New data elements

During the year, the National Health Data Committee considered many submissions for new data standards for inclusion in the National Health Data Dictionary. This is not a static environment and there is much work being undertaken. As a deliberative committee the NHDC approved the following data elements for inclusion in version 11 of the NHDD which is implemented on 1 July 2002. All data elements listed were endorsed by the National Health Information Management Group.

Version 11 sees:

- the introduction of a standard for the calculation of age standardised rates including a definition of the base population data upon which they are calculated;
- the possibility for greater planning information to be made available with the use of two new data elements that allow more detail about services provided to patients in hospitals;
- Cancer Registries catered for the first time with the introduction of a preliminary set of data definitions;
- the introduction of a definition of quality accreditation for hospitals that may lead to improved treatment services for patients; and
- the introduction of a definition of Removal date that replaces Admission date in Elective Surgery Waiting Times data collections.

Age-standardised rate

Admin. status: Current 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000769 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: A method of adjusting the crude rate to eliminate the effect of differences in population age structures when comparing crude rates for different periods of time, different geographic areas and/or different population sub-groups (eg between one year and the next and/or States and Territories, Indigenous and non-Indigenous populations).

Adjustments are usually undertaken for each of the comparison populations against a standard population (rather than adjusting one comparison population to resemble another). Sometimes a comparison population is referred to as a study population.

Context: Population health and health services research:
For valid comparisons of rates in different populations, such as incidence rates, prevalence rates, mortality rates and health service utilisation rates.

Relational and representational attributes

Datatype: Numeric *Field size:* *Min.* 1 *Max.* 7 *Layout:* NNNNNN.n

Formula:

Direct method	*Indirect method*
$SR = \frac{\sum(r_i P_i)}{\sum P_i}$	$SR = \frac{C}{\sum(R_i p_i)} \times R$

Where:

SR is the age-standardised rate for the population being studied

r_i is the age-group specific rate for age group i in the population being studied

P_i is the population of age group i in the standard population

C is the observed number of events* in the population being studied

$\sum R_i p_i$ is the expected number of events in the population being studied

R_i is the age-group specific rate for age group i in the standard population

p_i is the population for age group i in the population being studied

R is the crude rate in the standard population

* 'Events' can include deaths, incident or prevalent cases of disease or other conditions, or health care utilisation occurrences.

Guide for use: For the purposes of comparisons of population rates for Australia over time, and/or populations within Australia (eg States and Territories, Indigenous and non-Indigenous) the standard population to be used is the final 30 June estimated Australian resident total population (males plus females) for the most recent year ending in 1 (eg 1991, 2001).

There are two methods (viz. direct and indirect) of calculating age-standardised rates. The *direct* method is generally used for comparisons between study groups.

Guide for use: (continued

The ***indirect*** method is recommended when the age-specific rates for the population being studied are not known but the total number of events is known or when calculating rates for small populations where fluctuations in age-specific rates can affect the reliability of rates calculated using the direct method.

The standard population used for purposes of international comparisons is generally the World Standard Population as recommended by the World Health Organization or the European Standard Population.

Five year age groups should normally be used, with the age group 0-4 separated into 0 and 1 to 4, and ages over 85 years combined, thus 0, 1-4, 5-9, 10-14, ……., 80-84, 85+. If these age groups are not used, the actual age groups should be detailed in notes accompanying the age standardised population rate information.

Standardisation separately for males and females is not usually undertaken but may be appropriate for some applications, for example, hospitalisation rates for caesarean section is best undertaken using a female standard population rather than a standard population for both sexes. If standardisation is undertaken in this way this should be detailed in notes accompanying the age standardised population rate information.

When indirect age standardisation is undertaken for comparisons with or between Indigenous populations, the latest available rates could be used as the standard. In addition, age groups older than 70-74 years could be excluded. This is as recommended in the National Performance Indicators for Aboriginal and Torres Strait Islander Health Technical Specifications.

Related data: is related to the data element Crude rate, version 1

Administrative attributes

Source document: Textbooks of epidemiology, demography and biostatistics.

The notation used in this data element is based on Armitage P & Berry G 1994. Statistical Methods in Medical Research. Oxford: Blackwell Scientific Publications.

Source organisation: AIHW

Comments: Standardised rates are generally multiplied by 1,000 or 100,000 to avoid small decimal fractions. They are then called standardised rates per 1,000 or 100,000 population.

The *indirect* method is also used to calculate **standardised mortality ratios (SMRs)** and other standardised ratios, for example for health service utilisation. These ratios express the overall experience of a comparison population in terms of the standard population by calculating the ratio of observed to expected deaths in the comparison population:

$$SMR = \frac{C}{\sum(R_i p_i)}$$

The standard population used to calculate SMRs can be any population to which the comparison population is being compared. For example, if death rates for birthplace groups are compared to those of the Australian-born population using SMRs, the standard population would be the Australian-born population.

Sometimes the SMR is multiplied by 100 to express the ratio as a percentage, although this is not universally accepted. Not multiplying by 100 has the benefit of being able to say that the SMR was, for example, 2.3 times that expected rather than 130% higher.

Standardised ratios for hospitalisations and other events can be calculated using similar techniques.

Crude rate

Admin. status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000770 *Version number:* 1

Data element type: DERIVED DATA ELEMENT

Definition: The ratio of the number of events in the population being studied during a certain time period to the estimated population size midway through that time period.

Context: Population health and health services research

Required to calculate population rates, such as incidence rates, prevalence rates, mortality rates and health service utilisation rates.

Relational and representational attributes

Datatype: Numeric *Field size:* *Min.* 1 *Max.* 4 *Layout:* NNN.n

Formula:

$$R = \frac{d}{n}$$

Where:

R is the crude rate for the population being studied

d is the number of events for that population group

n is the total population for that population group

Related data: is used in the indirect method to calculate Age-standardised rate, version 1

Administrative attributes

Source document: Textbooks of epidemiology, demography and biostatistics.

The presentation of formulae in this data element is based on the notation used in Armitage P & Berry G 1994. Statistical Methods in Medical Research. Oxford: Blackwell Scientific Publications.

Source organisation: AIHW

Comments: Crude rates are generally multiplied by 1,000 or 100,000 to avoid small decimal fractions. It is then called the crude rate per 1,000 or 100,000 population.

Date of diagnosis of cancer

Admin. status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000771 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The date when the cancer was first diagnosed (whether at its primary site or as a metastasis).

Context: Patient administration system, cancer notification system, population cancer statistics, research.

Relational and representational attributes

Datatype: *Alphanumeric* Field size: Min. *8* Max. *8* Layout: *DDMMYYYY*

Data domain: Valid dates

Guide for use: Date of diagnosis must be:

>= Date of birth

<= Date of death

Diagnosis of cancer after death

If the patient is first diagnosed with the cancer in an autopsy report the date of diagnosis is the date of death as stated on the patient's death certificate.

Incidental diagnosis of cancer

If a patient is admitted for another condition (for example a broken leg or pregnancy), and a cancer is diagnosed incidentally then the date of diagnosis is the date the cancer was diagnostically determined, not the admission date.

Collection methods: Reporting rules:

The date of diagnosis is the date of the pathology report, if any, that first confirmed the diagnosis of cancer. This date may be found attached to a letter of referral or a patient's medical record from another institution or hospital. If this date is unavailable, or if no pathological test was done, then the date may be determined from one of the sources listed in the following sequence:

Date of the consultation at, or admission to, the hospital, clinic or institution when the cancer was first diagnosed. Note: DO NOT use the admission date of the current admission if the patient had a prior diagnosis of this cancer.

Date of first diagnosis as stated by a recognised medical practitioner or dentist. Note: This date may be found attached to a letter of referral or a patient's medical record from an institution or hospital.

Date the patient states they were first diagnosed with cancer. Note: This may be the only date available in a few cases (for example, patient was first diagnosed in a foreign country).

If components of the date are not known an estimate should be provided where possible with an estimated date flag to indicate that it is estimated. If an estimated date is not possible, a standard date of 15 June 1900 should be

used with a flag to indicate the date is not known.

Related data: is related to data element Date of birth, version 3

is related to data element Estimated date flag, version 1

Administrative attributes

Source document: Modified from the definition presented by the New South Wales Inpatient Statistics Collection Manual—2000/2001

Source organisation: International Agency for Research on Cancer, World Health Organization and International Association of Cancer Registries.

Date of procedure

Admin. status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000772 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: The date on which a procedure commenced during an inpatient episode of care.

Context: Admitted patient care Required to provide information on the timing of the procedure in relation to the episode of care.

Relational and representational attributes

Data type: Numeric *Field size: Min.* 8 *Max.* 8 *Layout*: DDMMYYYY

Data domain: Valid date

Guide for use: Admitted patients: record date of procedure for all procedures undertaken during an episode of care in accordance with the 3rd edition of ICD-10-AM Australian Coding Standards.

Collection methods: Right justified and zero filled (eg 1 May 2001 should read 01052001)

Date of procedure >= admission date

Date of procedure <= separation date

Related data: relates to the data element Procedure, version 5

Administrative attributes

Source organisation: National Centre for Classification in Health

National minimum data sets:

Comments: The National Centre for Classification in Health advises the National Health Data Committee of relevant changes to the ICD-10-AM

Reference: Australian Institute of Health and Welfare (AIHW) 2000. Australian hospital statistics 1998-1999. AIHW cat. no. HSE 11. Canberra: AIHW (Health Services Series no. 15)

Diagnosis onset type

Admin. status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000773 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: A qualifier for each coded diagnosis to indicate the onset and/or significance of the diagnosis to the episode of care

Context: Health services: improved analysis of diagnostic information, especially in relation to patient safety and adverse event monitoring

Relational and representational attributes

Data type: Numeric *Field size: Min.* 1 *Max.* 1 *Layout:* N

Data domain:

1 Primary condition

2 Post-admit condition

9 Unknown or uncertain

Guide for use: Assign the relevant diagnosis type flag to all of the ICD-10-AM disease codes recorded in the hospital morbidity system. Specific guidelines for correct assignment of diagnosis flag type are in ICD-10-AM Australian Coding Standards, Third Edition 1 July 2002.

The following rules only apply to:

- diagnoses which meet the criteria in the Australian Coding Standards (ACS) 0001 Principal diagnosis and ACS 0002 Additional diagnoses or a specialty standard which requires the use of an additional code(s).
- hospital morbidity data - 'episode of care' refers to hospital or day procedure episodes of care

1 Primary condition

- a condition present on admission such as the presenting problem, a comorbidity, chronic disease, disease status. In the case of neonates, the condition(s) present at birth.
- a previously existing condition not diagnosed until the current episode of care
- in delivered obstetric cases, all conditions which arise from the beginning of labour to the end of second stage

2 Post-admit condition

- a condition which arises during the current episode of care and would not have been present on admission

9 Unknown or uncertain

- a condition where the documentation does not support assignment to 1 or 2

Guide for use (continued):	**Explanatory Notes** The flag on external cause, place of occurrence and activity codes should match that of the corresponding injury or disease code. The flag on morphology codes should match that on the corresponding neoplasm code. Conditions meeting the criteria of principal diagnosis may, in come cases, have a flag of '2'.
Collection methods:	A diagnosis onset type should be recorded and coded upon completion of an episode of admitted patient care.
Related data:	relates to the data element Principal diagnosis, version 3 relates to the data element Additional diagnosis, version 4 relates to the data element External cause--admitted patient, version 4 relates to the data element Place of occurrence of external cause of injury, version 5 relates to the data element Activity when injured, version 2

Administrative attributes

Source organisation:	National Centre for Classification in Health
National minimum data sets:	

Laterality of primary cancer

Admin. Status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000774 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Laterality describes which side of a paired organ is the origin of the primary cancer. Each side of a paired organ is considered separately and described as lateral when occurring unless a physician determines that it is bilateral.

A paired organ is one in which there are two separate organs of the same kind, one on either side of the body (e.g. kidney, breast, ovary, testis, and lung).

Context: This information is collected for the purpose of differentiating the site of the primary cancer.

For example, a woman may present with a primary cancer in the left breast. She may return at a later stage with a new primary cancer in the right breast.

Relational and representational attributes

Datatype: Numeric *Field size:* *Min.* 1 *Max.* 1 *Layout:* N

Data domain:

1 Left

2 Right

3 Bilateral (Note: Bilateral cancers are very rare)

9 Not Known

Where not applicable, blank.

Guide for use: The valid ICDO values for the variable are provided in the list below:

1 Left: Origin of primary site is on the left side of a paired organ

Paired organs are: Breast (C50), Lung (C34), Kidney (C64), Ovary (C56), Eyes (C69), Arms (C76.4, C44.6, C49.1, C47.1, C40.0, C77.3,), Legs (C76.5, C44.7, C49.2, C47.2, C40.2, C77.4), Ears (C44.2, C49.0, C30.1), Testicles (C62), Parathyroid glands (C75.0), Adrenal glands (C74.9, C74.0, C74.1), Tonsils (C09.9, C02.4, C11.1, C09.0, C09.1, C03.9), Ureter (C66.9), Carotid body (C75.4), Vas deferens (C63.1), Optic nerve (C72.3)

2 Right: Origin of primary site is on the right side of a paired organ

3 Includes organs that are bilateral as a single primary (e.g. bilateral retinoblastoma (M9510/3, C69.2), (M9511/3, C69.2), (M9512/3, C69.2), (C69.6, C48.0), bilateral Wilms tumours (C64.9, M8960/3))

9 Unknown: It is unknown whether, for a paired organ the origin of the cancer was on the left or right side of the body.

Related data: is qualified by data element Primary site of cancer version 1

Collection methods: This information should be obtained from the patient's pathology report, the patient's medical record, or the patient's Medical Practitioner/Nursing Staff.

Administrative attributes

Source document:	International Classification of Diseases for Oncology, Second Edition (ICDO-2)
Source organisation:	World Health Organization

Morphology of cancer

Admin. status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000775 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: The morphology of a cancer refers to the histological classification of the cancer tissue (histopathological type) and a description of the course of development that a tumour is likely to take: benign or malignant (behaviour). The designation is based on a microscopic diagnosis of morphology by the pathologist (Esteban, Whelan, Laudico & Parkin 1995).

Context: This information is collected for the purpose of:

- classifying tumours into clinically relevant groupings on the basis of both their morphology (cell type) and their degree of invasion or malignancy as indicated by the behaviour code component (the last digit of the morphology code);
- monitoring the number of new cases of cancer for planning treatment services.

Relational and representational attributes

Datatype: Numeric *Field size: Min.* 5 *Max.* 5 *Layout:* NNNNN

Data domain: The current version of the International Classification of Diseases for Oncology (ICDO).

Guide for use: ICDO morphology describes histology and behaviour as separate variables, recognising that there are a large number of possible combinations.

In ICDO, morphology is a 4-digit number ranging from 8000 to 9989, and behaviour is a single digit which can be 0, 1, 2, 3, 6 or 9.

Record morphology codes in accordance with ICDO coding standards. Use the 5th digit to record behaviour. The 5th-digit behaviour code numbers used in ICDO are listed below (Source: International Classification of Diseases for Oncology, Second Edition (ICDO-2)):

0 Benign

1 Uncertain whether benign or malignant
- borderline malignancy
- low malignant potential

2 Carcinoma in situ
- intraepithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site
- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Collection methods: Cancer registry use:

In cancer registries morphology information should be obtained from a pathology report or pathology system, and recorded with/on the patient's medical record and/or the hospital's patient administration system. Additional information may also be sought from the patient's attending clinician or medical practitioner.

Hospital morbidity use:

In hospitals, the morphology code is modified for use with ICD-10-AM. The morphology code consists of histologic type (4 digits) and behaviour code (1 digit) ranging from 8000/0 to 9989/9. The "/" between the fourth and fifth digits is not supplied.

Administrative attributes

Source document: International Classification of Diseases for Oncology, Second Edition (ICDO-2)

New South Wales Inpatient Statistics Collection Manual–2000/2001

Source organisation: World Health Organization

New South Wales Health Department & State and Territory Cancer Registries

Primary site of cancer

Admin. status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000776 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The primary site is the site of origin of the tumour, as opposed to the secondary or metastatic sites. It is described by reporting the anatomical position (topography) of the tumour.

Context: This information is collected for the purpose of:

- classifying tumours into clinically-relevant groupings on the basis of both their site of origin and their histological type;
- monitoring the number of new cases of cancer for planning treatment services; and
- epidemiological studies.

Relational and representational attributes

Datatype: Alphnumeric *Field size:* *Min.* 3 *Max.* 5 *Layout:* ANNNN

Data domain: The current version of International Classification of Diseases for Oncology (ICDO) or International Statistical Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)

Guide for use: Report the primary site of cancer, if known, for patients who have been diagnosed with a cancer. In ICD-10, primary site is identified using a single 4–digit code Cxx.x or Dxx.x. In ICDO, primary site is identified using both the Cxx.x code identifying site and the behaviour code to identify whether the site is the primary site. The behaviour code numbers used in ICDO are listed below (Source: International Classification of Diseases for Oncology, Second Edition (ICDO-2)):

0 Benign

1 Uncertain whether benign or malignant
- borderline malignancy
- low malignant potential

2 Carcinoma in situ
- intra-epithelial
- non-infiltrating
- non-invasive

3 Malignant, primary site

6 Malignant, metastatic site
- malignant, secondary site

9 Malignant, uncertain whether primary or metastatic site

Related data: is a qualifier for Laterality of primary cancer version 1

Collection methods: Cancer Registries use Site codes from the current version of ICDO.

In a hospital setting, primary site of cancer should be recorded on the patient's medical record by the patient's attending clinician or medical practitioner, and coded by the hospital's medical records department.

Hospitals use Diagnosis codes from ICD-10-AM. Valid codes must start with C or D.

In hospital reporting, the diagnosis code for each separate primary site cancer will be reported as a "Principal Diagnosis" or an "Additional Diagnosis" as defined in the current edition of the Australian Coding Standards. In death reporting, ABS uses ICD-10.

Some ICD-10-AM diagnosis codes e.g. Mesothelioma and Kaposi's sarcoma, are based on morphology and not site alone, and include tumours of these types even where the primary site is unknown.

Administrative attributes

Source document: International Classification of Diseases and Related Health Problems, Tenth Revision (ICD-10)

International Classification of Diseases for Oncology, Second Edition

(ICDO-2)

International Statistical Classification of Diseases and Related Health Problems Tenth Revision, Australian Modification, Third Edition (July 2002), National Centre for Classification in Health, Sydney (ICD-10-AM).

Source organisation: World Health Organization

Quality accreditation/certification standard

Admin. status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000777 *Version number:* 1

Data element type: DATA ELEMENT

Definition: The quality accreditation/certification standard met by the hospital establishment as a whole.

Context: Hospitals

Required to identify the quality accreditation/certification standard met by the providers of services.

Relational and representational attributes

Datatype: Numeric *Field size:* *Min.* 1 *Max.* 1 *Layout:* N

Data domain:

1	Yes—Accredited or certified compliant with the standard
2	No—Not Accredited or certified compliant with the standard

Guide for use: Report the status code as at 30 June for each of the following standards: (this is a repeating field; one for each of the four accreditation standards listed.)

1st field	The International Organisation for Standardisation ISO 9000 quality family. Examples of the ISO 9000 quality family include: ISO 9001, ISO 9002, ISO 9003, ISO 9004:2000
2nd field	Australian Council on Healthcare Standards EQuIP
3rd field	Quality Improvement Council (QIC)
4th field	Australian Quality Council (AQC)

Administrative attributes

Source organisation: AIHW

Removal date

Admin. status: CURRENT 1/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000798 *Version number:* 1

Data element type: DATA ELEMENT

Definition: Date on which a patient is removed from an elective surgery waiting list.

Context: Elective surgery: this data element is necessary for the calculation of the waiting time at removal from an elective surgery waiting list.

Relational and representational attributes

Datatype: Numeric *Field size: Min.* 8 *Max.* 8 *Layout:* DDMMYYYY

Data domain: Valid date

Guide for use: This date is recorded when a patient is removed from an elective surgery waiting list.

Verification rules: Right justified and zero filled.
Removal date >= date of birth

Removal date >= listing date for care

Related data: is used in the calculation of waiting time at removal from elective surgery waiting list, version 1.

Administrative attributes

Source organisation: National Health Data Committee

National minimum data sets: Elective surgery waiting times from 1/07/2002 to

Comments: Removal date will be the same as admission date for patients in 'reason for removal from elective surgery waiting list' categories 1 and 2.

Tumour size at diagnosis—solid tumours

Admin. status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000778 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: The largest dimension of a solid tumour, measured in millimetres.

Context: This is used to measure the diameter of the largest dimension of breast cancers and other solid neoplasms for patient management, population cancer statistics and research.

Relational and representational attributes

Datatype: Numeric *Field size: Min.* 3 *Max.* 3 *Layout: NNN*

Data domain: Size in millimetres.

The valid values are:

001–997

999 Unknown

Guide for use The reporting standard for the size of solid tumours is:

Breast cancer or other solid neoplasms—the largest tumour dimension, measured to a precision of 1mm.

Tumour thickness at diagnosis—melanoma

Admin. status: CURRENT 01/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000779 ***Version number:*** 1

Data element type: DATA ELEMENT

Definition: The measured thickness of a melanoma in millimetres.

Context: Patient management, population cancer statistics and research.

Relational and representational attributes

Datatype: Numeric *Field size: Min.* 6 *Max.* 6 *Layout: NNN.NN*

Data domain: Size in millimetres.
The valid values are:
000.01–997.99
999.99 Unknown

Guide for use: The reporting standard for the thickness of melanoma is:
Primary cutaneous melanoma—the depth of penetration of tumour cells below the basal layer of the skin; measured to a precision of 0.01mm.

Waiting time at removal from elective surgery waiting list

Admin. status: CURRENT 1/07/2002

Identifying and definitional attributes

Knowledgebase ID: 000413 ***Version number:*** 1

Data element type: DERIVED DATA ELEMENT

Definition: The time elapsed for a patient on the elective surgery waiting list from the date they were added to the waiting list for the procedure to the date they were removed from the waiting list.

Context: Elective surgery: this is a critical elective surgery waiting times data element. It is used to determine whether patients were overdue, or had extended waits when they were removed from the waiting list. It is used to assist doctors and patients in making decisions about hospital referral, to assist in the planning and management of hospitals and in health care related research.

Relational and representational attributes

Datatype: Numeric *Field size:* *Min.* 1 *Max.* 4 *Layout:* NNNN

Data domain: Count in number of days

Guide for use: The number of days is calculated by subtracting the Listing date from the Removal date, minus any days when the patient was 'not ready for care', and also minus any days the patient was waiting with a less urgent clinical urgency category than their clinical urgency category at removal.

Days when the patient was not ready for care is calculated by subtracting the date(s) the person was recorded as 'not ready for care' from the date(s) the person was subsequently recorded as again being 'ready for care'.

If, at any time since being added to the waiting list for the elective surgical procedure, the patient has had a less urgent clinical urgency category than the category at removal, then the number of days waited at the less urgent clinical urgency category should be subtracted from the total number of days waited.

In cases where there has been only one category reassignment (i.e. to the more urgent category attached to the patient at removal) the number of days at the less urgent clinical urgency category should be calculated by subtracting the Listing date from the Category reassignment date. If the patient's clinical urgency was reclassified more than once, days spent in each period of less urgent clinical urgency than the one applying at removal should be calculated by subtracting one Category reassignment date from the subsequent Category reassignment date, and then adding the days together.

When a patient is removed from an elective surgery waiting list, for admission on an elective basis for the procedure they were awaiting, but the surgery is cancelled and the patient remains on or is placed back on the waiting list within the same hospital, the time waited on the list should continue.

Guide for use: (continued)

Therefore at the removal date the patient's waiting time includes the number of days waited on an elective surgery waiting list, both before and after any cancelled surgery admission. The time waited before the cancelled surgery should be counted as part of the total time waited by the patient.

Related data:

supersedes previous data element Waiting time at admission, version 1

is calculated using Listing date for care, version 3

is calculated using Removal date, version 4

is calculated using Category reassignment date, version 2

is qualified by Patient listing status, version 3

is qualified by Clinical urgency, version 2

is used in the derivation of Overdue patient, version 3

is used in the derivation of Extended wait patient, version 1

Administrative attributes

Source organisation:

Australian Institute of Health and Welfare, National Health Data Committee

National minimum data sets:

Elective surgery waiting times from 01/07/2001 to

Comments:

Elective surgery waiting times data collections include measures of waiting times at removal and at designated census dates. This data element is used to measure waiting times at removal whereas the data element Waiting time at Census Date measures waiting times at a designated census date.

The calculation of waiting times for patients who are transferred from an elective surgery waiting list managed by one public acute hospital to another will be investigated in the future. In this case, the amount of time waited on previous lists would follow the patient to the next. Therefore when the patient is removed from the waiting list (for admission or other reason), their waiting time would include the total number of days on all lists (less days not ready for care and days in lower urgency categories).