Waiting Time and Elective Surgery Policy

Summary The Waiting Time and Elective Surgery Policy is the reference guide for facilities to manage elective surgery and medical waiting lists. The policy covers the procedures that facilities are required to follow to adequately manage waiting lists to ensure that patients are treated within their clinical priority timeframe.

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Applies to Local Health Districts, Specialty Network Governed Statutory Health Corporations, Affiliated Health Organisations, Dental Schools and Clinics, Public Hospitals

Distributed to Public Health System, Divisions of General Practice, NSW Ambulance Service, Ministry of Health

Audience Local Health Districts & Network Executives;Hospital General Managers;Admission/Booking Staff

Secretary, NSW Health

NSW GOVERNMENT Health

POLICY STATEMENT

WAITING TIME AND ELECTIVE SURGERY POLICY

PURPOSE

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

MANDATORY REQUIREMENTS

This policy has been developed to promote clinically appropriate, consistent and equitable management of elective surgery patients and waiting lists in public hospitals across NSW. Local Heath Districts, Sydney Children's Hospitals Network, St Vincent's Health Network and hospitals must actively manage in compliance with the contents of this policy.

IMPLEMENTATION

Local Health Districts, Sydney Children's Hospitals Network and St Vincent's Health Network are responsible for the implementation of the Waiting Time and Elective Surgery Policy.

The Chief Executive has overall responsibility for ensuring:

- There are mechanisms in place to implement this policy
- Compliance with NSW Department of Health 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 elective surgery/procedure (with an allocated surgical indicator procedure code) regardless of admission type are recorded on the Inpatient Patient Administration System (PAS)/WLCOS.

The responsibilities of various positions under this policy are detailed in the Introduction (page 1) of the attached procedure.

REVISION

February 2012 (PD2012_011)	Director-General	Replaces PD2009_018. Updated to reflect amendments to current policy
April 2009 (PD2009_018)	Director-General	Updated and replaced PD2006_020
March 2006 (PD2006_020)	Director-General	Policy released

ATTACHMENT

- Waiting Time and Elective Surgery Policy

NSW GOVERNMENT Health

POLICY

Managing elective surgery patients in NSW public hospitals

Contents

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 this policy align with Commonwealth Categories in the National Data Dictionary.

Managing elective surgery 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 Surgery Policy has been developed to promote clinically appropriate, consistent & equitable management of elective surgery patients and waiting lists in public hospitals across NSW and has been approved by the Surgical Services Taskforce (SST). Hospitals must actively manage in compliance with the contents of this document.

This policy covers both Local Health Districts and the two networks (St Vincent's Health Network & Sydney Children's Hospitals Network).

The Chief Executive 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 elective surgery/procedure (with an allocated surgical indicator procedure code) regardless of admission type are recorded on the Inpatient Patient Administration System (PAS)/WLCOS.

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 available resources to promote the most effective use of available resources.
- Access to treatment is based on clinical need regardless of health insurance status.

RESPONSIBILITIES

Responsibilities of the Patient

- Follow the procedures and advice outlined in the information provided by the hospital.
- Advise the hospital of any change in decision to undergo the procedure/treatment.
- Follow hospital admission procedure and advise of any changes to the proposed admission such as availability or change of address or other contact details.
- Attend any preadmission appointments as required and present, on the day of admission.

Responsibilities of the GP

- Arrange referral for patients to a hospital which has surgeons with the appropriate expertise and waiting time for the anticipated elective surgical procedure (outpatient or private rooms waiting time, travelling time and patient choice should be considered).
- Provide the hospital with appropriate health information and personal details of the patient with referral.
- Liaise with the referring surgeon if there is a change in indications for surgery or change in patient's health with implications for surgery and treatment.

Responsibilities of the Surgeon

- Explain proposed procedure/treatment, options for treatment and potential complications.
- Anticipated length of stay and obtain written informed consent from the patient.
- Assign a clinical priority category for the procedure/treatment, as it applies to the individual patient as per the "Advice for Treating Doctors".
- If patient is classified as staged, the time interval when the patient will be ready for care should be indicated.
- Ensure that RFA forms are legible and minimum data set is completed.
- Forward the completed RFA direct to the hospital within 3 working days of the patient. agreeing to the proposed procedure/treatment (via the most relevant means e.g. mail, hand delivery, by patient or carer).
- Initiate prompt and appropriate communication with the referring GP regarding management of the patient.
- 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.
- Review Waiting List at least monthly and verify with the hospital.

Responsibilities of the Surgical Booking Clerk

- Ensure all relevant data is entered on the waiting list system within 3 working days, including changes notified by the patient, GP, surgeon, registrar, administrative or other staff.
- Check allocated Clinical Priority Categories against the Reference List (IB2012_004).
- Ensure all documentation and electronic data input is accurate, legible and complete.
- Comply with local procedures/protocols for administrative processes that support this Policy.
- Ensure procedures included in the excluded or discretionary list of procedures are not added to the waiting list without approval from the Clinical Director of Surgery.

Responsibilities of the Clinical Director of Surgical Services

- Ensure clinician compliance with this Policy.
- Review and manage applications to perform cosmetic and discretionary procedures or exceptions to the Policy.
- Promote efficient and effective waiting list management by clinicians within their hospital.
- Liaise with the District/Network Program Director of Surgical Services for escalation of any issues.

Responsibilities of the District/Network Program Director of Surgical Services

- Ensure all staff comply with this Policy.
- Ensure that mechanisms, including clear administrative and clinical procedures/protocols, are in place to implement this Policy and promote efficient and effective waiting list management within all levels of hospital management. This includes the provision of adequate facilities/ staff/work environment to facilitate the surgical management of patients referred to the hospital.
- Facilitate prompt and appropriate communication with the referring GP regarding management of the patient.
- Liaise with the State Program Director of Surgery and the Surgical Services Taskforce.

2. REFERRING PATIENTS TO THE WAITING LIST

POLICY	• Recommendation for Admission Form (RFA) only accepted from clinicians who are currently contracted and appropriately credentialed with the Local Health District/Network or facility. • Recommendation for Admission Form (RFA) must be complete, legible and accurate.

The referring doctor must:

- Have fully informed the patient about the planned procedure or treatment and obtained their consent (see PD2005_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 *A clinical assessment of the priority with which a patient requires elective admission*		
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 yet ready for admission (**staged**) and those who have deferred admission for personal reasons (**deferred**).	Not Ready for Care

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 (see Advice for Referring & Treating Doctors, Reference List for Clinical Priority Categories, (IB2012_004). 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 12).

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.

If any changes are made to a patient's original clinical priority category, by an authorised doctor, then the referring doctor should be notified, in writing (Appendix 7), of the change.

Written advice of any clinical priority category change should always be sent to the treating doctor.

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 Local Health District/Network 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 Local Health District/Network Program Director of Surgery.

Refer to "Advice for Referring and Treating Doctors" booklet for further information, IB2012_004.

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 Local Health District/Network 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 Local Health District/Network Program Director of Surgery for review prior to the patient being added to the waiting list.

- The patient should be advised when the Recommendation for Admission is going through the approval process.

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
Bilateral breast augmentation	Nil
Replacement breast prosthesis	Replacement for post cancer patients only
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
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 > C3
Laser photocoagulation	Nil

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
TMJ Arthrocentesis	Nil
Labioplasty	Nil

New Procedures and Prostheses

Local Health District/Network New Interventions Assessment Committees 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, PD2005_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 Local Health District/Network as part of normal waiting list management according to NSW Health Department policy.

Demand Management

Patients added to the elective surgery waiting list should be treated within their clinical priority timeframe.

Managers & Department Heads should actively monitor the current volume of each surgeon's waiting list plus the additions to the waiting list to ensure that there is capacity to undertake the patient's surgery within the recommended timeframe. If the surgeon does not have the capacity to undertake the surgery within the clinical priority timeframe then this should be managed in conjunction with the surgeon, patient and referring General Practitioner by considering:

- Additional theatre time at same or other facility.
- Transfer of patients to another surgeon with a shorter waiting list at the same facility.
- Transfer of patients to another surgeon with a shorter waiting list at another facility.
- Private sector option if the above prove unsuccessful (Local Health District/Network responsible for expenses incurred).

Dental Surgery

For operating lists that are dedicated to the Priority Oral Health Program – patients must be eligible for treatment as identified in the Priority Oral Health Program and List Management Protocols Policy Directive (PD2008_056).

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	Admission/Booking Staff
• Patient's full name • Patient's address • Patient's contact information (home, work & mobile telephone) • Patient's gender • Patient's date of birth • Medicare number • Clinical priority category • If classified as staged, the time interval when the patient will be ready for care should be indicated • 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) • General Practitioner's name and address (if available) • Interpreter required	• Planned admission date (if allocated) • Anticipated election status • Status review date (staged patients) • Short notice/Standby offers • Aboriginal & Torres Strait Islander Status (NSW Health Data Dictionary)

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).
- Specific preadmission requirements.
- 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 the patient agreeing to the proposed procedure/treatment (via the most relevant means e.g. mail, hand delivery, by patient or carer).

- Facsimiles(fax) RFA's should not be routinely used and only be accepted for urgent admissions where there is limited time to send a hard copy. An RFA (hardcopy) is to follow as soon as possible.

- 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 RFAs 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.

2.5. Information for Patients

POLICY	• 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). • Under the Medicare principles, public patients are allocated to a doctor by the hospital. While generally public patients will be admitted under the care of the referring surgeon this is not guaranteed. This must be explained to patients when they agree to be treated as a public patient.

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	• RFA forms are complete, accurate, legible and date stamped.
O	• Patients should be placed on the electronic waiting list within 3 working days of receipt of a completed RFA.
L	• An RFA with a requested admission date of >12 months should be discussed with the treating doctor before confirmation of acceptance.
I	• If an RFA is not presented within 3 months of the date the RFA was signed by the referring doctor a review of the patient's clinical condition may be required before the RFA is accepted.
C	• At the time of lodgement of the RFA, a patient should be ready for care and be able to accept an assigned planned admission date.
Y	• If the RFA is for a staged procedure, the time interval when the patient will become ready for care must be stated on the RFA.

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 13) when in receipt of RFAs to ensure that they are completed 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 sought as soon as possible in writing from the referring doctor (Appendix 1).
- When a Recommendation for Admission Form is received by the hospital, the hospital should ensure that the patient is placed on the waiting list within 3 working days. The practice of holding Recommendation for Admission Forms and not entering them onto the Patient Administration System is not permitted.
- Where there is a query about the appropriateness of the CPC, a discussion should occur 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 from receipt. If there is no clinical evidence provided on the RFA then the Reference List CPC (IB2012_004) should be used until clarification is sought from the treating doctor.
- The original RFA should remain in the booking office following presentation regardless of missing information. A **copy** of the RFA and incomplete RFA letter proforma (Appendix 1) or telephone call to the doctor should be used to complete the mandatory information. This is to ensure that the RFA is not lost or misplaced.

- If an RFA is presented with a planned operation date > 12 months ahead, discussion with the referring doctor will be required. The RFA will only be accepted if the patient's clinical condition requires surgical intervention within 12 months.

- Ideally, the referring doctor should have obtained the patient's consent prior to placing the patient's name on the waiting list and not deferred to time of admission or pre-admission clinic.

- The original listing date stamped on the RFA should be used when adding the RFA to the PAS.

- If there are problems with an RFA, the hospital **must advise** the referring doctor as soon as possible. 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 hospital staff.

- 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 option, 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** - A Local Health District/Network 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, PD2005_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. This is to ensure that the patient has been reviewed to assess that they are clinically ready to undergo the subsequent procedure.

- **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 priority category assigned to both bookings e.g. if one is category 2 (within 90 days) and the other is category 3 (within 365 days) then the category 2 takes precedence. However if both RFAs have the same clinical priority category the referring doctor should be asked to specify the priority.

  The only exception to the above is for ongoing regular treatment e.g. tissue expansion or 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.

- **Patients treated as Privately Referred Non Inpatients (PRNIP)**
  - All Elective Surgical patient's names should be added to the public hospital waiting list (PAS) regardless of admission type
  - A copy of the Recommendation for Admission Form is to be held at the public hospital
  - The patient should be managed as per the Waiting Time & Elective Surgery Policy.

- **Contracts with other Local Health District/Network** – Where a contract exist with a another Local Health District/Network to undertake public patient's surgery/procedures, the following actions should be undertaken:
  - Patient should remain on the original public hospital waiting list (PAS)
  - Patient should be added to the receiving public hospital waiting list (PAS) with the new listing date
  - A copy of the Recommendation for Admission Form is to be held at the original public hospital (with the original being forwarded to the new hospital)
  - The patient should be managed as per the Waiting Time & Elective Surgery Policy
  - The hospital where the procedure is undertaken should advise the original public hospital when the procedure is undertaken and patient is to be removed from the original hospitals waiting list.

- **Contracts with Private Hospitals** – Where a contract exist with a private hospital to undertake elective surgery/procedures for the Local Health District/Network, the following actions should be undertaken:
  - Patient should be added to the public hospital waiting list (PAS)
  - A copy of the Recommendation for Admission Form is to be held at the public hospital
  - The patient should be managed as per the Waiting Time & Elective Surgery Policy
  - The private hospital should advise the public hospital when the procedure is undertaken and patient is to be removed from the public hospital waiting list.

4. REGISTRATION ON THE WAITING LIST

POLICY	• Accurate entry of data on to the electronic waiting list is essential.

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 time, 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 working 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.

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 remains 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 (they should not be moved into NRFC).
- Following the clinical review, a new RFA is not required unless the original procedure being undertaken has changed.

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

- Change in the clinical condition of the patient.
- 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 **organised 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 must be at no cost to the patient

Circumstances triggering a Clinical Review:

5.3.1. Category 1 Patients:

Circumstance	Action
• When patient is listed as Category 1 but then requests deferment as Not Ready for Care > 15 cumulative days	• Consult with treating doctor, activate a management plan within 5 working days that includes documented Ready for Care date and if clinically appropriate, re-categorise. • Advise patient. • Advise GP.
• When total RFC time is > 30 days	• Request clinical review by appropriate clinician within 5 working days that includes documented Ready for Care date and if clinically appropriate, re-categorise. • Advise patient. • Advise GP.

5.3.2. Category 2 Patients:

Circumstance	Action
• When patient is listed as Category 2 but then requests deferment as Not Ready for Care > 45 cumulative days	Category 2 patients may require: • Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days. • Depending on Clinical Review outcome: o Allocated date o Re-categorisation o Removal from the waiting list. • Advise patient. • Advise GP.
• When total RFC time is > 90 days	Category 2 patients may require: • Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days Depending on clinical review outcome: o Allocated date o Re-categorisation o Removal from the waiting list. • Advise patient. • Advise GP.

5.3.3. Category 3 Patients:

Circumstance	Action
• When patient is listed as Category 3 but then requests deferment as Not Ready for Care > 180 cumulative days	Category 3 patients may require: • Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days. • Depending on Clinical Review outcome: o Allocated date o Re-categorisation o Removal from the waiting list. • Advise patient. • Advise GP.
• At 270 days, if the patient has no planned admission date within the timeframe	Category 3 patients may require: • Clinical review by the appropriate clinician preferably within 15 working days, but not exceeding 30 days. • Depending on Clinical Review outcome: o Allocated date o Re-categorisation o 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 8b). The patient is to be removed from the waiting list after 5 working 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 or recorded on the RFA 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.

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	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: • **Staged -** not ready for clinical reasons. • **Deferred -** not ready for personal reasons.

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

STAGED PROCEDURES

Not Ready for Care – Staged Only

- On request for admission the Not Ready for Care timeframe should be identified by the treating doctor and a RFC clinical priority category indicated.
- Once the identified NRFC staged timeframe is completed the patient then returns to the RFC category as indicated by the treating doctor.
- A PAD/TCI can be arranged whilst the patient is in the category of Not Ready for Care.

DEFERRED PROCEDURES

Not Ready for Care – Deferred Only

- The period of time the patient request deferment should be determined and the patient returned to the original CPC at that timeframe.
- A deferred patient should not exceed the timeframes for their clinical priority category as indicated above.

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)
Unfit • A co-morbidity exists which, until resolved, renders them unfit for the proposed treatment.
Planned • 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)
• 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	• Effective admission and discharge processes are required to ensure optimal use of operating theatre time and beds.

- **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
  - Community Care and Post discharge services for an effective communication to handover patient care to their General Practitioner or other relevant community services as required
  - Aboriginal Liaison Officer (ALO) if available, so the patient/carer is asked if they would like to request an ALO visit during their admission.

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, including the proposed length of stay, discharge procedures and post operative follow up.

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

Short notice Patients

"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.
- Patents on the "short notice" list should be called as "in turn" as much as possible.
- Once a patient has been on 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	Patient postponements should be avoided and only occur when all options are exhausted and senior management have made the decision. If a postponement is to proceed then the following steps should be taken: • 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 the postponement.

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 Local Health District 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 Local Health District/Network.

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.

If a postponement is to proceed then the following steps should be taken:

- 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.

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 relevant personnel – head of unit or specialty, medical administrator, clinical director, divisional manager, operating theatre manager, waiting time coordinator, hospital executive officer and Local Health District/Network Chief Executive or delegate.

- 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 postponed 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) Postponed patients are to be placed on the next available procedure/treatment list, appropriate to the patient's clinical priority category.
  - A new PAD should be allocated within 5 working days of the postponement.

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 surgeon should be advised

- The patient should be admitted and discharged
- The reason for cancellation should be recorded and an appropriate clinician should discuss with the requirement for surgery with the patient's General Practitioner
- If the surgery is still clinically required and the patient agrees, 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

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 Local Health District Patient Access Coordinator – 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 Local Health District (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.

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

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

The offer to the patient has to be considered "reasonable". 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 planned admission date or 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.
- Where the patient declines **two** genuine offers of treatment with another doctor or at another hospital, then the patient should be advised that they may be removed from the waiting list. The Local Health District Program Director of Surgery should review the patient's status on the waiting list in consultation with the original treating doctor prior to the patient being removed from the waiting list.

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 Local Health District/Network, 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.
- The original RFA should be sent to the receiving hospital and a copy retained for auditing at the original hospital.

For patients being treated by another LHD/Network see section 3.3 Contracts with other Local Health Districts/Networks.

5.10. Removing Patients from the Waiting List

POLICY	• In addition to removal from the waiting list once the planned procedure is performed, patients may need to be removed from the waiting list for other reasons. • 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.

Reason	**Category 1, 2 & 3 Actions**
Patient declines treatment or **requests** removal for other reasons. Patient defers treatment on 2 occasions (including other genuine offers of another doctor/hospital) 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 Patient fails **to arrive** to treatment on >1 occasion without giving prior notice and with no extenuating circumstances.	• Forward a copy of the RFA with a covering letter (Appendix 8b) 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. • Obtain authority for **Category 1 (30 day)** patients prior to removal from waiting list. Once decision is made to remove patient from waiting list: o Obtain unit head or delegated unit representative's written authorisation and documentation on RFA to remove and record of any discussion with patient o Remove patient from the waiting list o Advise GP that patient has been removed (Standard Letter Appendix 8a) o Send letter to patient (Appendix 8c) o Document actions on RFA and electronic record (refer to section 6.4).
Refusal of Clinical review Patient refused or failed to attend a clinical review or a pre-admission clinic when required.	• 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 8a and 8b). • Obtain authority for **Category 1 (30 day)** patients prior to removal from waiting list.

Reason	Category 1, 2 & 3 Actions
Patient not **contactable on 2 occasions (one by phone, one by letter)**	• Attempt to obtain patient's correct contact details via all these methods: o Referring doctor, GP, medical records, next of kin & telephone directory search o Obtain written authorisation of a Senior Medical Officer or delegate to remove o Remove patient from the waiting list o Advise referring doctor and GP that patient has been removed (Standard Letter Appendix 8a and 8b) o Document actions on RFA and electronic record (refer to section 6.4).
Patient **deceased**	• 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).

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	• Hospitals must keep accurate records of waiting list information. • Document any changes on RFA and electronic waiting list.

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 11) 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 LH District/Network*

- 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 GPs should be advised (Appendix 8a and 8b).

Reason	Information to be Recorded/Filed (RFA & Electronic)
Patient Deceased	• Record the name of the person who has notified the hospital that the patient is deceased.
Non contactable	• Evidence of contact: o patient letters returned (return to sender) o documentation of attempts to contact through referring doctor, GP, medical records, next of kin & telephone directory search.
Decline treatment or clinical review/not required	• Documentation that patient has been informed of the potential risks to their health and advised to contact referring doctor (Appendix 8c). • Obtain authority for **Category 1 (30 day)** patients prior to removal from waiting list.
Fail to Arrive for Treatment	• Documentation that: o Patient has failed to arrive for treatment on the planned admission date > 1 occasion without prior notice and without good reason o 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 Local Health District/Network 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 Local Health District/Network **monthly.** The Health Services Performance Improvement Branch at NSW Health will monitor duplicate bookings across NSW and distributed reports to Local Health Districts **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

POLICY	• 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.

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 Local Health District/Network 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 11).
- 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.

- 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 their patients to each treating doctor **monthly.**
- Treating Doctors must confirm this waiting list with waiting time coordinators.
- Changes required by treating doctor are to be undertaken.

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 9) and one by telephone.
- Audit letter must include:
  - Information on alternative options where available
  - Advice for clinical reassessment by treating doctor or GP
  - Hospital & District/Network contact details.
- Documentation of the patient audit must be readily available, and must include the responses received and the action taken.

8. DOCTOR'S LEAVE - TEMPORARY AND PERMANENT

POLICY	• 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.

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).

- ***Types of Leave***

Type of Leave	Action
Annual, Study, Conference Leave	• 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. • 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 Local Health District Executive or delegate. • During the leave period, no further patients should be added to the doctor's waiting list unless approved by the District/Network Program Director of Surgery.

Type of Leave	Action
Unplanned leave e.g. sick leave, bereavement leave	• A management plan for affected patients is to be **immediately** developed and implemented. • 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 Local Health District Executive or delegate. • During the leave period, no further patients should be added to the doctor's waiting list unless approved by the District/Network Program Director of Surgery.
Planned Resignation e.g. resignation from hospital, retirement,	• 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. • 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 and ensure existing and transferred patients are treated in queue order, within clinical priority categories: o If unable to immediately transfer patients to a replacement doctor's waiting list, patients are to remain on the treating doctor's list.

Type of Leave	Action
Unplanned Resignation or Death	• No addition of patients to the doctor's waiting list. • A management plan for all patients should be immediately developed and implemented. • 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 and 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 10).

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	The AIHW defines admission as 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: o Emergency Admission (Admission within 24 hours) o 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: o Medicare Eligible - Public patient o Medicare Eligible - Private patient o Medicare Eligible - Department of Veterans Affairs patient o Medicare Eligible - Other (compensable, Defence forces etc) o Medicare Ineligible – (e.g. Overseas visitor)
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
Clinical Priority Categories	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: **Category 1** Admission within **30 days** desirable **Category 2** Admission within **90 days** desirable **Category 3** Admission within **365 days** acceptable **Category 4** Not Ready for Care clinical reasons (staged) Not Ready for Care personal reasons (deferred)
Clinical Review	Review of a patient on the waiting list to ensure that their waiting time is appropriate for their clinical condition.
Cosmetic Surgery	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. These procedures do not attract a Medicare rebate.

Definition	Explanation
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)	Day Only Surgery involves the patient being admitted and discharged on the day of surgery. Also referred to as Day Surgery.
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.
EDO	EDO units are specifically designed to accommodate patients - elective and emergency, who meet specific admission criteria including: o 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 Care (National Health Data Dictionary) *Including planned/booked surgery*	Elective surgery comprises elective care where the procedures required by patients are listed in the surgical operations section of the Medicare benefits schedule, with the exclusion of specific procedures frequently done by non-surgical clinicians. Elective care is care that, in the opinion of the treating clinician, is necessary and admission for which can be delayed for at least twenty-four hours.
Elective admission	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). 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.
Electronic waiting list	Patient administration/management system used by the hospital to manage the waiting list e.g. CERNER, iPM & HOSPAS.

Definition	Explanation
Emergency admission	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. These patients are not routinely added to the waiting list, however if they are added for organisational reasons, then the patient is admitted and should be removed from the waiting list as an emergency admission. Where patients are admitted as an emergency (via emergency or as a direct admission) an emergency admission in the Patient Administration System should be generated. If the patient has an existing wait list booking, this should not be used for the emergency admission.
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.
High Volume Short Stay	High Volume Short Stay model builds on the success of the Extended Day Only model by concentrating high volume surgical procedures that require a hospital admission up to 72 hours.
Indicator procedure Code	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	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. The patient may be: o Ready for Care (Category 1, 2 or 3) o Not Ready for Care (Category 4: Staged or Deferred)
Local Health District/Network Access Coordinator	Provides information regarding elective admissions in public hospitals and investigates options where available.
Long-wait patients	Surgical patients who are Ready for Care and have been waiting for planned 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.

Definition	Explanation
Not Ready for Care (NRFC)	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: o staged - not ready for clinical reasons o deferred - not ready for personal reasons See **Clinical Review Section 5.3** for timeframe for NRFC patients. 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.
Not Ready for Care **"deferred"**	The AIHW defines a deferred patient as a patient who for personal reasons are not yet prepared to be admitted to hospital; for example, patients with work or other commitments which preclude their being admitted to hospital for a time. It is mandatory to indicate a reason for deferring. The reason a patient is deferred may be reported as follows: o a patient is going on holidays and will be unavailable for admission o a patient is unable to obtain home support o a patient is unable to accept a date due to work commitments o a patient is unable to accept a date for other significant reasons e.g. personal carer. Patients may not be added to the waiting list as Not Ready for Care deferred.
Not Ready for Care **"staged"**	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 staging. The reason a patient is staged may be reported as follows: **Unfit** o a co-morbidity exists which, until resolved, renders them unfit for the proposed treatment **Planned** o a patient requiring treatment as part of periodic treatment o a patient requiring treatment as part of a staged procedure (includes obstetric patients) o a planned re-admission for a patient with a predictable morbid process, requiring periodic treatment of the ongoing disease process o a planned re-admission for review of status following previous treatment .
Planned admission date	The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care. 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). A patient who has not been given a definite date for admission by the hospital is unscheduled (i.e. the admission is unscheduled).
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.

Definition	Explanation
Planned procedure	The planned procedure is the procedure or treatment the patient is to undergo when admitted.
Pooled lists	At some hospitals, doctors in particular specialties have agreed to include their public patients on a combined list for that specialty. 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. A doctor's private patients would not be included on a pooled list.
Postponement	A patient's elective admission may be postponed by the hospital due to high emergency admissions or other hospital related reasons. See Ready for Care "delayed". A patient may postpone for personal reasons. See Not Ready for Care "deferred".
Pre-admission	Patients are assessed before admission to the hospital for their suitability to undergo the intended procedure/treatment, associated anaesthetic and discharge plans.
Presenting Problem	The problem or concern that is the reason for seeking health care or assistance (NHDD).
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.
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"	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: o non-availability of operating theatre (staff, equipment, resources etc.) o non-availability of bed; o non-availability of bed; pressure of emergency admissions o non-availability of doctor. It is mandatory to indicate the reason for the patient's admission being delayed.

Definition	Explanation
Removing patients from the waiting list, other than for admission	Patients can be removed from the waiting list for reasons other than for admission: o patient declines treatment or requests removal o patient defers treatment on 2 occasions o patient defers & exceeds maximum number of Not Ready for Care days Cat 1 > 15 days; Cat 2 > 45 days; Cat 3 > 180 days o patient fails to arrive on 1 occasion, with no notice or extenuating circumstances o patient not contactable o patient deceased.
Recommendation for Admission form (RFA)	Requests for admission to hospital need to be on an approved form and contain a minimum data set as specified in this policy. 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.
Referring Doctor	Doctor who is referring the patient to the waiting list
Same Day Surgery	See Day Only Surgery (DO)
Specialty	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 specialty (e.g. Obstetrics/Gynaecology). The broad categories required for reporting to NSW Health Department are: o Cardiothoracic o ENT o General Surgery o Gynaecology o Neurosurgery o Ophthalmology o Orthopaedic o Plastic o Urology o Vascular o Dental o Medical o Renal Dialysis o Obstetrics. Hospitals may have many more specific clinical areas identified, but these should be categorised under the main specialty headings for central reporting.
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.

Definition	Explanation
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.

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 Surgery 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** (home, work & mobile)
- ☐ **Patient's gender**
- ☐ **Patient's date of birth**
- ☐ **Patient's Medicare number**
- ☐ **Clinical priority category**
- ☐ **If classified as staged, the time interval when the patient will e ready for care should be indicated**
- ☐ **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)
- ☐ **General Practitioner** (name and address if available)
- ☐ **Special requirements (e.g. ICU bed, theatre equipment)**
- ☐ **Interpreter required**

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>

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.

The hospital may remove you from the waiting list in consultation with your specialist if:

- the hospital is unable to contact you because you have not informed them of a change in your contact details.
- you fail to present for the procedure without providing the hospital with prior notice.
- you postpone your surgery on two occasions for personal or social reasons.

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>

Appendix 3 - GP Notification Letter (*if known and confirmed by patient*)

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>

Appendix 4 - Admission Letter

Dear <insert patient name>

We are pleased 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>

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>

Appendix 6 - Patient Notification Letter – Change to Not Ready for Care: Personal Reasons

Dear <insert patient name>

As you are aware you were referred to <hospital> for elective surgery. The clinical priority category allocated to this procedure is <CPC> and your registration date on the waiting list for this procedure is <date>.

I am writing to confirm that as of <date> your status on the elective surgery waiting list has changed to reflect that because of personal reasons, you are not available for surgery.

When scheduling patient for surgery the hospital considers the patient clinical priority category and the length of time the patient has waited for their surgery and have been ready for care. If your circumstances change and you are once again available for surgery you should notify the hospital as soon as possible.

It is important to note that there is a maximum timeframe that a patient can elect to defer their surgery for personal reasons. The timeframes are:

- **Category 1 patients (admission required within 30 days) = 15 days cumulative**
- **Category 2 patients (admission required within 90 days) = 45 days cumulative**
- **Category 3 patients (admission required within 365 days) = 180 days cumulative**

A representative from the <hospital> will contact you before you have reached these thresholds to confirm whether you are ready for your surgery. If you exceed the thresholds above for personal reasons, you may be removed from the waiting list in consultation with your treating doctor.

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>

Appendix 7 - 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 reviewed by <insert name> and 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>

Appendix 8a - 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>

Appendix 8b - 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>

Appendix 8c - 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> due to <insert reason>.
.

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>

Appendix 9 - 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 Local Health District 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>.

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>

Appendix 10 - 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>

Appendix 11 - Booking Clerk Form

Booking Clerk Form
(This form is Office Use Only – Administrative Staff)
Patients are not to be entered on the Waiting List until all the Minimum Data requirements are completed

RFA received with the following incomplete minimum data requirements (please tick boxes below)

☐ Patient's full name	☐ Planned admission date (if available)
☐ Patient's address	☐ Significant medical history
☐ Patient's contact information	☐ Treating doctor (if different)
☐ Patient's gender	☐ Patient's signed consent
☐ Patient's date of birth	☐ General Practitioner (name and address)
☐ Medicare number	☐ Interpreter required
☐ Clinical priority category	☐ Anticipated election status
☐ If classified as staged, time interval when ready for care	☐ Status review date (staged/deferred patients)
☐ Discharge intention	☐ Short Notice/Standby Offers
☐ Presenting problem	☐ Aboriginal & Torres Strait Islander Status
☐ Planned procedure/treatment	

RFA entered in Patient Administration System: Date:_____ Clerk:_____

Minimum Data Requirements Completed: ☐ Yes ☐ No

Completed RFA received in Admission Office: Date:_____ Clerk:_____

Patient Contacted/Instructions Given: Date:_____ Clerk:_____

This section is to be utilised to document all correspondence with the Referring or Treating Dr, Rooms, Clinics, Ward or patient after the booking has been entered in to the Patient Administration System. For Example: Delays, Cancellations and patient requests can be registered on this form**.**

Date	Clerk	Comments

Appendix 12 - Amendment to Elective Waiting Time Booking Form

NSW HEALTH Insert: Local Health District/Network 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

Appendix 13 - RFA Checklist

RFA Receipt Checklist

	Item for Checking	Action
Minimum Data Set **(Referring Doctor)**	atient's full name	***send incomplete RFA form letter to surgeon via fax***
	Patient's address	
	Patient's contact information	
	Patient's gender	
	Patient's date of birth	
	Patient's Medicare number	
	Clinical priority category	
	If classified as staged, time interval when ready for care	
	Discharge intention (no of nights in hospital)	
	Presenting problem	
	Planned procedure/treatment	
	Significant medical history	
	Treating doctor (if different)	
	Patient Consent (if available	
	General Practitioner	
	Aboriginal & Torres Strait Islander Status	
(Admission Staff)	Interpreter Required	Contact Interpreter Service when required (Pre-admission & admission).
	Special requirements (ICU bed, equipment)	For ICU bed Notify (name). For special equipment notify (name).
	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 date 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 Surgery Policy)	An escalation process should be in place according to the management structure.

11. REFERENCES

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

http://www.health.nsw.gov.au/policies/ib/2012/IB2012_004.html

Extended Day Only Admission Policy:

http://www.health.nsw.gov.au/policies/pd/2011/PD2011_045.html

High Volume Short Stay Surgical Model Toolkit:

http://www.health.nsw.gov.au/policies/gl/2012/GL2012_001.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:

- **C**linical severity
- **E**tiology or cause
- **A**natomy
- **P**athophysiology

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). http://www.simondodds.com/Venous/Spider_veins_FAQ.htm
C 2	Simple varicose veins. http://www.simondodds.com/Venous/Varicose_veins_FAQ.htm
C 3	Ankle oedema of venous origin (not foot oedema).
C 4	Skin pigmentation in the gaiter area (lipodermatosclerosis). http://www.simondodds.com/Venous/LDS.htm
C 5	A healed venous ulcer. http://www.simondodds.com/Venous/Venous_ulcer_FAQ.htm
C 6	An open venous ulcer. http://www.simondodds.com/Venous/Venous_ulcer_FAQ.htm

12. ACRONYMS

AIHW	Australian Institute of Health and Welfare
AMO	Attending Medical Officer
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
HVSS	High Volume Short Stay
ICU	Intensive Care Unit
LHD	Local Health District
NRFC	Not Ready for Care
PAD	Planned Admission Date
PAS	Patient Administration System
RFA	Recommendation for Admission
RFC	Ready for Care
SRD	Status Review Date
WC	Workers Compensation