Managing elective surgery patients in ACT public hospitals
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1 INTRODUCTION

Each year approximately 11,000 people from the Australian Capital Territory (ACT) and the surrounding region have elective surgery as patients of the ACT public hospital system.

Elective surgery is defined as surgery that, in the opinion of the treating clinician is necessary, and for which admission can be delayed for at least 24 hours. Elective surgery in the public hospital system is provided through the use of waiting lists, which are registers of patients who are waiting for elective care. Patients are placed on a waiting list and given a clinical priority category depending on the seriousness of their condition. Clinical priority categories 1, 2, and 3 referred to in this document align with National Health and Hospitals Network 2010 definitions. These definitions enable hospitals and clinicians to manage the demand for elective surgery based on the level of clinical need and the availability of appropriate facilities and clinical staff.

Examples of elective surgery include, but are not limited to, cataract removal, gall bladder removal, coronary artery surgery, inguinal hernia repair, total hip replacement and total knee replacement.

The capacity of the public health system to provide elective surgery is governed by a number of crucial factors. These include the demand for emergency surgery, demand for the surgical specialty, demand for hospital beds due to emergency and urgent medical care, the supply of surgeons, anaesthetists and nursing staff, theatre capacity, scheduling and management practices, and effective discharge planning of patients from hospital.

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

The Elective Surgery Access Policy 2011 has been revised and renamed to improve understanding and provide more detailed guidelines to promote clinically appropriate, consistent and equitable management of elective surgery patients and waiting lists in the ACT public hospital system.

This document named Waiting Time and Elective Surgery Access – Managing elective surgery patients in ACT public hospitals, provides the guidelines to implementing the Waiting Time and Elective Surgery Access Policy 2013 (DGD13-XXX).

Hospitals have a responsibility for ensuring compliance with the contents of this document, and that processes are in place to:

- Implement the framework
- Identify staff roles and responsibilities
- Validate the accuracy and integrity of reported data
- Regularly review individual hospital performance against Locally and Nationally set key performance indicators i.e. National Elective Surgery Targets (NEST)
- Train and educate staff managing elective patients and the waiting lists
The framework seeks to:

- Support active management of elective surgery patients
- Support best practice in elective surgery waiting list management
- Identify the rights and responsibilities of hospitals, referring surgeons and patients
- Improve communication among patients, hospitals, referring surgeons and community providers
- Support meaningful reporting to the public by hospitals and the government

The following principles underpin the framework:

- Referrals for elective surgery are clinically appropriate and are representative of a suitable treatment for the patient’s condition;
- Patients are provided with easy to understand information about access to elective surgery and their rights and responsibilities;
- Public patients are the shared responsibility of the hospital, the referring surgeon and the relevant specialty;
- Patients waiting for elective surgery are fully informed about, and have consented to the procedure/treatment;
- All documentation is complete, legible and accurate;
- Waiting list management services are provided in an efficient, transparent and patient-centred manner;
- The elective surgery waiting list is managed to ensure patients are treated equitably within clinically appropriate timeframes and with priority given to patients with an urgent clinical need;
- The scheduling of surgery is undertaken in consideration of available capacity;
- Hospitals minimise the impact and inconvenience to patients whose surgery they postpone;
- The elective surgery waiting list is managed to promote the most effective use of available resources;
- When a surgical specialty is unable to cope with increased demand, the hospital will be informed to escalate options for the patient;
- There is valid, reliable and accountable reporting of access to elective surgery.
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 desire 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 General Practitioner (GP):

- Arrange referral for patients to a hospital that has surgeons with the appropriate expertise and the least waiting time for the anticipated elective surgical procedure (outpatient waiting time, travelling time and patient choice should also 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 any indications for surgery or a change in patient’s health that may have implications for surgery and treatment

Responsibilities of the Surgeon or delegate (Registrar)

- Explain the proposed procedure/treatment, options for treatment and potential complications
- Obtain written informed consent from the patient and discuss the anticipated length of stay
- Assign an appropriate clinical priority category for the procedure/treatment
- If a patient is classified as staged, the time interval when the patient will be ready for care should be indicated
- Ensure that Request For Admission (RFA) forms are legible and the minimum data set is completed
- Forward completed RFA’s directly to the hospital within 5 working days
- Initiate prompt and appropriate communication with the referring GP regarding the proposed management of the patient
- Referring doctors must ensure they are available to perform the procedure within clinical priority timeframe; alternatively, the clinician should make arrangements for another clinician to perform the procedure within the appropriate clinical timeframe
- Review the 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
- Send ACTPAS generated letter (Appendix 1 – Patient Notification) to patient advising of listing on the waiting list
- Send ACTPAS generated letter (Appendix 3 - removal from waiting list) to surgeon, with a copy to the patient and the patient’s GP, when removing patient from the waiting list
- 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 (TCH) / Director of Perioperative Services (CHC).

Responsibilities of the Elective Surgery Liaison Nurse
- Manage clinical aspects of patients on the elective surgery waiting list in accordance with the Waiting Time and Elective Surgery Access framework.
- Develop and implement management plans for elective surgery waiting lists in consultation with surgeons
- Facilitate clinical review of patients on the waiting lists
- Review of patients on the waiting lists who are clinically Not Ready for Care (NRFC)
- Collaboration with Surgical Bookings clerks to effectively plan surgical lists in accordance with the Waiting Time and Elective Surgery Access framework

Responsibilities of the Elective Surgery Access Coordinator:
- Management and validation of the integrity of the elective surgery waiting list data
- Respond to calls and action queries received from Elective Surgery Information Phone Service
- Conduct mail-out clerical audits of patients on the elective surgery waiting list to ensure accuracy of patient information. On completion of the mail-out, a report must be provided to the relevant hospital and ACT Health management. This report must include:-
  - Type of audit conducted, methodology used, problems identified and recommendations for improvement
  - Number of patients removed and reasons for removal from the elective surgery waiting list
  - Prepare a report for Surgical Services Taskforce
- Send elective surgery waiting list to surgeons each month
Responsibilities of the Surgical Booking Manager (TCH) / Perioperative Floor Manager (CHC):

- Monitor and ensure compliance with this framework and take remedial action where issues are identified
- Management and performance of all Surgical Booking Clerks
- Monitor all audits and clinical reviews and take remedial action where issues are identified
- Monitor and ensure compliance with local procedures/protocols for administrative processes that support these guidelines

Responsibilities of the Heads of Unit:

- Ensure clinical compliance with these guidelines
- Liaise with surgeons to actively manage and regularly review long wait patients on their list and to facilitate timely admission
- Facilitate transfer of patients between surgeons/units/hospitals in consultation with Clinical Director of Surgical Services (TCH) / Director of Medical Services (CHC) in order to minimise waiting time, where necessary
- Authorise re-categorisation and removal of patients from the waiting list in accordance with this Framework
- Develop management plans in consultation with Craft Group

Responsibilities of the Clinical Director of Surgical Services (TCH) / Director of Medical Services (CHC):

- Ensure clinician compliance with this Framework
- Review and manage surgeon’s requests to perform cosmetic discretionary procedures or exceptions to the framework
- Promote efficient and effective waiting list management by clinicians within their hospital
- Liaise with Executive Director Division of Surgery and Oral Health (TCH) and Director Perioperative Services (CHC) for escalation of any issues

Responsibilities of the Executive Director Division of Surgery and Oral Health (TCH) / Director Perioperative Services (CHC):

- Ensure all staff comply with this Framework
- Ensure that mechanisms, including clear administrative and clinical procedures/protocols, are in place to implement this Framework 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
- Make Requests to the Surgical Services Taskforce about the allocation of resources between specialties/disciplines/hospitals for efficient waiting list management
Responsibilities of ACT Health:
- To develop a framework including principles, accountabilities and defined roles and responsibilities
- To ensure system wide equity of access for patients by monitoring a range of performance indicators
- To ensure hospitals have a process of consultation and communication with appropriate clinicians and services regarding reduced activity periods
- To collect data and disseminate waiting list information based on a robust reporting and accountability framework
- Distribute and monitor the use of any additional government funding allocated to improving the management of elective surgery

2 REFERRING PATIENTS FOR ELECTIVE SURGERY

The Request for Admission Form (RFA) will only be accepted from clinicians currently contracted and appropriately credentialed with the Medical and Dental Appointments Advisory Committee and the respective hospital.

Request for Admission Forms (RFA) must be complete, legible and accurate.

The referring surgeon must:
- Complete an approved Request for Admission Form (RFA)
- Ensure patients are fully informed about the risks and benefits of the procedure and have consented to the treatment offered. Patient consent should ideally be obtained prior to placing the patient on the waiting list and not deferred to time of admission or at the pre-admission clinic appointment
- Forward the completed RFA to the facility within 5 working days

2.1 Elective Surgery Categorisation

Categorisation of elective surgery patients is prioritised by clinical urgency and is required to ensure patients receive care in a timely and clinically appropriate manner. A clinical urgency priority is assigned by the referring surgeon.

The assignment of a clinical priority category is determined by clinical need following a clinical assessment indicating when a patient requires elective admission.

**Category 1:** Admission within 30 days is desirable for a condition that has the potential to deteriorate quickly to the point that it might become an emergency.

**Category 2:** Admission within 90 days is desirable for a condition causing some pain, dysfunction or disability, but which is not likely to deteriorate quickly or become an emergency.
Category 3: Admission within 365 days is acceptable for a condition which is unlikely to deteriorate quickly and which has little potential to become an emergency.

All public patients must be told that their treatment may be provided by a hospital appointed doctor, not a doctor of their choice. This must be explained when they agree to be treated as a public patient.

When a surgical booking date cannot be established within the appropriate timeframes, the Surgical Bookings Manager (TCH) / Director Perioperative Services (CHC) will explore the following options with the referring surgeon:

- Extra theatre sessions
- Transfer of the patient to another surgeon
- Transfer of the patient to another hospital
- Seek advice from ACT Health Elective Surgery Access Unit re possibility of transfer of category 2 or 3 patients to a private provider
- Re-categorisation with a surgical booking date, if clinically appropriate.

Following discussion of the above options with no appropriate outcome, the Surgical Bookings Manager (TCH) / Director Perioperative Services (CHC) will escalate the issue to the Head of Unit, the Clinical Director and Hospital Executive.

When the Surgical Bookings Manager (TCH) / Director Perioperative and Surgical Services (CHC) find no resolution with the above options, the hospital should conduct a formal review of the referring surgeon’s session allocation.

2.2 Reclassification of Clinical Priority Urgency Category

Re-categorisation of patients should reflect a change in the patient’s clinical need and must only occur following a clinical review. Authority to reclassify a patient’s clinical priority category may only be given by the doctor and must be advised by completing the reclassification of clinical priority form, stating a sound medical reason for the change. This may include a signed statement by the doctor that the patient’s clinical condition is suitable or appropriate to delay the surgery to a later date at a lower category. If there is no form or the form is incomplete, the re categorisation will not be processed.

If the doctor completes a new RFA form with a new clinical priority, this can only be accepted if the patient has signed the consent form, or the doctor provides written evidence that a clinical review has occurred.

If the new RFA has a different principal procedure listed, the original waiting list entry should be removed as “procedure no longer required”. The new RFA is then logged on with a new procedure with the listing date backdated to the original listing date.

Documentation of a re categorisation must be in the patient electronic record giving the reason for this change, and is made prior to, or following, listing on the waiting list.
Patients must be advised within three working days of any change in their clinical priority category. All changes must be documented in the electronic waiting list, including a brief summary of any telephone conversations.

The Elective Surgery Access Unit will conduct monthly audits of all re-categorisations of clinical urgency and report findings to hospital management and to the Surgical Services Taskforce.

2.3 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 the Clinical Director of Surgery or equivalent.

Where there is concern regarding the allocation of the Category 1 status, the issue should be referred to the Clinical Director of Surgery or equivalent.

2.4 Cosmetic & Discretionary Surgery - Inclusion/Exclusion Criteria

Surgery should meet an identified clinical need to improve the physical health of the patient. The referring surgeon must seek the approval of the Clinical Director of Surgical Services (TCH) / Director of Medical Services (CHC), in consultation with senior management before cosmetic and discretionary procedures are undertaken in any public hospital facility.

The referring surgeon must clearly document on the RFA, 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 is an essential requirement that ensures documentation of the clinical decision 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 Clinical Director of Surgical Services (TCH) / Director of Medical Services (CHC) for review prior to the patient being added to the elective surgery waiting list. Advice from the Health Technologies Assessment Committee may also be required.
The following list of surgical procedures should not routinely be performed in public hospitals in the ACT unless there is a clear clinical need to improve a patient’s physical health.

<table>
<thead>
<tr>
<th>Cosmetic Procedure</th>
<th>Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bilateral breast reduction</td>
<td>Severe disability due to breast size. The following conditions will be considered for reduction mammoplasty. Patients suffering from Virginal Hyperplasia/Hypertrophy. Patients with a significant disability who have grossly enlarged breasts such that personal care is hampered and related symptoms experienced - examples might be the older female who has had a significant stroke or a female confined to a wheelchair due to spina bifida or some females who are paraplegics.</td>
</tr>
<tr>
<td>Bilateral breast augmentation</td>
<td>Nil</td>
</tr>
<tr>
<td>Replacement breast prosthesis</td>
<td>Replacement for post cancer patients only</td>
</tr>
<tr>
<td>Hair transplant</td>
<td>Disfiguring hair loss due to severe burn</td>
</tr>
<tr>
<td>Blepharoplasty/Reduction of upper or lower eyelid</td>
<td>Severe visual impairment</td>
</tr>
<tr>
<td>Total rhinoplasty</td>
<td>Major facial trauma</td>
</tr>
<tr>
<td></td>
<td>Congenital abnormality - paediatrics</td>
</tr>
<tr>
<td>Liposuction</td>
<td>Nil</td>
</tr>
<tr>
<td>Abdominal lipectomy (Abdominoplasty)</td>
<td>Nil</td>
</tr>
<tr>
<td>Facelifts / Meloplasty</td>
<td>Nil</td>
</tr>
<tr>
<td>Correction of bat ear (&gt;16 years old)</td>
<td>Nil</td>
</tr>
<tr>
<td>Tattoo removal procedures</td>
<td>Nil</td>
</tr>
<tr>
<td>Removal of benign moles</td>
<td>Nil</td>
</tr>
<tr>
<td>Candela Laser</td>
<td>Congenital abnormality – paediatrics &lt; 17 years</td>
</tr>
<tr>
<td>Skin laser photocoagulation</td>
<td>Nil</td>
</tr>
</tbody>
</table>
### Discretionary Procedure

<table>
<thead>
<tr>
<th>Discretionary Procedure</th>
<th>Exception</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender reassignment surgery</td>
<td>Congenital abnormalities in children</td>
</tr>
<tr>
<td>Lengthening of penis procedure</td>
<td>Congenital abnormalities in children</td>
</tr>
<tr>
<td>Insertion of artificial erection devices</td>
<td>Nil</td>
</tr>
<tr>
<td>Reversal of sterilization</td>
<td>Nil</td>
</tr>
<tr>
<td>Social circumcision</td>
<td>Nil</td>
</tr>
<tr>
<td>TMJ Arthrocentesis</td>
<td>Nil</td>
</tr>
<tr>
<td>Labioplasty</td>
<td>Nil</td>
</tr>
</tbody>
</table>

#### New Procedures

- The Health Technologies Assessment Committee must formally approve new procedures not previously undertaken. Clinicians must also be appropriately accredited to undertake the procedure before patients are added to the elective surgery waiting list. A doctor may only refer patients for addition to the elective surgery waiting list for procedures when the clinician has been accredited by Medical and Dental Appointments Advisory Committee. Surgical procedures should only be conducted at the hospital by an appropriately skilled clinician and where the infrastructure exists to enable the proposed procedure to be performed.

#### Monitoring and Reporting

- Monitoring of the addition of excluded procedures to the elective surgery waiting list will be undertaken by the Surgical Booking Staff/Liaison Nurses at each hospital as part of normal waiting list management in accordance with the Framework.

### 2.5 Demand Management

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

Directors and Managers 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 patient surgery within the clinical priority 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 the same or another facility
- Transfer of patients to another surgeon with a shorter waiting time at the facility
- Transfer of patients to another surgeon with a shorter waiting list at another facility
- Other options, including seeking advice from ACT Health Strategy & Corporate Division re possibility of contracting work out to private sector
2.6 Completion of Request for Admission Form (RFA)

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

<table>
<thead>
<tr>
<th>Referring Doctor</th>
<th>Admission/Booking Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient’s full name</td>
<td>• Planned admission date (if allocated)</td>
</tr>
<tr>
<td>• Patient’s address</td>
<td>• Status review date</td>
</tr>
<tr>
<td>• Patient’s contact information (home, work &amp; mobile telephone)</td>
<td>(staged patients)</td>
</tr>
<tr>
<td>• Patient’s gender</td>
<td>• Short notice/Standby offers</td>
</tr>
<tr>
<td>• Patient’s date of birth</td>
<td></td>
</tr>
<tr>
<td>• Medicare number</td>
<td></td>
</tr>
<tr>
<td>• Clinical priority category</td>
<td></td>
</tr>
<tr>
<td>• If classified as staged, the time interval when the patient will be ready for care should be indicated</td>
<td></td>
</tr>
<tr>
<td>• Discharge intention (i.e. day only, or indication of number of nights in hospital)</td>
<td></td>
</tr>
<tr>
<td>• Presenting problem</td>
<td></td>
</tr>
<tr>
<td>• Planned procedure/treatment</td>
<td></td>
</tr>
<tr>
<td>• Estimated operating time</td>
<td></td>
</tr>
<tr>
<td>• Treating doctor (if different)</td>
<td></td>
</tr>
<tr>
<td>• Patient’s signed consent (if available)</td>
<td></td>
</tr>
<tr>
<td>• General Practitioner’s name and address (if available)</td>
<td></td>
</tr>
</tbody>
</table>

Other relevant information should be included on the RFA that may include:

- Significant medical history
- Specific preadmission requirements
- Special operating theatre equipment
- Requirement for an ICU/HDU bed post procedure
The referring doctor must:

Forward the completed RFA directly to the hospital within 5 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) of RFA’s should not be routinely used and only be accepted for urgent admissions where there is limited time to send a hard copy. A 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 5 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

2.7 Information for Patients

- 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 elective surgery 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 Request for Admission Form (RFA)
- Under the Medicare agreement, 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:
  o The reason for referral to the waiting list
  o The waiting list process, including clinical priority categories
  o The circumstances in which care might be provided by another doctor or health service
  o 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:
  o Provide the patient with sufficient information to enable them to choose whether to be treated as a private or public patient
  o 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

3 ACCEPTANCE OF REQUEST FOR ADMISSION FORM (RFA)

• RFA forms are complete, accurate, and legible and date stamped
• Patients should be placed on the electronic waiting list within 3 working days of receipt of a completed RFA
• A RFA with a requested admission date of >12 months should be discussed with the treating doctor before confirmation of acceptance
• If a RFA is not processed 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
• Patients should be ready for care at the time the RFA is lodged and be able to accept an assigned planned admission date
• 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 2.5 lists the minimum data set required for acceptance)
• RFA forms must be date stamped upon receipt
• When information is missing on the RFA, a telephone call to the referring doctor may be an appropriate option to ascertain the missing information.

• The original RFA should remain in the booking office following lodgement regardless of missing information. A copy of the RFA 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.

• Patients should be placed on the electronic waiting list within 3 working days of receipt of a completed RFA.

• A RFA with a requested admission date of >12 months should be discussed with the treating doctor before confirmation of acceptance. The RFA will only be accepted if the patient’s clinical condition requires surgical intervention within 12 months.

• If a RFA is presented for a procedure(s) a surgeon is unable to perform, for any reason, the RFA is not to be added to the surgeon’s waiting list and should be returned to the doctors rooms as soon as possible.

• On receipt of the RFA form from the consulting room or the outpatient department, the Surgical Booking Clerk is to check that the clinical priority box has been ticked. Any changes to the clinical urgency noted on receipt of the RFA are to be initialled by the doctor, on the RFA form. Changes to the clinical priority without the doctor’s initials are not to be accepted.

• 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 the time of admission or pre-admission clinic appointment.

• The original listing date stamped on the RFA should be used when adding the RFA to ACTPAS.

• If there are concerns or issues with an RFA, the hospital must advise the referring doctor as soon as possible. Patients should not be asked to transport the RFA between hospital and referring doctor. Communications about missing minimum data set information should be between the referring doctor and hospital staff.

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 Clinical Director of Surgery (TCH) or Director Perioperative Services (CHC) 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 - The Health Technologies Assessment Committee 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.

- Bilateral Procedures - e.g. right and left cataract extractions, right and left hip replacements
  - A 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. The 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 identify on the RFA which procedure is to be prioritised.

  The patient should remain RFC for both procedures until a surgery date is assigned to the first procedure, at which time the second procedure is made NRFC. Advice should be received from the doctor or patient when they can become RFC for the second procedure.

  The only exception to the above is for ongoing regular treatment e.g. tissue expansion or change of supra pubic catheters.

- Duplicate bookings - a RFA will not be accepted for the same procedure with different referring doctors at the same hospital; or for the 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.

- Contracts with Private Hospitals – Where a contract exist with a private hospital to undertake elective surgery/procedures for ACT Health, the following actions should be undertaken:
  - Patient should be added to the public hospital waiting list
  - A copy of the Request for Admission Form is to be held at the public hospital
  - The patient should be managed as per this Framework
  - 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 REGISTERING PATIENTS ON THE WAITING LIST

Waiting list management services are provided in an efficient, transparent and patient-centred manner.

Patients are provided with easy to understand information about access to elective surgery and their rights and responsibilities.

All documentation will be complete, legible and accurate.

4.1 Registration requirements

- The date stamped on the RFA is the date used for elective surgery waiting list registration (this is the date when the RFA is first received by the hospital)
- RFAs should not be registered until completed as per the requirements listed in this document
- Patients should be placed on the elective surgery waiting list within 3 working days of receiving a completed RFA
- On receipt of the RFA from the consulting rooms or the outpatient department, the Surgical Bookings Clerk is to check that the clinical priority box has been ticked
- Any changes to the clinical urgency noted on receipt of the RFA are to be initialled by the doctor
- Changes to the clinical priority **without** the doctor’s initials are **not** to be accepted. For example, if the doctor makes a change by ticking a clinical urgency box incorrectly, then ticking another box, the change must be initialled by the doctor
- RFAs without initialled changes will be returned to the referring surgeon
- At the time of registering a patient on the elective surgery waiting list, hospitals must consider their capacity to admit the patient within the recommended timeframe associated with the patient’s clinical priority category

4.2 Notification - Patient

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

- A notification letter is to be sent to the patient advising them that they have been placed on the waiting list
- Any patient documentation is to be attached to the RFA.
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 surgery and 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 is Ready for Care (RFC). Waiting time thus reflects a genuine waiting period.

Periods when patients are Not Ready for Care (NRFC) 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.
- Following a clinical examination, the patient may be reassigned a different priority rating from the initial category based on the clinical assessment.
- GPs can initiate a patient review, as some conditions will change while the patient is waiting for treatment. The patients should 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 a clinical review are to determine:

- Change in the clinical condition of the patient.
- Any required changes in the patient’s clinical urgency priority for the procedure.
- Is admission still required.

The clinical review can be facilitated by the Specialty Liaison Nurse or equivalent and conducted by an appropriate clinician:

- Treating doctor or delegate
- General Practitioner (GP)
- Specialist Consultant or delegate e.g. registrar
Circumstances triggering a Clinical Review:

### 5.3.1 Category 1 Patients

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Action</th>
</tr>
</thead>
</table>
| When the patient is listed as Category 1 but then requests deferment as NRFC > 15 cumulative days | - Consult with the treating doctor, request a management plan that includes documented RFC date and if clinically appropriate, re-categorise  
- Advise patient  
- Advise GP |
| When total RFC time is > 30 days                                             | - Request clinical review by an appropriate clinician that includes documented RFC date and if clinically appropriate, re-categorise  
- Advise patient  
- Advise GP |

### 5.3.2 Category 2 Patients

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Action</th>
</tr>
</thead>
</table>
| When the patient is listed as Category 2 but then requests deferment as NRFC > 45 cumulative days | Category 2 patients may require:  
- Clinical review by an appropriate clinician preferably within 15 working days, but not exceeding 30 days.  
- Depending on the Clinical Review outcome, the patient should be:  
  - Allocated a date  
  - Re-categorised  
  - Removed 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 the clinical review outcome, the patient should be:  
  - Allocated a date  
  - Re-categorised  
  - Removed from the waiting list  
- Advise patient  
- Advise GP |
5.3.3 Category 3 Patients

<table>
<thead>
<tr>
<th>Circumstance</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>When the patient is listed as Category 3 but then requests deferment as NRFC &gt; 180 cumulative days</td>
<td>Category 3 patients may require:</td>
</tr>
<tr>
<td></td>
<td>• Clinical review by an appropriate clinician preferably within 15 working days, but not exceeding 30 days.</td>
</tr>
<tr>
<td></td>
<td>• Depending on Clinical Review outcome, the patient should be:</td>
</tr>
<tr>
<td></td>
<td>o Allocated a date</td>
</tr>
<tr>
<td></td>
<td>o Re-categorised</td>
</tr>
<tr>
<td></td>
<td>o Removed from the waiting list</td>
</tr>
<tr>
<td></td>
<td>• Advise patient</td>
</tr>
<tr>
<td></td>
<td>• Advise GP</td>
</tr>
<tr>
<td>At 270 days, if the patient has no planned admission date within the timeframe</td>
<td>Category 3 patients may require:</td>
</tr>
<tr>
<td></td>
<td>• Clinical review by an appropriate clinician preferably within 15 working days, but not exceeding 30 days.</td>
</tr>
<tr>
<td></td>
<td>• Depending on Clinical Review outcome, the patient should be:</td>
</tr>
<tr>
<td></td>
<td>o Allocated a date</td>
</tr>
<tr>
<td></td>
<td>o Re-categorised</td>
</tr>
<tr>
<td></td>
<td>o Removed from the waiting list</td>
</tr>
<tr>
<td></td>
<td>• Advise patient</td>
</tr>
<tr>
<td></td>
<td>• Advise GP</td>
</tr>
</tbody>
</table>

- 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, the treating doctor must be consulted and the patient can be removed from 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. RFC.
A **Status Review Date** must be set each time a patient:

- Is added to the waiting list as a staged admission (NRFC) or defers admission whilst on the waiting list.
- Status changes from RFC to NRFC
- Status remains NRFC following a clinical assessment
- Specifies a forward planned admission date for his or her own non-medical reasons

A **Status Review (NRFC) 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 within the appropriate clinical priority category
- Have a planned admission date scheduled
- Be removed from the waiting list

5.4 **Ready for Care (RFC)**

A RFC 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 RFC if their admission is postponed/delayed due to reasons other than the patient’s 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 (NRFC)**

A **Not Ready for Care patient** can be defined as a patient who is not available to be admitted to hospital until a future date, and is either:

- **Staged** - not ready for clinical reasons
- **Deferred** - not ready for personal reasons
The maximum cumulative timeframes for patients deferring treatment is:

- **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 NRFC patients to ensure they become Ready for Care or are removed from the waiting list.
- NRFC implies that the patient will 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).
- The hospital must record the reason for staging and deferring patients on the electronic waiting list and on the patient’s RFA.

### 5.5.1 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 To Come In date can be arranged whilst the patient is in the category of NRFC.

### DEFERRED PROCEDURES

**Not Ready for Care – Deferred Only**

- The period of time the patient requests a deferment should be determined and the patient returned to the original clinical priority category within 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 include:

<table>
<thead>
<tr>
<th>Reasons to be Recorded for Not Ready for Care Staged (Clinical)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Unfit</strong></td>
</tr>
<tr>
<td>• A co-morbidity exists which, until resolved, renders them unfit for the proposed treatment</td>
</tr>
<tr>
<td><strong>Planned</strong></td>
</tr>
<tr>
<td>• A patient requiring treatment periodically (e.g. check cystoscopy)</td>
</tr>
<tr>
<td>• Patients for <em>routine</em> check cystoscopy should be staged to return to the waiting list on the month they are due for their surgery</td>
</tr>
<tr>
<td>• A patient requiring treatment as part of a staged procedure (e.g. removal of pins and plates)</td>
</tr>
</tbody>
</table>

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 include:

<table>
<thead>
<tr>
<th>Reasons to be Recorded for Not Ready for Care Deferred (Personal)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patient is going on holidays and will be unavailable for admission</td>
</tr>
<tr>
<td>• Patient is unable to obtain home support</td>
</tr>
<tr>
<td>• Patient is unable to accept a date due to work commitments</td>
</tr>
<tr>
<td>• Patient is unable to accept a date for other significant reasons e.g. personal carer</td>
</tr>
<tr>
<td>• A patient who specifically requests a forward planned admission date, for his or her own convenience or commitments should only have their RFC</td>
</tr>
<tr>
<td>• A decision to remove the patient from the waiting list may be made if a patient defers more than two offers or exceeds the maximum number of Not Ready for Care days. Refer to section 5.5</td>
</tr>
</tbody>
</table>
5.6 Admission Process

Effective admission and discharge processes are required to ensure optimal use of operating theatre time and hospital beds.

• **Equity and Priority of Access for Admission** - the following criteria must be considered when selecting 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
  - Specialty Liaison nurse (TCH)
  - 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

**Tentative Admission Date:**

A **Tentative To Come In (TCI) Date** is the date that it is proposed that a patient on the waiting list will be admitted for an episode of care. This date is to be entered on the electronic waiting list.

- Once a tentative TCI date is confirmed the patient should be contacted by phone to determine acceptance of admission followed by a letter – Appendix 4).
- Patient should be supplied with relevant information for their hospitalisation, including the proposed length of stay, discharge procedures and post operative care and follow up.

**Short Notice Patients:**

Patients may agree to be available at “short notice” to have their surgery performed. This is to be indicated in the electronic waiting list general comments section. For example if there is a cancellation, the Surgical Booking Clerks should maintain a list of patients who are available to have their procedure/treatment performed at short notice. Patients should be asked to indicate a preparedness to accept short notice of admission. The hospital should determine what period
Waiting Time and Elective Surgery Access

of time prior to admission is regarded as short notice and for which procedures short notice is appropriate.

Preadmission Assessment:
Patients must be clinically assessed before admission to the hospital to confirm suitability to undergo the intended procedure/treatment, associated anaesthetic and necessary discharge plans. Patients will be assessed by the relevant clinicians including registrars, nurses and allied health professionals in a public hospital clinic or by a telephone interview.

5.7 Hospital Initiated Postponement (HIP)
Hospital initiated postponements must be minimised. Decisions to postpone a patient’s surgery must involve relevant medical and perioperative staff, the Surgical Booking Clerk and senior hospital management.

Patients who are postponed by the hospital, doctor or for clinical reasons, remain “Ready for Care” “delayed” and the following actions taken:

- Inform the patient of the postponement with the maximum amount of notice
- Category 1 patients and patients postponed on the day of procedure/treatment must be notified by a senior member of the surgical/medical team. Appropriate perioperative management staff can notify all other patients, although it is preferable for the treating doctor or delegate to speak with the patient
- 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
- If a patient has been postponed twice and cannot be treated within the appropriate clinical priority timeframes, the hospital must actively investigate options for the procedure/treatment to be undertaken at another public hospital.
- 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
- Organise the rescheduled date for procedure/treatment and notify the patient of the new admission date on the day of postponement or within 5 working days, if possible
- Provide information about what they should do if their condition deteriorates
- The opportunity to discuss with a doctor, medical issues that might arise as a result of the postponement
The name and contact details of the Surgical Booking Clerk, should they require further information

5.8 Patient Initiated Postponement:

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

- Recorded on the 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 two (2) times for personal or social reasons, unless there are extenuating circumstances.

- 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 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
5.8.1 Reporting of Hospital Initiated Postponements (HIPs)

To ensure consistency of reporting of HIPs the following method is to be used:

- Elective theatre dates are booked 2-4 weeks in advance,
- Patients are phoned to confirm their availability, and a ‘To Come in’ date (TCI) is entered into ACTPAS
- A letter is sent to the patient confirming the date and details of admission
- HIPs are reported on all patients that have been notified of a date
- The Waiting List Entry in ACTPAS is checked for each patient to confirm patient notification has occurred

5.9 Avoiding Exceeding Clinical Priority Time Frames

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

- Clinical Review – refer to section 5.3
- Transfer of Patients to Doctors with a shorter waiting time (see 5.9.1 for more details).
- Transfer of Patients to another facility (see 5.9.2 for more details).
- Increase theatre utilisation (e.g. extra sessions).
- Use of short notice or adhoc lists
- Other options include seeking advice from the Elective Surgery Access Unit re possibility of 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 and escalation processes to avoid this and are required to achieve the following Clinical Priority time frames:

<table>
<thead>
<tr>
<th>Clinical Priority Category</th>
<th>Recommended allocation of TCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>No patient in Category 1 should wait longer than <strong>30 days</strong></td>
<td>TCI on listing or within 5 days</td>
</tr>
<tr>
<td>No patient in Category 2 should wait longer than <strong>90 days</strong></td>
<td>TCI within 45 days</td>
</tr>
<tr>
<td>No patient in Category 3 should wait longer than <strong>365 days</strong></td>
<td>TCI within 270 days</td>
</tr>
</tbody>
</table>
5.9.1 Transfer of Patients to Doctors with a shorter waiting time

The offer by the hospital to transfer the patient to another doctor with a shorter waiting time needs to be determined for each individual and the following should be 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
- If 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 new doctor will determine the requirement to review the patient
- The patient’s listing date and history must be that of the original booking. This ensures 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 ACT and Southern NSW Local Health District (SNSWLHD), 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 only when confirmation of the patient’s booking is received at the receiving hospital and documented using the following reason codes:
  - Removal reason code for interhospital transfer – *Transferred to another hospital’s waiting list*
- For interhospital transfers, the original RFA should be sent to the receiving hospital and a copy retained for auditing at the original hospital
- If a contracted patient, a copy should be sent to the receiving hospital and the original retained for auditing at the original hospital.
5.10 Removing Patients from the Waiting List

- 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.

<table>
<thead>
<tr>
<th>Reason</th>
<th>Category 1, 2 &amp; 3 Actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient declines treatment or requests removal for other reasons.</td>
<td>• Forward a copy of the RFA with a covering letter (Appendix 3) to the patient’s treating doctor informing them of the removal of the patient from the waiting list unless the treating doctor advises otherwise within 5 working days</td>
</tr>
<tr>
<td>Patient defers treatment on 2 occasions (including other genuine offers of another doctor/hospital) or in deferring exceeds the total cumulative maximum number of NRFC days: Cat 1 &gt; 30 days Cat 2 &gt; 90 days Cat 3 &gt; 180 days</td>
<td>• Obtain authority for <strong>Category 1 (30 day)</strong> patients prior to removal from the waiting list</td>
</tr>
</tbody>
</table>
| Patient fails to arrive for treatment on >1 occasion without giving prior notice and with no extenuating circumstances. | Once decision is made to remove a patient from waiting list:  
  o Obtain unit head or delegated unit representative’s authorisation to remove patient, and record in ACTPAS any discussion with patient  
  o Remove the patient from the waiting list  
  o Advise the GP that the patient has been removed (Standard Letter Appendix 3)  
  o Advise the patient of the removal on the waiting list (Standard Letter Appendix 3)  
  o Document all actions in the electronic record |
### Reason Category 1, 2 & 3 Actions

<table>
<thead>
<tr>
<th>Reason</th>
<th>Category 1, 2 &amp; 3 Actions</th>
</tr>
</thead>
</table>
| Patient not **contactable** on 2 occasions (one by phone, one by letter) | - Attempt to obtain the patient’s correct contact details via all the outlined methods below:  
  - Referring doctor, GP, medical records, next of kin & telephone directory search  
  - Remove the patient from the waiting list  
  - Advise referring doctor and GP that patient has been removed (Standard Letter Appendix 3)  
  - Document actions on the RFA and the electronic record |
| Patient **deceased**                 | - Obtain verification (usually verbally from the patient’s relative, general practitioner or specialist)  
  - Remove patient from the waiting list  
  - Document all actions on the RFA and the electronic record |

**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

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

Any changes made to a patient’s booking must be validated with documented evidence and reasons, and signed by a relevant staff member. The documentation must be attached (Appendix 4) to 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 in the patient’s electronic record for patients postponing their elective surgery and the reason for postponement documented.
- A patient’s postponement history should be readily available to staff making decisions about postponing future patients
6.2 Procedure being Undertaken at Another Hospital

- 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 only when confirmation of the patient’s surgery has been completed at the receiving hospital has been received and documented using the following reason codes:
  - Removal reason code for interhospital transfer - treated elsewhere; or
  - Removal reason code for contracted patient – ‘contracted patient – private hospital’ or ‘contracted patient – public hospital’

6.3 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 in the patient’s electronic record detailing the reason for removal and the date of removal.
- Treating doctors and GPs will be advised by mail (Appendix 3).

<table>
<thead>
<tr>
<th>Reason</th>
<th>Information to be Recorded/Filed (RFA &amp; Electronic)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Deceased</td>
<td>• Record the name of the person who has notified the hospital that the patient is deceased</td>
</tr>
<tr>
<td>Non contactable</td>
<td>• Evidence of contact:</td>
</tr>
<tr>
<td></td>
<td>o patient letters returned (return to sender)</td>
</tr>
<tr>
<td></td>
<td>o documentation of attempts to contact through referring Doctor, GP, medical records, next of kin &amp; telephone directory search.</td>
</tr>
<tr>
<td>Decline treatment or clinical review/not required</td>
<td>• Documentation that the patient has been informed of the potential risks to their health and advised to contact the referring doctor</td>
</tr>
<tr>
<td></td>
<td>• Obtain authority for Category 1 (30 day) patients prior to removal from waiting list</td>
</tr>
<tr>
<td>Fail to Arrive for Treatment</td>
<td>• Documentation that:</td>
</tr>
<tr>
<td></td>
<td>o Patient has failed to arrive for treatment on the planned admission date on &gt; 1 occasion without prior notice and without good reason</td>
</tr>
<tr>
<td></td>
<td>o Advise the patient to be clinically reassessed by the treating doctor.</td>
</tr>
</tbody>
</table>
7 AUDITING THE WAITING LIST

7.1 Request for Admission (RFA) Audit

- The Surgical Bookings Officer is responsible for the audit of RFA forms
- A review of the waiting list must be undertaken quarterly to ensure that accurate information is provided to clinicians and administrators on request

1. The Surgical Booking Clerk will assess the RFA for accuracy by cross checking patients listed on ACTPAS under each surgeon, against RFAs held in a folder, utilising the following minimum data set

2. Patient details:
   - Full name
   - Date of birth
   - Patient identity number (pid)
   - Gender
   - Address
   - Phone number
   - Accommodation status

3. Clinical details:
   - Diagnosis
   - Proposed procedure
   - Clinical priority category

- The Surgical Booking Clerk will document all necessary amendments or updates to details to provide a clear audit trail
- After each individual patient is audited, a comment must be placed in the comments section of patient’s waiting list entry in ACTPAS stating: ‘RFA AUDITED. DETAILS CORRECT’

7.2 Review of Waiting List by Treating Doctor

The Elective Surgery Access Coordinator will provide a waiting list report to each treating doctor monthly and undertake changes required by the treating doctor.

7.3 Clerical Audit

- RFC and NRFC Patients on the waiting list should be contacted if they have been waiting for six months or longer from listing date to ascertain if they still require admission. Two contacts should be attempted, one by letter (Appendix 2) and one by telephone.
• On completion of the clerical audits, a report must be sent to the Hospital Executive and to the Elective Surgery Access Manager for tabling at the Surgical Services Taskforce. This report must include:
  o The type of audit conducted, methodology used, problems identified and recommendations for improvement
  o The number of patients removed and reasons for removal from the waiting list

• Documentation of the patient audit must be made in the patient’s electronic record, including responses received and the action taken

• The Elective Surgery Access Team will conduct 3 monthly audits of compliance with this framework and report the results to the appropriate hospital management and for tabling at the Surgical Services Taskforce meeting

8 DOCTOR’S LEAVE – TEMPORARY OR PERMANENT
Includes Annual, Study, Conference and Unplanned sick or bereavement leave

- To ensure appropriate theatre scheduling, doctors are requested to provide as much notice of intended leave as possible (minimum of 4 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

To ensure appropriate theatre scheduling, doctors are requested to provide as much notice of intended leave as possible (minimum 4 weeks). Leave includes annual, study and conference.

The hospital will ensure appropriate communication of scheduled reduced activity periods, promulgated public holidays and recognised holiday periods. The hospital will develop and implement plans, in consultation with appropriate clinicians and services, regarding these periods.

A patient’s clinical priority category and listing date does not change as a result of doctor’s leave.

Patients whose clinical priority cannot be met during a period of leave may not be booked on that surgeon’s waiting list. A management plan for affected patients should be developed and implemented for all leave.

Affected patients are those who during the leave period:
  o Already had a planned admission date
  o Will exceed their clinical priority timeframe during the leave period.

A patient’s management plan should ensure affected patients:
  o Are assured that their queue order will not be affected
  o Know who the replacement doctor will be
Waiting Time and Elective Surgery Access

- Are advised if clinical review is required
- Are provided with information regarding their expected waiting time

A management plan for affected patients should be developed and implemented for all leave in consultation with the referring surgeon, Specialty Liaison Nurse (TCH), Head of Unit, Clinical Director of Surgery (TCH) / Director of Perioperative Services (CHC), and Surgical Bookings Clerk.

8.2 Resignation, Retirement or Sudden Death

Following notification of planned and unplanned resignation or retirement, sudden death or failure to be reappointed, no further patients should be added to the doctor’s waiting list beyond the capacity to ensure patients receive their surgery within clinically appropriate timeframes.

A management plan for affected patients requires:

- Consultation with Head of Unit, Clinical Director of Surgical Services (TCH) / Director of Medical Services (CHC), Perioperative Suite Management, Surgical Bookings Manager and relevant Booking Clerk
- Location of a replacement treating doctor in consultation with Head of Unit, Clinical Director of Surgical Services (TCH) / Director of Medical Services (CHC)
- Clinical review (within 3 months) is required for patients remaining on departing doctor’s waiting list
- Need to consider if the nominated doctor is willing to take on additional patients and has capacity to undertake the work.

All patients will be clinically and/or administratively reviewed and a plan developed by the Head of Unit.
### DEFINITIONS

<table>
<thead>
<tr>
<th>Definition</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Addition to the waiting list</td>
<td>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 Request 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 Request 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.</td>
</tr>
</tbody>
</table>
| Admission                          | The Australian Institute of Health and Welfare (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:  
- Emergency Admission (Admission within 24 hours)  
- Elective Admission (Admission > 24 hours) |
| Admission Date                     | Date on which an admitted patient commences an episode of care                                                                                                                                            |
| Admitted patient                   | A patient who undergoes a hospital’s admission process to receive treatment and/or care                                                                                                                |
| Anticipated election status        | Recorded when the patient is added to the waiting list, it is the anticipated financial election the patient will make when admitted for the planned procedure/treatment.  
Classifications are:  
- Medicare Eligible - Public patient  
- Medicare Eligible - Private patient  
- Medicare Eligible - Department of Veterans Affairs patient  
- Medicare Eligible - Other (compensable, Defence forces etc)  
- Medicare Ineligible – (e.g. Overseas visitor) |
<table>
<thead>
<tr>
<th>Definition</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clerical Audit</td>
<td>A clerical audit is a regular and routine clerical check that the information 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</td>
</tr>
</tbody>
</table>
| 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 is desirable  
  - **Category 2**: Admission within 90 days is desirable  
  - **Category 3**: Admission within 365 days is acceptable  
  - 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. |
| 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                                                                                                                              |
## Waiting Time and Elective Surgery Access

<table>
<thead>
<tr>
<th>Definition</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge Intention</td>
<td>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.</td>
</tr>
<tr>
<td>Discretionary Surgery</td>
<td>Surgical procedures that should not be undertaken in public hospitals in ACT unless essential for good health and authorised by Clinical Director of Surgical Services (CHHS) or Director of Medical Services (CHC).</td>
</tr>
<tr>
<td>DOSA</td>
<td>DOSA is an acronym for day of surgery admission.</td>
</tr>
<tr>
<td>EDSU</td>
<td>EDSU units are specifically designed to accommodate patients - elective and emergency, who meet specific admission criteria including: Absolute expectation of discharge within 24 hours, preadmission screening (elective patients), agreed clinical guidelines in place and agreement to protocol based nurse initiated discharge.</td>
</tr>
<tr>
<td>Elective Care (National Health Data Dictionary) Including planned/booked surgery</td>
<td>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.</td>
</tr>
<tr>
<td>Elective admission</td>
<td>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, and subsequent referral to a specialist and a Request for admission to hospital by the specialist (or general practitioner, where appropriate). The medical consultation may take place in a hospital outpatient clinic.</td>
</tr>
<tr>
<td>Electronic waiting list</td>
<td>Patient administration/ management system used by the hospital to manage the waiting list e.g. ACTPAS.</td>
</tr>
<tr>
<td>Definition</td>
<td>Explanation</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Emergency admission</td>
<td>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.</td>
</tr>
<tr>
<td>Emergency patients</td>
<td>Emergency patients are those whose clinical conditions indicate that they require admission to hospital within 24 hours.</td>
</tr>
<tr>
<td>Exceeding Clinical Priority Timeframes or Overdue</td>
<td>Patients are considered overdue if they have waited in excess of the time recommended for the assigned ready for care clinical priority category.</td>
</tr>
<tr>
<td>Indicator procedure Code</td>
<td>The procedure or treatment the patient is to undergo when admitted.</td>
</tr>
<tr>
<td>Inpatient</td>
<td>Patients who are formally admitted to a hospital or health service facility. Formally admitted patients can be Day Only or overnight.</td>
</tr>
<tr>
<td>Listing Date</td>
<td>Listing Date is the date of receipt of the Request for Admission Form. Calculation of waiting time starts from this date.</td>
</tr>
</tbody>
</table>
| 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:  
  - Ready for Care (Category 1, 2 or 3)  
  - Not Ready for Care (Staged or Deferred) |
<table>
<thead>
<tr>
<th>Definition</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-wait patients</td>
<td>Surgical patients who are Ready for Care and have been waiting for planned admission longer than 12 months are termed long-wait patients.</td>
</tr>
<tr>
<td>Medicare eligibility</td>
<td>Patients must be identified as being eligible or not eligible for treatment under the Medicare agreement 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.</td>
</tr>
<tr>
<td>Not Ready for Care (NRFC)</td>
<td>A Not Ready for Care patient can be defined as a patient who is not available to be admitted to hospital until a future date and is either:</td>
</tr>
<tr>
<td></td>
<td>- Staged - not ready for clinical reasons</td>
</tr>
<tr>
<td></td>
<td>- Deferred - not ready for personal reasons</td>
</tr>
<tr>
<td></td>
<td><em>See Clinical Review Section 5.3 for timeframe for NRFC patients.</em></td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>Not Ready for Care “deferred”</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>The reason a patient is deferred may be reported as follows:</td>
</tr>
<tr>
<td></td>
<td>- A patient is going on holidays and will be unavailable for admission</td>
</tr>
<tr>
<td></td>
<td>- A patient is unable to obtain home support</td>
</tr>
<tr>
<td></td>
<td>- A patient is unable to accept a date due to work commitments</td>
</tr>
<tr>
<td></td>
<td>- A patient is unable to accept a date for other significant reasons e.g. personal carer</td>
</tr>
<tr>
<td></td>
<td>Patients may not be added to the waiting list as Not Ready for Care deferred.</td>
</tr>
<tr>
<td>Definition</td>
<td>Explanation</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| 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**  
- A co-morbidity exists which, until resolved, renders them unfit for the proposed treatment  
**Planned**  
- A patient requiring treatment as part of periodic treatment  
- A patient requiring treatment as part of a staged procedure (includes obstetric patients)  
- A planned re-admission for a patient with a predictable morbid process, requiring periodic treatment of the ongoing disease process  
- A planned re-admission for review of status following previous treatment. |
| To Come In date             | The date on which it is proposed that a patient on the waiting list will be admitted for an episode of care.                                  |
| Planned length of stay      | The number of nights the patient is expected to stay in hospital as an inpatient. This information will be used for discharge planning and bed management. |
| Planned procedure           | The planned procedure is the procedure or treatment the patient is to undergo when admitted.                                                  |
| 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 also postpone for personal reasons.  
*See Not Ready for Care “deferred”* |
<p>| Pre-admission               | Patients are assessed before admission to the hospital for their suitability to undergo the intended procedure/treatment, associated anaesthetic and discharge plans. |</p>
<table>
<thead>
<tr>
<th>Definition</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presenting Problem</td>
<td>The problem or concern that is the reason for seeking health care or assistance (NHDD).</td>
</tr>
<tr>
<td>Private/Chargeable patients (including DVA &amp; WC etc)</td>
<td>Persons admitted to a public hospital who elect to choose their treating doctor(s) will be charged for medical services and accommodation.</td>
</tr>
<tr>
<td>Public Patient</td>
<td>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.</td>
</tr>
<tr>
<td>Ready for Care (RFC)</td>
<td>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.</td>
</tr>
</tbody>
</table>
| 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:  
  - Non-availability of operating theatre (staff, equipment, resources etc.)  
  - Non-availability of bed;  
  - Non-availability of bed; pressure of emergency admissions  
  - 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:
- Patient declines treatment or requests removal
- Patient defers treatment on 2 occasions
- Patient defers & exceeds the total cumulative maximum number of Not Ready for Care days  
  Cat 1 > 15 days;  Cat 2 > 45 days;  Cat 3 > 180 days
- Patient fails to arrive on 1 occasion, with no notice or extenuating circumstances
- Patient not contactable
- Patient deceased

Request 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 framework.

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 are:
- Cardiothoracic
- ENT
- General Surgery
- Gynaecology
- Neurosurgery
- Ophthalmology
- Orthopaedic
- Plastic
- Urology
- Vascular

Staged | See Not Ready for Care “staged”
### Definition

<table>
<thead>
<tr>
<th>Definition</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Short Notice/ Standby Patient</td>
<td>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.</td>
</tr>
<tr>
<td>Status Review Date (SRD)</td>
<td>This is the date determined for an assessment (clinical or administrative) of a deferred or staged person (i.e. Not Ready for Care) to determine if the patient has become ready for admission to the hospital at the first available opportunity (i.e. Ready for Care).</td>
</tr>
<tr>
<td>Treating doctor</td>
<td>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.</td>
</tr>
<tr>
<td>Waiting List</td>
<td>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.</td>
</tr>
<tr>
<td>Waiting Time</td>
<td>Time a patient spends as Ready for Care.</td>
</tr>
</tbody>
</table>
Dear <patient name>

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

Your doctor has determined the clinical priority for your admission. Our first priority is to ensure you receive your procedure/treatment within the clinical priority timeframe recommended by your referring doctor.

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 in the ACT.

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. 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

The attached “Access to Elective Surgery” brochure provides additional information about the ACT Elective Surgery Waiting List. Please take the time to read this brochure.

Should you have any questions, please do not hesitate to contact me on the number below or if you have access to the internet you can access information about surgeons’ waiting times at the ACT Health web site:


Yours sincerely

<signature block>
Dear <patient name>

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

To help us maintain an accurate waiting list we ask that you complete the attached form and return it in the envelope provided within 10 working days.

We acknowledge that you may have previously received and replied to this request; however it is important that this information is obtained regularly, so we can review and update our records. We apologise for any inconvenience.

Should your clinical condition change, you should notify your general practitioner or your specialist. 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 you wish to remain on the list within 10 working days of receiving this letter, you may be removed from the waiting list and your surgeon and your general practitioner will be advised accordingly.

Should you have any concerns or if we can assist you in any way please contact the Elective Surgery Access Coordinator on 6205-1122.

Yours sincerely

<signature block>
Appendix 2 – Audit letter

SECTION 1: YOUR PERSONAL DETAILS

Are the details shown below correct?

**My Surgeon is Dr**

<table>
<thead>
<tr>
<th>Patient Details</th>
<th>Local Doctor Details (GP)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Please insert details</td>
</tr>
</tbody>
</table>

**Change of Patient Details:**

<table>
<thead>
<tr>
<th>Name</th>
<th>Telephone (H)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td>Telephone (W)</td>
</tr>
<tr>
<td>Suburb</td>
<td>Telephone (M)</td>
</tr>
<tr>
<td>Postcode</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td></td>
</tr>
</tbody>
</table>

**SECTION 2: YOUR WAITING LIST SURGERY OPTIONS**

Please place a tick in your selected option:

**OPTION 1:** I still require my surgery and I AM READY FOR SURGERY AT THIS TIME. ☐ YES

**OPTION 2:** I have already had my surgery – please remove me from the waiting list. ☐

Please specify where you had your surgery & date:

____________________________________

**OPTION 3:** I no longer require the surgery – please remove me from the waiting list. ☐

Reason: __________________________________________

Thank you for taking the time to complete this form. Please sign this form and return it in the reply paid envelope within 10 working days.

**Signature**

______________________________

**Date**

______ / ______ / 2013
Appendix 3 - Removal from Waiting List Letter

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 elective surgery waiting list at <insert hospital name>, as the patient

<select reason>-
  • no longer requires treatment
  • seeking/treated elsewhere
  • treated by another surgeon
  • refused 2 dates for surgery
  • could not be contacted
  • patient not available within timeframe
  • requests removal
  • deceased

If you have any concerns or require further information about the removal of your patient’s name from the waiting list, please contact the Surgical Bookings Officer on <_____> between 9am to 4 pm Monday to Friday.

Yours sincerely

<Signature block>
Appendix 4 – Reclassification of Clinical Priority form

<table>
<thead>
<tr>
<th>Bar Code</th>
<th>Complete details of affix label</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Name</td>
<td>URN ________________________________________________</td>
</tr>
<tr>
<td>Recategorisation</td>
<td>Surname ___________________________________________</td>
</tr>
<tr>
<td>of Clinical Priority</td>
<td>Given name _________________________________________</td>
</tr>
<tr>
<td>Medical Officer</td>
<td>DOB ____________________  Gender____________________</td>
</tr>
</tbody>
</table>

Authorised Doctor (or Nominated Official)

Print Name: .................................................................
Signature: .................................................................

Date

Patient

Original Clinical Priority Category

Date of Change

New Clinical Priority Category

Reason for reclassification of Clinical Urgency:

- □ Deterioration in condition
- □ Improvement in condition
- □ Clinical Review

.......................................................................................................
.......................................................................................................
11 REFERENCES

Ministry of Health NSW - Advice for Referring & Treating Doctors – Managing Elective Patient/Waiting Lists:

Ministry of Health NSW – Waiting Time and Elective Surgery Framework – February 2012

The National Health Reform Agreement – Schedule C – Transparency & Performance

The National Health Reform Agreement – National Partnership Agreement on Improving Public Hospital Services
12  ACRONYMS

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>Cat</td>
<td>Category</td>
</tr>
<tr>
<td>CEO</td>
<td>Chief Executive Officer</td>
</tr>
<tr>
<td>CMBS</td>
<td>Commonwealth Medicare Benefits Schedule</td>
</tr>
<tr>
<td>CPC</td>
<td>Clinical Priority Category</td>
</tr>
<tr>
<td>DO</td>
<td>Day Only</td>
</tr>
<tr>
<td>DOSA</td>
<td>Day of Surgery Admission</td>
</tr>
<tr>
<td>DR</td>
<td>Doctor</td>
</tr>
<tr>
<td>DVA</td>
<td>Department of Veteran Affairs</td>
</tr>
<tr>
<td>EDO</td>
<td>Extended Day Only</td>
</tr>
<tr>
<td>GP</td>
<td>General Practitioner</td>
</tr>
<tr>
<td>HDU</td>
<td>High Dependency Unit</td>
</tr>
<tr>
<td>HVSS</td>
<td>High Volume Short Stay</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive Care Unit</td>
</tr>
<tr>
<td>NRFC</td>
<td>Not Ready for Care</td>
</tr>
<tr>
<td>PAS</td>
<td>Patient Administration System</td>
</tr>
<tr>
<td>RFA</td>
<td>Request for Admission</td>
</tr>
<tr>
<td>RFC</td>
<td>Ready for Care</td>
</tr>
<tr>
<td>SRD</td>
<td>Status Review Date</td>
</tr>
<tr>
<td>WC</td>
<td>Workers Compensation</td>
</tr>
</tbody>
</table>