Elective Patient Journey – Planned Care and Process Management

Policy Responsibilities and Authorisation

Department Responsible for Policy	Operational Performance and Support
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Authorised By	Executive Leadership Team
Date Authorised	
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Policy Review History

Version	Updated by	Role	Summary of Changes
01	Sana Maqsood	Data Quality Analyst / NPF Project Manager	• Policy rewritten as part of developing new policy and guideline system (on intranet) and processes

Elective Patient Journey – Planned Care and Process Management

Contents

1 Introduction

1.1 Purpose

This document outlines the Waikato DHB policy, process management and best practices to be followed by staff to manage the patient's elective pathway processes effectively.

This policy is aligned with the Ministry of Health 'Planned Care' principles which will enable Waikato DHB to provide more timely care in the most appropriate settings with the right workforce, including services that can be delivered in primary care and community settings.

This policy document will also help to achieve:

- A consistent standard for the administrative management of the elective patient journey.
- Auditable data quality that contributes to patient safety.
- Timely patient assessment and access to the best treatment options.
- Monitoring of referral wait times to ensure equitable access to care for all New Zealanders.
- Transparency and usability of referral wait times to plan services effectively.
- Compliance to internal and external performance indicators.
- Proactive, concise and timely communication with patient and GP to deliver the best care.
- Compliance with the MOH data collections and KPIs (National Patient flow (NPF), National Booking Reporting System (NBRS), National Minimum Data Set(NMDS) and National Non- Admitted Patient Collection(NNPAC)).
- Transparency of the service delivery process, equity of health outcomes and elimination of health disparities.

This policy sets a minimum standard for the Waikato DHB. Services may opt to have service-specific guidelines that extend the minimum standard outlined in the policy. Where issues arise with the staff not complying with the policy, the issue will be resolved between the relevant manager and the individual concerned. Failure to reach an agreement will be referred to the appropriate Director.

1.2 Scope

This policy applies to the elective patient journey that includes elective referrals, outpatient waitlist, diagnostics/Investigation/Tests, clinic scheduling, and appointment booking subsequently followed by elective admissions including inpatient waitlist, Day case Admissions.

1.3 Exclusions

- Management of acute patients except where the event impacts elective services
- Management of Henry Rongomau Bennett Centre - Mental Health referrals
- Management of community referrals
- Management of Te Puna Oranga (TPO) acute referrals
- Patient Flow Manager (PFM) referrals

2 Definitions

Abbreviation	Description
ACC	Accident Compensation Corporation
AAC	Anaesthetic Assessment Clinic
BPAC	Best Practices (Electronic Referral System)
CD	Clinical Director
can	Could Not Attend
CNS	Clinical Nurse Specialist
CPAC	Clinical Prioritisation Assessment Criteria
C2C	Clinician to Clinician
CRC	Community Referral Centre
CWS	Clinical Workstation System
DHB	District Health Board
DNA	Did Not Attend
DTT	Decision To Treat
ES	Elective Surgery
ESPI(s)	Elective Services Patient Flow Indicators
FCT	Faster Cancer Treatment
FSA	First Specialist Assessment
FU	Follow Up
GP	General Practitioner
HSCAN	High Suspicion of Cancer
HO	House Officer

IDF	Inter-District Flow
IP–WL	Inpatient Waitlist
iPM	Patient Management System
KPI	Key Performance Indicator
MoH	Ministry of Health
MCC	Meade Clinical Centre
NBRS	National Booking Reporting System
NHI	National Health Index
ncFSA	Non-Contact FSA
NPF	National Patient Flow
OP, IP	Outpatient, Inpatient
PFB	Patient Focused Booking
PHQ	Patient Health Questionnaire
PHP	Pre-hospital Preparedness
PVS	Price Volume Schedule
RCC	Referral Coordination Centre
RMO	Registered Medical Officer
SLA	Service Level Agreement
SBF	Surgical Booking Form
SMO	Senior Medical Officer
TCI	To Come In
WL	Waitlist
WESSP	Waikato Elective Surgical & Procedural Pathway

3 Policy Statements

The application and implementation of this policy is the responsibility of all staff that manage the elective patient pathway and undertake patient administration and clinical activities.

4 Roles and Responsibilities

4.1 Chief Executive Officer / Executive Director - Hospital & Community Services

This policy will be endorsed by the Chief Executive Officer (CEO) and Executive Director - Hospital and Community Services.

4.2 Directors, Clinical Directors, and Head of Department

- Directors, Clinical Directors, and Division Heads are responsible for ensuring adherence to this policy, and ensure there are adequate resources for its implementation.
- Work in clinical partnership with the relevant managers to ensure services are delivered effectively through the promotion of evidence-based practice and responsive patient-focused care in collaboration with other clinical and non-clinical services across the DHB.
- Each service has a process in place to identify urgent patients waiting on all elective waitlists. The criteria for booking order could be the highest scoring - longest waiting or from analysis of their demand to understand what the booking order needs to be.
- If a service is consistently receiving clinically inappropriate referrals, it is the responsibility of the Clinical Director - Strategy Funding and Primary Care to liaise with external referrers to discuss this matter.

4.3 Clinicians

- The elective referrals received at Waikato DHB is required to be triaged within six working days and within the Ministry of Health guidelines, using National Clinical Prioritisation Tools / agreed triaging criteria.
- Patients attending clinic appointment will be informed about the clinic outcome.
- When patient meets the criteria for a surgical procedure, WESPP/Surgical Booking form will be completed with the required information.
- Work collaboratively and in partnership with clinical and non-clinical staff to comply with policy requirements to manage the elective patient pathway.

4.4 Managers

- Oversee and co-ordinate adherence to agreed patient administration standards and processes for the designated Specialty / Service.
- Monitor, guide, audit and validate that key standards and processes required for the safe administrative management of the patient pathway are adhered to and ensure Ministry of Health compliance timeframes and targets are met.
- Monitor and audit internal processes to promote equity of access for Maori and other vulnerable patient groups.
- Monitor the Specialty / Service compliance with the Planned Care Indicators and other quality and performance standards.
- Notify the Operations Director and Clinical Director of any potential risks and issues.
- Monitor and manage the designated specialty Inpatient and Outpatient wait list, suspended list and planned appointments.
- Support Ministry of Health initiated projects/data collections.

- It is the responsibility of the Manager of each elective service to ensure that procedures are being booked in the correct order based on wait time and urgency score.
- Provide exception reporting and analysis to the Director (when required) if there are potential capacity/demand issues.
- Conduct the following activities in partnership with the Director, Manager, Clinical Director, and designated specialty leads:
- Manage the service delivery for designated specialty
- Quantify the service capacity and forecast the demand
- Ensure iPM data compliance to meet the MoH data collection requirement
- Alignment between production and funding contracts

4.5 Referral Coordination Centre (RCC)

- Ensure referrals received at RCC are processed and notified within timeframes as outlined in section 7.2 (Referrals processed by Referral Coordination Centre (RCC).
- Ensure patient details, address, eligibility status, and GP details are updated. If patient is not eligible for publically funded health services then send an email to Eligibility@waikatodhb.health.nz
- Monitor and communicate ESPI 1 performance with Managers and Clinical Directors.
- Communicate RCC performance issues and implication to the relevant service manager and clinical director.
- Perform an audit to verify the referral details recorded in iPM with the information received in BPAC referral.
- If ACC details are provided, enter this information on the referral. If the referral is likely to be an ACC related or specifies key injury/accident related terminology but it not flagged as ACC, send an email to accadmin@waikatodhb.health.nz to check for claim information.
- Work closely with the Data Quality team to monitor the accuracy and completeness of the data recorded in iPM.

4.6 Clinical Nurse Specialist (CNS)

- Monitor and manage the patient journey from the date of referral receipt until the date treatment is completed.
- Triage patients for urgency and is responsible for reviewing the outcome of the assessment and developing a plan.
- Contact ACC team to get the funding approval prior to the patient surgery when ACC details are not completed by the clinician on the WESPP/Surgical Booking Form.
- Provide clinical oversight and advice to the booking team on priority and urgency.
- Coordinate the plans and care of the complex patient – this will include vulnerable patients, patients with special or complex needs, and patients travelling distances.
- Proactively manage patients who did not attend (DNA) or could not attend (CNA), or are identified as high risk of not attending their scheduled appointments.
- Weekly/Fortnightly meetings with the anaesthetists to develop management plans for 'On Hold' patients.

- Monitor and manage the waitlists to ensure there is sufficient capacity to treat patients within the compliance timeframe. Where constraints are identified this should be escalated to the appropriate Manager and Clinical Director.
- Facilitate and communicate with key clinicians and clinical areas.

4.7 Pre-Hospital Preparedness (PHP Team)

- Pre Hospital Preparedness (PHP) admin creates barcode in iPM for WESSP/ Surgical Booking Form and add patients onto PHP Register (waitlist).
- PHP Nurse makes contact with the patient to complete final pre & post-operative checks for the surgery.
- Issues that may impact surgery are to be escalated to the surgical team, anaesthetist and CNS immediately.

4.8 Clinical Records

- Ensure appropriate documentation is prepared and available for the clinic prior to the patient appointment.
- Ensure patient's medical files and their versions/ volumes are traceable in iPM e.g. document dispatched date, location and transfers.

4.9 Administration Team Leaders

- Support administration staff to adhere to this policy.
- Ensure referrals, appointment and clinical priority requirements are met, and are processed within the agreed timeframes of Planned Care indicators.
- Audit and monitor the waitlist to ensure information is correct and accurate, and policy is followed to comply with the Ministry of Health Planned Care Indicators.
- Perform a random audit on iPM referrals to ensure the patient journey is linked with the correct specialty referral and take corrective actions where necessary.
- Guide the administration staff on the process of recording the clinic outcome when this is not indicated on the clinic outcome form.
- Ensure administration staff is aware of the process when a patient is unable to attend the outpatient appointment /surgery. For further guidance, refer to the section 12:Management of Patients not attending for Outpatient Appointment or Surgery)
- Monitor waitlist to ensure DNA/CNA and vulnerable patients have appointments negotiated in a timely manner.
- Work closely with the Data Quality team to monitor the accuracy and completeness of the data recorded in iPM.
- Liaise with the Computer Application Training Team to ensure staff is well trained and are aware of this policy.

5 Ministry of Health Planned Care Measures

Planned Care Initiative previously known as 'The Elective or Ambulatory Initiative' services encompasses medical and surgical activity that is delivered by hospitals. The intention of the Planned Care Initiative is to take more deliberate steps toward considering these concepts collectively and in the context of quality of services, service user's experience and equitable health outcomes.

As a patient moves through the pathway there are a number of key decisions/indicators from when the person is referred to the specialist through to when decisions are made about whether or not assessment, diagnostic and treatment will be given, to the point when the patient returns to the care of their GP (or primary care provider). These indicators are measured and reported through the Planned Care Performance Indicators.

5.1 Elective Services Patient Flow Indicators (ESPIs)

The following key indicators are being used to measure the DHB's performance of elective services:

ESPI 1: DHB services appropriately acknowledge and process more than 90% of all patient referrals in 15 calendar days or less.

ESPI 2: All patients accepted for an FSA should be seen within 4 months of the date of referral. The goal is no patients wait for more than 4 months for an FSA.

ESPI 5: All patients given a commitment to treatment should receive it within 120 days / 4 months. The goal is to ensure no patients given certainty status remain untreated after 4 months.

The following indicators (ESPI 3, ESPI 6 and ESPI 8) are compiled by the Ministry from these National Collections: NBRS, NNPAC, NMDS and NPF.

5.2 Faster Cancer Treatment (FCT) Indicators

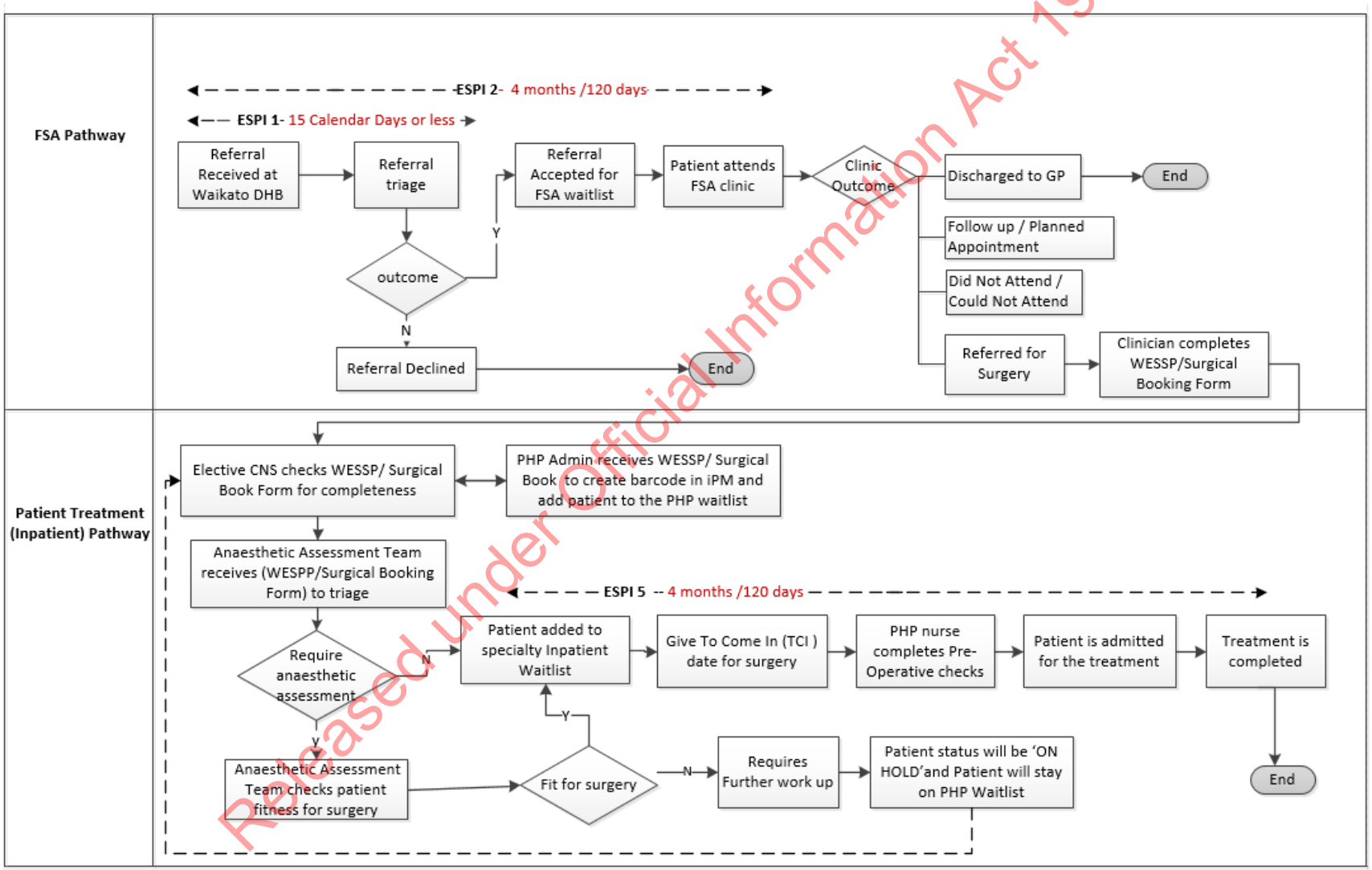
Definition of first/definitive cancer treatment: First cancer treatment is the first treatment a person receives for their cancer and includes surgery, radiation treatment, chemotherapy, targeted therapy, non-intervention management such as active surveillance, and palliative care. FCT is divided into 62 day indicator and 31 day indicator for reporting purpose.

- The **62 day indicator** is 90% of patients are to receive their first cancer treatment (or other management) within 62 days of being referred with a high suspicion of cancer. (The initial referral needs to be triaged as HSCAN and the patients need to be seen within two weeks).
- The **31 day indicator** is 85% and is the maximum length of time a patient should wait from the date of the decision to treat to receive their first treatment (or other management) for cancer.

5.3 Diagnostics Indicators

Some indicators are linked with the patients who are receiving the below diagnostics within required timeframes. For Example, Coronary Angiography, CT scan, MRI scan, Urgent Colonoscopy, Non- urgent Colonoscopy, Surveillance Colonoscopy.

6 Elective Patient Journey (FSA to the Surgery Completion) - Process Flow Diagram (Non- Cancer)



7 Policy Processes

7.1 Referrals Minimum Criteria for GP/Referrers

- All elective referrals sent to the Waikato DHB must contain the following minimum requirements:
  - Patient name – Surname, First name
  - Patient NHI
  - Date of Birth
  - Referrer name
  - Referrer organisation
  - Referrer contact details
  - The name of the service to which the patient is being referred
  - The name of the facility to which the patient is being referred
  - Suitable clinical information on why the patient is being referred(referral reason)
- All referrals will be reviewed by the SMO/ triage clinicians and if referral does not contain this minimum information, this will be returned to the GP/Referrer as per the clinician advice.
- The referrer should specify any special needs of patients that may include disabilities or any other requirements including Interpreter, vulnerable patients, hearing impairment, and any religious or spiritual support.
- Waikato DHB expects that when a patient is referred for a procedures/ treatment, the GP/Referrer deems that the patient is clinically fit, available and eligible for treatment within 4 months of referral to the DHB.

7.2 Referrals processed by Referral Coordination Centre (RCC)

- 90% of elective/non-acute referrals are processed by the RCC. RCC staff receives referrals from internal/external sources through the web based tool known 'Best Practice (BPAC)'.
- Some referrals are received via paper, email, or letter/fax and are entered into BPAC to provide a centralised view of the referrals. All BPAC referrals are triaged electronically by the triaging clinician and referral outcome is notified to the GP electronically.
- If a service is not using BPAC system, the RC staff will send the paper referral with a triage sheet to the service.
- RCC staff records all BPAC referrals information into iPM along with the referral triage and waitlist details as advised by the clinician.
- The following medical and surgical services referrals are processed by the RCC staff:

Medical Services	Surgical Services
○ Cardiology ○ Dermatology-General, Acute, and Suspected Skin Cancer ○ Gastroenterology – General, Hepatitis C, Colonoscopy direct access ○ General Medicine ○ Haematology	○ Maxillofacial ○ General Surgery - General, Colonoscopy direct access ○ Colonoscopy ○ Breast Care ○ Plastic Surgery – includes Burns ○ Orthopaedics ○ Gynaecology

○ Respiratory Medicine – General, Suspected Lung Cancer, Sleep study ○ Rheumatology ○ Infectious Diseases ○ Immunology ○ Endocrinology ○ Paediatric Medicine ○ Pain Management ○ Renal ○ Audiology ○ Physiotherapy ○ Occupational Therapy ○ Hand Therapy ○ Child Development Centre ○ Oncology ○ Older Persons and Rehabilitation ○ Mother craft ○ Neurology ○ Strength and Balance ○ Echocardiography ○ CRIU(Cardiac and Respiratory Tests) ○ Some Nurse Led Services i.e. Leg Ulcers	○ Ear Nose and Throat ○ Vascular Surgery ○ Paediatrics Surgery ○ Dental ○ Neurosurgery ○ Ophthalmology ○ Vascular Surgery ○ Women's Assessment Unit (Antenatal, Obstetrics) ○ Cardiac Procedures - Interventional, Electro - Physiology and Structural Heart Disease

- RCC staff will action the referrals in an agreed timeframe as given below:
- Urgent referrals will be processed within **24 hours** of receiving the referral
- Non – urgent referrals will be processed within **2 working days** of receiving the referral
- The date when a referral is received at the Waikato DHB is the date the clock starts for ESPI1. Once the referral is triaged and the decision is made to transfer to another specialty, the clock does not restart; the original date of the receipt of the referral remains the same.
- The RCC staff can amend errors in any referral in iPM. (This excludes referrals created by services, who will have to authorise the RCC separately for any change to the referral.)

7.3 Referrals processed by the Service

- Services may receive patient referrals through the BPAC, paper, email or fax. The service admin will create an iPM referral to book the patient for the clinic appointment.
- Paper referrals will be date stamped on the day of receipt by the organisation. This is then the official 'date of referral' as defined by the Ministry.
- The following services are required to comply with these guidelines as their referrals are not processed by the Referral Coordination Centre(RCC):
- Urology
- Mental Health
- Community Referral Centre (CRC)
- Diabetes
- Palliative Care

- Sexual Health
- Radiology
- Cardiothoracic
- Gynaecology (Only "Termination of Pregnancy (TOPs)", all other types of Gynaecology referrals are created by RCC staff).
- Some Nurse Led Services
- This policy will also be followed to manage the external provider referrals including Private Practices, Other DHBs.
- When a new patient is referred to a specialty and is identified as more suitable to be managed by another specialty, the patient can be transferred to the care of the appropriate Specialty. The date of the referral will remain unchanged (i.e. the date of receipt of referral at the Waikato DHB).

7.4 Principles for creating iPM Referrals

i. Patient details including address, contact number, residency status and ACC details (if applicable) must be checked before creating iPM referral. When a patient residency status is non-resident, the staff will send an email to Eligibility@waikatodhb.health.nz. When a referral is related to any injury with no ACC details, a query will be sent to accadmin@waikatodhb.health.nz. This information assists in early identification of patient eligibility for publically funded health services.

ii. Referrals are compulsory for all type of patient events/activities created in iPM.

iii. A referral is required to attach with patient journey in the following scenarios:
   - When a request of service is made to the hospital by external providers/GPs/Referrers.
   - All inpatient ward and theatre admissions.
   - Patient care is transferred from one service to another within the facility.
   - Patient care is transferred from one facility to another within the Waikato DHB.
   - For all clinic presentations, appointments and contacts .e.g. Direct Attend, Walk-in Patient, Follow-up, annually follow-ups, post-discharge follow-up, telehealth, phone consultations.

iv. Emergency Department staff will be creating referrals in the following conditions:
   - All acute admissions including acute theatre bookings which must have an associated inpatient admission.
   - All non-resident patients presenting in ED.
   - ED attendance where the ED discharge is Admit or transfer to the ward.
   - Patients are seen in ED and routinely discharged through the transit lounge.
   - All ACC patients including failed to wait in ED or referred to the outpatient clinic. ED staff will not be creating referrals for the non ACC patients referred to the outpatient clinics.
   - ED staff do not create a referral to admit patients in Women's Health and Mental Health and Addiction Services.

v. When creating a referral in iPM, the referral is required to contain the following minimum data requirements:
   - Referral received date
   - Date on letter
   - Referral source

- Referral Reason
- Priority
- Comments – problem/ issue as described in the referral letter
- Referred By
- Referred To – Clinician, specialty and Health Org
- Referral status
- ACC details - if the details are present in the referral
- Outcome tab – GP referred HSCAN, GP referred confirmed status
- Triage Outcome

vi. Record the patient's ethnicity in iPM if it is provided on referral by the GP/Referrer.

vii. Record the patients' residency status and country of birth if it is provided by the GP/Referrer.

viii. Referrals will be created in iPM with one of the following referral reasons:

Referral Reason	When to Use
Assessment	Use when the referrer is requesting for a non-FSA appointment for an assessment. Maybe a new referral for a patient already receiving treatment, or a patient recently discharged, but re-referred with the same condition. May include non-specialist assessments such as nurse assessment, anaesthetic pre-admission assessment, or allied health.
Emergency Department	Use for ED referrals by the Emergency Department for acute and elective patients.
Follow-up	Use when a new Referral is received for a patient currently or recently under care. Follow up is an assessment type of Referral. A follow up is a subsequent patient consultation with a registered medical practitioner of registrar level or above, or a registered nurse practitioner, for the same condition in the same specialty.
For Advice	Use for situations where the Referrer is not requesting a transfer of care but would like some advice. Most frequently this is the clinician to clinician/GP and does not include a written plan of care sent to the patient.
FSA	Use when the referral is for patient's first assessment by a registered medical practitioner of registrar level or above, or a registered nurse practitioner for a particular referral (or with a self-referral, for a discrete episode). The patient receives treatment, therapy, advice, diagnostic or investigatory procedures within three hours of the start of the consultation. This could be used when the referrer is requesting the specialist assessment but the specialist believes that the patient can be managed at the primary care and intends to manage this referral via non-contact FSA.
Investigation / Test	The referrer requests a test for the patient. Tests may be community referred (i.e. referred by a GP or private specialist) or include investigation/tests for patients who are under treatment by a DHB, either as an inpatient or outpatient. Investigation/Test is primarily a non-interventional investigation.e.g. Echo, ETT, Spirometry.

	An investigation test is performed to investigate the patient's problem/disease and monitor the severity of the disease to determine a course of treatment.
Procedure / Treatment	A procedure is a discrete therapeutic or diagnostic intervention. Includes all intended elective admissions for a procedure or treatment.i.e.Endoscopy. Some procedures include diagnostic components, such as a biopsy or angiography.

ix. A referral will contain one of the following statuses in iPM:
   - Awaiting Grading
   - Accepted
   - Declined
   - Diagnostic Required - when clinician advises tests

x. When a clinician advises a necessary diagnostic/ tests (For example, MRI to decide the referral outcome of either 'accepted or declined', the staff will be following the below process:
   - Select the referral status 'Diagnostic Required'
   - Place the referral onto the diagnostic waitlist and send a notification letter to GP/Referrer and Patient.
   - The clinician reviews the diagnostics/tests results and decides to see the patient in clinic, the diagnostic waitlist will be removed, referral status will be updated from 'Diagnostic Required' to 'Accepted', and the same referral will be used for FSA waitlist. The process of FSA booking will be followed (refer to section10.2 FSA Booking – ESPI 2 Start Date).
   - When a clinician decides to decline the referral, the referral status will be updated from 'Diagnostic Required' to 'Declined' and the referral will be completed with the completed reason. The clinician will be following the non-contact FSA (ncFSA) process to notify the referral outcome to GP/Referrer and Patient.

xi. All declined referrals will be marked as completed in iPM with the decline reason and completed reason.

xii. Referral outcome must be notified to the GP /Referrer within 15 calendar days of the receipt of the referral at the Waikato DHB.

xiii. Services are required to formally document the process of triaging referrals including triaging clinicians and the criteria to be adhered to. A current copy of this document will be lodged with the Manager or delegate. Each clinician responsible for triaging referrals must have dedicated time for this activity scheduled into their timetable.

xiv. Use the correct referral to link the patient elective journey. It is not acceptable to use referrals from different specialties or hospitals other than the one the patient is being admitted to.

xv. Once a referral is created for a specialty, this referral should not be overridden/ changed/copied with another specialty referral.

xvi. When a patient is transferred from one ward to another ward within the same facility for the same problem then the admitting referral will be used to link with the patient journey.

xvii. When a patient is discharged from the ward and requires post-discharge follow-up in the same specialty clinic, the ward referral will be used to link with the outpatient appointment.

7.5 Clinician to Clinician (C2C) Referrals / Internal Referrals

Clinicians may refer patients to other clinicians /colleagues in different service for advice/consultation. If a patient is referred and the other clinician identifies a new condition i.e. a condition not related to the original referral, it may be appropriate to discharge the patient back to their GP advising of this. (GP can then make the appropriate referral as required or seek advice from the appropriate specialty) or, in some circumstances, a specialty to specialty referral may be appropriate within the Waikato DHB.

- For internal referrals, a referral form approved by the relevant service directors (or delegate) will be completed by the Clinicians. While all efforts will be made to accommodate individual service needs, services do not have the authority to generate and use their own referral form.

7.6 Referrals from One Facility to Another within Waikato DHB

- When a patient is transferred between facilities for the same problem, the same referral will be used to link the patient journey.
- When a patient is transferred between facilities for a new problem, the admitting facility will be creating a new referral in iPM.

7.7 Referrals from other DHB's / Private Providers

There are few cases when a referral is directly sent to the service:

- When a patient has been assessed by Waikato DHB specialist at another DHB/Private Facility and referred to the Waikato DHB for treatment, a new referral 'Procedure/treatment' will be created by the Inpatient staff to link with the Inpatient waitlist.
- When a patient has been assessed by a specialist and referred to the Waikato DHB, this will be processed as a new referral. Following Clinician triage the patient's referral may be processed as either requiring an Inter-District Flow (IDF) process (New Referral - change of Domicile) or Follow Up - this must be discussed with the related specialty Manager for guidance on the appropriate process and action required.
- All referrals from other DHB's will be processed if the referral is on the correct DHB Letterhead as per the Inter-District Flow process otherwise the referral will be declined. An exception exists where the services may have an agreement with the other DHBs to treat the patient .e.g. oncology, haematology.
- Patients can be referred to the Waikato DHB from a private provider at any point during their treatment pathway. The referral must be processed as a new referral. When the referral is accepted by the clinician then this will be added to the outpatient waitlist with the clinical priority and timeframe.

7.8 Patient Opting to go to the private provider

The referral and waiting list for patients who notify Waikato DHB of their decision to seek private care will be closed from the date of this being advised by the patient, and the GP notified.

7.9 Direct Access Referrals

Direct Access referrals are managed by RCC and services where primary care clinicians request for the diagnostic services without an FSA being undertaken .e.g. Colonoscopy. These referrals will be created in iPM with the referral reason 'Procedure/Treatment'.

7.10 ACC injury related Referrals

All ACC injury related referral queries will be sent to accadmin@waikatodhb.health.nz.

When a patient is accepted for the surgery, the request to generate 'Assessment Report and Treatment Plan (ARTP)' will be sent to accsurgery@waiktodhb.health.nz by the SMO/Clinician.

7.11 Non – Eligibility Patient Referrals

When a patient referral is received and the patient residency status is non-resident, the staff should send a Non-Residency query at Eligibility@waikatodhb.health.nz. Non-eligible patients will be suspended on the waitlist until the eligibility criteria is confirmed by the Eligibility team.

7.12 Management of Open Referrals

- When the referral is older than a year from the date of last activity and there is no current activity or planned appointment attached to it, the referral will be completed in iPM. This is required to comply with the Ministry of Health directive as described in the 'National Patient Flow' data collection.
- A referral will be completed with a reason and will not be re-opened to attach new activities when the clinical outcome is discharged from the service or treatment is completed.

7.13 Management of Duplicate Referrals

- A referral is a duplicate when both (new & existing) referrals have exactly the same patient NHI; problem/diagnosis; referral received date and the referrer. Do not load this referral in iPM.
- A referral is not a duplicate when both (new & existing) referrals have exactly the same patient NHI; problem/diagnosis; referral received date but the referrer is different. Check the existing referral status in iPM and also create new referral with status '2nd Referral for review' and completed reason 'Patient current to service'.

7.14 Management of Non-Contact FSA Referrals

The below process will be followed for the ncFSA referrals:

- Clinician triages the referral and accepts for ncFSA.
- RCC staff record this referral in iPM and place onto ncFSA waitlist.
- Clinician dictates a care plan letter or completes the care plan template in BPAC for the patient and GP (In both cases, the referral needs to be placed onto ncFSA waitlist).
- When clinician completes the care plan in BPAC, RCC staff will create this referral in iPM and place onto ncFSA waitlist and will remove subsequently with the waitlist removal reason 'Treatment completed as ncFSA'.

- When clinician dictates a care plan for the patient, the booking clerk will be notified through the email /phone. The booking clerk will remove the patient from ncFSA waitlist with the removal reason 'Treated as ncFSA' and complete the referral. The booking clerk will be regularly monitoring ncFSA waitlist to ensure patients are being removed from the waitlist when their care plan has been dictated.

8 Clinical Review and Referral Triage / Prioritisation

When elective referrals are sent to the services for triage, the triage Clinicians/SMO/Nurse will be completing the triaging process within 6 calendars days of the receipt of the referral in the service.

Referrals indicated by the GP / Referrer as **Urgent priority, High Suspicion of Cancer, Confirmed Cancer** – must be triaged within one working day of receipt in the DHB.

The triaging Clinician/Nurse is responsible for ensuring that:

- The referral is triaged within the Ministry of Health guidelines.
- The referral is triaged according to the agreed assessment criteria for triaging.
- The triaging of referral is delegated by the triage clinician/nurse to a colleague when leave is taken and this should be documented on the leave request form or discussed with the Manager to determine the delegated triage clinician/nurse.
- Patients that do not require specialist care or meet clinician threshold for acceptance are returned to their GP/referrer for on-going monitoring and care.
- Referrals outcome will be clearly indicated by the triage clinician/nurse.
- When a referral is triaged and accepted then the clinical priority will need to be mentioned in the referral form.

9 Referral Notification to GP/ Referrer and Patient

- Waikato DHB services that are receiving FSA referrals should acknowledge and process more than 90% of referrals in 15 calendar days or less to meet ESPI 1 compliance.
- A referral outcome will be notified to the Patient and GP/Referrer to about the clinical decision.e.g. Referral is accepted/declined, diagnostics/test required, or will be managed through the ncFSA.
- The referral monitoring report 'NPF_ESPI1 Monitoring Tool 15Day' should be used by each service to track the ESPI-1 compliance and to take appropriate actions if required. If you cannot access the report, send an email to dataquality@waikatodhb.health.nz.

10 Outpatient Waitlist Management

10.1 Principles

- All patients who have their FSA referral accepted by the Waikato DHB are entitled to receive their first specialist assessment (FSA) within four months of the date of the receipt of the referral in the DHB to comply with ESPI 2.
- All services will ensure that session templates for outpatient clinics reflect the correct balance of FSA/Follow-up slots to meet demand.
- Outpatient sessions are required to be booked in accordance with the clinic template. Any variations to the approved session template will be approved by the Manager.

- FSA patients will be booked from FSA waitlist using the highest clinical priority/longest waiting.
- Waitlist must be created using the correct referral where there is not an appropriate referral, create a new referral.
- Use the 'Date Referral Received' for the 'Date on List' when creating an outpatient waitlist from FSA referral.
- FSA, diagnostics, and non-contact FSA must be managed on a separate unique waitlist.
- Where there is an authorised acuity tool, SLA must be in place. The patient should be booked under the guidance of the clinical team using acuity rating to establish clinical priority.
- Patient flow processes will be managed effectively, in line with the principles of clarity, timeliness, equity, and fairness.

10.2 First Specialist Assessment (FSA) Booking – ESPI 2 Start Date

- **Urgent, Priority 1, High Suspicion of Cancer or Confirmed Cancer** referrals must be booked within required clinical priority timeframe under the guidance of the clinical team.
- Non- Urgent patient referrals must be booked in chronological order - from date of referral i.e. longest wait first). The below table refers to the priority order to waitlist the patient for FSA.

Priority	Rules
HSCAN	A patient will be offered an appointment within 14 days of referral receipt date
Cat1	A patient will be offered an appointment within 30 days of referral receipt date
Cat 2	A patient will be offered an appointment within eight weeks of referral receipt date
Cat 3-4	A patient will be offered an appointment within four months of referral receipt date

- If service is using an acuity tool, patient prioritisation criteria should be documented.
- Patients that are older, have young families, or live rurally must have their appointment discussed by phone.
- The booking clerk will confirm and update the Patient's demographic details when contacting the patient. The details include 'Country of Birth', Place of Birth', 'Ethnicity', 'Address', for patients born in New Zealand, 'Next of Kin' (minimum two if possible) and 'GP details' including checking 'GP address'
- The booking clerk must check that the dependent resources entered on the OP Waitlist or diagnostic waitlist have been completed. If not contact the relevant service to ensure diagnostic referral has been received and when these will be completed. Appointments should be coordinated with other tests/diagnostics and or treatments.
- Where staff is unable to book the patient appointment within the required timeframes they must advise the Manager of the capacity shortfall and be guided as to when to book the affected patients.

- Where cancellations of the appointment are initiated by Waikato DHB, patients should be contacted and offered an alternative appointment at their convenience acknowledging the clinical priority, compliance and/or target timeframes. This will be done with advice and agreement of the responsible SMO.
- Approved elective services letters and communications must provide appointment details and associated information. Alternative methods of communication should be considered for patients who require a different method of communication such as email, texts.
- Re-scheduled and cancelled appointment must be recorded in iPM indicating either patient or DHB initiated reason.

10.3 Management of Outpatient Clinic – Session Templates

- Clinics will be booked in accordance with the session template. The Administration Team Leader (booking clerks or delegate) is responsible to ensure clinics are appropriately booked to meet the planned target.
- Services are responsible for the accuracy and management of their iPM clinic session templates.
- Services will review their outpatient clinic session templates annually to align with the agreed contract volumes and workforce availability.
- The master schedule describes the plan for the year ahead in a repeating pattern with the exception of planned interruptions (public holidays etc.).
- Changes to the clinic master schedule structure will be agreed and administered by the relevant service Manager. Once the master schedule is agreed, variations and cancellations will be managed as follows:
- The schedule will be reviewed by the Manager and the relevant service six weeks in advance and any potential risks or interruptions to the schedule identified and mitigated.
- It will be assumed that all lists or sessions planned to meet the service demands will be staffed and delivered according to the schedule.
- No clinic will be cancelled within two weeks of the date scheduled without the permission of the Director of the Service.
- No planned clinic will be cancelled within 72 hours of that clinic date without permission of the Operations Director at the time a decision is being sought.
- Variance to the master clinic schedule (requests outside of agreed plan i.e. additional clinics) must be negotiated six weeks prior to the change required. Variance to MCC requests should go to OOG@waikatodhb.health.nz
- Each service is required to plan for sufficient capacity (FSA clinic slots available in i.PM) to book all the patients on the FSA waiting list **within** the timeframes indicated when the referral is waitlisted.
- Each service is required to ensure that there are enough free (un-booked) follow-up clinic appointments available in iPM to meet their requirements. This should align with the service annual Price Volume Schedule (PVS) and/or delivery plan.
- If it is not possible to increase capacity for a defined period, this should be escalated through to the agreed escalation level in each service.

- Where capacity shortfalls can be predicted (For example, around public holidays) the service should control annual leave and other arrangements to ensure the continued delivery of the above timeframes.

10.4 Selection of Patients for Clinic Appointment

- Patients who require outpatient appointments will be booked on the following criteria to ensure equity and to minimise the social disruption in their normal routine:
  - Older patients (particularly those in rest home care), paediatric patients and patients travelling (For example, to Hamilton from the Thames, Tokoroa, Taumaranui and regional) are to be scheduled in the mid to late morning slots in the 'am' clinics and in the first appointment slots for 'pm' clinics.
  - It is expected appointments for the above-mentioned patient groups are discussed with the patient/parent/caregiver by phone before the appointment is made and notes made in the comments field.
  - For the patient from outside of Hamilton, the booking clerk should attempt to coordinate the appointments of patient waitlisted for more than one appointment (FSA or follow-up).
  - FSA that cannot be booked within the required timeframes must be discussed with the Manager for guidance on actions required.

11 Clinic Outcome for Outpatient Appointment

- When a patient attends the clinic, the clinician must record the clinic outcome on the 'Outcome Form'. This information is mandatory to comply with the Ministry of Health reporting requirements.
- All patients will be informed about the outcome of their clinic attendance before they leave the clinic.
- All clinic outcome forms must be checked on the day of the clinic to ensure urgent actions are completed on that day. When a clinic outcome is left blank or not completed then the clinic admin staff will contact the Clinic Nurse/Clinician to know the patient attendance/appointment outcome. In case of any issues, relevant speciality CNS can be contacted to follow-up on the patient clinic outcome.
- Appointment Outcome: Waitlist
- When a patient attendance outcome is 'Waitlist' which means patient requires surgery/procedure.
- When a clinician advises surgery as a treatment option after an FSA appointment, iPM outcome should be recorded as 'Waitlist'.
- When a clinician and patient agree surgery is the preferred option of treatment and the surgery is related to ACC injury, the SMO/Clinician must contact the DHB ACC Team at accsurgery@waikatodhb.health.nz to notify the surgery decision and request an 'Assessment Report and Treatment Plan (ARTP)' to be completed for funding prior approval.
- Appointment Outcome: Follow up appointments < 6 weeks:
  - Follow up appointments due in less than 6 weeks and not subject to test results will have the date and time discussed with the patient before they leave the clinic. If this is not possible then the patient should be contacted as soon as possible to ensure the new appointment date/time meets their needs.

- Follow up appointments subject to test results and/or Planned Follow-ups > 6 weeks:
  - Patients seen in the clinic and require a follow-up appointment will either be:
    - Booked for a follow-up appointment with the patient directly on the day of the outpatient appointment (designated specialities with specific follow up timeframes) by the outpatient reception staff. All follow up appointments are to be managed by the relevant specialty team under the guidance and direction of the Manager / Administration Team Leader.
    - Booked for an urgent follow-up appointment by phone (where possible) under the guidance of the clinical team.
    - Added to a 'Planned follow-up appointment' list according to the follow-up appointment timeframe under the guidance and direction of the CNS and Administration Team Leader to ensure bookings are made within the required timeframe, with appropriate dependent resources available.
    - Follow up appointments will be booked under the guidance of the clinical team, using the 'Follow-up appointment report' to ensure follow-up appointments are booked or planned within the required timeframe requested by the discharging clinician.
- Appointment Outcome: Discharged/Treatment Completed
  - When a clinician decides to discharge the patient from the service with no follow-up. The appointment outcome will be marked as 'Treatment Complete' and the relevant referral will be completed in iPM with an appropriate completion reason.

12 Management of Patients not attending the Outpatient Appointment or Surgery

Patients identified as high risk of non-attendance should be proactively supported to attend their appointments. Where appropriate referrals should be made to Waikato DHB Kaitiaki, Public Health Nurse, K'aute Pasifika or Whānau Ora providers either prior to scheduled appointment or following a missed appointment, or for difficult to contact patients.

Every free text entry in iPM must start with a date, comment and user name. E.g. 10/05/15 called the patient to offer surgery date of 10/06/15 but the patient declined – maqsoosa.

12.1 Outpatient Appointment - Did Not Attend (DNA)

A patient is classified as DNA if they did not attend the outpatient clinic appointment and there was no communication before the appointment.

- HSCAN and confirmed cancer DNA must be rebooked as per Clinician / CNS guidance.
- The appointment maker must contact the patient by phone to negotiate a new appointment day/time.
- FSA DNA status must be entered in the **waitlist comment** and DNA reason must be recorded in iPM under appointment outcome.
- When a patient is DNA on follow-up appointment, the DNA reason will be recorded in iPM under appointment 'Comments'.
- The patient's GP/Referrer should be notified each time a patient fails to attend the appointment.
- If a patient DNA's an appointment for a second time, the clinician will review the referral and clinical notes prior to the end of the clinic and indicate the required action on the clinic outcome form.

- The patient can be discharged back to the care of their GP/Referrer having first ensured that:
- the appointment was clearly communicated to the patient
- discharging the patient is not contrary to their best clinical interest
- the clinical interests of vulnerable patients are protected
- the responsible Clinician has been consulted

12.2 Outpatient Appointment - Could Not Attend (CNA)

- A patient is classified as CNA if they did not attend the outpatient clinic appointment and there was a communication before the appointment. This is considered as Cancellation in iPM.
- HSCAN, Priority 1 and Confirmed Cancer patients to be discussed with the relevant clinical team and Administration Team Leader / Manager.
- The outpatient admin staff will negotiate the reschedule appointment with the patient/caregiver within priority and compliance timeframe.
- When the FSA reschedule date is negotiated outside of the compliance timeframes, the waitlist comment should be updated to indicate appointment date was due to patient advising the clinic they could not attend (CNA). The Administration Team Leader / Manager must be informed when the compliance time frame will not be met.

12.3 Rescheduling Outpatient Appointment- Patient Request (PR)

- When a patient requests to reschedule the planned appointment, a new appointment date should be discussed with the relevant clinical team, Administration Team Leader / Manager.
- Schedule the reschedule appointment within the clinically indicated priority and compliance timeframe.
- If the FSA reschedule is negotiated outside of the compliance timeframes the waitlist comment must be updated to indicate appointment date was at Patient Request (PR).

12.4 Rescheduling Outpatient Appointment - Hospital Request (HR)

- HSCAN, Priority 1 and Confirmed Cancer to be discussed with the authorised service requesting the hospital reschedule.
- Consideration should be given to travel, urgency and patients identified as high risk or vulnerable when rescheduling the appointment.
- The Outpatient Booking Clerk will contact the patient/caregiver to advise the cancellation of the appointment and reason via the patients chosen method of contact.
- The Outpatient Booking Clerk will at the time of advisement of cancellation to patient/caregiver negotiate new FSA appointment within clinically indicated priority and compliance timeframe.
- If the FSA reschedule is negotiated outside of the compliance timeframes the waitlist comment must be updated to indicate appointment date was due to Hospital Reschedule (HR). The Administration Team Leader / Manager must be informed when the compliance time frame will not be met.

12.5 Planned Surgery / Procedure - Patient Did Not Attend (DNA) (Adult)

- If a patient fails to attend their planned elective procedure /surgery admission an attempt should be made (by the area they were expected to present too) to contact them immediately to find the reason. The outcome tab on the 'Admission Offer (TCI)' must be completed with the outcome date, outcome reason, and any relevant notes. The waitlist start date must remain the same.
- Urgent, Priority 1 and High Suspicion of Cancer, Confirmed Cancer patient DNA's must be immediately discussed with the CNS for guidance with the rebooking process. Consideration should be given to the barriers to attending and what support can be provided to resolve this. The patient GP and relevant service CNS should be contacted to assist with coordination.
- Paperwork (For example, WESPP/Surgical Booking Form) is returned to the CNS or nurse coordinating the care. They should contact the patient to negotiate a new date.
- If a patient fails to attend their planned elective procedure /surgery admission a second time the CNS / coordinating health care professional will discuss with the responsible SMO / clinician. The clinician will review the referral and clinical notes.
- Where the patient is discharged back to the GP/Referrer, both the GP/Referrer and patient (and referring clinician, if different), must be informed by the responsible SMO/clinician by letter.

12.6 Planned Surgery / Procedure Patient Did Not Attend (DNA) (Paediatric)

- Where a paediatric patient fails to attend their planned elective procedure /surgery admission an attempt should be made (by the area they were expected to present too) to contact them immediately to find out the reason. The outcome tab on the 'Admission Offer (TCI)' must be completed with the outcome date, outcome reason, and any relevant notes. The waitlist start date must remain the same.
- Paperwork (For example, WESPP/Surgical Booking Form) is returned to the CNS / nurse coordinating the care. They should contact the child parents/carer to negotiate a new date.
- If a paediatric patient fails to attend their planned elective procedure /surgery admission a second time the CNS / Coordinating Health Care Professional will discuss with the responsible SMO / Clinician.
- The paediatric patient's GP/Referrer or health provider and/or public health nurse should be contacted when a paediatric patient fails to attend a planned surgery/procedure event, in addition to direct contact with the patient's parent or legal guardian prior to rescheduling. Consideration needs to be given to barriers to attending and support required in resolving these.

12.7 Vulnerable Patients

It is essential that patients who are vulnerable for whatever reason identified at the point of referral and their journey actively supported by a coordinating health care professional and other support. This group of patients includes:

- Patients with intellectual disabilities
- Patients with physical disabilities or mobility problems or who require special support or assistance during attendance

- Children – known support attendance needed, clinical acuity or complexity or unable to contact and Māori, Pacific of other ethnicities living in New Zealand deprivation index 9 or 10(quintile 5).
- A patient who requires an interpreter
- People with dementia living alone
- Patients with cognitive problems.
- Patients reliant on others to attend hospital (For example, patients in residential care or reliant on carers to transport them).
- All relevant information must be recorded in iPM to ensure that when selecting a patient for admission, their needs are identified and appropriate arrangements are made.
- Any additional needs should be considered when negotiating appointments for patients under these criteria.
- To avoid social disruption and ensure equity of access and attendance to these patient groups specific focus should be given to
- negotiation of appointments to suit the patients' needs
- contacts made based on the patient preferred method
- coordination of (multiple) appointments where possible or procedures/surgeries where the patient requires more than one surgery
- Contact Enduring Power of Attorney (EPOA) as appropriate.

12.8 Hard to Contact Patient

- A patient who is unable to be contacted by phone on the information provided in iPM will have the following attempts made to contact them
- failure by phone or text message after three attempts (message left as able)
- contact the person named as next of kin
- contact GP/Referrer and/or other health providers to check current contact detail or establish the best method of contact
- refer to Waikato DHB Kaitiaki, appropriate CNS, Public Health Nurse or K'aute Pasifika, Whānau Ora providers.
- send a 10-day letter requesting the patient make contact.
- When a patient cannot be contacted, then the patient's information will be provided by the booking clerk/CNS to the responsible SMO/Clinician for decision to discharge the patient and return the patient to the care of their GP is removed from waitlist and a letter will be sent to both the patient and their GP/Referrer by the responsible SMO/Clinician.
- Urgent, Priority 1 and High Suspicion of Cancer, Confirmed Cancer patient - a referral should be made to the appropriate CNS to provide support.
- Paediatrics - a referral should be made to public health nurse to provide support.

12.9 Change of Patient Address

- A patient's address and other contact details should be checked and updated as required on every contact with Waikato DHB to ensure that their details are up-to-date
- Patients who change their address to the outside of Waikato DHB domicile whilst waiting for Elective admission should not be disadvantaged by the change in

circumstances. Their waiting time may need to be adjusted if they have not advised the DHB and do not respond to a TCI or validation letter/ contact. Otherwise, the patient will be referred to the domiciled DHB.

- If the patient cannot be contacted, then the patient's information will be provided to the responsible SMO/clinician for the decision to discharge the patient and return the patient to the care of their GP.

12.10 Transfer between Providers for Elective Surgery

Transfers to and from other providers must be managed with the consent of the patient and responsible SMO /clinician.

12.11 Transfer of SMO / Clinician for Elective Surgery

On occasion, patients may be offered to have their surgery /procedure performed by another SMO/clinician within the same specialty.

Where a patient declines the offer, it would be acceptable to select waitlist booking status 'Planned' in iPM until the date that the patient's requested surgeon is available. It should be fully explained to the patient so that they will wait longer.

13 Management of Hospital Driven Cancellation

A hospital initiated cancellation is when a patient is given an appointment date/time to attend the hospital and then the hospital chooses to change this time. Under this definition, a 'move' or 'rebooking' is a cancellation.

13.1 Clinic Cancellation

If Waikato DHB cancels a clinic or pre-anaesthetic assessment appointment the patient must be re-appointed in the next available appointment slot and in accordance with clinically indicated priority and compliance timeframes. Urgent, Priority 1 patients are to be scheduled immediately and under the guidance of the clinical team.

13.2 Theatre / Procedure Cancellation

- Once a TCI (to come in) date has been agreed with the patient, the date must not be cancelled within one week without approval by the Manager or delegated authority.
- All patients who have their surgery cancelled for non-clinical reasons within 72 hours require the approval of the Operations Director.
- All patients who have their surgery cancelled for non-clinical reasons on the day of admission will be offered a binding date within 28 days, and/or within clinical priority and/or compliance timeframe. A date should be agreed with the patient on the day of cancellation, where possible.
- All theatre session cancellations (less than 6 weeks) must be authorised by the Manager and Clinical Director in discussion with the Operations Director.
- Urgent, Priority 1 and High Suspicion of Cancer, Confirmed Cancer patient cancellations by the hospital must be discussed with the Manager and approved by the Operations Director.

14 Elective Admission including Day Cases

This policy applies to all patients who are waiting for and will be admitted for a surgical procedure, as an inpatient or day case on an elective or planned basis. The policy outlines how the Waikato DHB will communicate with patients and plan their admission within clinical priority and maximum compliance timeframe (ESPI 5).

Some health specialities are being reported in ESPI 5 as per the Ministry's requirement. However, this policy applies to all health specialities to ensure that patients are seen within the compliance timeframes.

14.1 Elective Surgical & Procedural Pathway - Key Principles

- Coordination of the patient journey is the responsibility of the Clinical Nurse Specialist (CNS). They are the primary point of contact for the patient. When the service does not have a CNS, the responsibility remains with the referring SMO/Clinician.
- When a patient and clinician agree surgery is the preferred treatment option, the decision will be noted on the Clinic Outcome Form.
- The WESSP/ Surgical Booking Form will be completed with the CPAC score.
- When a patient does not meet the clinical threshold, they must be informed of the outcome.
- When a patient meets the clinical threshold, they need to complete the 'Patient Health Questionnaire'.
- The required documentation i.e. WESPP /Surgical Booking Form (inclusive CPAC score and Procedure code) and Patient Health Questionnaire must be completed prior to a patient being added to the inpatient waitlist. Procedure information should match the CPAC score assigned for the specialty.
- The clinician will complete the patient ACC details including ACC claim number on the WESPP /Surgical Booking Form if patient injury/surgery is related to ACC.
- Pre-admission assessment and anaesthetic review are considered to be an integral part of the patient's admission. The policy is to ensure that assessment starts at the point the decision to treat is taken i.e. at the start of the waiting time. However, some patients may also require assessment within a month prior to admission.

14.2 Patient Assessment to add into Inpatient Waitlist

- The required documentation i.e. WESPP /Surgical Booking Form (inclusive CPAC score and Procedure code) and Patient Health Questionnaire will be sent to the Elective CNS to check for completion.
- The completed documentation (WESSP/ Surgical Booking Form and Patient Questionnaire) is forwarded to the Pre Hospital Preparedness (PHP) admin.
- Urgent (Priority 1) patients will be barcoded in iPM and added to the PHP waitlist within 48 hours.
- Non-urgent patients will be barcoded in iPM and added to the PHP waitlist within 72 hours.
- When patient's ACC details are not completed on WESPP/Surgical Booking Form by the Clinician/SMO, the Elective CNS/relevant SMO team will contact ACC team to get the funding approval prior to the patient surgery.

- The patient WESPP /Surgical Booking Form will be triaged by the Anaesthetic Assessment team. The triage outcome will result in;
- The patient being cleared as fit to proceed for surgery and do not need to be seen by the Anaesthetic Assessment team. These patients will be placed onto specialty IP waitlist.
- The patient requiring further assessment to establish fitness for surgery. These patients will be added to the Anaesthetic Assessment outpatient waitlist.
- Patient referred for 'Local Anaesthetic (LA)' surgery do not require Anaesthetic Assessment (AA) by Anaesthetist. These patients will be placed onto specialty IP waitlist.
- Patients identified on the WESPP/Surgical Booking Form as suitable for outsourcing and triaged by the appropriate Elective CNS can be sent to an external provider after anaesthetic assessment.

14.3 Anaesthetic Assessment Process

- A patient requires 'General Anaesthesia' for the surgery needs to be assessed by the Anaesthetic Assessment (AA) team as fit for surgery before being added to the inpatient waitlist.
- The pre-anaesthetic assessment process should be completed within 4 weeks for a routine patient without complications.
- Urgent, Priority 1 patients are to be scheduled immediately and under the guidance of the CNS and clinical team.
- If following an anaesthetic assessment, a patient is deemed unsuitable to proceed to surgery, this must be clearly communicated to the responsible CNS and SMO/Clinician by Anaesthetist team.
- The Anaesthetic Assessment team assesses the patient's fitness for surgery and assessment can be conducted via phone call, clinical notes review or clinic appointment.

14.4 Anaesthetic Assessment Clinic (AAC)

- Patients with significant co-morbidities/suspicious symptoms and/or undergoing more complex surgery will need further assessment and are required to attend a pre-anaesthetic assessment clinic appointment with a nurse and/or an anaesthetist, this should take place within 4 weeks of addition to the Anaesthetic Assessment waitlist.
- Urgent, Priority 1 patients are to be scheduled within one week and under the guidance of the clinical team and elective CNS.
- If a patient attending a speciality clinic for an FSA need surgery within 2 weeks and meets the criteria set by AAC , the CNS can arrange a 'walk-in' appointment' in AAC on the same day, this is accommodated where resources allows.
- If a patient requires onward referral to another service, or is pending the outcome of investigation/assessment to determine if the patient will proceed to surgery (i.e. a decision point) the patient is listed as 'On Hold' on the AAC waitlist returned to the care of CNS to coordinate the patients journey.
- The CNS meets weekly/fortnightly with the anaesthetists to discuss management of for 'On Hold' patients.

- All patient interactions will be lodged in iPM comment field starting with a date, comment and user name e.g. 10/05/15 called patient to offer surgery date of 10/06/15 but the patient declined - maqsoosa

14.5 Clearance for Surgery

- Once the patient is signed off as fit for surgery by the Anaesthetic team, the WESPP/Surgical Booking Form is returned to the CNS within 24 hours.
- The CNS will move patient from the PHP register/waitlist.
- The Inpatient Booking Clerk will add the patient to the appropriate speciality waitlist.
- On the date it is confirmed that a patient is to be added to the inpatient waitlist, the patient must be fit for admission, available and willing to proceed within the next 120 days/4 month (ESPI 5 -clock starts).

14.6 Addition to the Inpatient Waitlist / Waitlist start date (ESPI 5)

- Services where the patient requires Anaesthetic Assessment prior to surgery, the Inpatient waitlist start date will commence from the date the patient has received anaesthetic clearance as being fit for surgery.
- Services who are not using Anaesthetic Assessment, the waitlist start date is 'decision to treat' or when a patient is cleared as fit for surgery.
- Urgent, Priority 1 patients must be placed onto the Inpatient waitlist on the same day as receipt of waitlist documentation (WESPP/Surgical Booking Form).
- Non- urgent patients will be added to the Inpatient waiting list within two working days of receipt of the waitlist documentation forms (WESPP/Surgical Booking Form).
- All patient details recorded on the WESPP/Surgical Booking Form must be checked against information recorded in iPM and updated, where applicable.
- Patients who are available and fit for elective procedures or treatment within four month timeframe will be assigned Procedure type 'Normal' on the inpatient waitlist.
- Procedure types - Staged, Planned and Surveillance flags are used to identify patients who are to receive an elective procedure outside the required six month timeframe*(For definitions, please refer to Appendix).*
- Active Review status will be selected for those patients whom elective surgery is considered to be the best option for their care, but where the service is not available within the current capacity; and there is a realistic probability that the patient will be able to be offered treatment in the near future (e.g. within 10-12 month). Patients in Active Review are the patients who would next receive treatment if provider capacity increases.
- **Note:** Priority scores are an indicator of clinical acuity and are not to be altered unless authorised and documented by an appropriate clinical person and the hard copy of the referral grading sheet or waitlist booking to surgery form amended and signed (or documented by a clinician through the e-triage/e-referral process). Procedure code should be relevant for the CPAC score for the specialty.

15 Booking Patient for Surgery or Procedure

15.1 Surgical Patient's Booking Order

- The waiting list or 'Assured and Unbooked ESPI 5' Report will be used to select patients from the report for surgery, based on clinical priority and time waiting.
- Confirmation should be provided in writing of the TCI date and appointment details.
- Patients are treated in accordance with their clinical priority; clinically non-urgent patients are managed on a "next in turn" (chronological) basis and within the ESPI 5 compliance time 120 days / 4 month.
- Urgent, Priority 1 patients must be scheduled under the guidance of the CNS in conjunction with the clinical team. If required documentation/information has not been completed for an Urgent Priority 1 patient this must be immediately discussed with the Manager of elective services or relevant service Manager.
- Patients should be given at least two weeks' notice of their TCI (to come in) date and offered at least two dates. Where available, patients can be offered earlier dates e.g. when there are available theatre dates within three weeks, however, patients will have the right to decline without any impact on their waiting times.
- If a Clinician leaves Waikato DHB, any patient waitlisted under their name must be transferred to the lead consultant or another clinician as advised by the Manager.
- If at the time of being offered a surgical treatment or procedure and the patient wishes time to consider, this will be discussed by the listing SMO/clinician to call the relevant CNS within one month to check if they wish to proceed. The patient will have a procedure type 'Planned' on the waitlist until the date they wish to proceed with the surgery, this should be within the one month timeframe.

15.2 Pre - Operative Nurse Assessment by PHP Team

- The completed theatre list should be provided to the PHP team at least seven days prior to the date of surgery for routine non-urgent patients.
- Additions to a list (For example, as result of a sick patient being replaced) are to be provided to the PHP nurse immediately following confirmation of the TCI.
- Issues identified by the PHP nurse that may impact surgery are to be escalated to the surgical team, case anaesthetist and CNS immediately and documented in WESPP and Clinical Workstation System (CWS).This should include an inability to make direct contact with the patient.
- Consideration should be given to the barriers to attending and what support can be provided to resolve these. The patient's GP /Referrer and Community services may be contacted to assist with coordination of their hospital stay.
- The PHP nurse completes the final check prior to surgery, ensuring patient readiness. The patient is contacted to ensure they are fit and well for surgery, instructions regarding arrival time, NBM (Nil by Mouth) time and medication amendments are given to the patient.
- Pre-op preparation is explained and sent out to the patient. For example, bowel prep, chlorhexidine wash.
- Checks are made that pre- operative blood tests and x-rays are complete if not these are arranged. This is an opportunity for patients to ask questions about their hospital

stay and ensure they have transport and, plans in place to minimise delays at discharge. Pre and Post-operative information is given to the patient regarding their stay in hospital.

15.3 Removal from the Inpatient Waitlist List

The patient and their GP/Referrer must be informed in writing (iPM letter or dictated) by the responsible SMO/clinician (or delegate) of all decisions that result in the removal of the patient from the inpatient waitlist and/or discharge back to the care of the GP/Referrer.

- Patients may be removed from the waiting list without treatment for several reasons:
- Intended treatment is no longer required (patient or clinician advised).
- The patient has moved out of the area and opted to transfer to their domiciled DHB.
- The patient has personal circumstances that prevent acceptance of offer date for the foreseeable future.
- The patient has not attended an agreed TCI date and efforts to contact the patient have failed.
- The patient has cancelled a TCI date more than twice (providing it is not contrary to their best clinical interest and patient circumstances have been acknowledged) Clinician review completed and the patient must be discussed with the Managers.
- The patient is not fit for admission, not available or unwilling to proceed or unable to contact the patient.
- If following pre-anaesthetic assessment clearance and waitlist, there is a change in a patient's condition that may result in them becoming unfit for surgery, the CNS will liaise with the surgeon and **Anaesthetist** to establish the priority of treatment.
- When a patient requires onward referral to another service, requires more than four weeks to be optimal for surgery, or
- When the outcome of investigation/assessment is pending to determine the patient's fitness to proceed with the surgery (i.e. a decision point). In both cases, the patient should be removed from the inpatient waitlist and returned to 'on hold' under the case management of the CNS, or discharged back to the GP depending on the level of intervention required.
- The reason for removal must be recorded on the system and in the medical/clinical notes.
- Patients who advise the CNS that they do not wish to proceed with surgical treatment will be referred back to their responsible SMO/clinician with a view that the patient should be discharged to the care of their GP/Referrer. The patient will be removed from the waitlist.

16 Validation and Active Management of Waitlist

- It is the responsibility of the Manager to ensure ongoing weekly review, administrative validation and clinical validation of all waiting lists and suspend lists.
- Suspend lists must be reviewed weekly by the appropriate specialty nurse co-ordinator and/or Manager to ensure validation of the list. All actions taken must be recorded in the Suspend List Comments in iPM. (All clinical decisions/actions must be recorded in Waikato

DHB system by the clinical team (e.g. Peri-operative Nurse Co-ordinator).

- A clinical validation process must be undertaken on a weekly basis of all patients who are deferred/suspended for medical reasons by the clinical team (e.g. Peri-operative nurse coordinator).
- The Administration Team Leaders are responsible for ensuring appropriate and accurate data entry and update of patient details on the 'Current Waiting List Report' under the guidance of the Manager.
- If a clinician leaves Waikato DHB, any patients under their care will be transferred to the lead consultant or another clinician as advised by the Manager.

17 Management Information and Reporting

The Business Analysts will make available a wide range of detailed and summary information/reports to the management and Managers in the DHB to help manage and monitor performance against internal and external KPIs, using relevant Waikato DHB systems.

18 Monitoring and Audit

Managers and the Data Quality team will monitor and audit patient management processes in iPM and will work closely with stakeholders where any issues/ opportunities for improvement are identified.

19 Associated Documents

- Referral Coordination Centre (RCC) Manual
- Waikato DHB Outpatient Clinic Manual
- iPM Referral Process & Business Rules
- Ministry of Health - Planned Care Strategic Approach (ESPIs)
- Waikato DHB Electronic Result Acknowledgement: The Responsibilities of Senior Medical Officers and the Delegation of Authority to Resident Medical Officers policy (Ref. 1452)
- Operational Policy Framework 2018/2019
- Ministry of Health - Bowel Screening pilot monitoring indicators
- Ministry of Health- Faster Cancer Treatment indicators
- Ministry of Health NZ; NBRS for Elective Treatment Guide (January 2015), Guide to NBRS Procedure flags (June 2016), Guide to Active review (June 2016)
- Ministry of Health 'Common counting standards 2013-14final_Jan2017'
- Equity of Health Care for Māori: Framework https://www.health.govt.nz/system/files/documents/publications/equity-of-health-care-for-maori-a-framework-jun14.pdf
- National Collections Glossary

Appendix A - Glossary

Acute Admission (AC)

Acute Admission - An unplanned admission on the day of presentation at the admitting healthcare facility. Admission may have been from the emergency or outpatient departments of the healthcare facility or a transfer from another facility.
Reference: https://nsfl.health.govt.nz/purchase-units/common-counting-standards-2013%E2%80%9314

Admission Offer (TCI- To Come in) Date

This is the date the patient is told to arrive at the hospital for elective inpatient admission. This may be the same as the date of the procedure but may also be prior to the date of the procedure.

Arranged Admission (AA)

A planned admission where the admission date is less than seven days after the date the decision was made by the specialist that this admission was necessary; or the admission relates to normal maternity cases of 37 to 42 weeks gestation delivered during the event. These maternity patients will have been booked into the admitting facility (national collections).
Reference: https://nsfl.health.govt.nz/purchase-units/common-counting-standards-2013%E2%80%9314

Booking date

The date on which a patient is offered a (future) date of attendance at the hospital. This can be for an outpatient appointment or inpatient episode. It is mandatory that a letter must have been posted to the patient within 24 hours of the booking date informing the patient of their attendance date.

BPAC (Best Practice) System / Electronic Referral System

Best practice Decision Support is a web-based system that is designed specifically to support general practice in the management of a patient's health through screening, risk assessment, management and referral.

Cancellation (Patient initiated)

To be used where the DHB is made aware that the patient has chosen to receive the service in a non-publicly funded environment (i.e. Insurance or self-funded). This reason should only be used after Prioritisation. Reference: https://www.health.govt.nz/publication/national-patient-flow-file-specification

Clinician to Clinician (C2C) referrals

This is a type of elective referral where a hospital clinician requests a transfer of care to, or consultation with, another hospital clinician. These are classified as new referrals. Note, C2C stands for Clinician to Clinician.

Day Case Patient

A patient admitted for healthcare with a length of stay three hours or more but less than one day, regardless of intent. Day case events will have the same event start and end date. This term is synonymous with 'same day patient' and 'short stay event'.
Reference: National Collections Glossary

Did Not Attend (DNA)

A patient is classified as DNA if they did not attend the outpatient clinic appointment and there was no communication before the appointment. If there was communication, this is a cancellation.
Reference: https://nsfl.health.govt.nz/purchase-units/common-counting-standards-2013%E2%80%9314

Direct attend

A direct attend outpatient is one where the patient comes directly to an outpatient clinic without a prior written referral being received in the hospital and there is not an available clinic session.

Elective Admission (WN)

Elective admission is a planned admission where the admission date is seven or more days after the date the decision was made by the specialist that this admission was necessary.
Reference: https://nsfl.health.govt.nz/purchase-units/common-counting-standards-2013%E2%80%9314

First Specialist Assessment (FSA)
An FSA is a patient's first assessment by a registered medical practitioner of registrar level or above, or a registered nurse practitioner for a particular referral (or with a self-referral, for a discrete episode). The healthcare user receives treatment, therapy, advice, diagnostic or investigatory procedures within three hours of the start of the consultation. Service is provided in ward and/or designated outpatient clinic or by telehealth. Excludes ED and outpatient attendances for pre-admission assessment/screening (National Collections).
Reference: https://nsfl.health.govt.nz/purchase-units/common-counting-standards-2013%E2%80%9314

Inpatient (IP)
A patient admitted for healthcare. Includes day case (same day) events. Includes patients who are transferred from another healthcare facility, and or inter-departmental transfers (statistical discharge between specific health specialities) within the same facility. For events reported with an event end date before 1 July, 2013 the definition of 'inpatient' included 'where the intention at admission was that it would not be a day case event'. Reference: National Collections Glossary

Inpatient Length of Stay
The time in days between admission to hospital 'X' and discharge, death or transfer from hospital 'X', minus leave days from hospital 'X'.
Reference: National Collections Glossary

Multi-disciplinary Clinics
A multidisciplinary clinic constitutes of a mix of clinicians meeting with a patient together to provide an assessment, for example where an oncologist, surgeon and allied health specialist are present at the same appointment for the treatment of a cancer patient.
Reference: https://nsfl.health.govt.nz/purchase-units/common-counting-standards-2013%E2%80%9314

National Booking Reporting System (NBRS)
The National Booking Reporting System (NBRS) is a national collection that contains information by health specialty and booking status on how many patients are waiting for treatment (elective surgery), and how long they have had to wait for before receiving treatment.
Reference: https://www.health.govt.nz/search/results/National%20Booking%20Reporting%20System

National Collections Annual Maintenance Programme (NCAMP)
The National Collections Annual Maintenance Programme (NCAMP) is an annual project in order for the Ministry of Health to meet its statutory obligation of delivering information from the Ministry's national collections. NCAMP requires DHBs to initiate changes to their PMS. This covers NMDS data.
Reference:https://www.health.govt.nz/search/results/NCAMP%202020%20changes%20to%20the%20National%20Collections

National Minimum Dataset (NMDS)
The NMDS is used for policy formation, performance monitoring, research and review. It provides statistical information, reports, and analyses about the trends in the delivery of hospital inpatient and day-patient health services both nationally and on a provider basis. It is also used for funding purposes.
Reference:https://www.health.govt.nz/search/results/National%20Minimum%20Dataset%20%28hospital%20events%29

National Non-Admitted Patient Collection (NNPAC)
The National Non-Admitted Patient Collection is a national collection of non-admitted (outpatient and emergency department) activity, which was introduced 1 July 2006.
Reference: https://www.health.govt.nz/publication/national-non-admitted-patient-collection-file-specification

National Patient Flow (NPF)
The NPF collection will provide information on the patients referred for specialist services, the outcome of referrals and the time it takes to patients to access care. This collection will contribute to the better-integrated care so that patients can receive the most appropriate services, in the right setting and in a timely way to improve overall health outcomes. It will capture the outcome of the referral decision so that the demand for services and whether it is being appropriately met can be better understood. It will connect related patient referrals and activities to provide a complete view of the patients' secondary care.
Reference: https://www.health.govt.nz/publication/national-patient-flow-file-specification

Non-Contact FSA (NC FSA)

A review is undertaken of patient records and any diagnostic test results by a registered medical practitioner of registrar level or above, or a registered nurse practitioner. The original referral should only be generated after a face-to-face contact by the referrer. A written plan of care is developed for the patient and provision of that plan and other necessary advice is sent to the referring clinician and the patient. The non-contact FSA does not include the triaging of referral letters. The patient should not be present during the assessment.
Reference: https://nsfl.health.govt.nz/purchase-units/common-counting-standards-2013%E2%80%9314

Nurse Led Outpatient Clinic Definition

Assessment, treatment, education and/or management clinics led by a nurse specialist for specialist groups of clients.
Reference:https://nsfl.health.govt.nz/purchase-units/common-counting-standards-2013%E2%80%9314

Outpatient (OP)

An outpatient is a patient who receives a preadmission assessment, or a diagnostic procedure or treatment at a healthcare facility, and who is not admitted, and the specialist's intent is that they will leave that facility within three hours from the start of the consultation. When patients receive a general anaesthetic they are deemed not to be outpatients. All outpatients are elective.
Reference: National Collections Glossary

Procedure Types

- **Normal**

This is the default for all procedures that are not assigned Planned, Staged or Surveillance.

- **Planned**

A planned procedure is a procedure that is intentionally delayed, where the delay in treatment is for medical reasons and lasts for more than six months from the decision to treat.

- **Staged**

A staged procedure is the second (and any subsequent) in a series of procedures that must be performed in a sequenced order.

- **Surveillance**

A surveillance procedure type is used when the patient requires an ongoing series of routine surveillance procedures. The surveillance procedures are provided at regular (i.e. annual or longer) intervals to assess health status.
Reference: https://www.health.govt.nz/system/files/documents/publications/nbrs-file-specification-v4.4.pdf

Referral

A referral is a request to shift patient care from primary care to secondary/tertiary care. The actual transfer of responsibility is recorded by (usually) a change from one status to another or a change of responsible clinician. The request may precede the assumption of responsibility by some time, the difference being the waiting time.
A written document, from a medical professional, requesting a patient be assessed for, or receive hospital services. All elective referrals must be entered into iPM so an electronic record exists of the paper equivalent.
Note: elective referrals are divided between GP referrals and Internal or C2C referrals.

Responsible Clinician

For the purposes of this policy the responsible clinician is the person who has overall clinical responsibility for the healthcare provided to the patient/client. This may be the Senior Medical Officer, midwife, nurse, Mental Health and Addictions Service key worker, psychologist, physiotherapist, occupational therapist, dietician, social worker, speech language therapist, other Allied Health workers.

For patients/clients admitted under the Mental Health (Compulsory Assessment and Treatment) Act 1992, the term responsible clinician is legally defined by this Act, as 'the clinician in charge of the treatment of that patient.'

Walk-in Patients
When a clinician has agreed to see the patients in the clinic. All walk-in services are acute and a session is currently available.