



NEW SOUTH WALES AUDITOR-GENERAL'S REPORT

Planned surgery access

PERFORMANCE AUDIT | 14 MAY 2026

THE ROLE OF THE AUDITOR-GENERAL

The roles and responsibilities of the Auditor-General and the Audit Office, are set out in the *Government Sector Audit Act 1983* and the *Local Government Act 1993*.

We conduct financial or 'attest' audits of state public sector and local government entities' financial statements. We also audit the Consolidated State Financial Statements, a consolidation of all state public sector agencies' financial statements.

Financial audits are designed to give reasonable assurance that financial statements are true and fair, enhancing their value to end users. Also, the existence of such audits provides a constant stimulus to entities to ensure sound financial management.

Following a financial audit the Audit Office issues a variety of reports to entities and reports periodically to Parliament. In combination, these reports give opinions on the truth and fairness of financial statements, and comment on entity internal controls and governance, and compliance with certain laws, regulations and government directives. They may comment on financial prudence, probity and waste, and recommend operational improvements.

We also conduct performance audits. These assess whether the activities of government entities are being carried out effectively, economically, efficiently and in compliance with relevant laws. Audits may cover all or parts of an entity's operations, or consider particular issues across a number of entities. Our performance audits may also extend to activities of non-government entities that receive money or resources, whether directly or indirectly, from or on behalf of government entities for a particular purpose.

As well as financial and performance audits, the Auditor-General carries out special reviews, compliance engagements and audits requested under section 27B(3) of the *Government Sector Audit Act 1983*, and section 421E of the *Local Government Act 1993*.



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In accordance with section 38EC of the *Government Sector Audit Act 1983*, I present a report titled '**Planned surgery access**'.

A handwritten signature in black ink, which appears to read 'Bola Oyetunji'.

Bola Oyetunji

Auditor-General for New South Wales
14 May 2026

RECONCILIATION STATEMENT

We pay our respect and recognise Aboriginal peoples as the traditional custodians of the land in NSW who have cared for and protected the environment, waterways, and sacred sites over many millennia. We honour and thank the traditional custodians of the land on which our office is located, the Gadigal people of the Eora Nation, and the traditional custodians of all the lands on which our employees live and work. We pay our respects to their Elders past and present, and to the next generation of leaders.

We also acknowledge that our long history is shared with the histories of colonisation in New South Wales. We acknowledge the impacts of colonisation, and the resulting marginalisation and disadvantage of Aboriginal and Torres Strait Islander peoples in this state.

We embrace our role in holding government agencies to account for the delivery of effective services for Aboriginal and Torres Strait Islander peoples. We are committed to ensuring that our audits are culturally responsive, respectful and inclusive, and that we engage with Aboriginal and Torres Strait Islander peoples and communities in a meaningful and collaborative way.

We recognise the ancestral tie of Aboriginal and Torres Strait Islander peoples to this land, and we acknowledge that we have much to learn from their wisdom, rich and diverse culture, languages, knowledge and practices.

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1. Report snapshot

Objective

This audit assessed whether NSW Health efficiently and effectively provides access to planned surgery (also known as elective surgery) to public patients.

Key findings

NSW Health has mostly cleared the backlog of patients caused by pauses to planned surgery during COVID-19

Non-urgent planned surgery was paused several times during the COVID-19 pandemic between March 2020 and January 2022. This resulted in a backlog of overdue planned surgery patients, reaching a peak of almost 19,000 patients overdue for planned surgery in April 2022. At the end of the audit period in December 2025, this has dropped to approximately 3,900 overdue patients.

NSW Health is not completing planned surgery for all patients within clinically recommended timeframes

In 2024–25, only 4 of the 17 local health districts and specialty health networks met the goal of zero patients waiting longer than clinically recommended for surgery. There are also considerable variations in performance across districts.

NSW Health has not fully rolled out more efficient models for planned surgery

NSW Health has successfully trialled initiatives like surgery hubs and pooled waitlists to boost planned surgery efficiency but these are yet to be implemented across the state. NSW Health is focused on eliminating low-value surgical procedures that are not supported by strong clinical and patient outcome evidence.

NSW Health's planned surgery access policy supports effective waitlist management

The planned surgery access policy provides clear directives on waitlist management and scheduling surgery in line with the 'treat in turn' principle and clinical urgency categories. Recent updates to the policy strengthen clinical governance review requirements and provide guidance that aligns with NSW Health's efforts to increase planned surgery efficiency.

Despite local control weaknesses, NSW Health waitlist data can be relied upon

The administration of local planned surgery waitlists is reliant on manual data entry without automatic system checks. However, a system of structured clerical reviews mostly compensates for the control weaknesses. Waitlist data collected by NSW Health is suitable as a record of planned surgery access performance to inform decision-making.

Recommendations

The audit makes 3 recommendations to NSW Health.

- Define additional efficiency performance targets for inclusion in service agreements with local health districts.
- Identify and determine the planned surgery service delivery models that achieve greater efficiencies and surgical throughput, and target policy and investment accordingly.
- Develop additional risk-based guidance for local health districts to conduct regular reviews of waitlist management and compliance.

Fast facts

Over 230,000

planned surgeries were performed in 2024–25

\$2.3b

was NSW Health's estimated cost of providing planned surgery in 2024–25

Less than 25%

of local health districts reached the 2024–25 KPI of zero overdue patients

2. Executive summary

Context

Planned surgery, also known as elective surgery, is surgery that can be booked in advance following a specialist clinical assessment resulting in a patient's placement on the planned surgery waitlist. Under the Australian Medicare principles, patients can access planned surgeries free of charge in NSW public hospitals. Common planned surgery procedures include cataract extraction, joint replacement and gall bladder removal. Planned surgeries are scheduled in order of listing date by the patient's treating clinician, and in line with 3 clinical urgency categories that determine the priority of the procedure. Under these categories, urgent planned surgeries should be completed within 30 days, semi-urgent planned surgeries within 90 days and non-urgent planned surgeries within 365 days of the listing date.

The Ministry of Health and local health districts have a purchaser-provider relationship for the delivery of healthcare services, including planned surgery. The Ministry of Health establishes performance expectations and the policy environment, and distributes activity-based funding via service agreements. Local health districts are expected to achieve zero overdue patients for each clinical urgency category of planned surgery.

Semi-urgent and non-urgent planned surgeries were paused several times between March 2020 and January 2022 due to the COVID-19 pandemic. This led to a significant backlog of patients overdue for surgery.

Audit objective

This audit assessed whether NSW Health efficiently and effectively provides access to planned surgery to public patients across the state. The audit made this assessment by answering the following questions.

- Does NSW Health have effective policies, processes and data to manage planned surgery access?
- Is NSW Health effectively and efficiently managing planned surgery waitlists?

The main review period for this audit was between January 2022 and December 2025.

Conclusion

NSW Health has cleared most of the backlog of patients waiting for surgery caused by pauses to planned surgery during COVID-19. However, it is not meeting the nationally agreed target of 'zero patients waiting longer than clinically recommended for surgery'. Access to planned surgery is variable, with a disproportionately higher number of patients in some local health districts experiencing longer wait times than patients in other districts. In 2024-25, only 4 of the 17 local health districts and specialty health networks met the goal of zero patients waiting longer than clinically recommended for surgery.

NSW Health has effective policies, processes and data to manage planned surgery access and is reducing unnecessary surgeries and boosting planned surgery volumes to make better use of limited hospital resources. NSW Health has a fit for purpose policy that supports local health districts to manage planned surgery waitlists efficiently within constrained resources, supported by reliable systems data that informs decision-making. However, NSW Health is not systematically rolling out initiatives across the state that are known to improve the efficiency of planned surgery.

Key findings

NSW Health does not always complete planned surgeries for public patients within clinically recommended timeframes

NSW Health has mostly cleared the backlog of patients caused by pauses to semi-urgent and non-urgent planned surgery during COVID-19, from almost 19,000 overdue patients to an average of under 4,000 in the 6 months to December 2025. However, NSW Health is not completing planned surgery for all patients within clinically recommended timeframes, which is a key performance indicator (KPI). In 2024–25, only 4 of the 17 local health districts and specialty health networks met the goal of zero patients waiting longer than clinically recommended for surgery. Districts mostly achieved zero overdue patients in the urgent category, for patients who must be treated within 30 days.

Senior NSW Health officials advise that, rather than a goal of zero patients, the pre-COVID-19 2018–19 performance of about 1,000 overdue patients at the end of a given month is a more realistic and practical benchmark or baseline for what the system can sustainably achieve with current resources. However, even this level of performance was not achieved over the review period.

As of December 2025, there were 3,885 patients waiting longer than clinically recommended for planned surgery throughout the NSW Health network. There is also considerable variation in performance amongst the local health districts, meaning that the time public patients spend on the waitlist depends on the hospital at which their surgery is scheduled.

NSW Health is not maximising the use of more efficient models to deliver planned surgery

During the audit review period, NSW Health has trialled several initiatives to increase efficiency in delivering planned surgery. This includes surgical hubs, pooled surgery waitlists, and identifying and reducing unnecessary surgical interventions. However, NSW Health is yet to roll out these initiatives across the state, limiting their impact on system-wide efficiency.

NSW Health has continued to focus on eliminating certain surgical procedures – known as low-value procedures – that are not supported by strong clinical and patient outcome evidence. For example, NSW Health is providing funding for hospitals to divert patients from surgical care where it is clinically safe to do so. In addition, NSW Health revised its planned surgery access policy to require doctors to provide a clinical explanation and approval for procedures other than high-value procedures.

NSW Health has begun to identify and run surgical hubs: high-volume, short-stay centres that, due to their scale, can treat a larger number of patients. NSW Health expects that this model will achieve improved safety outcomes for patients relative to traditional models, due to clinical staff's frequent practice of certain procedures. Due to the volume of patients this model is also expected to result in more efficient delivery of planned surgery. Relatedly, NSW Health has endorsed international benchmarks that are intended to increase surgical efficiency and improve the system's ability to treat patients on time.

NSW Health identified expansion of pooled surgery waitlists as a key strategy to efficiently manage demand for planned surgery. The planned surgery access policy makes it clear that people on the planned surgery waitlist are patients of the district. Districts can allocate a suitable doctor to perform the required surgery, and the policy provides guidance on setting up pooled waitlist arrangements. However, local health districts struggle to implement these models at scale due to clinical workforce shortages and reluctance on the part of surgeons. The Ministry of Health could do more to monitor, encourage and support local health districts to expand this model where it is clinically safe to do so.

NSW Health's performance framework and governance activities focus on improving access to planned surgery

NSW Health uses its performance framework to focus local health districts on prioritising planned surgery access performance and reaching the target of zero overdue patients across all urgency categories by the end of the financial year. Underperforming local health districts must explain underperformance at regular performance discussions. Of the 17 local health districts, 8 were at escalated performance levels at some point over the review period, due in part to planned surgery access concerns. Additional planned surgery recovery meetings held between the Ministry of Health and local health districts demonstrated an effective regime of escalation and intervention for underperforming districts to target areas for improvement.

In July 2025, NSW Health introduced an additional KPI focused on day surgery rates for select procedures. This new KPI is intended to focus hospitals on reducing overnight bed use, improving theatre throughput and freeing capacity to treat more patients safely and efficiently.

NSW Health has invested in surgery volume intensification and outsourcing surgery to the private sector, measures that have been effective in reducing wait times for planned surgery in the short term. The number of patients overdue for surgery increased after the investments in outsourcing and volume intensification lapsed. Inflation in costs to deliver surgery and increased demand via population growth are key risks to the longer-term sustainability of planned surgery service delivery.

NSW Health has a fit for purpose planned surgery access policy that supports local health districts to manage their planned surgery waitlists

NSW Health has an up-to-date and fit for purpose planned surgery access policy, which provides districts with clear directives on key activities involved in waitlist management and scheduling of surgery in line with the 'treat in turn' principle, and clinical urgency categories. Following a recent update, the policy now strengthens clinical governance reviews for non-standard urgency categories and aligns with efforts to increase planned surgery efficiency, including day surgery and benchmarks for procedure numbers delivered per surgical session.

NSW Health has a good understanding of supply and demand for planned surgery

NSW Health has a good understanding of the supply of, and demand for, planned surgery. The discipline of managing the planned surgery waitlist week to week ensures that administrators are aware of short-term supply and demand factors. NSW Health is developing more comprehensive and consistent tools to further improve demand forecasting for planned surgery and to communicate results with administrative and clinical staff. NSW Health has identified longer-term constraints, including hospital bed capacity and a growing cohort of older patients requiring more surgical care. Both local health districts reviewed for this audit experienced clinical workforce shortages, particularly relating to anaesthetists, which affects their capacity to perform planned surgery in line with demand. Shortages tend to be more acute in regional hospitals.

NSW Health has robust processes to ensure waitlist data is fit for purpose, but there remain control weaknesses at the local health district level

The administration of planned surgery waitlists at local health districts is reliant on paper forms and manual data entry and a lack of automatic system checks. However, a structured system of clerical checking and ad hoc reviews mostly compensates for the control weaknesses of the manual paper-based process. The planned surgery access policy does not provide guidance on the frequency and scope of ad hoc reviews to support robust data quality.

NSW Health maintains a central waitlist data collection, which includes information on patients joining and leaving the planned surgery waitlists. Data in the collection is updated via a monthly extract from local health district patient administration systems and is subject to completeness and validity checks. Despite control weaknesses at the local level, NSW Health waitlist data is fit for purpose as a record of planned surgery access performance and to inform decision-making.

Recommendations

By June 2027, the Ministry of Health should:

1. Define additional efficiency performance targets for inclusion in service agreements with local health districts for the delivery of planned surgery by expanding and enforcing the current set of international benchmarks for surgical productivity
2. Identify and determine the planned surgery service delivery models that achieve greater efficiencies and surgical throughput, and target policy and investment accordingly
3. To supplement current clerical reviews, develop risk-based guidance for local health districts to conduct:
 - a) regular, sample-based compliance reviews of clinical urgency categorisation changes to support clinical review panels
 - b) periodic internal audits of planned surgery waitlist management and compliance.

3. Introduction

3.1. Planned surgery, the planned surgery waitlist and trends

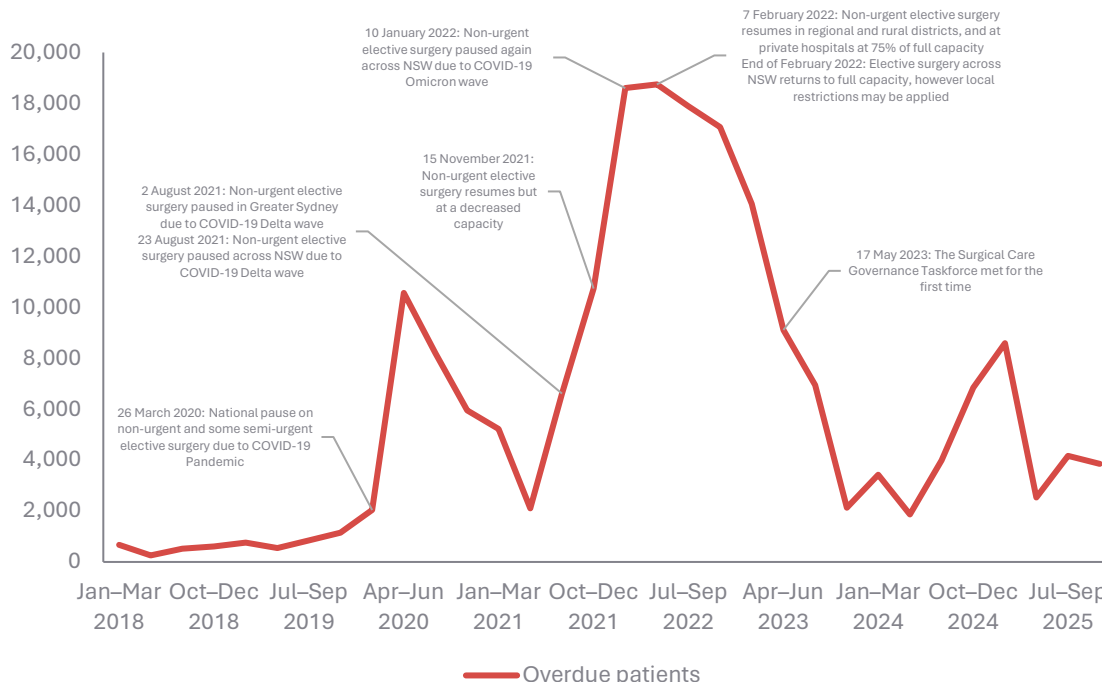
Planned surgery, also known as elective surgery, is surgery that can be booked in advance as a result of a specialist clinical assessment resulting in a patient’s placement on the planned surgery waitlist. Patients are listed on the planned surgery waitlist after seeing a specialist surgeon and submitting a Recommendation for Admission form, which contains details of the patient and their required surgical procedure. Under the Australian Government’s Medicare principles, patients who elect to be treated free of charge as public patients in NSW Health hospitals are treated based on clinical need and in line with ‘treat in turn’ principles. This means that surgeries are scheduled in order of listing date, and according to the following 3 clinical urgency categories informed by clinical need, which determine the priority of the procedure.

- Category 1: Urgent – to be treated within 30 days
- Category 2: Semi-urgent – to be treated within 90 days
- Category 3: Non-urgent – to be treated within 365 days.

NSW Health’s planned surgery access policy sets out the policy requirements and scheduling principles that local health districts and hospitals must follow when managing planned surgery waitlists. The policy, most recently revised in September 2025, applies to surgical procedures performed in an operating theatre, requiring anaesthesia and surgical techniques.

Non-urgent planned surgery was paused several times during the COVID-19 pandemic between March 2020 and January 2022. This resulted in a backlog of overdue planned surgery patients, reaching a peak of almost 19,000 patients overdue for planned surgery in April 2022. At the end of the audit period in December 2025, there were almost 3,900 overdue patients. Exhibit 1 shows the number of patients overdue for surgery from July 2018 to December 2025.

Exhibit 1 – NSW Health overdue patients from January 2018 to December 2025



Source: Bureau of Health Information data and Audit Office of New South Wales analysis.

In May 2023, the incoming NSW Government established the Surgical Care Governance Taskforce, an election commitment, to identify strategies to reduce the number of overdue patients. The taskforce delivered its final report in March 2024. The report assessed strategies to improve planned surgery access performance and efficiency and recommended improvements to future system performance.

3.2. Funding and cost of planned surgery

NSW public hospitals are mostly funded based on activity expressed in a common activity unit called Nationally Weighted Activity Units (NWAU) multiplied by the state price. The Ministry of Health purchases NWAU from local health districts, and nominates different categories of service activity, such as emergency, acute or non-acute care. Planned surgery is classified as acute care. Acute care also includes other types of admitted patient activity. More complex procedures consume more NWAU than less complex procedures. This method of funding supports technical efficiency by closely tying funding to activity.

NSW Health uses an activity-based costing methodology to estimate costs of surgical procedures. Exhibit 2 shows that NSW Health now spends about \$2.3 billion per year providing planned surgery.

Exhibit 2 – Cost of planned surgery

Year	2021–22	2022–23	2023–24	2024–25
Estimated costs of planned surgery	\$1.645b	\$1.923b	\$2.234b	\$2.327b

Source: Ministry of Health

3.3. Audit focus

Of the 17 local health districts and specialty health networks, 2 – South Western Sydney and Hunter New England – were selected to provide focus and illustrative examples for the audit. The audit team held interviews with clinical and administrative staff and reviewed relevant documentation from both districts to gain an understanding of local practices and initiatives to inform case studies throughout the audit report. The audit team visited Liverpool and Campbelltown Hospitals in South Western Sydney Local Health District, and John Hunter, Maitland and Tamworth Hospitals in Hunter New England Local Health District. See Appendix 2 for further details on the selected local health districts and hospitals, and Appendix 4 for further details on the selection of these 2 local health districts.

Three surgical specialties were selected to focus the audit’s inquiries at the chosen local health districts and hospitals: Ear, Nose and Throat (ENT); Ophthalmology; and Orthopaedics. These specialties perform high-volume procedures such as cataract surgery, hip and knee replacements, tonsil removals, and grommet insertions. These procedures also account for a high proportion of patients on the waitlist and overdue for surgery.

4. Planned surgery access performance and system stewardship

This chapter reports on overall NSW Health system planned surgery access performance and the Ministry of Health's role as system steward in setting expectations for system performance.

The Ministry of Health purchases hospital and other health services from local health districts. The NSW Health Performance Framework sets out arrangements for how the Ministry of Health monitors and assesses the performance of local health districts in delivering those services. Service agreements set out detailed Ministry of Health expectations, including for planned surgery access, performance and the available funding allocation.

Local health districts are regarded as performing to expectations for planned surgery access when they achieve zero overdue patients across all 3 clinical urgency categories. The time patients spend waiting for surgery is calculated as the time between listing date and treatment date, less any time spent not ready for care due to clinical or personal reasons.

Previously, local health districts were also assessed against Elective Surgery Access Performance (ESAP), which measured the proportion of patients treated on time, with a target of 100% for urgent, and 97% for semi-urgent and non-urgent categories, aligned with National Health Reform Agreement targets. However, in 2024, the Ministry reduced the numbers of KPIs in service agreements by changing the ESAP measure to an improvement measure rather than a formal KPI. Achieving the target of zero overdue patients for all categories means that local health districts also achieve the ESAP targets.

4.1. Performance

Less than 25% of local health districts achieved planned surgery access KPIs

Only 4 of the 17 local health districts and specialty health networks met the 'zero overdue patients for all categories' target for 2024–25, as shown in Exhibit 3. While local health districts generally meet targets for urgent planned surgery that is clinically indicated within 30 days of referral, most record overdue patients for semi-urgent and non-urgent categories. ESAP performance is set out in Appendix 3.

The 2 local health districts reviewed for this audit – South Western Sydney and Hunter New England – underperformed on planned surgery access KPIs over the review period. Both districts have experienced pressure on capacity to deliver planned surgery, including unplanned demand, infrastructure constraints and clinical workforce shortages, which are discussed in more detail in Chapter 5.

Exhibit 3 – Local health districts’ performance against zero overdue patients for all categories’ KPIs

Refer to Appendix 3 for a data table on overdue patients’ results for each clinical urgency category.

Local health district or speciality health network	June 2023, overdue patients	June 2024, overdue patients	June 2025, overdue patients
Central Coast	16	115	134
Far West	17	13	13
Hunter New England	840	553	430
Illawarra Shoalhaven	403	234	156
Mid North Coast	683	95	124
Murrumbidgee	592	18	477
Nepean Blue Mountains	971	0	0
Northern NSW	793	145	194
Northern Sydney	437	13	23
South Eastern Sydney	831	193	497
South Western Sydney	1,394	340	249
Southern NSW	0	<5	81
St Vincent's Health	58	0	0
Sydney Children's Hospitals	956	46	83
Sydney	0	0	<5 [#]
Western NSW	158	30	70
Western Sydney	958	62	<5 [#]
Total	9,107	1,859	2,534

Sydney Local Health District and Western Sydney Local Health District are considered by the Ministry of Health to have met the target of zero overdue patients for all categories in 2024–25.

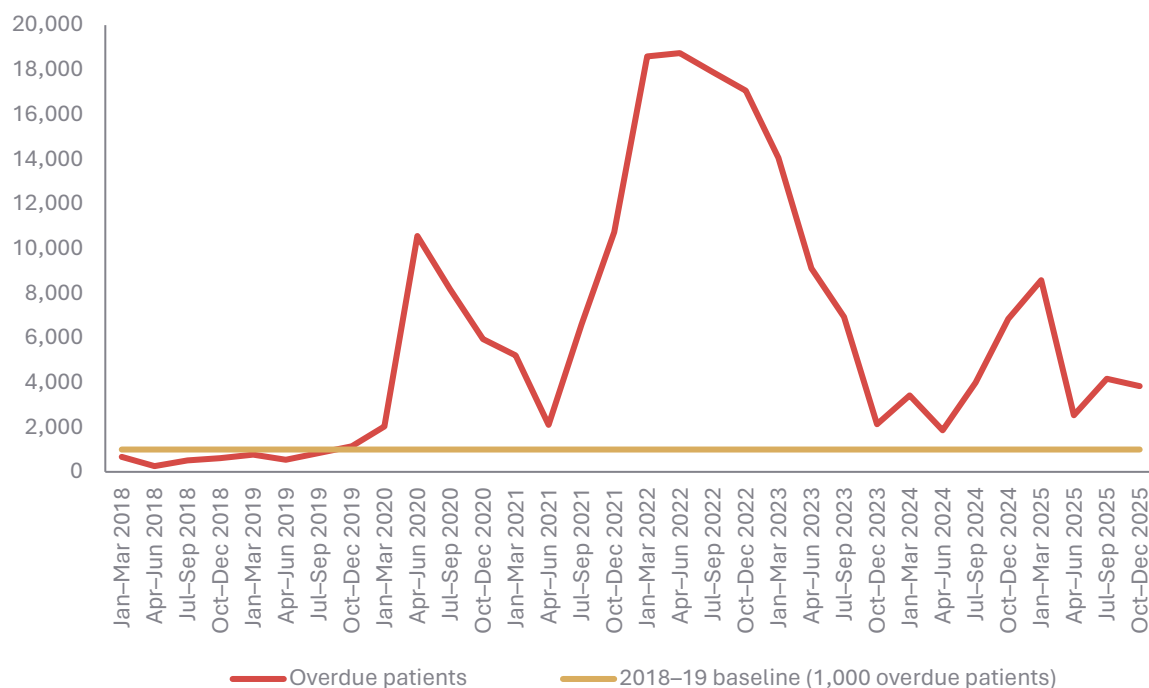
Source: Audit Office of New South Wales analysis of Bureau of Health Information data.

The Ministry of Health considers 2018–19 results to be the baseline for planned surgery access system performance against which the system underperforms

Despite the official KPI targeting zero overdue patients for planned surgery across all urgency categories, in practice senior NSW Health officials advise that they consider the 2018–19 performance to be an effective benchmark to gauge system performance, that is, around 1,000 overdue patients. NSW Health officials first identified 2018–19 as the baseline during the period immediately after the COVID-19-related pauses on planned surgery activity to set an expectation of what a return to normal looked like. However, this understanding has persisted as the Ministry of Health benchmark for what the system can deliver within current financial resources.

Exhibit 4 shows overdue patient performance against a nominal 1,000 overdue patients benchmark. The exhibit shows that NSW Health underperformed against the identified baseline over the review period. The Ministry of Health reports that limited funding and rising surgery demand prevent the system from reaching the 2018–19 baseline of zero overdue patients.

Exhibit 4 – Overdue patient performance from January 2018 to December 2025 against 2018–19 baseline



Source: Audit Office of New South Wales analysis of Bureau of Health Information data.

Once on the waitlist, regional patients experience similar wait times to metropolitan patients

Australian Medicare Principles provide for access to public hospital services, including access to planned surgery, on the basis of clinical need and not according to a person’s place of residence or background. In accordance with the principles, NSW Health is expected to provide reasonable access to a basic range of hospital services in regional areas. The Ministry of Health waitlist data summarised in Exhibit 5 shows that, over the review period, regional patients experienced similar wait times as patients in metropolitan areas.

Exhibit 5 – Median waiting days for metropolitan and regional hospitals by clinical urgency category

Cohort	2022–23, median waiting days			2023–24, median waiting days			2024–25, median waiting days		
	1	2	3	1	2	3	1	2	3
Clinical urgency categories									
Metropolitan local health districts	11	59	301	12	53	267	12	57	297
Regional local health districts	13	56	296	13	56	294	13	57	326
Differential	+2	-3	-5	+1	+3	+27	+1	0	+29

Source: Audit Office of New South Wales analysis of Ministry of Health data.

A very low proportion of patients experience multiple cancellations before receiving surgery

NSW Health's planned surgery access policy states that delays to patient care initiated by the hospital must be reported. Final approval for cancellation is generally approved by the general manager of a hospital. For example, in April 2025, Ministry of Health data shows that 2,761 instances of planned surgeries were delayed, with most delays occurring for doctor-related reasons. This compares with 18,188 planned surgery procedures completed in the same month. Analysis of Ministry of Health data reveals that, in April 2025, 206 patients faced a delay after already experiencing a postponed surgery within the prior year. Most of these patients had only one earlier delay during those 12 months, while fewer than 20 had undergone multiple delays in the same period.

Consistent with national data, 'private in public' patients have shorter wait times than public patients

Patients who hold private health insurance may elect to use this insurance cover to be admitted to a NSW Health public hospital as a private patient; these are private in public patients. In accordance with the planned surgery access policy, private in public patients who are recommended for planned surgery can choose their own treating doctor – usually their referring surgeon – but are to be managed in line with 'treat in turn' principles. In 2025–26, about 6% of patients receiving surgery in NSW public hospitals were private patients. National data shows that private in public patients wait less time for their planned surgery compared to public patients, with a median waiting time in 2023–24 of 26 days for private in public patients, compared to 48 days for public patients, across all clinical urgency categories. Compared with the national data, in NSW, private in public patients also wait less time for their planned surgeries. NSW Health data shows that in 2024–25, private in public patients had a median waiting time of 13 fewer days than public patients for semi-urgent surgeries, and 173 fewer days than public patients for non-urgent surgeries.

4.2. Stewardship

Planned surgery access KPIs focus attention on overdue patients

The performance framework has enabled local health districts to address planned surgery access performance and has focused Ministry of Health attention on local health districts requiring additional assistance. The performance framework sets out an escalation procedure for local health districts that have not achieved KPIs. As the performance of local health districts declines, 4 performance levels have progressively more Ministry of Health involvement. For example, in order to implement effective strategies to address access concerns, the Ministry of Health has established a planned surgery access recovery meeting as a forum for local health districts and the Ministry of Health to review progress against recovery plans and facilitate collaboration across the NSW Health network. Of the 17 local health districts, 8 were at escalated performance levels at some point over the review period, due in part to planned surgery access performance.

Day surgery targets introduced for 2025–26 are expected to improve overall system efficiency and effectiveness

In July 2025, the Ministry of Health introduced a day surgery KPI for 8 procedures that research indicated were suitable for day-only models of care. The new KPI targets 68% of the 8 identified procedures delivered as day-only surgery. The Ministry of Health also introduced an improvement measure for monitoring districts' reduction in average length of stay for hip and knee replacement procedures. Previously, local health districts were encouraged to explore same-day models of care but without targets or an expectation that they must explain performance in implementing these models of care.

Same-day surgery is potentially beneficial for patients in terms of health outcomes but also allows hospitals to achieve greater throughput because patients do not occupy an overnight bed. The saved bed days can then be used for additional planned or unplanned admissions. The Ministry of Health identified the British Association of Day Surgery benchmarks as aspirational targets to work towards in NSW. It expects to expand the scope of these targets over time. The new targets are expected to incentivise local health districts to adjust models of care to achieve better outcomes for patients and for the healthcare system.

During the review period, local health districts increased day surgery procedures overall, including for high-volume procedures. Ministry of Health analysis of same-day surgery indicates that increased prevalence of day surgery procedures for the 8 procedures subject to the new KPI contributed an additional 12,773 saved bed days in 2024–25. From July to November 2025, NSW Health delivered 45% of the eligible procedures as day surgery.

Funding enhancements to address the planned surgery waitlist backlog achieved short-term reductions in the planned surgery waitlist

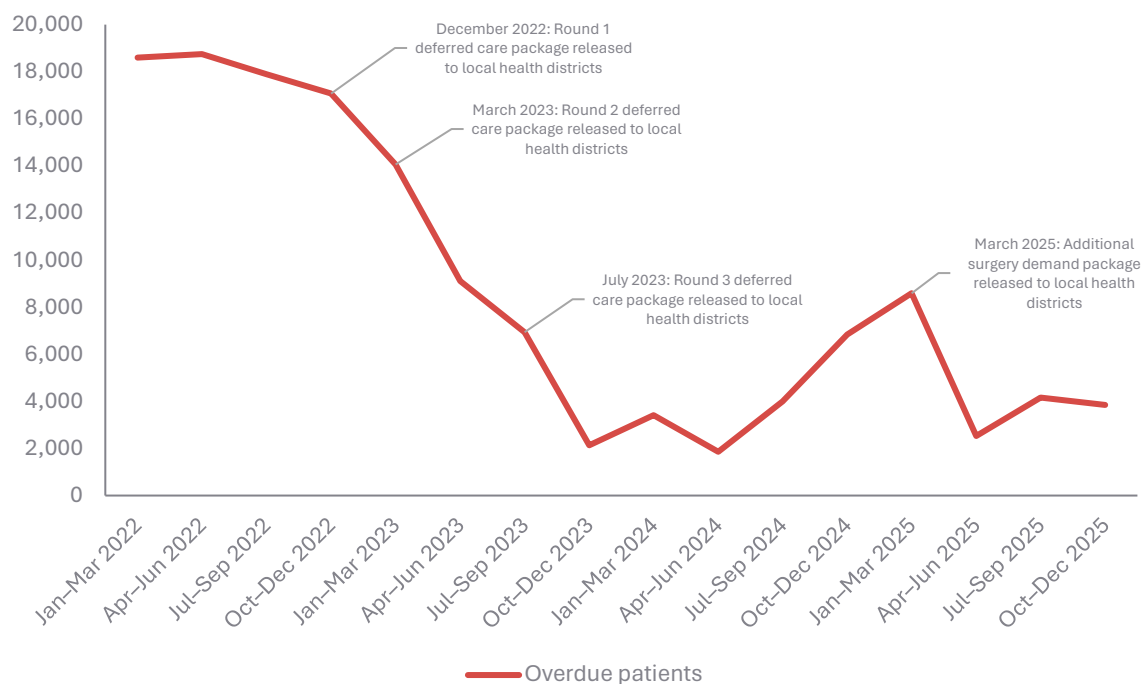
The NSW Government paused semi-urgent and non-urgent planned surgery at times during the COVID-19 pandemic, resulting in a significant backlog of patients overdue for planned surgery. The NSW Government committed additional funding between 2022 and 2025 to address the backlog.

- May 2022 deferred care package: \$405 million for 2022–23 and 2023–24 to address the planned surgery backlog.
- November 2024 additional surgery demand package: \$186 million for 2024–25 to address the planned surgery backlog.
- May 2025 ageing and population package: \$137 million for 2025–26 to fund general ageing and population factors affecting acute hospital services, including, but not limited to, planned surgery.

The Ministry of Health allocated \$414 million of the deferred care and additional surgery demand packages to local health districts to reduce overdue patients based on their number of patients overdue for surgery. It distributed the entire \$137 million ageing and population package to local health districts according to their demographic profiles.

The Ministry of Health retained a small reserve from the first 2 packages to facilitate cross-district flow of patients and for dedicated projects to achieve system reform. For example, in March 2023, part of the deferred care package was used to clear a backlog caused by changing the clinical urgency categorisation of second eye cataract procedures from non-urgent to semi-urgent in line with updated clinical evidence. That is, from an expectation that patients receive treatment within 365 days to 90 days. Exhibit 6 illustrates the trend in overdue patient numbers, indicating when targeted planned surgery funding enhancements were released to the local health districts.

Exhibit 6 – NSW overdue patients annotated with targeted planned surgery funding enhancements



Source: Audit Office of New South Wales analysis of Bureau of Health Information and Ministry of Health data.

The Ministry of Health stipulated performance thresholds for local health districts to receive funding from the first 2 funding packages. Local health districts were unable to meet Ministry of Health criteria for increasing surgical volume and hence were unable to demonstrate that they could effectively use additional funding to address the planned surgery backlog. NSW Health did not spend \$120 million of the deferred care package and submitted an unsuccessful carry forward budget bid.

In large part, the reduction in the COVID-19 backlog was achieved through increased intensity at hospitals and through outsourcing of certain procedures to the private sector. Increased intensity was achieved through scheduling and delivering additional surgical lists, such as twilight and weekend lists with the additional funding for staff overtime. The Ministry of Health also estimated that the resumption of regular ‘not ready for care’ audits from February 2022 contributed, with each exercise identifying between 200 and 1,400 patients who no longer needed to be on the planned surgery waitlist. Outsourcing as a strategy to address planned surgery access is considered further in Chapter 5. However, largely single-year funding enhancements provide limited certainty for NSW Health to invest in longer-term reforms to increase surgical capacity or efficiency.

The Surgical Care Governance Taskforce provided an effective strategic lens to support longer-term delivery of effective access to planned surgery

In April 2023, the incoming NSW Government established the Surgical Care Governance Taskforce as part of an election commitment to reduce the number of patients overdue for planned surgery. The taskforce replaced the Surgical Governance Committee and was succeeded by the Surgical Care Strategic Committee. All 3 iterations had similar membership. However, while the taskforce was directed specifically to reducing the COVID-19 backlog, the former Surgical Governance Committee and the current Surgical Care Strategic Committee are more focused on identifying medium to longer-term challenges and corresponding strategies. Between May 2023 and March 2024, the taskforce met monthly to consider progress towards reducing the planned surgery access backlog. During this time the taskforce was effective in providing a strategic lens to support longer-term improvements to planned surgery access and curating a suite of strategies for local health districts to deploy. For example, the taskforce promoted better-value care and greater use of day surgery as leading strategies for future development.

5. Managing planned surgery access

This chapter considers how NSW Health understands the supply of, and demand for, planned surgery, and how it implements strategies to meet this demand. Some patient cohorts experience barriers before they are placed on a planned surgery waitlist; this chapter first considers waitlist access issues, then considers NSW Health's management of waitlists.

5.1. Access to the planned surgery waitlist

The Isolated Patient Transport Access and Accommodation Scheme (IPTAAS) helps ease the financial burdens of patients who must travel for surgery, but is not currently funded to meet future demand

The IPTAAS provides financial assistance in the form of reimbursements for patients travelling long distances to receive specialised healthcare. It is available for planned surgery and other healthcare services. In 2024–25, NSW Health spent \$57.3 million on the IPTAAS, supporting 59,800 patients to receive specialist healthcare, including around 27,000 planned surgery patients. NSW Health's evaluation of the program shows that patients accessing the IPTAAS experienced better health outcomes than patients who did not access it. NSW Health estimates that the amount of funding it allocates to the IPTAAS cannot meet future demand at current service levels.

Local health districts run assessment prioritisation programs in partnership with local First Nations organisations to promote equitable access to planned surgery

First Nations patients do not wait longer than non-First Nations patients for planned surgery once placed on the waitlist. However, research indicates that First Nations patients experience barriers to healthcare prior to joining the planned surgery waitlist; these are often due to historical, culturally unsafe healthcare settings and practices. Consequently, both local health districts reviewed for this audit have entered into partnership agreements with local First Nations organisations for patients to access health services, including the provision of bulk-billed specialist doctor appointments through outreach clinics. These clinics allow for the prioritisation of assessment of First Nations patients to ensure they receive required surgical care where clinically indicated.

For example, Hunter New England Local Health District has implemented a priority pathway for First Nations children presenting with hearing issues to access specialist ENT care through the John Hunter Hospital outpatient clinic. Children are initially assessed by an allied health audiologist who consults with the ENT surgeon to confirm whether surgery is required, resulting in placement on the planned surgery waitlist according to clinical indications. The pathway resulted in reduced waiting times for assessment, as well as strong diagnostic outcomes and patient safety. In 2025, 215 children were seen through the pathway, with an average waiting time of 79 days.

5.2. Demand and capacity

Reviewed local health districts have a good understanding of the demand for planned surgery services and their capacity to treat patients on time

Both local health districts reviewed for this audit have actions to focus on reducing the number of patients overdue for planned surgery and ensuring that patients are treated in turn. They have daily and weekly meetings to identify short-term actual and potential barriers to treating patients on time, and they demonstrate flexibility in accommodating last minute changes. In addition, they are aware of seasonality in the demand for planned surgery and of the factors that affect their ability to treat patients on time. Further, they have plans to accommodate the predictable and routine surge in demand for hospital resources during winter months that constrain the number of beds available for planned surgery patients.

Both local health districts are also attuned to the effect of school holidays on their ability to run surgical services at full capacity and adjust planned surgery activity accordingly. Patients are added to the planned surgery waitlist after being assessed by a specialist surgeon, which mainly occurs through the surgeon's private rooms, or, less often, through local health district public outpatient clinics. NSW Health has limited visibility of the demand for planned surgery prior to patients being added to the planned surgery waitlist. The planned surgery access policy provides guidance on managing spikes in demand for surgery caused by doctor referrals in excess of local health districts' capacity to complete surgeries within the recommended clinical urgency timeframe. However, the local health districts reviewed for this audit report that this section of the policy is often difficult to enforce.

During fieldwork for this audit, both local health districts' clinical leaders spoke about the relative complexity of the needs of their planned surgery patients, and reported that this complexity is not always reflected in patient records. South Western Sydney Local Health District recently began a project to better reflect the clinical complexity and comorbidities of planned surgery patients, and the clinical services provided. The district hypothesises that patients on its waiting lists generally present later and with more comorbidities than in other parts of metropolitan Sydney. Improving the accuracy of clinical coding may support districts in their conversations with the Ministry around efficiency and access performance metrics.

NSW Health developed a series of tools to consistently identify and make use of surgical capacity

Both local health districts reviewed for this audit produce a series of local management reports on the status of their planned surgery waitlists and factors affecting their ability to treat patients on time, such as theatre efficiency and length of stay. In the last 3 years, NSW Health has invested in a series of centralised operational dashboards to harmonise practice and support a common understanding of effective waitlist management. For example, the Surgical Demand and Capacity Dashboard, commissioned in August 2025, was modelled on a design pioneered at Northern Sydney Local Health District.

The dashboard allows local health districts to consistently forecast the number of overdue patients by specialty and surgeon. This gives districts consistent tools to identify and address upcoming capacity bottlenecks and to initiate evidence-based discussions with clinicians where required to address any concerns. In time, NSW Health plans to introduce greater sophistication in forecasting to the dashboard to better support local health districts in understanding demand for planned surgery, existing constraints and identifying areas for improvement relative to peers.

Unplanned surgical activity levels can encroach on local health districts' ability to meet planned surgery performance targets

Hospitals are required to manage their operating theatre capacity to perform both emergency and planned surgery. Hospitals will typically schedule planned surgical lists in some of their theatres, while keeping their other theatres available for emergency surgery. Emergency surgery is higher priority than planned surgery and unexpected high volumes of emergency surgery can displace planned surgery. NSW Health publishes guidance for local health districts to manage and preserve capacity for planned and unplanned surgery. The Ministry of Health argues that local health districts should be able to effectively ring fence planned and unplanned surgery lists to ensure that the latter do not encroach on the former.

Both local health districts reviewed for this audit are exploring the implementation of 'catch and release' programs. These will reduce the demand of emergency patients on beds by saving bed days and better organising unplanned surgery lists to avoid encroaching on planned surgery lists. For example, South Western Sydney Local Health District is trialling an emergency gall bladder removal and hernia repair surgery catch and release program at Campbelltown Hospital. In this program, instead of the patient occupying a bed for multiple days while waiting for surgery, they will instead be sent home with remote monitoring and re-present to hospital on the day of their scheduled surgery. This allows for the use of hospital resources to be more evenly distributed.

Hunter New England Local Health District reported infrastructure challenges that compound increased unplanned hospital demand. The district has identified that bed block, stemming from unplanned surgery rather than operating theatre availability alone, is a major constraint in addressing the number of overdue patients on its waitlist. Therefore, the hospital cannot resolve its backlog only by operating additional theatres, but must invest in strategies to make beds available, increase the volume of surgery that does not require a bed or find ways to divert surgical volume away from the John Hunter Hospital. Hunter New England Local Health District has recently updated its district-wide clinical service planning to divert lower-acuity planned surgery to smaller hospitals, for example, by moving Orthopaedic surgery to Maitland Hospital and General surgery to Belmont Hospital.

NSW Health is supporting local health districts to implement clinical practices that help to safely reduce patients' length of stay following surgery, freeing up space for other patients

The amount of time that patients recover in hospital beds following surgery affects a hospital's ability to achieve higher surgical throughput and treat more patients within a given timeframe. Strategies that reduce patients' recovery time in hospital are therefore attractive to system administrators seeking to improve planned surgery access performance. Patients also benefit from a reduced length of stay in hospital, as they can recover in the comfort of their home and report improved satisfaction under these approaches compared with traditional surgery service models.

NSW Health's 2023 Enhanced Recovery After Surgery (ERAS) guidelines are a key example of how a strategy, once implemented within a surgical model of care, can safely reduce length of stay in hospitals and any unplanned readmissions. The ERAS guidelines are designed to improve patient reported outcomes, with reduced length of stay and early mobilisation, as well as patient safety outcomes, including reduction in postoperative complications and readmissions. The ERAS guidelines can support districts implementing models of care to achieve Ministry of Health day surgery targets. They also provide clinicians with evidence-based perioperative protocols that should be integrated into local surgical models of care.

Both local health districts reviewed for this audit have integrated ERAS protocols into models of care for delivering planned surgery to suitable patients. For example, since 2023, South Western Sydney has operationalised day surgery models of care guidelines incorporating ERAS protocols for patients undergoing planned tonsil and gall bladder removal surgeries. Overall, between 2023 and 2025, the district has achieved an average reduction in length of stay of 0.3 and 0.2 days for tonsil and gall bladder removal respectively. In late 2024, Hunter New England's Maitland Hospital implemented a Rapid Knee Arthroplasty project, which has embedded ERAS protocols into the knee replacement surgery model of care. In the first 6 months of the program to May 2025, the average length of stay for the 45 patients undergoing their surgery under this model of care was significantly reduced from 7.6 days in the first quarter of 2024, to 2 days. The hospital has also made cost savings associated with the reduced overnight hospital stays.

The Ministry of Health is encouraging local health districts to develop specialised surgical hubs to more efficiently treat patients waiting for planned surgery

NSW hospitals deliver planned surgery at varying rates of cost efficiency. For example, in 2024–25 the average cost per procedure for hip replacement was approximately \$25,200 at Concord Hospital and \$36,900 at St George Hospital. Over the review period, the Ministry of Health encouraged and incentivised local health districts to adopt hub models for high-volume or specialised surgical procedures. These hubs are expected to capitalise on the efficiencies that can be generated by concentrating clinical expertise and volume in one place. In September 2025, the Ministry of Health invited local health districts to apply for one-off funding to set up or expand surgical hubs and high-volume short stay centres. The Ministry of Health funded 24 projects across 13 districts for \$25.8 million in 2025–26. Districts are expected to cover costs from the 2026–27 financial year onwards.

Separate to Ministry of Health funding, Hunter New England Local Health District is also implementing a surgical hub model. In late 2025, Maitland Hospital opened the Hunter Joint Centre. The Centre will treat patients suitable for day-only and short-stay hip, shoulder and knee replacement procedures. It will have guaranteed access to a ring-fenced sixth operating theatre, accompanied by ring-fenced beds available for recovering patients. The centre aims to complete 5 joint procedures per 10-hour surgical session, compared with a current district average of 3 to 4 procedures per session.

In 2025, NSW Health endorsed the United Kingdom National Health Service's Getting It Right First Time (GIRFT) standard for several surgical procedures. For example, the GIRFT standards for cataract procedures are 6 cases performed per 4-hour surgical session. There is an opportunity in the future for the Ministry of Health to use the benchmarks to inform both performance monitoring of districts and hospitals and clinical service planning, including decisions to consolidate surgical services into hubs.

The local health districts reviewed for this audit identified a potential trade-off in establishing surgical hubs, where other hospitals in the district may experience degradation of experience in some surgical procedures as surgeons at non-hub sites complete fewer of the high-volume procedures targeted by the hubs. Further, local health districts assert that certain surgical skills cross-pollinate to emergency surgery settings, which presents nuanced challenges for larger trauma centres that must provide a full range of specialty surgical services.

The future of surgical hubs for regional areas is not well understood in the regional local health district reviewed for this report. Hunter New England Local Health District staff raised concerns that extensive implementation of surgical hubs might require regional patients to travel further for high-volume surgery procedures. Medicare principles require that regional patients are reasonably able to access surgical services. However, NSW Health does not have a clear definition of what travel is reasonable to implement this model at scale for regional areas.

NSW Health uses policy and funding levers to encourage better-value care and manage planned surgery waitlists

Over the review period, the Ministry of Health used policy and funding levers to encourage the system to deliver better-value care. Low-value procedures are procedures that have little to no benefit to patients. Aside from benefits to patients, concentration on better-value care means that scarce surgical resources are spent more effectively. In November 2023, the Agency for Clinical Innovation (ACI) released a clinical practice guide on value-based surgery. The ACI is the NSW Health organisation responsible for researching, identifying and designing clinically led innovations that improve patient experience and outcomes, and deliver efficient and sustainable healthcare services. The clinical practice guide on value-based surgery contains an evidence-based list of potentially low-value procedures that may have little to no benefit to patients. It also provides hospitals with a framework to review and make decisions on surgical activity in line with better-value care principles.

The updated planned surgery access policy, released in September 2025, has guidelines for integration of better-value care principles into planned surgery decision-making. Based on the ACI's guide, the policy has a list of potentially low-value procedures that must be reviewed in line with value-based care principles. The policy requires that potentially low-value procedures have 'a demonstrated clear clinical need to improve a patient's physical health'. The ACI intends to continually review and expand the list in the future in line with new evidence.

In August 2025, the Ministry of Health invited local health districts to express interest in additional funding to support access to high-value non-surgical care as an alternative to unnecessary surgery. Eight districts were successful in securing \$3.6 million for 2025–26.

Pooled waitlists are a key strategy to manage demand for planned surgery, but local health districts have been unable to implement them at scale

The planned surgery access policy makes clear that patients are patients of the hospital within the local health district. That is, the policy establishes that the local health district can allocate any appropriately qualified doctor to perform the required surgery. However, in practice, patients are largely assigned to the surgical waitlist of their referring doctor, and waiting time is contingent on that doctor's availability as well as the 'treat in turn' principles. A pooled waitlist is a mechanism to assign a patient's surgery to the next available treating doctor who is participating in the arrangement. This means that patients are assigned a date for surgery based on the date they are added to the waitlist and clinical urgency, rather than as a function of the date they are added to the waitlist, clinical urgency and the capacity of their referring doctor. NSW Health expects that pooled waitlists will result in shorter wait times for patients because hospitals will be better able to use any latent capacity among their surgical staff.

In March 2024, the Surgical Care Governance Taskforce's final report identified that the implementation of pooled waitlists across districts was an under-utilised strategy. Nine of the 17 districts and networks identified pooled arrangements as a locally implemented strategy. However, further inquiries at the 2 local health districts reviewed for this audit suggest that this arrangement is not widespread across most surgical procedures. In January 2026, Hunter New England and South Western Sydney Local Health Districts reported that they run one or 2 pooled waitlists each on a routine basis, comprising a small fraction of all surgical lists across these districts. The taskforce found that pooled waitlist arrangements are fit for purpose for high-volume procedures, such as hernia repair, tonsil removal and lower joint replacements. It argued that, as an evidence-based strategy to meet demand, there is a need to continue to promote the use of pooled waitlists where appropriate.

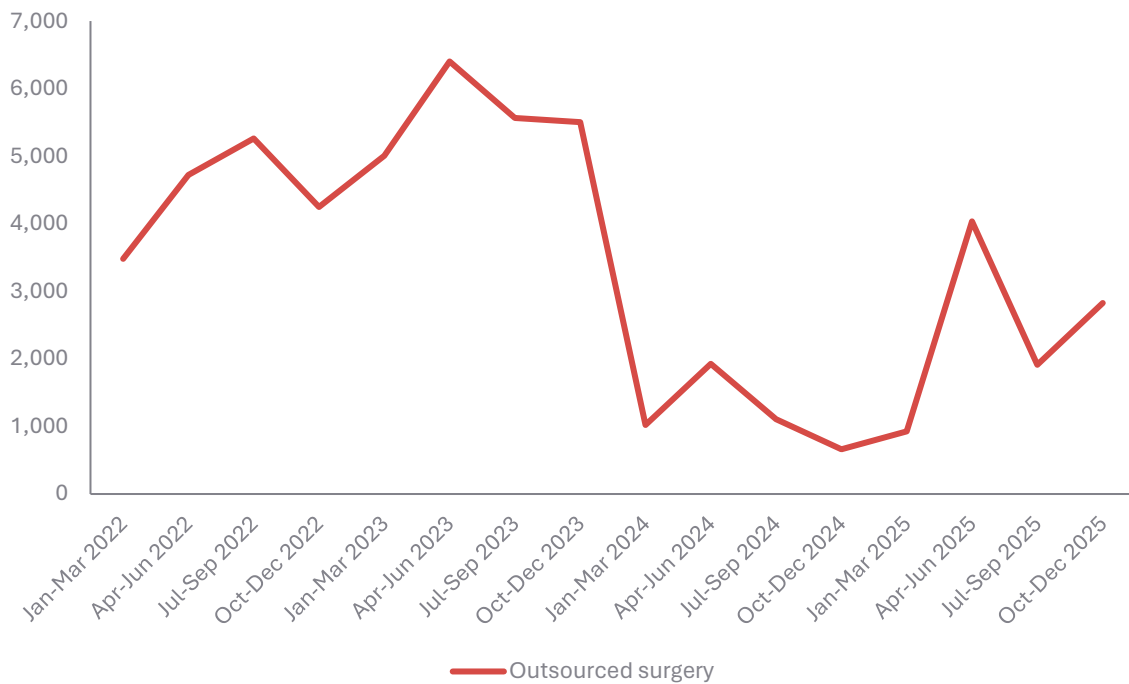
The updated planned surgery access policy, released in September 2025, included changes to give local health districts more operating authority to pursue pooled waitlist arrangements with their clinicians. It also provided clear guidance on how to communicate proposals to transfer a patient's care to another treating doctor, including as part of a routine pooled waitlist arrangement.

The local health districts reviewed for this audit identified pooled waitlists as a key strategy both within their surgical governance meeting papers and within performance meetings with the Ministry of Health. Both districts are seeking to establish additional pooled arrangements for selected specialties, including Ophthalmology, Gynaecology and General surgery. However, both districts reported that there are barriers to setting up pooled arrangements, mainly due to reluctance from clinical staff. Surgical workforce shortages in regional areas often exacerbate the power imbalance between doctors and hospital management, increasing the difficulty of implementing changes like greater use of pooled waitlists.

Outsourcing is effective in clearing short-term waitlist backlogs and remains an important surge capacity tool, but is not a substitute for longer-term reform

Outsourcing planned surgery procedures on public waitlists to private hospitals is a way to clear waitlist backlogs and reduce overdue patients in the short term. However, this approach can attract premium costs and degrade public hospital capacity in the longer term. Outsourcing was a key strategy employed to reduce the COVID-19 backlog and remains an important strategy for local health districts in addressing sudden increases in overdue patients for high-volume, low-complexity procedures. Exhibit 7 displays the quarterly number of procedures outsourced to private hospital operators over the review period and indicates a large volume of outsourced surgery to clear the COVID-19 backlog. It also shows subsequent surges to clear overdue patients leading up to the end of each annual performance cycle, utilising the additional government funding reported in Chapter 4.

Exhibit 7 – Outsourcing of planned surgery since January 2022



Source: Audit Office of New South Wales analysis of Bureau of Health Information data.

Between August 2022 and December 2025, NSW Health has purchased approximately \$446 million worth of procedures from private providers, using the price per NWAU for the relevant year. Under current procurement rules, local health districts are responsible for procurement and approvals and have the authority to purchase procedures at an agreed price under private provider service agreements. The Ministry of Health provides guidance to local health districts on what it considers reasonable pricing for outsourced public planned surgery based on an appraisal of market conditions. This guidance is an important control to guard against wasteful spending. The Ministry of Health expects that outsourcing may become a more attractive strategy in the near future, with private hospitals more willing to accept lower prices to undertake public planned surgery due to financial pressures.

The local health districts reviewed for this audit reported that outsourcing presents operational risks over the medium to long term because, often, doctors completing outsourced surgery at private hospitals also deliver surgery at public hospitals. Both districts reported that a risk of over-reliance on outsourcing to private hospitals will draw doctors and anaesthetists away from public hospitals due to more attractive pay in private hospitals, eroding the skills and expertise required to perform some surgical procedures in the public system. Therefore, outsourcing can be a zero-sum game for local health districts, especially outside metropolitan areas where private and public hospitals both rely on the same workforce resources, such as anaesthetists. Outsourcing is demonstrably a valuable tool to address surges in the number of overdue patients, but it is not a substitute for implementing other approaches to release and create capacity, or for treating the demand for planned surgery discussed in this report.

5.3. Workforce

Clinical workforce shortages affect selected local health districts' ability to deliver planned surgery and are more acute in regional settings

Australia, like many other countries, is experiencing a shortage in anaesthetists. Both local health districts reviewed for this audit have experienced anaesthetic workforce shortages that affect their ability to conduct planned surgery, as well as certain types of medical procedures. If an anaesthetist is not available for the scheduled operating theatre session, then surgeries must be cancelled and rescheduled to a later date. This risks patients being treated outside of their clinical urgency category timeframe.

In addition to providing anaesthesia services to surgical patients, anaesthetists are also required to provide sedation to patients undergoing some medical procedures, including endoscopy. A further risk from the shortage of anaesthetists is that, given the choice between deploying scarce anaesthetic resources on planned surgery or on medical procedures requiring anaesthesia, hospitals will rationally choose planned surgery. This is because there are targets for planned surgery but not for medical procedure access. This may result in longer wait times for patients waiting for medical procedures that require sedation.

Both local health districts reviewed for this audit developed local strategies to manage the shortage. Campbelltown Hospital in South Western Sydney Local Health District has introduced into their visiting medical officer contracts a minimum number of hours that an anaesthetist is expected to work. This gives the district certainty in scheduling surgical sessions above the standard zero-hour contracts, and, in practice, visiting medical officers generally work greater than the minimum hours.

Both districts are exploring ways of easing the burden on anaesthetists in order to better utilise their skills and expertise. For example, expanding nurse practitioner scopes of practice to include providing pain management services for patients that are currently provided by anaesthetists. Pending a successful evaluation, the districts anticipate that these changes will allow anaesthetists to spend more time in theatres supporting planned surgery and may, in combination with other efforts to streamline anaesthetists' roles, allow the districts to schedule additional planned surgery lists.

Regional hospitals face an additional challenge in attracting qualified anaesthetists to their towns. For this reason, many regional hospitals employ rural general practitioner anaesthetists to provide sedation to patients for minor, uncomplicated surgical procedures. In doing so, the rural general practitioner anaesthetists reduce the burden on specialist anaesthetists. However, this audit identified some regional variation in implementing this approach. For example, Tamworth Hospital has not endorsed this strategy, unlike other regional hospitals in the district. Reviewing whether this variation in practice within a district is warranted may be an option.

In August 2022, the Surgical Care Governance Taskforce identified the anaesthetist shortage as a key risk to the system's capacity to deliver planned surgery. The taskforce identified a need to increase the number of specialist anaesthetist fellows by between 6 and 15 per year until 2036 and anticipated the development of a strategy to achieve this outcome. The Ministry of Health reports that, in the absence of a formal strategy, actions have been taken to address the shortage through providing incentives for internationally trained anaesthetists to fill positions in areas of need. It further reports that it continues to discuss increasing the number of trainee places with the Australian and New Zealand College of Anaesthetists.

Regional hospitals experience distinct workforce challenges

Regional hospitals experience acute shortages in other parts of their specialist medical workforce. For example, Tamworth Hospital did not have an ENT specialist for the 8 years prior to 2022, which limited options available for patients requiring ENT surgery in the New England region.

In 2022, the NSW Parliamentary Inquiry into Health Outcomes and Access to Health and Hospital Services in Rural, Regional and Remote New South Wales published a report that highlighted health-sector workforce issues in regional NSW. In 2023, the Ministry of Health published its Regional Health Strategic Plan 2022–32 which identified priority areas and associated targets. Progress against the targets for each priority area are publicly reported in annual progress snapshots.

The first priority in the Ministry of Health’s plan is to strengthen the regional workforce by targeting regional workforce supply issues with supports such as training and upskilling of clinical staff and investments to improve recruitment and retention, including incentive benefits for hard-to-fill and critical roles and key worker accommodation. These initiatives are not specifically directed towards planned surgery services in regional NSW but are nevertheless expected to alleviate staff recruitment and retention challenges affecting planned surgery delivery.

Hospitals over-recruit medical roles to account for attrition and reduce the risk of workforce shortages

Junior doctors are doctors who are not yet trained through a specialist medical college and rotate through hospital departments as part of training. They are a core component of a hospital’s surgical workforce. The medical recruitment year for junior doctors commences each February. Towards the end of the previous year, junior doctors seek appointment as senior doctors and often leave junior doctor roles for permanent positions at other hospitals. Therefore, there is high attrition in junior doctor roles towards the end of the calendar year. The local health districts reviewed for this audit reported that, during this time, workforce shortages are at their worst and compounded by the limited ability to recruit doctors to fill vacant positions until the following February. All hospitals are vying to recruit from the same limited pool of available doctors, and hospitals may need to rely on locums to fill these gaps later in the year, attracting a premium cost.

Hunter New England Local Health District has recently implemented a strategy to over-recruit for junior surgical roles at the beginning of the 2026 year to account for successful candidates who are offered roles, but withdraw, as well as for expected attrition later in the year. The district anticipates that this will help ensure that it maintains capacity to keep services running throughout the year, with fewer cancellations of surgical lists and delays to patients’ surgeries.

In a similar strategy, aimed at addressing attrition risk and to account for expected withdrawals, Campbelltown Hospital in South Western Sydney over-recruits for visiting medical officer anaesthetists on minimum-hour contracts. Campbelltown Hospital also recruits Career Medical Officers – experienced doctors who have chosen not to specialise – at regular points throughout the year to cover the shortages arising from attrition.

6. Planned surgery access data quality

This report relies on waitlist data collected and maintained by the Ministry of Health. This chapter provides an assessment of the quality of that data.

NSW Health planned surgery data is generally fit for purpose

The Ministry of Health maintains the Wait List Data Stream, which contains information on all patients currently on the planned surgery waitlist in NSW public hospitals, as well as cancellations and removals from the planned surgery waitlist. Data is updated via a monthly extract from local health districts' patient administration systems. The Ministry of Health administers a series of system logic and completeness checks to the uploaded data and requires districts to correct errors within a 5-day window each month. As the Ministry of Health upgrades its data warehouses, error correcting is expected to be a more incremental task, resulting in fewer errors outstanding prior to the final upload to the Wait List Data Stream. Upgrades to data warehouses and medical records systems will also eliminate errors in calculating wait times for patients with periods of time that they are not ready for their surgery and changes in their clinical urgency category.

The Bureau of Health Information (BHI) is the NSW Health organisation charged with publishing regular information about the performance of the health system and advising the Minister and the Ministry of Health on the quality of key health datasets. The BHI extracts a copy of Ministry of Health planned surgery data from the Wait List Data Stream and conducts high-level quality assurance to assess reliability and validity prior to publication of the healthcare quarterly report. It engages with the Ministry of Health on actual or potential issues with data, such as impacts of industrial action, hospital or service-level changes, or changes in policy. The BHI has not flagged any issues with planned surgery access data over the review period and reports that it considers the data to be of high quality.

While Ministry of Health and BHI validity checks work to ensure that waitlist data is consistent and understood over time, both agencies are reliant on practices at local health districts. Nevertheless, the waitlist data is of reasonably high quality and fit for the purposes of monitoring and managing planned surgery access performance.

Local health district administration of planned surgery lacks preventative controls for managing the risks of non-compliance with the planned surgery access policy and the 'treat in turn' principle

The administration of planned surgery is reliant on paper Recommendation for Admission forms submitted by surgeons to the hospital. Hospital administrative staff receive the forms, date stamp them and then enter the data into the patient administration system within 3 business days. The planned surgery access policy sets out a minimum dataset that must be obtained to validly create a waitlist record for a patient within the patient administration system. Local health district staff are reliant on locally developed checklists, in the absence of electronic completeness and validity rules, to ensure that the minimum required data is correctly entered into the system.

The older patient administration systems at the 2 local health districts reviewed for this audit, which are of similar age to those used in the rest of the state, are not configured with segregation of duties controls and workflow approvals for changes to key fields such as clinical urgency category. This lack of preventative controls is significant as changes to these fields can affect the apparent planned surgery access performance of local health districts. The absence of preventative controls at the point of data entry means that local health districts are reliant on compensating ad hoc and routine detective controls to identify non-compliance with the 'treat in turn' principle.

A system of mandated, routine and ad hoc audits and reviews provides compensating controls over waitlist accuracy but could be improved

The planned surgery access policy requires local health districts to undertake a series of weekly, monthly and quarterly clerical reviews and audits of waitlist data to ensure accuracy. The audits maintain the accuracy of the list once it is entered into the patient administration system. Both local health districts reviewed for this review undertook these audits as required throughout the audit period.

Clerical reviews are supplemented by ad hoc reviews conducted by local health district internal audit divisions, sometimes with assistance or direction from the Ministry of Health. In the absence of preventative and system-enabled controls, these reviews provide an important compensating control. Both the Ministry of Health and local health districts are responsive to adverse findings of ad hoc reviews. None of the audits reviewed by this audit indicated systemic manipulation of waitlist data, and errors were attributed to mistake and misunderstanding of required processes. NSW Health does not currently require internal audits or similar compliance assurance reviews to be conducted at each district on a regular basis, nor is there a standardised control testing methodology for these reviews.

The planned surgery access policy states that clinical urgency categorisation should only be changed for clinical reasons. However, a consistent finding of ad hoc reviews is that clinical urgency categorisation is changed from more to less urgent due to operational and capacity issues. This is more likely to occur as patients approach the date on which they are recommended to have surgery. This pattern of changes in clinical urgency categorisation is inconsistent with holding local health districts properly accountable for waitlist performance. In September 2025, the Ministry of Health updated its planned surgery access policy, introducing facility-level clinical review panels. In the future, these panels may provide greater assurance that there are appropriate clinical reasons for a clinical urgency category deviating from NSW Health's recommended clinical urgency. Additional guidance to local health districts on establishing a regular pattern of ad hoc reviews will assist the clinical review panels achieve their purpose.

Appendix 1 – Response from entity

Response from NSW Health

NSW Health



Ref: H26/27266

Mr Bola Oyetunji
Auditor-General for New South Wales

NSW Health Response to the Planned Surgery Access Performance Audit Report

Dear Mr Oyetunji,

Thank you for the opportunity to respond to your Planned Surgery Access performance audit report.

I welcome the focus that this audit has given to the complexities of managing access to planned surgery in public hospitals and accept the recommendations made. The findings will be used to inform initiatives being implemented to enhance management of planned surgery across the State.

The reduction of planned surgery waiting times has been a significant focus for the NSW Health system, following the pauses to planned surgery during the COVID-19 pandemic. I am pleased to see the outcomes of this work reflected in this audit report and affirm that the monitoring of waiting times will remain a focus.

For context, it is important to note that planned surgeries are prioritised according to the clinical urgency category timeframe, which is allocated by the treating doctor. Only the treating doctor or delegate can change this timeframe, based on objective clinical evidence. The scheduling of patients is undertaken in consultation with the treating surgeon, to ensure that patients with the greatest clinical need are prioritised. Patients needing urgent surgery take precedence which may affect other patients, including delaying their surgery and this may impact on the interpretation of performance data. A decision to postpone surgery is only made after all other options are exhausted and following consultation with the treating doctor. The choice of the patient is also a critical factor in this decision and where the option to postpone surgery is taken, it is rescheduled as quickly as possible.

In collaboration with the Local Health Districts and Specialty Networks, the Ministry of Health has been leading the development of strategies to further enhance access to planned surgery statewide, including delivery of the following initiatives:

- Local Health Districts and Specialty Networks have secured funding to reduce overdue surgery by increasing surgery throughput by purchasing new equipment or establishing a high-volume short stay surgery program and introduce programs aimed at providing high-value, non-surgical care options to ensure timely access to appropriate care for patients.
- Providing an option for patients to have surgery sooner at another public or private hospital where clinically appropriate.
- The use of pooled lists to maximise available capacity supported with extended theatre sessions where workforce and clinical appropriateness allow.
- Completion of a series of waitlist policy compliance audits.
- Empowering clinicians to make evidence-based decisions for alternative treatments for some patients where surgery may not be beneficial.

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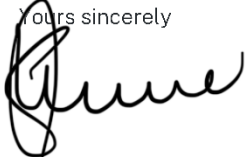
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health.nsw.gov.au

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Further initiatives are being considered in this area and NSW Health will continue to work to ensure patients receive their clinically recommended surgery within their allocated timeframe.

I appreciate the support offered by the Audit Office of NSW during this audit program.

Yours sincerely



Susan Pearce AM
Secretary, NSW Health

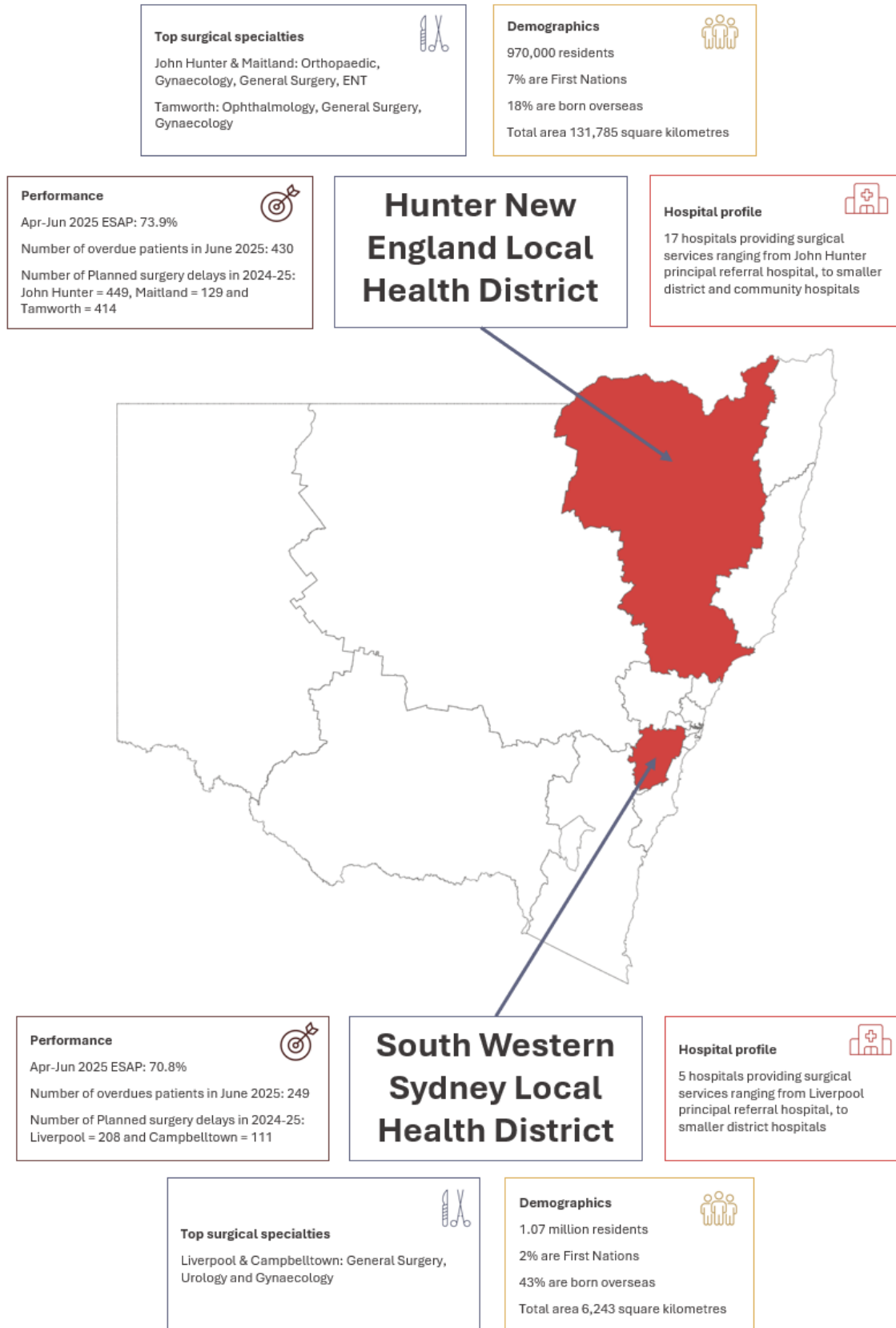
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Encl. NSW Health response to report recommendations

Recommendation	Responsibility	Position	Agency Response
By June 2027, the Ministry of Health should:			
<p>1. Define additional efficiency performance targets for inclusion in service agreements with local health districts for the delivery of planned surgery by expanding and enforcing the current set of international benchmarks for surgical productivity.</p>	Ministry of Health	Accept	<p>The Ministry is currently in the process of defining additional efficiency performance targets which includes additional same day surgery targets based on British Association of Day Surgery benchmarks and surgical throughput. These additional same day surgery targets will be incorporated into the FY 27 Service Level Agreement with the districts A dashboard to provide State view of throughput of procedures in operating theatres is currently under development to facilitate monitoring.</p>
<p>2. Identify and determine the planned surgery service delivery models that achieve greater efficiencies and surgical throughput, and target policy and investment accordingly.</p>	Ministry of Health	Accept	<p>Recent allocation of funding to support high volume surgical short stay units and surgical avoidance is due for formative evaluation in end of FY26. Outcome of the evaluation will inform next steps.</p> <p>Additional funding also supported non-surgical alternative models of care for example Osteoarthritis Chronic Care Program (OACCP) and Post-Operative Discharge Support Services (PODDS) which will similarly be evaluated for effectiveness and scaled where appropriate.</p>

Recommendation	Responsibility	Position	Agency Response
<p>3. To supplement current clerical reviews, develop risk-based guidance for local health districts to conduct:</p> <ul style="list-style-type: none"> a) regular, sample-based compliance reviews of clinical urgency categorisation changes to support clinical review panels b) periodic internal audits of planned surgery waitlist management and compliance 	Ministry of Health	Accept	Self-assessments are already available for sites to assess performance and compliance against planned surgery policy. Additional information can be developed in consultation with sites to identify what further information or guidance is required.

Appendix 2 – Reviewed local health district profiles



Appendix 3 – Data tables

This appendix contains information on planned surgery access activity and performance. Data was provided by the Ministry of Health.

Exhibit A3.1 – Overdue surgery performance by clinical urgency category

Local health district or specialty health network	June 2023, overdue patients			June 2024, overdue patients			June 2025, overdue patients		
	1	2	3	1	2	3	1	2	3
Central Coast	0	10	6	<5	60	55	<5	66	68
Far West	0	<5	17	0	<5	13	0	6	7
Hunter New England	0	301	539	0	225	328	0	156	274
Illawarra Shoalhaven	0	135	268	0	86	148	0	55	101
Mid North Coast	<5	99	584	<5	16	78	0	0	124
Murrumbidgee	<5	95	497	0	8	10	<5	107	370
Nepean Blue Mountains	0	366	605	0	0	0	0	0	0
Northern NSW	<5	343	450	<5	82	63	0	110	84
Northern Sydney	0	127	310	<5	<5	11	0	<5	23
South Eastern Sydney	0	334	497	0	95	98	0	158	339
South Western Sydney	0	455	939	0	158	182	0	144	105
Southern NSW	0	0	0	0	0	<5	0	11	70
St Vincents	0	35	23	0	0	0	0	0	0
Sydney Children's Hospital	0	264	692	0	<5	45	0	16	67
Sydney	0	0	0	0	0	0	0	<5	0
Western NSW	0	62	96	<5	<5	28	<5	<5	67
Western Sydney	0	497	461	0	62	<5	0	0	<5

Source: Audit Office of New South Wales analysis of Bureau of Health Information data.

Exhibit A3.2 – ESAP for local health districts across all urgency categories

Local health district or speciality health network	Apr–Jun 2023, ESAP %	Apr–Jun 2024, ESAP %	Apr–Jun 2025, ESAP % *
Central Coast	74.0%	86.7%	75.4%
Far West	87.5%	82.9%	70.8%
Hunter New England	87.1%	88.1%	73.9%
Illawarra Shoalhaven	76.6%	84.2%	79.9%
Mid North Coast	73.6%	85.5%	68.7%
Murrumbidgee	67.7%	84.3%	71.7%
Nepean Blue Mountains	71.3%	79.0%	83.7%
Northern NSW	76.4%	81.0%	75.2%
Northern Sydney	85.3%	90.2%	81.0%
South Eastern Sydney	66.5%	82.9%	62.0%
South Western Sydney	74.3%	82.0%	70.8%
Southern NSW	94.5%	100.0%	94.4%
St Vincent's Health	83.1%	98.1%	95.3%
Sydney Children's Hospitals	73.9%	88.9%	82.8%
Sydney	95.2%	99.8%	99.2%
Western NSW	86.0%	90.8%	81.3%
Western Sydney	76.8%	85.0%	72.1%

* ESAP was changed from a KPI to an improvement measure for 2024–25.

Source: Audit Office of New South Wales analysis of Bureau of Health Information data.

Appendix 4 – About the audit

Audit objective

This audit assessed whether NSW Health efficiently and effectively provides access to planned surgery to public patients across the state.

Audit criteria

We addressed the audit objective by examining the following lines of inquiry and criteria.

1. Does NSW Health have effective policies, processes and data to manage planned surgery access?
 - a) NSW Health collects accurate and reliable data to understand planned surgery access
 - b) NSW Health provides relevant information to patients and clinicians to inform decisions to access planned surgery in the public health system
 - c) The Ministry of Health ensures that planned surgery access and related policies are designed well to deliver timely and equitable access to planned surgery and are operating effectively in local health districts
 - d) The Ministry of Health effectively monitors and manages local health district planned surgery access performance and efficiency.
2. Is NSW Health effectively and efficiently managing planned surgery waitlists?
 - a) Selected local health districts maintain complete, accurate and up-to-date waitlist information
 - b) Selected local health districts understand the demand for, and supply of, planned surgery within the district
 - c) NSW Health develops and implements effective and efficient procedures, plans and strategies to manage access to planned surgeries
 - d) Local health districts achieve planned surgery access performance expectations.

Audit scope and focus

This audit focused on assessing whether NSW Health efficiently and effectively provides access to planned surgery to public patients across the state. The audit considered the Ministry of Health's role in overseeing and supporting local health districts' management of planned surgery. Activity-based funding cost information was used to determine the efficient delivery of planned surgery.

The main period of focus for this audit was from January 2022 to December 2025.

South Western Sydney and Hunter New England Local Health Districts were selected to provide focus and illustrative examples of local waitlist management activities and challenges in providing patients with timely access to planned surgery, in both a metropolitan and regional NSW context. These 2 districts were selected based on the following considerations.

- Setting and location of the district's hospital facilities (metropolitan, rural and remote)
- Planned surgery access performance of hospital facilities
- Local First Nations populations and planned surgery access performance compared to wider populations
- Demographic factors, including population growth and ageing, socioeconomic disadvantage, and cultural and linguistically diverse communities
- Prevalence of outsourcing arrangements with private hospitals and cross-border arrangements.

See Appendix 2 for further details on the selected local health districts.

The 3 surgical specialties of Ear, Nose and Throat, Ophthalmology and Orthopaedics were selected to focus the audit's inquiries at the selected local health districts and hospitals. These specialties contain high-volume procedures such as cataract surgery, hip and knee replacements, tonsil removals and grommet insertions. These procedures account for a high proportion of patients on the waitlist and overdue for surgery.

Audit exclusions

The audit did not question the merits of government policy objectives.

The audit also did not examine the following topics.

- Operations of private hospitals that have been contracted to provide planned surgeries on behalf of NSW Health
- Appropriateness of clinical decision-making, such as the initial allocation of clinical urgency category by the treating specialist doctor. However, the audit will consider how NSW Health assures itself that clinical decision-making is appropriate.

Audit approach

The audit's procedures included the following.

1. Interviewing Ministry of Health and local health district staff responsible for designing and administering planned surgery access policy.
The audit also involved consultation with other stakeholders, including:
 - Bureau of Health Information
 - Agency for Clinical Innovation
 - Clinical Excellence Commission
2. Examining key documents, including:
 - Papers from Ministry of Health planned surgery access committees
 - Planned surgery access policy and related documents
 - Performance management documents
3. Analysing planned surgery waitlist data.

The audit also examined:

- documentation from other stakeholders obtained throughout the audit, such as research and studies, statistical data and analysis
- information from other jurisdictions for comparison.

The audit approach was complemented by quality assurance processes within the Audit Office of New South Wales to ensure compliance with professional standards.

Audit methodology

Our performance audit methodology is designed to satisfy Australian Auditing Standard ASAE 3500 Performance Engagements and other professional standards. The standards require the audit team to comply with relevant ethical requirements and plan and perform the audit to obtain reasonable assurance and draw a conclusion on the audit objective. Our processes have also been designed to comply with requirements specified in the *Government Sector Audit Act 1983* and the *Local Government Act 1993*.

Acknowledgements

We gratefully acknowledge the cooperation and assistance provided by staff at the Ministry of Health and the reviewed local health districts.

Audit cost

The estimated cost of the audit, including staff costs and overheads, is approximately \$520,000.

Appendix 5 – Performance auditing

What are performance audits?

Performance audits assess whether the activities of state or local government entities are being carried out effectively, economically, efficiently and in compliance with relevant laws.

The activities examined by a performance audit may include a government program, all or part of an audited entity, or more than one entity. A performance audit can also consider particular issues that affect the whole public sector and/or the whole local government sector. They cannot question the merits of government policy objectives.

The Auditor-General's mandate to undertake audits is set out in the *Government Sector Audit Act 1983* for state government entities, and in the *Local Government Act 1993* for local government entities. This mandate includes audit of non-government sector entities where these entities have received money or other resources (whether directly or indirectly) from, or on behalf of, a government entity for a particular purpose (follow-the-dollar).

Why do we conduct performance audits?

Performance audits provide independent assurance to the NSW Parliament and the public.

Through their recommendations, performance audits seek to improve the value for money the community receives from government services.

Performance audits are selected at the discretion of the Auditor-General who seeks input from parliamentarians, state and local government entities, other interested stakeholders and Audit Office research.

How are performance audits selected?

When selecting and scoping topics, we aim to choose topics that reflect the interests of Parliament in holding the government to account. Performance audits are selected at the discretion of the Auditor-General based on our own research, suggestions from the public, and in consultation with parliamentarians, agency heads and key government stakeholders. Our three-year performance audit program is published on the website and is reviewed annually to ensure it continues to address significant issues of interest to Parliament, aligns with government priorities and reflects contemporary thinking on public sector management. Our program is sufficiently flexible to allow us to respond readily to any emerging issues.

What happens during the phases of a performance audit?

Performance audits have three key phases: planning, fieldwork and report writing.

During the planning phase, the audit team develops an understanding of the audit topic and responsible entities and defines the objective and scope of the audit.

The planning phase also identifies the audit criteria. These are standards of performance against which the audited entity, program or activities are assessed. Criteria may be based on relevant legislation, internal policies and procedures, industry standards, best practice, government targets, benchmarks or published guidelines.

During the fieldwork phase, audit teams will require access to books, records or any documentation deemed necessary in the conduct of the audit, including confidential information that is either Cabinet information within the meaning of the *Government Information (Public Access) Act 2009* or information that could be subject to a claim of privilege by the state or a public official in a court of law. Confidential information will not be disclosed, unless authorised by the Auditor-General.

At the completion of fieldwork, the audit team meets with management representatives to discuss all significant matters arising from the audit. Following this, a draft performance audit report is prepared.

The audit team then meets with management representatives to check that facts presented in the draft report are accurate and to seek input into developing practical recommendations on areas of improvement.

A final report is then provided to the accountable authority of the audited entity(ies), which will be invited to formally respond to the report. If the audit includes a follow-the-dollar component, the final report will also be provided to the governing body of the relevant entity. The report presented to the NSW Parliament includes any response from the accountable authority of the audited entity. The relevant Minister and the Treasurer are also provided with a copy of the final report for state government entities. For local government entities, the Secretary of the Department of Planning and Environment, the Minister for Local Government and other responsible Ministers will also be provided with a copy of the report. In performance audits that involve multiple entities, there may be responses from more than one audited entity or from a nominated coordinating entity.

Who checks to see if recommendations have been implemented?

After the report is presented to the NSW Parliament, it is usual for the entity's Audit and Risk Committee/Audit Risk and Improvement Committee to monitor progress with the implementation of recommendations.

In addition, it is the practice of NSW Parliament's Public Accounts Committee to conduct reviews or hold inquiries into matters raised in performance audit reports. The reviews and inquiries are usually held 12 months after the report received by the NSW Parliament. These reports are available on the NSW Parliament website.

Who audits the auditors?

Our performance audits are subject to internal and external quality reviews against relevant Australian standards.

The Public Accounts Committee appoints an independent reviewer to report on compliance with auditing practices and standards every 4 years. The reviewer's report is presented to the NSW Parliament and available on its website.

Periodic peer reviews by other Audit Offices test our activities against relevant standards and better practice.

Each audit is subject to internal review prior to its release.

Who pays for performance audits?

No fee is charged to entities for performance audits. Our performance audit services are funded by the NSW Parliament.

Further information and copies of reports

For further information, including copies of performance audit reports and a list of audits currently in-progress, please see our website www.audit.nsw.gov.au or contact us on 9275 7100.

OUR VISION

Our insights inform and challenge government to improve outcomes for citizens.

OUR PURPOSE

To help Parliament hold government accountable for its use of public resources.

OUR VALUES

Pride in purpose
Curious and open-minded
Valuing people
Contagious integrity
Courage (even when it's uncomfortable)



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