

Waiting Time and Elective Patient Management Policy

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Summary The Waiting Time and Elective Patient Management Policy is the reference guide for facilities to manage elective surgical and medical waiting lists. The policy covers the procedures that facilities are required to follow to adequately manage waiting lists.

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This Policy Directive may be varied, withdrawn or replaced at any time. Compliance with this directive is **mandatory** for NSW Health and is a condition of subsidy for public health organisations.

***WAITING TIME AND ELECTIVE PATIENT MANAGEMENT
POLICY***



Managing elective patients and waiting lists in NSW public hospitals

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1. INTRODUCTION

Each year approximately 200,000 patients have elective/procedures surgery in NSW public hospitals. Patients are placed on a waiting list and given a clinical priority depending on the seriousness of their condition. Clinical priority categories 1, 2, 3 referred to in the document align with Commonwealth Categories in the National Data Dictionary.

Managing elective patients and waiting lists is a key priority for the Government and NSW Health. The community insists on transparency and accountability. Patients expect timely, accessible and high quality patient centred services.

Waiting list management is a challenging, dynamic and complex process requiring input from and coordination by a multidisciplinary team.

The Waiting Time and Elective Patient Management Policy has been developed to promote clinically appropriate, consistent & equitable management of elective patients and waiting lists in public hospitals across NSW. Hospitals must actively manage in compliance with the contents of this document.

The Chief Executive or hospital delegate has overall responsibility for ensuring:

- There are mechanisms in place to implement this policy
- Compliance with NSW Health Department requirements
- Validation of the accuracy and integrity of reported data
- Regular review of individual hospital performance
- Training and education programs are in place for staff involved in managing elective patients and waiting lists
- All patients requiring surgery or procedures regardless of admission type will be recorded on the Patient Administration System (PAS)

Consistent, equitable and efficient waiting list management through the application of this policy is expected to achieve the following outcomes:

- A transparent, patient focused process
- Well informed patients and staff (clinical and non clinical) who understand the process, their roles and responsibilities
- Patients are assigned to the correct clinical priority category
- Patients are treated within clinically appropriate timeframes
- There is timely notification and effective communication with the patient in relation to their planned admission date for surgery and practical arrangements
- Active management of patients and their waiting list booking
- Appropriate and timely removal of patients from the waiting list
- Accurate data collection and documentation
- Accurate and timely auditing and reporting
- Regular system evaluation, monitoring and improvement
- Efficient and effective management of demand vs resource to promote the most effective use of available resources
- Access to treatment is based on clinical need regardless of health insurance status

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2. REFERRING PATIENTS TO THE WAITING LIST

P O L I C Y	<ul style="list-style-type: none"> • Recommendation for Admission Form (RFA) only accepted from clinicians who are currently contracted and appropriately credentialed with the Area Health Service or facility • Recommendation for Admission Form (RFA) must be complete, legible and accurate
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The referring doctor must:

- Have fully informed the patient about the planned procedure or treatment and obtained their consent (see PD 2005_406)
- Complete an approved Recommendation for Admission Form (RFA)
- Forward the completed RFA to facility within 3 working days

2.1. Clinical Priority Categories

Categorisation of Elective patients by clinical priority is required to ensure they receive care in a timely and clinically appropriate manner. A Clinical priority category is assigned by the referring doctor.

Clinical Priorities are:

Clinical Priority Category <i>A clinical assessment of the priority with which a patient requires elective admission</i>		
Category 1	Admission within 30 days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency	Ready for Care
Category 2	Admission within 90 days desirable for a condition which is not likely to deteriorate quickly or become an emergency	
Category 3	Admission within 365 days acceptable for a condition which is unlikely to deteriorate quickly and which has little potential to become an emergency	
Category 4	Patients who are either clinically not ready for admission (staged) and those who have deferred admission for personal reasons (deferred)	Not Ready for Care

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2.1.1. Reclassification of Clinical Priority Category

Documented evidence must be readily available to validate any changes to a patient's clinical priority category. Documentation must be signed by the relevant staff member and include **date and time** of notification of priority change, the **person notifying** priority change, **reason** for priority change (Appendix 10).

If there is no supporting clinical information supplied then the referring doctor should be contacted to provide the additional clinical information that supports the selected Clinical Priority Category (CPC). In addition there should be an escalation process to a senior manager where clinical information is missing.

Only an authorised doctor may undertake reclassification of patients between categories 1, 2 and 3.

The referring doctor is to be notified, in writing (appendix 6a), of any change to the original clinical priority category that was assigned.

Additionally, for Category 4 patients the **status review date** is recorded.

The documentation must be attached to or be part of the RFA and will become part of the patient's medical record. The electronic waiting list must be updated with any changes.

2.2. Urgent Surgery - Inclusion/Exclusion Criteria

The Category 1 Clinical Priority Category is specifically reserved for those patients whose clinical condition has the potential to deteriorate to the point that an emergency admission may eventuate if the condition is not treated within 30 days.

This category is **not** to be used to advance the date for **elective** surgery patients whose clinical condition is not likely to become an **emergency** e.g. vasectomy, joint replacement surgery, routine cataract surgery, routine tonsillectomy, removal of pins and plates unless for extenuating clinical reasons which have been discussed with senior management or the Area Program Director of Surgery or equivalent.

Where there is concern regarding the allocation of the Category 1 status, the issue should be referred to senior management and the Area Program Director of Surgery.

Refer to "Advice for Referring and Treating Doctors" booklet for further information, IB2009_018.

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2.3. Cosmetic & Discretionary Surgery - Inclusion/Exclusion Criteria

Surgery should meet an identified clinical need to improve the physical health of the patient.

- The approval of the Area Program Director of Surgery, in consultation with senior management should be sought by the referring doctor before cosmetic and discretionary procedures are undertaken in any public hospital facility
- The referring doctor should document on the Request for Admission form, at the time a patient is referred, objective medical criteria supporting the decision for surgery for all procedures that may be considered cosmetic or discretionary. This requirement supports appropriate documentation of clinical decision-making and the review process
- For procedures not appearing on the list below or where there is doubt about the nature of the proposed surgery, the request should be referred to the Area Program Director of Surgery for review prior to the patient being added to the waiting list. Advice from the Medicare Claims Review Panel can be sought for Cosmetic Surgery procedures (section 3 – Medicare Benefits Schedule (Mediguide) <http://www.medicareaustralia.au>).

The following list of surgical procedures should not routinely be performed in public hospitals in NSW unless there is a clear clinical need to improve a patient's physical health.

Cosmetic Procedure	Exception
Bilateral breast reduction	Severe Disability due to breast size
Hair transplant	Disfiguring Hair loss due to Severe Burn
Blepharoplasty/Reduction of upper or lower eyelid	Severe Visual Impairment
Total rhinoplasty	Major Facial Trauma - Congenital abnormality – paediatrics
Liposuction	Nil
Abdominal lipectomy (Abdominoplasty)	Nil
Bilateral breast augmentation	Nil
Meloplasty/Facelifts	Nil
Correction of bat ear (>16 years old)	Nil
Tattoo removal procedure	Nil
Removal of benign moles	Nil
Candela Laser	Congenital abnormality – paediatrics < 17 years
Varicose Veins	CEAP Grade > C2 (See classification page 52)
Laser photocoagulation	Nil

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Discretionary Procedure	Exception
Gender reassignment surgery	Congenital abnormalities in children
Lengthening of penis procedure	Congenital abnormalities in children
Insertion of artificial erection devices	Nil
Reversal of sterilization	Nil
Social circumcision	Nil
Oral Arthrocentesis	Nil

New Procedures and Prostheses

An Area New Interventions Assessment Committee or equivalent must formally approve new procedures not previously undertaken and the clinicians should be appropriately credentialed by relevant committee to undertake the procedure before patients are added to the waiting list. A doctor may only refer patients for addition to the waiting list for procedures for which the doctor has been given privileges by the relevant credentials committee.

For additional information refer to:

- Department of Health Policy Directive - Model Policy for the Safe Introduction of New Interventional Procedures into Clinical Practice, PD 2005_333
- RACS/ASERNIP-S <http://www.surgeons.org/asernip-s/>

Monitoring and Reporting

Monitoring of the addition of these excluded procedures to the waiting list will be undertaken by each Area Health Service as part of normal waiting list management according to NSW Health Department policy.

Bariatric Surgery

All patients wishing to access bariatric surgery in the public health system will be required to attend a designated multidisciplinary bariatric clinic. Patients will be considered for bariatric surgery following assessment and approval from the multidisciplinary team after all non-surgical options have been exhausted.

Dental Surgery

For operating lists that are dedicated to the Priority Oral Health Program – patients must be eligible for treatment as identified in the NSW Eligibility of Persons for Public Oral Health Care Policy Directive (PD2008_066).

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2.4. Completion of Recommendation for Admission Form (RFA)

- The following minimum data set on the Recommendation for Admission Form (RFA) is to be obtained by:

Referring Doctor	Admissions Staff
<ul style="list-style-type: none"> Patient's full name Patient's address Patient's contact information Patient's gender Patient's date of birth Medicare number Clinical priority category Discharge intention (i.e. day only, or indication of number of nights in hospital) Presenting problem Planned procedure/treatment Significant medical history (including allergies) Treating doctor (if different) Patient's signed consent (if available) Local medical officer's name and address (if available) 	<ul style="list-style-type: none"> Interpreter required Planned admission date (if allocated) Anticipated election status Status review date (staged patients) Short notice/Standby offers (see 5.6)

Any other relevant information should be included on the RFA e.g.

- Estimated operating time
- (especially if expected that the procedure will be outside benchmark timeframes)
- Special operating theatre equipment
- Requirement for an ICU/HDU bed post procedure

The referring doctor must:

- Forward the completed RFA direct to the hospital within 3 working days of seeing the patient (via the most relevant means e.g. mail, hand delivery, by patient or carer)
- Where patients require additional time to consider their options, the referring doctor must organise for the completed RFA to be forwarded within 3 working days of the patient's acceptance of the surgical option
- Expedite the transmission of RFA's for any urgent admissions e.g. patients in Category 1 (admission within 30 days)
- Where an urgent admission is requested, a facsimile can be used to communicate the information required and expedite receipt of the required information from the referring doctor's rooms or clinic

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2.5. Information for Patients

P O L I C Y	<ul style="list-style-type: none"> • Patients must be fully informed about the risks and benefits of the procedure and have consented to the treatment offered • Patient’s consent should ideally be obtained prior to placing the patient on the waiting list and not deferred to time of admission or pre-admission clinic • Consent must be confirmed in writing by having the patient sign the consent form included in the Recommendation for Admission Form (RFA) • Public patients are patients of the relevant public hospital, not of a particular doctor. All public patients must be told that their treatment will be provided by a hospital appointed doctor, not a doctor of their choice. This must be explained when they agree to be treated as a public patient
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The referring doctor **must** provide information to patients as follows:

- Explain the procedure/treatment:
 - What is involved
 - The risks associated with the proposed procedure/treatment
 - Other options for management of the condition
 - The need for consent
- Explain the waiting list:
 - The reason for referral to the waiting list
 - The waiting list process, including clinical priority categories
 - The circumstances in which care might be provided by another doctor or health service
 - That prioritisation is according to clinical need, regardless of whether the patient elects to be treated as a public or private patient
- Explain difference between admission as public or private patient:
 - provide the patient with sufficient information to enable them to choose whether to be treated as a private or public patient
 - where a patient elects to be treated as a private patient, the referring doctor must also ensure the patient is advised of the associated costs of treatment and that priority of treatment will be based on clinical priority regardless of insurance status

***Consent should be obtained in line with
Department of Health Policy Directive PD2005_406
Consent to Medical Treatment – Patient Information***

3. ACCEPTANCE OF RECOMMENDATION FOR ADMISSION FORM (RFA)

P O L I C Y	<ul style="list-style-type: none"> • Patients can be added to the electronic waiting list provided: <ul style="list-style-type: none"> ○ RFA forms are complete, accurate, legible and date stamped ○ The procedure can be undertaken within Clinical Priority Timeframes ○ Any requirements for variations from standard bookings are met • Patients should be placed on the electronic waiting list within 3 working days of receipt of a completed RFA • An RFA with a planned admission date of >12 months will not be accepted • An RFA will not be accepted if at the time of lodgement the patient is Not Ready for Care for personal reasons (Deferred)
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3.1. Completeness, Accuracy and Legibility

When RFA forms are received from the referring doctor, they should be examined by hospital staff to ensure completeness, accuracy and legibility of the relevant information. (Section 2.4 lists the minimum data set required for acceptance)

- RFA forms must be **date stamped** upon receipt
- It is recommended to use the RFA Checklist (Appendix 11) when in receipt of RFAs to ensure that they are complete appropriately or escalated to senior manager
- When information is missing on the RFA, a telephone call to the referring doctor may be an appropriate option to ascertain the missing information
- If minimum data set items are not provided or are illegible, the information should be **immediately sought** in writing from the referring doctor (Appendix 1)
- Where there is a query about the appropriateness of the CPC, a discussion should occur immediately between the referring doctor and senior management to resolve the issue and ensure that the patient is added to the waiting list within 3 working days
- The original RFA should not be sent back to the referring doctor if there is missing information. A copy of the RFA and incomplete RFA letter proforma (Appendix 1) should be used. This is to ensure that the RFA is not lost or misplaced for medicolegal reasons
- Ideally, the referring doctor should have obtained patient's consent prior to placing the patient on the waiting list and not deferred to time of admission or pre-admission clinic
- The hospital is **not obliged** to add a patient to its waiting list if information is incomplete, but patient circumstances should be considered
- The original listing date stamped on the RFA should be used when adding the RFA to the PAS
- An RFA will not be accepted if at the time of lodgement the patient is Not Ready for Care for personal reasons

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- If there are problems with a RFA, the hospital **must advise** the referring doctor **immediately**. Patients should not be asked to ferry the RFA between hospital and referring doctor. Communications about missing minimum data set information should be between the referring doctor and the hospital
- Arrangements should be in place to ensure equitable access to services for all eligible persons, regardless of their geographical location as per the Australian Health Care Agreement

3.2. Clinical Priority Timeframes

- Referring doctors must ensure they are available to perform the procedure within the clinical priority timeframe. Alternatively, the clinician should make arrangements for another clinician to perform the procedure within the appropriate clinical timeframe
- Where the surgeon does not have the capacity to undertake the procedure in the clinical priority timeframe or has not organised an alternative options, then the case should be escalated to senior management to explore alternative options for treatment

3.3. Variations from Standard Bookings

- **Procedure/treatment not provided** - if a procedure/treatment is not provided at the hospital nominated on the RFA, the RFA cannot be accepted. The referring doctor should be informed and alternative arrangements negotiated with senior management before accepting a revised RFA
- **New Procedures** - an Area New Interventions Assessment Committee or equivalent must formally approve new procedures. The RFA is not to be accepted by the hospital until approval for the procedure is given. A copy of the decision is to be forwarded to the hospital's admissions manager
- **For additional information refer to:**
 - * Department of Health Policy Directive - Model Policy for the Safe Introduction of New Interventional Procedures into Clinical Practice, PD 2005_333
 - * RACS/ASERNIP-S <http://www.surgeons.org/asernip-s/>
- **Bilateral Procedures** - *e.g. right and left cataract extractions, right and left hip replacements*
 - An RFA will only be accepted for one procedure unless the bilateral procedure is occurring in the same admission
- **Multiple bookings** - can be accepted if the treatments/procedures are independent of each other e.g. cataract extraction and joint replacement. Referring doctor must specify which procedures are prioritised. This may be indicated by the clinical category assigned to both bookings e.g. if one is category 2 and the other is category 3 then the category 2 takes precedence. However if both RFAs have the same clinical category the referring doctor should be asked to specify the priority

The only exception to the above is for on going regular treatment e.g. IV infusion for chemotherapy, venesection and change of supra pubic catheters

- **Duplicate bookings** - an RFA will not be accepted for the same procedure with different referring doctors at the same hospital; or same procedure at a different hospital. The patient is to be advised of the situation and asked to make a decision as to the preferred waiting list they wish to remain on.

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4. REGISTRATION ON THE WAITING LIST

P O L I C Y	<ul style="list-style-type: none">• Accurate entry of data on to the electronic waiting list is essential
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If data is not accurately entered, patient waiting times can be adversely affected causing inconsistency.

4.1. Registration Requirements

- The date stamped on the RFA form is the date used for wait list registration (this is the date when the RFA is first received by the hospital)
- RFA forms should be added to the waiting list when minimum data set available. The listing date is the original date of receipt of the RFA
- Patients should be placed on the electronic waiting list within 3 working days of first receiving the RFA form
- Where there is a question about the appropriateness of the CPC, then all efforts should be made to ensure that the patient is added to the waiting list within 3 working days

4.2. Notification - Patient

Within 3 working days of the patient being added to the waiting list:

- Send notification letter to the patient advising them that they have been placed on the waiting list, including approximate waiting, any changes to contact details (Appendix 2) or with a planned admission date
- Attach any patient documentation to the RFA

4.3. Notification - General Practitioner

The hospital should notify the nominated general practitioner in writing of the patient's placement on the waiting list within 3 days of being added to the waiting list (Appendix 3)

Notification should include:

- Patient's name and address
- Date of placement on the waiting list
- Proposed procedure
- Clinical priority category and definition
- Hospital contact information, including who to contact if the patient's condition changes
- NSW Health's Waiting Times Web Site

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5. MANAGING PATIENTS ON THE WAITING LIST

5.1. Compilation of a Waiting List

A **Waiting List** is kept by the hospital and contains the names and details of all patients registered as requiring elective admission to that hospital.

5.2. Waiting Times

The **Listing Date** is the date of receipt of the RFA. Calculation of waiting time starts from this date.

Calculation of a patient's waiting time includes only the time a patient spends as **Ready for Care**. Waiting time thus reflects a genuine waiting period.

Periods when patients are **Not Ready for Care** should be excluded in determining waiting time.

5.3. Clinical Review

- **Clinical Review** is **defined** as review of a patient on the waiting list to ensure that their waiting time is appropriate for their clinical condition
- examination may result in the patient being assigned a different priority rating from the initial category
- patients and GPs can initiate review, as some conditions will change while the patient is waiting for treatment
- patients remain in their current clinical priority category while undergoing clinical review.

The **major objectives** of clinical review are to determine:

- any change in priority for the procedure, with the resulting need to revise the patient's clinical priority category
- whether admission is still required

The clinical review is to be **organized by the hospital** and conducted by an appropriate clinician:

- Treating doctor or delegate
- General Practitioner (GP)
- Specialist Consultant or delegate e.g. registrar
- Registered nurse

Note: The clinical review should be at no cost to the patient

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Circumstances triggering a Clinical Review:

5.3.1. Category 1 Patients:

Circumstance	Action
<ul style="list-style-type: none"> When patient is listed as Category 1 but then requests deferment as Not Ready for Care > 15 cumulative days 	<ul style="list-style-type: none"> Consult with treating doctor, activate a management plan within 5 working days that includes documented Ready for Care date and if necessary re-categorise Advise patient Advise GP
<ul style="list-style-type: none"> When total time is > 30 days 	<ul style="list-style-type: none"> Request clinical review by appropriate clinician within 5 working days that includes documented Ready for Care date and if necessary re-categorise Advise patient Advise GP

5.3.2. Category 2 Patients:

Circumstance	Action
<ul style="list-style-type: none"> When patient is listed as Category 2 but then requests deferment as Not Ready for Care > 45 cumulative days 	<p>Category 2 patients may require:</p> <ul style="list-style-type: none"> Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days Depending on Clinical Review outcome: <ul style="list-style-type: none"> Allocated date Re-categorisation Removal from the waiting list Advise patient Advise GP
<ul style="list-style-type: none"> When total time is > 90 days 	<p>Category 2 patients may require:</p> <ul style="list-style-type: none"> Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days Depending on clinical review outcome: <ul style="list-style-type: none"> Allocated date Re-categorisation Removal from the waiting list Advise patient Advise GP

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5.3.3. Category 3 Patients:

Circumstance	Action
<ul style="list-style-type: none"> When patient is listed as Category 3 but then requests deferment as Not Ready for Care > 180 cumulative days 	<p>Category 3 patients may require:</p> <ul style="list-style-type: none"> Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days Depending on Clinical Review outcome: <ul style="list-style-type: none"> Allocated date Re-categorisation Removal from the waiting list Advise patient Advise GP
<ul style="list-style-type: none"> At 270 days, if the patient has no planned admission date within the timeframe 	<p>Category 3 patients may require:</p> <ul style="list-style-type: none"> Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days Depending on Clinical Review outcome: <ul style="list-style-type: none"> Allocated date Re-categorisation Removal from the waiting list Advise patient Advise GP

- When a patient **declines or fails to attend a Clinical Review**, a decision regarding the patient's status on the waiting list should be discussed with the surgeon or delegate and senior management as to whether the patient requires to remain on the waiting list
- If a patient **fails to attend a pre-admission clinic appointment** then their risk for surgery remains undetermined. In this case their status on the waiting list should be discussed with their treating doctor
- When a patient **declines** treatment, **fails to arrive** or **requests removal** from the waiting list, notification of the treating doctor is required (Appendix 6b). The patient is to be removed from the waiting list after 5 days if the treating doctor has not advised that the patient is to remain on the waiting list

Status Review Date is **defined** as the date when it is estimated that a deferred or staged patient will become ready for admission, i.e. Ready for Care

A **Status Review Date** must be **set** each time a patient:

- Is added to the waiting list as a staged admission (Not Ready for Care) or defers admission whilst on the waiting list
- Status changes from Ready for Care to Not Ready for Care
- Status remains Not Ready for Care after assessment
- Specifies a forward planned admission date for his or her own non-medical reasons

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A **Status Review Report**, listing details of each patient whose status review date will become due in the following month, must be generated at least monthly. Following an assessment, patients will either:

- Be assigned another status review date
- Be returned to Ready for Care with the appropriate clinical priority category
- Have a planned admission date scheduled
- Be removed from the waiting list

5.4. Ready for Care

A **Ready for Care** patient is defined as a patient who is available for admission to hospital for their planned procedure/treatment.

5.4.1. Delayed Patients

A patient remains classified as **Ready for Care** if their admission is postponed/delayed due to reasons other than their own availability, e.g. unavailability of doctor, operating theatre or bed.

5.4.2. Declined Patients

The hospital must record the reason for patients declining a planned admission date on the electronic waiting list and on the patient's RFA.

5.5. Not Ready for Care

P O L I C Y	<p>A Not Ready for Care patient can be defined as a patient who is not available to be admitted to hospital until some future date, and is either:</p> <ul style="list-style-type: none"> • staged - not ready for clinical reasons • deferred - not ready for personal reasons
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- There are timeframes for patient deferring treatment:
 - Cat 1 - 15 days (however, patient deferring their treatment in this category should be discussed with the referring doctor)
 - Cat 2 - 45 days
 - Cat 3 -180 days
- Hospitals are required to actively manage **Not Ready for Care** patients to ensure they become Ready for Care or are removed from the waiting list
- **Not Ready for Care (NRFC)** implies that the patient will once again become Ready for Care within the timeframes as indicated above. Should a patient require to be NRFC for a prolonged period of time (e.g. significant weight loss) prior to undergoing surgery, then the patient should **not** be placed on the waiting list or they should be removed from the waiting list (following discussions with the treating doctor) until the desired outcome is achieved.

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- The hospital must record the reason for staging and deferring patients on the electronic waiting list and on the patient’s RFA.

5.5.1. Patient Choice to Wait

- Patients are classified as **patient choice to wait** when they decline a genuine offer and insist on staying with their original treating doctor or facility
- Patients are not permitted to be classified as **patient choice to wait** (for doctor or hospital) in CPC 1 & 2.

5.5.2. Staged Patients

The hospital must record the reason for staging patients on the electronic waiting list and on the patient’s RFA. Reasons recorded may be:

Reasons to be Recorded for Not Ready for Care Staged (Clinical)
<p>Unfit</p> <ul style="list-style-type: none"> • A co-morbidity exists which, until resolved, renders them unfit for the proposed treatment
<p>Planned</p> <ul style="list-style-type: none"> • A patient requiring treatment periodically (e.g. check cystoscopy) A patient requiring treatment as part of a staged procedure (e.g. removal of pins and plates)

5.5.3. Deferred Patients

The hospital must record the reason for deferring patients on the electronic waiting list and on the patient’s RFA. Reasons recorded may be:

Reasons to be Recorded for Not Ready for Care Deferred (Personal)
<ul style="list-style-type: none"> • patient is going on holidays and will be unavailable for admission • patient is unable to obtain home support • patient is unable to accept a date due to work commitments • patient is unable to accept a date for other significant reasons e.g. personal carer

- A patient who specifically requests a **forward planned admission date**, for his or her own convenience or commitments should only have their status changed to Ready for Care once the hospital is advised that the patient is now Ready for Care
- A decision to remove the patient from the waiting list may be made if a patient defers > two occasions or exceeds the maximum number of Not Ready for Care days. Refer to section 5.10 Removing Patients from the Waiting List

5.6. Admission Process

P O L I C Y	<ul style="list-style-type: none"> Effective admission and discharge processes are required to ensure optimal use of operating theatre time and beds
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- Equity and Priority of Access for Admission** - the following **criteria** must be considered when choosing patients from the waiting list for admission:
 - clinical priority
 - the length of time the patient has waited in comparison with similar category patients
 - previous delays
 - pre-admission assessment issues/factors
e.g. elderly people living alone or those having to travel long distances
 - resource availability
e.g. theatre time, staffing, equipment and hospital capacity
- Relevant **consultation with** staff from:
 - Treating Doctor
 - Theatres
 - Admissions
 - Pre-admission
 - Division of Surgery waiting list coordinator
 - Other Departments if relevant e.g. Medicine, Radiology
- Planned Admission Date**

The **Planned Admission Date** is the date on which it is proposed that a patient on the waiting list will be admitted for an episode of care and entered on the electronic waiting list

- Once a planned admission date is determined the patient should be contacted by the most appropriate means (telephone or letter – appendix 4) to determine acceptance of admission
- Patient should be supplied with relevant information for their hospitalisation

Pre-admission Assessment

Patients must be assessed before admission to the hospital to confirm suitability to undergo the intended procedure/treatment, associated anaesthetic and necessary discharge plans, by relevant clinician/s e.g. GP, nurse, pre-op clinic **The “Pre Procedure Preparation Toolkit”** http://www.health.nsw.gov.au/policies/gl/2007/GL2007_018.html

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“Short notice” list Patients - Patients may agree to be available on the “short notice” list to have their surgery performed, e.g. if there is a cancellation.

Selection of “short notice” list patients

- Patients must agree to be on the “short notice” list
- Patients that have undergone a pre admission assessment
- Patients that have been clinically screened as not requiring attendance at the pre admission clinic and deemed suitable for the “short notice” list by the nurse screener
- Patients should reside within a reasonable travelling distance to the hospital

Calling in “short notice” list patients

- Patients should be given as much notice as possible about their proposed advancement on the list
- Patients on the “short notice” list should be called as “in turn” as much as possible
- Once a patient has been called in as a “short notice” list patient and their procedure has not gone ahead, a definite PAD should be made to ensure the patient is not inconvenienced further

5.7. Hospital Initiated Postponements

P O L I C Y	<p>Patient postponements should be avoided and only occur when all options are exhausted and senior management have made the decision.</p> <p>If a postponement is to proceed then the following steps should be taken:</p> <ul style="list-style-type: none"> • Record the reason • Patient rescheduled on next available list according to clinical priority category • A new PAD allocated within 5 working days of the postponement • The patient should be advised of a new PAD within 5 working days of postponement.
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Patients who are postponed by the hospital or doctor or for non clinical reasons remain Ready for Care “delayed” and the following actions taken.

5.7.1. Factors to Consider in Selecting Patients for Postponement

- Category 1 patients who have arrived must not be postponed without authorisation of a senior member of management and treating doctor or delegate e.g. registrar
- Postponed patients must have priority over others not previously postponed. Postponed patients are to be placed on the next available procedure/treatment list, appropriate to the patient’s clinical priority category. Where possible, postponed patients should be prioritised on the procedure/treatment list to minimise the chance of delay (e.g. first on list where appropriate)
- If a patient has been postponed twice and cannot be treated within appropriate clinical priority timeframes, the Area Health Service must actively investigate options for procedure/treatment to be undertaken at another facility (public or private). The cost is to be borne by the originating Area Health Service

Decisions to postpone must involve relevant medical and operating theatre staff, bed manager, waiting list manager, senior hospital management and consider:

- Reason for the postponement
- Clinical priority
- Postponement history
- Length of time on the waiting list
- Medical input from treating doctor or delegate

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5.7.2. Informing Patients of their Postponement

- Provide the patient with the maximum possible notice
Category 1 patients and patients postponed on the day of procedure/treatment should be notified by a senior member of the surgical/medical team or senior hospital manager

Any patient cancelled or postponed by the hospital or doctor on the day of their planned admission date after arrival to the hospital must be reported to the Executive Director of Surgical Services

- Offer the following support options to the patient, **where relevant**:
 - Contact a family member or friend
 - Arrange and pay for transport home, accommodation, food, etc.
 - Counselling services
 - Access to a complaints service
- Reschedule the patient on the next available list date for their procedure/treatment and notify the patient of the new admission date within 5 working days (Appendix 5)
- Patient is to be rebooked with original listing date and history where appropriate, including previous admission dates and delays

5.7.3. Patient Admitted and Surgery Not Performed

If a patient arrives for treatment/procedure and is admitted and then the surgery is cancelled due to hospital reasons, the following actions should be taken:

- The patient should be admitted and discharged
- The patient should be rebooked with the original listing date and history (clinical priority categories and delays etc)

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5.8. Patient Initiated Postponements

When a patient postpones an agreed date for procedure/treatment for personal or social reasons, a patient initiated postponement should be:

- recorded on electronic waiting list and RFA
- reviewed to determine if:
 - A new date is to be scheduled
 - The patient is to be categorised as Not Ready for Care “deferred”, or
 - Removed from the waiting list
 - Patients are only permitted to postpone maximum of 2 times for personal or social reasons

If a patient arrives for treatment/procedure and decides to cancel after admission, the following steps should be taken:

- The patient should be admitted and discharged
- the patient should be re-booked on day of discharge with original listing date
- Or removed from the waiting list

5.9. Avoiding Exceeding Clinical Priority Time Frames

It is not acceptable to have patients waiting past Clinical Priority time frames.

Hospitals must implement active management strategies to avoid this and are required to achieve the following Clinical Priority time frames:

Clinical Priority Category	Recommended allocation of PAD
No patient in Category 1 should wait longer than 30 days	PAD on booking
No patient in Category 2 should wait longer than 90 days	PAD within 45 days
No patient in Category 3 should wait longer than 365 days	PAD within 270 days

To avoid exceeding Clinical Priority time frames, at least weekly, a review of the waiting list should be undertaken and hospitals should consider the following **options**:

- Clinical Review – refer to section 5.3
- Contact the area patient access coordinators – they may have viable options
- Transfer of Patients to Doctors with a shorter waiting time (see 5.9.1 for more details)
- Transfer of Patients to another facility within the Area Health Service (see 5.9.2 for more details)
- Increase theatre utilization (e.g. extra sessions)
- Use of short notice or standby lists
- Other options including contracting work out to the private sector

5.9.1. Transfer of Patients to Doctors with a shorter waiting time

The offer to the patient has to be considered "reasonable" and "genuine". This needs to be determined for each individual and the following considered:

- The circumstances of the patient (e.g., age, available support, public transport, physical condition and the required procedure)
- The offer must be specific. The name of the clinician, hospital, and an estimate of the likely waiting period must be given
- The offer must be a credible alternative and be available if the patient decides to accept the offer

The new Doctor will determine the requirement to review the patient.

The patient's listing date and history must be that of the original booking. In this way an accurate record of waiting time is maintained. Where there is a delay in listing the patient on the shorter list, the patient must remain on the original list, pending confirmation of the patient's acceptance by the second doctor. The patient's current clinical priority category must be maintained, unless altered after clinical review by the new treating doctor.

5.9.2. Transferring Patients to Another Facility

When a patient is booked at one hospital and subsequently has the procedure carried out at a different hospital within the same Area Health Service, the following steps must be followed:

- The booking at the hospital where the patient will be treated is entered with the same listing date and history as the booking at the original hospital, and with the current clinical priority category
- The booking at the original hospital should be removed using the reason code treated elsewhere), on confirmation of the patient's booking at the receiving hospital
- Where the patient is transferred to another hospital at a different Area Health Service, then the patient is to be added to the new hospital's waiting list with the listing date being the day the RFA is received from the previous hospital or Area Health Service. Once the patient is booked onto the new hospital waiting list then they are to advise the original hospital to remove the booking from waiting list

5.9.3. Patients who Refuse a Reasonable and Genuine Offer to Transfer to Another Doctor or Facility

Clinical Priority Category 3 (admission within 365 days) patients who refuse a reasonable and genuine offer (as defined in 5.9.1) to transfer to the list of a doctor or hospital which will minimise their waiting time are to be reclassified as Not Ready for Care (NRFC) – "Patient Choice to Wait". They remain, in the same queue order on the waiting list and are to be admitted within their original clinical priority timeframe (see page 17). Patients are not permitted to be classified as **patient choice to wait** (for doctor or hospital) in Clinical Priority Category 1 & 2.

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5.10. Removing Patients from the Waiting List

P O L I C Y	<ul style="list-style-type: none"> • Patients can be removed from the waiting list for reasons other than for admission • Hospitals should exercise discretion on a case by case basis to avoid disadvantaging patients in the case of genuine hardship, misunderstanding and other unavoidable circumstances
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Reason	Category 1, 2 & 3 Actions
Patient declines treatment or requests removal for other reasons	<ul style="list-style-type: none"> • Forward a copy of the RFA with a covering letter (Appendix 6b) to the treating doctor within 24 hours of notification, informing removal of patient from the waiting list unless treating doctor advises otherwise within 5 working days
Patient defers treatment on 2 occasions or in deferring exceeds the maximum number of Not Ready for Care days: Cat 1 > 15 days Cat 2 > 45 days Cat 3 > 180 days	<ul style="list-style-type: none"> • Obtain authority for Category 1 (30 day) patients prior to removal from waiting list <p>Once decision is made to remove patient from waiting list:</p> <ul style="list-style-type: none"> • Obtain unit head or delegated unit representative's written authorisation and documentation on RFA to remove and record of any discussion with patient • Remove patient from the waiting list • Advise GP that patient has been removed (Standard Letter Appendix 6a) • Send letter to patient (Appendix 6c) • Document actions on RFA and electronic record (refer to section 6.4)
Patient fails to arrive to treatment on 1 occasion without giving prior notice and with no extenuating circumstances	<ul style="list-style-type: none"> • Send letter to patient (Appendix 6c) • Document actions on RFA and electronic record (refer to section 6.4)
Patient not contactable on 2 occasions (one by phone, one by letter) Refusal for Clinical Review	<ul style="list-style-type: none"> • Attempt to obtain patient's correct contact details via all these methods: <ul style="list-style-type: none"> • Referring doctor, GP, medical records, next of kin & telephone directory search • Obtain written authorisation of a Senior Medical Officer or delegate to remove • Remove patient from the waiting list • Advise referring doctor and GP that patient has been removed (Standard Letter Appendix 6a and 6b) • Document actions on RFA and electronic record (refer to section 6.4) • Patient refused or failed to attend a clinical review or a pre-admission clinic when required

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Patient deceased	<ul style="list-style-type: none">• Obtain verification (usually verbally from the patient's relative, general practitioner or specialist)• Remove patient from the waiting list• Document actions on RFA and electronic record (refer to section 6.4)
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Note:

If a patient was initially removed from the waiting list due to reasons other than admission and in the following month the waiting list record needed to be re-activated for the same procedure, then the patient should be re-booked with the original listing date and history (clinical priority category and delays etc.).

6. RECORD KEEPING

P O L I C Y	<ul style="list-style-type: none"> Hospitals must keep accurate records of waiting list information Document any changes on RFA and electronic waiting list
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Any changes made to a patient’s booking must be validated with documented evidence and reasons, and signed by relevant staff member. The documentation must be attached (Appendix 10) or be part of the RFA. The electronic waiting list must also be updated to reflect any changes.

6.1. Postponement of Planned Admission

- Accurate records are to be maintained for patients postponing and the reason for postponement (electronic waiting list and RFA)
- A patient’s postponement history should be readily available to the staff making decisions about postponing future patients

6.2. Exceeded Planned Admission Dates

- Generate and review **report** to identify patients who have exceeded planned admission dates at least monthly

6.3. Procedure being Undertaken at Another Hospital within same AHS

- Listing date and clinical priority category at other hospital will be same as original hospital
- The booking at the original hospital should be removed using the reason code (treated elsewhere) on confirmation of the patient’s booking at the receiving hospital

6.4. Removal of Patients from the Waiting List (other than admission)

- All patients who have been removed from the waiting list (other than admission) require documentation detailing reason for removal and date of removal. This should be part of or attached to the RFA
- Treating doctors and GP’s should be advised (Appendix 6a and 6b)

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Reason	Information to be Recorded/Filed (RFA & Electronic)
Patient Deceased	<ul style="list-style-type: none"> • Record the name of the person who has notified the hospital that the patient is deceased
Non contactable	<ul style="list-style-type: none"> • Evidence of contact: <ul style="list-style-type: none"> ○ patient letters returned (return to sender) ○ documentation of attempts to contact through referring doctor, GP, medical records, next of kin & telephone directory search
Decline treatment or clinical review/not required	<ul style="list-style-type: none"> • Documentation that patient has been informed of the potential risks to their health and advised to contact referring doctor (Appendix 6c) • Obtain authority for Category 1 (30 day) patients prior to removal from waiting list
Fail to Arrive for Treatment	<ul style="list-style-type: none"> • Documentation that: <ul style="list-style-type: none"> ○ Patient has failed to arrive for treatment on the planned admission date > 1 occasion without prior notice and without good reason ○ Advise patient to be clinically reassessed by treating doctor

6.5. Reporting

- Hospitals must ensure they have a documented process for removing patients from the waiting list (other than admission). Hospital to compile a list of patients who have been removed for authorisation by a senior hospital executive. This **authorisation** is to occur **monthly**. Removals list must be retained for the normal retention period and include the following information:
 - Patient's name
 - Reason for the patient's removal
 - Patient's clinical priority category
 - Patient's diagnosis
 - Patient's procedure
- **Monthly reports** must be **provided** to the hospital Executive Officer and Area CEO or delegate with the following information:
 - Patients who have incurred a delay during the month (previous month)
 - Patients on the list who have had two or more delays to their admission
 - All delayed patients who do not have a rescheduled planned admission date
- **Duplicate bookings** are to be monitored by each Area Health Service **monthly**, however, the Health Services Performance Improvement Branch at NSW Health will monitor duplicate bookings across NSW and distributed reports to Area Health Services **every six months**
- Any patient cancelled or postponed by the hospital or doctor on the day of their planned admission date after arrival to hospital must be reported to the hospital Executive Officer

7. AUDITING THE WAITING LIST

P O L I C Y	<ul style="list-style-type: none"> • Patient details on the waiting list are accurate, valid and complete • Transparent processes are in place for equitable access to elective surgery • Records relating to audits must be kept for three years
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7.1. Clerical Audit

- Each hospital is to identify a person responsible for the clerical audit of hospital waiting lists. The responsibility includes **conducting audits** and **reporting** the outcome of the audit to relevant management.
- Each Area Health Service is to nominate a person responsible for **monitoring** the **clerical audit** program across all hospitals, maintaining clerical audit standards and addressing issues arising from the audits
- A **review** of the waiting list must be undertaken (**at least weekly**) to ensure that accurate information is provided to clinicians and administrators on request
- Elements of the clerical audit that should be undertaken weekly include:
 - Ascertaining whether the patient has already has their procedure/treatment
 - Checking for duplicate bookings
 - Ensuring clinical priority category is appropriately assigned
 - Updating Status Review Date for Category 4 patients (dependant on original clinical priority category) see 5.3.1 & 2 & 3
 - Reviewing Exceeded Planned Admission Dates
 - Identifying patients on waiting list admitted through emergency department for the same procedure
 - Ensuring delayed patient is rescheduled for next available theatre session in consultation with treating doctor
- Documentation must provide a clear audit trail and must be readily available to validate any changes made to a patient's booking (electronic and RFA)
- RFAs should have:
 - A dedicated section to record all changes; or
 - A designated form attached to the RFA (appendix 10)
- On completion of clerical audits, a report signed by the responsible person conducting the audit must be sent to the relevant manager and appropriate committees and be available on request.
- This report must include:
 - The type of audit conducted, methodology used, problems identified and recommendations for improvement
 - The number of patients removed and reasons for removal from the waiting list

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- An **evaluation** of the **audit process** must be conducted regularly (**at least quarterly**) by the staff responsible for waiting list management at each facility
- NSW Health departmental officers conduct regular hospital visits and also engage an independent auditor to review the waiting list management process on a regular basis

7.2. Review of Waiting List by Treating Doctor

- The hospital must **provide a comprehensive list** of patients to each treating doctor **monthly**
- Treating Doctors must confirm waiting list with waiting time coordinators
- Changes required by treating doctor are to be undertaken
- The whole process should be undertaken within 10 days
- **Pooled lists** - the department head or his/her delegate is responsible for the review of pooled lists

7.3. Patient Audit

- Ready for Care and Not Ready for Care Patients on the waiting list should be **contacted** if they have been **waiting for greater than six months** from listing date, to ascertain if they still require admission. Two contacts should be attempted, one by letter (Appendix 7) and one by telephone
- Should the patient remain on the waiting list and no planned admission date allocated or the patient is Not Ready for Care, then contact needs to be made with the patient to ascertain if they still require their procedure
- Audit letter must include:
 - Information on alternative options where available
 - Advice for clinical reassessment by treating doctor or GP
 - Hospital & Area contact details
- Documentation of the patient audit must be readily available, and must include the responses received and the action taken.

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8. DOCTOR'S LEAVE - TEMPORARY AND PERMANENT

P O L I C Y	<ul style="list-style-type: none"> • To ensure appropriate theatre scheduling, doctors are requested to provide as much notice of intended leave as possible (minimum of 6 weeks) • A management plan for affected patients should be developed and implemented for all leave • A patient's clinical priority category and listing date does not change as a result of doctor's leave
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A patient's **management plan** should ensure affected patients:

- Are assured that their queue order will not be affected
- Know who the replacement doctor will be
- Are advised if clinical review is required
- Are provided with information regarding their expected waiting time

All contact with patients must be documented and be part of or attached to the patient's RFA.

Affected patients are those who during the leave period:

- Already had a planned admission date
- Will exceed their clinical priority timeframe during the leave period (see Clinical Priority Categories Section 2.1)

Type of Leave	Action
Annual, Study, Conference Leave	<ul style="list-style-type: none"> • Doctors are requested to provide as much notice of intended leave as possible (6 weeks) • A management plan for affected patients should be developed and implemented for all leave <ul style="list-style-type: none"> ○ Consult with relevant personnel – head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Area Chief Executive or delegate • During the leave period, no further patients should be added to the doctor's waiting list
Unplanned leave e.g. sick leave, bereavement leave	<ul style="list-style-type: none"> • A management plan for affected patients is to be immediately developed and implemented <ul style="list-style-type: none"> ○ Consult with relevant personnel – head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Area Chief Executive or delegate • During the leave period, no further patients should be added to the doctor's waiting list

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Type of Leave	Action
<p>Planned Resignation e.g. resignation from hospital, retirement, failure to be re-appointed</p>	<ul style="list-style-type: none"> • Notify affected patients and relevant GPs of intention to leave (if time permits); provide advice about patient’s management plan ASAP No addition of patients to the doctor’s waiting list upon notification of planned resignation unless there is capacity or for an urgent case A management plan for all patients should be developed and implemented <ul style="list-style-type: none"> ○ Consult with relevant personnel – head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Area Chief Executive or delegate ○ Locate replacement treating doctor in consultation with senior clinicians and management ○ Clinical review is required for patients remaining on departing doctor’s waiting list ○ Determine if departing doctor is willing to treat additional patients and has capacity to undertake the procedure/treatment to decrease the waiting list • Transfer patients to nominated treating doctor’s waiting list <ul style="list-style-type: none"> ○ Ensure existing and transferred patients are treated in queue order, within clinical priority categories ○ If unable to immediately transfer patients to a replacement doctor’s waiting list, patients are to remain on the treating doctor’s list
<p>Unplanned Resignation or Death</p>	<ul style="list-style-type: none"> • No addition of patients to the doctor’s waiting list • A management plan for all patients should be immediately developed and implemented <ul style="list-style-type: none"> ○ Consult with relevant personnel – head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Area Chief Executive or delegate ○ Locate replacement treating doctor in consultation with senior clinicians and management ○ Clinical review is required for patients remaining on departing doctor’s waiting list ○ Need to consider if nominated doctor is willing to take on additional patients and has capacity to undertake the work • Transfer patients to nominated treating doctor’s list <ul style="list-style-type: none"> ○ Ensure existing and transferred patients are treated in queue order, within clinical priority categories • If unable to immediately transfer patients to a replacement doctor’s waiting list, patients are to remain on the waiting list under an appropriate clinician or speciality • Notify relevant GPs of the resignation/death (Appendix 8)

9. DEFINITIONS

Definition	Explanation
Addition to the waiting list	As soon as a decision is made that a patient is in need of admission to the hospital and the admission is not required within 24 hours, the treating doctor should complete a Recommendation for Admission form and forward it to the hospital within 3 working days. The patient will be added to the electronic waiting list within 3 working days of receipt of a complete, accurate and legible Recommendation for Admission form. The date the RFA is received becomes the patient's listing date. This date is used in the calculation of the waiting time
Admission	Is the process whereby the hospital accepts responsibility for the patient's care and or treatment. Admission follows a clinical decision based upon specific criteria that a patient requires same day or overnight care and treatment There are two types of Admission: <ul style="list-style-type: none"> • Emergency Admission (Admission within 24 hours) • Elective Admission (Admission > 24 hours)
Admission Date	Date on which an admitted patient commences an episode of care
Admitted patient	A patient who undergoes a hospital's admission process to receive treatment and/or care
Anticipated election status	Recorded when the patient is added to the waiting list, it is the anticipated election the patient will make when admitted for the planned procedure/treatment. Classifications are: <ul style="list-style-type: none"> • Medicare Eligible - Public patient • Medicare Eligible - Private patient • Medicare Eligible - Department of Veterans Affairs patient • Medicare Eligible - Other (compensable, Defence forces etc) • Medicare Ineligible - Overseas visitor
Area Patient Access Coordinator	Provides information regarding booked admissions in public hospitals and investigate options where available
Clerical Audit	A clerical audit is a regular and routine clerical check that the information that the hospital has of patients waiting for admission is correct. It will facilitate the identification of patients who no longer require admission or who have duplicate bookings

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Definition	Explanation
Clinical Priority Categories	<p>A clinical priority category is allocated to a patient based on the referring doctor's assessment of the priority with which a patient requires elective admission. Clinical priority categories are:</p> <p>Category 1 Admission within 30 days desirable</p> <p>Category 2 Admission within 90 days desirable</p> <p>Category 3 Admission within 365 days acceptable</p> <p>Category 4 Not Ready for Care clinical reasons (staged) Not Ready for Care personal reasons (deferred)</p>
Clinical Review	Review of a patient on the waiting list to ensure that their waiting time is appropriate for their clinical condition
Cosmetic Surgery	<p>Procedure performed to reshape normal structures of the body, or to adorn parts of the body with the aim of improving the consumer's appearance and self-esteem.</p> <p>These procedures do not attract a Medicare rebate</p>
Day of surgery admission (DOSA)	Day of surgery admission - patients are admitted into hospital on the day of their procedure and remain in hospital for at least one post-operative night
Day Only Surgery (DO)	<p>Day Only Surgery involves the patient being admitted and discharged on the day of surgery.</p> <p>Also referred to as Day Surgery</p>
Declined Patient	A patient who declines a planned admission date for treatment
Deferred	See Not Ready for Care "deferred"
Delay	See postponement
Discharge Intention	Recorded when the person is added to the waiting list. It identifies whether the referring doctor expects that the person will be admitted and discharged on the same day (i.e. day patient) or will stay at least overnight
Discretionary Surgery	Surgical procedures that should not be undertaken in public hospitals in NSW unless essential for good health
DOSA	DOSA is an acronym for day of surgery admission

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Definition	Explanation
EDO	<p>EDO units are specifically designed to accommodate patients - elective and emergency, who meet specific admission criteria including:</p> <ul style="list-style-type: none"> absolute expectation of discharge within 24 hours, preadmission screening (elective patients), agreed clinical guidelines in place and agreement to protocol based nurse initiated discharge
Elective admission	<p>An admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least 24 hours (added to the waiting list)</p> <p>An elective admission usually results from a general practitioner consultation, referral to a specialist and a recommendation for admission to hospital by the specialist (or general practitioner, where appropriate). The medical consultation may take place in a hospital outpatient clinic</p>
Elective medical treatment	<p>Elective medical procedures are predominantly non-surgical procedures but do include procedures such as bronchoscopy, colonoscopy, endoscopy, gastroscopy etc</p>
Elective patients (sometimes referred to as booked patients)	<p>Elective patients are those who are having an elective admission</p>
Elective surgery	<p>Elective surgery is surgery performed on patients, that in the opinion of the treating clinician is necessary, and for which admission can be delayed for 24 hours. NSW has adopted the nationally agreed definition of elective surgery, as specified by the Australian Institute of Health and Welfare</p>
Elective surgical procedure	<p>In broad terms, a procedure is elective surgery if it is performed in an operating theatre facility under some form of anaesthesia and admission is not required within 24 hours of the decision by a surgeon to admit. It should be a surgical procedure included in the Commonwealth Medicare Benefits Schedule (CMBS) (Operations). Although this is sometimes not the case for approved new procedures not yet added to the CMBS. Anaesthesia includes general, regional or local anaesthesia or intravenous sedation</p> <p>Also see Non-surgical or diagnostic procedure</p>
Electronic waiting list	<p>Patient administration/ management system used by the hospital to manage the waiting list e.g. iPM, HOSPAS</p>

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Definition	Explanation
Emergency admission	<p>An admission of a patient for care or treatment which, in the opinion of the treating clinician, is necessary and admission for which should occur within 24 hours</p> <p>These patients are not usually added to the waiting list , however if they are added for organisational reasons then when the patient is admitted they should be removed from the waiting list as an emergency admission</p> <p>If already on the waiting list the patient should be removed and classified as an emergency. While most emergency admissions are processed or passed through the emergency department, many are referred directly from treating doctor to the ward</p>
Emergency patients	Emergency patients are those whose clinical conditions indicate that they require admission to hospital within 24 hours
Exceeding Clinical Priority Timeframes or Overdue	Patients are considered overdue if they have waited in excess of the time recommended for the assigned ready for care clinical priority category
Indicator procedure	The procedure or treatment the patient is to undergo when admitted. There are currently around 200 possible codes
Inpatient	Patients who are formally admitted to a hospital or health service facility. Formally admitted patients can be Day Only or overnight
Listing Date	Listing Date is the date of receipt of the Recommendation for Admission Form. Calculation of waiting time starts from this date.
Listing Status	<p>Indicates the status of the person on the waiting list that is the extent to which a patient is ready and available for admission. This may change while the patient is on the waiting list e.g. after a clinical review.</p> <p>The patient may be:</p> <ul style="list-style-type: none"> • Ready for Care (Category 1, 2 or 3) • Not Ready for Care (Category 4: Staged or Deferred)
Long-wait patients	Medical and surgical patients who are Ready for Care and have been waiting for elective admission longer than 12 months are termed long-wait patients
Medicare eligibility	Patients must be identified as being eligible or not eligible for treatment under Medicare for each episode, and a record of the patient's Medicare number is to be made at the time of listing - see Anticipated Election Status

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Definition	Explanation
<p>Not Ready for Care (NRFC)</p>	<p>A Not Ready for Care patient can be defined as a patient who is not available to be admitted to hospital until some future date and is either:</p> <ul style="list-style-type: none"> • staged – not ready for clinical reasons • deferred - not ready for personal reasons <p>See Clinical Review Section 5.3 for timeframe for NRFC patients</p> <p>A postponement of admission by the hospital does not render the patient Not Ready for Care. These patients should remain on the waiting list as they are still genuinely waiting, but are delayed</p>
<p>Not Ready for Care “deferred”</p>	<p>A patient is said to be deferred if for personal reasons he/she is not able to accept a definite date for admission. It is mandatory to indicate a reason for deferring</p> <p>The reason a patient is deferred may be reported as follows:</p> <ul style="list-style-type: none"> • a patient is going on holidays and will be unavailable for admission • a patient is unable to obtain home support • a patient is unable to accept a date due to work commitments • a patient is unable to accept a date for other significant reasons e.g. personal carer <p>Patients may not be added to the waiting list as Not Ready for Care deferred</p>
<p>Not Ready for Care “staged”</p>	<p>A patient is said to be staged if for clinical reasons they will not be ready for admission until some future date. It is mandatory to indicate a reason for deferring</p> <p>The reason a patient is staged may be reported as follows:</p> <p>Unfit</p> <ul style="list-style-type: none"> • a co-morbidity exists which, until resolved, renders them unfit for the proposed treatment <p>Planned</p> <ul style="list-style-type: none"> • a patient requiring treatment as part of periodic treatment • a patient requiring treatment as part of a staged procedure (includes obstetric patients) • a planned re-admission for a patient with a predictable morbid process, requiring periodic treatment of the ongoing disease process • a planned re-admission for review of status following previous treatment

Title: Waiting Time and Elective Patient Management Policy

Definition	Explanation
Non-surgical or diagnostic procedure	In broad terms, a procedure is non-surgical or diagnostic if it is performed outside an operating theatre or not performed by a surgeon - see also elective medical procedure
Planned admission date	<p>The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care</p> <p>A patient who has been allocated a definite date for admission by the hospital, has been scheduled (i.e. the admission or listing is scheduled)</p> <p>A patient who has not been given a definite date for admission by the hospital is unscheduled (i.e. the admission is unscheduled)</p>
Planned length of stay	The number of nights the patient is expected to stay in hospital as an inpatient. This information will be used for discharge planning and bed management
Planned procedure	The planned procedure is the procedure or treatment the patient is to undergo when admitted
Pooled lists	<p>At some hospitals, doctors in particular specialties have agreed to include their public patients on a combined list for that speciality. This means that patients may be treated by any one of the doctors belonging to the group. Patients may therefore be added to a waiting list by one doctor but admitted by another doctor. This does not mean that if a particular doctor is part of a pooled list group that this doctor does not also list and admit patients apart from the pooled list patients. Pooled lists are generally set up for the more common routine procedures</p> <p>A doctor's private patients would not be included on a pooled list</p>
Postponement	<p>A patient's elective admission may be postponed by the hospital due to high emergency admissions or other hospital related reasons.</p> <p>See Ready for Care "delayed"</p> <p>A patient may postpone for personal reasons</p> <p>See Not Ready for Care "deferred"</p>
Pre-admission	Patients are assessed before admission to the hospital for their suitability to undergo the intended procedure/treatment, associated anaesthetic and discharge plans
Private/Chargeable patients (including DVA & WC etc)	Persons admitted to a public hospital who elect to choose the treating doctor(s) will be charged for medical services and accommodation

Title: Waiting Time and Elective Patient Management Policy

Definition	Explanation
Public Patient	A Medicare eligible patient admitted to a public hospital who has agreed to be treated by a nominated doctor of the hospital's choice and to accept shared ward accommodation. This means the patient is not charged
Ready for Care (RFC)	A Ready for Care patient is defined as a patient who is available for admission to hospital. Ready for Care patients will be in clinical priority categories 1, 2 or 3
Ready for Care "Delayed"	<p>A patient is regarded as Ready for Care but delayed where the hospital decides to postpone admission and reschedule a person's planned admission date because of:</p> <ul style="list-style-type: none"> • non-availability of operating theatre (staff, equipment, resources etc.) • non-availability of bed; planned bed reduction • non-availability of bed; pressure of emergency admissions • non-availability of doctor <p>It is mandatory to indicate the reason for the patient's admission being delayed</p>
Removing patients from the waiting list, other than for admission	<p>Patients can be removed from the waiting list for reasons other than for admission:</p> <ul style="list-style-type: none"> • patient declines treatment or requests removal • patient defers treatment on 2 occasions • patient defers & exceeds maximum number of Not Ready for Care days Cat 1 > 15 days; Cat 2 > 45 days; Cat 3 > 180 days • patient fails to arrive on 1 occasion, with no notice or extenuating circumstances • patient not contactable • patient deceased
Recommendation for Admission form (RFA)	<p>Requests for admission to hospital need to be on an approved form and contain a minimum data set as specified in this policy</p> <p>Forms must have a dedicated section for documentation of relevant details regarding the booking, such as contact with patient, doctors, dates and reasons for changes or delays to planned admission dates. This dedicated section may be either part of the RFA or a particular form attached to the RFA. The documentation needs to provide a clear audit trail for all transactions and must be kept as part of the patient's medical record</p>
Referring Doctor	Doctor who is referring the patient to the waiting list

Title: Waiting Time and Elective Patient Management Policy

Definition	Explanation															
Same day Surgery	See Day Only Surgery (DO)															
Speciality	<p>Specialist's area of clinical expertise. Where a specialist undertakes surgical procedures, which can be classified into different specialities, then the specialist will have a different list for each speciality (e.g. Obstetrics/Gynaecology)</p> <p>The broad categories required for reporting to NSW Health Department are:</p> <table border="0" data-bbox="539 712 1241 952"> <tr> <td>Cardiothoracic</td> <td>ENT</td> <td>General Surgery</td> </tr> <tr> <td>Gynaecology</td> <td>Neurosurgery</td> <td>Ophthalmology</td> </tr> <tr> <td>Orthopaedic</td> <td>Plastic</td> <td>Urology</td> </tr> <tr> <td>Vascular</td> <td>Dental</td> <td>Medical</td> </tr> <tr> <td>Renal Dialysis</td> <td>Obstetrics</td> <td></td> </tr> </table> <p>Hospitals may have many more specific clinical areas identified, but these should be categorised under the main speciality headings for central reporting</p>	Cardiothoracic	ENT	General Surgery	Gynaecology	Neurosurgery	Ophthalmology	Orthopaedic	Plastic	Urology	Vascular	Dental	Medical	Renal Dialysis	Obstetrics	
Cardiothoracic	ENT	General Surgery														
Gynaecology	Neurosurgery	Ophthalmology														
Orthopaedic	Plastic	Urology														
Vascular	Dental	Medical														
Renal Dialysis	Obstetrics															
Staged	See Not Ready for Care "staged"															
Short Notice/ Standby Patient	Patients may agree to be available on the "short notice" list to have their surgery performed if there is a cancelled procedure. The hospital should determine what period of time prior to admission is regarded as short notice and for which procedures are appropriate															
Status review date (SRD)	This is the date determined for an assessment (clinical or administrative) as to whether a deferred or staged person (i.e. Not Ready for Care) has become ready for admission to the hospital at the first available opportunity (i.e. Ready for Care)															
Treating doctor	The medical officer/senior clinician (a visiting practitioner, staff specialist or academic clinician) responsible for the care of the patient, and under whose care the patient is to be admitted															
Waiting List	A waiting list is kept by the hospital. This contains the names and details of patients registered as requiring elective admission to that hospital. Admission may be for same day (admission and discharge on the same day) or other acute inpatient services requiring overnight or longer stay. These patients may or may not have a planned admission date and may be proposing to be public or private patients															
Waiting Time	Time a patient spends as Ready for Care															

Title: Waiting Time and Elective Patient Management Policy

10. APPENDICES

Appendix 1 - Incomplete RFA Letter

Dear <insert Dr name>

Incomplete Recommendation for Admission (RFA) Form

An RFA for <insert patient's name> has been received at the Admission/Booking office on <insert date> with incomplete information. The Department of Health's Waiting Time and Elective Patient Management Policy states that the hospital is unable to accept RFA forms unless all the mandatory information is completed.

Could you please provide the information requested below:

The following information/details are incomplete or missing on the RFA (Please Tick)

- Patient's full name**
- Patient's address**
- Patient's contact information**
- Patient's gender**
- Patient's Medicare number**
- Patient's date of birth**
- Clinical priority category**
- Discharge intention** (i.e. Day only, or indication of number of nights in hospital)
- Presenting problem**
- Planned procedure/treatment**
- Significant medical history** (including allergies)
- Treating doctor** (if different)
- Local medical officer** (name and address)
- Patient's signed consent** (if available)

- Special requirements e.g. ICU bed, theatre equipment**

Specify

Please complete the requested information on this letter and return it within 2 days by facsimile to..... This will enable the Admission/Booking Office to complete the patient's booking.

If you require further information please contact our <insert position name and contact number>.

Thank you for your assistance with this matter.

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 2 - Patient Notification Letter

Dear <patient name>

I am writing to confirm that as of <date> you have been placed on the <hospital name> elective surgery waiting under the care of <insert doctor>.

Your doctor has determined the clinical priority of your admission. The approximate waiting time is <insert waiting time> weeks/months from when your name was placed on the waiting list.

Our first priority is to ensure you receive your procedure/treatment within the clinical priority timeframe recommended by your referring doctor. Where possible, we will make every effort to;

1. allocate your referring doctor to perform your procedure
2. ensure your surgery is performed at <insert hospital name>

While every attempt will be made for you to have your procedure under the care of the referring surgeon, the hospital is committed to providing your surgery within the clinically recommended timeframe, which may involve referring you to another doctor or hospital.

Once a planned admission date has been allocated for your procedure, you will be notified of the date and provided with further information to help you prepare for your hospital stay. The name of your doctor and facility will be included in this letter.

Sometimes it is necessary to delay booked surgery to make way for life-threatening cases, which are admitted through the hospital's emergency department. These emergency cases will always receive priority over elective surgery. However, the hospital will make every effort to avoid such postponements and to reschedule delayed patients as soon as practicable.

Should your clinical condition change you should notify your general practitioner, your specialist or the hospital <insert position name and contact number of clinical staff who can provide advice on management of worsening condition>. Changes in your condition or general health may have implications for the timing of your procedure or lead to your clinical priority category being re-assessed.

As a patient on the waiting list, you have a responsibility to inform the hospital:

- If you decide not to proceed with the procedure for any reason. For example, if the procedure has been conducted at another hospital or you have decided to seek treatment privately or to opt for an alternative treatment
- Of any changes to your contact details
- If you are going to be unavailable for any extended period

If the hospital is unable to contact you because you have not informed them of a change in your contact details or you fail to present for the procedure without providing the hospital with prior notice, the hospital may remove you from the waiting list in consultation with your specialist.

If you have any queries about the hospital waiting list or booking procedures, please contact our <insert position name and contact number> or if you have access to the web you can access information about specialists' waiting times at the NSW Health web site:

<http://www.health.nsw.gov.au/hospitals/waitingtimes/index.asp>

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 3 - GP Notification Letter

Dear <insert gp's name>

I am writing to advise you that as of <date> your patient:

<Patient name>

<Patient address>

Has been placed on the <hospital name> elective surgery waiting list to undergo <procedure> under the care of <insert treating doctor's name>

As you may be aware, clinicians assign each elective patient with a clinical priority category according to clinical need, ensuring that priority is given to the patients who are most in need. There are four categories: These are:

- **Category 1:** Admission **within 30** days desirable for a condition that has the potential to deteriorate quickly to the point that it may become an emergency.
- **Category 2:** Admission **within 90 days** desirable for a condition that is not likely to deteriorate quickly or become an emergency.
- **Category 3:** Admission **within 365** days acceptable for a condition that is unlikely to deteriorate quickly and which has little potential to become an emergency.
- **Category 4:** Patients who are either clinically not ready for admission (**staged**) and those who have deferred admission for personal reasons (**deferred**) after placement on waiting list.

The referring doctor who examined and placed <insert patient name> on the waiting list allocated the patient a category <insert category>, and the approximate waiting time is <insert waiting time> weeks/months from when they were placed on the waiting list.

While every attempt will be made for your patient to have their procedure under the care of the referring surgeon, the hospital is committed to providing their surgery within the clinically recommended timeframe, which may involve referring them to another doctor or hospital.

When the patient is booked for the procedure, the patient will be advised of the proposed admission date and given further information to help prepare.

The patient has been advised to notify their general practitioner, the specialist or the hospital if their condition changes for a clinical review. If you are contacted and require advice on the management of the patient's condition, you can contact <insert position name and contact number of clinical staff who can provide advice on management of worsening condition>.

If you have any queries about the hospital waiting list or booking procedures, please contact our <insert position name and contact number> or if you have access to the web you can access information about specialists' waiting times at the NSW Health web site:

<http://www.health.nsw.gov.au/hospitals/waitingtimes/index.asp>

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 4 - Admission Letter

Dear <insert patient name>

We are please to advise that your Admission to <insert hospital name> has been arranged for <insert planned admission date>.

It is important to let us know your intention as soon as possible so we can make the right arrangements for your care.

If you **do** wish to have your operation on the above date, please advise the hospital on telephone number <insert number>.

Your confirmation is required within **5 working days** of receipt of this letter. Failure to confirm or attend the given date may result in your admission being cancelled.

If you wish to **postpone** or **cancel** your booking, please telephone the Admissions/Booking Office on <insert number> as soon as possible so that the hospital can schedule another patient. Please note that your clinical priority category will change if you postpone, and you may wish to discuss this with your treating doctor.

Prior to the procedure you may be required to attend the Pre-Admission clinic. At the clinic you will have any tests necessary and you may be required to complete admission paperwork, which will be processed by the admissions clerk.

All pre-operative instructions and any preparations required prior to the procedure will be given to you at the clinic. You will also have the opportunity to ask questions.

Your appointment at the clinic will be on <insert date> at <insert time>. You may be required to be at the clinic for <insert timeframe e.g. 2 hours).

Please bring any medications you are taking with you to the clinic appointment. You are also required to bring your Medicare Card, Health Fund and other relevant details with you.

If the clinic appointment is not suitable please contact <insert number> as soon as possible. Failure to attend the clinic appointment will mean that your date for the procedure is postponed until another appointment and rescheduled admission date can be arranged.

Please report to < insert location>, <insert directions> for your clinic appointment. (Include map or brochure about parking and public transport options)

If you have any queries about your admission to hospital, please contact our <insert position name and contact number>.

We look forward to providing your hospital care.

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 5 - Postponement/Delay Letter

Dear <insert patient name>

It is with regret that I must advise you, that due to unforeseen circumstances, it has been necessary to delay your admission to hospital. This delay has been discussed with your treating doctor.

I wish to apologise for any inconvenience this may cause, and to advise you that a new admission date has been scheduled.

Your admission is now rescheduled for<insert date/time>

If you require any additional information please do not hesitate to contact the Admission/Booking Office on <insert telephone number> between 9.00am to 4.00pm Monday to Friday.

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 6 - Change of Clinical Priority Category, Letter Advising Treating Doctor

Dear <insert Dr's name>

I am writing to advise you as of <insert date> your patient:

<insert patient name>

<insert patient address>

has had their clinical priority category changed from <insert clinical priority category> to <insert clinical priority category>.

If you have any concerns or require further information about the change in clinical priority category for your patient, please contact <insert position name and contact number>.

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 7a - Removal from Waiting List, Letter Advising GP

Dear <insert Dr's name>

I am writing to advise you as of <insert date> your patient:

<insert patient name>

<insert patient address>

has been removed from the waiting list at <insert hospital name>, due to <insert reason>. The patient has been advised to contact you if they have any concerns.

The patient's specialist <insert Dr's name> has also been made aware of <insert patient name> removal from the waiting list.

If you have any concerns or require further information about this removal from the waiting list, please contact <insert position name and contact number>.

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 7b - Removal from Waiting List, Letter Advising Treating Doctor

Dear <insert Dr's name>

I am writing to advise you as of <insert date> your patient:

<insert patient name>

<insert patient address>

(Choose the appropriate option)

has been removed from the waiting list at <insert hospital name>, due to <insert reason>. The patient has been advised to contact you if they have any concerns.

Or

will be removed from the waiting list at <insert hospital name>, due to <insert reason - **declines treatment, fails to arrive or requests removal**>, if you do not contact this office within 5 working days to advise that the patient is to remain on the waiting list.

If you have any concerns or require further information about the removal of your patient's name from the waiting list, please contact <insert position name and contact number>.

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 7c - Removal from the Waiting List, Letter Advising Patient

Dear <insert patient's name>

I am writing to advise you as of <insert date> your name was removed from <insert Dr's name> waiting list at <insert hospital name>.

.

Your specialist and general practitioner have been advised that your name has been removed from the waiting list. You may wish to discuss any concerns you have with them.

If you require further information about your removal from the waiting list, please contact <insert position name and contact number>.

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 8 - Audit Letter

Dear <patient's name>

We are continually updating our waiting lists so they remain accurate, complete and ensure your timely access to our services.

To enable us to keep our waiting list accurate we would ask you to complete the section below and return it in the envelope provided within **10 days**.

We acknowledge that you may have previously received and replied to this request, and apologise for any inconvenience caused, however it is important that this information is obtained regularly, reviewed and our records updated.

Should your clinical condition change you should notify your general practitioner, your specialist or the hospital <insert position name and contact number of clinical staff who can provide advice on management of worsening condition>. Changes in your condition or general health may have implications for the timing of your procedure or lead to your clinical priority category being re-assessed.

If you **do not** confirm that you wish to remain on the list within **10 working days** of receiving this letter, one other attempt will be made to contact you. If there is still no response your name, in consultation with your doctor may be removed from the Hospital's waiting list.

Would you please tick one of the boxes below

- I still require my surgery and I am ready for surgery at this time
- I wish to be taken off the waiting list as I have had my surgery elsewhere
- I wish to be taken off the waiting list, as I no longer require the surgery

If you wish to know your current waiting time or discuss an alternative option for your care please contact the Area Patient Access Coordinator on <insert number>.

Should you have any concerns or if we can assist you in any way please contact the Admission Office on <insert number> or if you have access to the web you can access information about specialists' waiting times at the NSW Health web site:

<http://www.health.nsw.gov.au/hospitals/waitingtimes/index.asp>

Thank you for taking the time to complete this form. Could you now sign this form and return it in the **envelope provided within 10 working days**.

Patient/Carer Signature: _____

Date: ____/____/____

Yours faithfully

<Signature block>

Title: Waiting Time and Elective Patient Management Policy

Appendix 9 - Notification to GP of Resignation/Death

Dear <insert gp's name>

I am writing to inform you that <insert Dr's name> is no longer admitting patients at this <insert hospital>.

Your patient <insert patient name> is currently on our waiting list and we will attempt to transfer your patient to another specialist's waiting list, however in the interim your patient may contact you for advice and information, or a referral to another specialist for the management of their condition.


If you have any concerns or require further information about this situation, please contact <insert position name and contact number>.

Yours faithfully

<Signature block>

Title: *Waiting Time and Elective Patient Management Policy*

Appendix 11 - Amendment to Elective Waiting Time Booking Form

 Insert Area Health Service Insert Hospital Name	Affix Patient Identification Label Here
Amendment to Elective Waiting Time Booking	

AMO: _____ Procedure: _____

Listing Date: _____ Original Clinical Priority: _____

Table 1: CPC Change

Date	Time	Changed to	Status Review Date	Reason for Change	Notified by	Initials

Table 2: Delay (Hospital Based)

Date	Time	Delay Reason	New PAD	Date Patient Notified Verbally	Date Patient Notified in Writing	Initials

Table 3: Deferral (Patient Based)

Date	Time	Defer Reason	Notified By	Status Review Date	Provisional PAD	Initials

Table 4: Staged (Clinically Based)

Date	Time	Staged Reason	Notified By	Status Review Date	Provisional PAD	Initials

Table 5: Removal from List (Other than Admission)

Date	Time	Removal Reason	CPC	Notified By	Written Clinical Authorisation (Cat 30 >Days)	Patient Notified in Writing	Specialist Notified in Writing	Initials

Title: *Waiting Time and Elective Patient Management Policy*

Appendix 12 - RFA Checklist

RFA Receipt Checklist

	Item for Checking	Action
Minimum Data Set (Referring Doctor)	Patient's full name	Send Incomplete RFA Form letter to surgeon via fax
	Patient's address	
	Patient's contact information	
	Patient's gender	
	Patient's Medicare number	
	Patient's date of birth	
	Clinical priority category	
	Discharge information (no of nights in hospital))	
	Planned procedure/treatment	
	Presenting problem	
	Significant medical history	
	Treating doctor (if different)	
	Local Medical officer (GP)	
	Patient Consent (if available)	
(Admission Staff)	Special requirements (ICU bed, equipment)	For ICU bed Notify (name) For special equipment notify (name)
	Interpreter Required	Contact Interpreter Service when required (Pre-admission & admission)
	Planned admission date (if available)	For data entry to PAS/Operating Theatre System
	Anticipated election status	Election status to be discuss with patient by Admission/clerical staff
	Status review date for staged patients (NRFC)	A status review date or planned admission date is required for all NRFC staged patients
Clinical Priority Category (CPC)		If CPC differs from reference list – RFA is to be referred to Admissions Manager for action
CPC 30 day Category Patients	Check that surgeon has allocated a planned admission date.	An RFA that has no dates or date is allocated outside 30 days to be referred to Admission Manager
Cosmetic & Discretionary Surgery List Check	Check that procedure is not listed under cosmetic or discretionary procedures (section 2.3 waiting times & Elective Patient Management Policy)	An escalation process should be in place according to the management structure

Title: *Waiting Time and Elective Patient Management Policy*

11. REFERENCES

Advice for Referring & Treating Doctors – Managing Elective Patient/Waiting Lists:

http://www.health.nsw.gov.au/policies/ib/2009/IB2009_018.html

Extended Day Only Policy:

http://www.health.nsw.gov.au/policies/pd/2007/PD2007_065.html

Surgical Activity during Christmas New Year Period Policy:

http://www.health.nsw.gov.au/policies/pd/2006/PD2006_105.html

Classification of Venous Disease

Venous disease of the legs can be classified according to the severity, cause, site and specific abnormality using the CEAP classification. Use of such a classification improves the accuracy of the diagnosis and improves communication between specialists. The elements of the CEAP classification are:

- Clinical severity
- Etiology or cause
- Anatomy
- Pathophysiology

For the initial assessment of a patient, the clinical severity is the most important and can be made by simple observation and does not need special tests. There are seven grades of increasing clinical severity:

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

Title: Waiting Time and Elective Patient Management Policy

12. ACRONYMS

AHS	Area Health Service
AMO	Attending Medical Officer
ASAP	As soon as possible
CAT	Category
CEAP	Clinical, Etiology, Anatomy, Pathophysiology
CEO	Chief Executive Officer
CMBS	Commonwealth Medicare Benefits Schedule
CPC	Clinical Priority Category
DO	Day Only
DOSA	Day of Surgery Admission
DR	Doctor
DVA	Department of Veteran Affairs
EDO	Extended Day Only
GP	General Practitioner
HDU	High Dependency Unit
ICU	Intensive Care Unit
KPI	Key Performance Indicator
NRFC	Not Ready for Care
PAD	Planned Admission Date
PAS	Patient Administration System
PPG	Photoplethysmography
RFA	Recommendation for Admission
RFC	Ready for Care
SRD	Status Review Date
WC	Workers Compensation