PLANNED CARE

Guidance documents for managing patients referred to the National Booking Reporting System (NBRS) for elective treatment

Process:	Guidance to managing patients referred to the National Booking Reporting System for elective treatment
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Table of contents

Purpose

1. The purpose of this paper is to provide guidance on managing patients within the National Booking Reporting System (NBRS), and consistency in the use of associated codes and categories. The guidance will provide advice on appropriate use of the following categories within NBRS:
    a. Booking status codes
    b. Exit categories
    c. Procedure flags.

Expectations

2. The Planned Care policy is that patients are provided with information on their eligibility for publicly funded treatment, their maximum waiting time, likely booking date, date they will next be assessed/ reviewed, care or treatment options, and who to contact if there is a problem. Treatment is expected to be provided within a maximum of four months. Any change in policy will be reflected in revisions to this document.

3. To meet the Planned Care policy expectation, patients assessed as benefiting from surgery will:
    a. Receive a booking date for treatment immediately (*Booked*).
    b. Be given an approximate date for treatment within the next four months (*Certainty*).
    c. Be provided with a plan of care and returned to the care of their general practitioner[1] (GP) or another care provider (*GP Care*).
4. NBRS is a national collection of booking information reported to the Ministry of Health. NBRS provides information by health specialty and booking status on how many patients are waiting for treatment, and how long they have had to wait before receiving treatment. NBRS is not a patient management system (PMS) for District Health Boards (DHBs) and should not include patients who are not expected to receive elective treatment within four months[2].
5. The overarching principle to guide inclusion of patients in reporting to NBRS is that the DHB is expecting to offer the patient treatment within four months *and* that the patient is fit, willing and able to accept the offer of treatment. This document provides guidance on appropriate referral to NBRS and alternative management options for patients.
6. Summary and performance reports for Elective Services Patient Flow Indicators (ESPIs) are available on the Ministry of Health public website. Underlying information can be found in:
    a. The Six-Month Rolling Reports, located on the Elective Services Quickr restricted website, under DHB Performance Reports.
    b. The Booking Behaviour Report, located on the Electives Services Quickr restricted website, under DHB Performance Reports.

Booking status code reporting

7. A booking status code is assigned to all records that are active in NBRS. Guidance will be provided on use of the following booking status codes:
    a. **Module 1 (pg.6) -** *Booked* (01), *Certainty* (02), *Deferred* (05) and *Rebooked* (06) - These booking status codes comprise the *Assured* group of patients:

[1] GP is used generically, but may include a wide range of primary care providers

[2] The exception to this is where there is a clinical reason for treatment to occur outside of four months – refer Module 3 – Procedure flags, for specific guidance.

i. This grouping comprises the categories that are included in the calculation of ESPIs, specifically ESPI 5 – patients waiting more than four months for treatment.

ii. **Module 4 (pg.15) -** Deferred (05) – Included in the above Assured calculation, specific guidance is also provided on use of the Deferred status, for both hospital and patient reasons.

8. Active Review is no longer accepted as a Booking Status. All patients must be given an Assured status or not entered into NBRS and returned to their GP for ongoing care.

Exit category reporting

9. **Module 2 (pg.10) -** Exit categories are assigned to all records exited from NBRS. Once exited, patients are not included within NBRS. The number of patients exited treated is the denominator for calculating ESPI 3 (in the last 12 months) and ESPI 8 (in the last month). There are five valid exit categories currently available for use[3]. Guidance is provided for use of the following three categories:

    a. Patient returned to primary care – the patient is below the access threshold for receiving publicly funded treatment and has been discharged to the care of their GP. Otherwise known as GP Care, this is a care pathway for patients for whom elective surgery is considered to be the best option for their care, but where the service is not available within provider capacity. As identified in Module 2 – Exit Categories this exit category should not be used for patients where a commitment of treatment within four months has been given.

        i. The exit date is the date a letter is sent to the GP returning the patient to their care.

    b. Removed due to changed patient circumstances – the patient is unable to proceed with treatment for personal reasons.

        i. The exit date is the date the patient or their representative notified the DHB of the change.

    c. Medically unfit for treatment – the patient is unable to proceed with treatment because they are not medically fit, and there is no known timeframe within which the patient will be able to receive treatment.

        i. The exit date is the date the patient is assessed as unfit.

Procedure flag reporting

10. **Module 3 (pg.12) -** NBRS records include a Procedure flag. A "Normal" flag is used for all records where there are no clinical exclusions to the requirement to provide treatment within four months. There are three procedure flags for situations where the procedure is expected to be provided outside the required maximum timeframe of four months for clinical reasons. These records are then excluded from all ESPI calculations. Guidance is provided on use of the following procedure code flags:

    a. *Staged* – Staged procedures involve a series of operations at different times to complete treatment. A Staged flag is applied to the second (and any subsequent) in a series of procedures that is required to complete the patient's treatment over a period of time e.g. months or years.

    b. *Planned* – A Planned flag is attached to a patient's procedure when the timing of a single elective procedure is intentionally delayed for *clinical or patient centred* reasons beyond four months from the decision to treat. Wherever possible, the timeframe for treatment should be known.

[3] Refer to the NBRS Data Dictionary for further detail on the remaining Exit Category codes

c. *Surveillance* – A Surveillance flag is attached to a patient's procedure 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.

Module 1 - Assured Status

When to use an Assured (Booked, Certainty, Deferred, Rebooked) status

11. In giving a patient Assurance of treatment within four months, a DHB is obliged to honour that commitment. DHBs need to give careful consideration to the commitments they give to ensure that all five Planned Care principles (equity, access, quality, timeliness and experience) are met for all patients.

12. A key priority of Planned Care is to provide patients with clarity about their access to treatment. One aspect of clarity is giving a firm commitment that treatment will be provided within the next four months (an Assured status):

    a. In confirming a commitment, patients whose treatment is considered urgent should be given a booking date immediately (Booked status).

    b. Patients whose priority is high, but who cannot be given an immediate treatment date should be given a Certainty status.

13. The *Guide to Managing Elective Services Patient Flow Indicators (ESPIs)* (available on the Elective Services Quickr website) provides more detailed advice on setting access thresholds and determining who should receive an assurance of treatment within four months. The Medical Council "Statement *of safe practice in an environment of resource limitation*"[4] also provides advice on clinical responsibility related to prioritisation, and DHB responsibility in managing referrals.

14. Decisions about who should receive an Assured status should consider surgical capacity, patient priority and the patient's availability to proceed with treatment. In determining access to treatment, four questions are posed:

    1. ***Is surgery the best option for the patient*****?** – if the patient and surgeon agree it is the best option, the next question is:

    2. ***Can surgery be provided within available capacity (within four months)?*** – how many patients can be given treatment, and what is this patient's priority, relative to other patients? If the answer is yes, the patient priority is within available capacity, the next question is:

    3. ***How quickly should surgery be provided?*** - the patient's assessed urgency should determine how quickly surgery should be provided, with the most urgent having the highest *priority*. If these questions result in a decision to offer the patient treatment within four months, the next question is:

    4. ***Is the patient fit, willing and able*** to accept a treatment date within the next four months?

15. The most challenging of the questions is often "can surgery be provided within the available capacity?" History is the best predictor of the future, and if nothing is changing in terms of scheduling or resources, it is reasonable to expect that a hospital will be able to treat the same number of patients that it has previously. The setting of Planned Care Initiative targets each year gives DHBs some surety of the level of elective surgery expected, by service, which provides an additional predictor of future capacity required.

16. If treatment can be provided within four months, the next factor to consider is which patients should be accepted. Provided clinical prioritisation is consistent, and patients are reliably treated in order of priority, it should be possible to determine the numerical priority score that represents the level of need that can be met within the available capacity.

[4] https://www.mcnz.org.nz/our-standards/current-standards/medical-care-and-prescribing/safe-practice-in-an-environment-of-resource-limitation/

17. If surgery can be provided, consideration should then be given to whether a patient is fit, willing and able to receive surgery within four months. If a patient is not expected to be meet these criteria, the patient should not be offered an Assured status immediately.

    a. The DHB should work with the patient to agree an appropriate plan of care, so that when the patient is able to accept treatment within four months, they are either reassessed or entered into NBRS with an appropriate Assured status.

    b. Whether a reassessment is required, or whether the patient can be entered directly into NBRS, will depend upon the reason for delay, and the timeframe from the initial assessment.

        i. If the delay is of relatively short duration and the patient's surgical condition is unlikely to have changed, then direct entry to NBRS would be the most appropriate approach.

        ii. If the delay is of longer duration or the patient's condition is unstable, then a clinical review prior to a decision about whether to proceed with treatment may be more appropriate.

When NOT to use Certainty status

Patient is below treatment threshold (capacity to treat within four months)

18. Clinical priority and ability to benefit should guide which patients are given Assurance of treatment within four months. Assurance should not be given to patients whose priority is low, relative to other patients, if treatment is unlikely to be provided within four months. These are patients whose priority is below the threshold for receiving treatment within four months. The care pathway for these patients is that they can be managed by their general practitioner (GP), or an alternative primary care provider. In some circumstances a DHB may also elect to follow the patient up with the specialist in an outpatient clinic. These patients are not included within NBRS. (Refer to Module 2 – Exit Categories for options to track or identify when patients cannot be offered treatment).

19. Patients that are below the treatment threshold at the time of assessment may later deteriorate. If that occurs, then a further clinical review may be requested and the DHB may then offer treatment.

Patient is above treatment threshold (within capacity to treat within four months) but unable to receive treatment within that timeframe

20. There may be patients who would benefit from surgery, and who are above the treatment threshold (i.e. the DHB is able to offer treatment within four months). However, there may be circumstances where the patient is not fit to accept treatment or has personal circumstances which mean they may not be available to accept a treatment date within the four-month timeframe.

21. If DHBs operate on the principle that patients should **only be offered treatment if they are fit, willing and able** to accept surgery when offered, then an Assured status should not be offered to patients who:

    a. Need to achieve a pre-requisite change prior to scheduling (e.g. stop smoking, lose 20kg, stabilise a medical condition).

        i. These patients should be managed by their GP or referred to another appropriate health specialty until fit to proceed.

    b. Are medically complex and potentially too high risk for anaesthetic – confirmation of fitness should be achieved prior to Certainty being given.

        i. These patients may require an anaesthetic assessment and clearance following a First Specialist Assessment (FSA) to confirm whether it is clinically appropriate to proceed with treatment.

ii. If the decision is that proceeding with treatment is too high risk, then Certainty should not be offered until both the patient and anaesthetist agree that it is appropriate to proceed.

c. Where there are clinical reasons (e.g. a corneal graft that will be done when tissue is available) or a patient has personal circumstances which mean a treatment date within four months cannot be accepted (e.g. a summer seasonal worker assessed in September and unable to accept treatment before the following March), these patients may, on a case by case basis, be given an Assured status and assigned a procedure flag of Planned.

i. For these patients the DHB will need to identify a process to confirm patient availability and a timeframe for confirming the offer of treatment.

ii. This may involve a PMS reminder alert, a "promise" report, a care plan that requires the patient or GP to re-contact the hospital, or some alternative mechanism.

iii. A patient should not automatically require a clinic reassessment or new FSA, unless their condition or circumstances have changed.

22. There are also situations where a patient can accept a treatment date within four months but the times when the patient is available may be limited. If this situation arises, **the DHB should have good processes to identify individual patient requirements at the time of referral for treatment, and work with the patient to meet their specific needs.** In some cases, this may require the DHB to be more flexible or organised in scheduling the patient's treatment. Patients should not be disadvantaged because a DHB does not have good systems in place to understand patient requirements for scheduling of treatment.

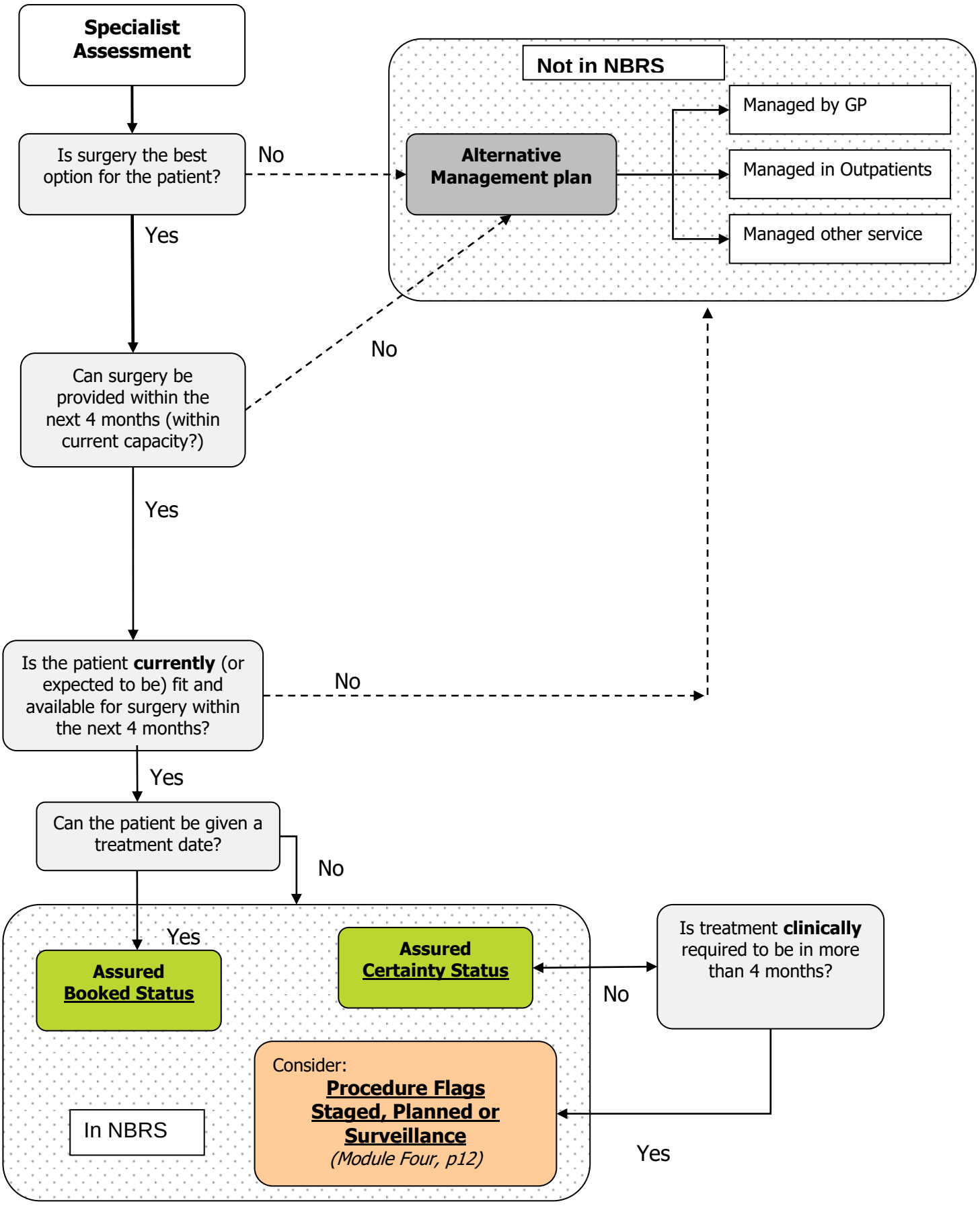
a. If a patient requires a longer than usual period of notice prior to accepting a treatment date, DHBs should work to accommodate these requirements. It is not appropriate to consider that a patient has declined treatment on the basis of a date offered with less than four weeks' notice, or the rejection of a single treatment date.

b. If a patient can accept treatment within three months, but not after three months, DHBs should have identified these requirements at the time the patient is referred for treatment.

i. In this situation the DHB should consider whether it is able to provide treatment within the three-month timeframe (preferred option), or whether the situation in 20 (c) above applies.

23. For further guidance on how to manage patients who are offered an Assured status, but who are then unable to accept an offered treatment date, refer to Module 4 – Deferred Status.

Flow Diagram – Decisions on assigning an Assured status



Module 2 – Exit Categories

GP Care (Category 13 - Patient returned to primary care)

When to use a GP Care exit category

24. *GP Care* is defined as a care pathway for patients whose clinical priority means they cannot be offered an Assured status. GP Care is not an NBRS status, i.e. patients are not in NBRS and are not actively waiting for elective surgery.
25. The exit category of "13 – Patient returned to primary care" is used to identify patients below the access threshold for receiving publicly funded treatment.
26. While not mandatory, this exit category can also be used if a DHB wishes to keep a transparent record within the national data collection of patients who are declined publicly funded treatment.
    a. To achieve this, the DHB will need to need to create an NBRS record for **all** patients referred for elective surgery, not just those accepted (as is the case in most DHBs). The NBRS booking status would need to be Certainty. The record would then be **IMMEDIATELY** exited with the category "13 – Patient returned to primary care". For this process to be used, the DHB must ensure that the NBRS exit occurs **on the same day** as the record is entered into NBRS.

When NOT to use a GP Care exit status

27. As the exit category "13 – Patient returned to primary care" is for patients who are below the access threshold for treatment, i.e. patients who are not accepted for elective surgery, the exit category should not be used for any patient with an Assured status (Certainty) who is removed from the treatment list (the one exception is as per 25 (a) above). Once a commitment of treatment within four months is given, it cannot be revoked by the DHB.
28. If a patient with an Assured status does not proceed to surgery for personal or medical reasons, the appropriate exit categories to consider are:
    a. 14 – Removed due to changed patient circumstances.
    b. 15 – Medically unfit for treatment.
29. In circumstances where a patient has been exited to GP Care and re-referred, this is a new referral, and if they are now considered eligible for treatment, a new NBRS record should be created.

Removed due to changed patient circumstances

When to use a "Removed due to changed patient circumstances" exit category

30. The exit category "14 – Removed due to changed patient circumstances" is used for all patients who are exited from NBRS without treatment for personal reasons (other than medical deferral). Personal reasons may include:
    a. The patient feels they are not ready or willing to proceed with treatment.
    b. The patient is unable to accept the DHB's offer of treatment date. As identified in Module 1 - Assured Status , DHBs should make every effort to accommodate patient preferences in scheduling treatment dates. However, if a date cannot be accepted, and a decision is made to remove the patient from NBRS, this exit category should be used. Reasons for declining treatment dates may include:
        i. Seasonal worker who is unable to accept a date until some point in the future

ii. Work or family circumstances mean the patient is unable to accept a treatment date in the near future

iii. The patient has received treatment in private (self or insurance funded)

iv. The patient is deceased.

c. The patient fails to attend theatre bookings. The DHB's policy on missed appointments / DNAs should be applied in this instance.

31. Refer to Module 4 – Deferred Status for guidance on management options for patients who are exited from NBRS for changed circumstances.

When NOT to use a "Removed due to changed patient circumstances" exit category

32. This exit category should not be used in the following circumstances:

    a. The patient is medically unfit to proceed with treatment.

    b. If the DHB is unable to provide the patient with treatment for any reason.

    c. If the patient has received publicly funded elective treatment or publicly funded acute treatment for the same condition. Note - if the patient received treatment in another DHB, or on the Mobile Bus, the appropriate exit category is still "exited treated".

Medically unfit for treatment

When to use "Medically unfit for treatment"

33. The exit category "15 – Medically unfit for treatment" is used for any patient who is unable to proceed with elective treatment because of a medical condition where the duration of the condition is extended or is unknown. Examples may include:

    a. A patient who develops a medical condition after referral and acceptance for treatment.

    b. A patient who, on preadmission assessment, is determined to be too high risk for anaesthesia.

34. A patient's medical condition may be self-reported by the patient, identified at preadmission assessment or the treating specialist may notify the booking clerk.

35. Refer to Module 4 – Deferred Status for guidance on management options for patients who are not medically fit to proceed with treatment.

When NOT to use "Medically unfit for treatment"

36. If it is known at the point of referral for treatment that a patient is not medically fit to proceed with treatment, they should not be included within NBRS (refer to Module 1 - Assured Status for guidance on options to manage patients in this circumstance).

37. The exit category should not be used in the following circumstances:

    a. The patient is unwell for a short period of time, e.g. is recovering from a short-term illness, such as a cold.

    b. The patient is unable to proceed with surgery because of personal circumstances, or because of a family situation rather than a personal medical condition.

    c. The patient is deceased.

    d. The medical condition is of a known, short duration. In this case the patient should remain in NBRS with an Assured status.

Module 3 – Procedure flags

38. There are four procedure flags – guidance is provided for three of these flags. These are: *Staged*, *Planned* and *Surveillance* procedure flags. The fourth "*Normal*" flag is used for all records where there are no clinical exclusions to the requirement to provide treatment within four months.

39. The three Procedure flags included here are 'attached' to records within NBRS if the patient's treatment is not expected within four months for clinical reasons, or where the patient's procedure is one of a series of procedures required over a period of time. The flag will exclude the patient's record from ESPI reporting, particularly from compliance with the four-month timeframe (ESPI 5).

40. These flags should only be used when a decision has been made to proceed with treatment, and the DHB has confirmed its commitment to provide treatment (i.e. the patient has an Assured status).

41. Further guidance on the use of Procedure flags is contained in the document titled: *Planned Care - National Booking Reporting System: Use of Staged, Planned and Surveillance Procedure Flags.*

Staged Procedures

42. A Staged procedure is the second (and any subsequent) in a series of procedures that is required to complete the patient's treatment over a period of time, for example, months or years. The timeframe for the second procedure and any subsequent procedures should be known at the time the initial treatment decision is made.

43. If the initial decision to treat includes a definitive plan to proceed with multiple procedures, the patient should have an NBRS record created, which is exited following the initial procedure. A Staged flag is attached to the NBRS records for second and subsequent procedures.

    a. The second (and subsequent procedures) will have the same Certainty date as the initial record, as this was the date the decision was made to treat, and the date the DHB accepted the patient for treatment.

    b. The clinical priority assigned to the initial procedure is also applied to the subsequent procedures, as the decision to treat was based on the priority for the initial procedure.

    c. Staged procedures are excluded from ESPI calculations, as the timeframe for the second and subsequent procedures may be outside the four-month timeframe.

44. Examples of Staged procedures are:

    a. Removal of metalware one year after hip surgery (excludes ACC direct purchased activity).

    b. Closure of colostomy 12 months after formation.

    c. Delayed breast reconstruction eight weeks following mastectomy and a course of chemotherapy – note in this example the Staged flag is used because the priority assigned to the initial procedure is carried forward to the second procedure, rather than because the procedure is expected to be outside the four-month timeframe.

Planned Procedures

When to use a Planned procedure flag

45. A Planned procedure flag is applied when the patient requires a procedure, but that procedure will not be offered within four months, due to clinical or patient centred reasons. In most instances the timeframe for treatment will be known and be confirmed to the patient.

46. An NBRS record is created with an Assured (Certainty) status, and a Planned flag is attached. Examples of Planned procedures are:

a. A paediatric procedure for a child once an age-related milestone is reached.

b. A procedure is scheduled to occur at a particular time, following a pregnancy and delivery.

Surveillance Procedures

47. A Surveillance procedure is one of an ongoing series of routine procedures that is provided at regular (i.e. annual or longer) intervals to assess health status in patients following an initial treatment or procedure.

48. Surveillance procedures may be diagnostic or therapeutic, or both. Examples of surveillance procedures are:

    a. Annual or biennial colonoscopy post colorectal cancer or because of a known family history of bowel cancer.
    b. Annual cystoscopy or gastroscopy.
    c. Dental assessment in patients with special needs.

When NOT to use a Procedure flag

49. The following are a series of situations or examples when a Staged, Planned or Surveillance procedure flag should **not** be used.

    a. **Staged:** A patient may be having a second or subsequent procedure, but the decision on whether to proceed with treatment is not made until after the initial procedure.

        i. An example of this situation may be a patient who has a procedure for scoliosis and it is not determined until after the first procedure whether any additional procedures will occur. If the decision is made at a later date that an additional procedure will be undertaken, the DHB will need to confirm its ability to provide the procedure within four months before confirming an Assured status. In this case the subsequent procedure would be treated as a new referral, with the Certainty date being the date the decision was made to proceed, and the patient prioritised for treatment. Clinical override may be applied in this situation if the priority for the second procedure is lower than the current access threshold.

    b. **Planned:** A procedure is required within a specifically defined clinical timeframe, but this is within four months from the initial decision to treat, e.g. treatment for talipes required when the patient is six months of age, and the patient was three months old at the time of the decision to treat.

        i. In this case a normal Assured status should be applied, and the patient scheduled to the appropriate timeframe.

    c. **Surveillance:** A patient is referred for a diagnostic procedure (such as a colonoscopy) which is the initial procedure, rather than one of an ongoing series, or where the subsequent surveillance procedure is to be less than four months from the initial screening or treatment procedure, e.g. first colonoscopy three months post treatment for colorectal cancer.

        i. In these cases, a normal Assured status should be applied and the procedure scheduled at the most appropriate time.

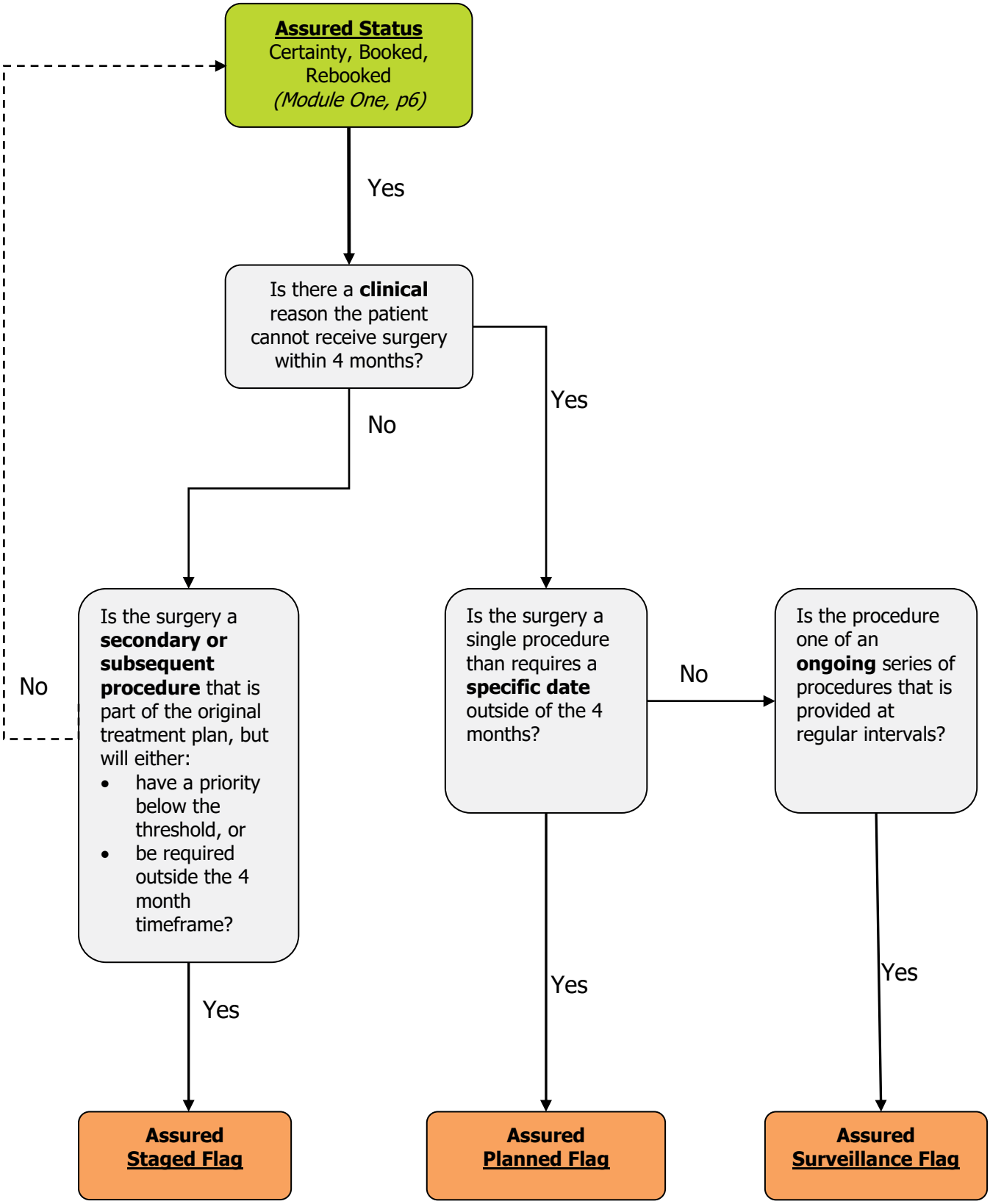
50. **Any procedure flag-** Procedure flags should not be used for:

    a. Patients who are medically deferred or unfit for treatment. Patients who are medically unfit are not “available” for surgery and should not be included in NBRS reporting.

    b. Patients who decline multiple offers of treatment.

    c. Patients whose treatment is deferred by the DHB – these patients do not fit the definitions identified for use of the procedure flags.

Flow Diagram – Decisions on using a Procedure flag



Module 4 – Deferred Status

When to use Deferred status

51. A *Deferred* status is assigned when a booked treatment date is deferred (i.e. treatment does not proceed on the intended date) and the procedure in not able to be immediately rebooked. The booking may be deferred by the patient or the hospital.

Deferred by hospital (DHB)

52. A DHB deferral is one where the treatment is delayed for DHB related reasons, often associated with a scheduling conflict. The deferral may occur prior to a patient's admission or be "on the day" of admission.
53. Most DHB deferrals can and should be avoided through good planning, although there will always be situations where a deferral is unavoidable (e.g. a specialist is unexpectedly ill and unavailable).
54. A Deferred status should be used for **all** provider deferred patients, if the patient's treatment is not able to be immediately rebooked. In all situations, the DHB is required to offer the patient another treatment date, i.e. the commitment cannot be revoked unless the patient decides not to proceed.
55. Patients whose treatment date is deferred by the hospital should be offered the next available treatment date – the preference is that the new booking should be made at the time of deferral, and the booking status of "*6 – Rebooked*" used.
    a. If this is not possible for scheduling or patient reasons a Deferred status is used. Patients should only have a Deferred status for **short periods** (i.e., a few weeks).
56. If a deferral occurs after a patient is admitted, the NBRS event should remain open and active – i.e. the NBRS exit should be linked to completion of the procedure, not the admission.
    a. If a DHB's patient management system automatically generates an NBRS exit at the point of admission, the DHB must have appropriate systems in place to ensure the record is reinstated in NBRS with the original Certainty date and other data elements.

Deferred by patient

57. A Deferred status may also be assigned for *Patient Deferred* reasons, if following a booking, the patient is unable to proceed and the expected timeframe for rebooking the patient is short. Some examples of patient deferred reasons are:
    a. A short-term illness (e.g. a cold) at the time of surgery.
    b. A holiday or family event has been arranged (of short duration or in the near future).
    c. The patient requires an extra 2-3 weeks to arrange a work or home situation.

When NOT to use Deferred status

58. A Deferred status should not be used if the patient did not previously have a Booked or Rebooked status. If a patient is unavailable for treatment prior to a treatment date being offered, and the deferral is of short-term duration, the previous status (Certainty) should not be changed.
59. Regardless of whether a treatment date has been offered or not, if a patient is not available for treatment for a prolonged or unknown period of time, a Deferred status should not be used. Instead the patient should be exited from NBRS, and a transfer of care initiated. This transfer will include an appropriate care plan or management pathway. The most appropriate management pathway for a patient will depend upon the reason for the deferral, and the expected time until treatment can proceed. The exit category should be:

a. “14 – Removed due to changed patient circumstances”

b. “15 – Medically unfit for treatment”

60. It is essential that DHBs have good systems for managing patients who are exited for medical or personal reasons. This includes:

    a. Clear procedures for communication and decision making that offer effective advice for the future.

    b. Identifying who care is transferred to, i.e. who is ‘responsible’ for the patient.

        i. In most cases the patient should be returned to the care of their GP, referred to another health specialty for treatment, or followed up in an outpatient clinic.

    c. An appropriate reinstatement pathway is also required, which may entail a follow-up reassessment with the specialist, a review of patient case notes, or automatic reinstatement, depending upon circumstances.

61. Patients exited from NBRS for personal or medical reasons should have a new NBRS event created if they are reinstated on the list. The new event Certainty date is the date the decision is made to reinstate the patient.

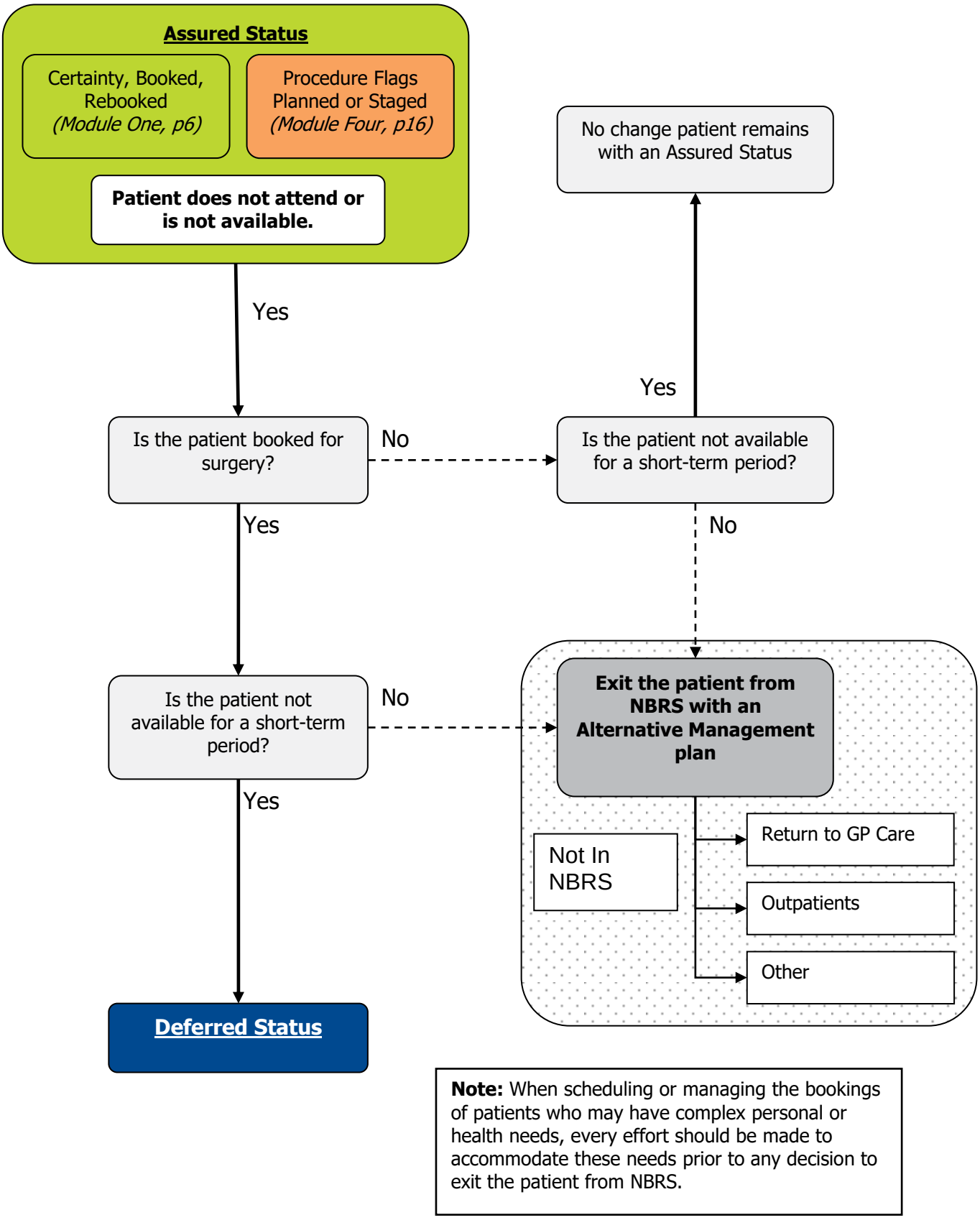
62. DHB processes should ensure that, where possible, a patient deferral is avoided. Patient preferences should be taken into account when scheduling, and adequate notice should be given.

    a. Definition of ‘adequate’ will vary from individual to individual, however, notice of less than one month is not considered to be reasonable for most people.

    b. Consideration should be given to approaches such as *Patient Focused Booking* for scheduling of treatment to optimise patient availability.

63. The most suitable approach for managing the patient’s access to treatment will be determined by the reason for the Deferral.

Flow Diagram – Decisions on use of Deferred status



Note: When scheduling or managing the bookings of patients who may have complex personal or health needs, every effort should be made to accommodate these needs prior to any decision to exit the patient from NBRS.

Guidance for managing other circumstances

64. **Specialist decides not to proceed –** in some cases a patient will be reviewed by a specialist who may decide that surgery is no longer the 'best option' for the patient. The patient should be exited from NBRS (*Changed patient circumstances*).

65. **Patient circumstances dictate when they are able to accept an offer of treatment –** patients frequently decline a treatment date because it is offered at an inconvenient time of the year, e.g. their preference is to receive treatment during the school holidays, or outside the shearing, lambing or fruit picking season.

    a. DHBs should attempt to identify these restrictions when accepting the patient for treatment (refer to Module 1 - Assured Status for guidance on giving Certainty in this situation). However, situations may arise where the patient restrictions are new or unknown at the time of acceptance to NBRS. If the patient is not available to accept treatment dates offered, and not expected to be within the four-month period, they should be exited from NBRS.

        i. Options to manage are to request the GP monitor the patient and re-refer if required, or

        ii. the DHB arrange an outpatient clinic appointment to reassess, or

        iii. the DHB retains the patient within their PMS and use a "bring up" reminder system to re-activate the offer of treatment at an appropriate time – this may operate in a similar way to an FSA wait list.

        iv. If a suitable date can be confirmed with the patient, but this is outside the four-month timeframe, on a **case by case** basis, the patient may be given Certainty and have a Planned flag applied.

66. **Patient is "not ready" for treatment –** if after having been given Certainty and offered a treatment date, a decision is made (regardless of whether this is by the patient or specialist) not to proceed with treatment, the patient should be exited from NBRS.

    a. Options to manage are to; request the GP monitor the patient and re-refer if required, or

    b. the DHB arrange an outpatient clinic appointment to reassess.

67. **Patient is "not available for treatment" because of a specific personal circumstance –** as well as being unavailable for work or school requirements, a patient may be unavailable for an extended period because of an unknown situation arising, e.g. caring for a sick dependent, recently started a new job, or important family occasion.

    a. The options for managing this remain the same as 65 above.

68. **Patient declines multiple treatment dates** – this may occur for a variety of reasons, which may not be known, or may be considered trivial by the DHB. Patients may decline treatment dates because they are not sure they wish to proceed with treatment.

    a. The best option in this situation is often to exit the patient from NBRS and arrange a clinical review in outpatients. This gives the patient and specialist the opportunity to discuss treatment options and an appropriate plan of care. If the patient decides to proceed with treatment, a new NBRS record and Certainty date are allocated.

    b. If the patient is not willing to commit to a treatment pathway, then they may be exited and returned to the care of their GP, who can re-refer if the patient agrees to proceed with treatment.

69. **Patient cannot be contacted** – every effort should be made to contact the patient. This should include contacting the patient's GP, writing to the patient, reviewing medical records to identify patient

reported emergency and alternative contacts. If following these efforts, the DHB is unable to contact the patient, they should be exited from NBRS.

a. The DHB should write to the patient advising of the next steps if they wish to proceed with treatment, and notify the GP and referrer that the patient has been removed.

70. **Patient does not attend preadmission assessment or the actual treatment booking –** it is important that the DHB make contact with the patient to verify the reason for nonattendance, and to confirm they received the initial treatment date. In this situation, the DHB's missed appointments / DNA policy should be applied.

    a. If the patient does not attend the preadmission assessment, and reasonable attempts to contact them are unsuccessful the NBRS event should be exited, and the GP/referrer notified. Reasonable attempts include contacting the GP, next of kin or other specified contacts. A letter should also go to the last known address of the patient.

    b. If the patient attends the preadmission assessment but does not attend the treatment appointment, the patient should be contacted to discuss an appropriate alternative date. If this cannot be confirmed or agreed with the patient, then the patient should be exited from NBRS.

    c. Management options are to transfer care to the GP, or to arrange an outpatient clinic review.

71. **Patient has moved out of the DHB district** – if a patient has moved out of the DHB district and is not willing to return for treatment (and associated preadmission assessment and follow up appointments) they can be exited from NBRS. The DHB may refer the patient to another specialist in the new DHB, or the patient should be advised to contact a local GP for referral.

    a. Note that if the patient has been given Certainty and is willing to return to the DHB for treatment, they should not be exited – the commitment of treatment remains.

72. **Patient is medically unfit for treatment for a prolonged or unknown timeframe –** a complex medical condition may arise following a patient being accepted for treatment. This may be self reported by the patient or identified at preadmission assessment. The patient should be exited from NBRS (*Medically unfit for treatment*).

    a. The goal should always be to reduce the occurrence of Medical Deferrals.

        i. Completion of a health status assessment should be part of any patient referral for surgical treatment and may require an anaesthetic assessment prior to referral to NBRS, or a medical care plan after acceptance to optimise their fitness for treatment.

        ii. Patients who are considered too high risk for anaesthetic should not be given a commitment of treatment until it has been determined that they are fit for treatment.

        iii. Similarly, patients who have not met any pre-requisites for treatment, such as weight loss, or stopping smoking, should not be added to NBRS until the pre-requisite is met.

    b. Options to manage the patient include implementing an appropriate management pathway or care plan until the patient is fit. Responsibility for care should be clearly identified, along with a process for advising when the patient is fit to proceed, and for reinstatement to NBRS.

        i. Transfer care to the patient's GP. The GP would then be responsible for advising if the patient is ready for reassessment or reinstatement on the treatment list.

        ii. Transfer the patient's care back to the outpatient clinic setting, with the specialist or clinic staff responsible for advising when the patient is ready for reinstatement on the treatment list.

        iii. Transfer the patient's care to the department or specialty they have been referred to for assessment or treatment. That service is then responsible for advising when the patient is ready for reassessment or reinstatement.