Guideline

Management of Outpatient (Non-Admitted) Services

Summary	This Guideline provides guidance to Local Health Districts and Specialty Health Networks on principles, procedures and processes to enable effective management of NSW Health outpatient services.
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Secretary, NSW Health

NSW Health
GUIDELINE

Management of Outpatient (Non-Admitted) Services

GUIDELINE SUMMARY

This Guideline sets out expectations for the management of outpatient services across NSW Health to ensure patients receive responsive and appropriate care that is patient-centred and focuses on outcomes that matter. It provides guidance for the planning, provision, and delivery of outpatient services. Adherence to this Guideline is intended to optimise outpatient care provided to the NSW population.

KEY PRINCIPLES

Local Health Districts and Specialty Health Networks are to use this Guideline to:

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

Articulating principles, procedures and processes for the optimal provision of outpatient services aims to improve patient and clinician experiences, and support patients to receive care within clinically recommended timeframes.

NSW Health organisations are to plan, deliver and manage outpatient services in accordance with this Guideline.

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 is to be respectful of, and responsive to the needs, values and preferences of patients.

Processes are to be in place to facilitate safe, timely and effective referral management. This includes ensuring referral screening takes place efficiently upon receipt of a referral, and appropriate management occurs thereafter. NSW Health organisations are, at a minimum, required to communicate with patients and referrers regarding referral receipt and triage outcome.

Categorisation of clinical urgency is based on clinical need, regardless of financial classification status or expected wait times. Every effort is to be made to ensure patients are seen within clinically recommended timeframes.

Active management of outpatient waitlists is to be part of routine processes to ensure timely access to care. This includes confirming waitlists are accurate and complete, managing changes in clinical urgency categories, waitlist suspensions, waitlist removals and waitlist reinstatements. In addition, waitlists are to be regularly audited as a core component of evaluating access performance and identification of potential risks.

Appointment management is to be patient-focused and take place based on clinical urgency and the 'Treat in Turn' principle. Adequate information is to be provided to patients to support accessing their outpatient appointment. Regular communication with referrers and General Practitioners (GPs), if not the referrer, should is to occur throughout the episode of care to maintain collaborative management of the patient.

Discharge (or transfer of care) planning is to commence at the first appointment with the aim to ensure patients are transferred back to the care of the referrer in a timely manner. Transfer of care summaries provided to referrers and/or GPs are to include ongoing management plans. Clear escalation pathways to streamline re-entry into outpatient services and forego the need for a re-referral are to be considered and communicated to referrers, where clinically indicated.

REVISION HISTORY

Version	Approved By	Amendment Notes
GL2023_014 April-2023	Deputy Secretary, Patient Experience and System Performance	Key changes include additional information on referral types and outcomes, communication with patients and referrers, governance arrangements, out-of-area referrals, waitlist management and service performance measures. Greater alignment to *Future Health*.
GL2019_011 July-2019	Deputy Secretary, Patient Experience and System Performance	Initial document

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1. BACKGROUND

NSW Health delivers healthcare services in emergency, surgery, 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.

Throughout this Guideline, the term ‘outpatient services’ is inclusive of all types of non-admitted care provided across multiple settings. This includes services provided at hospital-based clinics, community-based clinics and services delivered in patients’ homes.

Outpatient services assess, diagnose, and treat patients requiring clinical intervention beyond what is available in primary care, but that does not require admission to hospital. Outpatient services are a critical interface between inpatient care and primary care systems, and an important ongoing component in a patient’s care pathway.

Access to outpatient services 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 clinically and culturally safe, evidence based and reliable, and enable transparency around the performance of outpatient services and their ability to meet expectations.

This Guideline contributes to achieving NSW Health’s vision and aligns with strategic directions in the Future Health Strategy 2022-2032[1] [2], NSW Regional Health Strategic Plan 2022-2032[3], NSW Aboriginal Health Plan 2013–2023[4], NSW Virtual Care Strategy 2021-2026[5] and eHealth Strategy for NSW Health 2016–2026[6].

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

NSW Health recognises its responsibility to respond to climate risk, and environmental sustainability is one of six priority reform areas in the Future Health Strategy 2022-2032[1] [2]. Environmental sustainability is interlinked with other priorities including patient-centred care, accessibility, innovative models of care and optimising resources. These considerations are to be made alongside social and financial sustainability in terms of the design and delivery of outpatient services.

1.1. About this document

This Guideline 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 environmentally and financially sustainable services that are responsive to community need

- timely access to health services
- better integration of services across the system
- patient-centred care with a focus on outcomes, and
- transparent and meaningful performance targets informed by timely and reliable data.

Note: this Guideline may not be entirely applicable to some procedural, diagnostic and community-based services. In these cases, principles and processes in the Guideline are still to be followed, where possible.

1.2. Key definitions

Term	Definition
Aboriginal Controlled Community Health Services	Primary health care services initiated and operated by the local Aboriginal community to deliver holistic, comprehensive, and culturally appropriate health care to the community which controls it, through a locally elected Board of Management.
Clinically appropriate timeframe	Timeframe that meets professionally recognised standards of acceptable care.
Discharge	Agreed separation of patient from the outpatient service at completion of an episode of care.
Episode of care	A period of healthcare with a defined start and end. In the context of outpatient services, the start of the episode of care is the date of first attended outpatient appointment for a particular problem and the end of the episode of care is the date of last attended outpatient appointment for a particular problem.
Fly-in fly-out health practitioner	A health practitioner that temporarily visits a community to provide health care for a particular period, generally in regional, rural or remote areas.
General Practitioner	A medical practitioner who has postgraduate qualifications in general practice and who may have specialist registration as a General Practitioner.
Health practitioner (clinician)	A generic term used to describe a person who practices a health profession.
Incomplete referral	Where the minimum information required for safe, timely and effective clinical prioritisation is not available or is unintelligible.
Medical specialist	A medical practitioner who has completed advanced training in a medical specialty to diagnose and manage complex medical conditions.

Outpatient service (non-admitted service)	Services provided to patients: • Who do not undergo a formal admission process • Who do not occupy a hospital bed, and • By a recognised clinical team of one or more health practitioners within a hospital, community health service or multi-purpose service.
Patient-centred care	Care that is respectful of and responsive to individual patient preferences, needs, and values and emphasises a partnership approach between patients and health practitioners.
Primary care	Generally, the first point of contact for people to receive health care in the community.
Primary Health Networks	A national network of independent primary care organisations with the objective to streamline health services and better coordinate care.
Referral	A request for service within an outpatient service. This does not include follow-up requests for patients requiring an outpatient clinical review following separation from an inpatient episode of care.
Referrer	The individual who has issued a referral for a patient to an outpatient service.
State-wide referral criteria	Clinical-decision support tool to identify patients suitable to access an outpatient service and recommended clinical urgency category.
Wait time	Number of calendar days between the date of first referral receipt until the date of waitlist removal or census date. This excludes: • accumulative number of days a referral was awaiting further information (incomplete request) • accumulative number of days the patient was 'Not ready for care', and • accumulative number of days waiting at a less urgent clinical urgency category.

1.3. Legal and legislative framework

The *Health Services Act 1997* (NSW)[7] defines the public health system in NSW and prescribes functions and responsibilities for the provision of health services.

The *Health Services Act 1997* (NSW) also reaffirms the commitment of the NSW Government to the Medicare Principles and Commitments set out in section 26 of the *Health Insurance Act 1973* (Commonwealth)[8].

The *National Health Reform Agreement*[9] (NHRA) 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 2020-25 NHRA[10] demonstrates a joint commitment of the Commonwealth, and state and territory governments to continue providing increased funding for public hospitals and sets a new pathway for long-term reform of the Australian health system.

1.4. Guideline scope

1.4.1. Defining outpatient services

In outlining the scope of this Guideline, 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.

IHACPA 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 Health and Aged Care Pricing Authority (IHACPA). IHACPA 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:

- *In hospital outpatient clinics*
- *In community-based clinics*
- *In patients' homes"* [11].

The Definitions Manual[12] for the Tier 2 system 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.'*

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 [13].

Establishment Types are more granular than the national system and classify a service unit based on the services provided and the discipline or specialty of the usual healthcare provider. 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.

1.4.2. Services in scope

The full range of outpatient services operating within a Local Health District or Specialty Health Network are considered in scope of this Guideline. 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 2022-23[12]:

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.

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 and/or Clinical Nurse Specialists providing most services in a clinic.

Note: this Guideline may not be entirely applicable to some services within the 10, 30 and 40 series. In these cases, principles and processes in the Guideline are still to be followed, where possible.

1.5. Guideline principles

The Guideline is underpinned by the following principles:

- A patient-centred approach to care is adopted, where each person is respected as an individual and not as a problem or condition to be treated.
- NSW residents have access to outpatient services that are preferentially provided at a facility near their place of residence.

- Patients are seen within clinically recommended timeframes.
- Access is prioritised based on clinical need and with consideration to the patient's individual needs, level of vulnerability and disadvantage, and the broader impact upon the patient.
- Cultural considerations and recognition of past trauma associated with health services inform service delivery for priority populations, such as Aboriginal people and culturally and linguistically diverse communities.
- Care is integrated across all service settings.
- The outpatient service environment optimises the patient's experience.
- Timely and effective communication takes place between patients and referrers.
- Outpatient services are delivered in collaboration with other human services and justice agencies where applicable to promote safety, welfare, and wellbeing.
- The design and delivery of outpatient services contributes towards a financially and environmentally sustainable future.
- Evidence-based care and innovation to improve health outcomes that matter to patients, experiences of receiving care and experiences of providing care.

1.5.1. Patient-centred care

At the core of this Guideline 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 is to be respectful of, and responsive to the needs, values and preferences of patients.

Patient-centred care is particularly important among 'at risk', vulnerable, disadvantaged and priority populations, such as the young, elderly, people with a disability or mental illness, 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 people[14]. People in these populations can face inequity and communication difficulties that patient-centred care can help to address.

Adopting a value-based healthcare approach[15] helps to achieve patient-centred care and deliver the outcomes and experiences that matter to patients and the community.

Table 1 lists the key domains and topic areas that have been identified as most important to patients engaging with outpatient services [16] [17] [18].

Table 1: Key domains and topic areas identified as most important to patients engaging with outpatient services

Domains and topic areas that are most important to patients engaging with outpatient services, as identified by the Picker Institute Europe Review 2009 of NHS Outpatient Services, NSW Outpatient Survey 2014, NSW Outpatient Survey 2016	
Appointment and waiting	• understanding of appointment booking process • choice of hospital • length of wait to receive appointment date • flexibility of appointment date and time • ability for digital booking and cancellations • ability for digital record of all communications • receiving telephone call/SMS/email appointment confirmations and reminders • being told how long they would have to wait to be seen • receiving an apology and explanation if an appointment is delayed or cancelled • being told how to schedule a review appointment if needed
Facilities	• spacious and cheerful appearance in the waiting room or waiting area • good refreshment facilities nearby • good entertainment facilities, such as TV and books • good parking facilities – inexpensive, good availability, suitable payment method • better signage around the facility • availability of hand wash gels
Staff and interpersonal relationships	• having confidence and trust in the health professionals • feeling reassured • being treated as a human as opposed to a number • friendly, courteous, and empathetic reception staff • kind, polite, and respectful health professionals • being able to understand the explanations provided • having the opportunity to ask questions • involvement in decisions about care and treatment • awareness of medical condition • seeing same professional on repeat appointments • feeling able to complain if necessary • respect given to cultural and religious beliefs • receiving contact after a visit to follow-up on progress
Tests and treatments	• choice of treatment • information about where and when tests would take place • being told how long to wait for test results • test results being available when anticipated • being able to ask questions about test results • being fully informed about a treatment prior to it taking place

Information	• specific contact point to the outpatient service for more information • receiving important service and appointment information (including directions to clinic, what to bring, what to expect, what to do before and after) in verbal and written formats • receiving support and information to assist with self-management • cooperation and coordination of care between outpatient service and General Practitioner • receiving copies of the care plan • receiving copies of letters sent between outpatient service and General Practitioner

2. COMMUNICATION

Good communication is key to ensuring safe and high-quality outcomes throughout the patient journey. Clear and consistent communication is the basis of successful relationships and partnerships with patients and their carers, and all healthcare providers involved in outpatient services.

2.1. Key contact

Each hospital and community health facility are to have a single point of contact for enquiries about its outpatient services and referrals, with designated staff available to respond to information requests from General Practitioners, other referrers (internal and external) and the public.

All communication points and notifications to patients and referrers are to include this contact information.

2.2. Information about outpatient services available to referrers and patients

Different forms of information are to be available that are culturally and linguistically appropriate to the local communities and address the needs of those cohorts with specific communication requirements, such as people with cognitive impairment or challenges with hearing. Information about outpatient services and how they can be accessed are to be readily available on Local Health District, Specialty Health Network and individual hospital or community service websites, at a minimum, and are to include:

- outpatient services available at the facility
- criteria a patient is to meet to access the outpatient service
- any work-up that is to be completed before submitting a referral
- supporting information that is to accompany the referral (such as imaging, pathology test results), and
- alternative and/or supplementary options for care.

2.3. Referrals

Outpatient services are to, at a minimum, notify patients and referrers, in writing, of the acknowledgement of referral receipt and triage outcome. Notifications, in writing, may occur via SMS or email through system automated notifications, or letter.

Availability of state-wide referral criteria on the NSW Health website and through other relevant mechanisms (such as HealthPathways) is to provide greater transparency and consistency of referral requirements to access an outpatient service. Alternative care options is to be communicated to the patient and referrer in cases where a referral is redirected or not accepted and returned to the referrer.

Where there is a requirement for a very urgent or time-sensitive referral to be made prior to the referral being issued, communication is to occur between the referrer and a treating clinician from the nominated outpatient service via telephone for the referrer to advise of the clinical urgency based on clinical need.

2.4. Access and pathways to care

Outpatient services are to provide information regarding access for new appointments to patients, referrers and the community. Information regarding alternative pathways to receive care, including public and private care options, Aboriginal Community Controlled Health Services and non-government organisations, is also to be provided. Providing this information has the potential to assist patients and referrers to make informed decisions regarding the most appropriate care and management pathway.

2.5. Ongoing communication

Continuous contact with the referrer and General Practitioner, if not the referrer, from the point of referral receipt and throughout the episode of care is vital to establish and maintain collaborative management of the patient.

Clear and consistent communication is to be maintained with the patient and the referrer throughout the patient journey. This includes on receipt or transfer of the referral, while on the outpatient waitlist, following the first appointment, during the episode of care, and at the point of discharge.

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

All communication with the referrer and General Practitioner, if not the referrer, is to be documented in writing.

Clear and consistent communication is required for patients requiring follow-up care resulting from an inpatient admission or following an outpatient attendance. This includes information about future scheduled appointments and relevant contact details for the outpatient service.

3. DELIVERY OF OUTPATIENT SERVICES

3.1. Planning

Section 10 of the *Health Services Act 1997* (NSW)[7] states a function of Local Health Districts is to promote, protect and maintain the health of the residents in their area.

Health planning informs the nature of the outpatient services each Local Health District or Specialty Health Network provides, including specialties, 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 inpatient (admitted) or primary care settings. It occurs at the state, Local Health District or Specialty Health Network, and local level and involves consumers, clinicians, administrative and executive staff of Local Health Districts and Specialty Health Networks, Primary Health Networks, General Practitioners, medical and non-medical specialists, and other healthcare providers, such as Aboriginal Community Controlled Health Services and non-government organisations.

Local Health Districts and Specialty Health Networks are to determine what outpatient services to provide to meet the needs of its community. Where community need is unable to be met, Local Health Districts and Specialty Health Networks are to establish pathways to other appropriate services to ensure the needs of the community are met.

With a focus on the achievement of outcomes, Commissioning for Better Value[19] may be used as a framework when planning outpatient services.

Appropriate governance processes are to be in place for the establishment and modification of outpatient services. This includes registering a new outpatient service in HERO[20] in alignment with the classification principles[21] as well as updating service information on HealthPathways, NSW Health websites and other relevant mechanisms.

Formal governance arrangements in the form of Local Health District or Specialty Health Network and facility or service committees are to be in place to provide oversight and accountability of outpatient service planning, delivery and performance with a focus on value and outcomes for patients, carers and the broader health system.

3.2. Continuous quality improvement

Outpatient services are encouraged to undergo a regular process of continuous quality improvement to enhance outpatient service delivery and performance.

This may involve:

- networked approaches towards outpatient service planning and provision
- analysis of service needs through referral, wait time and appointment data
- analysis of ‘Did Not Attend’ rates, including specific services, specialties, appointment types or patient groups that have high rates
- analysis of utilisation of resources and waste, including equipment, consumables, and other disposable products
- consideration of embedding virtual care as a service modality option

- testing and evaluating alternate approaches to service delivery, including nurse-led or allied health-led models and requests for specialist advice
- reviewing the literature for alternative models of care and innovation that achieve better patient care outcomes and reduce low-value care, are clinically appropriate and meet community need
- utilising feedback from patients, clinicians, and other staff about opportunities for improvement, and
- information sharing to understand current practices between outpatient services on a national and international scale.

3.3. Managing Privately Referred Non-Inpatient services

The management of Privately Referred Non-Inpatient (PRNIP) services in relation to billing practices are outside the scope of this Guideline. Refer to the following documents for further information:

- Addendum to National Health Reform Agreement (2020-2025)[10], and
- Health Insurance Regulations 2018 (Commonwealth)[22].
- NSW Health *Fees Procedures Manual for Public Health Organisations*[23]
- NSW Health Guideline *Medicare Billing for Privately Referred Non-Inpatient Services in NSW Public Hospitals* (GL2021_005)[24]
- NSW Health Policy Directive *Registered Non-Inpatients in Recognised Hospitals* (PD2005_501)[25]

3.4. Managing demand and capacity

Outpatient services are to have processes in place to manage high service demands and articulate how this is differentiated from the care provided in primary care.

Potential strategies to manage demand and capacity may include reducing low-value care, minimising the number of unnecessary review appointments, and utilising the expertise of nursing, midwifery, allied health professionals and Aboriginal Health Practitioners to help reduce patient burden and optimise service capacity.

Every effort is to be made to ensure referrers understand what can and cannot be referred, and what options are available when a referral does not meet the referral criteria for a given outpatient service. Equally, patients are to be advised and supported through alternative pathways when their care needs can be more appropriately met through another outpatient service.

Referral pathways are to support primary care providers, such as General Practitioners, and other healthcare providers to make referrals for patients to access outpatient services, and systems are to recognise the ability of patients to self-refer, where appropriate.

3.5. Clinical governance

3.5.1. Duty to appropriately manage outpatient services

There are several processes throughout an outpatient service journey, all of which involve a duty to the patient to appropriately manage outpatient services. The organisation or individual who assumes the duty to the patient is dependent on the process. For example, there is to be a duty on a Local Health District or Specialty Health Network to appropriately manage referrals, waitlists and appointments for outpatient services provided to the community.

The duty to the patient applies throughout the outpatient service journey. This includes once a referral has been received by a Local Health District or Specialty Health Network, when a referral is accepted by a Local Health District or Specialty Health Network, and throughout the episode of care until the patient is transferred back to the care of the referrer or General Practitioner, if not the referrer.

For a patient on an outpatient waitlist, the duty includes the Local Health District or Specialty Health Network to make reasonable efforts to provide outpatient care, regardless of the modality used (such as virtual care, in the home, etc.) within clinically appropriate timeframes, communicating with patients, referrers and the General Practitioner, and responding to information on changes to the patient's condition.

3.5.2. Fly-in fly-out health practitioners and outreach services

Local Health Districts or Specialty Health Networks that use fly-in fly-out (FIFO) practitioners and/or provide outreach services are to establish clear arrangements with locally based services. This includes:

- an understanding of clinical interactions in line with local role delineation
- appropriate credentialing for outpatient service function
- clinical record keeping and medical record sharing
- clinical care in the absence of the FIFO practitioner
- clinical governance
- quality improvement initiatives
- compliance with mandatory reporting requirements, and
- service planning.

3.6. Ceasing or restricting the provision of outpatient services

Section 31 of the *Health Services Act 1997* (NSW)[7] states that Local Health Districts may cease or restrict health services under their control, subject to certain steps being taken.

Local Health Districts are to assess, on a case-by-case basis, whether a particular health service is to be ceased or restricted.

Before implementing any decision to cease or restrict the provision of an outpatient service, Local Health Districts are to comply with the requirements under section 31 of the *Health Services Act 1997* (NSW) including notifying the Health Secretary of the decision and

ensuring the decision is appropriate having regard to the Local Health District's functions, and the needs of its population.

3.7. Care provision partnerships

3.7.1. Local Health District and Specialty Health Network partners

Where outpatient services are provided through a cooperative arrangement between facilities, or Local Health Districts and Specialty Health Networks, a written service agreement, or equivalent, is to clearly identify the service with the responsibility for each aspect of the clinical and administrative functions. Such agreements are to have clear, specific and outcome-based goals.

3.7.2. Private and community partners

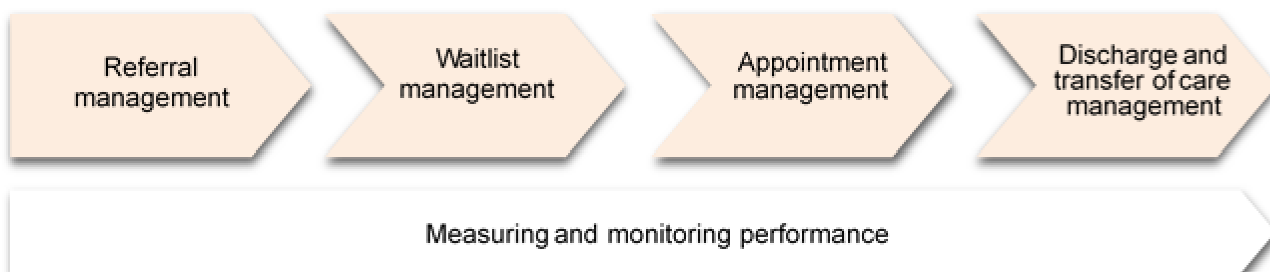
Opportunities to implement collaborative models of outpatient services with the private sector and other community service partners (such as Aboriginal Community Controlled Health Services, and non-government organisations) may be actively pursued through regular communication and service planning activities.

Where outpatient services are provided through a cooperative arrangement between the private sector and/or other community service partners, written service agreements, or equivalent, are to 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 Guideline. Such agreements are to have clear, specific and outcome-based goals.

4. OVERVIEW OF KEY PROCESS AND TIMEFRAMES

4.1. Key processes and recommended timeframes

This Guideline provides support regarding the following key processes involved in managing an outpatient service:



The 'Referral management' stage commences from receipt of an outpatient referral and ends when the patient is added to the outpatient waitlist, or when a referral is returned to a referrer.

The 'Waitlist management' stage commences when the patient is added to the outpatient waitlist and ends when the patient attends their new appointment or is otherwise removed.

The 'Appointment management' stage commences when an appointment is scheduled for a patient and ends when a decision has been made to discharge a patient or transfer care to the referrer, or alternative care setting (such as an inpatient ward).

The ‘Discharge and transfer of care management’ stage commences when a decision has been made to discharge a patient or transfer care to the referrer, or alternative care setting, and ends when the patient has been discharged or care is transferred back to the care of the referrer, or alternative care setting.

4.2. Recommended timeframes

Table 2 summarises the recommended timeframes for actions associated with the above key processes, excluding the following periods:

- accumulative number of days ‘Incomplete request’
- accumulative number of days ‘Not ready for care’ (on a waitlist), and
- accumulative number of days waiting for a less urgent category

Note: In the context of this Guideline, ‘days’ refers to calendar days.

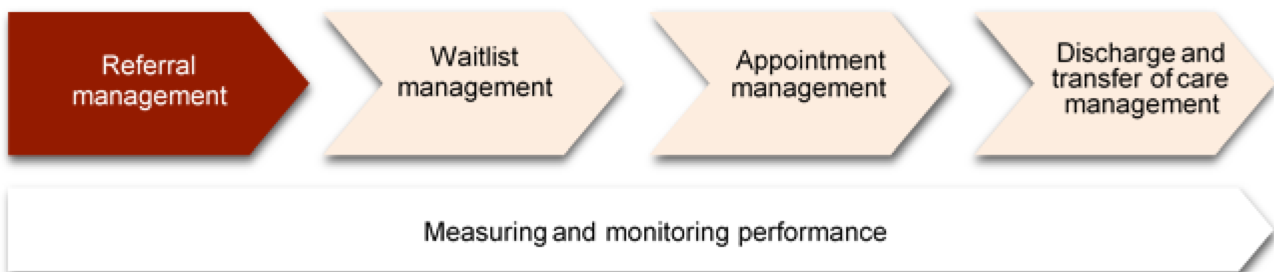
Table 2: Recommended timeframes for outpatient service management

Process	Guideline section		Key action	Recommended timeframe/regularity
Referral management	Referral screening	5.4.	Referrals are screened to ensure prompt registration, redirection, reassignment or return	Within 7 days of referral receipt
	Managing duplicate referrals	5.6.	Referrers are notified, in writing, of the duplicate	Within 7 days of referral receipt
	Managing incomplete referrals – notifying the patient and referrer	5.7.1.	Outpatient service requests for further information from referrer	Within 7 days of referral receipt
	Managing incomplete referrals – receipt of further information	5.7.2.	Referrer provides requested information to outpatient service	Within 14 days of request if further information is required
	Non-accepted, redirected, and reassigned referrals – non-accepted referrals	5.8.1.	Patients and referrers are notified, in writing, of the reason the referral is not accepted and recommendation for alternative care	Within 7 days of referral receipt

Process	Guideline section		Key action	Recommended timeframe/regularity
	Non-accepted, redirected, and reassigned referrals – redirected referrals	5.8.2.	Patients and referrers are notified, in writing, of the redirection	Within 7 days of the referral redirection
	Accepted referrals	5.15.	Referrals are clinically prioritised through the allocation of a clinical urgency category	Within 7 days of referral receipt
	Clinical urgency categories – Urgent	5.17.2.	Patients with referrals categorised as 'Category 1 – Urgent' are seen	Within 30 days of referral receipt
	Clinical urgency categories – Semi-urgent	5.17.3.	Patients with referrals categorised as 'Category 2 – Semi-urgent' are seen	Within 90 days of referral receipt
	Clinical urgency categories - Non-urgent	5.17.4.	Patients with referrals categorised as 'Category 3 – Non-urgent' are seen	Within 365 days of referral receipt
Waitlist management	Registration on the waitlist	6.2.	Accepted referrals are added to the outpatient service's waitlist	Within 7 days of referral acceptance
	Notifying the patient and referrer	6.3.	Patients and referrers are notified, in writing, of the acceptance of the referral	Within 7 days of referral acceptance
	Readiness for care – Not ready for care	6.6.2.	Maximum accumulative timeframe for 'Category 1 – Urgent' patients who are not ready for care	15 days
			Maximum accumulative timeframe for 'Category 2 – Semi-urgent' patients who are not ready for care	45 days
			Maximum accumulative timeframe for 'Category 3 – Non-urgent' patients who are not ready for care	180 days

Process	Guideline section		Key action	Recommended timeframe/regularity
	Waitlist auditing	6.9.	Outpatient services are to actively review, monitor and manage waitlists to support patients to be seen within clinically recommended timeframes	Weekly desktop audit Patient contact audit for patients on the outpatient waitlist for greater than six months without a scheduled appointment and have not been audited within the previous six months
Appointment management	Types of appointments – new appointments	7.2.1.	Referrers, and General Practitioners, if not the referrer, are notified when the patient has attended their new appointment	Within 14 days of the appointment date
Discharge and transfer of care management	Discharge summary on transfer of care	8.5.	Patients, their referrer, and General Practitioners are notified when the patient is discharged, or care has been transferred	Within 14 days of discharge from the outpatient service

5. REFERRAL MANAGEMENT



In the context of this Guideline, a referral is a request for service within an outpatient service. The information in a referral is considered a form of clinical handover and is to provide adequate information for safe transfer of care.

The primary objective of referral management is to ensure safe, timely clinical prioritisation.

5.1. Referral types

Table 3 displays the multiple types of referrals that outpatient services may receive. Each referral type involves different referral management processes.

Table 3: Referral types

Type	Sub-type	Description
New referral	External referral	A new referral to an outpatient service from a referrer external to NSW Health (e.g., General Practitioner, medical specialist in private practice). This includes self-referrals. A new, external referral would require a decision to accept the referral and the allocation of a clinical urgency category by the receiving service or clinician.
	Internal referral	A new referral to an outpatient service from a referrer internal to NSW Health (e.g., clinician within a public hospital or community health facility, District or Network, including 'out of area' referrals from other Districts or Networks). A new, internal referral would require a decision to accept the referral and the allocation of a clinical urgency category by the receiving service or clinician. Internal referrals include: - Referrals resulting from an Emergency Department presentation - Referrals from an inpatient admission for a condition that is unrelated to the reason for admission - Referrals from an outpatient attendance for a different, unrelated condition to the same or different outpatient service. - A clinician requesting an assessment, investigation, or diagnostic test from another clinician within the same public hospital or community health facility for a different condition. A new, internal referral does not include follow-up requests for patients requiring an outpatient clinical review following separation from an inpatient episode of care (see section 5.1.1.).
	Associated care referral	A sub-type of a new internal referral, requesting the involvement of another outpatient service to support the care of a patient for the same condition that was originally referred. For example, Ear, Nose & Throat referring to Speech Pathology for the same condition. Associated care referrals would require a decision to accept the referral and the allocation of a clinical urgency category by the receiving service or clinician.
Updated referral		An updated referral received following the acceptance of a new referral that contains additional information or requests for a patient that has not yet attended a new appointment and is currently on an outpatient waitlist. Such referrals require clinical review, and a decision regarding whether a patient may need a change in their clinical urgency category, or a removal from a waitlist.
Continuation referral		A referral that supports the ongoing management of a patient for an existing episode of care beyond the current referral validity period. Such referrals are to be clinically reviewed, and there is no need for a decision to accept the referral nor the allocation of a clinical urgency category by the receiving service or clinician.

5.1.1. Follow-up requests

Follow-up requests are requests for an appointment following the separation from an inpatient admission and/or outpatient service under the same specialty, clinician or clinical team. Such requests are directly scheduled for an appointment and do not require screening, triaging or management on an outpatient waitlist. The amount of time required for a review appointment is typically less compared to a new appointment.

Appendix 1 illustrates key characteristics of each outpatient referral type and follow-up requests.

5.2. Delivery modes

The delivery mode by which a referral is communicated is to ensure that referrals are provided in the timeliest manner, with all the required content, that is able to be securely received by the intended service on the first submission.

Where available, electronic referrals (e-Referrals) is to be used by referrers for sending and receiving referrals.

In some instances, it is possible and appropriate that a written referral document may follow a verbal referral, to ensure timely access to care. This may occur in instances of very urgent or time-sensitive referrals.

For example, a General Practitioner may phone the on-call registrar who accepts the referral and provides an outpatient appointment date or time, potentially to avoid an attendance to the Emergency Department. In this example, the written referral document that subsequently follows is to include relevant information from the verbal discussion with the on-call registrar to assist with appropriate processing and clinical handover, and the referral date is the date of the phone call (not the date that a written referral document was subsequently provided).

5.3. Referral requirements

Outpatient services are to have processes in place to ensure the following items are available, at a minimum, for all referrals to accurately identify the patient and service needs. Items include:

- patient’s full name
- patient’s date of birth
- patient’s sex
- patient’s presenting problem (onset, duration and severity) and/or condition based on provisional diagnosis
- requested outpatient service, and
- referrer’s details.

Every effort is to be made to ensure referrals also capture the following items to support with the identification of patient and service needs:

- patient’s address of usual residence

- patient's contact number
- patient's medical history (such as previous treatment, other relevant diagnoses, recent investigations, current medications and dosages, immunisations, allergies/adverse reactions)
- patient's suitability for virtual care, if required
- patient's Aboriginal and Torres Strait Islander status
- patient's requirement for an interpreter (if so, list preferred language)
- patient's special needs or reasonable adjustments to be made
- patient's willingness for surgery, if required, and
- reason for referral (such as new condition, deterioration in existing condition).

5.4. Referral screening

Referrals are to be screened **within 7 days** of receipt to ensure prompt registration, redirection, reassignment or return.

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

- determine the type of referral
- identify the patient
- ensure all required referral components are complete and accessible, and
- identify relevant service(s) requested to enable assignment to appropriate team or clinician.

If the referral passes screening, the referral is to progress to clinical prioritisation.

In some instances, referral screening may take place simultaneously with clinical prioritisation.

Where referrals do not pass screening, such referrals may be deemed incomplete.

See section 5.7. for the management of incomplete referrals.

5.5. Outpatient referrals register

All types of referrals received, regardless of the outcome, are to be registered within an outpatient referrals register, or system, to monitor and support the management of referrals.

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

- provide current, accurate and timely information on referrals and their status, and
- generate reports to support performance monitoring and reporting.

The register is to capture and report on include:

- all referral requirements listed in section 5.3.
- referral type

- type of healthcare provider making the referral (referral source)
- presenting problem or condition(s) for which the patient has been referred
- specialty or service to which the patient has been referred
- date the referral is made by referrer (this date is to reflect when the referrer issued the referral)
- date the referral is first received by the receiving Local Health District or Specialty Health Network (this date is not to be changed, even if the referrer is asked to provide additional information)
- date when the referrer was sent an acknowledgement of referral receipt
- date when the referrer was asked for further information, if applicable
- date when the referrer provided any additional information, if applicable
- date when the referral was clinically prioritised
- referral outcome (whether the referral was accepted or, if not, the reasons for non-acceptance)
- referral clinical urgency category, if applicable
- HERO service unit(s) patient is/are assigned to, and
- periods of 'Request incomplete', including start date, end date and reason.

5.6. Managing duplicate referrals

Outpatient services are to have processes in place to identify and manage duplicate referrals.

A duplicate referral is where a copy of the same referral is received. In these cases, the receiving outpatient service is to flag the referral as a duplicate in the relevant outpatient referrals register or referral management system.

Where appropriate, referrers are to be notified, in writing, of duplicate referrals **within 7 days** of referral receipt.

In cases where there is insufficient evidence to confirm the presence of a duplicate referral, a review is to be undertaken by a clinical representative in the outpatient service.

5.7. Managing incomplete referrals

Outpatient services are to have processes in place to identify and manage incomplete referrals.

An incomplete referral is where the minimum information required for safe, timely and effective clinical prioritisation is not available or is unintelligible. In these cases, the receiving outpatient service is to liaise with patients and/or referrers to obtain this information. This is to occur in a timely manner to ensure the patient is not disadvantaged in accessing care in the outpatient service.

Where a referral can be safely and appropriately clinically prioritised, other missing information (such as contact details) is to be collected concurrently or following clinical prioritisation. In these cases, referrals are not to be classified as ‘Request incomplete’.

5.7.1. Notifying the referrer and patient

For instances of an incomplete referral, outpatient services are to notify referrers **within 7 days** of referral receipt of the requirement for the necessary information.

The following information is to be included in the notification for incomplete referrals:

- available patient demographics (such as name, date of birth, sex)
- referral identification (such as presenting problem or condition, receiving specialty or service, receipt date)
- stating the referral is incomplete
- reason(s) why the referral is incomplete
- information/action(s) required to complete the referral
- advising referrers to return the complete referral within 14 days from the date of notification, or the referral may not be able to be accepted, and
- contact information to outpatient service for further information.

The outpatient service is to inform the patient that a request has been made to the referrer for further referral information and the reason(s) why the referral is incomplete.

Consideration is to be given to the time sensitivity and level of urgency of the referral, with referrals clearly identified as ‘Urgent’ prioritised to ensure patients are not disadvantaged due to awaiting further information. Where a referral requires further information urgently, the referrer is to be contacted via telephone for the missing information.

At the time the referrer has been requested for more information, the referral is to be classified as ‘Request incomplete’.

Any request for further information is to be documented to support with communication and auditing processes.

5.7.2. Receipt of further information

As part of the notification for further information, referrers are to be requested that the additional information is to be provided **within 14 days** of request.

Upon the receipt of further information, the referral is to be updated and progressed to clinical prioritisation.

In instances where requests for further information have not been provided within 14 days, outpatient services may advise the referrer that the referral is not able to be accepted. In these cases, the referral is to be classified as ‘Not accepted’, stating further information was not supplied by the referrer, and the patient and referrer are to be notified of this outcome. Any decision to not accept a referral with missing information is to consider the patient and referrer’s individual circumstances, and time sensitivity and level of urgency of the referral.

If further information has been received and the referral remains incomplete, the outpatient service is to make direct contact with the referrer to finalise the referral information and avoid further delay.

5.8. Non-accepted, redirected and reassigned referrals

The decision to not accept, redirect or reassign a referral is influenced by various factors.

Appendix 2 illustrates examples of circumstances when referrals may be not accepted (such as returned), redirected and reassigned.

Note: these circumstances are not intended to be exhaustive and are to be assessed on a case-by-case basis.

5.8.1. Non-accepted referrals

Referrals may not be accepted if the referral is not appropriate for the receiving outpatient service or if alternative care is considered more appropriate. Appropriate reasons for not accepting referrals include:

- referral does not meet state-wide referral criteria, where available, or in the absence of state-wide referral criteria, the referral does not meet locally defined referral criteria
- referral is not clinically appropriate for the service
- incomplete referrals where further information is not received upon request, and
- service capacity limitations exist and an equivalent, appropriate, and timelier outpatient service that addresses the patient's needs can be identified. The original outpatient service is to confirm the referral can be accepted by the nominated, alternative outpatient service and agreed to by the patient, at a minimum.

The following reasons are inappropriate for not accepting referrals:

- referral does not satisfy requirements for Medicare billing[23]
- financial classification of the patient
- blanket rejection of out-of-area referrals where they have not been assessed on a case-by-case basis whether it is necessary or desirable to access the health service, and
- service capacity limitations where an equivalent, appropriate and timelier outpatient service that addresses the patient's needs is **not** able to be identified. For example, it would **not** be appropriate to decline a referral due to long wait times without identifying an appropriate alternative service that the patient would be able to access within a shorter period.

Patients and referrers are to be notified, in writing, of non-accepted referrals **within 7 days** of referral receipt.

The following information is to be included in the notification to patients and referrers for non-accepted referrals:

- available patient demographics (such as name, date of birth, sex)

- referral identification (such as presenting problem or condition, receiving specialty or service, receipt date)
- stating the referral was not able to be accepted
- reason(s) why the referral was not able to be accepted
- advice or recommendation(s) for alternative care options, and
- advice to the patient to contact the referrer and outpatient service for more information.

5.8.2. Redirected referrals

Referrals may be redirected to another outpatient service within the same facility, Local Health District or Specialty Health Network where a clinical decision has been made that a care pathway other than the receiving outpatient service is more appropriate.

The receiving outpatient service is to make a reasonable attempt to redirect the referral to the appropriate specialty or service within the facility, Local Health District or Specialty Health Network. For example, a patient who is referred to an Orthopaedic clinic may be redirected to a Physiotherapy clinic if deemed more appropriate to address the patient’s needs.

Patients, referrers and General Practitioners, if not the referrer, are to be notified, in writing, of the redirection **within 7 days** of the referral being screened and/or clinically prioritised and deemed not appropriate for the receiving outpatient service.

Where it has been deemed appropriate to redirect a referral and the redirection may have a meaningful impact towards a patient (such as extensive travel, accessibility considerations), outpatient services are to seek agreement for the redirection from the patient.

5.8.3. Reassigned referrals

Referrals may be reassigned to another outpatient service within the same facility, Local Health District or Specialty Health Network where the outpatient clinic name addressed on the referral is not accurate, but the specialty is appropriate, and the referral only requires updating with the correct clinic name.

For example, a patient who is referred to a Fracture clinic may need to be re-assigned to an Orthopaedic clinic if the local practice is all fractures are managed by the Orthopaedic clinic.

The practice of reassigning a referral is not to have meaningful implications for the patient or referrer as this is an administrative exercise with no clinical decision-making required. As such, there is no requirement to notify patients, referrers and General Practitioners, if not the referrer, of the reassignment.

5.9. Managing internal referrals

Access to outpatient services is to be based upon clinical need and independent of referral source. That is, all else being equal, patients referred from an external referral source are to have equivalent access as those referred from an internal source. The same standards are also to be applied for referral screening and clinical prioritisation.

Accepted new, internal referrals are to be managed through an outpatient waitlist as per the standard for all types of new referrals.

Common internal referral sources include the Emergency Department and inter-specialty referrals.

Where appropriate, internal referrals are to be limited to instances where a patient requires urgent (within 30 days) access to outpatient care for a different problem or condition.

New, internal referrals for different conditions that are clinically prioritised as 'Semi-urgent' (within 90-days) or 'Non-urgent' (within 365-days) are not to be generated nor accepted except for associated care referrals (see section 5.9.1.). Instead, the treating clinician is to advise the patient's General Practitioner, whereby a decision can be made regarding the need for a referral and appropriate care pathway aligned with the patient's needs and preferences.

In all instances of internal referrals, including associated care referrals (see section 5.9.1.), the patient's General Practitioner is to be notified of the referral that has been generated.

5.9.1. Associated care referrals

An associated care referral is a sub-type of a new, internal referral. These are internal referrals requesting the involvement or support of another clinical service for the same problem or condition that is currently being managed. For example, a patient with knee osteoarthritis who is receiving care from a Rheumatology service may be internally referred to an Orthopaedic service and/or Physiotherapy service for assistance with management of the knee osteoarthritis.

If the reason for referral is for a different problem or condition to the presenting problem or condition, then the referral is not to be classified as associated care.

Unlike other forms of internal referrals, associated care referrals are exempt from the 'Urgent only' rule. That is, 'Semi-urgent' (90-days) and 'Non-urgent' (365-days) referrals may be generated and accepted for associated care referrals.

5.10. Managing updated referrals

An updated referral occurs when additional information, or updated information, is provided for a patient who has not yet attended a new appointment and is currently on an outpatient waitlist. This may or may not arise from the original referral source.

Updated referrals are to be clinically reviewed.

Based on the information within the updated referral, a decision may be made to change the current clinical urgency category of the patient (such as escalation to a higher urgency category) or possibly removal from a waitlist.

Patients, referrers and General Practitioners, if not the referrer, are to be notified, in writing, of the outcome of the updated referral.

5.11. Managing continuation referrals

A continuation referral supports the ongoing management of a patient who has commenced an outpatient episode of care.

Continuation referrals apply where patient is no longer on the outpatient waitlist, has attended at least one appointment and requires care beyond the current referral validity period.

Continuation referrals are received close to or following the expiration of the current referral validity period, or in cases where updated clinical information from the referrer will support patient care.

5.12. Out of area referrals

Out-of-area referrals occur when referrals are received by an outpatient service for a patient residing in another Local Health District.

Section 10(c) of the *Health Services Act 1997* (NSW)[7] states that Local Health Districts are to give residents outside its area, access to health services it provides as may be necessary or desirable.

The decision to issue and accept out-of-area referrals is to be considered on a case-by-case basis.

Prior to a decision being made to issue and/or accept an out-of-area referral, consideration is to be given to the availability for appropriate care to be provided to the patient in a setting closer to the patient's residence and/or where care is in alignment with a patient's needs.

Reasons for out-of-area referrals are to be clearly stated on the referral to inform receiving outpatient services of the reason the referral was made to that specific location.

Referrals received from out-of-area are not to be declined without reasonable alternative care options provided to the patient and referrer.

5.13. Referrals from private sector

Patients are to be prioritised for access to care based on their clinical need, irrespective of the referral source. All else being equal, a patient referred or otherwise redirected from a medical specialist in private practice is not to be granted earlier access to a public outpatient service relative to a patient with the same clinical needs referred from a General Practitioner or other referral source. Such patients are not to 'jump' the outpatient waitlist as this has the potential to disadvantage patients with more clinically urgent needs.

Medical specialists in private practice who decide to redirect a referral to a public outpatient service are to do so with the patient and referrer's consent. The redirected referral is to include information noting the patient and referrer have consented to the redirection. This is to ensure patients and referrers provide informed consent and the patient and referrer anticipates any subsequent correspondence from the public outpatient service.

If a medical specialist in private practice redirects a referral to a public outpatient service and has the authority to triage the same referral (for example, works in a public outpatient service and has the clinical authority to triage referrals), the triage outcome is to be provided with the referral. Such referrals are considered 'pre-triaged'.

5.14. Pre-triaged referrals

Pre-triaged referrals are a sub-group of referrals that occur when the clinical urgency has been determined prior to or at referral receipt. This reduces the need for the referral to be

sent for further clinical triage within the outpatient service, avoiding duplication of work and more timely access to care.

Pre-triaged referrals may occur when a referral is received from a medical specialist in private practice who has the authority to triage a referral for the public outpatient service.

For example, where a referral has been redirected from a medical specialist in private practice and a clinical urgency category has already been assigned by that clinician. Triage practices and outcomes are not to differ between referrals clinically prioritised in the private sector and referrals clinically prioritised within the public outpatient service.

Another scenario is where the service request has been accepted and clinically prioritised prior to the receipt of the physical referral document. This could occur in instances of urgent referrals where a General Practitioner phones an on-call registrar and the patient is booked into the next available outpatient clinic. In this case, the registrar has accepted and clinically prioritised the referral before the physical referral document has been submitted or received by the outpatient service. Where such instances exist, the referrer is to be requested to include a record of the discussion in the referral with the agreed plan. The referral receipt date and waitlist start date are the date that the registrar was first contacted by the referrer, and not the date that the physical referral document was received.

Other instances include circumstances where blanket triage rules are in operation. This may include outpatient services that receive referrals from an Emergency Department, whereby all referrals may be pre-triaged as ‘Rapid access’ upon receipt.

Pre-triaged referrals do not need to be sent for further clinical triage within the outpatient service. This is to ensure the timely provision of care and improve the efficiency of referral management.

Pre-triaged referrals are to have a triage outcome date that is the same as the referral received date.

Note: referrals with a suggested clinical urgency (for example, recommendation made by the referrer and still require clinical triage) are not equivalent to pre-triaged referrals (for example, outcome made by a triaging clinician).

5.15. Accepted referrals

A referral is deemed accepted when satisfying eligibility requirements (such as referral criteria) and assignment of a clinical urgency category has been made.

Processes are to be put in place to accept referrals from internal and external healthcare providers including patient self-referral (where referral from a healthcare provider is not required), where appropriate.

Patients and referrers are to be notified, in writing, of the acceptance of the referral **within 7 days** from referral receipt.

The following information is to be included in the notification to patients and referrers for accepted referrals:

- patient demographics (such as name, date of birth, sex)

- referral identification (for example, presenting problem or condition, receiving specialty or service, receipt date)
- stating the referral was accepted
- relevant prioritisation or timeframe based on clinical urgency category (such as 'Category 1' and/or 'Within 30 days')
- access considerations for a new appointment with the outpatient service for the patient's clinical urgency category, and
- contact information to the outpatient service for further information.

5.16. Facilitating service access

Local Health Districts and Specialty Health Networks are to actively monitor the current volume and trends in new referrals to outpatient services to ensure there is capacity to see patients within clinically recommended timeframes.

Where a service is not provided or capacity is limited, the Local Health District or Specialty Health Network are to consider arranging for the referral to be accepted by an alternative healthcare provider. See section 5.8. for more information on non-accepted, redirected or reassigned referrals.

5.17. Clinical urgency categories

Categorisation of patients by clinical urgency category is required to ensure care is provided in a timely, equitable and clinically appropriate manner. A clinical urgency category is based on the patient's clinical need, regardless of their financial classification or election status. This is to be appropriate to the patient and their clinical condition, and not influenced by current wait times or service demand and capacity.

5.17.1. Rapid access

'Rapid access' is the clinical urgency category that can be used within outpatient services that require patients to be seen in a timeframe that are unable to wait up to 30 days for an appointment.

The 'Rapid access' category is not standardised to a particular timeframe, but instead is booked according to the needs of the patient. For example, some 'Rapid access' patients may receive care on the day of the referral whilst other patients may receive care within one week.

A 'Rapid access' appointment can be used for patients requiring immediate access to an outpatient service. These appointments do not form part of reporting for wait times for care but are included in new patient activity performance measures.

Patients suitable for a 'Rapid access' appointment may include appropriate patients diverted from Emergency Departments and patients referred with a clearly demonstrated rapid need for specialist outpatient assessment and care (such as referral from an Emergency Department for management of a fracture in an Orthopaedic clinic).

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.

5.17.2. Category 1 – Urgent (30 days)

Referrals are to be categorised as 'Urgent' if the patient's clinical condition, as identified from referral details, is clinically recommended to be seen **within 30 days** of referral receipt.

5.17.3. Category 2 – Semi-urgent (90 days)

Referrals are to be categorised as 'Semi-urgent' if the patient's clinical condition, as identified from referral details, is clinically recommended to be seen **within 90 days** of referral receipt.

5.17.4. Category 3 – Non-urgent (365 days)

Referrals are to be categorised as 'Non-urgent' if the patient's clinical condition, as identified from referral details, is clinically recommended to be seen **within 365 days** of referral receipt.

5.18. Clinical prioritisation in individual disciplines

Patients are to be assigned a clinical prioritisation (urgency) category based on their clinical need, and not based on wait times, service demand and capacity, financial classification or election status.

Clinical prioritisation is to be guided by state-wide referral criteria and triage guidelines, where they exist. Variations from established criteria and guidelines are to be documented with clinical reasoning.

In some clinical areas, it may be necessary to further sub-categorise patients to ensure appropriate management of clinical risks. Sub-categorisations may be used sparingly to best meet patient and operational needs. For reporting purposes, local sub-categorisations are to map to the next standardised clinical urgency category. For example, if a service elects to use a 180-day sub-category, the referral is to map to the 365-day standardised clinical urgency category for reporting. Similarly, if a service elects to use a 60-day sub-category, the referral is to map to the 90-day standardised clinical urgency category.

5.18.1. Approaches for clinical prioritisation

The most appropriate staffing model for clinical prioritisation depends on the outpatient service and the patient group.

The use of nursing, midwifery and allied health professionals for clinical prioritisation has been shown as safe and effective in many specialties. This is provided, there are clear prioritisation guidelines and access to medical specialist advice in cases where the patient's clinical urgency category is difficult to determine.

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

In some cases, outpatient services may employ a centralised triage model, whereby all referrals received are clinically prioritised by a single member of the clinical team for a defined period. This can be performed using a rostered approach to distribute the workload among clinicians within the outpatient service.

Outpatient services are to develop a referral business continuity plan to ensure high quality, timely referral management during instances of planned and unplanned staff leave.

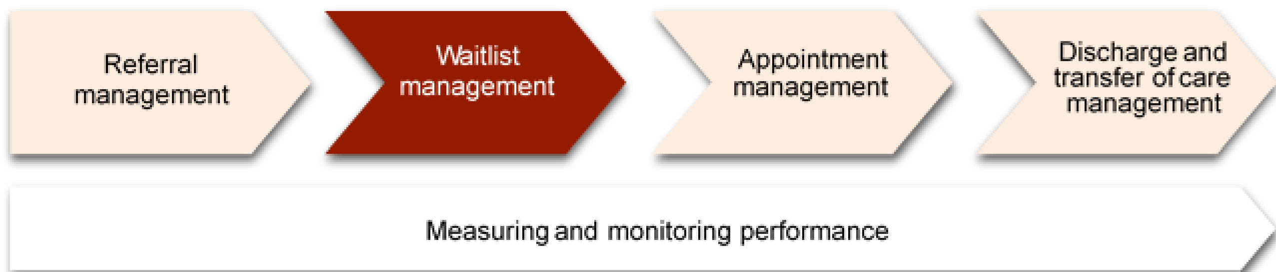
5.18.2. Timeframes for clinical prioritisation

Outpatient services are to ensure referrals are prioritised within a clinically appropriate timeframe. This is essential to managing clinical risk and efficient management of referrals.

Appropriate prioritisation is to occur as follows:

- prioritisation **within 7 days** of referral receipt, and
- where referrers have contacted the service regarding the need for a very urgent or time-sensitive referral, earlier prioritisation and appointment scheduling may be required.

6. WAITLIST MANAGEMENT



6.1. Waitlist structure

Patients on an outpatient waitlist are patients of the Local Health District or Specialty Network, not of a particular clinician. This means that care can be provided by any appropriately qualified clinician employed or engaged by the Local Health District or Specialty Network.

Wherever possible, outpatient services are to use the smallest number of waitlists that are clinically appropriate for their services. In many instances, this involves using a single ‘pooled’ waitlist for a given outpatient service or subspecialty.

Patients on a pooled outpatient waitlist are to be ‘treated in turn’ and offered an appointment based on their clinical urgency category and time waited.

Consideration is to be given to establishing a centralised outpatient waitlist across a Local Health District or Specialty Network for a given specialty or service. This may avoid duplication of outpatient waitlists across facilities, reduce burden on referrers, manage disruptions in service delivery, such as staff leave, and improve equity of access to outpatient services.

Separate outpatient waitlists are not to be:

- used for individual clinicians working within a clinical team, unless this is required for clinical reasons, and
- constructed for patients with different financial classifications. This is to ensure that a patient's financial classification does not influence access to an outpatient service.

6.2. Registration on the waitlist

Access to outpatient services is to be provided by registering new, accepted referrals on the waitlist of a given outpatient service.

Registration on the outpatient waitlist is to occur **within 7 days** of referral acceptance.

In limited instances, a waitlist registration may be created retrospectively to accommodate for very urgent, time-sensitive appointments.

Note: the waitlist start date is the referral received date. In many cases, the waitlist create date (such as the date the waitlist was created) will be after the waitlist start date.

6.2.1. Waitlist registration exclusions

A patient cannot be registered on an outpatient waitlist if they:

- are already known to be on an outpatient waitlist at another facility for management of the same reason for referral, or
- require an outpatient review appointment (such as post-surgery, post-admitted care, post-outpatient attendance) (see section 5.1.1.).

6.3. Notifying the patient and referrer

Outpatient services are to notify the patient and referrer of the placement on the outpatient waitlist **within 7 days** of referral acceptance.

The following information is to be included in the notification for waitlist registrations:

- patient demographics (such as name, date of birth, sex)
- referral identification (for example, presenting problem or condition, receiving specialty or service, receipt date)
- confirmation of the name of the outpatient service
- relevant prioritisation or timeframe based on clinical urgency category (such as 'Category 1' or 'Within 30 days')
- information about access considerations for a new appointment with the outpatient service for the patient's clinical urgency category
- confirmation of the waitlist start date
- the maximum 'Not ready for care' timeframe for the clinical urgency category (see section 6.6.2.)

- need for the referrer or General Practitioner if not the referrer, to continue to provide care and regular clinical review for the patient until their outpatient appointment
- advice that failing to attend the new appointment without prior notification may result in removal from the waitlist
- advice that more than two deferments of an appointment offer may result in removal from the waitlist
- advice to keep the outpatient service updated of any change in the patient's clinical condition or changes in contact details, and
- contact information to the outpatient service for enquiries relating to the referral, waitlist and/or appointment.

Note: this notification is to occur simultaneously to referral acceptance and may therefore replace the notification to patients and referrers for an accepted referral (see section 5.15.).

6.4. Transfer of care to alternative service

In cases where a patient is on an outpatient waitlist and it has been deemed appropriate to transfer care of a patient to an alternative service, outpatient services are to seek agreement for the transfer of care from the patient.

Where patients agree to be transferred to an alternative service, the sending outpatient service is to:

- document the patient's agreement
- notify the referrer and General Practitioner, if this is not the referrer, and
- document all communication about the patient transfer and ensure this is retained in the patient's medical record and the outpatient referrals register.

For all patients on the outpatient waitlist who are being transferred to an alternative service, their referral history is to reflect the receipt of the referral before the alternative offer was made. This aims to ensure an accurate record is maintained of time elapsed before the patient is seen. In addition, the patient's current clinical urgency category (if applicable) is to be maintained, unless altered after clinical review of the referral information by the new treating clinician.

The alternative service is to:

- be a specific and credible alternative, and available if the patient agrees to the transfer of care. The alternative service is to account for the circumstances of each patient, such as age, Aboriginal and Torres Strait Islander status, mobility, available support, mode of transport, physical condition, and the required procedure, and
- include the name of the receiving outpatient service, hospital or community service and an estimate of the wait time to access the service.

Patients is still to be registered on the outpatient waitlist by the original outpatient service until the referral is accepted by the receiving outpatient service. All information regarding the outpatient waitlist and referral(s) is to be transferred to the receiving outpatient service.

Note: the wait time is not to be reset when a patient is transferred between outpatient services.

Where a patient has been booked at one facility and subsequently has the appointment provided at a different facility:

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

Where patients decline the offer to be transferred to an alternative service, the original outpatient service is to liaise with the patient to understand the reasons for declining and provide support with addressing barriers to transferring care to the alternative service.

6.5. Active waitlist management

Outpatient services is to have routine processes in place to actively review and manage waitlists. Active waitlist management strategies for outpatient services include, but are not limited to:

- regular communication with patients and General Practitioners
- regular updates on changes to clinical status or contact details
- auditing processes, including clinical and administrative auditing, such as error checks)
- duplicate checks, including cross-check with elective surgery list and across outpatient services for the same condition
- outlier checks, such as administrative errors, unexpected findings
- awareness of current waitlist status against clinically recommended timeframes
- management of patients who 'Did Not Attend' a new appointment from a waitlist
- management of suspensions, including review date
- management of reinstatements, and
- governance, such as nominated position(s) and clear accountabilities to ensure optimal waitlist management, including triggers for escalation.

6.6. Readiness for care

Outpatient services are to have processes to identify the readiness for care of all patients. This is to be classified as 'Ready for care' or 'Not ready for care' in terms of their ability to accept an offer of appointment for an outpatient service.

6.6.1. Ready for care

'Ready for care' patients have been assessed as requiring an outpatient appointment by a relevant clinician and the patient indicates they are available to attend an appointment for an outpatient service.

6.6.2. Not ready for care

‘Not ready for care’ patients are not able to accept an outpatient appointment. This may occur in the following circumstances:

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

Patients may have more than one period of being ‘Not ready for care’.

If a new appointment is rescheduled by a patient, the outpatient service is to suspend the count of days waiting from the original appointment date that was cancelled, by assigning a ‘Not ready for care’ status, until the date of the rescheduled appointment.

If a new appointment is rescheduled by the outpatient service, it is not appropriate to assign the patient with a ‘Not ready for care’ status.

In instances where a patient has been escalated to a more urgent clinical urgency category, any ‘Not ready for care’ days accrued at the less urgent clinical urgency category are not to be included in the calculation of accumulated ‘Not ready for care’ days. Conversely, in instances where a patient has been de-escalated to a less urgent clinical urgency category, any ‘Not ready for care’ days accrued at the more urgent clinical urgency category are to be included in the calculation of accumulated ‘Not ready for care’ days.

The maximum accumulative timeframes for being ‘Not ready for care’ are as follows:

- 15 days for ‘Urgent’ patients
- 45 days for ‘Semi-urgent’ patients
- 180 days for ‘Non-urgent’ patients.

Patients are to be notified of the maximum accumulative ‘Not ready for care’ timeframes upon placement on the outpatient waitlist (see section 6.3.).

If a patient defers on more than two occasions and/or exceeds the maximum accumulative timeframe of being ‘Not ready for care’ for their clinical urgency category, consideration may be given to removing the patient from the outpatient waitlist.

Where patients are awaiting a surveillance procedure or appointment that is clinically indicated to take place in the distant future, it may be appropriate for patients to exceed the maximum accumulative timeframe of being ‘Not ready for care’ for their clinical urgency category. In these circumstances, such patients are not to be removed from the waitlist.

Where a patient is classified as ‘Rapid access’ or ‘Urgent’ and wishes to cancel or postpone their appointment, or where the maximum accumulative timeframe for ‘Not ready for care’ is breached for any clinical urgency category, escalation to a clinical delegate is required to approve this request. In these cases, the patient is to be contacted to discuss the nature of the cancellation or postponement, and potential implications. The outcome is to be documented.

Outpatient services are to regularly review patients with a ‘Not ready for care’ status to ensure these patients are given the opportunity to be ready for care within the maximum accumulative timeframe for their clinical urgency category.

Note: wait times exclude periods of time where a patient is categorised as ‘Not ready for care’.

6.7. Removal of patients from waitlists

Outpatient services are to use systems and processes to ensure that the removal of patients from waitlists are undertaken by an authorised staff member in line with appropriate reasons for removal.

Consistent with the principles of patient-centred care, outpatient waitlist removals are to occur on a case-by-case basis to ensure the needs of ‘at risk’, vulnerable and priority populations are considered and to avoid disadvantaging patients in the event of genuine hardship, misunderstanding or other unavoidable circumstances. The reason for removal is to be recorded in the patient administration system and the patient’s medical record.

Patients are to be removed from the outpatient waitlist once they have attended a new appointment in the relevant outpatient service, irrespective of delivery mode. All patients removed from the outpatient waitlist in these circumstances are deemed ‘Ready for care’ with the appropriate clinical urgency category assigned.

Note: patients are not to be removed from the outpatient waitlist once a new appointment has been scheduled, and the patient is yet to attend a new appointment.

Table 4 lists reasons for removal from the outpatient waitlist and the suggested actions associated with the waitlist removal.

Table 4: Reasons for outpatient waitlist removals

<table>
<tr><th>Reason</th><th>Suggested Actions</th></tr>
<tr><td>Patient attended new outpatient appointment</td><td>Removal of patient from the waitlist</td></tr>
<tr><td>Patient-initiated cancellation and/or rescheduling on two consecutively booked appointments</td><td rowspan="3">For ‘Rapid access’ and ‘Urgent’ patients, a clinical team member are to contact the patient to:
- Understand the reason for the cancellation/missed appointment or deferment, and re-book an appointment, where applicable, or
- Authorise the waitlist removal.
Documentation of the date of removal, outcome, and reason, if known, is to occur.
Communication to referrer and patient informing of removal within 7 days, including reason for removal.</td></tr>
<tr><td>Patient fails to attend a new outpatient appointment without prior notification</td></tr>
<tr><td>Patient is not ready for care for a period that is greater than the maximum accumulative timeframe permitted for their urgency category</td></tr>
<tr><td>Patient requests removal from outpatient waitlist (for example, seeking care elsewhere, care no longer required)</td><td rowspan="3">Documentation of the date of removal and outcome is to occur.
Communication to referrer informing of removal within 7 days, including reason for removal.</td></tr>
<tr><td>Referrer withdraws the referral</td></tr>
<tr><td>Clinic-initiated removal (for example, patient is seen in the private sector, following clinical review)</td></tr>
</table>

Reason	Suggested Actions
Patient is not contactable on two reasonable attempts, including at least two different modes of communication	
Patient is deceased	

6.8. Reinstatement of patients to the waitlist

In cases where a patient has been removed from the outpatient waitlist but notifies the outpatient service they wish to be reinstated to the waitlist, this request is to be escalated to an authorised delegate.

Consistent with the principles of patient-centred care, a patient's individual circumstances and 'at risk' status is to be carefully considered as part of decision-making for reinstatement onto the outpatient waitlist.

If a decision is made to re-instate the patient onto the waitlist, the waitlist entry may be suspended from the waitlist removal date to the date of reinstatement.

In instances of waitlist reinstatements after a patient fails to attend a new appointment, the 'Not ready for care' period is to be applied from the date of the 'Did Not Attend' appointment until the date of the new, scheduled appointment. A 'Not ready for care' period is not to be added in instances where the waitlist reinstatement is due to a facility, clinician or administrative error.

Documentation is to capture the date of reinstatement and reason(s) for the reinstatement.

Confirmation of the outcome with the patient and referrer is to occur.

6.9. Waitlist auditing

Outpatient services are to have processes in place to audit the waitlist to provide a true representation of the number of patients awaiting a new appointment.

Outpatient services are to work towards the following timeframes for auditing the waitlist:

- weekly desktop audit, and
- patient contact audit for patients on the outpatient waitlist for greater than six months without a scheduled, new appointment and have not been audited within the previous six months.

6.9.1. Desktop audit

Outpatient services are to undertake desktop audits on a weekly basis to ensure the waitlist is accurate and up to date.

A desktop audit of the outpatient waitlist is to be conducted by an administrative staff member, where available, to confirm the following, at a minimum:

- check for duplicate outpatient waitlist entries
- check a clinical urgency category has been assigned for every patient

- identify patients whose clinically recommended timeframe (based on the clinical urgency category assigned) will be exceeded in the next 7 days
- identify patients whose ‘Not ready for care’ period (based on the maximum accumulative timeframes) will be exceeded in the next 7 days
- identify patients who have attended a new outpatient appointment in the last 7 days and ensure they have been removed from the outpatient waitlist
- identify patients who have requested removal from the outpatient waitlist in the last 7 days and ensure they have been removed from the outpatient waitlist
- identify patients who have had their referrals withdrawn from a referrer in the last 7 days and ensure they have been removed the outpatient waitlist
- identify patients who have been not contactable on two reasonable attempts, including at least two different modes of communication, in the last 7 days and ensure they have been removed from the outpatient waitlist
- identify patients who have deceased in the last 7 days and ensure they have been removed from the outpatient waitlist, and
- identify patients who have been deemed suitable for outpatient waitlist removal for other reasons in the last 7 days and ensure they have been removed from the outpatient waitlist.

Outcomes of the desktop audit are to be documented and reported to a nominated senior staff member in the outpatient service. This may include the Head of Department, or equivalent, and/or other senior non-clinical staff members in the outpatient service.

6.9.2. Patient contact audit

Outpatient services are to audit patients who are on the waitlist for greater than six months without a scheduled, new appointment and have not been audited within the previous six months to update details and ascertain whether an appointment is still required.

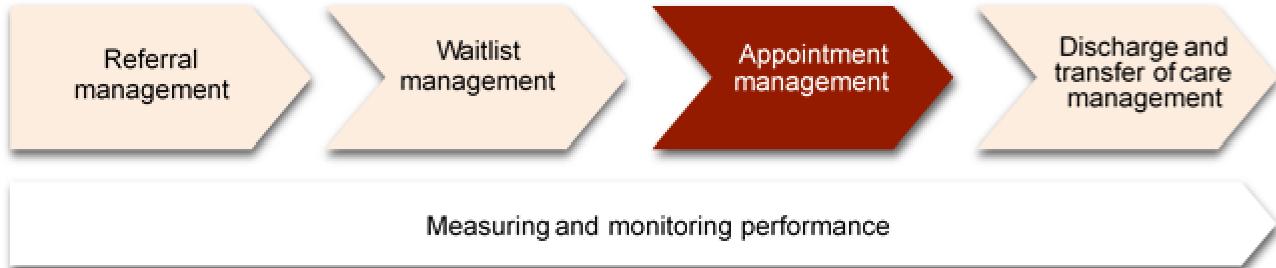
A patient contact audit of the outpatient waitlist may be administrative or clinical. If any clinical information is collected, the patient contact audit is to be conducted by a clinician. In all cases, the patient contact audit is to be undertaken through a telephone call to confirm the following, at a minimum:

- the patient’s details are correct, including contact information, referrer and General Practitioner details, and
- if the patient still requires an appointment.

Patients may be re-prioritised after clinical review in response to new information provided by the referrer or patient.

Where re-prioritisation occurs, the waitlist entry is to be updated, including the new clinical urgency category, and the reason and date of the re-prioritisation.

7. APPOINTMENT MANAGEMENT



7.1. Types of appointments

7.1.1. New appointments

A new appointment is an appointment for a patient that is booked from the waitlist of a given outpatient service. It does not include post-discharge review for an admitted patient episode.

New appointments typically require a longer duration as the patient's problem or condition would be unknown to the clinician or clinical team.

Referrers, and General Practitioners, if not the referrer, are to be notified when the patient has attended their new appointment **within 14 days** of the appointment date. This notification is to include all relevant information to support safe, timely and collaborative management of the patient.

7.1.2. Review appointments

A review appointment is an appointment where a patient is not booked from the waitlist of a given outpatient service. This is either as a follow-up after an inpatient admission or after an attended appointment.

Review appointments are for the continuing management or treatment of the problem or condition until the patient is discharged from the outpatient service.

Review appointments also occur where a patient is followed up by a different member of the same clinical team for the same problem or condition.

Review appointments typically require a shorter duration as the patient's problem or condition would be known to the clinician or clinical team.

7.2. Scheduling

7.2.1. New appointments

New appointments are to be scheduled from the outpatient waitlist using the 'Treat in Turn' principle[26] (i.e. based on a patient's clinical urgency and time spent on the waitlist).

All attended, new appointments are to be associated with a removal of the patient from the outpatient waitlist.

‘Rapid access’ and ‘Urgent’ patients are to be allocated a new appointment immediately upon acceptance of the referral and placement on the waitlist. In limited instances, waitlist registrations may be created retrospectively, where necessary, to avoid barriers in providing very urgent or time-sensitive appointments.

Outpatient services are to comply with the NSW Health Policy Directive *Client Registration Policy* (PD2007_094)[27] to ensure mandatory data requirements are fulfilled at the time of booking new appointments and when a patient attends their new appointment.

7.2.2. All appointments

Outpatient services are to give patients as much notice as reasonably appropriate before the appointment.

Factors that are not to influence the scheduling of all appointments include the referral source, patient’s financial classification, election status or place of residence, or clinician’s preferences.

Outpatient services are to take into consideration an individual’s circumstances when scheduling appointments. Considerations include the need to travel long distances, concurrent appointments, appointment dependencies (such as imaging, pathology, other investigations), availability of interpreter resources, availability of patient supports (such as parents, carers, staff escorts) and access to technology or devices.

Allowances are to be made to accommodate patients with additional needs, such as significant mobility impairment, intellectual disability, or communication difficulties. In these instances, appointments may need to be scheduled for an extended period to ensure all patients receive an equivalent standard of care.

Where practical, patients are to be booked into individual and staggered appointment times proportional to the number of clinicians working in the outpatient service, rather than all patients booked at one given time. That is, a patient is to receive an appointment time instead of all patients receiving the same arrival time.

Where practical and clinically appropriate, patients are to be booked with the same clinician or clinical team at each appointment for continuity of care.

7.3. Delivery modes

There are various modes of service delivery available for outpatient appointments. These include, but are not limited to, in-person and virtual care modalities, such as audio (telephone) and audio-visual (videoconferencing).

The delivery mode for a given appointment is to be selected based on clinical appropriateness and in alignment with patient preferences. This may change over time based on patient needs and the care journey.

Virtual care offers considerable advantages for some patients, especially in rural or remote areas or where travel to access healthcare services is inconvenient. The use of virtual care in outpatient service or other appropriate care settings also promotes environmental sustainability by reducing carbon emissions from patient transportation.

Where virtual care has been deemed clinically appropriate and circumstances do not enable a patient to attend an appointment in person, a reasonable attempt is to be made to exhaust all virtual care options to ensure a patient is able to attend the appointment through an alternative means (such as use of telephone instead of videoconferencing).

For more information on virtual care, visit the NSW Health Virtual Care website.

7.4. Patient-focused bookings

Outpatient services are to schedule appointments consistent with the concept of patient-focused bookings. That is, when an appointment becomes available, patients are notified or contacted to schedule an appointment and a conversation between the outpatient service and patient is to occur, where practical, to ensure an appointment is booked optimally aligned with the patient's needs and preferences.

Patient-focused bookings aim to reduce the number of patient-initiated cancellations, rescheduled appointments and 'Did Not Attend' rates as well as improve patient satisfaction.

7.5. Communication with patients about the appointment

Patients are to receive the following information, at a minimum, in written form prior to an outpatient appointment:

- name of the outpatient service
- 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, location and delivery mode of appointment – with wayfinding information or relevant instructions to access an appointment delivered through virtual care, whichever is appropriate
- parking information, including concessional parking (if applicable)
- investigations needing to be performed before the appointment
- what to bring, such as x-rays, investigation results and Medicare card
- other information needed to prepare for the appointment
- the clinical team responsible for their care
- a contact person in the outpatient service for further information
- special requirements (if applicable)
- how to reschedule or cancel appointments, and
- implications of failing to attend an appointment (for example, potential removal from the outpatient waitlist if patient reschedules or cancels two consecutively booked appointments or fails to attend a new appointment without prior notification).

Appointment reminders are to be issued to patients and/or carers, where possible, to minimise the occurrence of non-attended appointments.

Outpatient services are to consider the use of different formats in communicating with patients about their appointments to maximise the accessibility of health information.

7.6. Patient-initiated cancellations and rescheduling

Outpatient services are to have processes in place to minimise patient-initiated cancellations and rescheduling of outpatient service appointments and support appropriate use of resources if appointment cancellations occur.

When a patient requests to cancel or reschedule an outpatient appointment, outpatient services are to:

- consider if the patient is on the outpatient waitlist and, if so, consider the patient's status on the waitlist (such as 'Ready for care' or 'Not ready for care') as well as the clinical urgency category of the patient
- consider the history of the appointment, including any prior cancellations or reschedules
- consider removal from the outpatient waitlist where the patient has previously deferred a booked appointment or has breached the maximum accumulative timeframe of 'Not ready care' for their clinical urgency category.
    - For 'Rapid access' or 'Urgent' patients, removal is to be authorised from a clinical team member. Where applicable, the referrer and patient are to be notified, in writing, of the outpatient waitlist removal within 7 days, including reason for removal (see section 6.8.).
- document the patient-initiated cancellation or request to reschedule.
    - This is to include the date the patient contacted the service, staff member who liaised with the patient, requestor (such as patient, parent, sibling), reason for cancellation or reschedule, and outcome (for example, removal from the waitlist, appointment rebooked).
- aim to reschedule the appointment as early as possible, and
- aim to fill the vacated appointment time with another patient, if appropriate.

7.7. Managing 'Did Not Attend'

High 'Did Not Attend' rates in outpatient services tend to be associated with long wait times, poor communication with patients, simultaneous referrals to multiple services of the same type, unnecessary review appointments, and variable patient input into appointment times.

In cases where 'Rapid access' or 'Urgent' patients do not attend a new appointment, a member of the clinical team is to attempt to contact the patient to understand the reasons for the 'Did Not Attend'. The interaction or contact attempt is to be documented , including the date, the clinician who contacted the patient, reason for 'Did Not Attend', and outcome (such as removal from the waitlist, appointment rebooked).

The patient's needs and individual circumstances are to always be considered when deciding the outcome for the patient in response to a 'Did Not Attend'.

If a patient fails to attend an outpatient service appointment, the patient are to be sent written notification of the 'Did Not Attend' and invited to contact the outpatient service to rebook the appointment.

The following information is to be included in the written notification:

- outpatient service or clinic
- appointment date and time
- clear statement that the appointment was not attended
- if removed from the waitlist, include the reason (see section 6.8.), and
- contact information to the outpatient service to rebook the appointment, if required.

7.8. Clinic-initiated cancellations and rescheduling

Outpatient services are to maintain records of clinic-initiated cancellations and reschedules. If a patient's appointment is required to be cancelled or rescheduled, the outpatient service is to:

- give the patient as much notice as possible
- consider the patient's status on the outpatient waitlist and clinical urgency category of the patient
- consider the history of the appointment, including any prior cancellations or reschedules
- document the clinic-initiated cancellation or request to reschedule. This is to include the date the outpatient service contacted the patient, staff member liaised with patient, reason for cancellation or reschedule, and outcome (such as removal from the waitlist, appointment rebooked)
- aim to reschedule the appointment as early as possible, and
- aim to reschedule the vacated appointment time for use by another patient, if appropriate.

Outpatient services are to implement strategies to minimise clinic-initiated cancellations and reschedules while maximising service efficiency. Strategies include, but are not limited to:

- managing planned staff leave
- managing scheduled equipment maintenance, and
- regular review of cancellation causes.

7.9. Managing 'Did Not Wait'

A 'Did Not Wait' outcome occurs when patients arrive for a scheduled appointment but did not receive care. This may be due to appointment delays, unforeseen unavailability of clinicians, emergency appointments, appointment errors and personal circumstances.

For 'Rapid access' or 'Urgent' patients, this is to be escalated to a member of the clinical team to avoid delays in care or a postponement.

Outpatient services are to consider the needs of individuals who cannot wait for a scheduled appointment that has been delayed or postponed.

In some instances, outpatient services may wish to provide:

- assistance and reimbursement for transport home
- the opportunity to discuss issues that might arise because of the postponement with a clinical team member, and/or
- the name and contact details of a staff member if they require further information.

Outpatient services are to make every effort to rebook the patient's appointment prior to patients who 'Did Not Wait' leaving the facility.

7.10. Outcomes of attended appointments

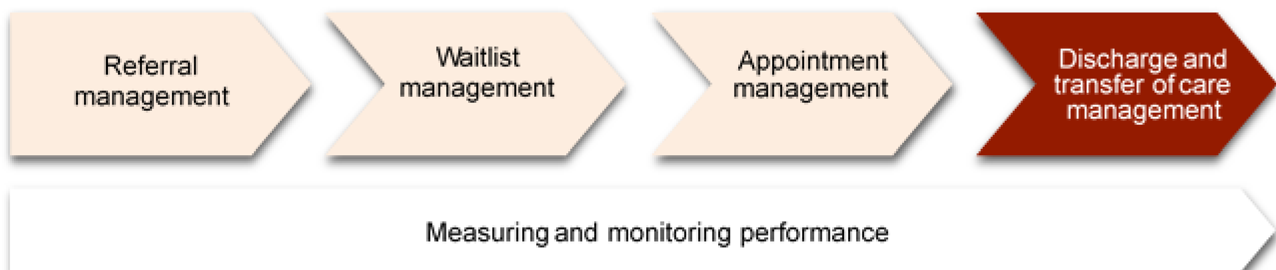
The outcome of outpatient appointments are to be captured and recorded within the patient administration system for each attended patient appointment.

Outcomes of attended outpatient appointments include:

- outpatient review appointment required
- discharged from outpatient service
- admitted from outpatient service
- added to elective surgery or procedure waitlist, and
- patient did not wait.

Such data may help to inform measures such as discharge rates, surgical conversion rates (for surgical specialist clinics), outpatient service to inpatient admission rates, 'Did Not Wait' rates and assist with episode of care measures such as the average number of outpatient appointments.

8. DISCHARGE AND TRANSFER OF CARE MANAGEMENT



A patient's ongoing management is to be transferred from NSW Health outpatient services when the single course of treatment is completed, pre-determined discharge criteria have been met or another health service can more appropriately provide care.

8.1. Discharge planning

Discharge (or transfer of care) planning is the critical link between an outpatient service and referrer and General Practitioner, if not the referrer.

Discharge planning is to commence at the new appointment and continue until the patient is referred to another service for ongoing care or to the care of the referrer.

Discharge planning considers the patient's ongoing care needs and is to be undertaken in consultation with the patient, and relevant healthcare provider(s). This aims to promote timely discharge.

8.2. Timely discharge

Discharge from the outpatient service is to be timely, and patients transferred to their referrer or other setting for ongoing care as clinically appropriate.

Patients are to be discharged from outpatient services when the course of treatment is completed or when another healthcare provider can more appropriately manage the patient.

8.2.1. Multiple review appointments

Outpatient services are to have clear processes to avoid unnecessary review appointments to help reduce patient burden and optimise service capacity.

Junior clinicians are to be supported by senior clinicians to review active caseloads and provide advice on timely discharge planning and management.

In medical-led specialist outpatient services, where a patient has attended two or more review appointments with a registrar, any future appointments within the course of treatment is to include a review by a medical specialist to inform the subsequent care pathway.

8.3. Discharge criteria

Clear discharge criteria promote consistency of discharge practices and assists with decision-making for ongoing care planning to help reduce patient burden and optimise service capacity.

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

Outpatient services personnel are to receive training in the application of these criteria and discharge related systems and processes.

Senior clinicians are to support junior clinicians to discharge patients in a safe and timely manner. This could include the provision of training to junior clinicians on criteria-led discharge practices.

8.4. Documentation of discharge

All discharges are to be recorded within the patient administration system and patient's medical record once it is identified that the patient is ready for discharge from the outpatient service.

8.5. Discharge summary on transfer of care

A discharge (or transfer of care) summary is to be provided to the referrer and General Practitioner, if not the referrer, where a copy of the summary is retained in the patient's medical record.

An ongoing management or action plan (such as alternative healthcare providers, self-management options) is to be included with the discharge summary to minimise premature re-referral.

Clear escalation pathways are to be identified within the discharge summary and communicated with the patient. This may include defined indications for patients to schedule a review appointment for the same problem or condition without the need for a re-referral and/or be re-added to an outpatient waitlist.

Patients, their referrer, and General Practitioners, if not the referrer, are to be notified when the patient is discharged, or care is transferred **within 14 days** of discharge from the outpatient service.

On discharge or transfer of care, a discharge summary is to be provided to the referrer and General Practitioner, if not the referrer, and the ongoing healthcare provider, as appropriate. This summary is to include:

- patient demographics (such as name, date of birth, sex)
- date of first appointment to outpatient service
- reason for referral to the outpatient service
- summary of interventions provided and their outcomes including any diagnosis derived
- date of discharge
- reason for discharge
- relevant risks
- ongoing care management or action plan, including self-management
- other community supports that have been arranged (where required)
- escalation pathways, including indications and processes for re-entry, and
- relevant contact details for the outpatient service.

8.6. Processes for re-entry of recently discharged patients

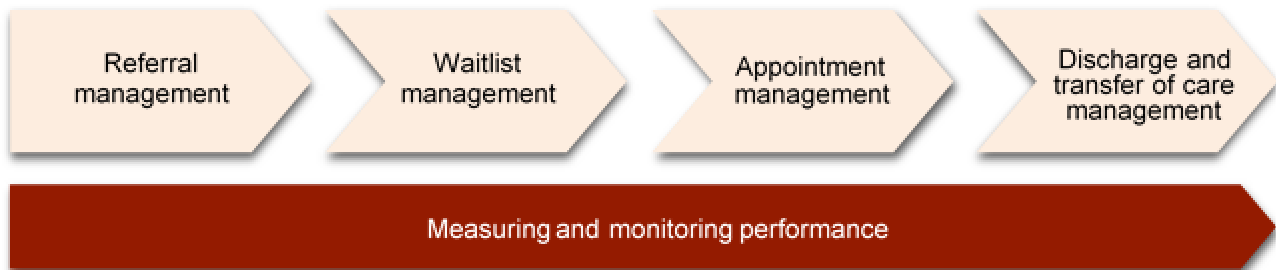
Clear processes for re-entry into outpatient services are designed to support clinicians to discharge patients with confidence that they can re-access care as required based on clinical need.

Outpatient services are to avoid 'just in case' appointment scheduling (for example, provisional reasons such as a possible flare-up) and, instead, establish clear re-entry pathways to maximise service capacity and ensure patients can receive timely care when needed.

In the event it is clinically determined that a recently discharged patient requires another review appointment for the same condition, there are to be documented processes to streamline re-access into the outpatient service.

Recently discharged patients who re-access an outpatient service are to be scheduled as a review appointment and therefore, are not to be re-added to an outpatient waitlist.

9. 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 outpatient services in NSW.

9.1. Monitoring measures and performance

Accountability for the delivery of safe, high quality outpatient services lies with each Local Health District and Specialty Health Network, and systems and processes are to 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.

Where possible, data and information collected for monitoring and measuring performance in outpatient services are to be disaggregated by Aboriginality.

Figure 1: Outpatient service performance measures

Appendix 3 provides additional details for each measure to support with accurate performance monitoring of outpatient services.

9.2. Activity reporting

NSW Health Policy Directive *Non-Admitted Patient Activity Reporting Requirements* (PD2013_010)[28] details the requirements for outpatient services in reporting non-admitted activity.

All non-admitted patient services provided by or on behalf of Local Health Districts and Specialty Health Networks are in scope of the NSW reporting requirements, regardless of the patient service billing arrangement – whether privately referred, compensable or Medicare ineligible – and funding program or funding source.

This includes outpatient services contracted to a private sector organisation, not-for-profit organisations, or Visiting Medical Officers that are paid by an NSW Health organisation under a fee-for-service or sessional service contract.

Local Health Districts and Specialty Health Networks are required to participate in minimum data set reporting to the NSW Ministry of Health for outpatient services. The outpatient service information collected is in line with the minimum dataset.

Data management practices include:

- capturing data once, if possible
- 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, and
- review data before use to ensure it is fit-for-purpose.

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

9.3. Feedback from patients, carers and clinicians

Delivering value-based, patient-centred care and outcomes that matter to patients and the community involves engaging with them and supporting their empowerment.

Value-based, patient-centred care means identifying opportunities for improvement and working collaboratively to develop strategies to improve the patient experience.

A significant aspect of a highly patient-centred culture requires collecting feedback with patients, carers and referrers to ensure that outpatient services are meeting their needs.

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

The NSW Patient Reported Measures (PRM) program[29] has used a co-design approach to develop the Patient Reported Outcome Measures (PROM) and Patient Experience Measures (PREM) surveys to be used across NSW Health services. This is to ensure experience and outcome measures on feedback from patients and carers are standardised across the health system.

Similarly, referrers and clinicians working in outpatient settings are to be engaged in the feedback and improvement cycle, working collaboratively to evaluate and improve the

service. This may occur through multidisciplinary staff meetings, quality improvement initiatives or other identified activities, such as engagement with Aboriginal Community Controlled Health Services through Local Health District/Specialty Health Network partnership meetings.

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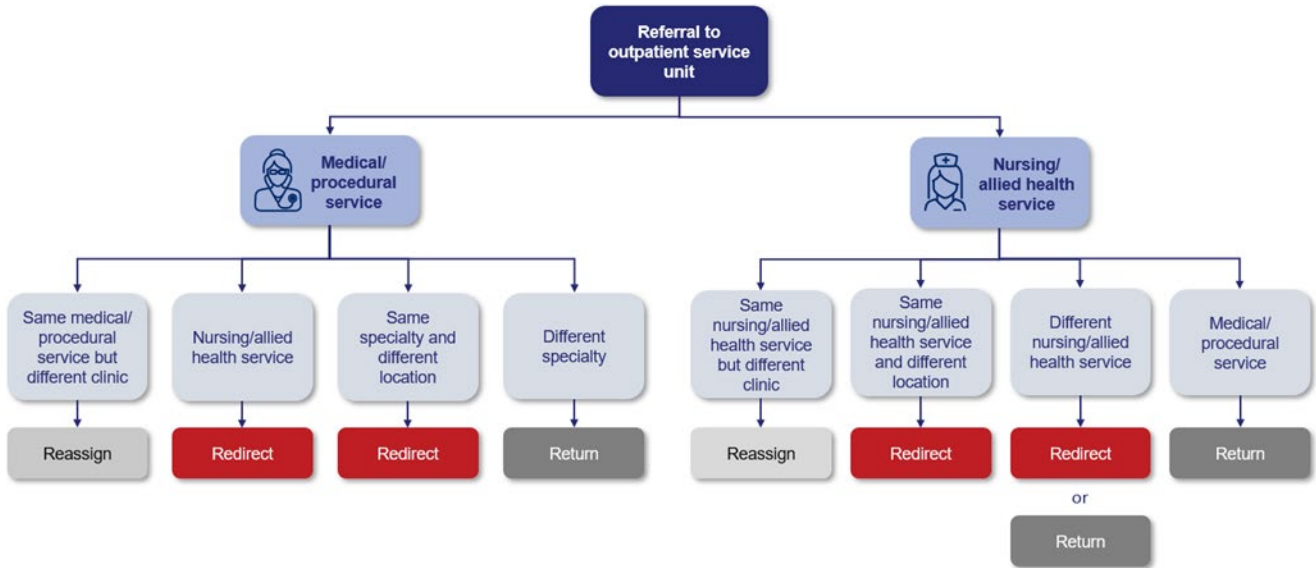
11. APPENDICES

1. Characteristics of different outpatient referrals and follow-up requests
2. Flow chart for non-accepted, redirected and returned referrals
3. Outpatient service performance measures
    - 3.1. Referral management performance measure
    - 3.2. Waitlist management performance measure
    - 3.3. Appointment management performance measure
    - 3.4. Discharge/Transfer of care performance measure

11.1. Appendix 1: Characteristics of different outpatient referrals and follow-up requests

		External source	Internal source	Screening required	Clinical triage or review required	Decision to accept/reject required	Decision re: triage cat required	Non-urgent triage possible	Added to WL required (if accepted)	Results in new appointment	Wait time meaningful	Direct appointment booking
New referral	External	✓	✗	✓	✓	✓	✓	✓	✓	✓	✓	✗
	Internal	✗	✓	✓	✓	✓	✓	✗	✓	✓	✓	✗
	Associated care	✗	✓	✓	✓	✓	✓	✓	✓	✓	✓	✗
Updated referral		✓	✗	✓	✓	✗	✓	✓	N/A	✗	✗	✗
Continuation referral		✓	✗	✓	✓	✗	✗	N/A	N/A	✗	✗	✗
Follow-up requests		✗	✓	✗	✗	✗	✗	N/A	✗	✗	✗	✓

11.2. Appendix 2: Flow chart for non-accepted, redirected and returned referrals



11.3. Appendix 3: Outpatient service performance measures

11.3.1. Referral management performance measures

REFERRAL MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
R1. Number of referrals received	N/A	Total number of referrals that were received by an outpatient service over a defined period, irrespective of the outcome.	Help with informing referral management resource requirements, as well as identifying changes in the volume of service requests across time.	The number of referrals received across a period (by referral receipt date) for a given outpatient service by referral type (new/updated/ continuation).	Includes referrals that may not be accepted by an outpatient service. Therefore, this is not the best indicator of accepted demand for a service.	In the first quarter of the 2021/22 financial year, the ABC Outpatient Service received 5,000 referrals, of which 4,000 were new, 500 were updated, and 500 were continuation.
R2. Percentage of referrals screened within 7 days	100%	Proportion of referrals received over a defined period for an outpatient service that were screened within 7 calendar days of receipt.	Best practice referral management involves timely screening of referrals. This measure provides an indicator of timely referral management performance and can help explain variations in performance in the timeliness of clinical triage (R3, R4).	Numerator: number of referrals received across a defined period for a given outpatient service that were screened within 7 or less calendar days from the date of referral receipt. Denominator: total number of referrals received across a given period for a given outpatient service.	For some outpatient services, screening will occur simultaneously with clinical triage. Screening is indicated for new, updated and continuation referrals.	In the first quarter of the 2021/22 financial year, 95% of the referrals received for the ABC Outpatient Service were screened within 7 calendar days of receipt.

REFERRAL MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
R3. Median time to triage	N/A	Median time frame from receipt of a new referral to clinical triage, for a given outpatient service over a defined period.	Best practice referral management involves timely triaging of referrals. This measure provides an indicator of the central tendency of the time taken to triage referrals.	Limited to new referrals that have been triaged within a defined period for a given outpatient service. Time, in calendar days, from referral receipt date to triage outcome date, adjusted for the cumulative period a referral was 'Request incomplete'. The median is the period in which half of the referrals had received a triage outcome.	Excludes referrals that may have been received in the period that have not yet, or do not, require clinical triage (e.g., updated and continuation referrals).	In the first quarter of the 2021/22 financial year, the median time frame from referral receipt to clinical triage for the ABC Outpatient Service was 6 calendar days.

REFERRAL MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
R4. Percentage of referrals triaged within 7 days	100%	Proportion of triaged new referrals that were allocated a triage outcome within 7 or less days from the date of receipt, for a given outpatient service over a defined period.	Best practice referral management involves timely triaging of referrals. This measure provides an indicator of a service's performance in triaging referrals within an acceptable period.	Limited to new referrals that have been triaged within a defined period for a given outpatient service. Time, in calendar days, from referral receipt date to triage outcome date, adjusted for the cumulative period a referral was 'Request incomplete'. Numerator: new referrals triaged within 7 or less calendar days from referral receipt over a given period. Denominator: all new referrals triaged over a given period.	Excludes referrals that may have been received in the period that have not yet or do not require clinical triage (e.g., updated and continuation referrals).	In the first quarter of the 2021/22 financial year, 85% of new referrals received by the ABC Outpatient Service were triaged within 7 calendar days of receipt.

REFERRAL MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
R5. Percentage of incomplete referrals returned to referrer within 7 days	100%	Proportion of incomplete referrals that were returned to the referrer within 7 days of receipt, for a given outpatient service over a defined period.	Best practice referral management includes the timely resolution of incomplete referrals. Incomplete referrals are those that require further information from the referrer to enable safe, accurate and timely clinical triage. This measure provides an indicator of service performance in notifying referrers of the need to provide additional information within an acceptable period.	Referrals that have been flagged as incomplete within a defined period for a given outpatient service. Time, in calendar days, from referral receipt date to the referrer notification date.	A reporting lag time of at least 7 calendar days from the end of the defined period is required. This is to ensure complete capture of the outcomes of all referrals flagged as incomplete within the period. For example, the measure for the period ending 30/6/23 would not be able to be accurately reported until 7/7/23.	In the first quarter of the 2021/22 financial year, 95% of incomplete referrals within the ABC Outpatient Service were returned to the referrer within 7 calendar days.

REFERRAL MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
R6. Percentage of complete referrals on first receipt	N/A	Proportion of new referrals that contain sufficient information on first receipt to permit clinical triage without requesting further information from the referrer.	Indicator of referral quality and can be used to help identify the need to develop or modify referral support tools (e.g., HealthPathways, e-Referrals, referral templates, state-wide referral criteria) to assist referrers in providing information required for clinical triage. Higher quality referrals support patients, referrers, and outpatient services to ensure safe, timely and accurate triage.	Limited to new referrals that have been triaged within a defined period for a given outpatient service. Numerator: number of new referrals triaged across the period that were not flagged as incomplete at any stage. Denominator: all new referrals triaged over a given period.	Excludes referrals that may have been received in the period that have not yet, or do not, require clinical triage (e.g., updated and continuation referrals).	In the first quarter of the 2021/22 financial year, 65% of referrals triaged within the ABC Outpatient Service were complete on first receipt.

REFERRAL MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
R7. Percentage of appropriate referrals	N/A	Proportion of new referrals that were triaged by a given outpatient service across a defined period and determined to be eligible and subsequently accepted by the service to receive care.	Indicator of referral quality and can be used to help identify the need to develop or modify referral support tools (e.g., referral directories, HealthPathways, e-Referrals, state-wide referral criteria) to ensure that patients are referred to the most appropriate outpatient service at the first attempt.	Limited to new referrals that have been triaged within a defined period for a given outpatient service with a definitive outcome (i.e., accepted/declined). Numerator: number of new referrals triaged across the period that were accepted to receive care. Denominator: number of new referrals triaged across the period with a definitive outcome (i.e., accepted or declined, and not awaiting further information).	Excludes referrals that may have been received in the period that have not yet, or do not, require clinical triage (e.g., updated and continuation referrals). Excludes referrals that have been triaged that do not have a definitive outcome. For example, referrals awaiting further information from the referrer to finalise the triage outcome decision.	In the first quarter of the 2021/22 financial year, 75% of referrals triaged within the ABC Outpatient Service were accepted and deemed appropriate for the service.

REFERRAL MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
R8. Percentage of triage outcomes	N/A	Summarises the triage outcomes for a given outpatient service over a defined period.	Helpful to understand the demand for a service. Variation in the distribution of triage outcomes between triaging clinicians, and across time, may help to identify the need for clinical triage support tools.	Limited to new referrals that have been triaged within a defined period for a given outpatient service with a definitive outcome (i.e., accepted/declined). New referrals triaged by triage outcome.	Excludes referrals that may have been received in the period that have not yet, or do not, require clinical triage (e.g., updated and continuation referrals). Excludes referrals that have been triaged that do not have a definitive outcome, for example, referrals awaiting further information from the referrer to finalise the triage outcome decision.	In the first quarter of the 2021/22 financial year, 15% of referrals triaged within the ABC Outpatient Service were not accepted. Most (60%) referrals were triaged as requiring 'Non-urgent' (within 365 days) care, with 15% triaged as 'Semi-urgent' (within 90 days), 9% 'Urgent' (within 30-days), and 1% requiring 'Rapid access'.

11.3.2. Waitlist management performance measures

WAITLIST MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
W1. Number of waitlist additions	N/A	Number of new patients accepted to receive care by a given outpatient service over a defined period.	Understand the accepted new patient demand for outpatient service and can be used to inform service planning. Stratifying by clinical presentation (or subspecialty area), urgency category, and referral source can be highly informative in enabling service delivery to best align with the needs of the community. When considered in context with W5, this measure helps to explain changes in waitlist volume across time.	The number of new waitlist additions for identified clinic(s) across the defined period. By urgency category.	Includes any patients who may have been added and subsequently removed within the same period.	In the first quarter of the 2021/22 financial year, 500 new patients were added to the ABC Outpatient Service waitlist. Of these patients, 10 (2%) required 'Rapid access' care, 50 (10%) required 'Urgent' care (within 30-days), 200 (40%) required 'Semi-urgent' care (within 90-days), and 240 (48%) required 'Non-urgent' care (within 365-days).

WAITLIST MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
W2. Number of patients on waitlist	N/A	Number of patients on a waitlist for a given outpatient service at a given census date (often the end of a reporting period).	Understand the current unmet demand for a given outpatient service. Changes in this measure across time is helpful in informing the likely access performance trend of a service, as well as the impact of any strategies designed to improve access.	The number of patients on a given outpatient service waitlist at a given census date. By urgency category.	Includes patients on the waitlist with a scheduled new appointment who have not yet attended their appointment. Includes patients Not Ready for Care.	As at 30/9/21, there were 2,500 patients on the outpatient waitlist for the ABC Outpatient Service. Of these, 50 (2%) were in the 'Rapid access' category, 250 (10%) were in the 'Urgent' category (within 30-days), 1,000 (40%) were in the 'Semi-urgent' category, and 1,200 (48%) were in the 'Non-urgent' category (within 365-days).

WAITLIST MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
W3. Number of patients overdue on waitlist	0	Number of patients on a given outpatient service waitlist at a given census date (often the end of a reporting period), where the wait time exceeds the clinical urgency category timeframe.	Understanding the current unmet demand for a given outpatient service and the access performance of that service.	The number of patients on a given outpatient service waitlist at a given census date, limited to instances where the wait time exceeds the clinical urgency category timeframe. By urgency category.	Includes patients on the waitlist with a scheduled new appointment who have not yet attended their appointment. Includes patients 'Not ready for care' at the census date that have exceeded the wait time relevant for their clinical urgency category. Excludes patients in the 'Rapid access' urgency category.	As at 30/9/21, there were 1,000 patients on the outpatient waitlist for the ABC Outpatient Service, who were overdue for their new appointment. Of these, 0 (0%) were in the 'Urgent' category (within 30-days), 900 (90%) were in the 'Semi-urgent' category, and 100 (10%) were in the 'Non-urgent' category (within 365-days)

WAITLIST MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
W4. Number of unbooked 'Urgent' patients	0	Number of patients on a waitlist for a given outpatient service triaged within the 'Rapid access' or 'Urgent' (within 30-days) urgency categories that do not have a scheduled appointment at a given census date.	Best practice waitlist management includes providing a scheduled appointment as soon as possible following the acceptance of a 'Rapid access' or 'Urgent' (within 30-days) referral. This measure is important in helping to understand the access performance of a given service for patients with urgent clinical needs. Changes in this measure across time helps to inform changes in access performance for clinically urgent patients.	The number of patients on a given outpatient service waitlist at a given census date, limited to instances where the urgency category is 'Rapid access' or 'Urgent' (within 30-days), and an appointment has not been scheduled.	Excludes patients 'Not ready for care'.	As at 30/9/21, there were 250 'Urgent' patients on the outpatient waitlist for the ABC Outpatient Service who had not yet been scheduled a new appointment. This represents an increase of 50 patients compared to 30/6/21.

WAITLIST MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
W5. Number of waitlist removals	N/A	Number of patients removed from a given outpatient service waitlist across a defined period.	When considered in context with W1, this measure helps to explain changes in waitlist volume across time. Understand the distribution of reasons for waitlist removal may help inform service delivery and patient/referrer communications.	The number of patients removed from a given outpatient service waitlist across a defined period. By waitlist removal reason. By urgency category.	Includes patients added and removed within the same reporting period.	In the first quarter of the 2021/22 financial year, 600 patients were removed from the ABC Outpatient Service waitlist. Of these, 500 (83%) were removed as they attended a new appointment, 94 (16%) were removed as they had sought care elsewhere, and 6 (1%) were deceased.
W6. Number of new patients seen from waitlist	N/A	Number of patients removed from a given outpatient service waitlist across a defined period, as an outcome of attending a new appointment.	Reflects the observed capacity of an outpatient service to provide care for new patients. It is critical in understanding the balance between demand and capacity, resource requirements, and as a key determinant of access performance.	The number of patients removed from a given outpatient service waitlist across a defined period, where the removal reason is 'non-admitted patient service provided'. By urgency category.	Includes patients added and removed within the same reporting period.	In the first quarter of the 2021/22 financial year, 500 new patients were seen from the ABC Outpatient Service waitlist. Of these, 5 (83%) were 'Rapid access', 200 were 'Urgent' (within 30 days), 200 were 'Semi-urgent' (within 90-days) and 95 were 'Non-urgent' (within 365-days).

WAITLIST MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
W7. Median wait time	N/A	Median wait time experienced by new patients who were seen in a given outpatient service from the waitlist across a defined period.	Reflects the central tendency of the wait times experienced by new patients who have received a new appointment. This measure is a key indicator of access performance. Limited to the experiences of patients who have been able to be provided an appointment, and therefore needs to be considered in conjunction with the measures of the unmet demand still on the waitlist (W2, W3, W4).	Patients removed from a given outpatient service waitlist across a defined period, where the removal reason is 'non-admitted patient service provided'. By urgency category.	A patient's wait time is calculated as the number of calendar days between the date of referral receipt until the date of waitlist removal excluding: the accumulative number of days a referral was 'Request incomplete'; the accumulative number of days a patient was 'Not ready for care'; and the accumulative number of days waiting at a less urgent category. The median wait time represents the timeframe in which half of the patients waited to be seen. The remaining 50% of patients waited longer than this timeframe. Excludes patients in the 'Rapid access' urgency category.	In the first quarter of the 2021/22 financial year, the median wait time for new patients seen in the ABC Outpatient Service waitlist was within 24 days for 'Urgent' (within 30-days) referrals, within 80 days for 'Semi-Urgent' (within 90-days) referrals, and within 400 days for 'Non-Urgent' (within 365-days) referrals.

W8. 90th percentile wait time	N/A	90th percentile wait time experienced by new patients who were seen in a given outpatient service from the waitlist across a defined period.	Reflects the wait times experienced by new patients who have received a new appointment. This measure is a key indicator of access performance. Note: this measure is limited to the experiences of patients who have been able to be provided an appointment, and therefore needs to be considered in conjunction with the measures of the unmet demand still on the waitlist (W2, W3, W4).	Patients removed from a given outpatient service waitlist across a defined period, where the removal reason is 'non-admitted patient service provided'. By urgency category.	A patient's wait time is calculated as the number of calendar days between the date of referral receipt until the date of waitlist removal excluding: the accumulative number of days a referral was 'Request incomplete'; the accumulative number of days a patient was 'Not ready for care; and the accumulative number of days waiting at a less urgent clinical urgency category. The 90th percentile wait time represents the amount of time in which 90% of the patients seen in the period waited for their appointment. The remaining 10% of patients who were seen in the period waited longer than this time. Excludes patients in the 'Rapid access' urgency category.	In the first quarter of the 2021/22 financial year, the 90th percentile wait time for new patients seen in the ABC Outpatient Service waitlist was 34 days for 'Urgent' (within 30-days) referrals, 180 days for 'Semi-Urgent' (within 90-days) referrals, and 555 days for 'Non-Urgent' (within 365-days) referrals.

WAITLIST MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
W9. Percentage of patients seen on time	100%	Proportion of patients who were seen in a given outpatient service across a defined period, within the clinically recommended timeframe for their urgency category.	Reflects the wait times experienced by new patients who have received a new appointment. This measure is a key indicator of access performance. Note: this measure is limited to the experiences of patients who have been able to be provided an appointment, and therefore needs to be considered in conjunction with the measures of the unmet demand still on the waitlist (W2, W4).	Patients removed from a given outpatient service waitlist across a defined period, where the removal reason is 'non-admitted patient service provided'. By urgency category.	A patient's wait time is calculated as the number of calendar days between the date of referral receipt until the date of waitlist removal excluding: the accumulative number of days a referral was 'Request incomplete'; the accumulative number of days a patient was 'Not ready for care'; and the accumulative number of days waiting at a less urgent category. Excludes patients in the 'Rapid access' urgency category. Numerator: number of new patients seen from the waitlist who waited within the relevant urgency category timeframe. Denominator: number of new patients seen from the waitlist.	In the first quarter of the 2021/22 financial year, 70% of new patients seen in the ABC Outpatient Service were seen on time. 90% of 'Urgent' (within 30-days), 80% of 'Semi-Urgent' (within 90-days), and 40% of 'Non-Urgent' (within 365 days) patients were seen within their clinically recommended timeframe.

11.3.3. Appointment management performance measures

APPOINTMENT MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
A1. Number of attended appointments	N/A	Number of attended appointments within a given outpatient service over a defined period.	Understanding the activity of an outpatient service and is a component of many other activity measures.	The number of appointments within a given outpatient service over a defined period with an attended status.	Includes new and review appointment types.	In the first quarter of the 2021/22 financial year, there were 8,500 attended appointments within the ABC Outpatient Service.
A2. Percentage of Did Not Attend	N/A	Proportion of scheduled appointments within a given outpatient service over a defined period, with an outcome of an unplanned non-attendance.	Did Not Attend rates may help inform and evaluate strategies designed to reduce inefficiencies and barriers to access created by non-attended appointments. Did Not Attend Rates may also help to identify subgroups of patients with higher likelihoods of non-attendance to inform strategies that help patients access the care they require.	Numerator: number of appointments within a given outpatient service across a defined period with an outcome of 'Did Not Attend'. Denominator: total of attended and 'Did Not Attend' appointments within a given clinic(s) across a defined period.	Does not include cancelled or rescheduled appointments.	In the first quarter of the 2021/22 financial year, the 'Did Not Attend' rate of the ABC Outpatient Service was 11%.

APPOINTMENT MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
A3. Percentage of appointments delivered through virtual care	N/A	Proportion of attended appointments within a given outpatient service over a defined period, which were delivered through virtual care (i.e., audio or audiovisual technology).	Virtual care helps to provide appropriate outpatient care to patients who may otherwise experience increased burden with attending an in-person appointment. Measuring the use of virtual care helps to inform service delivery, resource requirements, and strategies designed to further support patients to receive outpatient care.	Numerator: number of attended appointments within a given outpatient service across a defined period with a delivery mode of audio or audiovisual. Denominator: total number of attended appointments within a given clinic(s) across a defined period.	Excludes include 'Did Not Attend', cancelled or rescheduled appointments.	In the first quarter of the 2021/22 financial year, the ABC Outpatient Service delivered 15% of its activity through virtual care.

APPOINTMENT MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
A4. New to review ratio	N/A	Ratio of new to review appointments within a given outpatient service across a defined period	The new to review ratio helps to inform the competing demand for outpatient appointments between new patients booked from the waitlist for a new appointment, and patients requiring a review appointment. This measure may help inform service delivery models that optimise the efficiency of a service and increase the service capacity to meet the needs of the community.	Numerator: number of attended new appointments for new patients seen from a given outpatient service waitlist across a defined period. Denominator: total attended appointments in a given outpatient service across a defined period that are not new patient appointments.	Limited to attended appointments. Excludes ‘Did Not Attend’, cancelled and rescheduled appointments.	In the first quarter of the 2021/22 financial year, the ABC Outpatient Service had a new to review ratio of 1:3. This means that for every new patient seen in the outpatient service from the waitlist, there were 3 review appointments that were provided.

APPOINTMENT MANAGEMENT						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
A5. Percentage of new attended appointments with correspondence to General Practitioner/ referrer within 14 days	100%	Proportion of new attended appointments that have correspondence delivered to the General Practitioner/referrer within 14 calendar days of attendance.	Timely communication with General Practitioners/referrers following a new appointment attendance in an outpatient service is central to delivering best practice patient-centred care. This measure is a performance indicator of timely communication with referrers/General Practitioners.	Numerator: number of new attended appointments seen from a given outpatient service waitlist across a defined period, where correspondence is delivered to the referrer/General Practitioner within 14 calendar days. Denominator: total number of new attended appointments seen from a given outpatient service waitlist across a defined period.	Limited to attended appointments. Excludes 'Did not Attend', cancelled and rescheduled appointments.	In the first quarter of the 2021/22 financial year, 86% of new attended appointments in the ABC Outpatient Service were associated with correspondence back to the referrer/General Practitioner within 14 calendar days.

11.3.4. Discharge/Transfer of care performance measures

DISCHARGE / TRANSFER OF CARE						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
D1. Number of patients discharged	N/A	Number of patients who were discharged from a given outpatient service over a defined period.	Reflects the volume of patients no longer requiring care within a given outpatient service and helps to identify possible capacity limitations.	The number of appointments within a given outpatient service over a defined period with an outcome of 'discharged'.	N/A	In the first quarter of the 2021/22 financial year, there were 245 patients discharged from the ABC Outpatient Service.
D2. Number of patients admitted from outpatient service	N/A	Number of patients who were admitted to hospital as an outcome from an attended outpatient appointment, across a defined period.	Reflects the volume of patients flowing directly from a non-admitted to admitted setting and may help inform bed management strategies.	The number of appointments within a given outpatient service over a defined period with an outcome of 'admitted from clinic'.	N/A	In the first quarter of the 2021/22 financial year, there were 23 patients admitted to hospital as an outcome from an attendance in the ABC Outpatient Service.
D3. Number of patients added to elective surgery waitlist	N/A	Number of patients who were added to an elective surgical waitlist as an outcome from attendance in a given clinic(s) over a defined period.	Reflects the volume of patients flowing onto an elective surgical waitlist, and may help inform service delivery models, theatre allocations, resource requirements and service planning.	The number of appointments within a given outpatient service over a defined period with an outcome of 'added to elective surgical waitlist'.	N/A	In the first quarter of the 2021/22 financial year, there were 110 patients added to an elective surgery waitlist as an outcome from an attendance in the ABC Outpatient Service.

DISCHARGE / TRANSFER OF CARE						
Measure	**Target**	**Description**	**Intended purpose**	**Cohort description**	**Further detail**	**Example**
D4. Percentage of discharges with correspondence to referrer/General Practitioner within 14 days	100%	Proportion of appointments with a discharge outcome that have correspondence delivered to the referrer/General Practitioner within 14 days of the appointment.	Timely communication with referrers/General Practitioners following discharge from an outpatient service is central to delivering best practice patient-centred care. This measure is a performance indicator of timely communication with these partners.	Numerator: number of appointments in a given outpatient service across a defined period with an outcome of 'discharged', where correspondence is delivered to the referrer/General Practitioner within 14 days. Denominator: total number of appointments in a given outpatient service across a defined period with an outcome of 'discharged'.	N/A	In the first quarter of the 2021/22 financial year, 95% of discharges from the ABC Outpatient Service were associated with correspondence back to the referrer/General Practitioner within 14 days.