

SESLHD GUIDELINE COVER SHEET



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KEY TERMS	Waitlist, Elective Surgery, ESAP
SUMMARY	This guideline is designed to make the management of elective surgery cases within SESLHD transparent, equitable and standardised. Informing relevant staff of reporting responsibilities.

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SESLHD Guide for Managing Elective Surgery Waitlists

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Section 1 - Background

South Eastern Sydney Local Health District performs more than 20,000 elective surgeries each year. It is a key requirement that we achieve the obligations under the Service Agreement with NSW Health in relation to waitlist and targets. This guide supports the management of elective surgery waiting lists to ensure compliance with the Waiting Time and Elective Surgery Policy in promoting clinically appropriate, consistent and equitable management of elective surgery patients within the LHD.

Section 2 - Principles

The key principles of Elective Surgery Wait List Management:

- All patients are allocated a Clinical Urgency Category (CUC) depending on the seriousness of their condition i.e. Category 1 < 30 days, Category 2 < 90 days and Category 3 < 365 days
- Treatment access is based on clinical need regardless of health insurance status
- All patients are placed on the surgical wait list within three working days on receipt of a Request For Admission (RFA)
- All patients receive timely notification in relation to their Planned Admission Date (PAD)
- Patients have their clinical procedure conducted within the appropriate clinical priority timeframe
- Patients who become unwell and/or are Not Ready For Care (NRFC)/suspended, receive a clinical review by an appropriate clinician
- Reporting on waitlists is conducted as specified, with corrections made prior to final submission to Ministry of Health (MoH) in electronic systems

These principles should be monitored and managed on a day to day basis to ensure compliance and transparency of practice.

EXCLUSIONS

Medical procedures which are booked through surgical bookings are not required to adhere to all aspects of this policy.

Section 3 - Definitions

Elective Surgery Access Performance (ESAP):

- ESAP is a metric measuring patients who were admitted within their clinical priority timeframe and expressed as a percentage of all admissions. A patient who is overdue is not calculated in this number until they are admitted. ESAP only includes admitted surgical patients.

Overdue Patients:

- Overdue refers to any patient who is on list and has not had their surgery within their recommended clinical priority timeframe. Overdue patients are reported at the end of each month, when the patient was due in the month and did not receive their surgery in that month.

Clinical Urgency Categories (CUC):

Category 1 (A)	Admission within 30 days	Desirable for a condition that has the potential to deteriorate quickly to the point it may become an emergency
Category 2 (B)	Admission within 90 days	Desirable for a condition that is not likely to deteriorate quickly or become an emergency
Category 3 (C)	Admission within 365 days	Acceptable for a condition which is unlikely to deteriorate quickly and which has little potential to become an emergency
Category 4 (D)	Not Ready for Care (staged and deferred)	Patients who are either not ready for admission (staged) or those who have deferred admission for personal reasons (deferred)

Section 4 - Responsibilities

Patients are responsible for:

- Following procedures and advice outlined in the information provided by the hospital
- Advising the hospital of any changes in decisions to undergo the procedure or treatment
- Following hospital admission procedures and advising of any changes to the proposed admission, eg. availability or change of address
- Attending any preadmission appointments (if required) and presenting on the day of admission at the time specified by the hospital

Surgeons are responsible for:

- Explaining the proposed procedure or treatment, options for treatment and potential complications to the patient and/or carer. This should include anticipated length of stay and post-operative recovery.
- Obtaining written consent from the patient and/or carer on the RFA
- Assigning a recommended CUC for the procedure or treatment, as it applies to the individual patient, as per the [NSW Ministry of Health Information Bulletin IB2012_004 - Advice for Referring and Treating Doctors – Waiting Time and Elective Surgery Policy](#).
- Communicating the CUC timeframe to the patient and/or carer
- Indicating when a patient will be ready for care if the patient is classified as staged
- Ensuring the RFA form is written legibly and all sections are completed
- Supporting delivery of the completed RFA to the hospital within three working days of completion
- Communicate with the referring GP regarding surgical management of the patient
- Notifying the Booking Clerk or Waitlist Manager of any changes in the patient's condition and/or CUC prior to surgery
- Ensuring 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 timeframe
- Reviewing their waitlist monthly and verifying the list with the hospital.

Booking Clerks are responsible for:

- Ensure all relevant data is entered on the waiting list system within three working days, including changes notified by the patient, GP, surgeon, administrative or other staff
- Check allocated CUC against the reference list ([IB2012_004](#)), if allocated CUC does not match reference list flag with the Waitlist Manager
- Ensure all documentation and electronic data input is accurate, legible and complete
- Comply with local procedures and protocols for administrative processes that support the policy
- Ensure procedures included in the excluded or discretionary list of procedures are not added to the waiting list without approval by the District Executive.

Waitlist Managers are responsible for:

- Maintaining overall management of waitlists and reporting on performance to site and District
- Ensure all staff adhere to the guidelines
- Liaise with surgeons/theatre managers to create capacity where possible to make full use of surgical lists
- Following guidelines below on meeting reporting requirements and data cleansing
- Ensuring there are staff able to perform role in case of absence from site.

Data Managers are responsible for:

- Provide support to sites by running reports as required to ensure accurate reporting to site, District and MoH.

District Managers are responsible for:

- Provide support to sites as required to help with achieving targets set by the MoH and submission of data.

Section 5 – Useful Resources

5.1 Waiting Time and Elective Surgery Policy

The [NSW Ministry of Health Policy Directive POD2012_011 - Waiting Time and Elective Surgery Policy](#) governs elective surgery waitlist management in NSW. In all instances where there is a perceived variance in this guide from the policy – the information in PD2012_011 should be followed.

5.2 Advice for Referring and Treating Doctors

The [NSW Ministry of Health Information Bulletin IB2012_004 - Advice for Referring and Treating Doctors- Waiting Time and Elective Surgery Policy](#), is a recommended guide of accepted Clinical Urgency Categories (CUC) has been developed with the assistance of specialist craft groups to ensure that patients with similar conditions are prioritised in a similar way. A searchable list can be found in the [NSW Health performance documents](#).

5.3 NSW Surgery Performance Page

On this site you will find a number of resources to assist with the management of elective surgery including policies, links to relevant ACI sites and a comprehensive [waitlist management resource guide](#).

5.4 SESLHD ORBIT Surgery Dashboard

Developed in 2017 in order to assist waitlist managers with their core business functions and to provide high level overview of elective surgery performance across SESLHD. The [Orbit Surgery Dashboard](#) is updated from HIE data.

5.5 Medical procedures

Medical procedures such as colonoscopies are booked through waitlists. Although these are not reported with the surgical data, the list still needs to be maintained. The Agency for Clinical Innovation (ACI) has released [NSW colonoscopy categorisation guide](#) for reference.

Section 6 – Referring and Registering Patients to a Waitlist

6.1 Request For Admission (RFA)

The process for an RFA is shown below.

General Practitioner/Outpatients	Surgeon Assessment & Referral	Recommendation for Admission (RFA)	RFA received at Hospital
<ul style="list-style-type: none"> • Patient sees GP and is referred to surgeon 	<ul style="list-style-type: none"> • Patient is assessed and surgeon makes recommendation 	<ul style="list-style-type: none"> • Surgeon completes RFA and assigns Clinical Priority 	<ul style="list-style-type: none"> • RFA is checked and registered onto the Waitling List

RFAs are the essential piece of communication that a surgeon sends to the hospital requesting admission for a patient, requesting a Planned Admission Date (PAD) to be allocated at a future time. RFAs must be:

- only accepted by clinicians who are currently contracted and appropriately credentialed with the LHD or facility
- legibly written and filled out completely
- assigned a CUC by the referring surgeon

Only an authorised doctor may reclassify patients between each priority category. The booking and waitlist staff must notify the referring doctor in writing of any change in the original CUC.

6.2 Acceptance of the RFA

Prior to acceptance of any RFA, the form should be reviewed using the checklist in table below. Any anomalies should be escalated to the Waitlist Manager of the site as soon as possible. Accurate data entry in the electronic waiting list is essential, to avoid duplication and incorrect reporting. A patients waiting time can be adversely affected by inaccurately entering information.

	Items to be checked	Action
Minimum Data Set	Patients Details: full name, address, contact information, gender, medicare number, date of birth, CUC, discharge information, planned procedure, presenting problem, medical history, treating doctor, GP, consent (if available), special requirements (e.g. critical care bed, equipment, vulnerable patient), interpreter, PAD (if available), anticipated election status, status review date (staged patients).	If incomplete send RFA incomplete form letter to Surgeon PD2012_011 (page 42) Ensure information escalated to relevant managers for Critical Care bed or Special Equipment For interpreter services contact 9515 0030
Clinical Urgency Category (CUC)	Check against reference list IB2012_004	If CUC differs from reference list without supporting clinical information then refer RFA to the appropriate manager.

Category 1 (A) patients (within 30 days)	PAD should be allocated	An RFA that has no PAD or the date is outside the 30 days CUC then refer to appropriate manager.
Cosmetic and Discretionary Surgery	Check the procedure is not listed under the cosmetic or discretionary procedures list located in PD2012_011 (pages 5&6)	If the procedure is listed, escalate the RFA to a senior manager.
Bilateral Procedures	Check the patient has only one booking for the same procedure at any one time located in PD2012_011 (page 11)	If more than one booking for the same procedure escalate to appropriate manager for discussion with surgeon.

6.3 Steps to Register a Patient on the Waitlist

1. Booking staff date stamp the RFA on day it is received. This becomes the listing date and is used in calculation of waiting time.
2. Booking/Admission staff must contact the patient by letter or phone to advise patient is on the list for a procedure.
3. Booking/Admission staff must contact the patients General Practitioner (GP) in writing within three days of the patient being added to the waiting list.
4. Hospitals must keep accurate records of waiting list information and document any changes on the RFA form and electronic waitlist where applicable.
5. Any changes made to a patients booking must be validated with documented evidence and signed by the booking/admissions staff member.

Allocating a Planned Admission Date (PAD) is dependent on the patient CUC, see below.

Clinical Priority	Recommended Allocation of PAD
Category 1 (A) 30 days	PAD on booking
Category 2 (B) 90 days	PAD recommended within 45 days
Category 3 (C) 365 days	PAD recommended within 270 days

Section 7 – Auditing and Reporting

7.1 Auditing and Reporting the Waitlist

The Waiting time and Elective Surgery policy outlines the weekly and monthly auditing requirements to be compliant with the policy. In addition each site is to evaluate their audit process at least quarterly.

Each Local Health District/Network is to nominate a person responsible for monitoring the clerical audit program across all hospitals, maintaining clerical audit standards and addressing issues arising from the audits. In SESLHD this falls to the Surgical Clinical Stream Nurse Manager.

7.2 Weekly Clerical Audit/ Reporting

Each hospital is to identify a person responsible for the clerical audit of the elective surgery waiting list. The responsibility includes conducting the weekly clerical audit and reporting the outcome to the relevant manager. Generally the waitlist manager will conduct the weekly audit.

On completion of clerical audits, a report signed by the responsible person conducting the audit must be sent to the relevant manager and tabled at the appropriate committee.

An example of this report approved for use in SESLHD can be found in Appendix A.

7.3 Monthly Clerical Audit/ Reporting

On completion of monthly audit, a report signed by the responsible person conducting the audit must be sent to the relevant hospital executive manager or their delegate and tabled at the appropriate committee.

An example of this report approved for use in SESLHD can be found in Appendix B.

7.4 Quarterly Evaluation

An evaluation of the audit process must be conducted regularly (at least quarterly) by the staff responsible for waiting list management at each facility

An example of this evaluation report approved for use in SESLHD can be found in Appendix C.

7.5 Patient Audit

All patients who have been on the waitlist for greater than six months should be contacted to ascertain if they still require admission. In iPM this is conducted through a batch review – details on how to complete a batch review can be found in Appendix D. A form letter is available in iPM to send to these patients.

7.6 ESAP and Overdue reporting to SESLHD

Each month SESLHD board and SESLHD executive council meet. Each site is required to supply elective surgery data including ESAP figures, the number of overdue patients split by category and specialty, and a narrative around this including factors affecting on time performance and current plan to improve performance. All information supplied should be approved by the hospital executive prior to submission.

Who to supply to: SESLHD Organisational Performance Support Manager. The data must be correct by the 5th of the month in time for a report to be completed.

7.7 Waiting List Collection On-Line System (WLCOS)

Each month the Ministry of Health runs a waitlist extract containing overdue patients, patients admitted after their due date and waitlist errors. This is supplied to each LHD for checking and correction.

When correcting errors both the source system (iPM) and WLCOS should match. This means that a correction needs to be processed on iPM and the same correction made in WLCOS. The WLCOS system is complex to use due to age of the system, please ensure that you are aware how to make the changes required. Other sites may be able to give advice.

Timeframes for WLCOS extract and corrections:

- 1st day of month: data is loaded into WLCOS. Standard errors and queries become available.
- Preliminary reports are processed and sent out ASAP after the data load. Additional errors, Not Treated on Time and Overdue numbers available.
- LHDs correct errors in both their source system and WLCOS.
- 8th day of month final reports are processed and sent out.
- COB 10th working day of month - WLCOS is closed for changes.
- Coordinators need to confirm Not Treated On Time and Overdue numbers from final report - Limited opportunity to amend critical records (ie: NTOT and overdues) (MOH only)
- 12th day of month data is locked and reports extracted and sent for Performance reporting.

7.8 Monthly Reports supplied by Business Intelligence Efficiency Unit (BIEU)

Beginning of the month:

- On the 1st of the month a report is sent out to each site containing the patients on list who are overdue at the end of the previous month, and the patients that were admitted after their due date. This report helps the sites to correct errors in reports in a timely manner before the WLCOS final reports are due. Remember any changes made after the 1st of the month when the WLCOS extract has been pulled need to be changed in both iPM and WLCOS.

Mid-month report:

- A mid-month extract is sent for the purpose of planning and identifying potential 'admit by' errors. The report will contain patients that were admitted after their due date, patients that are on list and overdue, patients that are on list due that month and do not have a TCI date. Check this against your own records, make changes by the end of the month or work to find surgery dates for patients without a TCI date.

Peritonectomy Report:

- There is an agreement with the MoH that patients who have a peritonectomy code are excluded from reportable data. BIEU will send out a report to the St George Waitlist Manager for verification prior to submission to the MoH.

7.9 EDWARD rollout

EDWARD is NSW Health's strategic clinical data warehouse that will replace WLCOS. The plan is for dual reporting to start December 2021 with a replacement of the current reporting system in early 2022.

Section 8 - Managing Patients on Waitlist

8.1 Clinical Prioritisation

Clinical priority categories are designed to facilitate access to elective surgery for patients according to clinical need, maximise equity of access, minimise harm associated with delayed access and support an appropriate balance between consistency of practice and clinical decision making when assigning an urgency category.

Treating doctors are responsible for assigning the clinical priority category to each patient referred to the elective surgery wait list in line with the [NSW Ministry of Health Information Bulletin IB2012_004 - Advice for Treating Doctors – Waiting Time and Elective Surgery Policy](#).

Where a patient requires a higher clinical priority category, the treating doctor should supply supporting documentation. Each hospital should have a process for review and approval to ensure that access to elective surgery is fair and equitable and suitable for the needs of each patient.

Communication back to the treating doctor is important in ensuring a transparent process and provides the opportunity for escalation if required. Example letters are provided in Appendix E, F, G, H.

8.2 Suggested process for CUC changes

A suggested process for managing the allocation of clinical priority categories is outlined below.

1. Where there is a query about the appropriateness of the CUC a letter will be sent to the treating doctor requesting further clinical information to support the allocation of the higher clinical priority category, within 14 days. Booking/Admission staff must contact the patient by letter or phone to advise patient is on the list for a procedure. If there is no clinical evidence provided on the RFA then the reference list CUC will be used until clarification is sought from the treating doctor.
2. When clinical information is provided to support the allocation of the CUC – the Director of Medical Services/Director of Surgery/HOD will review and make a decision to accept or not. This may involve further discussion with the treating doctor.
3. If accepted this will be documented on the RFA and on the patient administration system. A letter will be sent to the treating doctor confirming the CUC has been accepted.
4. If the non-recommended CUC is declined, the Treating Doctor will be informed in writing, and the RFA added to the elective surgery list using the recommended CUC.
5. If following a request to the treating doctor, no supporting clinical documentation is received, a letter will be sent to the treating doctor advising that the recommended clinical priority category will be used

8.3 Doctors Leave

Surgical booking and admission staff are requested to advise management of any leave the doctor may have scheduled. This assists with:

- Appropriate theatre scheduling, doctors are requested to provide as much notice of intended leave as possible (minimum six weeks)
- Development and implementation of a management plan for affected patients
- Ensuring a patients CUC and listing date does not change as a result of doctors leave

8.4 Not Ready For Care (NRFC)/ Suspended

A NRFC patient is not available to be admitted to hospital until a future date, and is either:

- **Staged (not ready for clinical reasons)**
 - Unfit – where a comorbidity exists which, until resolved, renders then unfit for the proposed treatment
 - Planned- the patient requires the procedure/treatment periodically, the patient requires treatment as part of a staged procedure or the patient is booked for more than one independent procedure and the procedure is the lowest clinical priority
- **Deferred (not ready for personal reasons)**
 - Patent is on holidays, has work commitments, personal carer, home support or other reasons is unavailable for admission

Maximum days a patient can defer treatment is shown below per category.

Category	Maximum Timeframe
Category 1 (30 days)	15 days (deferral for Cat 1 (A) need to be discussed with the treating doctor)
Category 2 (90 days)	45 days
Category 3 (365 days)	180 days

8.5 Managing NRFC

A Status Review Date (SRD) should be allocated to a patient who is NRFC. The patient becomes ready for admission to the hospital at the first available opportunity. The patient should be contacted by the Booking Staff once the SRD has elapsed to determine the RFC status.

The MoH conducts audits of NRFC patients three times a year. It is the responsibility of each site to ensure patients on NRFC list are correct and followed up.

8.6 Removals from the Waiting List

Patients can be removed from the waiting list for reasons other than admission. Hospitals should exercise discretion on a case by case basis to avoid disadvantaging patients.

Reasons for removal include:

- Patient declines treatment
- Patient defers treatment on two (2) occasions
- Patient fails to arrive
- Patient not contactable (by phone or letter)
- Refuses clinical review
- Patient deceased

If a patient was initially removed from the waiting list due to reasons other than admission and in the following month the wait list record needs to be reactivated for the same procedure, the booking staff should rebook the patient from the original listing date and include a full history.

It is essential that advice letters concerning the removal of a patient from the waiting list are sent to the treating doctor, General Practitioner and the patient.

Section 9 – References and Revision & Approval History

References

[Waiting Time and Elective Surgery Policy PD2012_011](#)

[Advice for Referring and Treating Doctors- Waiting Time and Elective Surgery Policy IB2012_004](#)

[NSW Health Performance Surgery CPC List](#)

[NSW Health- Elective Surgery Waitlist Management Resource Guide](#)

[NSW Colonoscopy Categorisation](#)

Revision and Approval History

Date	Revision no:	Author and approval
April 2021	DRAFT	G Cramery A/SESLHD Clinical Stream Manager – developed guideline
June 2021	DRAFT	Draft for comment period.
August 2021	DRAFT	No feedback received. Executive Sponsor approval received at consultation stage, noting no changes made to document. To be tabled at Clinical and Quality Council meeting.
August 2021	1	Endorsed by SESLHD Clinical and Quality Council.

Date of report:

Policy Ref.	Audit Requirement	Report	Issues Identified Y/N	Corrections made / Comments
7.2	Duplicate Booking at Same Facility Check for duplicate bookings	RSE_WLIST 45		
7.2	Check correct CUC assigned	WLI015_SBB		
7.2	Status Review/WL Open Suspension w priority Not =9/ WLPriority=9 and No Current Suspension/ WL Suspension W.Out Resume Date Update status review date for Category 4 patients	RSE_WLIST12/ RSE_AUDIT04, RSE_AUDIT 11/RSE_AUDIT 12		
7.2	Planned Admission Date Passed ➤ Review exceeded planned admission dates ➤ Ascertain whether a patient has already had their procedure	WLI008_SBB		
7.2	Emergency Admission and has an Active WL Booking Identify patients on list admitted through ED for same procedure	RSE_WLIST39		
7.2	Patient Delays with No Rescheduled TCI Ensure delayed patient is rescheduled for next available theatre session	WLI014_SBB		
7.2	Number of patients removed and reasons for removal from the waiting list Patients Removed from WL excl. due to Admission	RSE_WLIST 44		
Recommendations for improvement:				

Location of audit files:			
Name and signature of auditor:		Name and signature of manager:	
Date:		Date:	

This report should be submitted to relevant executive/manager and tabled at the relevant governance committee

Date of report:

Policy Ref.	Audit Requirement	Report	Issues identified Y/N	Corrections made / Comments
7.3	Patients Removed from WL excl. due to Admission Patients who have been removed from waitlist	RSE_WLIST44		
7.3	Planned Admission Delays *Patients who have incurred a delay	WLI012_SBB		
7.3	*Patients with Two or More Planned Admission Delays *Patients who have had 2 or more delays	WLI013_SBB		
7.3	*Patient Delays with No Rescheduled TCI Patients who have been delayed and do not have a rescheduled PAD	WLI014_SBB		
7.3	Duplicate Booking at Same Facility	RSE_WLIST 45		
7.3	Theatres KPI Report Surginet Patients cancelled or postponed after admission on their day of surgery	SN027A		
7.3	Waitlist Summary by AMO Comprehensive list of patients for each treating doctor	RSE_WLIST34		

* This report must also be supplied to the LHD/Network CEO or delegate

Recommendations for improvement:

Location of audit files:			
Name and signature of auditor:		Name and signature of Senior Hospital Executive:	
Date:		Date:	

This report should be submitted to relevant executive/manager and tabled at the relevant governance committee

An evaluation of the audit process must be conducted regularly (at least quarterly) by the staff responsible for waiting list management at each facility

Date of evaluation:

Evaluation period:

1. Weekly clerical audit has been completed in line with section 7.1 of the Waiting Time and Elective Surgery Policy and includes:
 - Ascertaining whether the patient has already had their procedure/treatment
 - Checking for duplicate bookings
 - Ensuring Clinical Priority Category is appropriately assigned
 - Updating status review date for Category 4 patients
 - Reviewing exceeded planned admission dates
 - Identifying patients on list admitted through emergency department for the same procedure
 - Ensuring delayed patients are rescheduled for the next available theatre session in consultation with the treating doctor

Weekly clerical audit conducted Y/N	Elements of clerical audit meet policy requirements Y/N	Evidence of corrections or required actions completed weekly Y/N
Issues identified with weekly clerk		
Recommendations		
Weekly audit report generated and sent to relevant manager Y/N	Reports are signed by relevant manager Y/N	Reports are tabled at relevant governance committee meeting Y/N
Recommendations		

Evaluation of elective surgery waitlist monthly reporting:

2. Hospital has a documented process for removing patients from the waiting list

A list of patients who have been removed from the waiting list is provided monthly Y/N	List of removed patients is authorised and signed by a senior hospital executive monthly Y/N

3. Monthly reports are completed in line with section 6.5 of the Waiting Time and Elective Surgery Policy:

- Removals from the waitlist for reasons other than admission
- Patients who have incurred a delay during the previous month
- Patients on list who have had two or more delays to their admission
- All delayed patients who do not have a rescheduled planned admission date
- Duplicate bookings
- Any patients cancelled or postponed by the hospital or doctor after arrival to hospital on the day of admission

Monthly reports conducted Y/N	Elements of monthly report meet policy requirements Y/N	Evidence of corrections or required actions completed Y/N	Monthly report has been signed by a senior hospital executive

4. Monthly report must be provided to the LHD/Network CEO or delegate monthly:


- Patients who have incurred a delay during the previous month
- Patients on list who have had two or more delays to their admission
- All delayed patients who do not have a rescheduled planned admission date

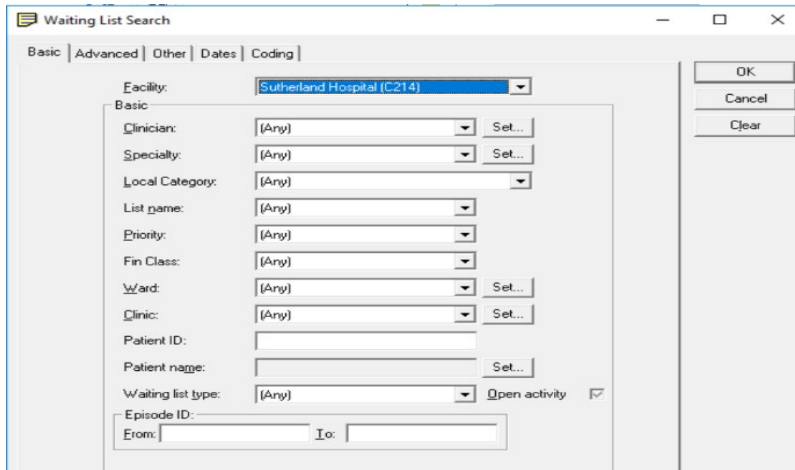
Monthly reports conducted Y/N	Monthly report has been sent to LHD/Network CEO
Issues identified with monthly reporting process	
Recommendations	

Recommendations			
Requirement	Yes/No	Comment:	
A person is nominated and is responsible for the clerical audit and reporting outcomes to the relevant management Y/N		Name of person:	
The LHD/Network has a person responsible for monitoring the clerical audit program across all hospitals, maintaining clerical audit standards and addressing issues arising from the audits Y/N		Name of person:	
Audit documents are available for past 3 years Y/N			
Location of audit documents			

Auditor : Name and signature:		Senior Hospital Executive: Name and Signature:	
DATE:		DATE:	

This report should be submitted to relevant executive/manager and tabled at the relevant governance committee

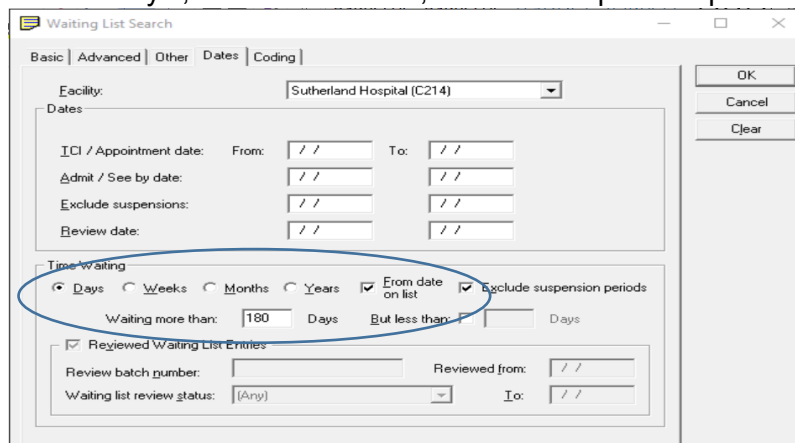
1. Click on the Waiting List View  button in iPM.
The waiting list search screen will appear.



2. Uncheck the 'open activity' box



3. Click on the 'Dates' tab
Select: 'days', 'from date on list', 'exclude suspension periods' and input '180 days'

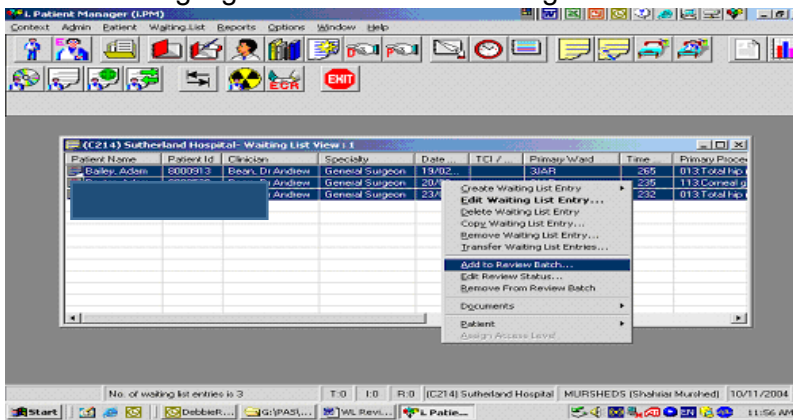


4. Uncheck the 'Reviewed waiting list entries' box

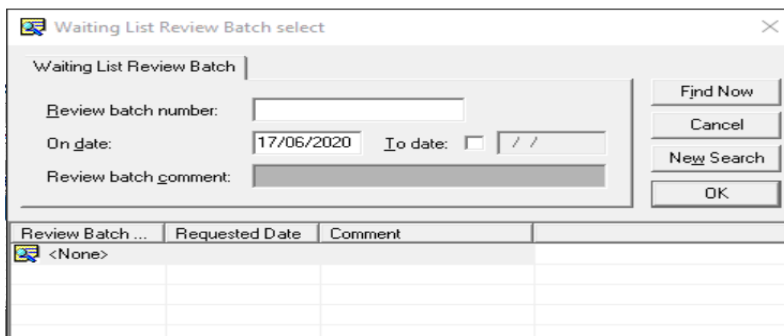


5. Click OK and the 'Waiting List View' Screen will appear with the matching entries

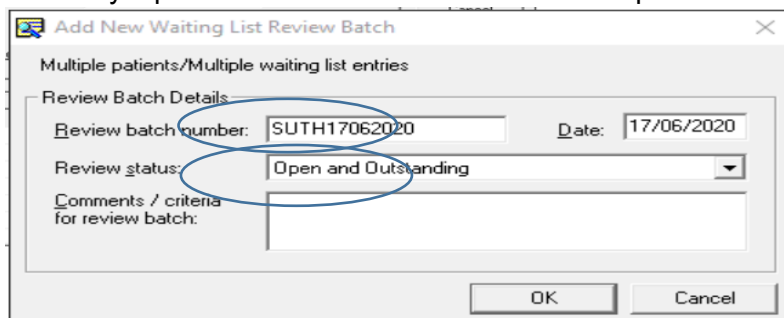
6. Select and highlight all entries and then right click and select 'Add to Review Batch'



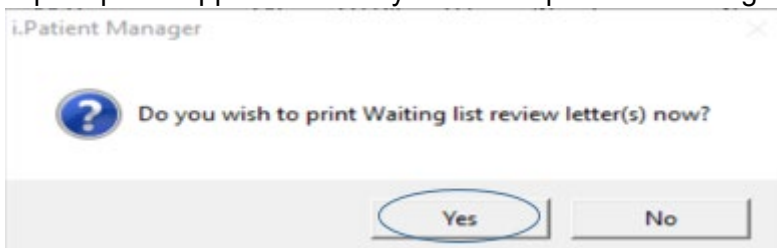
7. Select 'none' and click OK



8. The 'Add New Waiting List Review Batch' screen will appear. Manually input a batch review number. Select 'Open and Outstanding' and click OK



9. A prompt will appear to ask if you wish to print the Waiting List Review Letters – select Yes



10. The bulk print screen will appear – select the appropriate template.

If desired an option to print a GP letter will also appear.

Upon completing a review batch each patient from the audit review will need to be marked off with an outcome that will either keep them on the waiting list for surgery or remove them from the waiting list.

There are two options to update a patient that are in a review batch.

Search a patient individually or search via the review batch which brings up all patients in the review and you can select each patient individually from there.

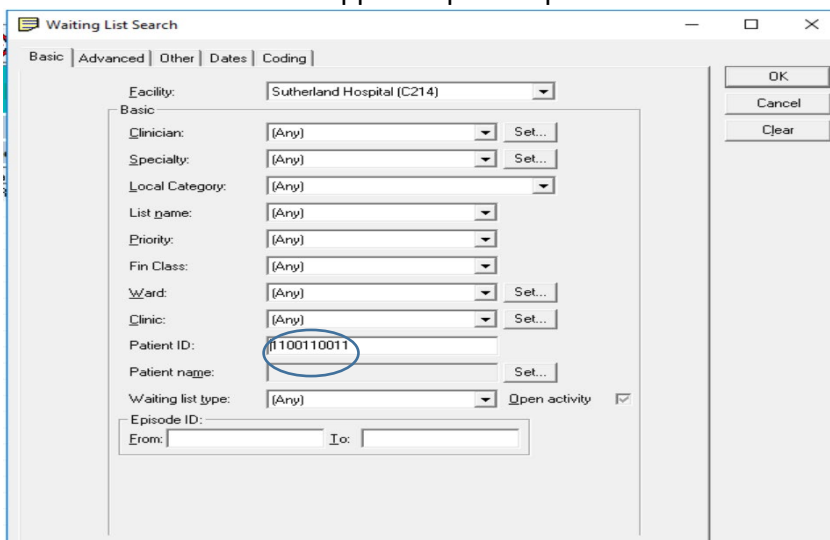
Both are described below. For either option the instructions from step 4 are the same.

Searching a patient individually

1. When you receive a response from a patient, click on the Waiting List Search icon



2. The search box will appear input the patient's MRN and click OK



3. Right click on the patient's waitlist entry to bring up the text box and select 'Edit Review Status'

Clinician	Specialty	Date ...	TCL / ...	Primary Ward	Time ...	Primary Proced...	Primary Diagnosis	Suspension Per...	Priority	Offer Confirm
Keeley, Dr An...	Orthopaedics	18/12...		3PER	182	013.Total hip re...	<None>			

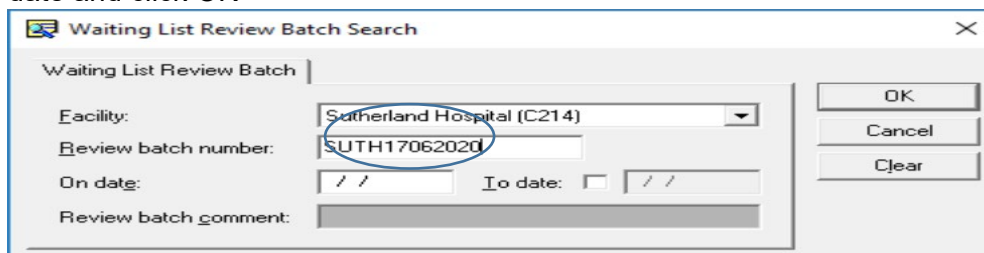
- Create Waiting List Entry >
- Edit Waiting List Entry...**
- Delete Waiting List Entry
- Copy Waiting List Entry...
- Remove Waiting List Entry...
- Transfer Waiting List Entries...
- Add to Review Batch...
- Edit Review Status...**
- Remove From Review Batch
- Documents >
- Patient >

Searching via the review batch

1. Click on the Waiting List Review Batch Search Icon



2. The search box will appear. Enter either the review batch number, or the review date and click OK



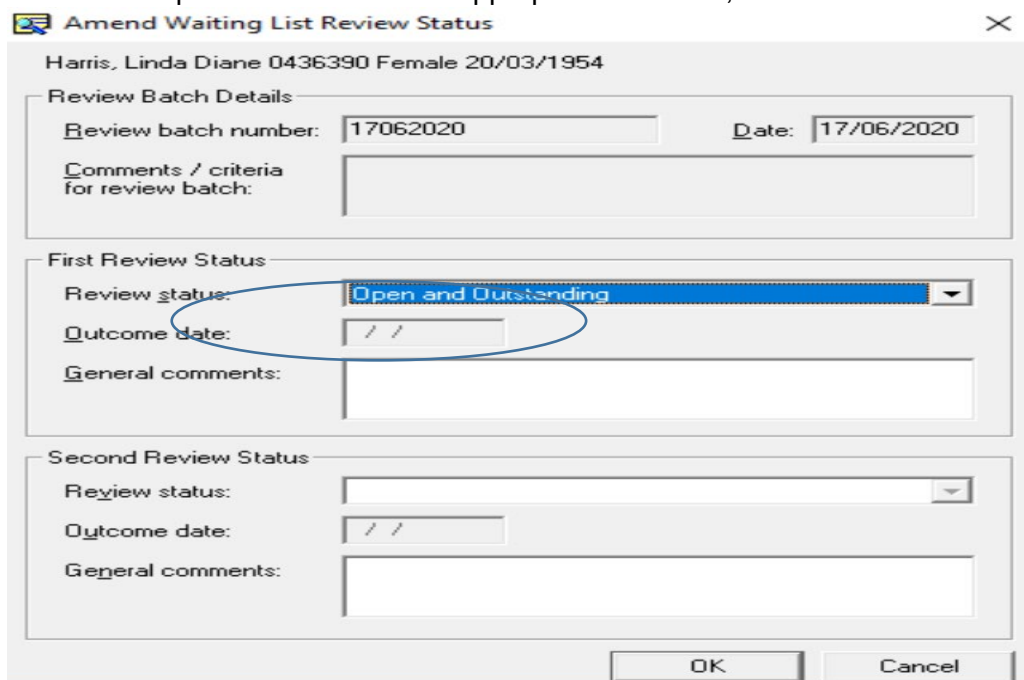
3. The Waiting List review view will appear with your review batch. Double click on the review batch to expand the view to all patients.

Find the patient that you wish to update and right click. And select 'Edit Review Status'

Id	Clinician	Specialty	Date ...	TL / ...	Primary Ward	Time ...
32	Viglione, Dr Wa...	Orthopaedics				
7						
8						
10						
328						
71						
385						
20						
32						
37						
33						
101						
34						
35						
34						
355						

- Create Waiting List Entry >
- Edit Waiting List Entry...**
- Delete Waiting List Entry
- Copy Waiting List Entry...
- Remove Waiting List Entry...
- Transfer Waiting List Entries...
- Add to Review Batch...
- Edit Review Status...**
- Remove From Review Batch
- Documents >
- Patient >

4. The Amend Waiting List Review Status window will appear. From the drop down list select the appropriate outcome, enter the date and select OK



- **Closed & Complete** – patient’s review status is updated on the batch, patient is to remain on the waiting list.
- **Treatment Complete** – patient’s review status is updated on the batch, waiting list record removed at the same time as the review status update.

This can be used for a patient who does not wish to remain on the list for the procedure or who has been treated elsewhere.

- **Moved on Trace** – used for a patient who cannot be contacted, will prompt the user also remove the waiting list entry at the same time as the Review status update.
- **Failed to Reply** – used for patients’ who do not respond within the nominated timeframe. This will prompt the user to enter the patient on a subsequent batch to allow a second review.
- **Closed Patient Died** – The user treated elsewhere for this condition, will prompt the user to also remove the waiting list entry at the same time as the review status update.

5. Once all entries on a Review Batch have been actioned the batch will be acknowledged in the system as complete and will appear with a red tick.

FAX

To:	Fax:
	Phone:
From:	Fax:
Department:	Phone:
Date: / /	Number of pages:
Subject: Clinical supporting documentation for allocation of Clinical Urgency Category	

Patient Details		Procedure	CUC allocated on RFA	Reference list CUC
Patient Name				
D.O.B				

Dear Dr

We received a recommendation for admission (RFA) for the patient listed above. The allocated Clinical Urgency Category (CUC) differs from the reference list CUC in [IB2012_004 Advice for Referring and Treating Doctors – Waiting Time and Elective Surgery Policy](#).

Appropriate categorisation of patients with similar conditions enhances the health systems ability to manage patient access equitably, so that priority is given to the patients with the greatest clinical need.

Individual patient exceptions to the recommended CUC are facilitated by supporting documentation. The received RFA does not include sufficient clinical information to support the allocated CUC.

We request that you provide further clinical information to support the allocation of the higher CUC within 14 days. While we are waiting for the supporting documentation the reference list CUC will be assigned.

Your response will be reviewed and considered by the Dr <INSERT NAME>, <POSITION>, <HOSPITAL> and you will be notified of the decision.

If no response is received within 14 days, the reference list CUC will continue to be used to manage the care of the patient.

Yours sincerely,

NAME
Waitlist Manager

<Decision Maker Name>
Position

Date:

Dear Dr

Acceptance of allocation of Clinical Urgency Category

Patient Details		Procedure	CUC allocated on RFA
Patient Name			
D.O.B			

Thank you for providing the requested clinical information.

The documentation has been reviewed by Dr <NAME>, <POSITION>, < HOSPITAL> and has been accepted. The clinical urgency that you allocated to the patient will remain. The patient administration system has been updated to reflect the allocated CUC.

Yours sincerely,

<NAME>
Waitlist Manager

<Decision Maker Name>
Position

Date:

Dear Dr

Failure to provide clinical supporting documentation for allocation of Clinical Urgency Category (CUC)

Patient Details		Procedure	CPC allocated on RFA	Reference list CPC
Patient Name				
D.O.B				

We refer to the letter sent to you on <DATE> regarding the allocation of the clinical priority category to the patient listed above.

In the letter you were requested to provide further clinical information to support the allocation of the higher clinical priority category within 14 days.

Unfortunately no response has been received. In line with the Waiting Time and Elective Surgery Policy the reference list CPC has been allocated.

For further information please contact Dr <NAME>, <POSITION>, < HOSPITAL> <INSERT CONTACT NUMBER>.

Yours sincerely,

<NAME>
Waitlist Manager

<Decision Maker Name>
Position