Outpatient Services Framework

**Summary** The Outpatient Services Framework provides guidance on the expectations of the NSW Ministry of Health for the planning, provision and management of outpatient services, and outlines clear goals and targets to which outpatient service units can work towards.

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**Audience** Administration, Clinical, Allied Health, Medical, Nursing, Dietitian
OUTPATIENT SERVICES FRAMEWORK

PURPOSE
The Outpatient Services Framework outlines the principles to be adopted, and the procedures and processes to be applied, to enable effective management of NSW Health outpatient services. It is intended to support system leadership and give the direction required to achieve the following service outcomes:

- equitable, effective and sustainable services that are responsive to community need
- timely access to health services
- better integration of services across the system
- patient-centred care
- transparent and appropriate performance targets, informed by timely and reliable data.

KEY PRINCIPLES
The principles underpinning the Outpatient Services Framework are:

- A patient-centred approach to care is adopted, where each person is respected as an individual and not as a condition to be treated.
- Priority of access to outpatient services is based on clinical need.
- The provision of care is responsive to the patient’s individual needs and circumstances, including their level of vulnerability and disadvantage.
- Care is integrated across all service settings.
- The outpatient service unit environment optimises the patient’s experience.
- Timely and effective communication takes place between patients, carers and referrers.
- Innovation is encouraged to achieve better patient care outcomes.
- Where possible, patients are referred to outpatient service units at a facility near their place of residence, or at another District or Network facility as close as practicable to their place of residence.
- Outpatient services are delivered in collaboration with other human services and justice agencies where applicable to promote safety, welfare and wellbeing.

USE OF THE GUIDELINE
Local Health Districts and Specialist Health Networks should use this Guideline to:

- understand the expectations of the NSW Ministry of Health regarding the standards to be met for the planning, delivery and management of outpatient services
- identify gaps or required improvements in order to meet these standards
- establish goals and timeframes to implement solutions and change processes.

REVISION HISTORY

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<tr>
<td>July-2019</td>
<td>Deputy Secretary</td>
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## GLOSSARY

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<thead>
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<th>Term</th>
<th>Definition</th>
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<tr>
<td>Allied health practitioner</td>
<td>A trained health practitioner that is not part of the medical, dental or nursing professions</td>
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<tr>
<td>Chronic disease or condition</td>
<td>Long lasting condition that has been (or is likely to be) present for six months or longer, for example, asthma, cancer, heart disease, diabetes, arthritis and stroke</td>
</tr>
<tr>
<td>Clinically appropriate timeframe</td>
<td>Timeframe that meets professionally recognised standards of acceptable medical care</td>
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<tr>
<td>Consultant physician</td>
<td>A medical health practitioner who has completed advanced training in a medical specialty to diagnose and manage complex medical conditions – also known as a ‘specialist’</td>
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<tr>
<td>Discharge</td>
<td>Agreed separation of patient from outpatient services at completion of an episode of care</td>
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<tr>
<td>Fly-in/fly-out health practitioner</td>
<td>A health practitioner that flies into the community to provide health care for a particular period of time, generally in a regional or remote area, and flies out when the care period concludes</td>
</tr>
<tr>
<td>General practitioner (GP)</td>
<td>A medical health practitioner who provides routine primary health care in the community and does not specialise in one particular area of medicine</td>
</tr>
<tr>
<td>Health practitioner</td>
<td>A generic term used to describe a person who practises a health profession</td>
</tr>
<tr>
<td>Health service provider</td>
<td>Any person or organisation who is involved in or associated with the provision of health care to a patient</td>
</tr>
<tr>
<td>Medical officer</td>
<td>A non-specialist medical health practitioner who may work in a variety of clinical settings in a hospital</td>
</tr>
<tr>
<td>Medical practitioner</td>
<td>A health practitioner who is registered in the medical profession under the Health Practitioner Regulation National Law (NSW)</td>
</tr>
<tr>
<td>Occasion of service</td>
<td>Any examination, consultation, treatment or other service provided by a health service provider in a non-admitted setting to a client/patient on each occasion such service is provided</td>
</tr>
<tr>
<td>Outpatient service</td>
<td>A medical service provided to patients who do not undergo a formal admission process and do not occupy a hospital bed</td>
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<tr>
<td>Outpatient service unit</td>
<td>A recognised clinical team of one or more health practitioners within a hospital, multi-purpose service or community health service that provides non-admitted patient services and/or non-admitted patient support activities</td>
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<tr>
<td>Term</td>
<td>Definition</td>
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</tr>
<tr>
<td>Person-centred care</td>
<td>Care that is respectful of and responsive to individual patient preferences, needs, and values and emphasises a partnership approach between patients and health practitioners</td>
</tr>
<tr>
<td>Patient-centred care</td>
<td>See ‘person-centred care’</td>
</tr>
<tr>
<td>Patient self-referral</td>
<td>When a patient independently contacts or ‘refers’ themselves to an outpatient service unit for care or treatment because medical referral by a GP or other health practitioner is not required eg for allied health services</td>
</tr>
<tr>
<td>Primary health care</td>
<td>The front line of health care and usually the first point of contact for most people for most illnesses</td>
</tr>
<tr>
<td>Primary Health Networks</td>
<td>A national network of independent primary health care organisations (replaced Medicare Locals from 1 July 2015) with the objective to improve coordination of care, particularly for those with chronic and complex conditions</td>
</tr>
<tr>
<td>Referral</td>
<td>A request for service from a health practitioner for a specific assessment or intervention – must be given in writing, dated and signed by the referring practitioner</td>
</tr>
<tr>
<td>Referrer</td>
<td>Health practitioner who has issued a referral for a patient to attend another health service provider or a specialist/consultant physician</td>
</tr>
<tr>
<td>Specialist</td>
<td>See ‘consultant physician’</td>
</tr>
<tr>
<td>Visiting Medical Officer</td>
<td>A medical health practitioner who has finished their training in one of the medical specialties and is engaged under a contract to provide services in a public hospital to public patients (rather than being an employee)</td>
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</tbody>
</table>
1 FOREWORD

The Outpatient Services Framework sets out NSW Health’s commitment to the people of NSW that they will be able to see the health professional best suited to their needs, and receive responsive and person-centred care within a clinically appropriate timeframe. It provides guidance on the expectations of the NSW Ministry of Health for the planning, provision and management of outpatient services, and outlines clear goals and targets to which outpatient service units can work towards.

Public hospitals in New South Wales provide specialist and generalist services in admitted and non-admitted settings. With an increasing burden of complex and long-term chronic disease, there is a greater focus in the healthcare system on providing optimal, patient-centred care outside of inpatient settings. Outpatient services are a critical interface between the hospital and primary care systems, and an important ongoing component in a patient’s care pathway.

Access to outpatient service units can affect patient outcomes and influence demands on other parts of the healthcare system. While the capacity for local responsiveness to meet the healthcare needs of our communities is important, a system level approach is required to ensure best practice standards are understood and consistently applied. This will support equitable and timely access to care that is safe, evidence based and reliable, and enable transparency around the performance of outpatient services and their ability to meet expectations.

2 INTRODUCTION

2.1 Strategic context

Outpatient services assess, diagnose and treat patients requiring specialist clinical intervention beyond what is available in primary health care, but that does not require admission to hospital.

Every year, the overall demand on NSW Health services grows, and the number of people accessing emergency departments and being admitted to hospital increases. This is similarly experienced by NSW Health outpatient services, which provide a significant amount of clinical activity. In 2017/18, there were 11,000 registered outpatient service units that provided 24 million clinical ‘occasions of service’ (OOS). Of these OOS, 14.5 million were for patients that were not privately referred and 9.5 million were for privately referred patients.

The Outpatient Services Framework contributes to the Premier’s Priority to improve service levels in hospitals and is aligned with key directions in the NSW State Health Plan: Towards 2021¹, the NSW Rural Health Plan: Towards 2021², NSW Aboriginal

Health Plan 2013–2023 and the eHealth Strategy for NSW Health 2016–2026. These plans and strategies provide a strategic framework for NSW Health’s key programs, policies and plans. They set priorities across the system for providing ‘the right care, in the right place, at the right time’ for everyone.

Achieving the goals, directions and strategies in these documents requires clear, co-ordinated and collaborative prioritisation of patient care delivery and supportive leadership. This exemplifies the CORE values of NSW Health – Collaboration, Openness, Respect and Empowerment.

2.2 Regulatory and legislative context

The **Health Services Act 1997** defines the public health system in NSW, and prescribes functions and responsibilities for the provision of health services. The **National Health Reform Agreement** was entered into by all states, territories and the Commonwealth in August 2011. It sets out the shared intention of the Commonwealth, and state and territory governments to work in partnership to improve health outcomes for all Australians and ensure the sustainability of the Australian health system.

The **Health Services Act 1997** also reaffirms the NSW Government commitment to the Medicare Principles and Commitments set out in section 26 of the **Health Insurance Act 1973 (Cth)**.

The **Health Insurance Regulations 2018** provide the basis for defining a referral and particular responsibilities and obligations throughout the framework, such as who can issue a referral and the duration of its validity.

2.3 Purpose of the framework

The Outpatient Services Framework outlines the principles to be adopted, and the procedures and processes to be applied, to enable effective management of NSW Health outpatient services. It is intended to support system leadership and give the direction required to achieve the following service outcomes:

- equitable, effective and sustainable services that are responsive to community need
- timely access to health services
- better integration of services across the system
- patient-centred care
transient and appropriate performance targets, informed by timely and reliable data.

Articulating principles and processes for the optimal provision of outpatient services will improve the patient experience and support patients to receive an outpatient appointment within clinically appropriate timeframes.

2.4 Framework scope

2.4.1 Defining outpatient services

In outlining the scope of the framework, it is important to first define how outpatient services are recognised and referred to within national and state classification systems, and how these systems link together.

**IHPA Tier 2 Non-Admitted Care Services Classification**

NSW adheres to national data definitions endorsed by national data governance bodies, and the corresponding classification of non-admitted patient services by the Independent Hospital Pricing Authority (IHPA). Under the Tier 2 Non-Admitted Care Services system\(^9\), IHPA defines non-admitted care as follows:

*‘Non-admitted care encompasses services provided to patients who do not undergo a formal admission process and do not occupy a hospital bed. For example, services provided by hospitals:*

- hospital outpatient clinics
- community based clinics
- patients’ homes*\(^{10}\)

The Definitions Manual\(^{11}\) for the Tier 2 system 2018-19 notes the following regarding how to refer to non-admitted care:

*‘The term ‘non-admitted care clinics’ can be used interchangeably with the term ‘non-admitted patient service units’. A service unit is a recognised clinical team of one or more healthcare providers within a hospital, multi-purpose service or community health service that provides non-admitted patient services and/or non-admitted patient support activities. Non-admitted care clinics may otherwise be referred to as:*

- outpatient clinics
- ambulatory care clinics.’


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\(^9\) Note: IHPA is developing a new classification for non-admitted care – the Australian Non-Admitted Care Classification (ANACC) – with the aim of replacing the current Tier 2 system.


**NSW Health Non-Admitted Patient Establishment Type Classification**

In NSW, the classification used to group service units for collection of data under the NSW Health Non-Admitted Patient Data Collection system is the Establishment Type Classification.

Establishment Types are more granular than the national system and classify a service unit based on the services provided and the discipline/speciality of the lead provider i.e. the member of the team with the responsibility for clinical governance. Each type is mapped to a Tier 2 class for the purposes of reporting to the Commonwealth and national Activity Based Funding (ABF) and costing.


For the purposes of this framework, except where a direct quote is made from another source, the term ‘outpatient service unit’ has been used to refer to clinics or units that provide non-admitted care, including outpatient service clinics, allied health services and community health services.

### 2.4.2 Outpatient services in scope

The full range of outpatient service units operating within a Local Health District (District) or Speciality Health Network (Network) are considered in scope of this framework. This includes classes that map to the 10, 20, 30 and 40 series of the Tier 2 non-admitted care services.

Following is the description of these services drawn from the Tier 2 Non-Admitted Services Definitions Manual 2018-19:

**10 series – Procedures**
The 10 series is used to capture clinics where health care professionals provide procedural based health services.

**20 series – Medical consultation**
The 20 series is used to capture clinics where the nature of the medical consultation means it is typically provided by a medical or nurse practitioner. In medical clinics, it is assumed that there may also be input from allied health personnel and/or Clinical Nurse Specialists (CNS).

**30 series – Diagnostic services**
The 30 series is used to capture clinics that provide diagnostic services as inputs to the healthcare services of other non-admitted clinics.

**40 series – Allied health and/or clinical nurse specialist intervention**
The 40 series is used to capture clinics where there are allied health personnel / CNSs providing the majority of services in a clinic.
2.5 Principles of the framework

The principles underpinning the Outpatient Services Framework are:

- A patient-centred approach to care is adopted, where each person is respected as an individual and not as a condition to be treated.
- Priority of access to outpatient services is based on clinical need.
- The provision of care is responsive to the patient’s individual needs and circumstances, including their level of vulnerability and disadvantage.
- Care is integrated across all service settings.
- The outpatient service unit environment optimises the patient’s experience.
- Timely and effective communication takes place between patients, carers and referrers.
- Innovation is encouraged to achieve better patient care outcomes.
- Where possible, patients are referred to outpatient service units at a facility near their place of residence, or at another District or Network facility as close as practicable to their place of residence.
- Outpatient services are delivered in collaboration with other human services and justice agencies where applicable to promote safety, welfare and wellbeing.

2.5.1 Patient-centred Care

At the core of this framework is the principle of patient-centred care. While access to care in the outpatient setting is prioritised based on clinical need, the way in which the care itself is provided once this prioritisation has occurred must be respectful of, and responsive to the preferences, needs and values of patients.

Patient-centred care is particularly important among ‘at risk’ vulnerable or disadvantaged populations, such as the young, elderly, disabled or mentally ill; those with a non-normative gender or sexual orientation; those from culturally and linguistically diverse backgrounds, low socio-economic or rural and remote areas; and Aboriginal and Torres Strait Islander peoples. People in these populations can face inequity and communication difficulties that patient-centred care can help to address.

Research conducted by the Picker Institute in 1993 provided the foundation for the development of modern concepts of patient-centred care and subsequent Picker surveys measured the patient experience of health care. In 2009 the Picker Institute Europe conducted a review of the UK National Health Service (NHS) outpatient service, in preparation for undertaking the NHS Patient Survey Program. This review identified the

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following key domains, or core measures of outpatient experience, and the topic areas that are most important to patients\textsuperscript{13}.

<table>
<thead>
<tr>
<th>Topic areas that are most important to patients using outpatient services, as identified by the 2009 Picker Institute Europe Review</th>
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<tbody>
<tr>
<td><strong>Appointment and waiting</strong></td>
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<tr>
<td>- length of wait to receive appointment date</td>
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<tr>
<td>- choice of hospital</td>
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<tr>
<td>- flexibility of appointment date and time</td>
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<tr>
<td>- being told how long they would have to wait to be seen</td>
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<tr>
<td>- receiving an apology if the appointment was delayed</td>
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<tr>
<td>- appearance of the waiting room or waiting area</td>
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<tr>
<td>- having a good range of entertainment facilities in case of delay</td>
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<tr>
<td><strong>Facilities</strong></td>
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<td>- spacious and cheerful looking waiting area</td>
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<td>- good refreshment facilities nearby</td>
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<td>- good entertainment facilities, such as TV and books</td>
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<td>- good parking facilities – inexpensive, good availability, suitable payment method</td>
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<td>- better signage around the hospital</td>
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<td>- availability of hand wash gels</td>
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<tr>
<td><strong>Staff and interpersonal relationships</strong></td>
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<tr>
<td>- having confidence and trust in the health professionals</td>
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<td>- feeling reassured</td>
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<td>- courteous reception staff</td>
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<td>- being able to understand the explanations provided</td>
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<td>- having the opportunity to ask questions</td>
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<td>- awareness of medical condition</td>
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<td>- seeing same professional on repeat visits</td>
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<tr>
<td>- feeling able to complain if necessary</td>
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<tr>
<td><strong>Tests and treatments</strong></td>
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<tr>
<td>- information about where and when tests would take place</td>
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<tr>
<td>- being told how long to wait for test results</td>
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<td>- test results being available when anticipated</td>
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<tr>
<td>- being able to ask questions about test results</td>
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<tr>
<td>- being fully informed about a treatment prior to it taking place</td>
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<tr>
<td><strong>Information</strong></td>
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<tr>
<td>- receiving copies of letters sent between hospital and general practitioner (GP)</td>
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<tr>
<td>- cooperation and coordination of care between hospital and GP</td>
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<tr>
<td>- being given important information in both verbal and written formats</td>
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3 COMMUNICATION

Good communication is key to ensure quality and safety outcomes throughout the patient journey. It is also the basis of successful relationships and partnerships with patients and their carers, and all service providers involved in outpatient services.

3.1 Key contact

Each hospital should have a clear point of contact for enquiries about outpatient services and referrals, with designated staff available to respond to information requests from general practitioners (GPs), other referring health practitioners and the general public.

3.2 Information about outpatient services is available

Different forms of information should be available that are culturally and linguistically appropriate to the local communities. Information about outpatient services and how they can be accessed should be readily available on District, Network and individual hospital websites, and should include:

- outpatient service units available at the facility
- criteria a patient must meet to access the unit
- any work-up that must be completed before submitting a referral
- supporting information that must accompany the referral e.g. test results.

3.3 Ongoing communication

Communication that is clear and consistent should be maintained with the patient/carer and the referring health practitioner throughout the patient journey – on receipt of the referral, during treatment and at the point of discharge.

Mechanisms will need to be in place to ensure early identification of patients who are concurrently managed by other services. Proactive communication with these services should occur to ensure a coordinated approach.

4 DELIVERING OUTPATIENT SERVICES

4.1 Planning

The function of Districts and Networks is to promote, protect and maintain the health of the residents in their area.

Health planning informs the nature of the outpatient services each District and Network provides, including specialities, locations and service models.

Planning for outpatient services considers the current and future requirements for specialist and complex care that is not available within the admitted or primary health setting. It occurs at the state, District or Network, and local level and involves patients and carers, health practitioners, administrative and executive staff of Districts and
Networks, Primary Health Networks, GPs, consultant physicians and other service providers such as Aboriginal Controlled Health Services.

The District or Network determines the outpatient services it provides to meet the greatest need of its population, and proactively manages referral acceptance according to community need, service availability and capacity.

### 4.2 Managing demand

There is often a significant imbalance between the available capacity of a service and the ability to meet demand within the community. Outpatient services need systems to support how they cope with this demand, understand and communicate their core business, and articulate how this is differentiated from the care given in primary care.

Referrers need to understand what can and cannot be referred and what options are available when a referral does not meet the outpatient service unit’s referral criteria. Equally patients should be advised and supported through alternative pathways when their needs cannot be met through the outpatient service unit.

Referral pathways should support primary providers such as GPs and allied health practitioners to make referrals for patients to access outpatient services, and systems should also recognise the ability of patients to self-refer.

### 4.3 Care provision partnerships

#### 4.3.1 Local Health District and Network partners

Where outpatient services are provided through a cooperative arrangement between facilities, or Districts and Networks, a service agreement should clearly identify the service with the responsibility for each aspect of the clinical and administrative functions. This is particularly important for fly-in/fly-out health practitioner arrangements.

#### 4.3.2 Out of area referrals

While the function of a District or Network is to promote, protect and maintain the health of the residents in its area, patients who live outside the District or Network may also seek access to outpatient service units.

Accepting out-of-area referrals is based on capacity and demand of the service and also other factors, such as:

- availability of the service in neighbouring/other Districts or Networks
- clinical need/risk
- disadvantage and vulnerability.

Access to outpatient service units needs to be structured so as not to disadvantage patients who have legitimate access needs that cannot be met elsewhere.

#### 4.3.3 Private sector partners

Opportunities to implement collaborative models of outpatient services with private sector partners should be actively pursued through regular communication and service planning.
activities. Service agreements should clearly identify the service with the responsibility for each aspect of the clinical and administrative functions, and ensure these are undertaken in alignment with this framework.

4.4 Ceasing the provision of outpatient services

Before a District or Network implements any decision to stop providing an existing outpatient service, it must notify the Health Secretary of the decision and ensure the decision is appropriate with regard to its functions. Where demand for an outpatient service is low or other challenges exist, for example a lack of workforce capacity, services are to be provided by other facilities. This can be done in consultation with the District or Network, or through alternative partnership models and use of innovative technologies.

4.5 Clinical governance

4.5.1 Duty of care

When a referral is accepted by a District or Network, this acceptance creates a duty of care towards the patient. For a patient on an appointment list, this includes a duty to make reasonable efforts to provide outpatient care, regardless of the model used (eg telehealth, in the home etc) within clinically appropriate timeframes, communicating with patients/carers, referring health practitioners and the nominated GP, and responding to information on changes to the patient’s conditions.

4.5.2 Fly-in/fly-out health practitioners

Districts and Networks that use fly-in/fly-out clinical service arrangements for outpatient services should provide clarity about the relationship between fly-in/fly-out practitioners and locally-based services. This includes an understanding of clinical interactions in line with local role delineation, appropriate credentialing for clinic function, clinical record keeping and record sharing, clinical care in the absence of the practitioner, clinical governance, quality improvement initiatives, compliance with mandatory reporting requirements and service planning.

5 OVERVIEW OF KEY PROCESS AND TIMEFRAMES

5.1 Key processes and recommended timeframes

The framework provides guidance regarding the following key processes involved in managing an outpatient service unit:

- Receiving and managing referrals
- Clinical prioritisation
- Managing appointment lists
- Booking appointments
- Discharge and transfer of care
- Measuring and monitoring performance

Appendix 1 provides a flow chart that maps these processes.

### 5.2 Recommended timeframes

The table below provides a summary of the recommended timeframes for particular actions associated with the above processes:

<table>
<thead>
<tr>
<th>Process</th>
<th>Framework section</th>
<th>Key action</th>
<th>Recommended timeframe / regularity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Receiving and managing referrals</td>
<td>Referral screening</td>
<td>6.3 Referrals are screened to ensure prompt registration, redirection or return.</td>
<td>Within 5 working days of receipt</td>
</tr>
<tr>
<td></td>
<td>Redirect referral</td>
<td>6.6 Referring health practitioners and GPs are notified in writing of the recommendation for alternative care.</td>
<td>Within 5 working days of the referral being assessed and deemed not appropriate/not accepted by an authorised staff member</td>
</tr>
<tr>
<td>Clinical prioritisation</td>
<td>Clinical prioritisation categories - Urgent</td>
<td>7.1.2 Patients with referrals categorised as urgent are seen.</td>
<td>Within 30 days of referral receipt</td>
</tr>
<tr>
<td></td>
<td>Clinical prioritisation categories – Non-urgent</td>
<td>7.1.3 Patients with referrals categorised as non-urgent are seen.</td>
<td>Beyond 30 days and within up to 365 days of referral receipt</td>
</tr>
<tr>
<td></td>
<td>Timeframes for clinical prioritisation</td>
<td>7.3 Referrals are prioritised.</td>
<td>Within 5 working days of receiving a referral that contains all required information</td>
</tr>
<tr>
<td>Managing appointment lists</td>
<td>Scheduling</td>
<td>8.1 Appointments are booked or the patient is added to an appointment list.</td>
<td>Within 5 working days of referral prioritisation</td>
</tr>
<tr>
<td></td>
<td>Monitoring of appointment lists</td>
<td>8.6 Appointment list for urgent patients who have been on the list for more than one month are reviewed.</td>
<td>Weekly</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Appointment list for non-urgent patients who have been on the list for more than three months are reviewed.</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
### Outpatient Services Framework

<table>
<thead>
<tr>
<th>Listing status – Not ready for appointment</th>
<th>8.7.2</th>
<th>Patients who are unavailable may be suspended from the appointment list and asked to recontact the service when they are available.</th>
<th>Six-monthly</th>
<th>If patient unavailable for up to 3 months</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Patients who are unavailable may be removed from the appointment list, with written advice to the health practitioner, GP and patient.</td>
<td></td>
<td>If patient unavailable for 3 months or more</td>
</tr>
</tbody>
</table>

#### Booking appointments

<table>
<thead>
<tr>
<th>Booking systems</th>
<th>9.3</th>
<th>Outpatient service unit list of patients for appointments are generated.</th>
<th>Minimum of 20 working days in advance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Patients are given notice before their appointment.</td>
<td>10 working days in advance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Monitoring length of appointments</th>
<th>9.5</th>
<th>Outpatient service unit schedules and appointment slots are reviewed to account for changing demands.</th>
<th>Annually</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>‘Did not attend’ (DNA) rates - Failure to attend new appointments</th>
<th>9.7.1</th>
<th>Patients are reinstated on the appointment list without penalty, at their request.</th>
<th></th>
<th>If patient contacts service within 20 days of receiving written notification of their intended removal from the appointment list</th>
</tr>
</thead>
</table>
| ‘Did not attend’ (DNA) rates - Failure to attend subsequent/review appointments | 9.7.2 | Patients who have been offered a rebooking for a missed appointment are removed from the appointment list when they do not respond.  
* needs of ‘at risk’ populations should be taken into account before this action is taken |  | If patient does not contact service within 10 days of the offer being made |

| Hospital initiated postponements – For non-urgent patients | 9.8.1 | Patients are notified of a new appointment date after a hospital initiated postponement. | Within 5 working days of postponement |
6 RECEIVING AND MANAGING REFERRALS

A referral is a request for service from a health practitioner for a specific assessment or intervention. The information in a referral is considered a form of clinical handover and must provide adequate information for safe transfer of care. The referral must be given in writing, dated and signed by the referring practitioner. Processes need to be in place to accept referrals from internal and external service partners including patient self-referral (where medical referral is not required, such as an allied health outpatient service unit) where appropriate.

6.1 Who can make a referral

Regulation 96 from the Health Insurance Regulations 2018 provide the following advice regarding who can make a referral:

1. A medical practitioner may refer a patient to a specialist or consultant physician.
2. An optometrist may refer a patient to a specialist who is an ophthalmologist.
3. A dental practitioner who is approved by the Minister for the purposes of paragraph (b) of the definition of professional service in subsection 3(1) of the Act may refer a patient to a specialist or consultant physician.
4. A dental practitioner to whom subsection (3) does not apply may refer a patient to a specialist (but not a consultant physician).
5. A participating midwife may refer a patient to an obstetrician or paediatrician.
6. A participating nurse practitioner may refer a patient to a specialist or consultant physician.

In addition, an allied health practitioner can refer to another allied health practitioner and patients can refer themselves where medical referral is not required.

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15 Health Insurance Regulations 2018, Part 11, Division 4
### 6.2 Referral forms

Outpatient services should have standardised referral forms to capture the following minimum information, and these forms should be easily accessible to service providers who make referrals.

<table>
<thead>
<tr>
<th>Outpatient service unit information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Clinic use only</strong></td>
</tr>
<tr>
<td>a) Date referral received by outpatient service</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient/client details</th>
</tr>
</thead>
<tbody>
<tr>
<td>d) Patient’s full name</td>
</tr>
<tr>
<td>g) Patient’s telephone contact number – home, mobile and alternative</td>
</tr>
<tr>
<td>j) Patient’s sex/gender</td>
</tr>
<tr>
<td>m) Whether the patient identifies as Aboriginal or Torres Strait Islander</td>
</tr>
<tr>
<td>p) Patient compensable status if applicable (such as DVA, WorkCover, motor vehicle insurance)</td>
</tr>
<tr>
<td>s) Name of the patient’s GP (if not the referrer)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical details</th>
</tr>
</thead>
<tbody>
<tr>
<td>u) Relevant information about the patient’s condition – dependent upon condition, but should include:</td>
</tr>
<tr>
<td>i. presenting symptoms (onset, duration and severity, if appropriate)</td>
</tr>
<tr>
<td>ii. physical findings</td>
</tr>
<tr>
<td>iii. health practitioner or GP diagnosis or provisional diagnosis, if relevant</td>
</tr>
<tr>
<td>iv. results of any relevant investigations, if appropriate</td>
</tr>
<tr>
<td>v. details of previous treatment (include systemic and topical medications prescribed for the condition and any surgery)</td>
</tr>
<tr>
<td>vi. details of any associated medical conditions which may affect the condition or its treatment (such as diabetes)</td>
</tr>
<tr>
<td>vii. current medications and dosages (include any drug allergies)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Referrer details</th>
</tr>
</thead>
<tbody>
<tr>
<td>v) Referrer’s name</td>
</tr>
</tbody>
</table>
y) Referrer’s telephone contact number, email and fax number

2) Signature of health practitioner and date referral made

Appendix 2 provides an example of a standard referral form.

6.3 Referral screening

Referrals should be screened within 5 working days of receipt to ensure prompt registration, redirection or return.

Screening of referrals by a delegated staff member in the outpatient service assists to:

- ensure all required information is available
- determine the suitability of the referral for acceptance
- stream into the correct specialty.

The delegated staff member may redirect or expedite care in consultation with the treating health practitioner or specialist/consultant physician as required – see 7.2 for further advice regarding prioritisation.

6.4 Outpatient referrals register

All referrals received, regardless of whether the referral is accepted or was received in error, should be registered in the local outpatient service unit’s referrals register to monitor and support the management of referrals.

The outpatient referrals register or system should be maintained and able to:

- provide current, accurate and timely information on referrals and their status
- generate reports to support performance monitoring and reporting, for example capacity across the District or Network, attendance rates, or number of patients who need or have an appointment.

The minimum data sets the register should be able to capture and report on include:

- all information contained on the referral form
- date the referral is first received by the receiving District or Network (this date should not be changed, even if the health practitioner is asked to provide additional information)
- type of service provider making the referral (source of referral)
- service to which the patient has been referred
- date when the referrer was sent an acknowledgement of referral receipt
- date when the referrer was asked for further information
- date when the referrer provided any additional information
• referral outcome (whether the referral was accepted or, if not, the reasons for non-acceptance)
• referral urgency category (if applicable).

6.5 Referrals requiring further information

Where the required information is not provided or is unintelligible, the receiving District or Network should work with the referring health practitioner to obtain the required information. This should occur in a timely manner so that the patient is not disadvantaged.

Where a referral requires further information urgently, the referrer should be contacted on the telephone for the remaining information.

Appendix 3 provides an example of a request for further referral information due to an incomplete referral.

6.6 Alternative care

Where a pathway other than an outpatient service is considered more appropriate, the receiving service should recommend alternative care to the referrer.

Referrers and GPs should be notified in writing of the recommendation for alternative care within 5 working days of the referral being screened and clinically prioritised and deemed not appropriate/not accepted by an authorised staff member.

6.7 Validity of referrals

6.7.1 Period of validity

Regulation 102 from the Health Insurance Regulations 2018 stipulates that:

• A referral that states it is valid for a fixed period is valid until the end of that period after the first service rendered in accordance with the referral.
• A referral that states it is valid indefinitely is valid for an indefinite period.
• A referral that does not state a time for which it remains valid is valid until 12 months after the first service rendered in accordance with the referral.

The Regulations provide the following advice regarding the period of validity of referrals from specific referrers:

<table>
<thead>
<tr>
<th>Referrer</th>
<th>Period of validity of referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specialist or consultant physician</td>
<td>a) For a maximum of 3 months after the first service given in accordance with the referral; or</td>
</tr>
<tr>
<td></td>
<td>b) if the referred person is a patient in a hospital at the time of referral and continues to be for more than 3 months -- until the person ceases to be a patient in a hospital.</td>
</tr>
</tbody>
</table>
Participating midwife | For a maximum of 12 months after the first service is given in accordance with the referral, and for one pregnancy only.
---|---
Participating nurse practitioner | For a maximum of 12 months after the first service is given in accordance with the referral.

Referrals for chronic or long-term conditions that will extend beyond 12 months should indicate the period for the referral as ‘indefinite’.

6.7.2 Validity of existing referrals

A new referral is required to replace an existing referral under the following circumstances:

- If care is extended beyond the referral validity timeframe
- If an unrelated illness or condition that may initiate a new course of treatment is identified.

If a second referral is received for a referred patient for the same condition due to an escalation of the condition, the existing referral should be updated in the registry.

6.8 Hospital generated referrals

A hospital generated referral can be initiated as a result of:

- an inpatient admission for a new condition that is unrelated to the ongoing reason for admission
- emergency department presentations
- one consultant physician requesting an assessment, investigation or diagnostic test from another consultant physician within the same hospital.

A hospital generated referral does not include referrals for admitted patients requiring an appointment post discharge from an inpatient unit. Additionally, no patient who presents at an emergency department is to be privately referred for treatment of, or examinations relating to, the episode of illness which caused him/her to attend the emergency department.16

6.9 Referrals from private rooms

Specialists or consultant physicians who have seen a patient in their private rooms may only refer the patient to an outpatient service unit of a hospital for services that they are not accredited to provide in that public facility.

For example, an ophthalmologist who is accredited to perform a cataract procedure at a public hospital should refer a patient needing cataract surgery that they have seen in

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their private rooms directly to their public hospital elective surgery list. This is regardless of the patient’s election. The patient should not be referred to a public outpatient service unit for further assessment for the same condition.

6.10 Facilitating service access

Acceptance of referrals depends on service availability and capacity to see the patient within the clinically appropriate timeframe. Districts and Networks should actively monitor the current volume and trends in new referrals to outpatient services to ensure there is capacity to see the patient within the recommended timeframe.

Where the service is not provided or the capacity is limited, the receiving District or Network should make arrangements for the referral to be accepted by an alternative service provider. See 8.4 for options regarding redistribution of patients.

6.11 Privately Referred Non-Inpatients (PRNI)

Privately referred patients can access outpatient service units when:

- The patient has elected to be treated as a private patient, and
- The specialist or consultant physician exercises a right of private practice at the hospital.

The following referral conditions must also be met:

- The patient has a written referral from a health practitioner with a valid provider number (dated and signed by the referring health practitioner) to a named specialist/consultant physician with a valid provider number. The referral is “arm’s length” - that is, completed prior to the professional service to which the referral relates.
- The patient is informed at the time the appointment is made of any financial charges associated with their treatment and whether these will be fully covered by Medicare (bulk-billed).

In addition:

- Cross-referrals between specialists/consultant physicians should occur in consultation with the patient’s GP/primary referrer.
- It is the responsibility of the treating health practitioner and the public health organisation to ensure that the correct Medicare item is claimed for the service/consultation provided.
- Referral pathways should not be designed or controlled so as to deny access to free public hospital outpatient services.

Districts and Networks offering privately referred non-inpatient services must comply with all applicable rules and legislation, including the NSW Health Fees Procedures Manual.
for Public Health Organisations\textsuperscript{17}, the Health Insurance Regulations 2018, and NSW Health Policy PD2005_051 Registered Non-Inpatients in Recognised Hospitals.

Further advice can also be accessed from the Department of Health webpage: \textit{Services provided under rights of private practice at public hospital outpatient departments}\textsuperscript{18} at:


7 \textbf{CLINICAL PRIORITISATION}

7.1 Clinical prioritisation categories

7.1.1 Rapid access (within 72 hours) or next available outpatient service unit

Rapid access service units are managed locally by the specific specialities that operate them.

A rapid access appointment can be used for patients requiring immediate access to an outpatient service unit (within 72 hours of referral). These appointments do not form a component of an outpatient service appointment list but help provide immediate access to outpatient services for patients who are not appropriate to be placed on the appointment list.

Patients suitable for a rapid access appointment may include appropriate patients diverted from public hospital emergency departments, and patients referred by health practitioners with a clearly demonstrated urgent need for specialist assessment and care.

Assessment and care facilitated using a rapid access appointment may avoid the need for a future presentation to an emergency department or a hospital inpatient admission.

7.1.2 Urgent

Referrals should be categorised as urgent if the patient’s clinical condition has the potential to deteriorate quickly, with significant consequences for health and quality of life, or where time sensitive treatment may have a significant impact on patient outcomes. These patients should be seen \textbf{within 30 days} of referral receipt.


7.1.3 Non-urgent

Referrals should be categorised as non-urgent if the patient’s clinical condition is unlikely to deteriorate quickly or have significant consequences for the person’s health and quality of life. These patients can be seen beyond 30 days and within up to 365 days of referral receipt.

7.2 Clinical prioritisation in individual specialities

In most outpatient service units, patients referred should be assigned a priority category based on their clinical need.

In some clinical areas, it may be necessary to further categorise patients within the urgent or non-urgent categories to ensure appropriate management of clinical risks.

The use of nursing, midwifery and allied health staff for clinical prioritisation has been shown as highly safe and effective in many specialties. This is provided there are clear prioritisation guidelines and access to specialist advice in cases where the patient’s urgency is difficult to determine. However, the most appropriate staffing model for triage depends on the outpatient service unit and the patient group. Some outpatient service units may be better suited to specialist/consultant physician-led triaging.

Where clinical prioritisation is undertaken by junior staff, there should be clear processes in place for escalation to more senior decision-makers if required. This may be in the case of difficult decisions or where new information becomes available that challenges the original prioritisation decision.

Mechanisms for facilitating quality and consistency in clinical prioritisation include:

- ensuring referrals contain all necessary information
- facilitating discussion between the referrer and specialist where appropriate
- clearly agreed and documented staff responsibilities for clinical prioritisation
- transparent arrangements to cover staff leave and staff training
- regular review of protocols and adherence to documented requirements
- documented escalation pathways for when services cannot be offered.

7.3 Timeframes for clinical prioritisation

Outpatient service units should ensure referrals are prioritised within a clinically appropriate timeframe. This is essential to managing risk for referred patients and for the efficient management of referrals.

Appropriate prioritisation should occur as follows:

- Prioritisation **within 5 working days** of receiving a referral that contains all information necessary for this function to be undertaken.
- Where referrers have requested an urgent appointment, earlier prioritisation and appointment scheduling may be required.
• Re-prioritisation may occur after clinical review of a patient’s referral by a specialist or delegate. The clinical review may occur in response to new information provided by the referrer or the patient or as part of a validation of patients requiring an appointment.

• Outpatient service units identify a contact point for referrers to communicate a change in their patient’s condition.

• Where re-prioritisation occurs, the reasons for this are documented and the new category recorded on the patient’s record.

8 MANAGING APPOINTMENT LISTS

8.1 Scheduling

The scheduling of appointments is based on the clinical requirements for each patient and providing access to care within the accepted clinically appropriate timeframes.

Rapid access patients should be allocated an appointment immediately and not placed on the appointment list.

Appointments should be booked or the patient added to an appointment list within 5 working days of accepting the referral and triaging according to clinical priority.

8.2 Communication with patients and referrers

The patient/carer, referring health practitioner and patient’s GP, if this is not the referrer, should be advised about:

• the expected timeframe for an appointment

• the course of action to be followed if changes occur in clinical condition

• the need for the referring health practitioner or GP to continue to provide care and regular clinical review for the patient until their outpatient appointment.

8.3 Redistribution of patients

An outpatient service unit may identify that the service is unable or unlikely to be able to provide assessment or treatment within the clinically appropriate timeframe. In this case, the receiving District or Network is responsible for expediting access to care in discussion with the referring health practitioner.

Options may include:
• pooling public patients on a combined list - note that patients should still be registered by the original outpatient service unit that received the referral to support appropriate transfer of documentation
• sending the referral to another health practitioner in the same specialty, either in the District or Network, outside of the District or Network, or in private rooms.

8.3.1 Pooling public patients on a combined list

Health practitioners and consultant physicians may also agree to pool their public patients on a combined list for that specialty or subspecialty. For outpatient service appointment list pooling and redistribution, public patients are patients of the District or Network, not of a particular physician. This means the treatment can be provided by any District or Network appointed physician in the relevant speciality.

Any offer of treatment by an alternative physician should be:
• a specific and credible alternative, and available if the patient decides to accept it
• include the name of the physician and outpatient service unit, hospital and planned appointment date or an estimate of the likely time until an available appointment.

8.3.2 Sending the referral to another health practitioner within the same specialty

The feasibility of any transfer of a patient to another health practitioner within the same specialty needs to account for the circumstances of each patient, such as age, mobility, available support, mode of transport, physical condition and the required procedure.

When sending the referral to another health practitioner within the same specialty, the receiving District or Network should:
• send the referral to another public hospital in the District or Network that provides the services and can offer a time for an outpatient service appointment sooner
• consider referring to a consultant physician’s private rooms, with discussion and patient consent.

Where patients accept an offer for their referral to be sent to another health practitioner or facility, the sending District or Network should:
• document the patient acceptance
• notify the referrer and GP, if they are not the referrer
• document all communication about the patient transfer and ensure this is retained in the patient’s health care record and the referral register.

8.4 Patient declines treatment with another health practitioner or hospital

If the patient declines two genuine offers of treatment with another health practitioner or at another hospital, the patient should be advised they may be removed from the outpatient appointment list. In line with the principles of patient-centred care, the patient’s individual circumstances and ‘at risk’ status should be carefully considered.
before such advice is provided and strategies identified to address any disadvantage or vulnerability.

The District or Network should review the patient’s status on the outpatient services appointment list in consultation with the original treating referring health practitioner before the patient is removed from the list.

8.5 Patient accepts treatment with another health practitioner

If a patient accepts the alternative offer, the new health practitioner determines the requirement to review the patient.

For all patients being moved to an alternative health practitioner, their referral history should reflect receipt of the original referral before the alternative offer was made, so that an accurate record of time elapsed before the patient is seen is maintained. The patient’s current urgency category (if applicable) should also be maintained, unless altered after clinical review of the referral information by the new treating health practitioner.

When a patient is booked at one facility and subsequently has the appointment provided at a different facility within the same District or Network, these steps should be followed:

- The original referral is sent to the receiving facility and a copy retained for auditing at the original facility.
- The referral history, including urgency category, informs the appointment at the receiving facility so as not to disadvantage the patient.

8.6 Validation and monitoring of appointment lists

Outpatient services clinics should keep accurate appointment information, including records of any booking postponements, cancellations and changes to a patient’s urgency category.

Appointment lists should be regularly validated, using a standard process, so they reflect the true picture of the number of patients who need an appointment.

Validation should confirm:

- records and patient details are correct, including referring health practitioner or GP details
- if the patient still requires an appointment (medical condition has not changed)
- if the patient is available at short notice
- the date or approximate timeframe when the health practitioner (or GP if different) last reviewed the patient.

Appointment lists should be actively reviewed, monitored and managed so that:

- patients are seen within clinically appropriate timeframes
- appointments are not being rescheduled without good reason
- appointments for the same patient are not continually rescheduled
• patients in lower priority categories and those who have been rescheduled are still seen within the accepted clinically appropriate timeframes.

Reviews of appointment lists are important and recommended timeframes that outpatient service units should work towards are:

• **weekly review of the appointment list for urgent patients** who have been on the list for more than one month
• **monthly review of the appointment list for non-urgent patients** who have been on the list for more than three months
• **six-monthly audit** of the complete appointment list.

### 8.7 Listing status

Outpatient services should have processes to identify the listing status of all patients. This is to be classified as ‘ready for appointment’ or ‘not ready for appointment’ in terms of their ability to accept an offer of appointment for an outpatient service.

#### 8.7.1 Ready for appointment

‘Ready for appointment’ patients have been assessed as requiring an outpatient appointment by an attending medical officer, relevant health practitioner, or the patient themselves. They are available to attend an outpatient appointment.

#### 8.7.2 Not ready for appointment

‘Not ready for appointment’ patients are not in a position to accept an outpatient appointment. This may include:

- patients whose health status or situation precludes them from accepting an appointment
- patients who wish to defer their appointment for personal reasons.

If a patient is offered an appointment but declares themselves unavailable for a period of time, these procedures apply:

- If the patient is **unavailable for up to 3 months**, they may be suspended from the appointment list and asked to recontact the service when they are available.
- Once the service is notified that the patient is available, the patient may be reinstated to the appointment list without penalty, according to the original referral receipt date minus the suspension period.
- If the patient is **unavailable for 3 months or more**, they may be removed from the appointment list with written advice to the health practitioner, GP and patient.
- Urgent patients wishing to defer appointments for outpatient services require direct (telephone) consultation with a health practitioner to assess appropriate action and subsequent communication with the health practitioner. The outcome should be documented in the patient’s healthcare record.
8.7.3 Removal of patients from appointment lists

Outpatient services should use systems and processes to ensure that the removal of patients from appointment lists are done by an authorised officer in line with the appropriate ‘reasons for removal’. Discretion should be exercised case by case to ensure the needs of ‘at risk’ populations are considered and to avoid disadvantaging patients in the case of genuine hardship, misunderstanding or other unavoidable circumstances. The reason for removal should be recorded in the patient administration system and the patient’s healthcare record.

Reasons for removal from the outpatient service appointment list include:

- The patient has attended an appointment at the outpatient service unit and further appointments are not required.
- The patient is no longer required to attend the outpatient service unit after a clinical review or administrative audit ascertains this.
- The patient has advised that an appointment is no longer required and has requested that their name is removed from the outpatient service unit appointment list.
- The patient has advised that they have or will attend elsewhere for treatment of the same condition.
- The patient has not presented for two consecutive booked outpatient service unit appointments without prior notice to the unit. On these occasions the decision to remove the patient from the appointment list should be discussed with the medical officer or relevant health practitioner. (Further advice regarding recommended actions when a patient fails to attend outpatient appointments is provided at 9.6 and 9.7 of this document).
- The patient has not responded within a reasonable period to a minimum of three attempts to contact them, including at least two telephone calls, and alternative contact details cannot be obtained from the health practitioner or other source.
- The patient has not responded to audit measures and cannot be located.
- The patient is deceased.

9 BOOKING APPOINTMENTS

9.1 Maximising appointment times

Outpatient services should have processes in place to maximise the number of patients seen in the recommended timeframe and to minimise the occurrence of rescheduling.
Processes may include:

- immediate booking of urgent patient appointments (from the acceptance date of the referral and placement on to the appointment list)
- booking patients into individual and staggered appointment times rather than block appointments
- booking time slots that are appropriate to the clinical complexity of the patient
- booking an interpreter on set days if there are a high number of Culturally and Linguistically Diverse (CALD) patients needing an interpreting service
- scheduling appointments to reflect the number of treating health practitioners working in that outpatient service unit – for example, if there are three treating health practitioners in attendance, no more than three appointments should be offered for any one timeslot
- using booking systems that have the ability to offer any cancelled appointments to high priority patients.

9.2 Types of appointment

Initial (new) appointment:

- This is an initial or new service event for a patient at a given outpatient service unit for a condition. It does not include post-discharge review for an admitted patient episode.

Subsequent (review) appointment:

- This is any subsequent or review service event in the given outpatient service unit needed for the continuing management or treatment of the condition until the patient is discharged from the unit. It includes post-discharge review for an admitted patient episode.

9.3 Booking systems

Booking systems should support patient-centred booking, which enables:

- patient choice as far as practicable for non-urgent appointments
- consideration of patient’s needs and circumstances – such as disabilities, social and geographic factors, and concurrent appointments within the hospital or facility
- the arrangement of appointment times to facilitate patients being seen by the same health practitioner or specialist team at each appointment where possible.

Booking systems should also:

- generate outpatient service unit lists of patients for appointments a minimum of 20 working days in advance to enable maximum appointment efficiency
- send invitations for patients to contact the outpatient service unit to make an appointment, using the patient’s nominated communication method – such as letter, text message or email
• manage variances in responses – for example, if all appointments are not accepted for a week, extra letters, emails or calls can be generated in advance
• manage failures to respond to invitation and liaise with the health practitioner or GP
• provide patients with 10 working days' notice before the appointment unless they have indicated they are available at short notice
• have appointment reminder processes where possible to minimise the occurrence of missed appointments and short-notice cancellations
• link initial and subsequent appointments to the associated referral to enable continuum of care, ensure patient safety and facilitate ongoing management of the appointment list
• classify appointments as ‘initial’ or ‘subsequent’ – the first visit for any referral is an initial visit and all following visits for the same condition are subsequent/review visits.

Outpatient services should have procedures to minimise the cancellation of outpatient service appointments and support appropriate use of resources if cancellations occur. Appendix 4 provides information on text message reminders.

9.4 Communication with patients on booking the appointment

Patients booked into their first outpatient service unit appointment should receive written information about:
• the outpatient service unit
• their rights and responsibilities as patients, such as notifying the service of change of address or contact details, inability to attend an appointment, or appointments that are no longer required
• time, date and location of appointment – with clear information to help the patient to find the outpatient service in time for their appointment
• parking information, including concessional parking
• what to bring, such as x-rays, investigation results, medications, Medicare card
• the specialist or clinical unit responsible for their care
• a contact person in the specialist outpatient service unit for further information
• investigations needing to be performed before the outpatient service unit appointment
• any information needed to prepare for the appointment
• special requirements (if applicable)
• how to confirm, reschedule or cancel appointments
• consequences of a failure to attend a confirmed appointment.
The Sydney Children’s Hospital Randwick webpage ‘Being an outpatient’19 provides an excellent example of information to be provided for outpatients. Appendix 5 provides an example of an appointment confirmation letter and wayfinding information.

### 9.5 Monitoring length of appointments

Outpatient service unit schedules and appointment slots should be reviewed annually to account for changing demands.

### 9.6 Managing cancellations

When cancelling outpatient service unit appointments at the request of a patient, staff should:

- reschedule the cancelled appointment for the patient, if appropriate
- reschedule the vacated appointment time for use by another patient, if appropriate.

If the patient does not wish to reschedule, they should be removed from the appointment list, and the referrer and patient/carer notified in writing of this action.

### 9.7 ‘Did not attend’ (DNA) rates

High ‘did not attend’ (DNA) rates in outpatient service units tend to be associated with long waiting times, poor communication with patients, simultaneous referrals to multiple services of the same type, unnecessary subsequent/review appointments, and variable patient input into appointment times.

Analysis of DNA rates, particularly for specific services, specialties or patient groups may provide the service with valuable information about areas for improvement.

Unnecessary subsequent/review appointments are a common cause of patients not attending appointments. This is particularly true for patients who are being unnecessarily kept on an active appointment list, when their care could be transferred back to a primary healthcare provider.

#### 9.7.1 Failure to attend initial outpatient appointments

If a patient fails to attend two booked initial outpatient appointments for the same outpatient service unit, the patient may be removed from the appointment list. Before removing them from the list, the unit should make a genuine effort to contact the patient by their preferred method of communication.

If the patient cannot be contacted, the referrer/GP and patient should be advised in writing that the patient is being removed from the appointment list. If the referrer and patient or carer receive this written confirmation and contact the unit within 20 working days of removal, they should be asked to contact the unit again.

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days to advise they want to remain on the list, the patient should be reinstated to the list without penalty.

The patient’s needs and circumstances should always be considered.

9.7.2 Failure to attend subsequent/review appointments

If a patient fails to attend a booked subsequent/review outpatient service appointment, the attending health practitioner should be consulted to determine if the patient is to be removed from the appointment list or invited to rebook the appointment. If the patient is removed from the list, the referrer and patient/carer should be notified in writing.

When a patient is offered a rebooking for a missed appointment, the patient should respond to the offer **within 10 working days**.

When a patient fails to attend for a booked appointment made from an invited rebooking or fails to respond to an offer to rebook using their nominated communication method, the patient should be removed from the appointment list.

As with the removal of patients from appointment lists, the needs of ‘at risk’ populations should be taken into account and careful consideration given to individual circumstances to avoid disadvantaging patients in the case of genuine hardship, misunderstanding or other unavoidable circumstances. The reason for removal should be recorded in the patient administration system and the patient’s healthcare record and the GP, referrer and patient should be notified in writing.

9.8 Hospital initiated postponements

9.8.1 For non-urgent patients

Outpatient services should maintain records of hospital-initiated postponements. If a patient’s appointment is required to be postponed, the service should:

- give the patient as much notice as possible
- reschedule the patient for the next available appointment
- prioritise the patient over those whose appointments have not been postponed, if the same urgency
- notify the patient of a new appointment date **within 5 working days** of the postponement.

Patients who have arrived for a scheduled appointment that has been significantly delayed or postponed, and who cannot wait, should be offered:

- assistance and reimbursement for transport home
- the opportunity to discuss, with a clinical staff member, issues that might arise as a result of the postponement
- the name and contact details of a staff member if they require further information.
9.8.2 For urgent patients

Urgent patients should not be postponed without authorisation of the treating specialist/consultant physician or health practitioner. Where urgent patients are postponed, the patient/carer, their referring health practitioner and their GP should be consulted.

Outpatient services should implement processes to minimise hospital initiated postponements while maximising service efficiency, such as:

- managing planned staff leave
- managing of scheduled equipment maintenance
- regular review of cancellation causes by the manager of the outpatient service and the accountable treating officer or health practitioner.

9.9 Patient declining care

If a patient declines treatment and wishes to cancel their ongoing appointments, the outpatient service has a duty of care to inform the patient of any potential risks to their health as a result of not attending the appointment. This conversation should be conducted by a health practitioner and documented in the patient’s health care record. This applies to all patients who declined treatment and wish to cancel their appointment.

For urgent patients, the request to cancel should be referred to the treating specialist or health practitioner, relevant outpatient service unit head or delegated unit representative. Depending on a patient’s diagnosis, the specialist or health practitioner contacts the patient and either requests the patient attends a clinical review and discusses the consequences of their decision, or authorises the removal of the patient from the appointment list.

All other patients who decline treatment and request to be removed from the appointment list are automatically removed. The referrer, health practitioner, GP, and patient/carer are notified in writing of this action.

9.10 Communication with health practitioners and GPs

Continued contact with the referring health practitioner and GP during the consultative period is vital to establish and maintain collaborative management of the patient. Contact with the referring health practitioner and GP may be by letter, fax, email or telephone.

Documentation of all communication with the referring health practitioner, GP (including telephonic and electronic media) should be retained in the patient’s healthcare record. Appendix 6 provides an example of a referrer notification letter.
10 DISCHARGE AND TRANSFER OF CARE

10.1 Timely discharge

Discharge from the outpatient service unit should be timely and patients returned to their referring health practitioner or other setting for ongoing care as clinically appropriate.

Patients should be discharged from outpatient services when the single course of treatment is completed or when another health care provider can more appropriately provide the service.

Criteria may be used to identify patients for whom ongoing outpatient care may be appropriate. This includes patients who:

- need ongoing clinical care and have management plans already in place that need monitoring
- have unresolved clinical problems relating to the reasons for referral
- require monitoring of new or potentially harmful therapy that cannot be safely undertaken in other settings or by other services
- have complex conditions that are unable to be safely treated by another service
- are enlisted in a funded and approved research protocol.

10.2 Discharge criteria

Specific discharge criteria and guidelines for individual specialties should be developed locally to help identify the point at which the episode of care is complete to expedite discharge from the service.

Outpatient services staff should receive training in the application of these criteria and discharge related systems and processes.

Allied health and nursing staff, as well as junior health practitioners, will require targeted training in criteria-led discharge practice and should be supported to initiate discharge for less complex patients.

Standard systems should be in place for senior health practitioners to support junior health practitioners to discharge patients in a safe and timely manner. If the discharge date is not clear after two subsequent/review appointments by a junior health practitioner, a senior health practitioner should review the patient on the third subsequent/review appointment.
An ongoing care management or action plan should be included with all discharge summaries provided to health practitioners to minimise premature re-referrals.

### 10.3 Standardised discharge process

Discharge processes should be streamlined to maximise the efficiency, flow and capacity of the outpatient service, and standardised discharge systems and processes used to reduce duplication of effort. All discharges should be recorded on the scheduling system of the patient administration system and the patient’s healthcare record.

### 10.4 Discharge summary on transfer of care

Patients, their referring health practitioners and GPs should be notified when the patient is discharged and removed from the list **within 10 working days** of discharge from the outpatient service unit.

On discharge or transfer, a discharge/transfer summary is provided to the referring health practitioner and GP (if the GP is not the referrer), and the ongoing service provider as appropriate. This summary should include:

- date of first visit
- reason for referral to the outpatient service unit
- summary of interventions provided and their outcomes including any diagnosis derived
- reason for discharge
- date of discharge
- relevant risks
- ongoing management plan
- other community supports that have been arranged.

### 11 MEASURING AND MONITORING PERFORMANCE

Outpatient services are a critical element of the complex delivery of health services in NSW and are subject to the health system performance processes of the NSW Health Performance Framework. The performance framework sets out the processes by which the NSW Ministry of Health monitors, assesses and responds to the performance of public sector health services in NSW.
11.1 Monitoring measures and performance

Accountability for the delivery of safe, high quality outpatient services lies with each District and Network and systems and processes should be developed at the local level to monitor the performance and effective management of outpatient services.

For each stage of the outpatient process, the following indicators are recommended to cover the range of NSW Health performance domains of patient-centred culture, accessibility, timeliness, equity, safety, effectiveness and appropriateness.

Targets have been recommended for the following key measures:

<table>
<thead>
<tr>
<th>Measure</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrals assessed for urgency, within 5 days of receipt (%)</td>
<td>100</td>
</tr>
<tr>
<td>Patients who wait longer than 365 days for an initial specialist outpatient service appointment (number)</td>
<td>0</td>
</tr>
<tr>
<td>Discharge letters forwarded to the referrer within 10 working days (%)</td>
<td>100</td>
</tr>
</tbody>
</table>

Appendix 7 'Outpatients Services Improvement Guide Dashboard' provides guidance to outpatient services in monitoring the performance of their services.

11.2 Reporting

NSW Health PD2013_010 – Non-Admitted Patient Activity Reporting Requirements details the requirements for outpatient services in reporting non-admitted activity.

All non-admitted patient services provided by or on behalf of Districts and Networks are in scope of the NSW reporting requirements, regardless of the patient service billing.

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arrangement – whether privately referred, compensable or Medicare ineligible – and funding program or funding source.

This includes non-admitted patient services contracted to a private sector organisation, not-for-profit organisation, or Visiting Medical Officer that are paid for by a NSW Health organisation under a fee for service or sessional service contract.

Districts and Networks are required to participate in minimum data set reporting to the NSW Ministry of Health for outpatient services, as well as any additional national data collections required under the National Partnership Agreement for Improving Public Hospitals. The outpatient service information collected is in line with the minimum dataset.

Data management practices include:
- capturing data once if possible
- capturing data as close as possible to the source
- validate data as close to the point of capture as possible
- correct data as close to the point of capture as possible
- share and re-use data to eliminate duplication wherever possible
- review data before use to ensure it is fit-for-purpose.

Processes should be in place to validate the accuracy of outpatient service data and take corrective action where required, to ensure data quality and integrity.

11.3 Feedback from patients and referrers

A significant aspect of a highly patient-centred culture requires checking in with patients and carers to ensure that services are meeting their needs. It also means identifying opportunities for improvement and working together to develop strategies to improve the patient experience.

Patient and carer feedback systems may include patient surveys, real-time systems such as patient experience trackers, focus groups and consumer consultations.

Similarly, staff should be engaged in the feedback and improvement cycle, working together to evaluate and improve the service. This may occur through multidisciplinary staff meetings, quality improvement initiatives or other staff activities.
Appendix 1: Flow chart of outpatient service unit key processes
Appendix 2: Example of a standard referral form

<table>
<thead>
<tr>
<th>&lt;NAME OF OUTPATIENT SERVICE UNIT&gt;</th>
<th>Patient Referral Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;Address of unit&gt;</td>
<td></td>
</tr>
<tr>
<td>&lt;Phone, fax and email of unit&gt;</td>
<td></td>
</tr>
</tbody>
</table>

### Outpatient Clinic use only

<table>
<thead>
<tr>
<th>Referral received:</th>
<th>/</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referrer notified of receipt:</td>
<td>/</td>
</tr>
</tbody>
</table>

### Referral to:

#### Patient details

<table>
<thead>
<tr>
<th>Patient name:</th>
<th>Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Title:</th>
<th>Mr ☐ Mrs ☐ Ms ☐ Miss ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare number:</td>
<td>Date of birth: / /</td>
</tr>
<tr>
<td>Sex/gender:</td>
<td>M (male) ☐ F (female) ☐ X (indeterminate/intersex/unspecified) ☐</td>
</tr>
<tr>
<td>Compensable status:</td>
<td>DVA ☐ WorkCover ☐ Motor Vehicle Third Party Insurance ☐ Other ☐</td>
</tr>
<tr>
<td>Phone:</td>
<td>W (work) H (home) M (mobile)</td>
</tr>
<tr>
<td>Email:</td>
<td></td>
</tr>
<tr>
<td>Identifies as of Aboriginal or Torres Strait Islander origin:</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Interpreter required:</td>
<td>Yes ☐ No ☐</td>
</tr>
<tr>
<td>Language:</td>
<td></td>
</tr>
<tr>
<td>Carer name (if appropriate):</td>
<td>GP name (if not referrer):</td>
</tr>
<tr>
<td>Phone:</td>
<td>Phone/email:</td>
</tr>
<tr>
<td>Email:</td>
<td>Address:</td>
</tr>
</tbody>
</table>

### Clinical details

<table>
<thead>
<tr>
<th>Reason for referral: (including presenting symptoms -onset, duration and severity, if appropriate - and physical findings)</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Any previous treatment or investigations for referral condition: Yes ☐ No ☐</td>
<td>Description: (please attach investigation outcomes)</td>
</tr>
<tr>
<td>Any previous surgery: Yes ☐</td>
<td>Description:</td>
</tr>
<tr>
<td>Any other co-existing conditions: Yes ☐</td>
<td>Description:</td>
</tr>
<tr>
<td>Any current medication: (including any allergies) Yes ☐</td>
<td>Description and dosage:</td>
</tr>
</tbody>
</table>

---
### Referrer details

<table>
<thead>
<tr>
<th>Name:</th>
<th>GP ☐</th>
<th>Other ☐</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider number:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Signature:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date:</td>
<td>/</td>
<td>/</td>
</tr>
</tbody>
</table>

**Other details if required**
Appendix 3: Example of a letter or email to request further referral information

Enquiries to: <outpatient service unit name>  
<hospital name>  
Telephone: <telephone number>  
Fax: <fax number>

[date]  
<Referrer name>  
<Referrer address>

Dear <Referrer name>,

I am contacting you to advise that we received an incomplete referral form on <date referral received> for your patient:  
<Patient name>  
<Patient address>

Could you please provide us with the information required below within 20 days of the date on this letter, either by email to <email address>, by fax to <fax number>, or by return post.

<table>
<thead>
<tr>
<th>Information Required</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of clinic or specialist to whom the patient is being referred</td>
<td></td>
</tr>
<tr>
<td>Patient’s full name</td>
<td></td>
</tr>
<tr>
<td>Patient’s full address</td>
<td></td>
</tr>
<tr>
<td>Patient’s contact information – telephone number and email address</td>
<td></td>
</tr>
<tr>
<td>Patient’s gender</td>
<td></td>
</tr>
<tr>
<td>Patient’s date of birth</td>
<td></td>
</tr>
<tr>
<td>Patient’s Medicare number</td>
<td></td>
</tr>
<tr>
<td>Whether the patient identifies as Aboriginal or Torres Strait Islander</td>
<td></td>
</tr>
<tr>
<td>Whether the patient requires an interpreter, and if so what language is required</td>
<td></td>
</tr>
<tr>
<td>Whether the patient has special needs or requires reasonable adjustments due to a disability, and if so what is required</td>
<td></td>
</tr>
<tr>
<td>Patient compensable status if applicable (such as DVA, WorkCover, motor vehicle insurance)</td>
<td></td>
</tr>
<tr>
<td>Details of any associated medical conditions which may affect the condition or its treatment</td>
<td></td>
</tr>
<tr>
<td>Name of the patient’s carer (if appropriate) and contact details</td>
<td></td>
</tr>
<tr>
<td>Name of the patient’s GP (if not the referrer) and contact details</td>
<td></td>
</tr>
<tr>
<td>Current medications and dosages (include any drug allergies)</td>
<td></td>
</tr>
<tr>
<td>Referrer’s Medicare provider number (if a health professional)</td>
<td></td>
</tr>
<tr>
<td>Other (see below for details)</td>
<td></td>
</tr>
</tbody>
</table>

Please note that if we do not receive the information required, the patient will be removed from any outpatient services list related to this referral. We will notify both you and the patient of this in writing.

Thank you for your prompt attention to this request. If you have any queries, please contact our <insert position name and contact number>.

Yours sincerely

<Signature block>
Appendix 4: Behavioural Insights Unit text message trial outcomes

The Behavioural Insights Unit in the NSW Department of Premier and Cabinet used insights gained from the behavioural science literature to design seven new reminder messages that were tested against the standard message sent out by the hospital. The ‘avoided loss to hospital’ message (highlighted in the table below) was the highest performer and reduced DNAs by almost 20% compared to the standard message. More information is available from the Behavioural Insights Unit at BehaviouralInsights@dpc.nsw.gov.au.

<table>
<thead>
<tr>
<th>Name</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard message</td>
<td>You have an appointment with Dr [XXXXX] in [XXXXXX] on [Date] at [Time]. For enquiries, call 8382-3150. Do not reply.</td>
</tr>
<tr>
<td>Avoided loss to hospital</td>
<td>We are expecting you at [Clinic XXXXXX] to see Dr [XXXXX] on [Day] [Date] at [Time]. If you attend, the hospital will not lose the $125 we lose when a patient does not turn up. Call 8382 3150 if you need to cancel or rearrange.</td>
</tr>
<tr>
<td>Avoided loss to patients</td>
<td>We are expecting you at [Clinic XXXXXX] to see Dr [XXXXX] on [Day] [Date] at [Time]. By attending, the hospital will not lose the $125 that we lose when a patient does not turn up. This money will be used to treat other patients. Call 8382 3150 if you need to cancel or rearrange.</td>
</tr>
<tr>
<td>Aggregate loss to hospital</td>
<td>We are expecting you at [Clinic XXXXXX] to see Dr [XXXXX] on [Day] [Date] at [Time]. Last year the hospital lost $500,000 due to lost appointments. Call 8382 3150 if you need to cancel or rearrange.</td>
</tr>
<tr>
<td>Loss to hospital</td>
<td>We are expecting you at [Clinic XXXXXX] to see Dr [XXXXX] on [Day] [Date] at [Time]. If you do not attend, the hospital loses $125. Call 8382-3150 if you need to cancel or rearrange.</td>
</tr>
<tr>
<td>Loss to patients</td>
<td>We are expecting you at [Clinic XXXXXX] to see Dr [XXXXX] on [Day] [Date] at [Time]. If you do not attend, the hospital loses $125 that can be used to treat other patients. Call 8382-3150 if you need to cancel or rearrange.</td>
</tr>
<tr>
<td>Free not to attend</td>
<td>We are expecting you at [Clinic XXXXXX] to see Dr [XXXXX] on [Day] [Date] at [Time]. You are free not to attend but please call us on 8382 3150 if you need to cancel or rearrange.</td>
</tr>
<tr>
<td>Recording</td>
<td>We are expecting you at [Clinic XXXXXX] to see Dr [XXXXX] on [Day] [Date] at [Time]. Please attend or call 8382 3150 to cancel/rearrange, or we will record this as a missed appointment.</td>
</tr>
</tbody>
</table>
Appendix 5: Example of a letter to confirm patient appointment

<table>
<thead>
<tr>
<th>Enquiries to: &lt;outpatient service unit name&gt; &lt;hospital name&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone: &lt;telephone number&gt; Fax: &lt;fax number&gt;</td>
</tr>
<tr>
<td>Hospital reference number: &lt;patient UR&gt;</td>
</tr>
</tbody>
</table>

 Dante >

 <Patient name> <Patient address>

Dear <Patient name>

Thank you for confirming your appointment at the <outpatient service unit name>, details as below:

<outpatient service unit address>

<appointment time and date>

Attached is information about how to find the clinic and what to bring on the day.

If you are unable to attend this appointment, please advise us as soon as possible on <contact number>.

Yours sincerely

<Signature block>
Wayfinding information

Getting to the hospital

The <outpatient service unit name> is at <block name, hospital and street address>

Hospital map

Getting to the outpatient service unit

Plan your trip and find the best route to <hospital name> for you at 131500.com.au or call Transport NSW Information on 131 500.

Car parking

Parking is located on <street name> and rates are below

<table>
<thead>
<tr>
<th>parking rates information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

What to bring

Please bring the following to your outpatient services appointment:
<details of what to bring ie medicare card, scans, etc>

How long to allow for your appointment

The outpatient service unit will do its best to see you at the appointment time shown. These times are monitored as part of our commitment to ensure patients are seen at their given appointment time. In <month/year> patients were seen on average within <X minutes> of their outpatient service unit appointment time. Please call <contact number> as soon as possible so we can offer another patient the appointment time.
Appendix 6: Example of a letter or email to notify referrer of patient placement on appointment list

Enquiries to: <outpatient service unit name>
<hospital name>
Telephone: <telephone number>
Fax: <fax number>
Hospital reference number: <patient UR>

<date>
<Referrer name>
<Referrer address>

Dear <Referrer name>

I am contacting you to advise that as of <date> your patient:
<Patient name>
<Patient address>
has been placed on the <hospital name> outpatient services appointment list at <outpatient service unit name>.

The outpatient service unit team has reviewed the referral and the approximate time to an appointment is <weeks/months> from the date they were placed on the appointment list, as noted above.

When the patient is booked for the appointment, they will be advised by telephone of the proposed date and given further information to help prepare.

The patient has been advised to notify their GP if their condition changes, for a clinical review.

If you have any queries about the outpatient services appointment list or booking procedures, please contact our <position name and contact number>.

Yours sincerely

<Signature block>
## Appendix 7: Outpatient services improvement guide dashboard

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>DEFINITION / SOURCE</th>
<th>HOW TO IMPROVE</th>
</tr>
</thead>
<tbody>
<tr>
<td>☀ ACCESS TO SERVICES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The referrals the outpatient service unit receives are within the criteria for that unit. Patients receive timely access to appropriate care.</td>
<td>% of appropriate referrals</td>
<td><em>Numerator:</em> number of appropriate referrals meeting criteria for inclusion to service. <em>Denominator:</em> total number of referrals.</td>
</tr>
<tr>
<td>The referrals the outpatient service unit receives contain sufficient clinical information to triage the patient. Patients receive timely access to appropriate care. Outpatient service unit staff obtains relevant information at referral. Referrers make one referral, without having to send further information or new referrals.</td>
<td>% complete referrals</td>
<td><em>Numerator:</em> number of referrals meeting criteria for complete referrals. <em>Denominator:</em> total number of referrals.</td>
</tr>
<tr>
<td>Outpatient service unit systems are in place to manage incomplete referrals. Patients receive timely access to appropriate care. Outpatient service unit staff have a clear process for collecting information with predetermined timeframes.</td>
<td>Time to complete referrals within recommended parameters</td>
<td>Standardised or e-referrals that prompt for required information. Ready access to referral forms or published referral criteria stating necessary information.</td>
</tr>
<tr>
<td>Patients arrive at their initial appointment with sufficient work-up for a specialist to provide active treatment / make an active decision.</td>
<td>% of patients with complete work-up at initial appointment</td>
<td><em>Numerator:</em> number of patients with appropriate work-up for initial appointment, according to local guidelines. <em>Denominator:</em> total number of initial appointments.</td>
</tr>
</tbody>
</table>
### Referral Management

<table>
<thead>
<tr>
<th>Description</th>
<th>Formula/Approach</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>A system is in place for urgent patients to be seen in a timely manner.</td>
<td>% referrals assessed for urgency, within 5 days of receipt (Target: 100%)</td>
<td>Criteria developed to identify priority patients. Procedure in place for referrals to be triaged.</td>
</tr>
<tr>
<td>Patients receive timely access to care.</td>
<td>Numerator: number of new referrals triaged within expected timeframe.</td>
<td>Denominator: total number of new referrals.</td>
</tr>
<tr>
<td>Outpatient service unit staff can monitor types of referrals to ensure the unit schedule reflects actual demand. Referrers have confidence their patient will receive care in a clinically recommended timeframe.</td>
<td>Time from receipt of referral to appointment is within clinically recommended timeframes</td>
<td>Numerator: number of referrals seen within clinically recommended timeframes. Denominator: Total number of referrals.</td>
</tr>
<tr>
<td>Referrals are triaged for urgency to ensure patients have clinically appropriate access to care. Patients receive timely access to care. Outpatient service unit staff can monitor types of referrals received to ensure that the unit schedule reflects actual demand. Referrers have confidence that their patient will receive care in a clinically recommended timeframe.</td>
<td>% referrals assessed for urgency, within 5 days of receipt (Target: 100%)</td>
<td>Numerator: number of new referrals triaged within expected timeframe. Denominator: total number of new referrals.</td>
</tr>
<tr>
<td>All patients seen within their clinical priority category. Patients receive timely access to care. Outpatient service unit staff have a clear expectation and process for triaging patients. Referrers have confidence in services available and approximate waiting times for their patients.</td>
<td>Number of patients who wait longer than 365 days for an initial specialist outpatient service appointment (Target: 0)</td>
<td>Clear triaging process and criteria. Demand for services is compared to current resources and outpatient service unit capacity to ensure adequate.</td>
</tr>
<tr>
<td>Cancellation of patients’ appointments by specialist outpatient services are minimised. Patients receive timely access to care and are not unduly inconvenienced. Clinic staff have adequate knowledge of medical leave that can affect capacity of the outpatient service unit. Referrers have confidence in which services are available and the approximate waiting times.</td>
<td>% of hospital initiated cancellations</td>
<td>Manage staff leave. Regular review of outpatient service unit schedules to ensure adequate staff coverage.</td>
</tr>
</tbody>
</table>
## OUTPATIENT SERVICE UNIT MANAGEMENT

<table>
<thead>
<tr>
<th>DNA rates are monitored to ensure that capacity is maximised. Patients have clearly defined expectations and responsibilities. Outpatient service units have clear policies and procedures for minimising, responding to and recording DNAs.</th>
<th>% of appointments not attended (DNA) by patients</th>
<th>Numerator: did not attend (DNA) appointments. Denominator: All booked appointments.</th>
<th>Review outpatient service units 6 weeks out for schedule.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time spent in outpatient service units by patients is recorded and communicated. Patients are aware of time to be spent in the unit.</td>
<td>Time spent by patients in outpatient service unit</td>
<td>Time spent in outpatient service unit by patients – patient time of arrival to time of departure from unit.</td>
<td>Patient appointment bookings need to reflect the capacity of the outpatient service unit. Data can be obtained by patient satisfaction surveys and/or time stamp studies.</td>
</tr>
<tr>
<td>Patients have a positive experience of care.</td>
<td>Numbers of complaints</td>
<td>Numerator: number of complaints. Denominator: number of patients through outpatient service unit for the same period.</td>
<td>Centralised admin staff management. Clear communication to patients as to the waiting list and appointment process.</td>
</tr>
<tr>
<td>Patients are satisfied with the quality of care provided.</td>
<td>% of patients satisfied with their specialist outpatient services experience</td>
<td>According to patient survey.</td>
<td>Identify opportunities for improvement from patient perspective, identify strategies for improvement.</td>
</tr>
<tr>
<td>Patients and outpatient service unit staff have a safe and high quality experience.</td>
<td>Number of clinical incidents</td>
<td></td>
<td>Regular reviews of processes.</td>
</tr>
</tbody>
</table>

## TRANSFER OF CARE

<table>
<thead>
<tr>
<th>All patients and their GPs receive a detailed discharge letter detailing care +/- treatment given with follow up.</th>
<th>% discharge letters forwarded to referrer within five working days (Target: 100%)</th>
<th>Numerator: number of discharge letters sent within 5 working days. Denominator: total number of discharges for same period.</th>
<th>Standardised discharge letters. Design of outpatient service with patient experience and outcomes at the centre.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial appointments involve active treatment or decision making about care. Sufficient information at referral minimises need for patients to attend outpatient service unit for more appointments than necessary.</td>
<td>Service measure – initial/subsequent</td>
<td>Ratio of subsequent/review appointments to initial appointments.</td>
<td>Criteria-led discharge.</td>
</tr>
</tbody>
</table>
References


13. Health Services Act 1997 No 154, Chapter 3, Part 3, Section 31

14. Health Insurance Regulations 2018, Part 11, Division 4


