgery early in the day to support their control in so far as is possible. In the event that they are on an afternoon list, advice should be given around fasting, early breakfast etc.

12.3 Pregnancy Testing

Females undergoing surgery that may compromise a potential pregnancy, or that could be complicated due to a pregnancy should undergo a pregnancy test prior to the procedure for confirmatory purposes. To avoid delays, these procedures should not be scheduled first to allow time for the tests to be carried out.

12.4 Neurodiversity and Dementia

Ideally, the amount of time spent in an elective care facility should be kept to a minimum for any patient with neurodiversity or dementia to minimise disruption and avoid stress. These patients should be scheduled earlier in the day, where possible to avoid delays which are more likely to occur as the day progresses. Infrastructural design is important to facilitate patients with enhanced needs and this is covered by the operational workstream.

12.5 Recovery Times

Procedures which are likely to require a longer recovery time should be scheduled earlier in the day to avoid unplanned admissions or delayed discharge e.g., Laparoscopic Cholecystectomy

12.6 Infection Prevention and Control

Patients should have their microbiological history taken as part of the pre-assessment. A review of the results should influence patient placement on the scheduling list to ensure optimal patient flow and avoid delayed discharge or unplanned admission.

12.7 Access to Radiography

When scheduling patients, the requirement for radiography must be flagged on the booking form. The timing of these patients on the list needs to align with the availability of the radiography staff.

12.8 Specific Theatre/ Equipment Requirements

When scheduling patients, the requirement for specific equipment/laser/lead lined theatres must be flagged on the booking form to avoid delays or cancellations.

13.0 Safe Surgery

The National Policy and Procedure for Safe Surgery endorses the principles of the World Health Organisation (WHO) Surgical Safety Checklist and the HSE's Patient Safety Strategy to ensure that every patient undergoing a surgical procedure has the safest possible care.

The policy and procedure, based on best practice and evidence, introduces key safety steps that should be incorporated into each operating theatre department to support the development of a safety culture and to improve communication among operating department teams. It applies to every patient undergoing surgery in the Irish hospital setting and to all healthcare staff involved in the surgical patient pathway.

The Policy includes five stages for Safe Surgery, including Team Briefing and Debriefing, to accompany Sign In, Time Out and Sign Out. The link to the policy and audit tool can be found here.

14.0 Post Operative Discharge Criteria

It is important that there is a locally agreed discharge process, endorsed by the multidisciplinary team. This should outline not only general discharge criteria but also procedure-specific criteria. It is essential that healthcare professionals responsible for patient discharge receive appropriate education and training to ensure their competence. The sections below outline some suggestions to standardise the process across the elective care facilities.

14.1 Stage I to Stage II Recovery

Appropriately trained surgical and anaesthesia staff must remain on site until the final patient is discharged to ensure the safe management of any potential emergency clinical situations

The modified Aldrete scoring system is utilised to objectively assess a patient's readiness for discharge from Stage I to Stage II recovery following anaesthesia (16). This scoring system evaluates key physiological parameters to ensure the patient has sufficiently recovered from the immediate effects of anaesthesia and is stable enough to transition to a lower level of monitoring.

Patients are assessed based on ten critical criteria:

1. Activity: The ability to move extremities voluntarily or on command.
2. Circulation: Blood pressure and heart rate within an acceptable range of preoperative baseline.
3. Oxygen Saturation: Maintenance of adequate oxygen levels with/without supplemental oxygen.
4. Respiration: The ability to breathe deeply and cough effectively, indicating adequate respiratory function.
5. Consciousness: The patient is awake, responsive, or easily arousable.
6. Pain control: Adequate pain management with appropriate interventions.
7. Nausea and vomiting: Minimal or well-controlled symptoms.
8. Temperature: The ability to regulate and maintain a stable body temperature
9. Post Spinal: Return of motor and sensory function
10. Surgical site stability: No significant bleeding or other surgical concerns.

Each category is assigned a score from 0 to 2, with a maximum possible score of 20 points. A modified Aldrete score of ≥ 18 is typically considered appropriate for discharge from Stage 1 recovery, provided there are no other concerning clinical factors. For example, if the patient is scoring zero in any category. Upon achieving an acceptable modified Aldrete score and meeting the above criteria, the patient may be safely transitioned to Stage 2 recovery, where they receive continued observation before hospital discharge. This structured approach ensures a standardised, safe, and effective transition from the immediate post-anaesthesia period, reducing complications and promoting patient well-being.

The template proforma for this is outlined in Appendix 3.

The Irish National Early Warning System (INEWS) recommends that a full set of INEWS observations should be undertaken and documented on the INEWS chart when a patient is transferred between areas within a hospital or on discharge from a higher-level care (HLOC), Emergency Department or theatre recovery room and again on arrival to the ward. A full set of INEWS physiological observation should be recorded on all occasions.

14.2 Stage II Recovery to Discharge

Discharge planning must be an integral part of the elective pathway, starting from the initial consultation and continuing through each stage of the patient's journey on the day of their procedure.

There are a number of key physiological parameters to ensure patients meet clinical stability criteria and are stable enough to be discharged. A patients INEWS should be routinely recorded and documented post operatively and until discharge from Stage II Recovery. INEWS promotes early recognition of patient deterioration and escalation of care must be based both on the INEWS score and clinical judgement. Patients are assessed based on the following criteria:

- Vital signs - stability compared to pre-operative baseline.
- Ambulation – must be able to ambulate as per pre operative level
- Nausea/Vomiting – should have minimal nausea and vomiting
- Pain – minimal or no pain
- Surgical bleeding – should be consistent with expected blood loss for the procedure
- Fluid intake/output – should be able to tolerate adequate fluids and has voided

14.2.1 Modified PADSS Scoring Criteria

The Modified **Post Anaesthetic Discharge Scoring System (PADSS)** (17) (18) is a standardised tool used to determine a patient's readiness for safe discharge from Stage II recovery following day surgery.

Based on the criteria outlined above each category is assigned a score from 0 to 2, with a maximum possible score of 12 points and a minimum total score of 9 is required prior to discharge. A modified PADSS score of ≥ 9 is typically considered appropriate for discharge from Stage II recovery to home, where vital signs must score 2 and provided there are no other concerning clinical factors. e.g., if the patient is scoring zero in any category.

In addition, the patient must be awake and orientated and accompanied home by a responsible adult and have a responsible adult remain with them for the first 24 hours post-surgery, as per the patient selection criteria. All post-discharge education, instructions, and emergency contact details must be clearly explained to the patient prior to leaving.

Upon achieving an acceptable modified PADSS score and meeting the criteria, the patient may be safely discharged from to Stage II recovery. The modified PADSS score must include the INEWS, be used in conjunction with clinical judgement and the consultant/operating team must deem the patient fit for discharge. Both PADSS score and INEWS are complementary tools, they should be used together to support safe patient assessment and care.

A discharge checklist has been developed based on the checklist developed by the British Association of Day Surgery (2016) (19), and the NCPS Elective Surgery Model of Care (20), which provides a clear and structured tool to support staff in ensuring a smooth and safe discharge home for patients. **See Appendix 5.**

14.3 Criteria Led Discharge

Criteria Led Discharge (CLD) has been piloted and embedded in the NHS and is currently in use in some hospitals in Ireland. This is a process used in hospitals and healthcare settings where patients are discharged based on predefined clinical criteria rather than waiting for a medical review. Key to the success of criteria led discharge is having a multidisciplinary team agree on a set of discharge criteria that is specific to the patient's procedure. It then allows for an appropriately trained clinical staff to discharge the patient once they meet the agreed-upon criteria (19).

CLD is the process and PADSS as outlined in 14.2.1 can be one of the tools used within that process

14.3.1 Scope of Criteria Led Discharge

- Patient eligibility: patients selected for this process will depend on their clinical stability and complexity of their condition/procedure
- Predefined discharge criteria
- Multidisciplinary team involvement
- Standardisation of documentation
- Patient safety and readiness

14.3.2 Determining what Procedures are Suitable for Criteria Led Discharge

- The proposed procedures for CLD are brought to the attention of the CLD Working Group Quality/Process Improvement Officer/local implementation group.
- The main stakeholders will meet to discuss the suitability of the procedure and to identify specific criteria for CLD.
- There must be a local structures/processes in place to ensure the suitable procedures and agreed criteria are reviewed and approved prior to implementation.
- Implementing a robust governance framework and providing training for healthcare practitioners are essential to ensure the safe and effective execution of CLD.
- The operating team, including the consultant and registrar, must assess and document the patient's suitability for criteria led discharge in the patient's operating notes.

14.3.3 Removal from Criteria Led Discharge Pathway

At any stage, if the patient is deemed unsuitable for the CLD they can be removed from the pathway. The surgical team must be informed of this and it must be documented in the patient pathway notes.

14.3.4 Patient Communication

The discharge process must be discussed with the patient in advance of the surgery. Providing clear information about the process helps set expectations and ensures the patient is well-informed.

14.3.5 Audit of Discharge Protocols

Auditing the hospital discharge process is an important measure to ensure patient safety and maintain high standards of care. The discharge procedure should be appropriate to both the clinical interventions performed and the individual needs of the patient. The metrics for this are outlined in Section 17.

See **Appendix 6** for the Criteria Led Discharge (CLD), Patient Process, and **Appendix 7** for an example of CLD for Adult Patients Post Tonsillectomy

14.4 Endoscopy Discharge

Monitoring of patients who have received sedation should extend into the recovery period until the patient's conscious state has consistently returned to baseline. This requires sufficient staff trained in sedation, monitoring and the recognition of complications. Patients should be formally assessed for suitability for discharge.

14.4.1 Standards and Guidance for Sedation

The Academy of Medical Royal Colleges (21) recommend discharge criteria as follows:

1. The patient has returned to their baseline level of consciousness.
2. Vital signs are within normal limits for that patient.
3. Respiratory status is not compromised.
4. Pain and discomfort have been addressed.

Patients meeting discharge criteria following sedation should be discharged into the care of a suitable adult (18 years and above). This carer needs to be available to support the patient for 24 hours after the procedure. Verbal and written instructions should be provided that are appropriate for both the sedation received and procedure performed.

14.4.2 Recovery from Endoscopy

Recovery from endoscopy can be divided into multiple stages:

First stage: Return to baseline consciousness levels and function. The patient is awake and protective reflexes have returned.

Second stage: Preparing the patient to leave the endoscopy unit. This will include information exchange, follow-up planning and discharge advice for both patient and carers. At this stage, the patient will be able to resume normal activities such as eating and drinking.

Late stage: Occurs after the patient has left the department.

Protocols and practices need to ensure safety of the patient throughout all three stages.

(BSG Safe Sedation Guidelines 2023) (10).

15.0 Procedure Complications

15.1 Intraoperative Complications

Adhering to the guidance on patient and procedure selection will minimise the risk of any intra-operative or post-operative complications. However, all sites need to be prepared in the event of an emergency, cardiac arrest, anaphylaxis, local toxicity, malignant hyperpyrexia, difficult airway and intraoperative haemorrhaging. This list is not exhaustive.

15.1.1 Blood Products

The procedures being undertaken will determine the appropriate transfusion support. If there is a possibility of transfusion/significant blood loss, appropriately risk-assessed arrangements need to be put in place to ensure appropriate transfusion support is in place. This requires involvement of the supporting transfusion service early in planning. Many transfusion services require two separate samples from the patient to verify blood group (historical results are acceptable). Pathways will need to be set up per site to address this.
In addition, a pathway must be established to ensure a patient can have their 'Group and Hold' performed within the appropriate time frame. This needs to be less than 72 hours prior to their surgery but also sufficiently distant in time of surgery to allow antibody identification by the laboratory. For this reason, the 'Group and Hold' should not be performed on the day of the procedure.

The arrangement for transfusion support is more challenging if the Surgical Hub/Elective Hospital is not collocated with a transfusion laboratory. This must be considered if there is a possibility of blood loss, as group O-RhD negative blood may be required on-site on the day of surgery. There must also be an arrangement for timely provision of cross-matched blood and products in case of unexpected intra operative life-threatening haemorrhage. Any patients identified during 'Group and Screen' to have antibodies, should be referred to a hospital that have onsite transfusion service if there is a risk of bleeding.

15.1.2 Emergency Equipment and Consumable Requirement

Sites should have equipment and a number of prepared kits ready in the event of emergency.

The following lists the emergency equipment required, but the number of each will be dependent on the site configuration and number of theatres:

- ***Crash trolleys will be needed in each area of the surgical hub and elective hospital***
- ***Malignant Hyperthermia trolley***
- ***Difficult airway trolley***
- ***Art line boxes (all supplies needed for running and placing an art line in each)***
- ***Central line boxes (as art line boxes)***
- ***Tracheostomy box (including set)***
- ***Anaphylaxis box (all guidelines and algorithms included)***
- ***An emergency mobile press (contains major general set top and bottom, basic general set, aortic aneurysm set top and bottom, basic vascular set***
- ***All consumables and blood products needed for major bleed and open cases***
- ***Unexpected Adult Intra-Operative Life-Threatening Haemorrhage Poster***
- ***Blood Products, relevant consumables***

This is not an exhaustive list and requires a full risk assessment to identify any additional kits that may be required. If necessary, the agreed escalation protocol applies as outlined in Section 16.

15.2 Post-operative Complications

There must be a dedicated 24/7 phone line for patients to call in the event of any postoperative complication staffed by an individual with appropriate clinical experience. During daytime hours, calls may be manged by day surgery staff. Out of hours must be transferred to a senior clinical person or NCHD on-call.

In the event that the patient reports feeling acutely unwell, with a potential emergency, the on-call clinician will advise whether the patient should contact the emergency services e.g., an ambulance or attend the nearest appropriate emergency hospital equipped to manage their complication. They will be advised to bring a copy of their discharge and operation notes.

If the situation is assessed as non-urgent, the patient will be directed to return to the referring hospital for review and further management. The on-call clinician will inform the surgical team in the relevant hospital and will remind the patient of the need to bring their discharge and operation notes with them. The person who is staffing the support line will coordinate and guide the patient through the appropriate steps to ensure timely and safe follow-up care.

16.0 Escalation and Transfer Protocols

16.1 Unplanned Admissions – Background

The aim of this guidance is to minimise the risk to patients needing additional care beyond what can be safely provided by the elective care facilities. In some cases, it may be necessary to admit a patient to award in the governing hospital, or in more serious cases to a high-dependency or intensive care unit.

A review of the national HIPE file for 2018 by the HPO identified 49 hospitals in Ireland where a total of 75,272 day case procedures involving an anaesthetic had been carried out. Based on this review a further, more detailed examination of 37 hospitals was undertaken so as to identify any episodes of emergency readmission to these hospitals within two post-operative days of discharge.

The emergency readmission rate based on the data presented above is 0.2% (117 emergency readmissions out of a total of 61,904-day cases), which is well below the rate considered acceptable by the Royal College of Anaesthetists. However, this figure of 0.2% must be interpreted with considerable caution. The 117 cases identified by the audit are emergency readmissions to the same hospital (or hospital group) where the original day case procedure was performed, but it is not known how many patients were readmitted as emergencies to a different hospital *(22)*.

There is no doubt however, that the inability to identify patients who required emergency readmission to a hospital other than the one where the original procedure was carried out is a significant impediment to any audit. HIPE does not have a means of identifying a patient who has a procedure in one hospital and is then admitted to another hospital but it is hoped that this facility will be improved with the development of a National Health Identifier. Please see section 17.5.3 on readmission rates.

The inclusion criteria and patient selection criteria will keep this to a minimum but it will not absolutely prevent these events from happening.

Each elective care facility must have a standard operating procedure in place for the management of all patients requiring escalation and transfer. It is the responsibility of the governing hospital in the case of surgical hubs or the health region for the elective hospitals to ensure that there are documented and agreed pathways in place.

16.2 Admissions to Intensive Care Unit (ICU)/High Dependency Unit (HDU)

1. There must be a pre-agreed no-refusal protocol in place for the unplanned admission of cases to ICU/HDU from the day-surgery unit, including a list of typical cases requiring transfer to ICU/HDU from the day-surgery unit. (It is estimated that less than 10% of unplanned admissions from day-surgery will require critical care).
2. The reasons for admission to critical care may include conditions such as cardiac complications (including ROSC post cardiac arrest), anaphylaxis, aspiration, malignant hyperpyrexia, suxamethonium apnoea, the requirement for inotropic or vasopressor support, persistent hypotension, ongoing bleeding or post-operative confusion.
3. A referral pathway in this situation would require direct verbal and written communication between the consultant anaesthesiologist in the day-care unit and the on-call ICU consultant (and/or the on-call consultant cardiologist) in the receiving hospital, as well as a medical escort by a suitably-trained anaesthesiologist for the ambulance transfer and a written transfer record.
4. Direct verbal and written communication from the day-surgery surgical team to the on-call receiving surgical team in the receiving hospital would also be required.

16.3 Admissions to a Surgical Ward or Post Anaesthesia Care Unit (PACU)

In Ireland, there is some variance in the title of the 'post-anaesthesia care unit'. However, internationally this is recognised as a designated area where patients are brought after surgery to safely regain full consciousness from anaesthesia and receive appropriate post-operative care. For the purpose of this document, such an area will be referred to as a post-anaesthetic care unit (PACU).

1. There must be an agreed protocol in pace for the unplanned admission of cases to a surgical ward or PACU, also known as an operating department recovery room, including a list of typical cases requiring transfer to a surgical ward or PACU
2. Most unplanned admissions from the day-surgery unit would likely require admission to a surgical ward or PACU under the care of the on-call surgical team.
3. The most likely causes for such unplanned admissions include persistent post-operative nausea and vomiting, uncontrolled pain requiring repeated doses of opioid medication, drain insertion, unexpected findings of malignancy or urinary retention.
4. Such a referral would require direct verbal and written communication between the day-surgery surgical team and the on-call surgical team in the receiving hospital, as well as a suitably-trained nurse escort for the ambulance transfer and a written transfer record.
5. In the event that the transferred patient requires an overnight stay in a PACU, there should also be direct verbal and written communication between the day-surgery anaesthesiology team and the on-call anaesthesiology team in the receiving hospital, as well as direct verbal and written communication between the day-surgery surgical team and the on-call surgical team in the receiving hospital.

16.4 Communication with the National Ambulance Service

To describe the most appropriate resource, referral should go through the 1800-ACCEPT system.
The level of ambulance resource needed should be described as:
Level 0 - Walking
Level 1 - Ward Level
Level 2 - HDU Level
Level 3 - ICU Level

Levels 0 and 1 require Protocol 37 with EMT.
Levels 2 and 3 may require the MICAS service if the patient is intubated.
For Level 2, Protocol 37 an EMT may be appropriate if the patient is not intubated. This should be agreed as part of the 1800-ACCEPT system and discussion.

16.5 Communication with the Receiving Hospital

As outlined above, communication with the receiving hospital is key to a safe transfer of the patient. In addition to the surgical and anaesthetic team communications, there should also be communication and handover with the nursing team and site/bed manager. The Association of Anaesthetists Guidelines for Day-Case Surgery, 2019, recommends that 'robust, tested communications and written service level transfer agreements (should exist) between the stand-alone unit, the nearest acute hospital, it's intensive care unit and the ambulance service (23). This is further supported by the Royal College of Anaesthetists 2021 (24).

The Department of Health has produced a National Clinical Effectiveness Committee (NCEC) guideline (No 11) on Communication (Clinical Handover) in Acute and Children's Hospital Services (25). This guideline recommends clear procedures, supportive environments, and staff education to reduce errors and improve patient safety during these high-risk transitions, emphasizing principles like focused, concise, timely, complete, and organised communication. The $ISBAR_3$ clinical handover tool is the nationally recommended standardised tool for conducting clinical handover for both situations. It provides a standardised framework, at the same time permitting clinical handover to be tailored to the needs of each department or facility.

The HSE and the Office of Nursing and Midwifery have developed various education and training resources which can be accessed here.

The Model of Care for Elective Surgery which was published by the HSE, RCSI and the CAI in 2013 includes a chapter on day-case surgery and has as an appendix of a sample Transfer Communication Record (20).

16.5.1 Critical Care Transfer

There are standardised transport records that all hospitals use for Critical Care transfers. The links to these are provided below. There are also guidelines and support tools found on each website, to including QR codes to support regional hospitals who have to undertake their own transport. www.nasccrs.ie

Adults – MICAS: http://www.nasccrs.ie/Files/Adult-CCTR.pdf

17.0 Perioperative Metrics and Key Performance Indicators

The metrics and Key Performance Indicators (KPI's) for the elective care facilities need to meet with the operational goals and strategies to demonstrate good return on investment and cost efficiency. This will be demonstrated through monitoring of all aspects of the surgical hubs/elective hospital process. Central to all this is the patient journey and patient safety. There is considerable crossover between operational and clinical metrics. As such the complete list will be published in both this document and the HSE Operational Policy document.

'Standard practices' in hospitals sometimes reduce productivity. As the new facilities open, there is an opportunity to ensure new ways of working are embedded and become the new 'business as usual'. Maintaining theatre productivity in the surgical hubs and elective hospitals is critical to delivering on their potential. Standardisation of terms used to document critical points in the patient's journey through the operating theatre department enables consistency across hospitals, facilitates training, improves efficiency and reduces cost. It avoids wasted effort arising from repeated and variable definition at multiple sites across public hospitals and enables successful quality improvement initiatives to be shared within and between hospital groups.

17.1 Metrics for Monitoring Key Performance Indicators & Staffing

A multidisciplinary team was set up to look at the full range of metrics and KPI's. The following metrics and KPI's are extensive and each facility will require a data management team and business intelligence analyst to support the accurate collection of data. It is recognised that every facility will not have the capacity to collect and monitor all the performance indicators outlined in Table 3 from the outset, but it is hoped that these would be adopted as resources are secured to support the data collection. Responsibility for collection and reporting should be divided into operational and clinical, so as no one person is entirely responsible.

17.2 Key Performance Indicators – Operational

The following Operational KPIs for Elective Care Facilities are recommended:

Table 3. Operational Metrics and KPI's

Equity of Access				
	Data Collection	**Measurement**	**Benchmark**	**Value**
HUB & HOSPITAL	National Steering Group review of local site waiting lists to ensure equity of access for all hospitals within the health regions	WL reduction rate across sites	Equal access	Population equity of access

Outpatient Diagnostics and Treatment				
	Data Collection	Measurement	Benchmark	Value
ELECTIVE HOSPITAL ONLY	No. of patients seen in OPD Staffing to support (NCHD Admin)	No. of patients seen in OPD vs maximum able to be seen in session	100 %	Safe staffing for OPD including maximum OPD clinic numbers (This may be specialty dependent)

Preattendance and Preassessment				
	Data Collection	***Measurement***	***Benchmark***	***Value***
HUB & HOSPITAL	Total Time from referral to DC Waiting List	Date referral Added to DC WL –> Treatment TCI	TBD	This metric is thought to be a more valuable metric of improvement and equity of access, as opposed to gross numbers on the waiting list.
	Date Listed for Procedure	OPD – Date Listed	Sláintecare Targets	Meeting Sláintecare targets and showing effectiveness of the Elective Facilities
	Date of Preassessment (GA/ Sedation Only)	Within 3 months of being listed	N/A	
	Date of Procedure	Within 8 weeks of being listed	100%	
	No. of patients seen in preassessment Max able to be seen in session No. virtual / No. face to face	Utilisation of Preassessment Ratio	100% (ratio of the number of patients seen/maximum capacity to see patients)	Performance and Utilisation assessment
	No. of patients that did not attend	DNA Rate	1% or less	Performance and Utilisation assessment

Staff Reported Metrics				
	Data Collection	***Measurement***	***Benchmark***	***Value***
HUB & HOSPITAL	Staff Utilisation Rate (%)	***(This is captured as part of the TMM model)***		
	Staff Satisfaction and Well-being index	TBD	TBD	Promoting Staff satisfaction and sustainability

Financial Metrics				
	Data Collection	***Measurement***	***Benchmark***	***lue***
HUB & HOSPITAL	Cost per Surgery	Cost vs. M3/M4 cost	TBD	***Cost Effectiveness and Productivity***
	Cost of DNA Attendances	TBD	TBD	
	Cost of on-day Cancellation	TBD	TBD	
	Supply and Equipment Utilisation	TBD	TBD	

17.3 Key Performance Indicators – Clinical

The following Clinical Key Performance Indicators (KPIs) for Elective Care Facilities are recommended:

Table 4. Clinical Metrics and KPI's

Elective Care Facility Patient Flow – Applicable to Main Theatre and Minor Operating Rooms				
	Data Collection	***Measurement***	***Benchmark***	***Value***
HUB & HOSPITAL	Time of Arrival at Facility Ready for theatre	Patient Experience Time – Arrival	2-3 hours	Patient Flow Measurement
	Ready for Theatre - Called to Theatre	Patient Experience Time - Theatre	< 15mins	Patient Flow Measurement
	Cancellation ***Patient*** Refused Surgery Cancelled the Slot Did not attend ***Clinical*** Procedure not required Patient not fit for surgery Pre-Assess/Op issue Case Deferred ***Hospital*** Scheduling	Patient Cancellation Rate %	2% or less	Performance and Utilisation assessment
	Procedure carried out by OPD Consultant	Consent Continuity	TBD	Continuity of Care /Pooled patients
	Time Spent in Stage 1 Recovery	Patient Experience Time	TBD	Patient Flow Measurement
	Time Spent in Stage 2 Recovery prior to discharge	Patient Experience Time	TBD	Patient Flow Measurement

Theatre/Operating Room Access & Flow Metrics (TMM) Applicable to Main Theatre and Minor Operating Rooms

	Data Collection	*Measurement*	*Benchmark*	*Value*
	Briefing carried out as per Safe Surgery Policy on daily basis	% Days that Briefing Stage is conducted	100%	Audit of this stage of the safe surgery policy
HUB & HOSPITAL	TMM Implemented (Theatre Measurement Model)	Yes / No	100% Yes	Performance and Utilisation
	Theatre starting on time	% Cases starting on time	TBD	
	Capacity – Possible Time	TMM - Hrs	TBD	
	Access – Available Time (Staffed time)	TMM - Hrs	TBD	
	Flow/Usage – Used Time	TMM - Hrs	TBD	
	% Available & % Utilisation	TMM %	TBD	
	Number of Patients Treated	TMM # Patients	TBD	
HUB & HOSPITAL	Scheduling per session ***(Monitoring metrics will determine operator/procedure timings and these learnings should be used to optimise scheduling)***	No	Operator and Specialty specific – will be determined with data collection	
	Debriefing carried out as per Safe Surgery Policy on daily basis	% Days that Debriefing Stage is conducted	100%	Audit of this stage of the Safe Surgery Policy

Intra-Operative Metrics – Requiring Anaesthesia (GA or Sedation)

	Data Collection	*Measurement*	*Benchmark*	*Value*
	Safe Surgery 3 time points (Sign In, Time out, Sign out)	Protocol Being adhered to	100%	Monitor for patient safety trends
HUB & HOSPITAL	Prophylactic Antibiotic use *Appropriate prescribing*	Against Clinical Guidelines	100%	Antimicrobial Stewardship
	No of Anaesthetic / Emergency Events e.g., Anaphylaxis, Intraop Haem.	Incidence Rate	<5% -TBD	Monitor for patient safety trends
	Adherence to Clinical Guidelines	TBD	TBD	E.g., adhering to national guidance e.g., Lap Chole

Intra-Operative Metrics – Requiring Local Anaesthesia

	Data Collection	*Measurement*	*Benchmark*	*Value*
HUB & HOSPITAL	Safe Surgery 2 time points ***Sign In/Time Out & Sign Out***	Protocol Being adhered to	100%	Monitor for patient safety trends
	Prophylactic Antibiotic use *Appropriate prescribing*	Against Clinical Guidelines	100%	Antimicrobial Stewardship
	No. of Anaesthetic / Emergency Events	Incidence Rate	<5% -TBD	Monitor for patient safety trends
	Adherence to Clinical Guidelines	TBD	TBD	E.g., adhering to national guidance e.g., Lap Chole

Post-Operative Complication Metrics – All Cases – Immediate

	Data Collection	*Measurement*	*Benchmark*	*Value*
HUB & HOSPITAL	Unplanned return to theatre (same facility / same day)	Rate/number scheduled	TBD	Monitor for patient safety trends
	Prophylactic Antibiotic use-Appropriate duration	Adherence to guidelines	TBD	
	Patient required transfer to Ward in M3/M4 hospital	Rate/number scheduled	TBD	
	Patient required transfer to ICU/HDU in M3/M4 hospital	Rate/number scheduled	TBD	
	Mortality Rate (time frame to be defined)	Rate/number scheduled	TBD	

General Post Operative Metrics

	Data Collection	*Measurement*	*Benchmark*	*Value*
HUB & HOSPITAL	Patient discharged using CLD (GA/Sedation only)	Rate No. CLD/ Total Scheduled	TBD - ~75%	Establish CLD as default
	Procedure listed as appropriate for the facility	Incidence of list extension	0%	Patient Safety
	Procedure carried out in appropriate room type	As per agreed list	100%	Promote optimal utilisation of elective facilities
	Appropriate attire worn	As per agreed list	100%	
	De-brief as per Safe Surgery	Protocol Being adhered to	TBD	Monitor for patient safety trends
	Patient Suitable for Patient Initiated Review (PIR)	Rate No. PIR / Total Scheduled	TBD – 75%	Monitor for patient safety trends

24 hours Post Operative Metrics - Main Theatre Cases only				
	Data Collection	***Measurement***	***Benchmark***	***Value***
HUB & HOSPITAL	No. of Surgical Site Infections	Incidence Rate	TBD	Monitor for patient safety trends
	VTE (Venous Thromboembolism)	Incidence Rate	TBD	Monitor for patient safety trends
	Readmission Rate (Total) *(*within 30 days relating to same condition/treatment, accepting that this will be to a different hospital)	Incidence Rate	TBD	Monitor for patient safety trends
	Readmission Rate for CLD patients (within 30 days relating to same condition/treatment)	Incidence Rate	TBD	Monitor for patient safety trends

Patient Reported Metrics				
	Data Collection	***Measurement***	***Benchmark***	***Value***
HUB & HOSPITAL	Pain Management Effectiveness%	TBD	TBD	Quality of Care
	Patient Satisfaction Score (1-10) ***To include areas such as access to care if required following discharge, if further care was required, where and how was it accessed etc***	80% >	80% >	Quality of Care, communication, discharge support and overall experience
	Patient Initiated Review *Planning*	No. of appointments made in time frame	***TBD***	Performance, Planning and Effectiveness
	Patient Initiated Review *Appropriateness*	Determination that patient needed a review	***TBD***	PIR Selection Quality Improvement

17.4 The Theatre Measurement Model (TMM)

The Transforming Theatre Programme, now incorporated into the National Perioperative Patient Pathway Enhancement Programme (NPPPEP), have developed a standard set of 'timestamps' which embed principles of flow in normal work practices. The five timestamps track the patient journey through the theatre/operating room and generate a balanced suite of actionable metrics to support improvement around patient capacity, access and flow. The Theatre Measurement Model (TMM) uses standardised operational and technical definitions to generate the following metrics and supporting Gantt charts around; on-time starts, inter-operative intervals, early finishes, over-runs, % utilisation, number of cases treated, along with theatre/operating room Used Time (patient flow), Available Time (patient and staff access) and Possible Time (capacity). These standardised time stamps are shown in Figure 3 and should be implemented from the outset.

Figure 3. The NPPPEP Theatre Measurement Model Minimum Five Time Stamps

17.5 Notes on Metrics and KPI's

17.5.1 Operating Theatre Metrics- Utilisation KPI

Theatre utilisation is dependent on various factors such as the procedure type, procedure duration, staff resources, presence of an anaesthetic room and number of anaesthetic staff assigned etc. Setting a national benchmark for all facilities will not be possible until the hubs and elective hospitals are up and running. A more accurate specialty or list specific utilisation and throughput KPI should be identified based on case durations and agreed inter-operative interval as the facilities develop. The NPPPEP theatre optimisation modelling (based on TMM outputs) provides this information. It will also enable scheduling the appropriate number and mix of patients to optimise theatre time, which can be done per surgeon. The aim will be to have national standard KPI's that all of the facilities will then benchmark themselves against.

17.5.2 The Default Position

The list of procedures outlined in Appendix 1 indicates whether the procedure should be carried out in 'Street Clothes' or Hospital Attire and also if the procedure is appropriate for a main theatre, minor ops theatre or outpatient chair. The guidance in this appendix should be considered the default standard for appropriate clothing and location unless there is a justification otherwise.

17.5.3 Readmission

A readmission is a patient who is admitted as an emergency to a Model 3 or 4 hospital within 30 days of their initial surgery at any one of the elective care facilities where the previous discharge is under the care of a surgical specialty. This is regardless of whether the preceding admission was elective or emergency and regardless of whether the second emergency admission relates to the first episode of care or not. This is based on the HSE definitions for readmissions but amended to take into account that patients cannot be readmitted to the elective care facilities as these are day case only facilities (26).

Current data from HIPE on readmission following a procedure has some challenges, especially as a patient may not re-present to the hospital where the procedure originally took place. Availability of a unique patient identifier is necessary for most accurate measurement. Until this is fully implemented, it is important that current data is collected and analysed as comprehensively as possible. It will also be important to capture patients readmitted that were discharged based on criteria to ensure the safety and effectiveness of this method.

The governing hospital should ensure they have clear visibility and understanding of any deviation from KPI's in relation to readmission. Any deviations should prompt a root cause analysis and actions taken to make improvements.

17.5.4 Patient Initiated Review

The HSE have published national guidance in 2024 on patient initiated review (27). It will be very beneficial to monitor this initiative from two aspects. Firstly, to determine how often patients will initiate a review to allow for planning, and secondly to evaluate if offering the patient-initiated review appointment was appropriate in the first instance.

17.6 Endoscopy Quality Assurance and Key Quality Indicators

The Joint Advisory Group (JAG) was established in 1994 in response to the expanding multidisciplinary nature of endoscopy. JAG now works across three main areas: endoscopy training, accreditation of endoscopy services and accreditation of screening endoscopists (28). Accreditation is a supportive process of evaluating the quality of clinical services by guiding services through a quality framework. It promotes quality improvement through highlighting areas of best practice and areas for change, encouraging the continued development of the clinical service. The JAG accreditation pathway involves self-assessment and quality improvement against the standards. The JAG standards cover all aspects of a high-quality clinical service and are organised into four domains:

1. Clinical quality: The clinical quality domain encompasses the service's role in safe and effective diagnosis, treatment and ongoing management. Key to this is the service infrastructure including leadership and governance.
2. Patient experience: The patient experience domain encompasses the service's role in providing efficient and patient-centred care for all patients, which includes reviewing waiting times, facilities and the environment.
3. Workforce: The workforce domain focuses on effective training and support for staff, including the recruitment, retention and continued professional development of team members.
4. Training: The training domain reviews the support and development of trainee endoscopists, including appraisal and competencies.

(JAG Standards, 2023) (28)

It is envisaged that the elective hospitals will be participating in the JAG accreditation self-assessment pathway to achieve accreditation.

17.6.1 Endoscopy Key Quality Indicators

The National Gastrointestinal Endoscopy Quality Improvement (NEQI) Programme was developed under the remit of the Conjoint Board in Ireland of the Royal College of Physicians of Ireland and Royal College of Surgeons in Ireland. The objective of the NEQI Programme is to provide a framework which enables those providing endoscopic services in Ireland to drive continuous quality improvement and enhance patient care. The National GI Endoscopy Quality Improvement (QI) Guidelines (2020) define key areas of quality improvement (QI) in the delivery of endoscopic procedures (29).

17.6.2 Summary of QI Target and Recommendations

Table 5. Summary of QI Targets

Key Quality Indicator	QI Target	Reason/Evidence for Target
COLONOSCOPY		
Caecal Intubation Rate	**Minimum Target: ≥90%** **Achievable Target: ≥95%**	International Standards
Percentage of colonoscopies where polyp(s) are detected	**≥20%**	Working Group Opinion and National Data from NQAIS-Endoscopy
Percentage of colonoscopies where the comfort score is 1, 2, or 3 per Endoscopist	**≥90%** (of colonoscopies with a Comfort Score of 1 to 3)	Working Group Opinion, NQAIS-Endoscopy and International Standard
Percentage of colonoscopies where bowel preparation is classified as excellent or adequate	**Minimum Target: ≥90%** **Achievable Target: ≥95%** (Of colonoscopies recorded as excellent or adequate)	International Standards
UPPER GI ENDOSCOPY		
Percentage of successful intubations per Endoscopist	**≥95%**	Working Group Opinion and NQAIS-Endoscopy Data
Percentage of cases in which Duodenal second part intubation was achieved per Endoscopist	**≥95%**	International Standards
Percentage of cases in which retroflexion was performed	**≥95%**	International Standards

Table 6. Summary of QI Recommendations

Key Quality Indicator	QI Recommendation	Reason/Evidence for Target
Volume of Oesophagogastro-duodenoscopy procedures, Flexible Sigmoidoscopy and Colonoscopy procedures performed by each Endoscopist	Performing more procedures is a possible means to increase proficiency in meeting QI targets	International Standards
COLONOSCOPY		
Withdrawal time	Median withdrawal time of ≥6min for negative screening or diagnostic procedures	International Standards
Number of polyps with histology requested expressed as a % of all polyps excised per endoscopist	≥90%	International Standards
Percentage of colonoscopies where tattooing of suspected malignant tumours took place	≥60%	Working Group Opinion
Number of incidents of colonic perforation	<1 per 1,000 colonoscopies performed	International Standards
Number of incidents of post polypectomy perforation	<2 per 1,000 colonoscopies performed	International Standards
Number of incidents of post polypectomy bleeding requiring transfusion	<0.5% colonoscopies where polypectomy is performed	Number of incidents of post polypectomy bleeding requiring transfusion
UPPER GI ENDOSCOPY		
Percentage of repeat endoscopies requested in cases where gastric ulcer(s) is present. Repeat endoscopy to be completed within 12 weeks	≥80%	International Standards and Working Group opinion

These have been extracted from the National GI Endoscopy Quality Improvement Programme (NEQI) which published guidelines in 2020 (29).

18.0 Clinical Governance

The following is the governance construct that was approved by the Elective Care Programme Steering Group:

- **National Oversight:** National oversight should be established to support the recommended governance approach to ensure consistency, equity of access, activity-based funding approach and oversight of the delivery of a national network of elective care provision.
- **Regional governance**: Each Elective Hospital located within a Health Region will sit within that HSE Health Region construct from an operational and clinical governance perspective and leverage resources and structures at a regional level including corporate and clinical services.
- **Link to Model 4 hospital**: Within each Health Region, the elective hospital will have a link to acute hospital(s) to leverage resources, processes, allow for staff rotation and enable patient pathways.
- **Regional implementation**: It will be a matter for each Health Region to establish the links and arrangements between the elective hospital and their Model (3/4) hospitals, acknowledging this may be constructed differently depending on the specific arrangements within the particular Health Region.

19.0 Management of Laboratory Samples

Laboratory services for elective hospitals should be planned to reflect the principles and recommendation in the HSE Outline Strategic Plan for Laboratory Services 2026-2035 (30), and relevant guidance from the HSE Laboratory Services Programme. As per this plan, all laboratories and near-patient-testing services should operate a quality system consistent with an appropriate standard such as the EN ISO 15189 (2022) or EN ISO 17025 standard. Transfusion services must be accredited. As per General recommendations for managing access to HSE and HSE funded Laboratory Services, "laboratory users are responsible for timely review of laboratory results and for acting on the result in in a timely manner or bringing the result to the attention of a team member who can act on the result in a timely manner". In the absence of an alternate agreed hospital protocol, the consultant surgeon performing the procedure is responsible for the follow-up, communication and actions arising from histology and other results on their patient.

To ensure equity of access to the surgical hubs and elective hospitals across the country, there will be a requirement to have Consultants Pathologists in all relevant disciplines with adequate specific sessions committed on a routine basis to support the elective hospital and those sessions must be delivered on site at the elective hospital where on site delivery is required to support the service. In addition to the requirement for dedicated Consultant Pathologist WTEs, the elective hospital with require adequate dedicated Medical Scientists and other laboratory personnel WTE to support the service, although in general they will work together as members of the laboratory network that supports the elective hospital. Space and equipment to support the service should also be designated.

19.1 Surgical Hubs

The likelihood is that the surgical hubs will utilise their Model 3 or 4 hospital laboratory and where needed, additional resources will be appointed. A local arrangement for transport will be needed to ensure the safe transit of samples to the agreed laboratory. In some cases, near patient testing services on site may be required

19.2 Elective Hospitals

Elective hospitals should have laboratory service turn-around times that are appropriate to meet their needs. This is likely to require an on-site laboratory or near patient testing to assure prompt access in particular to basic haematology and clinical biochemistry testing that requires a short turn-around time. As per the HSE Outline Strategic Plan for Laboratory Services 2026-2035 any on-site service should operate as part of a laboratory network with a single quality system for laboratories in the network (30). For services where turn-around time requirements can be met from an established laboratory in another hospital (network hub) those services should be provided from the hub.

19.3 Specimen Pathway

Laboratory specimen pathways refer to the journey a patient's specimen takes from collection to final test results. This pathway is crucial to ensure accurate diagnostic testing and patient safety and these are often already well-established locally. Requirements will be specified in the laboratory quality system.

Each consultant should have access to the electronic reporting system at the elective facility and must check the laboratory system for results of samples obtained. Reporting systems must be robust and will be addressed in the laboratory quality system.

20.0 Patient Follow Up

20.1 Day 1 Post Procedure Follow-Up

A phone call to the patient the day following the procedure is recommended. This can be carried out by an administration person following an agreed set of questions with red flags that will identify any queries that need to be escalated to clinical staff. This interaction ensures patent satisfaction and allows for early identification of any potential issues or concerns, so that they can be addressed during the working day and will reduce the requirement for out-of-hours calls. This is applicable only to patients who have undergone general anaesthesia/sedation.

20.2 Patient Initiated Review

Patient Initiated Review (PIR), also known as Patient Initiated Follow-Up (PIFU), is a healthcare approach where patients or their carers can proactively schedule follow-up outpatient appointments as needed, rather than waiting for a pre-arranged, fixed appointment. PIR aims to empower patients by giving them more control over their healthcare journey and allowing them to access care when they need it, rather than being tied to a rigid schedule.

PIR can help optimise new patient appointment availability, reduce unnecessary follow-up appointments, enhance patient experience and autonomy and reduce need on administration.

The HSE has published a ***Patient Initiated Review (PIR) National Guidance Document*** which outlines the framework for implementing PIR in Ireland which can be accessed here. This policy should be implemented in both the surgical hubs and the elective hospitals

20.2.1 Patients Likely to Benefit from PIR

Given the high-volume, low complexity nature and the exclusion criteria that have been applied, the cohort of patients attending the elective care facilities should be in the majority suitable for PIR and this should be considered the default. However, PIR may not be suitable for all patients and a patient's ability to benefit from PIR needs to be carefully considered by the clinical team.

For PIR to be suitable for a patient (and or their family and/or carer(s), as appropriate), the following criteria should be met:

- Satisfies the exclusion criteria established by the specialty team.
- Low risk that urgent follow-up care will be required.
- Patient is confident and able to take responsibility for their care for the time they will be on the PIR pathway.
- Patient /carer has a clear understanding of condition and which changes in their symptoms will require a PIR review.

20.2.2 Patients Unlikely to Benefit from PIR

The following types of patients are unlikely to benefit from PIR:

- Health issues that are particularly complex.
- Not able to contact the service easily (e.g., limited access/ability to use email, phone, text etc.)
- Transitioning between child and adult services.

20.2.3 PIR Processes

- **Set-up**: Establish exclusion criteria, patient education, and appointment tracking.
- **Enrolment**: Patients must consent and receive guidance on how to request reviews.
- **Appointments**: Patients contact a designated service when they need a review.

- **Expiration**: If a patient does not use PIR within the agreed timeframe, they may be discharged.

Each elective care facility should refer to the clinical guidance published to incorporate the following

- **Roles and Responsibilities**
- **Primary Care Considerations**
- **Waiting List Management**
- **Data & Reporting**
- **Education Toolkit**
- **Communication Materials**

The clinical guidance (here) document incorporates very useful proformas that can be used to implement the PIR guidance. Examples include:

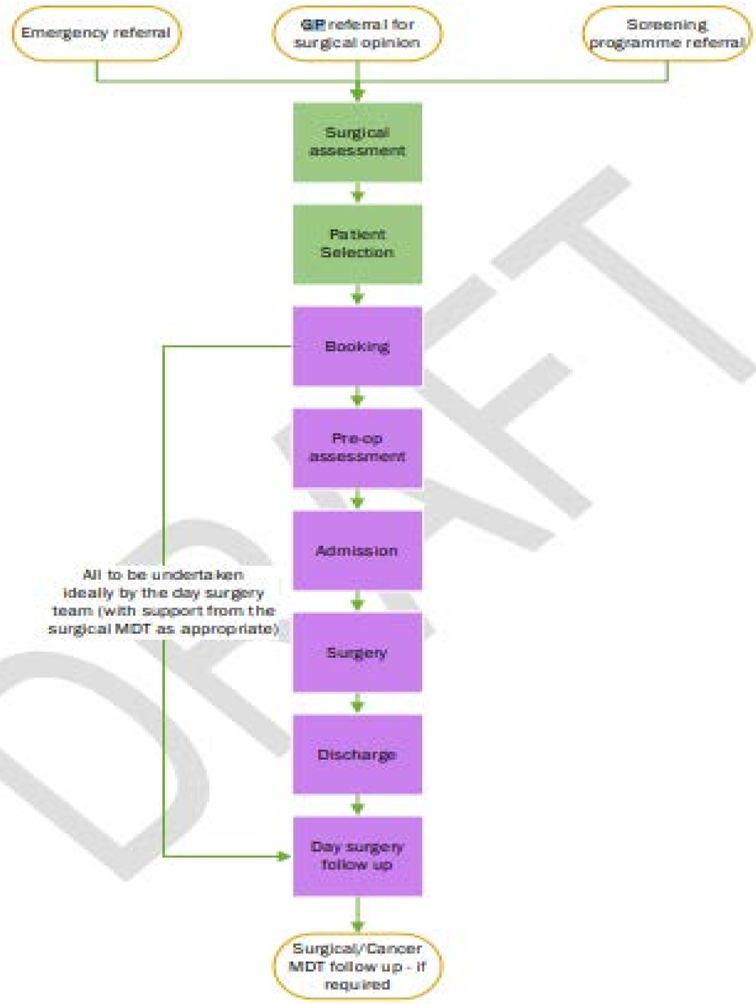
- PIR Clinical Template
- PIR Patient Information Leaflet
- PIR Patient Plan / Education Leaflet (Condition Specific)
- PIR Patient Enrolment Letter
- PIR Patient Discharge Letter

21.0 Primary Care, Community and the Elective Care Facilities

21.1 Patient Pathway

While the elective care facilities are being set up, the initial pathway will be a referral from a GP for an outpatient consultation with a surgical specialty to determine the optimal treatment pathway. As the service matures, there may in a minority of cases be instances where GP's may be able to avail of direct access for very specific procedures and with criteria. Figure 4 outlines the general pathway.

Figure 4. Proposed Referral Pathway



21.2 Referrals

A pre-emptive review of chronic conditions such as hypertension, atrial fibrillation, diabetes and anaemia, in order to optimise a patient prior to referral is extremely valuable. GPs will also likely have knowledge of social factors and can provide advice about lifestyle choices that may impact on surgical outcomes, including smoking, high body mass index, alcohol consumption and recreational drug use.

It is hoped that this guidance will be of value for GP colleagues to increase the awareness of the increasing range of procedures which may be undertaken as day case surgery and the expanding patient groups considered suitable. The message to the patients should be of the day case nature of surgery, to avoid the expectation that they will be in hospital for a number of days as historically may have been the case. Primary Care GP's play a vital role in starting the day surgery message.

21.3 Communication to Primary Care/Nursing Home Discharge Letter

Once a patient is discharged electronically from the system, a standard discharge letter should be generated for primary care. This letter should indicate whether the patient is required to come back for a review or if they are suitable for a patient-initiated review option. If the patient is returning to a nursing home, a copy should be made available for the nursing home also.

Standardised prescriptions of analgesia are key to good postoperative pain outcomes. Ideally, all procedures should be mapped to a specific pain category and the corresponding analgesia automatically prescribed at the end of the procedure. This information should populate directly into the GP discharge letter.

If any strong opioids are prescribed, the prescription should include instructions to the GP indicating that repeat prescription is not advised to avoid the increasing risk of opioid dependence in the community. The HSE have published guidance on this which is available here (31).

Consideration should be given to late discharge patients who live in rural areas, who may not have access to late opening pharmacies. Where possible, prescriptions could be issued in advance to cover until the following day.

The details of the discharge letter and prescription are outlined in section 22 in Opportunities for Information Technology.

21.4 Wound and Suture Management

In alignment with the Sláintecare policy of treating the right patient in the right place at the right time by the right person, wound and suture management could be carried out in a community or primary care setting by trained staff, but it is recognised that this may not be a readily available resource.

The HSE have published guidance on wound management which is available here (32).

For each surgical hub setting, there has to be agreement and an understanding about the availability of the service, and how the patient accesses it. Ideally, there would be an electronic link to the community service, so that the patient could be booked in advance and the information regarding the procedure and wound management easily shared and available. This information would also be issued to the patient at the time of discharge and should include the nature of the wound closure, i.e., number of sutures or clips, adhesive, absorbable material etc. Community services have the potential to provide this service with a robust communication line to ensure that they have the necessary information and instruments required. Importantly, they also need an agreed escalation pathway back.

These arrangements need to be established locally for each facility. In the absence of any primary or community service, the responsibility should lie with the governing Model 3 or 4 hospital to ensure wound management follow up.

22.0 Opportunities for Information Technology

Efficient and effective day case surgery relies heavily on robust information technology. Ideally an electronic patient record (EPR) should support the entire day surgery pathway. When designed with this in mind, it can be instrumental in driving the success of day surgery.

Components of such a system include:

22.1 Electronic Theatre Booking Form

Listing patients electronically by the surgeon directly from their outpatient clinic confers a number of benefits. In particular, it ensures that the procedure intended by the clinician is accurately recorded and transferred directly to the patient's record and subsequent theatre operating list. This avoids transcription errors that may arise from matching procedure description to PAS codes or misinterpreting handwritten notes.

This system will ideally include the following:

• A drop-down menu of common procedures automatically mapped to the correct ICD-10 code, with the ability to amend with free text if required.

• Management intent (day case or inpatient)

• Details of equipment required (e.g., x-ray, laser theatre and specific equipment)

• Ability to highlight any medications which need stopping preoperatively e.g., anticoagulation, biologic medication. This enables clear communication with the Preoperative Assessment Services (PAS), who can then arrange stopping and bridging therapy if required

• Other communication to PAS teams

• Urgency

• Free text section for messages to the booking team. Ideally the procedure description and equipment required should populate directly onto the theatre operating list to enable good communication in advance with the theatre staff and into the hospital booking system and preoperative assessment record to avoid transcription errors.

22.2 Electronic Preoperative Assessment

The following benefits can be realised with digital Pre-assessment:

Enhanced Patient Safety:

- Early risk identification: Clinical decision support tools can flag high-risk patients or incomplete information for further review.
- Improved accuracy: Electronic forms reduce the risk of transcription errors and ensure standardised data capture.
- Timely interventions: Enables earlier identification of patients who require further tests, optimisation, or specialist input.

Enhanced Efficiency: Digital pre-assessment streamlines the evaluation process for low-risk patients, allowing preassessments to be reviewed and actioned more quickly.

Streamlined workflows: Reduces administrative workload by automating data collection, triage and documentation, thus improving resource allocation.

Reduced duplication: Information is entered once and accessible across the care team, minimizing repeated questions and documentation.

Audit and quality improvement: Data can be easily extracted for reporting, audit, and continuous improvement initiatives.

Convenience: patients can enter their information at their own pace from home, reducing the need for in-person visits.

Consistent assessment: All patients receive a structured, uniform assessment regardless of location or assessor.

Data collected should include all the key aspects of the patient's medical history formulated as a series of dropdown menus ideally with decision support guidance. Any investigations required will ideally be ordered directly from this system and results will populate automatically into the record.

22.3 Electronic Patient Reminder/Confirmation

The system should be designed to send a Short Message Service (SMS) to all patients 48 hours prior to any attendance at and elective care facility. This can be standardised text that will remind them of their date, time for their procedure and fasting and medication instructions. There should be a Y /N to confirm receipt and a number to contact if they are no longer able to attend.

22.4 Electronic Record of the Day of Surgery

From the point that the patient arrives, there will be multiple data collection points including registration, pre-surgery admission, operating department notes including anaesthesia and intra and post operative documentation and finally their post op recovery notes.

Key data for collection would include:

- Any reasons for cancellation after arrival
- Personnel involved in the patients care
- The 5 TMM timestamps of Anaesthetic Start, Surgery Start, Surgery Finish, Anaesthetic Finish and Left theatre.
- Additional time stamps, if possible, to include admission time and discharge time
- Record of the procedure undertaken, type of anaesthesia and the staff involved
- Key outcome data from primary recovery such as pain and nausea scores
- Documentation of discharge criteria being achieved with details of time and nurse undertaking the discharge
- Information regarding whether a patient was admitted or discharged and reason for any unplanned admission

22.5 Electronic Procedure Notes

This should include key information which would populate directly into the patients discharge letter which is generated automatically at point of discharge:

- Procedure undertaken/correct Hospital In-Patient Enquiry (HIPE) Code
- Description of procedure
- Staff involved
- Antibiotics
- VTE prophylaxis
- Details of specimens sent
- Follow-up required (clinic appointment)
- Any specific information to primary care
- Whether the surgeons wish to see the patient prior to criteria-led discharge

Follow-up information should download onto a master spreadsheet viewable by the administration team to ensure that all appointments are booked. If a specimen is sent this information should download onto a specific spreadsheet to ensure that all specimens are followed up and results checked.

A copy of this procedure note and anaesthetic record should accompany the patient home in the event that there is a post operative complication and they are advised to bring this with them in the event that they need to attend any hospital which may not be the one where they had the procedure carried out.

22.6 Electronic Anaesthetic Charts

These support accurate documentation of vital signs, physiological parameters, medications administered, and procedures undertaken using simple drop-down menus and an interface between the computer system and anaesthetic monitors to enable data transfer.

22.7 Electronic Prescription of Take-Home Analgesia and Postoperative Instructions

Standardised prescriptions of analgesia are key to good postoperative pain outcomes. Ideally all procedures should be mapped to a specific pain category and the corresponding analgesia automatically prescribed at the end of the procedure. This information should populate directly into the GP discharge letter and Nursing Home letter if appropriate. If any strong opioids are prescribed (such as oxy-codone following day case joint replacements), the prescription should include instructions to the GP indicating that repeat prescription is not advised to avoid the increasing risk of opioid dependence in the community.

Patients must have the following information prior to discharge. This should be explained to them and their carer and also provided in written form. Given the day case nature and patient selection, it is unlikely that there will be any change to a patient's regular medication and this should be stated. Any change to this should be noted for their GP.

- Prescription for 4 day supply of postoperative medication (33)
- Instructions as to when the medication is next due
- Instructions on what they should and should not be doing post-operatively
- Instruction on wound management and follow up
- Details of who to contact in an emergency. This must be a dedicated phone line to the day surgery unit within hours and an individual with appropriate clinical experience out of hours. It is not appropriate for them to be directed to GP out-of-hours services, the emergency department or 999.

22.8 Electronic Discharge Checklist

The British Association for Day Surgery (BADS) (19), and the NCPS Elective Surgery Model of Care (20) have published examples of discharge checklists. These have been considered and adapted in to a standardised template that sites can adopt and amend locally. This can be found in **Appendix 5**.

22.9 Automatic Generation of Discharge Letter

Once a patient is discharged electronically from the system (i.e., utilising the Criteria Led Discharge or by their consultant if CLD is not appropriate, then a discharge letter should be generated. The HIQA National Standard for Patient Discharge Summary (2013) sets out the *minimum dataset* that must be included in any discharge/transfer communication (34). The minimum includes:

HIQA Standard	***Examples of Additional information for the Elective Care Facilities***
Patient identifiers	*Name, Address, DOB, Gender, HCRN, Discharge Destination*
Diagnosis and procedures	*To include date of procedure and the surgeon who performed it*
Investigations and results	*If available*
Allergies/alerts	*As is*
Medications (on admission, changes, on transfer)	*Type of Anaesthesia, analgesia and other medications prescribed and a reminder to step down any opioids prescribed*
Ongoing care needs and follow-up	*Follow-up required if not for Patient Initiated Review*
Key contact information	*Details for the patient of a contact telephone number to call if assistance is required over night*
	Any information for the GP for surgeon's operation notes
	Details of person completing the Discharge summary

This standard applies to both discharge to the community and inter-hospital transfers**.**

The HSE National Clinical Effectiveness Committee (NCEC) has emphasised that structured clinical handover tools (e.g., ISBAR**:** Identify, Situation, Background, Assessment, Recommendation) should be used during hospital transfers (35). This ensures consistent communication whether verbal, written, or electronic.

The administration team at the elective care facility are responsible for ensuring that copies (paper or electronic) are issued to, or incorporated into:

- Patients notes
- The GP (and nursing home if applicable)
- The patient to take home

22.10 Escalation/Transfer to Acute Hospital

There are standardised transport records that all hospitals use for Critical Care transfers. The links to theses are provided below. There are also guidelines and support tools found on each website, including QR codes to support regional hospitals who have to undertake their own transport. These can be found at www.nasccrs.ie. Adults – MICAS: http://www.nasccrs.ie/Files/Adult-CCTR.pdf

22.11 Patient Information on their Mobile Phone

Patients should be encouraged to take photographs on their mobile phone of the discharge information before they leave, if they are happy to do so and are satisfied with the data security on their phone. In the event that they misplace their information or require it in an emergency, this can be a useful way of clinicians being able to access important data in the event of any complication or emergency admission.

22.12 Electronic Record of Follow-up Telephone call

Each morning a list should be generated by the IT system with patient details from the previous day. This should include the patient's name, their telephone number and procedure undertaken. An appropriately trained person can make the call to the patient to check on how they are 24 hours after their procedure and to answer any questions that they may have. As the follow-up call is made, the patient is removed from the list. Information obtained from the telephone call is entered directly onto the IT system via a series of drop-down menus (e.g., pain score: none/mild/moderate/severe).

If in any event an electronic patient record is not available at the elective facility, then all patient notes should be in one chart/document.

23.0 Training in the Elective Care Facilities

Future Consultant Surgeons and Anaesthesiologists will need to adapt to delivering healthcare within a changing landscape. Training provides the opportunity to develop professional mindsets and attitudes, in order to incorporate flexible working patterns going forward. This is a key component of the Sláintecare Reform Policy including the implementation of the Public Only Consultant Contract (2023) and the establishment of the regional health areas (2024). A combined surgical and anaesthesia approach is likely to be the basis on which an agreed policy can be formulated, enabling the development of a set of principles that underline the importance of training within the context of the National Elective Care Programme.

As part of the work of the National Elective Care Clinical Guidance Group (NECCGG), a review was completed of both the agreed procedures for the elective hospitals and surgical hubs and also of the actual ambulatory case mix that has been undertaken at the Reeve's Day Surgery Centre (RDSC), Dublin. This review has reinforced the view that both of these elective facilities will provide excellent training opportunities going forward.

23.1 Surgical Perspective

Ambulatory and elective care facilities are critical to our Irish surgical training programmes. The planned surgical hubs and elective hospitals can provide excellent training opportunities for trainees across all surgical specialties and incorporating all phases of surgical training, i.e., Phase 1 (ST1/ ST2), Phase 2 (ST 3-6) and Phase 3 (ST 7-8). The exact training opportunities will be mapped to the curriculum in consultation with the various Training Programme Directors and the RCSI's training director as the project evolves.

Surgical training is based on an intercollegiate curriculum across the UK and Ireland, firmly established and published and available for all parties to review. It is an outcomes-based curriculum and is designed to train individuals to the standard of a day 1 Consultant. Emphasis is placed on the development of capabilities in practice of which there are a total of five. This method of training applies to all surgical specialties and there is a common assessment framework as trainee's progress through the various specialty programmes.

Capability in practice number 4 refers to the management of an operating list. This capability refers to the need to manage all patients with conditions requiring operative treatment within each specialty. A trainee has to develop the skills to perform all the administrative and clinical tasks required of a consultant surgeon in order that all patients requiring operative treatment receive it safely and appropriately. A more detailed explanation of the rationale behind this does include an emphasis on case selection, appropriate time management and productivity.

23.2 Anaesthesia Perspective

The anaesthesia perspective supports that held by surgery. Excluding elective hospitals would make it extremely difficult, if not impossible, for Basic and Higher Specialty Trainees to meet the College of Anaesthesiologists of Ireland (CAI) curriculum requirements for ambulatory surgery. The latest Anaesthesiology workforce planning report requires conversion of non-training scheme Non Consultant Hospital Doctor (NCHD) posts to be converted to training posts to increase the scheme's annual intake from 50 to 90 by 2026 (36). Therefore, the requirement for modular training in ambulatory anaesthesia will double. The Acute hospitals will not be able to meet this demand if a large proportion of the day surgery moves out to elective hospitals.

Evidence from the National Perioperative Patient Pathway Enhancement Programme (NPPPEP) metrics suggests that intra-operative intervals are shortened when there is an NCHD allocated to an operating list thereby improving utilisation. Recruitment for future appointments will be facilitated if anaesthesiologists rotate through these elective facilities during their training, endorsing the principle of 'You have to see it to be it'.

23.3 Surgical and Anaesthetic Consensus and Recommendation

There is a concern that the involvement of trainees within the day-to-day running of elective theatre lists in ambulatory and elective hospital facilities might somehow slow down or reduce operating theatre productivity. This has not been the experience of the training coordinators, nor the hospital management at the RDSC. However, it is recognised that providing training opportunities requires the support of the hospital managers.

There is already an inspection process agreed to ensure that facilities are appropriate for surgical training to meet the needs of both the hospital and also for the surgical trainees and this would also be developed for the surgical hubs and elective hospitals.

During the COVID pandemic, an arrangement existed whereby trainees and consultants carried out elective surgical cases in the private hospital sector in a timely and productive manner. Lists can therefore be arranged and managed in a time sensitive manner and still provide appropriate training opportunities across the various surgical specialties and across the infrastructure that is planned for the national elective care facilities.

The elective care facilities present significant training opportunities for all surgical and anaesthesia specialties. Training needs should be embedded in both the infrastructure and operational design of both the surgical hubs and elective hospitals.

The necessary steps from both an RCSI and CAI perspective will include the following:

1. Plan and inspect each surgical hub/elective hospital site as they come on board as an appropriate training site on behalf of RCSI/CAI
2. Agree on the training specialties and procedures which are appropriate for training recognition.
3. Modify the RCSI/CAI eLogbook as necessary to capture trainee operative activity.
4. Determine what procedures are appropriate for trainee involvement across each of the three phases of surgical training.

23.4 Training Opportunities for Nursing at the Surgical Hubs & Elective Hospitals

Surgical care, including perioperative and elective surgery, is a critical component of our healthcare system. Nursing students work collaboratively within a multidisciplinary team alongside other healthcare professionals to ensure the delivery of high-quality patient care in the perioperative environment. Both undergraduate and postgraduate nursing students engage in comprehensive studies on the complexities of health and illness. Clinical placements within the surgical hubs and elective hospitals provide a valuable opportunity to integrate and apply the theoretical knowledge and practical skills acquired in the classroom into real-world healthcare settings. Successfully completing clinical competencies is a fundamental aspect of the nurse learner's progression through the learning programme. Having undergraduate and post graduate nurse's complete clinical placements in elective hospitals offers several key benefits for both students and the healthcare system, including the following:

- Elective hospitals provide a structured and predictable setting, allowing students to develop essential preoperative, perioperative, and postoperative nursing skills in a low-acuity environment compared to emergency or acute settings.

- They gain experience in infection prevention and control, wound management, and surgical nursing without the unpredictability of emergency cases.
- Students can observe and participate in standardised surgical procedures with less pressure, fostering confidence and competence.
- Elective surgeries involve pre-planned procedures, giving students the chance to follow a patient's journey from admission to discharge. This helps build skills in patient education, informed consent, and postoperative recovery planning.
- Unlike emergency departments or acute care settings, elective hospitals operate with predictable schedules, allowing students to focus on learning rather than reacting to high-pressure situations.
- This controlled pace fosters a supportive learning environment, promoting confidence and clinical decision-making.

Overall, clinical placements in elective hospitals provide undergraduate nurses with a structured, high-quality learning experience that builds foundational skills, fosters confidence, and enhances multidisciplinary teamwork, ultimately preparing them for diverse nursing roles in the future.

The NECCGG has reviewed the list of procedures appropriate for the elective facilities, highlighting the valuable opportunities for completing clinical placements at the elective facilities.

The Nursing & Midwifery Board of Ireland (NMBI) conduct site inspections of university and college departments, along with their affiliated hospitals and health services to ensure excellence in nursing and midwifery education and practice. The elective hospitals and the surgical hubs will also undergo these inspections.

The governing Model 3 or 4 hospital will oversee the allocation of nurse learners to the surgical hubs and elective hospitals to complete their clinical placements. Given this responsibility, it is essential that the elective facilities are well equipped to provide high-quality training opportunities for nurse learners, with strong support from hospital management.

23.5 Training Opportunities for Health and Social Care Professionals

Health and Social Care Professionals (HSCPs) play a vital role in the delivery of holistic, patient-centred care across the surgical pathway. The integration of HSCP students, such as physiotherapists, occupational therapists, radiographers, dietitians, speech and language therapists, podiatrists and medical social workers, into clinical placements at surgical hubs and elective hospitals offers a unique opportunity to develop their professional competencies in a structured, multidisciplinary environment.

CORU, the regulatory body for HSCPs in Ireland, mandates that most HSCP students complete a minimum of 1,000 clinical placement hours as part of their professional education programmes. Meeting this requirement is essential for registration and future practice.

Elective hospitals and surgical hubs provide an ideal setting for HSCP learners to gain practical experience in supporting patients undergoing planned surgical procedures. These placements offer several key benefits:

• **Interdisciplinary Collaboration**

HSCP students work closely with nursing, medical, and administrative teams, enhancing their understanding of collaborative care models and the importance of integrated service delivery.

• **Patient-Centred Rehabilitation**

Students gain experience in prehabilitation and postoperative rehabilitation, supporting patients in regaining function and independence following surgery.

• **Predictable Clinical Environment**

The scheduled nature of elective procedures allows HSCP learners to engage in planned interventions, assessments, and follow-ups, fostering confidence and clinical reasoning in a low-pressure setting.

• **Exposure to Standardised Protocols**

Students become familiar with evidence-based care pathways, surgical protocols, and discharge planning processes, which are essential for safe and effective patient care.

• **Enhanced Learning Opportunities**

The structured pace of elective care supports reflective practice, supervision, and feedback, enabling HSCP students to consolidate their academic learning with hands-on experience.

The NECCGG recognises the value of HSCP involvement in elective care and supports the inclusion of HSCP learners in clinical placements at these facilities. These placements not only enhance the educational experience of HSCP students but also contribute to the continued growth and development of a skilled, multidisciplinary workforce capable of delivering high-quality elective care.

As with nursing placements, the elective hospitals and surgical hubs will be subject to quality assurance processes, including site inspections by relevant professional and regulatory bodies. The governing Model 3/4 hospital will coordinate the allocation of HSCP students to ensure equitable access to training opportunities and alignment with educational programme requirements.

Strong support from hospital leadership, dedicated practice educators, and robust placement infrastructure will be essential to ensure that HSCP learners receive a high-quality, enriching clinical education experience.

23.6 Training Opportunities for Endoscopy Trainees, Nurse Endoscopists

The planned surgical hubs and elective hospitals provide an excellent training opportunity for endoscopy trainees. Training to perform and achieve competency in upper and lower gastrointestinal (GI) endoscopy is a key component of specialist training in Gastroenterology, which is currently administered by the Irish Committee on Higher Medical Training at the Royal College of Physicians of Ireland (RCPI) and in General Surgery, as part of the Higher Surgical Training Schemes.
In 2021, the Endoscopy Programme launched the Competency Model for Skills Training in GI Endoscopy in Ireland which offers a framework for delivery and certification of competency-based training in GI endoscopy (Link) (37). It covers training in upper and lower GI endoscopy, both the diagnostic and core therapeutic aspects (i.e., endoscopic haemostasis and polypectomy).

The competency model can be used to support training in the surgical hubs and elective hospitals, outside the traditional teaching hospitals. With current demands on hospitals, these hubs provide an excellent protected training opportunity for endoscopy trainees and may also support the further development of advanced nurse practice (ANP) roles.
Appropriate AV equipment should be included in the endoscopy rooms in the surgical hubs/elective hospitals to facilitate the delivery of training courses for both trainees and consultants.

23.7 Simulation Training at the Elective Care Facilities

Simulation training utilises simulated scenarios to prepare healthcare professionals for real-life emergency situations. This training helps build confidence, competence, and teamwork skills, especially in high-pressure environments where quick decision-making is crucial.

The HSE has published a report on *The Implementation of Simulation on Clinical Sites: A National Strategic Guide (2022).* This report made recommendations for the development of a simulation centre and a strategic plan to support the delivery of simulation activities that meets standards of best practice (38). Given that some of the elective care facilities will be located a distance from Model 3 or 4 hospitals, simulation training to safely manage emergency scenarios on the clinical sites will provide interprofessional education to improve the safety, efficiency, and effectiveness of healthcare services. The following list of simulation training is not exhaustive but at a minimum should include:

- ***Cardiac Arrest***
- ***Anaphylaxis***
- ***Malignant Hyperpyrexia***
- ***Difficult Airway***
- ***Emergency Transfer to Model 4 site including NAS ISBAR Communication***
- ***Unexpected Intraoperative Life-Threatening Hemorrhage***

24.0 New Technology, Innovation, Research and Clinical Audit

Innovations in surgery have revolutionised patient care, making procedures safer, less invasive, and more effective. Advances such as robotic-assisted surgery, minimally invasive techniques, and enhanced imaging technologies have improved surgical precision and reduced recovery times. The integration of artificial intelligence and machine learning into surgical planning and intraoperative decision-making is enabling personalised and data-driven approaches. Developments in 3D printing allow for custom implants and surgical models, enhancing preoperative planning and training. Additionally, breakthroughs in regenerative medicine and bioengineering are opening new frontiers in tissue repair and organ transplantation. These innovations are not only transforming outcomes but also reshaping the way surgical care is delivered across disciplines.

The seamless integration of new technologies into Ireland's healthcare system is essential for enhancing patient care. Implementing a unified digital health record system, integrating AI diagnostics and image-guided surgery platforms would improve data accessibility, operational efficiency, and, ultimately, patient outcomes.

A publication by RCSI that looks at Technology and Innovation outlines the following key recommendations for surgical training that should be included in the elective care facilities (39).

- New and disruptive technologies will and should play a crucial part in the developmentof surgical practice.
- There should be a clear training and educational strategy developed, resourced and implemented for surgeons and the wider surgical team to deal with the workforce and skills needs to maximise the positive impacts from new technologies.
- Research and research methodologies will be required to evaluate how these new technologies improve the quality of patient care, improve outcomes, reduce complications and adverse incidents, support productivity and manage costs.
- Surgical training needs to develop to be more inclusive of other disciplines and professions, including digital and engineering expertise.
- Robotic surgery is the current significant technological development in surgicalpractice and training and educational programmes need to integrate robotic training and clinical experience into the delivery of the curriculum
- The advancement of digital and data driven technology has presented a training paradigm we have not seen before. The digital ecosystem in surgery facilitates a more measurable environment with respect to acquisition of surgical skills, definition of proficiency and maintenance of skills. Understanding how we take these measurable elements of operative skills into the assessment of competence is required.
- The future technological environment for surgical training will be a continuous pursuit of assuring digital and artificial intelligence literacy among our trainers, trainees, researchers and educators.

24.1 Digital surgery

Digital surgery plays a transformative role in modern healthcare by integrating advanced technologies such as artificial intelligence (AI), robotics, data analytics, augmented reality (AR), and connectivity into the surgical environment. Its primary aim is to enhance surgical precision, improve patient outcomes, and support clinical decision-making. Digital surgery enables real-time guidance through imaging and navigation systems, allows for preoperative planning using 3D models, and provides intraoperative analytics that help reduce variability and complications. AI algorithms can assist in identifying anatomical structures, predicting risks, and recommending optimal surgical strategies. Postoperatively, digital tools facilitate detailed analysis of surgical performance and outcomes, enabling continuous learning and improvement. Furthermore, connected platforms support remote collaboration, training, and even telesurgery, broadening access to expertise. Ultimately, digital surgery represents a shift toward safer, smarter, and more personalised surgical care.

24.2 Professional Codes of Conduct

RCSI has published various documents to support the provision of professional conduct and integrity and it is expected that all surgical staff who provide care for patients in the elective care facilities will adhere to these:

RCSI - Code of Practice for Surgeons (2018) (Link) (40)

RCSI - Robotic Surgery Governance in Ireland – A Guide to good practice (Link) (41)

RCSI - GENERAL DATA PROTECTION REGULATIONS (GDPR) - A GUIDE FOR SURGEONS (Link) (42)

College of Anaesthetists, Ireland- Professionalism in Anaesthesia, Intensive Care and Pain Medicine 2018 (Link) (43)

NMBI - Code of Professional Conduct and Ethics for Registered Nurses and Registered Midwives Incorporating the Scope of Practice and Professional Guidance (Link)

24.3 Research and Clinical Audit

Research and clinical audit will be encouraged in the elective care facilities and will be contributing to patient safety, quality of care, innovation and healthcare system efficiency. The key reasons include:

1. Improved Patient Outcomes

Evidence-based practices: Research identifies the most effective surgical techniques, anaesthesia protocols, and post-operative care methods, leading to better patient outcomes.

Clinical Audit: Clinical Audit ensures evidenced based standards are being complied with, providing assurance on the quality of care provided or identifying areas for quality improvement

Risk reduction: Research studies and clinical audit help in understanding and mitigating complications such as infections, bleeding, or poor wound healing.

2. Optimization of Surgical Techniques and Protocols

Research supports the development and refinement of minimally invasive procedures, robotic-assisted surgeries, and enhanced recovery protocols (e.g., ERAS).

It allows surgeons to stay current with the latest methods, improving accuracy and reducing recovery time.

3. Enhanced Patient Safety

Investigating causes of adverse events and near misses helps create safer surgical environments.

Research drives the implementation of checklists, infection control measures, and systems for monitoring surgical outcomes.

4. Cost-Effectiveness and Resource Utilisation

Research helps evaluate the cost-effectiveness of surgical interventions, contributing to more efficient hospital resource management.

It informs decisions about which procedures and equipment provide the best value.

5. Personalized and Patient-Centered Care

Research supports the tailoring of surgical care to individual patient profiles, improving satisfaction and outcomes.

Research studies and clinical audit often include patient-reported outcomes, ensuring that care strategies align with patient needs and preferences.

6. Training and Continuous Improvement

Hospitals involved in research and clinical audit create a culture of learning and innovation, attracting skilled clinicians and fostering high standards of training.

Ongoing research helps identify gaps in practice and areas for improvement.

7. Contribution to Medical Knowledge

Elective surgical hospitals conducting research contribute to the broader scientific understanding of surgical care.

Findings can influence national and international guidelines and standards of care.

8. Regulatory Compliance and Accreditation

In many regions, participation in clinical research and clinical audit supports hospital accreditation and regulatory compliance.

Research and clinical audit activity can demonstrate a hospital's commitment to quality improvement and excellence.

Summary

Research and clinical audit will be a core driver of clinical excellence, innovation, and patient safety. By embedding research and clinical audit into these elective facilities, these hospitals ensure that patients receive the most effective, efficient, and safe care possible. Any research conducted which can include the trial of new technology or equipment as well as technique or medication must have undergone an evaluation by the local research ethics committee to ensure the appropriateness and safety of the study along with robust patient information, consent and data protection impact assessments.

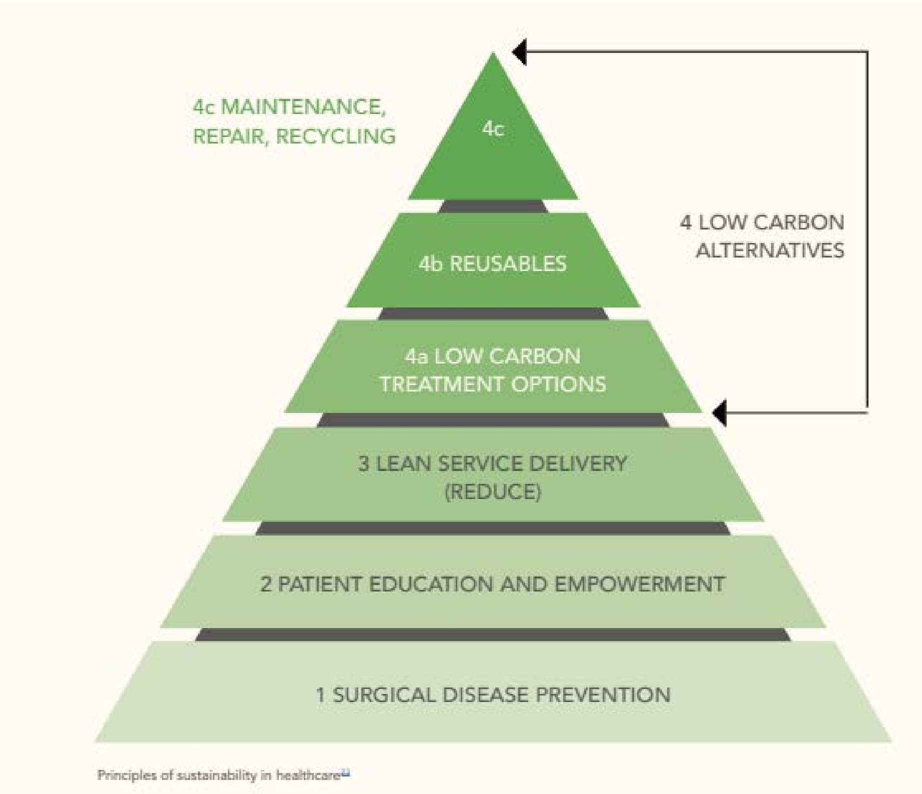
24.4 RCSI – National Surgical Research Support Centre

RCSI has established a National Surgical Research Support Centre (NSRSC) (Link) to support surgical trial activity in Ireland. The aim being to encourage and facilitate surgical trials and research to generate high-quality evidence in surgery and embed a culture of research in clinical practice to improve patient outcomes. The NSRSC provides every patient access to high quality surgical trials and innovative cutting-edge technology in Ireland. For any planned surgical trials, it is recommended that the research team contact NSRSC@rcsi.ie for information and support.

25.0 Sustainability

The HSE is committed to achieving net-zero emissions no later than 2050, delivering healthcare which is environmentally and socially sustainable (44). RCSI have published a document entitled 'SUSTAINABILITY PRINCIPLES AND PRACTICE IN SURGERY' which outlines the means by which any new elective care facility can reduce the environmental impact of surgical care by interventions throughout the surgical care pathway (45). This can best be addressed by evaluating the 4 principles of sustainable healthcare, according to the "Centre for Sustainable Health Care". They are presented in the figure below:

Figure 5. Principles of Sustainability in Healthcare (RCSI)



The Intercollegiate Royal Colleges of Surgeons have produced a "Green Theatre Checklist" to support current best practice in delivering sustainable surgical care before, during and after surgery. This should be adopted at all the Elective Care Facilities. See Appendix 10.

The whole patient perioperative journey can be streamlined by optimising the patient's health pre-operatively, reducing unnecessary hospital visits by digital-health engagement and appropriate use of ambulatory care. Reducing the need for unnecessary surgical care can be facilitated by utilising shared-decision making programs. These programs facilitate patient-surgeon dialogue aimed at enabling the patient to become more active in decisions surrounding their care.

Sustainable practices must become a "core competency' for all members of the surgical team. This will require education and skills training programs to be embedded as a component of CPD. On-site "Green Theatre Champions" will facilitate the implementation of the Green Theatre Checklist.

26.0 Useful resources

- ***A suite of eLearning resources are available at www.hseland.ie and can be easily accessed through the AMRIC HUB.***

Other AMRIC guidance and poster/webinar resources are available on www.hpsc.ie

1. Focus on cleaning and management of the physical environment as per the National Clinical Guideline (NCG) Infection Prevention and Control, No. 30. (Click here) (2).
2. Recommend adhering to the AMRIC guidance recommendations on the Prevention of Surgical Site Infection. (Click here) (3).
3. Adherence to the recommended prescribing practices for Surgical Antibiotic Prophylaxis and Duration (Click here) (4).

- ***Policy and Procedure for Safe Surgery (here)***
- ***Model of Care for Pre-assessment Services (here)***
- ***NPPPEP User Manual (here)***
- ***RCSI - Clinical Guidance for Surgical Hubs (here)***
- ***ERAS - https://erassociety.org/guidelines/***
- ***National Centre of Clinical Audit (here)***
- ***Clinical Handover: The HSE and the Office of Nursing and Midwifery have developed various education and training resources which can be accessed here.***
- ***There are standardised transport records that all hospitals use for Critical Care transfers. The links to theses are provided below. There are also guidelines and support tools found on each website, to including QR codes to support regional hospitals who have to undertake their own transport. at: www.nasccrs.ie Adults – MICAS: http://www.nasccrs.ie/Files/Adult-CCTR.pdf***
- ***https://www2.healthservice.hse.ie/organisation/ncca/***

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Appendices

Appendix 1 (a,b,c)	***List of Procedures by Specialty and Suitable Location***
Appendix 2	***Terms of Reference for the National Elective Care Clinical Guidance Group***
Appendix 3	***Proforma for the Modified Aldrete Discharge Criteria***
Appendix 4	***Proforma for PADSS Stage 2 Recovery to home***
Appendix 5	***Proforma for Discharge Checklist***
Appendix 6	***Criteria Led Discharge – Patient Process***
Appendix 7	***Criteria Led Discharge – Example -Adult Patients Post Tonsillectomy***
Appendix 8	***Draft Standardised Consent Form TBC***
Appendix 9	***Informed Consent Supporting Information TBC***
Appendix 10	***Green Theatre Checklist***

Appendix 1 – List of Procedures by Specialty and Suitable Location

The procedures list below are suitable for both the Surgical Hubs and the Elective Hospitals. Please note that procedures are listed next to the Specialties that carry out the majority of this type of procedure, but it is recognised that many procedures are carried out by multiple specialties.

Appendix 1a Procedures suitable for both the Surgical Hubs and the Elective Hospitals

Specialty	Procedure No	Procedure Name	Treat Room Type	Chair/Bed	Attire SC/HA	Suitable Facility
Anaesthetic / Pain Relief	1825000	Admin anaes arnd spin accessory nerve	DC	Chr	HA	SH&EH
Anaesthetic / Pain Relief	3901302	Admin anaes post prim rami spin nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1825200	Admin anaes agent arnd cervical plexus	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	3913401	Ins sbc impl neurostimulator	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1827402	Admin anaes arnd paravert lumbar nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	9001800	Epidural inj/o other/cmb thrpc subs	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1827403	Admin anaes arnd paravert sacral nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1828601	Admin anaes arnd lumbar portion SNS	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1826400	Admin anaes agent arnd pudendal nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1827401	Admin anaes arnd paravert thoracic nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1821629	Caudal inj/o local anaesthetic	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	4033000	Decompression of spinal nerve roots	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1824200	Admin anaes arnd occipital nerve	DC	Chr	HA	SH&EH
Anaesthetic / Pain Relief	9002800	Epidural injection of steroid	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1825400	Admin anaes agent arnd brachial plexus	DC	Chr	HA	SH&EH
Anaesthetic / Pain Relief	3932300	Other perc neurotomy by radiofrequency	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1827404	Admin anaes arnd paravert ccygl nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1827800	Admin anaes arnd sciatic nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	3911800	Perc nrotmy, facet jt denrv by radiofreq	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1827400	Admin anaes arnd paravert cervical nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	9620919	Load drug delv device oth & unsp agt	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	9001100	Oth dx proc spinal canal/cord structures	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	3911500	Perc neurotomy of prim rami of spin nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1828800	Admin anaes arnd coeliac plexus	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1823600	Admin anaes arnd perph br trigem nerve	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1826200	Admin anaes arnd iliohypogastric nrv	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1829600	Admin neurolytic into lumbar SNS	DC	Bed	HA	SH&EH
Anaesthetic / Pain Relief	3910900	Trigeminal gangliotomy by radiofrequency	OT	Bed	HA	SH&EH
Anaesthetic / Pain Relief	9002900	Administration of sympatholytic agent	OT	Bed	HA	SH&EH
Anaesthetic / Pain Relief	3914000	Epidural injct for lysis of adhesions	OT	Bed	HA	SH&EH
Anaesthetic / Pain Relief	3901300	Admin agent into zygo-apophyseal joint	OT	Chr	HA	SH&EH
Anaesthetic / Pain Relief	1826201	Admin anaes arnd ilio-inguinal nrv	OT	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1826000	Admin anaes arnd mult intcstl nrv	OT	Bed	HA	SH&EH
Anaesthetic / Pain Relief	1821627	Epidural inj/o local anaesthetic	OT	Bed	HA	SH&EH
Anaesthetic / Pain Relief	3913500	R/O sbc impl neurostimulator	OT	Bed	HA	SH&EH

Anaesthetic / Pain Relief	9002802	Caudal injection of steroid	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1826202	Admin anaes arnd genitofemoral nrv	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	9620909	Load drug delv device oth / unsp agt	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1827203	Admin anaes arnd sural nrv	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1826600	Admin anaes arnd ulnar nrv	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1828400	Admin anaes arnd cervical portion SNS	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1827000	Admin anaes arnd femoral nrv	OT	Bed	SC	SH&EH
Anaesthetic / Pain Relief	9002200	Admin anaes arnd other perph nrv	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	9619709	IM admin of pharmac agt oth & unsp agent	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1825600	Admin anaes arnd suprascapular nrv	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1826602	Admin anaes arnd median nrv	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1825800	Admin anaes arnd single intcstl nrv	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1826601	Admin anaes agent arnd radial nrv	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1827202	Admin anaes arnd popliteal nrv	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	9056000	Admin of other agt into soft tissue NEC	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	1836001	Admin of agent into soft tissue NEC	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	9620519	Other admin of pharmac agent oth & unsp	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	9217800	Heat therapy	OT	Chr	SC	SH&EH
Anaesthetic / Pain Relief	9619703	IM admin of pharmac agent steroid	OT	Chr	SC	SH&EH
Dermatology	3100000	Micro controlled serial exc lsn skin	MO	Chr	SC	SH&EH
Dermatology	3019500	Curettage lesion of skin, single lsn	MO	Chr	SC	SH&EH
Dermatology	9067600	Other proc on skin & subcutaneous tissue	MO	Chr	SC	SH&EH
Dermatology	9620500	Other admin of pharmac agent antineopl	MO	Chr	SC	SH&EH
Dermatology	1410000	Laser photcoag continuous blood vessels	MO	Chr	SC	SH&EH
Dermatology	9213800	Removal FB from head/neck wo incision	MO	Chr	SC	SH&EH
Dermatology	3019501	Curettage lsn skin, multiple lsn	MO	Chr	SC	SH&EH
Dermatology	3007528	Biopsy of external ear	MO	Chr	SC	SH&EH
Dermatology	9214200	Removal of other device from trunk	MO	Chr	SC	SH&EH
Dermatology	3019503	Laser to multiple skin lesions	MO	Chr	SC	SH&EH
Dermatology	3019502	Laser to lesion of skin, single lesion	OT	Chr	SC	SH&EH
Dermatology	9602000	Skin integrity assessment	OT	Chr	SC	SH&EH
Dermatology	9620503	Other admin of pharmac agent steroid	OT	Chr	SC	SH&EH
Gastroenterology	3047808	Removal of gastrostomy tube	EN	Bed	HA	SH&EH
Gastroenterology	3047303	Oesophagoscopy	EN	Bed	SC	SH&EH
Gastroenterology	1180000	Oesophageal motility test	OD	Chr	SC	SH&EH
Gastroenterology	5503600	Ultrasound of abdomen	OD	Chr	SC	SH&EH
Gastroenterology	1375700	Therapeutic venesection	OT	Bed	SC	SH&EH
General Surgery	3060900	Lap repair of femoral hernia, unilateral	DC	Bed	HA	SH&EH
General Surgery	3064407	Excision of lesion of testicle	DC	50%B	HA	SH&EH
General Surgery	9057500	Excision of soft tissue, NEC	DC	Chr	HA	SH&EH
General Surgery	3760400	Exploration scrotal contents, unilateral	DC	Bed	HA	SH&EH
General Surgery	4554800	Removal of breast prosthesis	DC	Bed	HA	SH&EH
General Surgery	3156300	Surgical eversion of inverted nipple	DC	Bed	HA	SH&EH
General Surgery	3156000	Excision of accessory breast tissue	DC	Bed	HA	SH&EH
General Surgery	3064401	Exploration of spermatic cord	DC	Bed	HA	SH&EH

General Surgery	3030000	Sentinel lymph node biopsy of axilla	DC	Bed	HA	SH&EH
General Surgery	3150001	Open biopsy of breast	DC	Bed	HA	SH&EH
General Surgery	3018600	Removal of plantar wart	DC	50%b	HA	SH&EH
General Surgery	3065300	Male circumcision	DC	Bed	HA	SH&EH
General Surgery	3022302	Other incision & drainage of SSCT	DC	Bed	HA	SH&EH
General Surgery	3151500	Re-excision of lesion of breast	DC	Bed	HA	SH&EH
General Surgery	3007517	Biopsy of abdominal wall or umbilicus	DC	Bed	HA	SH&EH
General Surgery	3009900	Excision of sinus of SSCT	DC	Chr	HA	SH&EH
General Surgery	9209000	R/O FB from rectum or anus wo incision	DC	Chr	HA	SH&EH
General Surgery	3006200	Removal of subdermal hormone implant	DC	Chr	HA	SH&EH
General Surgery	3150000	Excision of lesion of breast	DC	Bed	HA	SH&EH
General Surgery	3217700	Removal of anal wart	DC	50%B	HA	SH&EH
General Surgery	9220200	R/O therapeutic device, NEC	DC	Bed	HA	SH&EH
General Surgery	3761300	Epididymectomy, unilateral	DC	50%B	HA	SH&EH
General Surgery	3211100	Excision rectal mucosa, rectal prolapse	DC	Bed	HA	SH&EH
General Surgery	3214200	Excision of anal skin tag	DC	50%B	HA	SH&EH
General Surgery	9031500	Endoscopic e/o lesion tissue anus	DC	Bed	HA	SH&EH
General Surgery	3007534	Biopsy of anus	DC	50%B	HA	SH&EH
General Surgery	9031501	Excision other lesion or tissue anus	DC	Bed	HA	SH&EH
General Surgery	3216600	Insertion of anal seton	DC	Bed	HA	SH&EH
General Surgery	3216602	Removal of anal seton	DC	Bed	HA	SH&EH
General Surgery	3216601	Adjustment of anal seton	DC	Bed	HA	SH&EH
General Surgery	3155400	Microdochotomy of breast	DC	Bed	HA	SH&EH
General Surgery	3040301	Repair of other abdominal wall hernia	DC	Bed	HA	SH&EH
General Surgery	3060903	Lap repair inguinal hernia, bilateral	DC	Bed	HA	SH&EH
General Surgery	3061701	Repair of epigastric hernia	DC	Bed	HA	SH&EH
General Surgery	3061402	Repair of inguinal hernia, unilateral	DC	Bed	HA	SH&EH
General Surgery	3044800	Lap chole w expl CBD v cystic duct	DC	Bed	HA	SH&EH
General Surgery	3060902	Lap repair inguinal hernia, unilateral	DC	Bed	HA	SH&EH
General Surgery	3061403	Repair of inguinal hernia, bilateral	DC	Bed	HA	SH&EH
General Surgery	3215902	Ins seton & exc anal fist inv low sphc	DC	Bed	HA	SH&EH
General Surgery	3214201	Excision of anal polyp	DC	Bed	HA	SH&EH
General Surgery	3044500	Laparoscopic cholecystectomy	DC	Bed	HA	SH&EH
General Surgery	3033200	Excision of lymph node of axilla	DC	Bed	HA	SH&EH
General Surgery	3018901	Removal of other wart	DC	50%B	HA	SH&EH
General Surgery	3032900	Excision of lymph node of groin	DC	50%B	HA	SH&EH
General Surgery	3762303	Vasectomy, bilateral	DC	50%B	HA	SH&EH
General surgery	3155700	Excision of duct (central) of breast	DC	Bed	HA	SH&EH
General surgery	3209900	Per anal submucosal exc, lsn/tis rectum	DC	Bed	HA	SH&EH
General surgery	3067601	Excision of pilonidal sinus/cyst/abscess	DC	50%B	HA	SH&EH
General surgery	3213800	Haemorrhoidectomy	DC	Bed	HA	SH&EH
General surgery	9033800	Incision of rectum or anus	DC	50%B	HA	SH&EH
General surgery	3067600	Incision of pilonidal sinus/cyst/abscess	DC	Bed	HA	SH&EH
General surgery	3040300	Repair of incisional hernia	DC	Bed	HA	SH&EH
General surgery	3057200	Laparoscopic appendicectomy	DC	Bed	HA	SH&EH

General surgery	3152400	Subcutaneous mastectomy, unilateral	DC	Bed	HA	SH&EH
General surgery	3217401	Drainage of perianal abscess	DC	50%B	HA	SH&EH
General surgery	3061400	Repair of femoral hernia, unilateral	DC	Bed	HA	SH&EH
General surgery	3044300	Cholecystectomy	DC	Bed	HA	SH&EH
General surgery	3040504	Repair other abdo wall hernia w prosth	DC	Bed	HA	SH&EH
General surgery	3215300	Dilation of anus	DC	50%B	HA	SH&EH
General surgery	3040501	Repair incisional hernia with prosthesis	DC	Bed	HA	SH&EH
General surgery	3213501	Destruction of haemorrhoids	DC	Bed	HA	SH&EH
General surgery	9624202	Biopsy lymphatic structure axillary	DC	Bed	HA	SH&EH
General surgery	3210500	Per anal e/o anorectal lsn/tis	DC	50%B	HA	SH&EH
General surgery	3155100	Incision and drainage of breast	DC	50%B	HA	SH&EH
General surgery	9034100	Other excision of lesion of rectum	DC	50%B	HA	SH&EH
General surgery	9624302	Sentinel lymph n biopsy axillary	DC	Bed	HA	SH&EH
General surgery	4503306	Excision vascular anomaly oth site	DC	50%B	HA	SH&EH
General Surgery	9028200	Excision of lymph node of other site	DC	Bed	SC	SH&EH
General Surgery	3120501	Excision of ulcer of SSCT	DC	Chr	SC	SH&EH
General Surgery	3061700	Repair of umbilical hernia	DC	Bed	SC	SH&EH
General Surgery	3213200	Admin sclerosing agt for haemorrhoids	EN	50%B	SC	SH&EH
General Surgery	3213500	Rubber band ligation of haemorrhoids	EN	50%B	SC	SH&EH
General Surgery	9034401	Admin/o thrpc agent to anorectal rgn	EN	50%B	SC	SH&EH
General Surgery	3207800	Rigid sigmoidoscopy w PP 1 to 9 polyps	EN	50%B	SC	SH&EH
General Surgery	3453004	Removal of venous catheter	MO	50%B	HA	SH&EH
General Surgery	3156600	Excision of accessory nipple	MO	Chr	HA	SH&EH
General Surgery	9206700	Dilation of enterostomy stoma	MO	Chr	HA	SH&EH
General Surgery	3019506	Electrotherapy of single skin lesion	MO	Chr	SC	SH&EH
General Surgery	3214700	Incision of perianal thrombus	MO	Chr	SC	SH&EH
General Surgery	4790600	Debridement of toenail	MO	Chr	SC	SH&EH
General Surgery	3007501	Biopsy of soft tissue	MO	Chr	SC	SH&EH
General Surgery	3410900	Biopsy of temporal artery	MO	Chr	SC	SH&EH
General Surgery	3123504	Excision of lesion SSCT, foot	MO	Chr	SC	SH&EH
General Surgery	3123503	Excision of lesion SSCT, leg	MO	Chr	SC	SH&EH
General Surgery	3120500	Exc lesion of SSCT, other site	MO	Chr	SC	SH&EH
General Surgery	3123501	Excision lesion of SSCT, neck	MO	Chr	SC	SH&EH
General Surgery	4791600	Partial resection of ingrown toenail	MO	Chr	SC	SH&EH
General Surgery	4652800	Wedge resection of ingrown fingernail	MO	Chr	SC	SH&EH
General Surgery	4790601	Removal of toenail	MO	Chr	SC	SH&EH
General Surgery	4791500	Wedge resection of ingrown toenail	MO	Chr	SC	SH&EH
General Surgery	4791800	Radical excision of ingrown toenail bed	MO	Chr	SC	SH&EH
General Surgery	1183000	Anal manometry	OD	Chr	SC	SH&EH
General Surgery	3207500	Rigid sigmoidoscopy	OD	Chr	SC	SH&EH
General Surgery	4554600	Intraderm colour skin for nipple/areola	OD	Chr	SC	SH&EH
General Surgery	3217100	Anorectal examination	OT	50%B	HA	SH&EH
General surgery	3154800	Core biopsy of breast	OT	Chr	SC	SH&EH
General surgery	9072500	Aspiration of breast	OT	Chr	SC	SH&EH
General surgery	3009400	Perc [needle] biopsy of soft tissue	OT	Chr	SC	SH&EH

Gynaecology	3039300	Laparoscopic division abdo adhesions	DC	Bed	HA	SH&EH
Gynaecology	9044802	Tot lap abdo hystrectmy w R/O adnexa	DC	Bed	HA	SH&EH
Gynaecology	3565304	Abdo hystrectmy w R/O adnexa	DC	Bed	HA	SH&EH
Gynaecology	3564903	Myomectomy of uterus	DC	Bed	HA	SH&EH
Gynaecology	3555700	Excision of lesion of vagina	OT	Chr	SC	SH&EH
OMFS	9732201	Full dental clearance	DC	Bed	HA	SH&EH
OMFS	9732303	Surg R/O 3 teeth w R/O bone	DC	Bed	HA	SH&EH
OMFS	9732304	Surg R/O 4 teeth w R/O bone	DC	Bed	HA	SH&EH
OMFS	9732305	Surg R/O 5 - 9 teeth w R/O bone	DC	Bed	HA	SH&EH
OMFS	9732306	Surg R/O 10 - 14 teeth w R/O bone	DC	Bed	HA	SH&EH
OMFS	9732307	Surg R/O >= 15 teeth w R/O bone	DC	Bed	HA	SH&EH
OMFS	9738800	Transplantation of tooth or tooth bud	DC	Bed	HA	SH&EH
OMFS	9014102	Exc/destruction of lesion of palate	DC	Bed	HA	SH&EH
OMFS	9731105	R/O 5 - 9 teeth or part(s) thereof	DC	Chr	SC	SH&EH
OMFS	3026601	Marsupialisation cyst salivary gland/dct	MO	Chair	HA	SH&EH
OMFS	3028101	Labial fraenectomy	MO	Bed	HA	SH&EH
OMFS	5210200	R/O pin/screw/wire maxilla/mandible/zygo	MO	Bed	HA	SH&EH
OMFS	4171600	Intranasal removal FB, maxillary antrum	MO	Bed	HA	SH&EH
OMFS	4567600	Other repair of mouth	MO	Bed	HA	SH&EH
OMFS	4586500	Arthrocentesis TMJ	MO	Bed	HA	SH&EH
OMFS	4584900	Bone graft to maxillary sinus	MO	Bed	HA	SH&EH
OMFS	9732206	Surg R/O 10 - 14 teeth wo R/O bone / div	MO	Bed	HA	SH&EH
OMFS	9732207	Surg R/O >= 15 teeth wo R/O bone / div	MO	Bed	HA	SH&EH
OMFS	9732302	Surg R/O 2 teeth w R/O bone	MO	Bed	HA	SH&EH
OMFS	9737900	Marsupialisation of cyst in oral cavity	MO	Chair	HA	SH&EH
OMFS	9738500	Surgical repositioning unerupted tooth	MO	Chair	HA	SH&EH
OMFS	9014101	Excision of other lesion of mouth	MO	Chr	SC	SH&EH
OMFS	3028300	Excision of cyst of mouth	MO	Chr	SC	SH&EH
OMFS	3007524	Biopsy of soft palate	MO	Chair	SC	SH&EH
OMFS	9732200	Surg R/O 1 tooth wo R/O bone / div	MO	Chair	SC	SH&EH
OMFS	4172200	Closure of oro-antral fistula	MO	Chair	SC	SH&EH
OMFS	4582300	R/O arch bars frm maxilla or mandible	MO	Chair	SC	SH&EH
OMFS	9732202	Surg R/O 2 teeth wo R/O bone / div	MO	Chair	SC	SH&EH
OMFS	9732203	Surg R/O 3 teeth wo R/O bone / div	MO	Chair	SC	SH&EH
OMFS	9732204	Surg R/O 4 teeth wo R/O bone / div	MO	Chair	SC	SH&EH
OMFS	9732205	Surg R/O 5 - 9 teeth wo R/O bone / div	MO	Chair	SC	SH&EH
OMFS	9732301	Surg R/O 1 tooth w R/O bone	MO	Chair	SC	SH&EH
OMFS	9737700	Dental Rx inv R/O or repair soft tis NEC	MO	Chair	SC	SH&EH
OMFS	9743200	Apicectomy, per root	MO	Chair	SC	SH&EH
OMFS	9743400	Apical seal of root canal, per canal	MO	Chair	SC	SH&EH
OMFS	3007100	Biopsy of skin & subcutaneous tissue	MO	Chair	SC	SH&EH
OMFS	9731101	Removal of 1 tooth or part(s) thereof	MO	Chr	SC	SH&EH
OMFS	9731102	Removal of 2 teeth or part(s) thereof	MO	Chr	SC	SH&EH
OMFS	9731104	Removal of 4 teeth or part(s) thereof	MO	Chr	SC	SH&EH
OMFS	9731103	Removal of 3 teeth or part(s) thereof	MO	Chr	SC	SH&EH

OMFS	9731108	R/O ? teeth or part(s) thereof	MO	Chr	SC	SH&EH
OMFS	3007523	Biopsy of oral cavity	OD	Chr	SC	SH&EH
OMFS	4579900	Aspiration biopsy of jaw cyst	OD	Chair	SC	SH&EH
OMFS	3019504	Cryotherapy of single skin lesion	OD	Chair	SC	SH&EH
OMFS	3019505	Cryotherapy of multiple skin lesions	OD	Chair	SC	SH&EH
OMFS	5020000	Biopsy of bone, not elsewhere classified	OD	Chair	SC	SH&EH
OMFS	9701100	Comprehensive oral examination	OD	Chr	SC	SH&EH
OMFS	9777600	Impression for denture repair	OT	Chr	SC	SH&EH
OMFS	9711100	Removal of plaque or stain of teeth	OT	Chr	SC	SH&EH
Ophthalmology	4258700	Correction trichiasis by cryothrpy 1 eye	DC	Chr	HA	SH&EH
Ophthalmology	4270204	Phacoem & aspr cataract w IOL foldable	DC	Chr	HA	SH&EH
Ophthalmology	4270205	Phacoem & aspr cataract w IOL other	DC	Chr	HA	SH&EH
Ophthalmology	4286600	Rep ect/entropion by rep infer retrac	DC	Chr	HA	SH&EH
Ophthalmology	4286601	Rep ect/entropion oth rep infer retrac	DC	Chr	HA	SH&EH
Ophthalmology	4283301	Strabismus proc inv 1 or 2 musc, 2 eyes	DC	Chr	HA	SH&EH
Ophthalmology	4566501	Full thickness wedge excision of eyelid	DC	Chr	HA	SH&EH
Ophthalmology	4258100	Cauterisation of ectropion	DC	Chr	HA	SH&EH
Ophthalmology	4562601	Cor ectropion/entropion w wedge resect	DC	Chr	HA	SH&EH
Ophthalmology	4562302	Cor ptosis resec / advance levator musc	DC	Chr	HA	SH&EH
Ophthalmology	4561401	Tarsal strip procedure	DC	Chr	HA	SH&EH
Ophthalmology	4283300	Strabismus proc inv 1 or 2 muscles 1 eye	DC	Chr	HA	SH&EH
Ophthalmology	4277000	Destruction of ciliary body	DC	Chr	HA	SH&EH
Ophthalmology	4280600	Destruction of lesion of iris by laser	DC	Chr	HA	SH&EH
Ophthalmology	4268600	Excision of pterygium	DC	Chr	HA	SH&EH
Ophthalmology	4269807	Phacoem of crystalline lens	DC	Chr	HA	SH&EH
Ophthalmology	4273400	Capsulotomy of lens	DC	Chr	SC	SH&EH
Ophthalmology	9008400	Incision of eyelid	DC	Chr	SC	SH&EH
Ophthalmology	4261700	Incision of lacrimal punctum	DC	Chr	SC	SH&EH
Ophthalmology	4262200	Occlusion lacm punctum by cautery	DC	Chr	SC	SH&EH
Ophthalmology	4269802	Phacoemulsification & aspr cataract	DC	Chr	SC	SH&EH
Ophthalmology	4266800	Removal of corneal sutures	DC	Chr	SC	SH&EH
Ophthalmology	4257500	Excision of cyst of tarsal plate	DC	Chr	SC	SH&EH
Ophthalmology	4278800	Capsulotomy of lens by laser	DC	Chr	SC	SH&EH
Ophthalmology	4261401	Probing lacrimal passages, unilateral	DC	Chr	SC	SH&EH
Ophthalmology	4261501	Probing of lacrimal passages, bilateral	DC	Chr	SC	SH&EH
Ophthalmology	4259000	Lateral canthoplasty	MO	Chr	HA	SH&EH
Ophthalmology	3123000	Exc of lesion SSCT, eyelid	MO	Chr	SC	SH&EH
Ophthalmology	4265200	Corneal collagen cross linking [CXL]	MO	Chr	SC	SH&EH
Ophthalmology	1121200	Examination of optic fundi	OD	Chr	SC	SH&EH
Ophthalmology	9201600	Tonometry	OD	Chr	SC	SH&EH
Ophthalmology	4250300	Ophthalmological examination	OD	Chr	SC	SH&EH
Ophthalmology	1122100	Full quantitative comput perimetry bil	OD	Chr	SC	SH&EH
Ophthalmology	5503000	Ultrasound of orbital contents	OD	Chr	SC	SH&EH
Ophthalmology	4274003	Admin therapeutic agt in post chamber	OT	Chr	SC	SH&EH
Ophthalmology	1837000	Admin of botulinum toxin into eyelid	OT	Chr	SC	SH&EH

Ophthalmology	4562600	Correction ectropion/entropion by suture	OT	Chr	SC	SH&EH
Ophthalmology	4282401	Subconjunctival administration of agent	OT	Chr	SC	SH&EH
Ophthalmology	4278200	Trabeculoplasty	OT	Chr	SC	SH&EH
Ophthalmology	4262000	Occlusion of lacrimal punctum by plug	OT	Chr	SC	SH&EH
Ophthalmology	4278500	Iridotomy by laser	OT	Chr	SC	SH&EH
Ophthalmology	4258704	Correction trichiasis electrolysis 1 eye	OT	Chr	SC	SH&EH
Ophthalmology	4258705	Correction trichiasis electrolysis, eyes	OT	Chr	SC	SH&EH
Ophthalmology	4273401	Capsulotomy of lens	OT	Chr	SC	SH&EH
Ophthalmology	4258800	Correction of trichiasis	OT	Chr	SC	SH&EH
Ophthalmology	4562700	Correction of ectropion or entropion NEC	OT	Chr	SC	SH&EH
Orthopaedics	4895100	Arthro decomp subacrom space	DC	Bed	HA	SH&EH
Orthopaedics	4955702	Arthro exc meniscal margin/plica knee	DC	Bed	HA	SH&EH
Orthopaedics	4956101	Arthro meniscectomy knee, debride/plasty	DC	Bed	HA	SH&EH
Orthopaedics	4956102	Arthro R/O loose bd knee debride/plasty	DC	Bed	HA	SH&EH
Orthopaedics	4984500	Arthrodesis 1st metatarsophalangeal jt	DC	Bed	HA	SH&EH
Orthopaedics	4955801	Arthroscopic chondroplasty of knee	DC	Bed	HA	SH&EH
Orthopaedics	4955800	Arthroscopic debridement of knee	DC	Bed	HA	SH&EH
Orthopaedics	4894800	Arthroscopic debridement of shoulder	DC	Bed	HA	SH&EH
Orthopaedics	4956003	Arthroscopic meniscectomy of knee	DC	Bed	HA	SH&EH
Orthopaedics	4970302	Arthroscopic removal loose body of ankle	DC	Bed	HA	SH&EH
Orthopaedics	4956300	Arthroscopic repair of meniscus of knee	DC	Bed	HA	SH&EH
Orthopaedics	4956001	Arthroscopic trimming ligament of knee	DC	Chr	HA	SH&EH
Orthopaedics	4921800	Arthroscopy of wrist	DC	Chr	HA	SH&EH
Orthopaedics	4983700	Cor hal val osteot metarsl trsf tend uni	DC	Bed	HA	SH&EH
Orthopaedics	4983600	Cor h-valgus osteotomy 1st metarsl bil	DC	Bed	HA	SH&EH
Orthopaedics	4985100	Correction hammer toe, internal fixation	DC	Chr	HA	SH&EH
Orthopaedics	4984800	Correction of hammer toe	DC	Chr	HA	SH&EH
Orthopaedics	4792701	R/O pin, screw or wire from femur	DC	Bed	HA	SH&EH
Orthopaedics	9250899	Neuraxial block, ASA 99	DC	Bed	HA	SH&EH
Orthopaedics	1827600	Admin anaes arnd paravert nrv mult lvl	DC	Bed	HA	SH&EH
Orthopaedics	3024100	Excision of lesion of bone, NEC	DC	Bed	HA	SH&EH
Orthopaedics	9609400	R/O asst/adaptive device/aid/equip	DC	Bed	HA	SH&EH
Orthopaedics	4630000	Arthrodesis interphalangeal joint, hand	DC	Chr	HA	SH&EH
Orthopaedics	4636300	Release of tendon sheath of hand	DC	Chr	HA	SH&EH
Orthopaedics	3010700	Excision of ganglion, NEC	DC	Chr	HA	SH&EH
Orthopaedics	3901301	Admin agent into costotransverse joint	DC	Bed	HA	SH&EH
Orthopaedics	3933000	Open neurolysis of peripheral nerve, NEC	DC	Chr	HA	SH&EH
Orthopaedics	4972700	Lengthening of Achilles' tendon	DC	Bed	HA	SH&EH
Orthopaedics	4633001	Repair ligament or capsule of MCP joint	DC	Chr	HA	SH&EH
Orthopaedics	4793001	Removal of plate, rod or nail from femur	DC	Bed	HA	SH&EH
Orthopaedics	4793000	Removal of plate, rod or nail, NEC	DC	Bed	HA	SH&EH
Orthopaedics	4792700	Removal of pin, screw or wire, NEC	DC	20%B	HA	SH&EH
Orthopaedics	4630001	Arthrodesis metacarpophalangeal joint	DC	Chr	HA	SH&EH
Orthopaedics	3011100	Excision of large bursa	DC	Bed	HA	SH&EH
Orthopaedics	4793301	Excision of exostosis of bne of foot	DC	Bed	HA	SH&EH

Orthopaedics	4840301	Osteotomy of toe with internal fixation	DC	Bed	HA	SH&EH
Orthopaedics	4955700	Arthroscopy of knee	DC	Bed	HA	SH&EH
Orthopaedics	4894500	Arthroscopy of shoulder	DC	Bed	HA	SH&EH
Orthopaedics	4983300	Cor h-valgus osteotmy 1st metarsl uni	DC	Bed	HA	SH&EH
Orthopaedics	9060601	Removal of other soft tissue implant	DC	Chr	HA	SH&EH
Orthopaedics	4733601	Closed rdctn fracture metacarpus w IF	DC	Bed	HA	SH&EH
Orthopaedics	4746501	Open reduction fracture clavicle w IF	DC	Bed	HA	SH&EH
Orthopaedics	4896000	Arthroscopic reconstruction of shoulder	DC	Bed	HA	SH&EH
Orthopaedics	4735701	Open rdctn fracture carpal scaphoid IF	DC	Bed	HA	SH&EH
Orthopaedics	4971801	Repair of Achilles' tendon	DC	Bed	HA	SH&EH
Orthopaedics	4931800	Total arthroplasty of hip, unilateral	DC	Bed	HA	SH&EH
Orthopaedics	4730101	Closed reduction fx phalanx hand with IF	DC	Bed	HA	SH&EH
Orthopaedics	4732401	Closed rdctn fx proximal phlx hand w IF	DC	Bed	HA	SH&EH
Orthopaedics	4650000	Excision of ganglion of dorsal wrist	DC	Bed	HA	SH&EH
Orthopaedics	4736302	Closed rdctn fracture distal radius IF	DC	Bed	HA	SH&EH
Orthopaedics	4895700	Arthroscopic stabilisation of shoulder	DC	Bed	HA	SH&EH
Orthopaedics	4731000	Open reduction fx phalanx hand with IF	DC	Bed	HA	SH&EH
Orthopaedics	4731001	Open rdctn fracture metacarpus with IF	DC	Bed	HA	SH&EH
Orthopaedics	4956000	Arthroscopic removal of loose body, knee	DC	50%b	HA	SH&EH
Orthopaedics	4760301	Open rdctn fx ank IF >=2 diats fib malus	DC	Bed	HA	SH&EH
Orthopaedics	4641700	Transfer of tendon of hand	DC	Bed	HA	SH&EH
Orthopaedics	4736700	Closed rdctn fracture distal radius w IF	DC	Bed	HA	SH&EH
Orthopaedics	4730001	Closed rdctn fx distal phalanx hand IF	DC	Bed	HA	SH&EH
Orthopaedics	3932100	Transposition of nerve	DC	Bed	HA	SH&EH
Orthopaedics	4763901	Open reduction fracture metatarsus w IF	DC	Bed	HA	SH&EH
Orthopaedics	9057400	Excision of lesion of joint, NEC	DC	Chr	HA	SH&EH
Orthopaedics	4742901	Open rdctn fx proximal humerus w IF	DC	Bed	HA	SH&EH
Orthopaedics	4736300	Closed reduction fracture distal radius	DC	Bed	HA	SH&EH
Orthopaedics	4632400	Arthroplasty of carpal bone	DC	Bed	HA	SH&EH
Orthopaedics	4823300	Bone graft to scaphoid internal fixation	DC	Bed	HA	SH&EH
Orthopaedics	4630900	Arthroplasty of IPJ hand, 1 joint	DC	Bed	HA	SH&EH
Orthopaedics	4731201	Closed rdctn fx mid phalanx hand w IF	DC	Bed	HA	SH&EH
Orthopaedics	4738403	Open rdctn fracture shaft of ulna w IF	DC	Bed	HA	SH&EH
Orthopaedics	4894801	Arthroscopic removal loose body shoulder	DC	Bed	HA	SH&EH
Orthopaedics	4912101	Arthroscopic removal loose body elbow	DC	Bed	HA	SH&EH
Orthopaedics	4910000	Arthrotomy of elbow	DC	Bed	HA	SH&EH
Orthopaedics	4891200	Arthrotomy of shoulder	DC	Bed	HA	SH&EH
Orthopaedics	4910002	Release of elbow contracture	DC	Bed	HA	SH&EH
Orthopaedics	4922400	Arthroscopic debridement of wrist	DC	Bed	HA	SH&EH
Orthopaedics	4921200	Arthrotomy of wrist	DC	Bed	HA	SH&EH
Orthopaedics	4703002	Closed rdctn disloc carpometacarpal jt	DC	Bed	HA	SH&EH
Orthopaedics	4640200	Bone graft of metacarpal bone	DC	Bed	HA	SH&EH
Orthopaedics	4643800	Closed fixation of mallet finger	DC	Chr	HA	SH&EH
Orthopaedics	4953900	Arthroscopic reconstruction of knee	DC	50%B	HA	SH&EH
Orthopaedics	4955701	Arthroscopic biopsy of knee	DC	50%B	HA	SH&EH

Orthopaedics	4956002	Arthroscopic lateral release of knee	DC	50%B	HA	SH&EH
Orthopaedics	4956600	Arthroscopic synovectomy of knee	DC	50%B	HA	SH&EH
Orthopaedics	4955900	Arthro chondroplasty knee w dril/implant	DC	50%B	HA	SH&EH
Orthopaedics	4956100	Arthro lat release knee w debride/plasty	DC	50%B	HA	SH&EH
Orthopaedics	4953901	Reconstruction of knee	DC	95%B	HA	SH&EH
Orthopaedics	4956900	Quadricepsplasty of knee	DC	95%B	HA	SH&EH
Orthopaedics	4705700	Closed reduction dislocation of patella	DC	95%B	HA	SH&EH
Orthopaedics	9061101	Patellar tendon advancement	DC	95%B	HA	SH&EH
Orthopaedics	4970000	Arthroscopy of ankle	DC	Bed	HA	SH&EH
Orthopaedics	4970301	Arthroscopic trimming osteophyte, ankle	DC	Bed	HA	SH&EH
Orthopaedics	4759700	Closed reduction of fracture of ankle	DC	Bed	HA	SH&EH
Orthopaedics	4971200	Arthrodesis of ankle	DC	Bed	HA	SH&EH
Orthopaedics	4760000	Clsd rdctn fx ankle IF diats/fib/malus	DC	Bed	HA	SH&EH
Orthopaedics	4970600	Arthrotomy of ankle	DC	Bed	HA	SH&EH
Orthopaedics	4759400	Immobilisation of fracture of ankle, NEC	DC	Bed	HA	SH&EH
Orthopaedics	9055900	Arthrodesis of toe	DC	Bed	HA	SH&EH
Orthopaedics	4766301	Closed rdctn fx phalanx great toe w IF	DC	Bed	HA	SH&EH
Orthopaedics	4767200	Closed rdctn fx phalanx not great toe	DC	Bed	HA	SH&EH
Orthopaedics	4706901	Closed reduction dislocation of toe w IF	DC	Bed	HA	SH&EH
Orthopaedics	4762101	Closed rdctn fx tarsometatarsal jt w IF	DC	Bed	HA	SH&EH
Orthopaedics	5030900	Adjustment ring fixator or similar dev	DC	Bed	HA	SH&EH
Orthopaedics	4936000	Arthroscopy of hip	DC	Bed	HA	SH&EH
Orthopaedics	4649400	Excision of ganglion of hand	DC	Chr	SC	SH&EH
Orthopaedics	4637200	Palmar fasciectomy Dupuytren's, 1 digit	DC	Bed	SC	SH&EH
Orthopaedics	4637500	Palmar fasciectomy Dupuytren's, 2 digits	DC	Bed	SC	SH&EH
Orthopaedics	3933101	Release of carpal tunnel	DC	Chr	SC	SH&EH
Orthopaedics	9001900	Caudal inj/o oth/cmb therapeutic subs	MO	65%B	HA	SH&EH
Orthopaedics	5011500	Manipulation/mobilisation of joint NEC	MO	Chr	HA	SH&EH
Orthopaedics	1821606	Epdl infus other/cmb thrpc subs	MO	Bed	HA	SH&EH
Orthopaedics	4794800	Removal of external fixation device	MO	Chr	HA	SH&EH
Orthopaedics	5010600	Joint stabilisation, NEC	MO	Bed	HA	SH&EH
Orthopaedics	3933100	Endoscopic release of carpal tunnel	MO	Chr	SC	SH&EH
Orthopaedics	3135000	Excision of lesion of soft tissue, NEC	MO	Chr	SC	SH&EH
Orthopaedics	9220000	Removal of sutures, NEC	MO	Chr	SC	SH&EH
Orthopaedics	1829200	Admin neurolytic into oth perph nrv	MO	Chr	SC	SH&EH
Orthopaedics	9250000	Routine preoperative anaes assessment	OD	Chr	SC	SH&EH
Orthopaedics	9609200	Applicn/fit/adjust/replace oth dev/equip	OT	Chr	SC	SH&EH
Orthopaedics	5012400	Aspiration jt/oth synovial cavity NEC	OT	Chr	SC	SH&EH
Orthopaedics	5012401	Admin agt into jt/oth synovl cavity NEC	OT	Chr	SC	SH&EH
Orthopaedics	9555004	Allied health intervention, podiatry	OT	Chr	SC	SH&EH
Orthopaedics	9206200	Administration of other serum	OT	Chr	SC	SH&EH
Orthopaedics	9068603	Vacuum dressing	OT	Chr	SC	SH&EH
Otholaryngology	4150600	Excision of aural polyp, external ear	DC	Chr	HA	SH&EH
Otholaryngology	4190700	Insertion of nasal septal button	DC	Bed	HA	SH&EH
Otholaryngology	4173706	Intranasal R/O polyp ethmoidal sinus	DC	Chr	HA	SH&EH

Otholaryngology	4171603	Intranasal R/O polyp, maxillary antrum	DC	Chr	HA	SH&EH
Otholaryngology	4579700	OI, fix trnscut abtmt for atchmt BAHA	DC	Bed	HA	SH&EH
Otholaryngology	4181001	Uvulectomy	DC	Chr	HA	SH&EH
Otholaryngology	3007500	Biopsy of lymph node	DC	Bed	HA	SH&EH
Otholaryngology	3030001	Sentinel lymph node biopsy NEC	DC	Bed	HA	SH&EH
Otholaryngology	9013500	Excision of lesion of tongue	DC	Bed	HA	SH&EH
Otholaryngology	3142300	Excision of lymph node of neck	DC	Bed	HA	SH&EH
Otholaryngology	4190400	Bronchoscopy with dilation	DC	Bed	HA	SH&EH
Otholaryngology	4162601	Myringotomy, bilateral	DC	Bed	HA	SH&EH
Otholaryngology	4180100	Adenoidectomy without tonsillectomy	DC	Bed	HA	SH&EH
Otholaryngology	4163201	Myringotomy w insertion of tube, bil	DC	Bed	HA	SH&EH
Otholaryngology	4178901	Tonsillectomy with adenoidectomy	DC	Bed	HA	SH&EH
Otholaryngology	4162600	Myringotomy, unilateral	DC	Bed	HA	SH&EH
Otholaryngology	4178900	Tonsillectomy without adenoidectomy	DC	Bed	HA	SH&EH
Otholaryngology	9204600	Replacement of tracheostomy tube	DC	Chr	HA	SH&EH
Otholaryngology	4185500	Microlaryngoscopy	DC	Bed	HA	SH&EH
Otholaryngology	1836800	Admin of botulinum toxin into vocal cord	DC	Chr	HA	SH&EH
Otholaryngology	9013100	Local excision other intranasal lesion	DC	Bed	HA	SH&EH
Otholaryngology	4163200	Myringotomy w insertion of tube, uni	DC	Bed	HA	SH&EH
Otholaryngology	4167400	Cauterisation/diathermy nasal turbinates	DC	Bed	HA	SH&EH
Otholaryngology	4153000	Myringoplasty postaural or endaural appr	DC	Bed	HA	SH&EH
Otholaryngology	4167102	Septoplasty	DC	Bed	HA	SH&EH
Otholaryngology	4186400	Microlaryngoscopy w R/O lesion	DC	Bed	HA	SH&EH
Otholaryngology	4186100	Microlaryngoscopy R/O lesion by laser	DC	Chr	HA	SH&EH
Otholaryngology	4167401	Destruction procedures on nasal septum	DC	Bed	HA	SH&EH
Otholaryngology	4181600	Rigid oesophagoscopy	DC	Bed	HA	SH&EH
Otholaryngology	4182200	Rigid oesophagoscopy with biopsy	DC	Bed	HA	SH&EH
Otholaryngology	9625701	Functional endoscopic sinus surg [FESS]	DC	Bed	HA	SH&EH
Otholaryngology	4187001	Admin of agent into larynx or vocal cord	DC	Bed	HA	SH&EH
Otholaryngology	9624201	Biopsy lymphatic structure neck/cervical	DC	Bed	HA	SH&EH
Otholaryngology	4163202	Insertion of myringotomy tube uni	DC	Bed	HA	SH&EH
Otholaryngology	4171602	Intranasal maxillary antrostomy, bil	DC	Bed	HA	SH&EH
Otholaryngology	3030601	Total thyroid lobectomy, unilateral	DC	Bed	HA	SH&EH
Otholaryngology	4163500	Excision of lesion of middle ear	DC	Bed	HA	SH&EH
Otholaryngology	4163203	Insertion of myringotomy tube bilateral	DC	Bed	HA	SH&EH
Otholaryngology	9011401	Administration of agent into middle ear	DC	Bed	HA	SH&EH
Otholaryngology	9014400	Excision lesion of tonsils or adenoids	DC	Bed	HA	SH&EH
Otholaryngology	4167103	Septoplasty, submucous resec nasal sept	DC	Bed	HA	SH&EH
Otholaryngology	4579400	OI impl titanium fixture, atchmt BAHA	DC	Bed	HA	SH&EH
Otholaryngology	4173703	Ethmoidectomy, bilateral	DC	Bed	HA	SH&EH
Otholaryngology	4188500	Tracheo-oesophageal fistulisation	DC	Bed	HA	SH&EH
Otholaryngology	4164400	Excision rim perforated tympanic memb	DC	Bed	HA	SH&EH
Otholaryngology	4167101	Closure of perforation of nasal septum	DC	Bed	HA	SH&EH
Otholaryngology	4168300	Division of nasal adhesions	DC	Chr	HA/SC	SH&EH
Otholaryngology	9013300	Other procedures on nose	DC	Chr	SC	SH&EH

Otholaryngology	3007525	Biopsy of tonsils or adenoids	DC	Chr	SC	SH&EH
Otholaryngology	4170400	Aspr & lav nasal sinus thru nat ostium	DC	Chr	SC	SH&EH
Otholaryngology	3007519	Biopsy of tongue	MO	Chr	SC	SH&EH
Otholaryngology	4166800	Removal of nasal polyp	OD	Chr	HA	SH&EH
Otholaryngology	4176401	Sinoscopy	OD	Chr	HA	SH&EH
Otholaryngology	1132400	Tympanometry using standard probe tone	OD	Chr	SC	SH&EH
Otholaryngology	4176403	Fibreoptic laryngoscopy	OD	Chr	SC	SH&EH
Otholaryngology	1130000	Brain stem evoked response audiometry	OD	Chr	SC	SH&EH
Otholaryngology	1130600	Other audiometry	OD	Chr	SC	SH&EH
Otholaryngology	4176100	Exam nasal cavity or postnasal spc w Bx	OD	Chr	SC	SH&EH
Otholaryngology	4165300	Exam nasal cavity or postnasal space	OD	Chr	SC	SH&EH
Otholaryngology	4176400	Nasendoscopy	OD	Chr	SC	SH&EH
Otholaryngology	9606300	Rotating chair evaln vestibular function	OD	Chr	SC	SH&EH
Otholaryngology	4165000	Inspection tympanic membrane, unilateral	OD	Chr	SC	SH&EH
Otholaryngology	4184900	Laryngoscopy	OD	Chr	SC	SH&EH
Otholaryngology	4165001	Inspection tympanic membrane, bilateral	OD	Chr	SC	SH&EH
Otholaryngology	4176402	Fibreoptic examination of pharynx	OD	Chr	SC	SH&EH
Otholaryngology	9011900	Otoscopy	OD	Chr	SC	SH&EH
Otholaryngology	4165900	Removal of intranasal foreign body	OD	Chr	SC	SH&EH
Otholaryngology	4773800	Closed reduction fx nasal bone	OD	Chr	SC	SH&EH
Otholaryngology	3009410	Perc [needle] biopsy of thyroid gland	OD	Chr	SC	SH&EH
Otholaryngology	4167700	Arrest of anterior nasal haemorrhage	OD	Chr	SC	SH&EH
Otholaryngology	3009409	Perc needle Bx salivary gland or duct	OD	Chr	SC	SH&EH
Otholaryngology	9004700	Aspiration of thyroid	OD	Chr	SC	SH&EH
Otholaryngology	4150000	R/O FB from auditory canal wo incision	OD	Chr	SC	SH&EH
Otholaryngology	4164700	Ear toilet, unilateral	OT	Chr	SC	SH&EH
Otholaryngology	4164701	Ear toilet, bilateral	OT	Chr	SC	SH&EH
Otholaryngology	9203100	Removal of nasal packing	OT	Chr	SC	SH&EH
Otholaryngology	9017906	Management of tracheostomy	OT	Chr	SC	SH&EH
Otholaryngology	3021602	Other aspiration of SSCT	OT	Chr	SC	SH&EH
Plastic surgery	4555200	Replacement of breast prosthesis	DC	Bed	HA	SH&EH
Plastic surgery	4565900	Correction of bat ear	DC	Chr	HA	SH&EH
Plastic surgery	4646400	Amputation supernumerary digit of hand	DC	Chr	HA	SH&EH
Plastic surgery	4501802	Fat graft	DC	Bed	HA	SH&EH
Plastic surgery	4642000	Primary repair extensor tendon of hand	DC	Chr	HA	SH&EH
Plastic surgery	4551500	Revision scar of other site 7 cm or less	DC	Chr	HA	SH&EH
Plastic surgery	3930000	Primary repair of nerve	DC	Chr	HA	SH&EH
Plastic surgery	3002301	Debride sft tis incl bone or cart	DC	Chr	HA	SH&EH
Plastic surgery	4558400	Liposuction	DC	Chr	HA	SH&EH
Plastic surgery	4637800	Palmr fasciectomy Dupuytren's >= 3 dgt	DC	Chr	HA	SH&EH
Plastic surgery	4555600	Mastopexy	DC	Bed	HA	SH&EH
Plastic surgery	4523900	Revision of local skin flap	DC	Chr	HA	SH&EH
Plastic surgery	4552800	Augmentation mammoplasty, bilateral	DC	Bed	HA	SH&EH
Plastic surgery	3022400	Perc drainage abscess, soft tissue	DC	Bed	SC	SH&EH
Plastic surgery	3019507	Electrotherapy of multiple skin lesions	DC	Chr	SC	SH&EH

Plastic surgery	4636900	Palmar fasciectomy Dupuytren's contract	DC	Bed	SC	SH&EH
Plastic surgery	4636600	Sbc fasciotomy Dupuytren's contracture	DC	Chr	SC	SH&EH
Plastic surgery	4650100	Excision of ganglion of volar wrist	DC	Chr	SC	SH&EH
Plastic surgery	9011100	Other procedures on external ear	DC	Chr	SC	SH&EH
Plastic surgery	3019000	Laser to lesion of face or neck	DC	Chr	SC	SH&EH
Plastic surgery	3932402	R/O lsn from superficial perph nerve	DC	Chr	SC	SH&EH
Plastic surgery	4633000	Repair ligament or capsule of IPJ hand	DC	Chr	SC	SH&EH
Plastic surgery	4649200	Correction contracture of digit of hand	DC	Chr	SC	SH&EH
Plastic surgery	4554500	Reconstruction of nipple	DC	Chr	SC	SH&EH
Plastic surgery	4646500	Amputation of finger	DC	Chr	SC	SH&EH
Plastic surgery	4648300	Revision amputation stump of hand/finger	DC	Chr	SC	SH&EH
Plastic surgery	9067300	Correction of syndactyly	DC	Chr	SC	SH&EH
Plastic surgery	4638100	Release IPJ capsule Dupuytren's contract	DC	Chr	SC	SH&EH
Plastic surgery	4566500	Full thickness wedge excision of lip	MO	Bed	HA	SH&EH
Plastic surgery	4543900	Small split skin graft of other site	MO	Chr	HA	SH&EH
Plastic surgery	3002300	Debridement of soft tissue	MO	Chr	HA	SH&EH
Plastic surgery	4503000	Exc vasc anomaly SSCT/mucous surf, small	MO	Chr	SC	SH&EH
Plastic surgery	3123500	Exc lesion SSCT, oth site of head	MO	Chr	SC	SH&EH
Plastic surgery	3123002	Excision of lesion SSCT, ear	MO	Chr	SC	SH&EH
Plastic surgery	3123502	Excision of lesion SSCT, hand	MO	Chr	SC	SH&EH
Plastic surgery	4566502	Full thickness wedge excision of ear	MO	Chr	SC	SH&EH
Plastic surgery	4651600	Debridement of fingernail	MO	Chr	SC	SH&EH
Plastic surgery	9066100	Other incision of SSCT	MO	Chr	SC	SH&EH
Plastic surgery	3123001	Excision of lesion SSCT, nose	MO	Chr	SC	SH&EH
Plastic surgery	3123004	Excision lesion SSCT, finger	MO	Chr	SC	SH&EH
Plastic surgery	4649501	Excision ganglion distal digit of hand	MO	Chr	SC	SH&EH
Plastic surgery	4651601	Removal of fingernail	MO	Chr	SC	SH&EH
Plastic surgery	4550600	Rev scar of face 3 cm or less in length	MO	Chr	SC	SH&EH
Plastic surgery	4648600	Primary repair of nail or nail bed	MO	Chr	SC	SH&EH
Plastic surgery	9054500	Incision of soft tissue of hand	MO	Chr	SC	SH&EH
Plastic surgery	3123003	Excision of lesion SSCT, lip	MO	Chr	SC	SH&EH
Plastic surgery	9625500	Wound management NEC	MO	Chr	SC	SH&EH
Plastic surgery	9068601	Non exc debridement skin & sbc tissue	MO	Chr	SC	SH&EH
Plastic surgery	9066500	Exc debridement skin & sbc tissue	MO	Chr	SC	SH&EH
Plastic surgery	9066501	Debridement skin & sbc tissue NEC	MO	Chr	SC	SH&EH
Plastic surgery	3002600	Repair wound SSCT, oth site superficial	MO	Chr	SC	SH&EH
Plastic surgery	4648601	Primary repair of fingernail	MO	Chr	SC	SH&EH
Plastic surgery	3005202	Repair of wound of lip	MO	Chr	SC	SH&EH
Plastic surgery	3022301	Incision & drainage of abscess of SSCT	MO	Chr	SC	SH&EH
Plastic surgery	3002900	Repair wnd SSCT oth site inv soft tis	MO	Chr	SC	SH&EH
Plastic surgery	3005200	Repair of wound of external ear	MO	Chr	SC	SH&EH
Plastic surgery	4648900	Secondary repair of nail or nail bed	MO	Chr	SC	SH&EH
Plastic surgery	3022300	Incision & drainage of haematoma of SSCT	MO	Chr	SC	SH&EH
Plastic surgery	4520601	Local skin flap of nose	MO	Chr	SC	SH&EH
Plastic surgery	4653400	Radical excision of fingernail bed	MO	Chr	SC	SH&EH

Plastic surgery	4545101	Full thickness skin graft of nose	MO	Chr	SC	SH&EH
Plastic surgery	3005500	Dressing of wound	OT	Chr	SC	SH&EH
Plastic surgery	3020700	Administration of agent into skin lesion	OT	Chr	SC	SH&EH
Plastic surgery	4556601	Injection into tissue expander	OT	Chr	SC	SH&EH
Plastic surgery	9066000	Administration of agent into SSCT	OT	Chr	SC	SH&EH
Plastic surgery	1410600	Laser photcoag pulsed vasc lesion	OT	Chr	SC	SH&EH
Plastic surgery	4502502	CO2 laser resurfacing to other site	OT	Chr	SC	SH&EH
Plastic surgery	9620003	Sbc admin of pharmac agt steroid	OT	Chr	SC	SH&EH
Urology	3731500	Urethroscopy	DC	Bed	HA	SH&EH
Urology	3730300	Dilation of urethral stricture	DC	Bed	HA	SH&EH
Urology	3660800	Percutaneous replacement ureteric stent	DC	Bed	HA	SH&EH
Urology	3063100	Excision of hydrocele	DC	Bed	HA	SH&EH
Urology	3685100	Endosc admin of agt into bladder wall	DC	Chr	HA	SH&EH
Urology	3760404	Expl scrotal contents fix testis, uni	DC	Bed	HA	SH&EH
Urology	9040202	Dorsal or lateral slit of prepuce	DC	Chr	HA	SH&EH
Urology	3743500	Fraenuloplasty of penis	DC	Bed	HA	SH&EH
Urology	3743800	Partial excision of scrotum	DC	70%B	HA	SH&EH
Urology	3064102	Orchidectomy ins testicular prosth uni	DC	Bed	HA	SH&EH
Urology	3760102	Excision of epididymal cyst, unilateral	DC	Bed	HA	SH&EH
Urology	3064100	Orchidectomy, unilateral	DC	Bed	HA	SH&EH
Urology	9036000	Other excision of lesion of bladder	DC	Bed	HA	SH&EH
Urology	3063500	Repair of varicocele	DC	Bed	HA	SH&EH
Urology	3682101	Endoscopic insertion of ureteric stent	DC	Bed	HA	SH&EH
Urology	9620103	Intracv admin of pharmac agent steroid	DC	Chr	HA	SH&EH
Urology	3680003	Endosc R/O indwelling urinary catheter	DC	Chr	HA	SH&EH
Urology	3682103	Endoscopic replacement of ureteric stent	DC	Bed	HA	SH&EH
Urology	3680600	Endoscopic biopsy of ureter	DC	Bed	HA	SH&EH
Urology	3681101	Endoscopic insertion of urethral stent	DC	Bed	HA	SH&EH
Urology	3721500	Endoscopic biopsy of prostate	DC	20%B	HA	SH&EH
Urology	3682400	Endoscopic ureteric cath, unilateral	DC	Bed	HA	SH&EH
Urology	3680301	Endoscopic dilation of ureter	DC	Bed	HA	SH&EH
Urology	9040300	Local excision of lesion of penis	DC	Chr	HA	SH&EH
Urology	3680001	Endosc replace indwel urinary catheter	DC	Bed	HA	SH&EH
Urology	3682700	Endosc controlled hydrodilation bladder	DC	Bed	HA	SH&EH
Urology	3680000	Bladder catheterisation	DC	Chr	HA	SH&EH
Urology	3683301	Endoscopic removal of ureteric stent	DC	Bed	HA	SH&EH
Urology	3684504	Endosc resec single lsn bladder > 2 cm	DC	Bed	HA	SH&EH
Urology	3681201	Cystoscopy through artificial stoma	DC	Chr	HA	SH&EH
Urology	3684002	Endosc resec sgl blader lsn tiss <= 2 cm	DC	Bed	HA	SH&EH
Urology	3680300	Ureteroscopy	DC	Bed	HA	SH&EH
Urology	3684505	Endosc resection mult lesions bladder	DC	Bed	HA	SH&EH
Urology	9620100	Intracv admin of pharmac agent antineopl	DC	Chr	HA	SH&EH
Urology	3731803	Endosc laser frag/extr ureth calculus	DC	Bed	HA	SH&EH
Urology	3684000	Endosc dest bladder lsn / tiss <= 2 cm	DC	Bed	HA	SH&EH
Urology	3680901	Endoscopic destruction ureteric lesion	DC	Bed	HA	SH&EH

Urology	9620109	Intracv admin pharmac agent oth & unsp	DC	Chr	HA	SH&EH
Urology	3684501	Endosc dest of multiple lesions bladder	DC	Bed	HA	SH&EH
Urology	3760414	Fixation of testis unilateral	DC	Bed	HA	SH&EH
Urology	3760416	Fixation of testis bilateral	DC	Bed	HA	SH&EH
Urology	3681800	Endosc uretc cath fluorosc image UT uni	DC	Bed	HA	SH&EH
Urology	3686300	Litholapaxy of bladder	DC	Bed	HA	SH&EH
Urology	3665603	Endosc frag and extr of calc of kidney	DC	Bed	HA	SH&EH
Urology	3681801	Endosc uretc cath fluorosc image UT bil	DC	Bed	HA	SH&EH
Urology	3665602	Endoscopic frag of calculus of kidney	DC	Bed	HA	SH&EH
Urology	3680602	Endosc extr ureteric calc via ureterosc	DC	Bed	HA	SH&EH
Urology	3721901	Bx prost / sem ves v trnsperinl	MO	Chr	HA	SH&EH
Urology	3656100	Closed biopsy of kidney	MO	Bed	HA	SH&EH
Urology	3701100	Percutaneous cystotomy [cystostomy]	MO	Bed	HA	SH&EH
Urology	3662401	Percutaneous drainage of kidney	MO	Bed	HA	SH&EH
Urology	9615500	Stimulation therapy, NEC	MO	Chr	SC	SH&EH
Urology	3007527	Biopsy of penis	MO	Chr	SC	SH&EH
Urology	3664900	Replacement nephrostomy drainage tube	OD	Chr	HA	SH&EH
Urology	3721800	Needle biopsy of prostate or sem ves	OD	Chr	SC	SH&EH
Urology	5560000	U/s prostate, bladder, urethra	OD	Chr	SC	SH&EH
Urology	1190300	Cystometrography	OD	Chr	SC	SH&EH
Urology	3721900	Transrectal needle biopsy of prostate	OD	Chr	SC	SH&EH
Urology	3681200	Cystoscopy	OD	20%B	SC	SH&EH
Urology	3683600	Endoscopic biopsy of bladder	OD	Chr ?	SC	SH&EH
Urology	1190000	Urine flow study	OD	Chr	SC	SH&EH
Urology	5508400	Ultrasound of urinary bladder	OD	Chr	SC	SH&EH
Urology	3721600	Bx prost / sem ves v trnsrectl	OD	Chr	SC	SH&EH
Urology	3532110	Trsncath embolisation oth bl vesl	OT	Chr	HA	SH&EH
Urology	9615800	Bladder retraining	OT	Chr	SC	SH&EH
Urology	3741500	Administration of agent into penis	OT	Chr	SC	SH&EH
Urology	3654600	ESWL of urinary tract	OT	Chr	SC	SH&EH
Urology	9211900	Removal other urinary drainage device	OT	Chr	SC	SH&EH
Urology	3680002	Replacement of cystostomy tube	OT	Chr	SC	SH&EH
Urology	3062800	Percutaneous aspiration of hydrocele	OT	Chr	SC	SH&EH
Urology	9620119	Intracv admin pharmac agent oth & unsp	OT	Chr	SC	SH&EH
Urology	3760417	Perc aspr drain scrotum tunica vaginalis	OT	Chr	SC	SH&EH
Urology	9620102	Intracv admin pharmac agent anti-infect	OT	Chr	SC	SH&EH
Vascular surgery	3251100	Interptn saphofemor saphopoptl jnct VV	DC	Bed	HA	SH&EH
Vascular surgery	3250801	Interruption sapheno-popliteal jnct VV	DC	Bed	HA	SH&EH
Vascular surgery	3251400	Reoperation for VV of lower limb	DC	Bed	HA	SH&EH
Vascular surgery	3250800	Interptn VV great or small saph veins	DC	Bed	HA	SH&EH
Vascular surgery	3250401	Interruption multiple tributaries of VV	DC	Bed	HA	SH&EH
Vascular surgery	3252000	Endovenous interptn of veins	DC	Bed	HA	SH&EH
Vascular surgery	5997003	Peripheral arteriography	DC	Chr	HA	SH&EH
Vascular surgery	3250400	Interruption VV multiple tributaries	DC	Bed	HA	SH&EH
Vascular surgery	4502702	Admin of agent into vascular lesion	DC	Bed	HA	SH&EH

Vascular surgery	3451200	Construction AV fistula w graft of vein	DC	Bed	HA	SH&EH
Vascular surgery	3450901	Arteriovenous anastomosis of upper limb	DC	Chr	SC	SH&EH
Vascular surgery	9001300	Biopsy of nerve	MO	Chr	SC	SH&EH
Vascular surgery	3250001	Multiple injections of varicose veins	OT	Chr	SC	SH&EH
Vascular surgery	3250000	Micro injections of venular flares	OT	Chr	SC	SH&EH

The procedures listed below are suitable for the elective hospitals only. Please note that procedures are listed next to the specialties that carry out the majority of this type of procedure, but it is recognised that many procedures are carried out by multiple specialties.

Appendix 1b Procedures Suitable to be carried out in the Elective Hospitals only

Specialty	Procedure No	Procedure Name	Treat Room Type	Chair/Bed	Attire SC/HA	Suitable Facility
Gastroenterology	3047300	Panendoscopy to duodenum	EN	Bed	HA	El. Only
Gastroenterology	3208401	Fibreoptic colonoscopy heptc flexure, Bx	EN	Bed	HA	El. Only
Gastroenterology	3047304	Oesophagoscopy with biopsy	EN	Bed	HA	El. Only
Gastroenterology	3047302	Panendoscopy through artificial stoma	EN	Bed	HA	El. Only
Gastroenterology	3209001	Fibreoptic colonoscopy to caecum w Bx	EN	Bed	HA	El. Only
Gastroenterology	3048501	Endosc sphincterotomy extr calculus CBD	EN	Bed	HA	El. Only
Gastroenterology	3048400	ERCP	EN	Bed	HA	El. Only
Gastroenterology	3044200	Choledochoscopy	EN	Bed	HA	El. Only
Gastroenterology	3009405	Percutaneous needle biopsy of pancreas	EN	Bed	HA	El. Only
Gastroenterology	9029702	Endosc mucosal resec lrg intes	EN	Bed	HA	El. Only
Gastroenterology	3048200	Repeat ins perc endosc gastrostomy tube	EN	Bed	HA	El. Only
Gastroenterology	3007516	Biopsy of pancreas	EN	Bed	HA	El. Only
Gastroenterology	3047604	Endosc admin agt lesion or tissue oesoph	EN	Bed	HA	El. Only
Gastroenterology	9029701	Endosc mucosal resec stomch	EN	Bed	HA	El. Only
Gastroenterology	3047807	Endosc admin agt lsn stomach/duodenum	EN	Bed	HA	El. Only
Gastroenterology	3047301	Panendoscopy to duodenum with biopsy	EN	Bed	SC	El. Only
Gastroenterology	3047307	Panendo to duodnm w tattooing	EN	Bed	SC	El. Only
Gastroenterology	1182000	Panendoscopy via camera capsule	OD	Chr	SC	El. Only
General Surgery	3056302	Repair of parastomal hernia	DC	Bed	HA	El. Only
General surgery	3151800	Simple mastectomy, unilateral	DC	Bed	HA	El. Only
General surgery	3052700	Fundoplasty, laparoscopic approach	DC	Bed	HA	El. Only
General surgery	3053304	Lap oesophagogastric myotomy fundoplasty	DC	Bed	HA	El. Only
General surgery	3052702	Fundoplasty, abdominal approach	DC	Bed	HA	El. Only
General surgery	3053000	Fundoplasty with cardiopexy	DC	Bed	HA	El. Only
General surgery	3146600	Revision fundoplasty	DC	Bed	HA	El. Only
General surgery	3052701	Lap fundoplasty w closure diaph hiatus	DC	Bed	HA	El. Only
General surgery	3052703	Abdo fundoplasty w closure diaph hiatus	DC	Bed	HA	El. Only
General surgery	3053200	Oesophagogastric myotomy, lap appr	DC	Bed	HA	El. Only
General surgery	3053202	Oesophagogastric myotomy, abdominal appr	DC	Bed	HA	El. Only
General surgery	3037800	Division of abdominal adhesions	DC	Bed	HA	El. Only

General surgery	3146200	Insertion of feeding jejunostomy tube	DC	Bed	HA	El. Only
General surgery	9030600	Lap insertion feeding jejunostomy tube	DC	Bed	HA	El. Only
General surgery	3048100	Initial ins perc endosc gastrostomy tube	DC	Bed	HA	El. Only
General Surgery	3153600	Localisation of lesion of breast	DC	50%B	SC	El. Only
General Surgery	3208402	Colonosc to heptc flexure w tattooing	EN	Bed	HA	El. Only
General Surgery	4181900	Other endoscopic dilation of oesophagus	EN	Bed	HA	El. Only
General Surgery	3047804	Panendoscopy to duodenum w exc of lesion	EN	Bed	HA	El. Only
General Surgery	3209002	Colonosc to caecum w tattooing	EN	Bed	HA	El. Only
General Surgery	3209300	Fibreoptic colonoscopy to caecum w PP	EN	Bed	HA	El. Only
General Surgery	4183200	Endoscopic balloon dilation oesophagus	EN	Bed	HA	El. Only
General Surgery	3208700	Fibroptc colonsc to hepatic flexure w PP	EN	Bed	HA	El. Only
General Surgery	3047801	Panendoscopy to duodenum with diathermy	EN	Bed	HA	El. Only
General Surgery	3207501	Rigid sigmoidoscopy with biopsy	EN	Bed	HA	El. Only
General Surgery	3208400	Fibreoptic colonoscopy t hepatic flexure	EN	Bed	HA	El. Only
General Surgery	3209000	Fibreoptic colonoscopy to caecum	EN	Bed	HA	El. Only
General Surgery	3209400	Endoscopic dilation colorectal stricture	EN	Bed	HA	El. Only
General surgery	4183100	Endoscopic pneumatic dilation oesophagus	EN	Bed	HA	El. Only
General surgery	3047805	Percutaneous endoscopic jejunostomy	EN	Bed	HA	El. Only
General surgery	3047822	Endosc dest lesion or tissue oesophagus	EN	Bed	SC	El. Only
General surgery	9034402	Admin/o agt lesion tissue anorectal rgn	EN	50%B	SC	El. Only
Gynaecology	3564001	Curettage of uterus without dilation	DC	Bed	HA	El. Only
Gynaecology	3569402	Laparoscopic salpingolysis	DC	Bed	HA	El. Only
Gynaecology	3123005	Excision lesion SSCT, genitals	DC	Bed	HA	El. Only
Gynaecology	9043800	Other procedures on vagina	DC	Bed	HA	El. Only
Gynaecology	3039000	Laparoscopy	DC	Bed	HA	El. Only
Gynaecology	3551800	Aspiration of ovarian cyst	DC	Bed	HA	El. Only
Gynaecology	3561400	Colposcopy	DC	Chr	HA	El. Only
Gynaecology	3733900	Inj/o paraurethral bulk, female incont	DC	Bed	HA	El. Only
Gynaecology	3563811	Laparoscopic salpingo-oophorectomy, uni	DC	Bed	HA	El. Only
Gynaecology	3563706	Biopsy of ovary	DC	Bed	HA	El. Only
Gynaecology	3553903	Biopsy of vagina	DC	Bed	HA	El. Only
Gynaecology	3563812	Laparoscopic salpingo-oophorectomy, bil	DC	Bed	HA	El. Only
Gynaecology	3563807	Laparoscopic partial salpingectomy, uni	DC	Bed	HA	El. Only
Gynaecology	3560802	Biopsy of cervix	DC	Chr	HA	El. Only
Gynaecology	3563301	Polypectomy of uterus via hysteroscopy	DC	Chr	HA	El. Only
Gynaecology	3563300	Division of intrauterine adhesions	DC	Bed	HA	El. Only
Gynaecology	3562200	Endosc destruction proc on uterus	DC	Bed	HA	El. Only
Gynaecology	3564000	Dilation & curettage of uterus [D&C]	DC	Bed	HA	El. Only
Gynaecology	3564700	Large loop excision transformation zone	DC	Bed	HA	El. Only
Gynaecology	3563804	Laparoscopic ovarian cystectomy, uni	DC	Bed	HA	El. Only
Gynaecology	3563802	Laparoscopic oophorectomy, unilateral	DC	Bed	HA	El. Only
Gynaecology	3563809	Laparoscopic salpingectomy, unilateral	DC	Bed	HA	El. Only
Gynaecology	3561800	Cone biopsy of cervix	DC	Bed	HA	El. Only
Gynaecology	3550900	Hymenectomy	DC	Bed	HA	El. Only

Gynaecology	3563708	Laparoscopic ovarian drilling	DC	Bed	HA	El. Only
Gynaecology	3568800	Laparoscopic sterilisation	DC	Bed	HA	El. Only
Gynaecology	3563801	Laparoscopic partial oophorectomy	DC	Bed	HA	El. Only
Gynaecology	3563702	Lap diathermy of lesion of pelvic cavity	DC	Bed	HA	El. Only
Gynaecology	3563810	Laparoscopic salpingectomy, bilateral	DC	Bed	HA	El. Only
Gynaecology	3563400	Division uterine septum, hysteroscopy	DC	Bed	HA	El. Only
Gynaecology	3562300	Myomectomy of uterus via hysteroscopy	DC	Bed	HA	El. Only
Gynaecology	3564901	Myomectomy of uterus via laparoscopy	DC	Bed	HA	El. Only
Gynaecology	3532106	Trnscath embolisation bl vesl, pelvis	DC	Bed	HA	El. Only
Gynaecology	3007537	Biopsy of peritoneum	DC	Bed	HA	El. Only
Gynaecology	3556900	Enlargement of vaginal orifice	DC	Bed	HA	El. Only
Gynaecology	3553600	Hemivulvectomy	DC	Bed	HA	El. Only
Gynaecology	3563710	Lap excision of lesion of pelvic cavity	DC	Bed	HA	El. Only
Gynaecology	3553300	Vulvoplasty	DC	Bed	HA	El. Only
Gynaecology	9044600	Other incision of vulva or perineum	DC	Bed	HA	El. Only
Gynaecology	3563805	Laparoscopic ovarian cystectomy, bil	DC	Bed	HA	El. Only
Gynaecology	3564002	Dilation of cervix	DC	Bed	HA	El. Only
Gynaecology	3561500	Biopsy of vulva	MO	Chr	HA	El. Only
Gynaecology	3561100	Cervical polypectomy	MO	Bed	HA	El. Only
Gynaecology	3551300	Treatment of Bartholin's gland cyst	MO	Bed	HA	El. Only
Gynaecology	9044000	Excision of lesion of vulva	MO	Bed	HA	El. Only
Gynaecology	3561101	Partial excision of cervix	MO	Chr	HA	El. Only
Gynaecology	9213001	Specimen colln cervical cancer screening	MO	Chr	SC	El. Only
Gynaecology	3563000	Diagnostic hysteroscopy	OD	Chr	HA	El. Only
Gynaecology	1191700	Cystometrography with >= 1 measurements	OD	Chr	SC	El. Only
Gynaecology	9213000	Papanicolaou smear study	OD	Chr	SC	El. Only
Gynaecology	5506500	Ultrasound of pelvis	OD	Chr	SC	El. Only
Gynaecology	9210700	Insertion of other vaginal pessary	OT	Chr	SC	El. Only
Gynaecology	9210900	Replacement of other vaginal pessary	OT	Chr	SC	El. Only
Gynaecology	9211400	Removal of other vaginal pessary	OT	Chr	SC	El. Only
Gynaecology	3550600	Replacement of intrauterine device [IUD]	OT	Chr	SC	El. Only
Gynaecology	3550602	Removal of intrauterine device [IUD]	OT	Chr	SC	El. Only
Gynaecology	3550300	Insertion intrauterine device	OT	Chr	SC	El. Only
Gynaecology	3560800	Cautery of cervix	OT	Chr	SC	El. Only
Ophthalmology	9618800	Other angiography of eye	OD	Chr	SC	El. Only
Ophthalmology	1121900	Optical coherence tomography	OD	Chr	SC	El. Only
Ophthalmology	1121800	Retinal photography of both eyes	OD	Chr	SC	El. Only
Ophthalmology	1121500	Retinal angiography	OD	Chr	SC	El. Only
Ophthalmology	1232600	Bilateral retinal photography	OD	Chr	SC	El. Only
Plastic surgery	4639602	Ostectomy of finger	DC	Chr	SC	El. Only
Plastic surgery	9220100	Removal of foreign body wo incision NEC	DC	Chr	SC	El. Only
Plastic surgery	3006400	R/O foreign body from SSCT w incision	MO	Chr	SC	El. Only
Plastic surgery	3006800	Removal FB in soft tissue NEC	MO	Chr	SC	El. Only
Plastic surgery	3006100	R/O foreign body from SSCT wo incision	OT	Chr	SC	El. Only

Respiratory Med	4188905	Bronchospy	EN			El. Only
Respiratory Med	4189201	Bronchospy with excision of Lesion	EN			El. Only
Respiratory Med	4188900	Rigid Bronchospy	EN			El. Only
Respiratory Med	4189800	Fiberoptic Bronchospy	EN			El. Only
Respiratory Med	4189801	Fiberoptic Bronchospy with piopsey	EN			El. Only
Urology	3780300	Orchidopexy for undescended testis, uni	DC	Bed	HA	El. Only
Urology	3684003	Endosc dest sgl blader lsn tiss <= 2 cm	DC	Bed	HA	El. Only
Vascular surgery	3530306	Perc transluminal balloon angioplasty	DC	Bed	HA	El. Only

The procedure list below are procedures that would be suitable for the elective hospital as planned urgent elective orthopaedic procedures.

Appendix 1c Planned Urgent Elective Procedures Suitable to be Carried Out in the Elective Hospitals

Specialty	Procedure No	Procedure Name	Treat Room Type	Chair/Bed	Attire SC/HA	Suitable Facility
Urgent Elect Ortho	4643200	Prim rep flexor tend hand dstl A1 pully	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4796302	Repair of tendon of hand, NEC	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4642600	Prim rep flexor tendon hand prx A1 pully	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4760001	Open rdctn fx ankle IF diats/fib/malus	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4758500	Internal fixation of fracture of patella	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4970900	Stabilisation of ankle	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4756605	Open reduction fx fibula w internal fix	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4980900	Open tenotomy of foot	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4980000	Prim repair flexor/extensor tendon foot	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4911200	Silastic replace of radial head of elbow	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4762401	Open rdctn fx tarsometatarsal jt w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4840300	Osteotomy metatarsal bone with IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4971800	Other repair of tendon of ankle	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4840002	Osteotomy of metatarsal bone	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4840004	Ostectomy of metatarsal bone	DC	Bed	HA	SH&EH
Urgent Elect Ortho	9055800	Open reduction of fracture of ankle	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4840003	Osteotomy of toe	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4795400	Repair of tendon, NEC	DC	Bed	HA	SH&EH
Urgent Elect Ortho	3023500	Repair of ruptured muscle, NEC	DC	Bed	HA	SH&EH
Urgent Elect Ortho	9057200	Ostectomy, not elsewhere classified	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4796300	Open tenotomy, not elsewhere classified	DC	Bed	HA	SH&EH
Urgent Elect Ortho	3540000	Vertebroplasty, 1 vertebral body	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4736602	Open rdctn fracture distal radius w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4739901	Open reduction fracture olecranon w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4734201	Open rdctn fracture metacarpus w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4733001	Open rdctn fx proximal phalanx hand IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4745001	Open reduction fracture shaft humerus IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4739301	Open rdctn fx shaft radius & ulna IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4740801	Open rdctn fracture radial head/neck IF	DC	Bed	HA	SH&EH

Urgent Elect Ortho	4730601	Open rdctn fx distal phalanx hand w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4738402	Open rdctn fracture shaft radius w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4890900	Rep rotator cuff decomp subacrom space	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4890600	Repair of rotator cuff	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4736603	Open reduction fracture distal ulna w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4731801	Open rdctn fx middle phalanx hand w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4736600	Open reduction fracture distal radius	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4703900	Open reduction dislocation IPJ hand	DC	Bed	HA	SH&EH
Urgent Elect Ortho	9053300	Other repair of shoulder	DC	Bed	HA	SH&EH
Urgent Elect Ortho	5033900	Transfer ant tibialis tend to lat column	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4733301	Opn rdctn intrartclr fx prx phlx hnd IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4736601	Open reduction fracture of distal ulna	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4950002	Removal of loose body of knee	DC	50%B	HA	SH&EH
Urgent Elect Ortho	4767203	Open rdctn fx phalanx not great toe IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4743201	Opn rdctn intrartclr fx prx humerus IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4704500	Open reduction dislocation MCP joint	DC	Chr	HA	SH&EH
Urgent Elect Ortho	4735101	Open rdctn fracture carpus w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4766601	Open rdctn fx phalanx of great toe w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4700600	Open reduction dislocation of clavicle	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4644200	Opn rdctn intrartclr fx mallet finger	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4742900	Open reduction fracture proximal humerus	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4734501	Opn rdctn intrartclr fx metacarpus IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4733000	Open rdctn fx proximal phalanx hand	DC	Bed	HA	SH&EH
Urgent Elect Ortho	9053600	Other repair of elbow	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4644100	Open repair of mallet finger	DC	Chr	HA	SH&EH
Urgent Elect Ortho	4910001	Removal of loose body of elbow	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4731800	Open rdctn fracture middle phalanx hand	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4763001	Open reduction fracture of tarsus w IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4739300	Open rdctn fracture shaft radius & ulna	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4735700	Open reduction fracture carpal scaphoid	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4740800	Open rdctn fracture radial head/neck	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4738603	Open rdctn fx shaft ulna w disloc & IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4740201	Opn rdctn fx olecranon prt ostectmy IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4739900	Open reduction of fracture of olecranon	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4822700	Bone graft to radius or ulna with IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4746500	Open reduction of fracture of clavicle	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4738601	Open rdctn fx shaft radius w disloc IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4703300	Open reduction of dislocation of carpus	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4758801	IF fx tibial artlr surf rep/recon ligmt	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4734200	Open reduction fracture of metacarpus	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4745000	Open reduction fracture shaft of humerus	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4707201	Open reduction dislocation toe with IF	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4738401	Open reduction fracture of shaft of ulna	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4706000	Open reduction of dislocation of patella	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4763900	Open reduction fracture of metatarsus	DC	Bed	HA	SH&EH

Urgent Elect Ortho	4735100	Open reduction of fracture of carpus	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4738602	Open rdctn fracture shaft ulna w disloc	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4740200	Open rdctn fx olecranon prt ostectomy	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4762400	Open rdctn fx of tarsometatarsal joint	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4823600	Bone graft to scaphoid w IF & osteotomy	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4738600	Open rdctn fx shaft radius w disloc	DC	Bed	HA	SH&EH
Urgent Elect Ortho	4761806	Open reduction fracture talus w disloc	DC	Bed	HA	SH&EH

Appendix 2 – National Elective Care Clinical Guidance Group (NECCGG)

Terms of Reference

1.0 Aim of the National Elective Care Clinical Guidance Group (NECCGG)

The NECCGG will support the delivery and sustainability of the national elective surgical hubs and elective hospitals programme. This national group, using the Surgical Hubs Clinical Guidance document as a reference, will promote standardisation and optimisation of surgical hub and elective hospital development across Ireland. The Group will be tasked with agreeing and facilitating the implementation of clinical guidance and patient pathways. This will support equity of access and uniformity of service quality for patients in each health region.

The overarching aim is to support the newly established surgical hubs and elective hospitals to provide scheduled surgical care that is characterised by effectiveness, efficiency, accountability, sustainability, resilience and with high levels of staff morale and patient satisfaction.

2.0 OBJECTIVES OF THE NECCGG

1. Establish an appropriate national clinical group to support shared learning across all surgical hubs/elective hospitals as they develop.
2. Reduce waste by collaboratively developing and sharing a suite of documentation templates that can be adapted to meet local needs in all relevant clinical areas to include preassessment, nursing and perioperative care.
3. Liaise with primary care to ensure integration of surgical hub/elective hospital activity with the community, including development of standard templates for discharge and other documents.
4. Establish clinical pathways for specific high-volume conditions that are suitable for local implementation, with special consideration to developing and sustaining adequate flow of appropriate patients to ensure that all capacity is optimally utilised.
5. Embed a culture of teaching and learning in each surgical hub/elective hospital to ensure a sustainable workforce.
6. To review the timestamps and Key Performance Indicators outlined in the national Surgical Hubs Clinical Guidance document and identify opportunities to integrate these measures into standard work in the hubs and elective hospitals.
7. Develop proposals for time-limited referral protocols in collaboration with the NTPF that will ensure equitable patient access across regions, based on clinical need and chronology of waiting lists, to ensure that all spare capacity is optimally utilised.
8. To consider input from HSE experts in environmental sustainability in the tender and purchasing of reusable and disposable equipment so that environmental impact of decisions is considered.

3.0 STRUCTURE OF THE NECCGG

Chair: Nominated by the CCO

Project Co-ordinator: Nurse lead NCPS, supported by the National Clinical Programme in Surgery

Regional Representation: The programme will seek nomination of an appropriate consultant surgeon, consultant anaesthesiologist, nurse manager with perioperative experience and scheduled care led from the REO of each Regional Health Area.

Training Representation: The programme will seek nominees from RCSI and the College of Anaesthesiologists.

Other Representation:

The chair will have discretion to co-opt other members onto the group, or form subgroups, as required to ensure appropriate expertise and representation relating to specific areas under review (such as, but not limited to NCHDs, patient and service user partner, primary care, radiology, medical science/laboratory)

Term: The group will be initially convened for a two-year period after which the programme will be reviewed by the CCO.

Nominees have the right to discontinue with NECCGG and would ask that this be notified in writing to the Chair and Secretariat. Members who are absent for more than 3 meetings in a row without reason, may be replaced but will be notified.

4.0 GOVERNANCE OF THE NECCGG

The NECCGG will report to the Office of the Chief Clinical Officer, through the NCPS in its role as Secretariat.

The NCPS has a dual reporting structure to the HSE and to the RCSI Committee for Surgical Affairs (CSA).

5.0 QUORUM AND DECISION-MAKING

A minimum of 50% of membership and one Chair are required for decision-making purposes in the NECCGG.
This section describes the outcome options for strength of opinions or decisions. Options are as follows:

- ***Unanimity: All in agreement***
- ***2/3 Majority: 2/3 of the members in attendance were in agreement***
- ***Majority: More than 50% members who attended were in agreement***
- ***Lack of Consensus: PSAG could not reach a majority decision***

6.0 FREQUENCY OF NSHCSG MEETINGS

Approximately six NECCGG meetings will be held per annum to support the rapid development of the Surgical Hubs, but at a minimum, NSHCSG meetings will be conducted quarterly.

7.0 AGENDA, MINUTES AND DECISION PAPERS

In advance of a NECCGG meeting, the following will be forwarded to all members:

- ***Agenda***
- ***Actions/brief minutes of previous meeting***
- ***Any other documents/information to be considered at the meeting***

If members wish to forward an agenda item, they must forward it to the Chair/NCPS Programme Manager at least 48 hours in advance of the NECCGG meeting.

To facilitate timely implementation of group outputs, proposed clinical design documents (e.g., patient pathways, templates, etc.) can be reviewed at the monthly NCPS meeting and recommended to the CCO for approval or referral to the Clinical Forum.

Note: Patient and Service User Partnership

The NECCGG is one workstream that reports into the National Elective Care Steering Group which have established a patient and service user partnership. A patient representative is a member of this group and attends monthly meetings. In addition, the NCPS were introduced to the patient and service membership by the Elective Care Programme early in this project so that the ask for feedback would be understood. Once the draft was ready, the document was forwarded to the representative on 1st July 2025 for onward circulation and a meeting was offered to present the work and answer any questions. All feedback was considered and incorporated. Multistakeholder feedback was subsequently received and the draft was updated. On the advice of the office of the HSE Public Involvement Culture and Risk Management, it was recommended a short 4-page summary of the document which highlighted the key issues for patients, was prepared and circulated along with the main document as reference. The full document was also circulated to the RCSI Committee for Surgical Affairs and to the RCSI Council which has two lay members. Any feedback received was considered and incorporated where appropriate.

Appendix 3 – Proforma for the Modified Aldrete Discharge Criteria

Modified Aldrete Discharge Criteria – Stage 1 to Stage 2 Recovery		
Physiological Discharge Criteria		
Physical Activity		Insert score below
Moves all extremities on command	2	
Moves two extremities/some weakness in movement of extremities	1	
Unable to move extremities	0	
Circulation		
+/-20mmHg of pre-anaesthesia level	2	
+/- 20mmhg – 49mmHg of pre-anaesthesia level	1	
+/- 50mmHg of pre-anaesthesia level	0	
Oxygen Saturation		
SpO_2 >96% on room air	2	
Supplemental O_2 required to maintain SpO_2 >94%	1	
SpO_2 >92% with O_2 supplementation	0	
Respiration		
Breathe deeply, cough freely	2	
Dyspnoeic, shallow or limited breathing	1	
Apnoeic	0	
Level of Consciousness		
Fully awake and oriented	2	
Arousable on calling	1	
Not Responding	0	
Postoperative Pain		
None or mild discomfort (0-3)	2	
Moderate to severe pain, controlled by I.V analgesics (4-7)	1	
Persistent severe pain (8-10)	0	
Nausea & Vomiting		
None/Mild Nausea. No active Vomiting	2	
Transient vomiting or retching	1	
Persistent moderate/severe nausea & vomiting	0	
Temperature		
Tympanic Temperature (≥ 36▫C)	2	
Tympanic Temperature (> 35 -35.5▫C)	1	
Tympanic Temperature (< 35 ▫C)	0	
Post Spinal/Epidural Patient		
Block Level below T10	2	
Block level at T9-T10	1	
Block Level <T9	0	
Surgical Site Stability		
No active bleeding, minimal drainage, wound intact	2	
Minor bleeding or drainage controlled with simple dressings; no intervention required	1	
Active bleeding requiring intervention, excessive drainage	0	
Overall total score		

Patients must have a score of 18 or greater to be discharged from stage 1 recovery unless the patient scores 0 in any category. Any 0 parameters must be discussed with the clinician and an improvement seen before discharge from stage 1 recovery.

Appendix 4 – Post Anaesthesia Discharge Scoring System (PADSS) Stage 2 Recovery to Home

PADSS – Stage 2 Recovery – Home		
Physiological Parameters	Each category is scored from 0-2	
Vital Signs		*Insert score below*
< 20% of preoperative baseline	2	
20-40% of preoperative baseline	1	
>40% of preoperative baseline	0	
Physical Activity - Must be able to ambulate at pre-operative level		
Ambulates as pre operatively.	2	
Requires assistance	1	
Unable to ambulate	0	
Postoperative Pain – minimal or no pain		
None or mild discomfort	2	
Moderate to severe pain	1	
Persistent severe pain	0	
Nausea & Vomiting		
None/Mild Nausea. No active Vomiting	2	
Moderate	1	
Persistent moderate/severe nausea & vomiting	0	
Surgical Bleeding		
Consistent with expected blood loss for procedure	2	
Minor bleeding or drainage controlled with simple dressings; no intervention required	1	
Active bleeding requiring intervention, excessive drainage	0	
Fluid Intake/Output		
Tolerates oral fluids and has voided	2	
Tolerates oral fluids or voided	1	
Cannot tolerate oral fluids and has not voided	0	
Overall total score		

Based on the criteria outlined above, each category is assigned a score from 0 to 2, with a maximum possible score of 12 points. A minimum total score of 9 is required prior to discharge. A modified PADSS score of ≥ 9 is typically considered appropriate for discharge from Stage II recovery to home, vital signs must score 2 and provided there are no other concerning clinical factors. e.g., if the patient is scoring zero in any category. Upon achieving an acceptable modified PADSS score and meeting the criteria, the patient may be safely discharged from Stage II recovery to home.

Appendix 5 **Discharge Checklist** *(Draft to be adapted locally as required)*

Name: Gender
Address: DOB
HCRN: Note: ______________________________

Discharge Checklist	Yes	No	N/A	Details
General				
PADSS & procedure specific discharge criteria completed				
Patient is orientated to time, person and place				
Cannula removed				
All dressings checked				
All personal belongings returned				
Responsible person present				
Carer for 24 hours post operatively *(GA and Sedation Only)*				
Post Operative Instructions *Patient and/or carer are given written and verbal post operative instructions and information on:*				
Post Operative instructions which are procedure specific				
Procedure findings and treatment				
Medication management				
Prescription				
Removal of sutures/clips if required				
Wound care & dressing instructions				
Diet & hydration explained				
Physical Activity and/or restrictions				
What to do in an Emergency				
Warning signs and symptoms explained and level at which treatment is required				
Patient knows who to contact in an emergency				
Follow up				
Patient Initiated Review				
GP				
Outpatient				
Other				
Postoperative telephone call required				
Documentation				
Referral letter e.g., PHN, physio etc.				
Patient copy of discharge letter/documentation/summary				
Medical Certificate (if applicable)				
Patient encouraged to take a photo of their discharge summary to have in the case of an emergency				

______________________________ _______________ _______________

Signature / Printed Name **Date** **Time**

(Adapted from the British Association of Day Surgery 2016 and the NCPS Elective Surgery Model of Care)

Appendix 6 – Criteria Led Discharge (CLD) Patient Process *(Acknowledgment to South Infirmary Victoria, University Hospital)*

Appendix 1

Criteria Led Discharge (CLD) Patient Process

1. Preparing for discharge commences on the morning of admission by informing the patient of the CLD process and the possibility of selection for CLD.
2. The operating surgeon completes the "suitability for CLD" section in the ICP on writing up the operation note immediately post-surgery.
3. The Recovery Nurse communicates suitability of patient for CLD to ward nurse on clinical handover.
4. Selected patients are given a patient information leaflet explaining what Criteria Led Discharge is once awake and alert post operatively.
5. Nursing staff members are responsible for monitoring the patient against the documented criteria at 4 hourly, 6 hourly and 8 hourly intervals.
6. Discharge is dependent on the patient meeting a set of pre-approved clinical criteria. All discharge criteria must be achieved prior to discharge. Nursing staff are required to escalate failure to achieve criteria to the relevant medical team. If the patient is no longer suitable for the CLD process, approval is revoked by the medical doctor. This is documented in the CLD record.
7. Medical staff discuss patient's achievement of discharge criteria on medical rounds.
8. The patient is involved by confirming their own readiness for discharge.
9. Having achieved outlined clinical criteria, patients can be discharged from the SIVUH at any time between 09:00hrs to 22:00hrs with relevant discharge documentation.
10. Patients are accompanied on discharge from the SIVUH by a relative or nominated other.

Appendix 7 – Criteria Led Discharge – Example -Adult Patients Post Tonsillectomy

Criteria Led Discharge for Adult Patients Post Tonsillectomy

Part A – to be completed by the Operating Surgeon Post - Surgery Date:______ Time:______

Suitable for Criteria Led Discharge ☐ Unsuitable for Criteria Led Discharge: ☐

Name of Surgeon:	Signature of Surgeon:	IMC No.:

Part B: Criteria Led Discharge (Approved Discharge Criteria incorporating surgical and anaesthetic criteria)
All Discharge Criteria must be achieved prior to discharge
A = Achieved NA = not achieved

Patient returned to ward post operatively @ time________________

	Discharge Criteria	4 hrs post op		6 hrs post op		8 hrs post op		10hrs post op		Criteria Achieved		Signature:	IMC/NMBI No.
		A	NA	A	NA	A	NA	A	NA	Date	Time		
1	INEWS (within normal patient parameters)												
2	Tolerating Fluids and Diet (minimal nausea and vomiting before discharge)												
3	Pain Score (acceptable pain managed by patient)												
4	No active surgical bleeding from tonsil site (oral or nasal ooze/excessive swallowing)												
5	Ambulating at pre-op level												
6	Discharge advice/ instructions inclusive of contact details given												

Part C: Revoke Medical Approval for Criteria Led Discharge (completed by Senior Medical Clinician)

Reason for removal from CLD Process: Date: Time:

Name:________________ Signature:________________________ IMC NO._________________

Part D: Time of Achievement of Criteria Led Discharge: ____________

Criteria LED Discharge not achieved: ☐ Reason ____

Name:__________________ Signature:____________________________ NMBI No. ________________

Appendix 8 - Template Consent Form for Day Case Surgery

Appendix 9 - Informed Consent Supporting Information

Note – The consent form and supporting information is currently being reviewed by the HSE National Office for Human Rights and Equality (October 2025). Once approved the consent form will be made available to all sites as part of Appendix 8 of this document. Further information on the practicalities of seeking consent will also be found in the updated Appendix 9. This consent serves as a template for sites to adapt locally.

Appendix 10 - Green Theatre Checklist

Intercollegiate Green Theatre Checklist v2.0

Below is a list of recommendations to reduce the environmental impact of operating theatres. Interventions in the **green** rows can be implemented on the day without prior preparation and can be used as part of a daily pre-operative checklist. Interventions in the **white** rows are those requiring wider stakeholder engagement and planning and may be suitable for monthly review or to help identify areas for quality improvement projects. Relevant guidance and academic literature supporting this checklist is included in the Compendium of Evidence, available at this link:

Anaesthesia

1 Limit Nitrous Oxide (N_2O) to specific cases where there is evidence of clinical benefit ☐

Decommission manifolds and switch to N_2O cylinders at point of use (or repair pipe leaks if centralized delivery still used)

2 Consider TIVA and ensure that all drug waste and giving sets are disposed of through the pharmaceutical waste stream ☐

3 If using inhalational anaesthesia: ☐
- use low-flow anaesthesia (via end-tidal anaesthetic gas control, if available)

Remove desflurane from formulary

4 Reduce waste:
- avoid unnecessary equipment and opt for reusables (e.g. laryngoscopes, body warmers, slide sheets, trays, soda lime canisters) ☐
- transfer single-use objects with the patient if still needed (e.g. facemasks, suction) ☐

Review and rationalise pre-prepared single-use equipment packs and PPE requirements for standard procedures

5 Minimise drug waste ("*Don't open unless needed*", pre-empt propofol use, titrate O_2) and dispose in correct pharmaceutical waste stream ☐

Use air instead of oxygen as the ventilator drive gas

Preparing for Surgery

6 Evaluate PPE and sterile field requirements:
- rationalise use of non-sterile single-use gloves and PPE and opt for reusables when possible ☐
- limit sterile field to necessary areas only ☐

Ensure availability of reusable textiles, including theatre hats, sterile gowns, patient drapes, and trolley covers

7 Reduce water and energy consumption: ☐
- *'rub don't scrub'*: after first water scrub of day, you can use alcohol rub for subsequent cases

Install automatic or pedal-controlled water taps

8 Avoid clinically unnecessary interventions (e.g. antibiotics, urinary catheterisation, histology examinations) ☐

Intraoperative Equipment

9 REVIEW AND RATIONALISE:
- clarify necessary kit for case and specify what should be available to open only if needed: "Just in time" ☐
- take the opportunity to review instrument sets and identify any targets for overage reduction ☐

- Review pre-prepared single-use surgical packs and engage with suppliers to remove surplus items and identify those that can be replaced with reusable options (to be included in instrument sets)
- Review reusable instrument sets, remove overage, integrate supplementary items into sets, consolidate sets only if it allows smaller/fewer sets (please see guidance)

10 REDUCE: unnecessary waste and single-use equipment, "*don't open it unless you need it*", limit CO_2 insufflation ☐

11 REUSE: opt for reusables, hybrid, or remanufactured equipment instead of single-use (e.g. gallipots, light handles, staplers, energy devices) ☐

Consider sourcing reusable, hybrid or remanufactured alternatives for single-use equipment

12 REPLACE: switch to low carbon alternatives (e.g. skin sutures vs. clips, "loose" antiseptic solutions in reusable gallipots) ☐

After the Operation

13 POWER OFF: Heating, Ventilation, Air conditioning (HVAC), AGSS, lights, computers and equipment out-of-hours ☐

- Switch off AGSS when theatres are not in use or volatile anaesthesia is not being utilised
- Introduce "shut-down" and "power on" checklists
- Install occupancy sensors and automatise "set-back" modes HVAC systems

14 RECYCLE/use lowest carbon appropriate waste streams:
- use recycling waste streams for packaging or, if not available, domestic waste stream (prior to patient entering the room) ☐
- use non-infectious offensive waste streams (yellow/black tiger) unless clear risk of infection (orange) ☐
- ensure only appropriate contents in sharps bins (sharps/drugs) ☐

- Switch to low impact sharp bins e.g. reusable or cardboard boxes
- Arrange metals/battery collection where possible

15 REPAIR: ensure damaged reusable equipment is repaired, encourage active maintenance ☐

DISCLAIMER: These suggestions are based upon current evidence and broadly generalisable, however, specific environmental impacts will depend upon local infrastructure and individual Trusts' implementation strategies.

Intercollegiate Green Theatre Checklist v2.0. November 2024.

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