Outpatient Services Implementation Standard

1. Purpose
The Outpatient Services Implementation Standard provides a suite of processes that have been developed to enable the operationalisation of the Governance of Outpatient Services Policy. The Implementation Standard provide a platform for the implementation of best practice management practices and is a detailed guide to ensure consistent processes are adopted across all Queensland Health facilities. This implementation standard is also necessary to create process and practice standards that will enable the evaluation of service performance across all sites.

2. Scope
This standard applies to all facilities that provide Queensland Health public or private outpatient services. Outpatient Services are inclusive of, but not limited to medical, surgical, cancer care, maternity, paediatric, renal, nursing and allied health services.

Compliance with this standard is mandatory for all Queensland Health employees, volunteers, and contractors engaged in delivery of Queensland Health outpatient services.

3. Definition of Terms
Definition of all key terms used in this Standard are listed in the Glossary of Policy Terms (Attachment to Outpatients Services Governance Policy).

4. Supporting Documents
- Queensland Health Governance of Outpatient Services Policy
- Australian Charter of Healthcare Rights
- Business Rules for the National Healthcare Agreement;
- Private Patients and Queensland Health – Guidelines on Australian Government Requirements;
- Queensland Health Admitted Patient Data Collection (QHAPDC) Manual;
- IRM 11.1-3 Leave – General – Notice for Absences – Visiting Medical Officers
- Attachment 1 – Patients Rights and Responsibilities
- Attachment 2 – Referring Practitioners Roles and Responsibilities
- Attachment 3 – Approved Outpatient Services Letter Suite
5. Requirements

5.1 Quality and Accountability

Service Provision

5.1.1 Provision of Outpatient Services in Queensland public hospitals is in accordance with the details contained in the Business Rules for the National Healthcare Agreement and District Health Service plans.

5.1.2 Outpatient consultation is conducted for the purposes of accessing specialist assessment and management which is not available in primary health care settings. This process may include:

- Investigation and diagnosis of conditions not able to be provided by the referring practitioner;
- Advice and/or provision of treatment and management of complex conditions;
- Reassurance for the patient;
- Provision of a second opinion.

5.1.3 Outpatient Services are integral to the care pathway of patients and may occur at the beginning, middle or end of the patient journey within the hospital setting.

5.1.4 In most cases, patients will be referred to Outpatient Services at a facility near to their place of residence (e.g. “home” district), or at another District’s facility as close as practicable to their place of residence.

5.1.5 In situations where Outpatient Services are provided through a cooperative arrangement between facilities (e.g. outreach services), a service agreement should clearly identify the service with the responsibility for each aspect of clinical and administrative service provision.

5.1.6 Outpatient Services will be evidence-based with due consideration of treatment options and with the consent of the patient.

- Evidence-based clinical practice is the integration of best research evidence with clinical expertise and patient values.
- Queensland Health promotes evidence-based clinical practice in all services, including outpatient services.
- Decisions to undertake assessments and treatments within Outpatient Services are made with due consideration of expected benefits, the attendant clinical risks and opportunities for complimentary treatments which may include but are not limited to care by their general practitioner, allied health or community health services.
- For more information on evidence-based practice see the website: http://www.health.qld.gov.au/cpic/resources/evid_based_practice.asp

5.1.7 Informed consent will be obtained from the patient, guardian or attorney prior to undertaking designated treatments or procedures.

- Informed consent shall comply with relevant Queensland Health policies and legislation.
- For more information see the website: http://www.health.qld.gov.au/informedconsent/default.asp

5.1.8 Outpatient Services will deliver coordinated care, clinical follow-up and appropriate discharge planning.

5.1.9 Patients and carers are the primary focus of Outpatient Services:

- Patients and carers will be informed, educated and supported throughout the process;
- Patients, carers and primary health care providers will be given the opportunity to participate in decision making and be actively involved in their health care management;
- Patients will be provided with information that identifies patients’ rights and responsibilities, consumer advocacy and the process for lodging complaints.

5.1.10 Referring practitioners and other relevant health care professionals will be involved in and informed about Outpatient Services.

5.1.11 Appropriate diagnostic tests may be ordered for the patient to enable required investigations to be performed prior to the clinic appointment.

5.1.12 During the initial consultation with the patient an agreed pathway of care and treatment will be developed, implemented and documented.
5.1.13 Following the initial consultation the patient may be:

- Returned to the referring practitioner with recommendations for ongoing management;
- Listed for elective admission;
- Followed-up in Outpatient Services; or
- Admitted to hospital.

5.1.14 Decisions to undertake clinical follow-up in Outpatient Services should be made with due consideration of the expected benefits and the opportunities for accessing appropriate alternative services.

5.1.15 When clinical follow-up in Outpatient Services are required for a defined period, the referring practitioner will be kept informed during this period.

5.1.16 Patients for whom ongoing outpatient care may be appropriate include:

- Patients requiring monitoring of the effectiveness of commenced management plans;
- Patients with unresolved clinical problems relating to the reason/s for referral;
- Patients requiring monitoring of new and/or potentially harmful therapy that cannot be safely undertaken in other settings or by other services;
- Patients with complex conditions that are unable to be safely treated by another service;
- Patients who are enlisted in a funded and approved research protocol.

5.1.17 In order to optimise continuity of care, outpatient service procedures will facilitate patients being seen by the same clinician or team at each appointment wherever possible.

5.1.18 Admitted patients with a scheduled outpatient appointment will be reviewed in the inpatient (ward) area and not in the outpatient service area where appropriate:

- The only exceptions to this would include patients requiring access to procedural work only able to be provided in the outpatient service area because of the necessary specialised equipment being situated there;
- Each patient’s case will be considered individually with patient safety, dignity, privacy and comfort as the primary considerations.

5.1.19 Patients who have been assessed as requiring admission directly from Outpatient Services will be transferred to the appropriate inpatient or procedural area with minimal delay.

5.1.20 Patients requiring future admission for elective surgery will be placed on a wait list after specific criteria and processes are fulfilled (See QH Standards for Elective Surgery).

**Discharge**

5.1.21 Patients will be discharged from Outpatient Services when the single course of treatment is completed or when another health care provider can more appropriately provide the service.

5.1.22 Discharge planning will commence at the initial encounter and will continue through to the patient being returned to the care of the referring practitioner.

5.1.23 If it is more appropriate for the service to be provided by another health care provider, the patient will be transferred into their care.

5.1.24 A discharge/transfer summary will be provided to the referring practitioner and the ongoing service provider as appropriate.

5.1.25 An ongoing management/action plan will be included with the discharge summary in order to minimise premature re-referral.

**Compliance with Queensland Health Requirements**

5.1.26 Hospitals will administer systems designed to maximise the efficient and effective management of Outpatient Services:

- Queensland Health outpatient services and systems will be managed in accordance with the policy and standards outlined in the *Queensland Health Safety and Quality Strategic Plan 2005-2010*, including the principles of consumer involvement, access, appropriateness, safety, effectiveness and efficiency. For further information see: [http://qheps.health.qld.gov.au/drac/docs/qh_sqstratplan05.pdf](http://qheps.health.qld.gov.au/drac/docs/qh_sqstratplan05.pdf)
- Decisions involving Outpatient Services will be undertaken within an integrated risk management framework;
Implementing changes to improve services will incorporate the principles and tools described in the Queensland Health Managing Organisational Change “How to Guide” see: http://qheps.health.qld.gov.au/hrbt/man_org_chnge_guide.pdf

5.1.27 Hospitals will have specific processes in place to manage planned leave for outpatient staff due to the critical impact that these staff have on the provision of Outpatient Services. These processes will include:

- Establishment of a leave management process that is in accordance with Industrial and HR requirements and is underpinned by a communication strategy;
- Approval of leave by the relevant line manager a minimum of four (4) weeks in advance;
- Notification of approved leave to the Accountable Officer and designated outpatient service staff a minimum of four weeks in advance;
- Timely notification to the designated outpatient staff about upcoming leave that will affect appointment and/or clinic lists;
- Proactive planning of conference leave;
- Conducting bi-annual reviews of the impact of staff leave on appointment schedules.

5.2 Communication

5.2.1 Appropriate and timely communication is vitally important when providing information about Outpatient Services to patients, referring practitioners and health care professionals. Patients and relevant health care professionals will be notified of the expected wait for appointment bookings for Outpatient Services.

5.2.2 The communication process and method of transmission will be flexible according to the information required and the intended audience and needs to be inclusive of:

- Different styles to suit the intended message and the audience – written, telephone, video, face-to-face;
- Special needs – interpretation, translation, cultural differences;

5.2.3 Designated staff are responsible for providing all information required to support the achievement of timely clinical outcomes and effective appointment scheduling.

5.2.4 General information will be provided to the patient and will include:

- Patient rights (e.g. free treatment, respect, free interpreter, etc.), and responsibilities (e.g. advising of any change of name, address or telephone number, or inability to attend appointments) – see: Australian Charter of Healthcare Rights at: http://www.health.qld.gov.au/cpic/hlthcr_exp_improve/australiancharter.asp
- The need for a written referral to gain access to Outpatient Services (with some exclusions);
- The need for a valid referral for continuation of services, if applicable;
- Time, date and location of appointment/s, and what to bring (e.g. x-rays, investigation results, medications, Medicare card);
- Investigations needing to be performed before the clinic appointment;
- Special requirements (if applicable);
- How to confirm, reschedule or cancel appointments;
- Placement on the Outpatient Services wait list;
- The need to visit the referring practitioner for clinical review whilst waiting an appointment;
- The course of action to be followed if changes occur in clinical condition;
- Reasons for removal from the clinic wait list.

5.2.5 Patients registered on an Outpatient Services wait list will be formally notified of:

- Placement on the wait list;
- Appointment offer;
- Postponement/reschedule;
- Failure to attend for a confirmed appointment;
- Removal from the wait list.

5.2.6 Documentation of all communication with patients (including telephone and electronic media) will be retained in the patient’s medical record regardless of whether the patient commences an episode of care at that facility.

5.2.7 Designated staff will respond to information requests made by referring practitioners to support the achievement of timely clinical outcomes and effective referral practices.
5.2.8 Prior to referring patients for consultation in outpatient clinics, referring practitioners may request access information regarding:

- Status of the Outpatient Services wait list;
- Types of specialties offered;
- Estimated waiting times;
- Supporting diagnostics and clinical information required for triaging;
- Referral guidelines.

5.2.9 Should a referral be received for a service that is not provided at a facility a letter will be forwarded to the referring practitioner and patient notifying them that the service requested is not available and alternative arrangements need to be made.

- The original letter of referral will be returned to the referring practitioner;
- A copy of the referral will be retained in the patient’s medical record with a copy of the correspondence to the patient and the referring practitioner.

5.2.10 Designated staff are responsible for coordinating information to the referring practitioner regarding:

- Referral content;
- Receipt of referral;
- Categorisation;
- Patient placement on the outpatient wait list;
- Regular clinical review of the patient whilst awaiting an outpatient appointment;
- Notifying the hospital about any significant changes to the patient’s condition;
- Date and nature of appointment (and any changes or postponements);
- Special requirements (if applicable);
- Reasons for removal from wait list.

5.2.11 Continued contact with the referring practitioner during the term of the consultative period (single course of treatment), is vital to ensure that collaborative management of the patient is established and maintained:

- Contact may be undertaken by letter, fax, email or telephone;
- Documentation of all communication with referring practitioners (including telephonic and electronic media) will be retained in the patient’s medical record regardless of whether the patient commences an episode of care at that facility.

5.2.12 The referring practitioner will be formally notified of:

- Placement of a patient on the Outpatient Services wait list;
- Appointment details;
- Failure of the patient to attend for a confirmed appointment;
- Patient-initiated cancellations;
- Removal of a referred patient from the outpatient wait list.

5.2.13 When a referring practitioner is a medical officer within the hospital (e.g. emergency department, inpatient unit or other outpatient clinic), the medical officer will notify the patient’s nominated general practitioner of the referral made on their behalf. All subsequent correspondence regarding the patient’s outpatient appointment will be directed to the nominated general practitioner.

5.2.14 The hospital will also have in place processes to inform medical officers within the hospital about estimated waiting times for Outpatient Services appointments.

5.2.15 Patients from the Department of Corrective Services including Correctional Centres, Watch Houses and secure mental health facilities are accorded the treatment available to all patients – however, for security reasons, the patient and their relatives will not be informed of outpatient clinic appointment details.

- The patient may be advised that at some time in the future they may attend a facility for an outpatient clinic appointment;
- Details of dates for outpatient appointments will be directly conveyed to the delegate from the Department of Corrective Services or appropriate authority.
5.3 Referral Management

5.3.1 Hospitals will implement processes to appropriately manage referrals received for services that are not provided (or have been deferred or suspended); and ensure patients and referring practitioners are notified within five (5) days that alternative arrangements for treatment will be required.

5.3.2 A waiting list for deferred or suspended service/s or services that are not provided will not be maintained under any circumstance.

5.3.3 Referring practitioners will be notified in writing of the need to seek alternative arrangements for services not provided, suspended or deferred within five (5) working days of receipt of a referral.

Access

5.3.4 Access to Outpatient Services is only possible through the lodgement of a written referral from a recognised referral source.

5.3.5 Only patients with a valid referral are able to access Outpatient Services, however, it is not mandatory to obtain a referral in order to access public outpatient maternity services (e.g. ante-natal clinic services), nursing or allied health outpatient services.

5.3.6 A written referral may be in the form of a letter, facsimile or other electronic medium. Electronic referrals should be received via a Secure Web Transfer (SWT). All referrals must be signed by the referring Practitioner and for the purpose of the electronic signature a Public Key Infrastructure (PKI) constitutes as a signature.

5.3.7 For admitted patients requiring an appointment for clinical review following separation for an inpatient episode of care, a referral can include documentation in the patient’s medical record requesting an appointment at an outpatient service.

Referrals

5.3.8 Referrals will be in writing with sufficient information to enable informed determination of clinical urgency and acceptance of referrals will be subject to referral content, consideration of service location and patient status.

5.3.9 Referrals that do not contain sufficient information to accurately categorise the level of clinical urgency cannot be accepted and will be returned to the referring practitioner for further detail.

5.3.10 The ongoing care of the referred patient remains the responsibility of the referring practitioner until such time as the referral has been accepted and the patient has completed an initial consultation with a hospital doctor or health professional as appropriate.

5.3.11 A record of the receipt, non-acceptance and return of the referral for additional information will be maintained in the patient’s medical record.

5.3.12 Patients may be referred to Outpatient Services from:
- General Practitioners;
- Medical Officers from within the hospital;
- Emergency department – acceptance of fracture referrals and urgent (Category 1) only;
- Follow-up care resulting from an admitted episode of care;
- On-referral relevant to the course of treatment.
- Medical Officer’s private rooms;
- Medical Officers in other hospitals (transfers);
- Other health care professionals (e.g. Optometrist referral to Ophthalmologist).

5.3.13 Internal medical officers are required to discharge patients to the care of their nominated general practitioner for consideration of a new referral and treatment options, thereby ensuring monitoring whilst awaiting access – Category 1 conditions will be an exception and should be forwarded internally to the required outpatient service.
Referral validity

5.3.14 Referrals for Outpatient Services remain valid for a single course of treatment for specified periods (three months, twelve months or ongoing) as indicated by the referring practitioner.

5.3.15 If referred by a specialist or internal consultant the active life of the referral is three (3) months from the initial outpatient consultation.

5.3.16 If referred by a general practitioner the active life of the referral is twelve (12) months from the initial outpatient consultation.

5.3.17 Referrals for longer than twelve (12) months should only be used where the patient’s clinical condition requires continuing care and management of a specialist or consultant physician for a specific condition or specific conditions (examples of such conditions could include, but are not limited to, the specialties of renal medicine and oncology). In these cases the period for referral should clearly be expressed as “indefinite”.

5.3.18 A single course of treatment involves an initial attendance by a specialist or consultant physician and the continuing management/treatment up to the stage where the patient is referred back to the care of the referring practitioner.

5.3.19 If a single course of treatment is extended beyond the referral validity timeframe, a new referral for continuation of care will be required.

5.3.20 The presentation of an unrelated illness or condition will initiate a new course of treatment which will require a new referral.

Adequate information for categorisation

5.3.21 Hospitals will have in place systems and processes to ensure patient referrals to Outpatient Services contain adequate information to allow for informed categorisation of clinical urgency, prioritisation and direction of patients to appropriate services.

5.3.22 Standardised referral formats will be utilised to facilitate the provision of adequate referral content.

5.3.23 Referrals to Outpatient Services will be in writing (e.g. letter, facsimile, electronic file) and as a minimum contain the following:

- The patient’s full name (and aliases);
- The name of the parent or caregiver (if appropriate);
- The patient’s full address;
- The patient’s telephone contact number – home, mobile and alternative;
- The patient’s date of birth;
- The patient’s preferred language and interpreter requirement;
- The patient’s Medicare number;
- The referring practitioner’s full name
- The referring practitioner’s full address;
- The referring practitioner’s contact number – telephone, facsimile, email;
- The referring practitioner’s Provider Number;
- Relevant information about the patient’s condition:
  - Presenting symptoms (evolution and duration);
  - Physical findings;
  - Details of previous treatment (include systemic and topical medications prescribed for the condition);
  - Details of any associated medical conditions which may affect the condition or its treatment (e.g. diabetes);
  - Current medications and dosages (include any drug allergies);
- Relevant psychological and social issues including impact on:
  - Employment;
  - Education;
  - Home;
  - Activities of daily living – low/medium/high.
- Patient choice to be treated as public or private patient;
- Patient status (e.g. DVA, Work Cover, Motor Vehicle Insurance etc.).
5.3.24 Hospitals will implement procedures to inform referring practitioners with respect to appropriate referral content and relevant investigations to assist with categorisation of clinical urgency, accurate assessment and treatment.

**Categorisation of Referral (Determination of Clinical Urgency)**

5.3.25 Hospitals will implement procedures to ensure referrals accepted by Outpatient Services are categorised according to their degree of clinical urgency within five (5) working days of receipt.

5.3.26 The categorisation of referrals facilitates equitable and timely access to appropriate services according to the assessed urgency of need.

5.3.27 All Outpatient Services will implement procedures to manage referral categorisation that include:

- Review of referrals by a delegated nurse within twenty-four (24) hours of receipt in the Outpatient Service to determine the suitability of the referral for acceptance and streaming into the correct specialty. The nurse may undertake action to reroute or expedite care in consultation with the medical officer as required;
- Categorisation of referrals by a medical officer within five (5) days of receipt of the referral;
- Registration of all referrals on the wait list within two (2) days of receipt;
- Updating the wait list register occurs once categorisation has taken place.

**Referral responsibility**

5.3.28 The medical officer or health professional responsible for the specialty is responsible for categorisation of the referrals.

5.3.29 The task of categorisation may be delegated to a nominated officer (e.g. medical registrar, resident, senior registered nurse or health professional where clearly defined categorisation protocols have been documented).

5.3.30 The medical officer or nominated officer will direct inappropriate or incomplete referrals to the referring practitioner with corresponding documentation to support this action.

**Use of urgency categories**

5.3.31 Clinical urgency categories have been defined for use in Outpatient Services undertaken in Queensland public hospitals – allocation of the clinical urgency category requires the fulfilment of ALL criteria listed for that category:

5.3.32 **Category 1**

- Appointment within thirty (30) days is desirable; AND
- Condition will require more complex or emergent care if assessment is delayed; AND
- Condition will have significant impact on quality of life if care is delayed beyond thirty (30) days.

5.3.33 **Category 2**

- Appointment within ninety (90) days is desirable; AND
- Condition has potential to require more complex care if assessment is delayed; AND
- Condition has the potential to have some impact on quality of life if care is delayed beyond ninety (90) days.

5.3.34 **Category 3**

- Appointment within 365 days desirable; AND
- Condition is unlikely to deteriorate quickly; AND
- Condition is unlikely to require more complex care if assessment is delayed beyond 365 days.
5.3.35 If a patient does not fulfil ALL the criteria for Category 1, then Category 2 will be considered.

5.3.36 If a patient does not fulfil ALL the criteria for Category 2, then the patient is allocated Category 3 status.

5.4 Appointment Management

Waiting Times

5.4.1 Allocation of appointments for patients accessing Outpatient Services is based on prioritisation according to clinical urgency and waiting time. In cases where factors other than clinical urgency and waiting time influence patient selection for outpatient consultation, it should be possible to demonstrate that no patient with similar characteristics has a higher urgency category, or has waited longer for an appointment.

5.4.2 The prioritisation process will occur in a systematic manner so that urgent patients are treated sooner, and waiting time to consultation is minimised.

5.4.3 Patients categorised with a higher clinical urgency will be scheduled for an appointment date ahead of patients categorised with a lower clinical urgency (i.e. Category 1 before Category 2; Category 2 before Category 3).

5.4.4 Prioritisation within clinical urgency categories will be based upon factors that may include:
- Patient co-morbidities;
- Medication requirements;
- Patient social and community support;
- Patient access factors (e.g. distance of residence from the treatment centre; availability of transport and accommodation).

5.4.5 Patients within the same urgency category who have waited longer will receive priority when all other relevant factors are equal.

5.4.6 Patients whose outpatient appointments have been previously postponed for clinical or hospital-related reasons will be given priority and rescheduled for the next available appointment.

Appointment Management – scheduling system

5.4.7 Hospitals will utilise and maintain a corporately approved electronic appointment scheduling system.

5.4.8 The system for appointment scheduling or booking of patient appointments in Outpatient Services will be a corporately approved electronic scheduling system. The system needs to support the requirements of Queensland Health in the collection and collation of activity and performance data required to meet state and Australian government information, funding and reporting obligations.

5.4.9 The appointment scheduling or booking system allows patients to be allocated an appointment from the Outpatient Services wait list.

5.4.10 The appointment scheduling system records relevant details about the patient and the outpatient appointment.

5.4.11 Patients listed on the appointment scheduling system will be a subset of those listed on the Outpatient Services wait list (i.e. patients booked for an appointment but not yet seen).

5.4.12 The appointment scheduling or booking system will facilitate the immediate booking of Category 1 patients within the accepted timeframe (30 days) from when they are placed on the wait list.

5.4.13 The patient will remain on the electronic scheduling system until such time as they are discharged or removed.
5.4.14 Hospitals will manage procedures that maximise the number of patients seen within the recommended times and expedite appointments for any patients not seen able to be seen within those timeframes:
   - Designated staff are responsible for arranging outpatient appointments.
   - Selection of patients from the Outpatient Services wait list on the basis of clinical urgency and waiting time will assist in maximising the number of patients seen within the recommended timeframes;
   - Processes to assist in maximising the number of patients seen within the recommended timeframes will include:
     - An audit schedule to be maintained by designated staff;
     - All new case appointment slots to be filled for each clinic session;
     - Employment of Failed To Attend (FTA) management strategies;
     - Effective appointment templates to reflect but not be limited to:
       a. An acceptable new to review appointment ratio;
       b. Identification of semi-urgent appointment slot/s;
       c. Individual appointment times for patients;
       d. Appointment timing will reflect the number of staff attending the clinic;
       e. Six-monthly review of templates;

5.4.15 If services are overburdened, priority will be given to patients in the acute phase of their treatment over those returning for surveillance.

5.4.16 Designated staff will have the initial responsibility for arranging outpatient service appointments within the desired timeframe for the patient’s assigned clinical urgency category. Should the designated staff be unable to arrange appointments in the recommended timeframe, the Accountable Officer will assume responsibility for expediting access to outpatient services.

5.4.17 Patients waiting longer than the recommended timeframes for Outpatient Services may be offered alternative opportunities including:
   - Transfer from consultant to another within the same specialty;
   - Complementary treatment management;
   - Transfer to another public hospital that provides the services and where a shorter waiting time for an Outpatient Services appointment is available;
   - Transfer to a private clinic.

5.4.18 Where patients accept an offer for transfer to another medical officer or hospital, appropriate arrangements will be made for:
   - Documentation of the patient election;
   - Notification to the referring practitioner;
   - Documentation of the transfer in the patient medical record and Outpatient Services wait list system;
   - Documentation of all correspondence/communication regarding the patient transfer to be retained in the patient’s medical record.

Scheduling Processes

5.4.19 Patients will be booked into staggered appointment times rather than booking block appointments for the clinic – group or class activities are exceptions to this rule.

5.4.20 Appointment times will be allocated in a patient-focussed manner.

5.4.21 Where possible, appointment times should be arranged to facilitate patients being seen by the same clinician or specialist team at each appointment;

5.4.22 Social and geographic factors will be taken into consideration in the allocation of appointment times

5.4.23 Scheduling of Outpatient Services appointments will reflect the number of medical officers working within that clinic – e.g. if there are three (3) medical officers in attendance, no more than three (3) appointments should be offered for any one specific time slot.

5.4.24 Hospitals are to implement procedures to ensure that patients are allocated to clinics with due consideration of teaching time for undergraduate and post graduate health professionals.

Identifying eligible patients

5.4.25 Hospitals will have in place processes to identify all patients referred to Outpatient Services as eligible or ineligible, compensable and public or private.

5.4.27 Eligible patients include Australian citizens and visitors from countries with which Australia has a Reciprocal Health Care Agreement for “immediately necessary” care. Eligible patients may choose to receive public hospital services free of charge. However, hospital accommodation and treatment as a private patient is not covered. For further information see:


5.4.28 Ineligible patients include all overseas students and visitors from countries that do not have a Reciprocal Health Care Agreement with Australia. Ineligible patients may be charged for public hospital services. For further information see: [http://qheps.health.qld.gov.au/rspu/html/rev_gen/rev_fee_pay.htm](http://qheps.health.qld.gov.au/rspu/html/rev_gen/rev_fee_pay.htm)

5.4.29 A compensable patient is entitled to compensation that includes the cost of their public and/or private hospital care. There are four broad categories of compensable patients:

- Department of Veterans’ Affairs;
- Motor Accident Insurance Commission;
- Work Cover;
- Other Third Party;


5.4.30 Private patients referred to a nominated hospital staff specialist, visiting medical officer or health professional with right of private practice may elect to receive treatment as a private patient under the following conditions:

- Participation of staff in the private practice scheme in no way compromises or adversely affects the timeliness or quality of treatment of public patients;
- Private patients may be charged an amount determined by Queensland Health.


### Identifying listing status

5.4.31 Hospitals will have in place processes to identify the Listing Status of all patients referred to Outpatient Services as either “Ready for Care” or “Not Ready for Care”. The application of “Not Ready for Care” listing is patient focussed and not determined by health service issues such as the availability of human or material resources.

5.4.32 A patient’s status is classified as either “Ready for Care” or “Not Ready for Care” in terms of their ability to accept an offer of appointment for an outpatient service.

5.4.33 In the context of Outpatient Services, “Ready for Care” patients are those who are prepared to attend the outpatient clinic. To be listed as “Ready for Care” a patient shall:

- Have been assessed as requiring an outpatient appointment by an attending medical officer or relevant health care worker;
- Be available to attend an outpatient appointment (with reasonable leeway for negotiation on specific appointment dates).

5.4.34 “Not Ready for Care” patients are those who are not in a position to accept an offer of appointment to attend the Outpatient Service. These patients are either:

- Patients whose health status precludes them from accepting an appointment;
- Patients who wish to defer their appointment for personal reasons. Deferment of an appointment for personal reasons may extend for a period of up to three (3) months – for longer periods the patient will be removed from the appointment list and a new referral will be required. Category 1 patients wishing to defer appointments for Outpatient Services will require direct (telephone) consultation with a clinician to assess appropriate action and subsequent communication with the referring practitioner. Liaising with the triaging medical officer should also be undertaken.

5.4.35 Designation of “Not Ready for Care” status will be supported by documentation of the reason/s for the inability to accept the outpatient service appointment.
Linking appointments to referrals

5.4.36 All scheduled appointments will be linked to the associated referral.

5.4.37 For reasons of patient safety, ensuring continuum of care and facilitating on-going management of the wait list, all appointments that are scheduled for an outpatient service appointment will be linked to the associated referral.

5.4.38 A "New Case" appointment is a non-admitted patient service under a specialist, consultant physician or health professional's care for a new problem not previously treated and discharged from the same clinical service.

Allocating appointments

5.4.39 Appointments for Outpatient Services are allocated on the basis of clinical urgency utilising a partial booking system.

5.4.40 The partial booking system applies to both new and repeat case appointment scheduling.

5.4.41 Patients will be offered an appointment date no more than thirty (30) days in advance of the offered date.

5.4.42 All patients will confirm the offer of appointment within fourteen (14) days of the offer being made.

5.4.43 A letter of confirmation of the booked appointment will be sent to the patient and referring practitioner.

5.4.44 Appointment offers that are not confirmed within the specified timeframe will be offered to other patients.

5.4.45 The appointment scheduling or booking system will facilitate the immediate booking of Category 1 patients within the accepted timeframe (30 days) from when they are placed on the wait list.

5.4.46 A partial booking system that allocates appointments no more than thirty (30) days in advance of the offered appointment date will be utilised for Category 2 and Category 3 patients. The partial booking system integrates the Outpatient Services wait list with the appointment scheduling process and provides a number of benefits including:
   - The ability to offer any cancelled appointments to patients of high priority remaining on the wait list;
   - Reduction in the frequency of rebooking and rescheduling of appointments;
   - Assistance with reallocation of appointments as a result of clinic rescheduling.

Failure to attend for a booked appointment

5.4.47 Hospitals will introduce procedures to identify and contact patients who do not attend for their booked outpatient service appointment.

5.4.48 Written notification (or appropriate communication measures as required) of failure to attend for a booked outpatient service appointment together with the appropriate requested action will be sent to the patient and the referring practitioner.

5.4.49 When a patient fails to attend for a booked New Case outpatient service appointment, the patient will be removed from the appointment schedule and the referral (together with the responsibility for ongoing care of the patient) is returned to the referring practitioner. The patient will be notified of this action in writing. Clinician discretion will be used to determine whether the patient is contacted directly regarding their non-attendance relative to the assessed degree of clinical urgency of their condition.

Reviewing urgency level

5.4.50 Local department procedures will describe the process of clinician referral review including urgency level, and decisions to remove patients from the appointment schedule, and returning the responsibility to the referring practitioner.

5.4.51 When a patient fails to attend for a booked Repeat Case outpatient service appointment, consultation with the attending clinician is undertaken in order to determine whether the patient is to be removed from the appointment schedule or invited to rebook the appointment. If the patient is removed from the appointment schedule, the referral (together with the responsibility for ongoing care of the patient) is returned to the referring practitioner. The patient will be notified in writing of this action.

5.4.52 When a decision has been made to offer a patient a rebooking for a missed appointment they shall be required to respond to the offer within fourteen (14) days.
5.4.53 When a patient fails to attend for a booked appointment made from an invited rebooking, or fails to respond to a letter of offer to rebook, the patient will be removed from the appointment schedule and the referral (together with the responsibility for the ongoing care of the patient) is returned to the referring practitioner. The patient will be notified in writing of these actions.

5.4.54 Hospitals will inform and educate patients about the effects of non-attendance for booked appointments in order to minimise the occurrence and consequences of missed outpatient appointments.

- Education may include the provision of information about patient responsibilities and the effects of missed appointments on service provision;
- Other measures utilised to reduce missed appointments should include:
  - Keeping the patient and the referring practitioner informed through written and verbal communication;
  - Patient confirmation of offer of appointment;
  - Telephone or SMS reminder of booked appointment 1-7 days prior to the appointment date;
  - Redistribution of referrals to hospitals providing a service closer to the patient’s residential address – with the consent of the patient and the referring practitioner;
  - Reduction of follow-up visits – once the single course of treatment has concluded patients are returned to the care of the referring practitioner;
  - Regular administrative auditing and clinical review of patients on the wait list.

Management of Cancellations

5.4.55 Hospitals will have in place procedures to minimise the cancellation of outpatient service appointments and to ensure appropriate utilisation of hospital resources should cancellations occur.

5.4.56 Appointment cancellations may occur because of the necessity to balance the needs of patients requiring urgent appointments or emergency care and those requiring assessment less urgently.

5.4.57 Cancellations of appointments may be initiated either by the patient due to personal reasons or by the hospital.

5.4.58 Hospitals may need to cancel outpatient appointments or clinics due to unforeseen circumstances such as the need for a specialist to attend emergency surgery, or other factors related to human resources, equipment or facilities.

5.4.59 Hospitals will educate patients in order to minimise the occurrence and consequences of patient-initiated cancellation of booked outpatient service appointments.

- Education will include the provision of information about patient responsibilities and the effects of late notification of cancellation on service provision;
- Information about the clinical implications of appointment cancellation should be emphasised;
- Patients may request cancellation of booked outpatient service appointments for clinical, personal or social reasons;
- When cancelling booked outpatient service appointments at the request of a patient, staff will ensure:
  - Rescheduling of the cancelled appointment for the patient, if appropriate;
  - Rescheduling of the vacated appointment time for use by another patient, if appropriate.

5.4.60 When a patient cancels a booked appointment and does not wish to reschedule, consultation with the attending clinician will take place prior to the removal of the patient from the appointment schedule.

5.4.61 Hospitals will implement processes to minimise hospital-initiated cancellations, while maximising service efficiency. These processes will include:

- Management of staff leave;
- Management of scheduled equipment maintenance;
- Regular review of cancellation causes by the Manager of the Outpatient Service and the Accountable Officer.

5.4.62 When a decision has been made to cancel appointments for a particular clinic session, arrangements will be made, where possible, for any available clinic time to be utilised for other patients.
5.4.63 Hospitals will implement processes to ensure, wherever possible, that rescheduling and cancellation of appointments or clinics is carried out with due consideration of clinical urgency and other patient-related factors:

- Attending clinicians will review and are responsible for the rescheduling of all affected patients in order to determine a safe, timely and appropriate course of care;
- Rescheduling of more urgent patients is undertaken prior to those of a less urgent nature;
- Patients who have experienced more than one hospital-initiated cancellation will be treated as high priority and immediately rescheduled for the next available appointment;
- The social and geographic circumstances of a patient are to be taken into consideration in the event of rescheduling (e.g. patients who need to travel long distances, and those who are carers should be given special consideration).

5.4.64 When hospital-initiated cancellations of appointments or clinics is necessary, hospital staff and other practitioners (including visiting medical officers) will make every effort to minimise the impact on patients:

- The patient should be notified as soon as possible after the decision to alter the booked appointment is made;
- The patient should be offered a booking for the next available clinic list. If immediate allocation of a new date is not possible at the time of cancellation, a new date will be allocated within forty-eight (48) hours. Confirmation of the new date will be made in writing to the patient.

**Wait List System**

5.4.65 Hospitals will maintain a wait list to register essential details about all patients (public and private) requiring outpatient service consultation.

5.4.66 An Outpatient Service wait list contains details about all patients who require an outpatient appointment, from the time that the hospital receives the referral until the initial appointment has been allocated, or the patient has been removed from the wait list.

5.4.67 A referral received by an Outpatient Service that is allocated a non-admitted patient care clinical urgency category is referred to as an “Accepted” referral.

5.4.68 Following receipt of an outpatient occasion of service the status of the associated referral will be updated on the system to ensure that those referrals are no longer included in wait list management procedures.

5.4.69 The system utilised to register patients on the Outpatient Services wait list will be a corporately approved electronic scheduling system.

5.4.70 The essential patient details to be registered will include:

- Patient identification details (Unit Record Number);
- Patient contact details;
- Referring practitioner details (name, address, contact numbers);
- Date referral written;
- Date referral received;
- Date referral accepted and clinical urgency category;
- Allocated specialty (consultant/clinician name if known/applicable);
- Reason for presentation (provisional diagnosis).

5.4.71 Patient information contained in the wait list register will be handled in accordance with all relevant legislation and Queensland Health policies. For further information see:


**Removal from the Outpatient Service Wait List or Appointment Schedule**

5.4.72 Hospitals will manage processes to ensure patients are removed from the Outpatient Service wait list or appointment schedule according to the appropriate ‘reasons for removal’, and under the authorisation of the attending medical officer, health professional, or Accountable Officer

5.4.73 Removal of patients from the Outpatient Service wait list or appointment schedule is necessary to maintain the accuracy of the outpatient service information systems.

5.4.74 The patient and the referring practitioner will be notified in writing when the patient is removed from the Outpatient Service wait list or appointment schedule for reasons other than the completion of a single
course of treatment (these include: non-response to audit; failure to attend for booked appointment/s; declining an offer of appointment).

5.4.75 The reason for removal from the Outpatient Service wait list or appointment schedule is updated on the patient’s wait list record and in the patient’s medical record.

Reasons for removal

5.4.76 Reasons for removal from the Outpatient Service wait list or appointment schedule include:
- Patient request to have name removed;
- Clinical review or administrative audit ascertains that outpatient service attendance is no longer required;
- Advice that the patient has been or will be attending elsewhere for treatment of the same condition;
- The patient has:
  - Declined the offer of a clinic appointment without valid reason;
  - Not presented for a booked clinic appointment and has not contacted the hospital;
  - Not responded to audit measures and cannot be located;
- The patient is deceased.

5.5 Privately Referred Non-Admitted Patients

Commonwealth Funding Arrangements

5.5.1 Current Commonwealth Government funding arrangements for public hospitals allow for the treatment of private outpatients if all the following requirements are met:
- The patient shall choose to be treated as a private patient;
- The patient will have a referral to a named specialist; and
- The medical specialist shall be exercising a right of private practice at the hospital.

Referrals

5.5.2 All referrals to a private (including bulk-billed) outpatient service will be to a named specialist / consultant with a right of private practice.
- Referrals may be made to the principal specialist of the clinic and the patient may be treated (and billed) by another specialist operating within the same specialty.

5.5.3 All hospitals will ensure that patients are provided with the option to attend a public or private (including bulk-billed) outpatient service.
- Referral pathways will not be designed nor controlled so as to deny access to free public hospital outpatient services.
- Referrals to a named specialist will not be a prerequisite for access to outpatient services.

Patients

5.5.4 Patients will freely choose to be treated as a private (including bulk-billed) patient – this election is made prior to the patient presenting at the outpatient service.

5.5.5 Patients will be informed at the time the appointment is made of any financial charges associated with their treatment and whether these will be fully covered by Medicare (i.e. bulk-billed).

Treating Clinicians

5.5.6 The treating clinician is responsible for ensuring that all their private (including bulk-billed) patient services are claimed in accordance with Medicare requirements.
- It is the responsibility of the treating clinician to ensure that the correct Medicare item is claimed for the service/consultation provided.
- Where applicable (eg. Under Option B), facility charges, including any "minor theatre" fees, are payable by the treating clinician.

Medicare/Billing

5.5.7 The private relationship between the clinician and the patient is recognised: systems are in place to allow clinicians to bill Medicare for outpatient services provided.

5.5.8 Medicare details shall be obtained (manually or electronically) and a Medicare voucher completed.
- Item numbers, as advised by the treating clinician, are recorded on the patient voucher;
- The Medicare voucher is not valid until signed by the patient;
The Medicare voucher will not be signed by the patient prior to the consultation/procedure, and the voucher will be signed prior to the patient leaving the outpatient service.

### 5.6 Monitoring and Reporting

5.6.1 The Accountable Officer will organise and oversee the development of processes to evaluate Outpatient Services performance and activity within specified parameters on a monthly basis. The developed indicators (see Table 1) will provide the basis for workforce and service planning as well as providing direction for identification of issues impacting on access to services and service efficiency and the development of strategies to address these.

5.6.2 The Accountable Officer will ensure that the Outpatient Services Implementation Standard is adopted as the minimum standard for outpatient services management practices.

5.6.3 The Accountable Officer is responsible for overseeing the monitoring and coordination of the Outpatient Services wait list and ensuring the integrity of the wait list data.

5.6.4 The Manager of the Outpatient Service is responsible for the monitoring and coordination of the wait list to ensure all patients are allocated appointments according to clinical urgency (category), with all management practices consistent with this Implementation Standard.

5.6.5 Hospitals will ensure that Outpatient Services are managed within the framework provided by this Implementation Standard as the minimum practice standard.

5.6.6 Hospitals will undertake an annual audit to determine compliance with the Outpatient Services Implementation Standard.

5.6.7 Hospitals may develop additional business rules to improve outpatient service practices, however, these will support the Outpatient Services Implementation Standard;

5.6.8 All additional business rules will be registered with the Access Improvement Service identifying:

- The additional rules;
- The reason for the changes.

### Clinical Monitoring

5.6.9 Hospitals will introduce processes to ensure that all patients placed on a Outpatient Service wait list who have waited longer than the recommended timeframe for their determined clinical urgency category will have regular, formal reviews of their clinical condition until their initial consultation.

5.6.10 The referring practitioner will assume the responsibility for clinical monitoring and communication to facilitate timely and appropriate clinical management of their patients registered on the Outpatient Service wait list who are awaiting initial consultation.

5.6.11 Clinical monitoring of patients awaiting an initial consultation for an Outpatient Service is most appropriately conducted by the referring practitioner.

5.6.12 Referring practitioners will be notified of the need to monitor the patient’s clinical condition and communicate any changes to their condition.

5.6.13 Referring practitioners will be asked to notify the hospital in writing of any changes to the patient’s clinical status. The need for subsequent re-categorisation will then be considered by the triaging clinician.

5.6.14 A record of notification of any changes to the clinical status of patients registered on the Outpatient Services wait list will be maintained in the patient’s medical record.

### Administrative Audit

5.6.15 Hospitals will implement a system of regular administrative audit to ensure the Outpatient Services wait list provides an accurate record of patients awaiting outpatient consultation.

5.6.16 Wait list audits will be conducted by a designated person and are undertaken in order to:

- Identify wait list records that are incorrect (e.g. duplicate records, patients seen but not removed);
- Confirm patient details to maintain the accuracy of wait list records;
- Identify patients no longer requiring the service.
5.6.17 Administrative audit involves contacting patients by letter, telephone or other appropriate methods.

5.6.18 Two attempts shall be made to contact patients – generally this would consist of a letter and a follow-up phone call.

**Administrative audit or outpatient service wait lists**

5.6.19 The administrative audit of outpatient service wait lists will include:

- Weekly audit of Category 1 patients who have waited longer than thirty (30) days for an appointment. (Due to the clinical urgency related to long wait Category 1 patients, it is advisable that contact with the patient and referring practitioner be undertaken by a clinician with ongoing consideration of alternative management options which may include inter-facility transfer where applicable.)
- Six (6) monthly audit of Category 2 patients who have waited longer than ninety (90) days for an appointment.
- Twelve (12) monthly audit of Category 3 patients who have waited longer than three hundred and sixty-five (365) days for an appointment.
- Annual audit of the complete waiting list.

5.6.20 Patient contact as part of the administrative audit process will:

- Verify/update contact details;
- Ascertain whether the patient still requires the outpatient service appointment (i.e. has not attended for a consultation elsewhere for the same condition);
- Identify whether the patient has been registered on a wait list at another hospital for the same condition;
- Identify the date when the patient was last reviewed by the referring practitioner.

**6. Review**

This Standard is due for review on: 25 November 2011

**7. History**

<table>
<thead>
<tr>
<th>Date of new / revised policy</th>
<th>Amended to...........</th>
</tr>
</thead>
<tbody>
<tr>
<td>November 2010</td>
<td>Governance of Outpatient Services Policy and Implementation Standard</td>
</tr>
</tbody>
</table>

**8. Responsibilities**

Hospitals will identify an Accountable Officer who is responsible for Outpatient Services, acknowledging the need for performance accountability. The Accountable Officer is responsible for establishing and chairing the District Outpatient Services Management Committee. The District Outpatient Services Management Committee membership will consist of, but not be limited to: Member of the District Executive, local General Practitioner, relevant General Practice Division representative, Nurse Unit Manager/Outpatient Services Manager, physician, surgeon, private practice clinics representative, allied health representative and administrative staff representative.

**Table 1 Positions, Responsibilities and Accountabilities.**

<table>
<thead>
<tr>
<th>Position</th>
<th>Responsibility(ies)</th>
<th>Accountabilities / Audit Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatients Accountable Officer</td>
<td>The Accountable Officer will organise and oversee the development of processes to evaluate Outpatient Services performance and activity within specified parameters on a monthly basis and be responsible for: Establishing and chairing the District Outpatient</td>
<td>District Management Outpatient Service Management Committee Established and meets regularly.</td>
</tr>
</tbody>
</table>
Services Management Committee;
- Working with staff to instigate positive change and enhance outpatient service performance and throughput;
- Initiation of clinical reform in order to improve patient access, maximise patient outcomes and support the provision of consistent high quality and efficient outpatient services.

The accountable officer will oversee and ensure that patient-level electronic data on referrals for outpatient services and patients treated is provided corporately. The accountable officer will also ensure:
- Outpatient Services are management processes comply with the Outpatient Services Implementation Standard
- All referral letters received are date stamped (with date of receipt), recorded in the appointment scheduling system and filed appropriately within two (2) days of receipt
- All referral letters for Outpatient Services are categorised within five (5) days of receipt
- Referring practitioners and patients are notified of any services that have been requested that are either not provided by Queensland Health or unavailable at that facility
- All information regarding the progress of the patient referral is conveyed to the patient and referring practitioner including:
  - Acknowledgement of receipt;
  - Status of the referral including:
    - Categorisation;
    - Placement on wait list with approximate wait time;
    - Offer of appointment date;
    - Confirmation of appointment date.
- The return of the referral to the referring practitioner if it does not contain the adequate or appropriate degree of information required to enable an informed assessment of the degree of clinical urgency of the patient's presenting condition, advising them that until the additional requested information is received, the referral cannot be accepted
- The accuracy and integrity of the Outpatient Service wait list are maintained through a regular process of clinical review and administrative audit
- Current elective surgery wait lists are available for review by consultant medical officers at each surgical clinic session
- All alterations to and selections from the Elective Surgery wait list are accurately and concisely conveyed to the surgical booking office
- The accurate collection and collation of the activity and performance data requirements as identified by Queensland Health to meet state and the Australian government information, funding and reporting obligations

The following indicators are undertaken/reported on a monthly basis:
- Auditing of referrals on the wait list;
- Number of referral received in each specialty;
- Number of New Cases seen in each specialty;
- Number of discharges for each specialty;
- Ratio of New Case appointment to Repeat Case appointment in each specialty;
- Maximum days wait for appointment by clinical urgency category in each specialty;
- Conversion ratio from outpatient to elective surgery wait list in each surgical specialty;
- Total number of patients waiting for an appointment by clinical urgency category in each specialty;
- Failure to attend rates in each specialty;
- Cancellation rates (patient and hospital-initiated) in each specialty;
- Reschedule rates (patient and hospital-initiated) in each specialty;
- Percentage compliance with the 5 day triage policy.
### Coordination of clinic lists to provide appointments for long wait elective surgery patients requiring a clinical review.

### District Chief Executive Officer

The District Chief Executive Officer has the overall responsibility for ensuring there are mechanisms in place to:

- Implement and maintain compliance with the Outpatient Services Implementation Standard;
- Facilitate efficient and effective Outpatient Services management practices through the provision of adequate facilities and staffing and a suitable work environment;
- Validate the accuracy and integrity of all reported data;
- Regularly review outpatient service performance.
- Appoint an Outpatient Services Accountable Officer with the responsibility for the management of outpatient services.

An Accountable Officer is appointed.

### All Outpatient Medical Officers and Health Professionals involved in the provision of Qld Health Outpatient Services.

All Outpatient Medical Officers and Health Professionals involved in the provision of Qld Health Outpatient Services will:

- Ensure patients are provided with accurate information relating to their condition and treatment and are invited to participate in the decision-making process regarding the determination of that treatment,
- Ensure that the referring practitioner is informed of the treatment plan and the patient’s progress during care and at the time of discharge from the service,
- Discharge patients back to the care/supervision of their referring practitioner as soon as practicable or when the single course of treatment has completed,
- Provide four (4) weeks written notice of planned leave or clinic session modifications to the Outpatient Service Manager (or nominated delegate), including relief arrangements and/or cancellation, rescheduling or reduction of clinic appointment/session numbers,
- Notify the Outpatient Service Manager (or nominated delegate) as soon as practicable, of any unplanned/emergent incidents that either prevent them from either attending for a scheduled clinic session or commencing a scheduled clinic session on time,
- Liaise with clinic staff to determine further clinical actions regarding patients who fail to attend for their booked appointments.

Monitor discharge rates.

### Specialty Director/Consultant Medical Officers.

Specialty Director/Consultant Medical Officers will:

- Ensure all referral letters for clinics within their specialty are triaged, categorised by clinical urgency and prioritised within five (5) days of receipt.

Referrals are triaged and categorised by clinical urgency and prioritised within five days of receipt.
Queensland Health Standard: Outpatient Services

<table>
<thead>
<tr>
<th>Elective Surgery Coordination/Liaison Officers.</th>
<th>Elective Surgery Coordination/Liaison Officers will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Liaise with Outpatient Service staff to ensure that patients who may require elective surgery are allocated to the appropriate medical officer with the shortest waiting time,</td>
</tr>
<tr>
<td></td>
<td>• Liaise with Outpatient Service staff to coordinate appointments for undertaking clinical review of any patients registered on the Elective Surgery Wait List identified as requiring a clinical review of their condition,</td>
</tr>
<tr>
<td></td>
<td>• Ensure that Elective Surgery wait list reports are available for consultation by relevant medical officers at the time of their clinic session.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Queensland Health</th>
<th>Queensland Health will:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Facilitate the efficient and effective management of Outpatient Services through regular review and development of the Outpatient Services Governance Policy, and Outpatient Services Implementation Standard.</td>
</tr>
<tr>
<td></td>
<td>• Monitor hospital activity and performance against identified indicators in order to identify issues that impact upon the management of Outpatient Services.</td>
</tr>
<tr>
<td></td>
<td>• Assist in the development of strategies for improvement as required to ensure system wide equity of access relative to clinical need</td>
</tr>
<tr>
<td></td>
<td>• Publish and disseminate statewide Outpatient Service wait list information in accordance with the Standard</td>
</tr>
<tr>
<td></td>
<td>• Develop, maintain and support information systems that facilitate the effective and efficient management of Queensland Health Outpatient Services</td>
</tr>
<tr>
<td></td>
<td>• Continue to commit the resources necessary to improve the health of the people of Queensland</td>
</tr>
</tbody>
</table>

Monitor elective surgery waiting list.

Publish and disseminate statewide Outpatient Service wait list information in accordance with the Standard.

Dr Tony O’Connell and Chief Executive Officer, Centre for Healthcare Improvement.

Approval Date: 25 November 2010

Implementation Date: 25 November 2010.