1. **Statement**

The Specialist Outpatient Services Implementation Standard outlines the suite of business rules and processes for ensuring equitable access for all patients requiring specialist medical outpatient services at Queensland public hospitals by providing best-practice waitlist management processes aimed at facilitating treatment of patients within clinically recommended timeframes.

This standard does not replace, but is additional to, the professional self-regulation and individual accountability for clinical judgement that are an integral component of healthcare.

2. **Scope**

Specialist outpatient services are conducted for the purpose of assessment and management of conditions which require specialist opinion above that available within the primary healthcare setting. This will 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 healthcare conditions.

The Specialist Outpatient Services Implementation Standard provides minimum requirements for care for all patients requiring assessment within or access to specialist outpatient services and outlines the business rules and processes and demonstrates best practice for:

- all employees, contractors and consultants within Queensland public Hospital and Health Services (HHSs),
- departmental divisions and commercialised business units that are involved directly or indirectly (via support services or management functions) in the provision of specialist outpatient services as defined by the Specialist Outpatient Data Collection Manual.

The business rules and processes outlined in the Specialist Outpatient Services Implementation Standard apply to both new and review appointments.

2.1 **Out of Scope**

The following services are out of scope for the business rules and processes outlined in the Specialist Outpatient Services Implementation Standard:

- Allied health
- Diagnostics
- Maternity.

However, where possible, the business rules and processes outlined in the Specialist Outpatient Implementation Standard should be used as a guide for managing out of scope services unless covered by another guideline or implementation standard.
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Specialist Outpatient Services Implementation Standard
Clinical Excellence Division
Healthcare Improvement Unit
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3. Requirements

3.1 Guiding principles

Provision of specialist outpatient services in Queensland public Hospital and Health Services (HHSs) must be in accordance with the details contained in the business rules for the National Healthcare Agreement and HHS Service Agreements.

Specialist outpatient services should:

1. have patients and carers as the primary focus
2. be proactive, equitable and transparent in the management and delivery of services
3. support patients to be seen as close to their home as possible, by the most appropriate clinician for the level of care required
4. provide patients with the appropriate treatment option that will result in care as close as possible to their clinically recommended timeframe
5. optimise continuity of care by facilitating patients being seen by the same clinician or team at each appointment wherever possible
6. deliver coordinated care, clinical follow-up and appropriate discharge planning for patients and carers
7. include the development of an agreed pathway of care and treatment during the initial consultation in partnership with the patient
8. empower patients to participate in decision making and to make informed choices about their pathway of care
9. ensure the ordering of appropriate diagnostic tests/investigations to support diagnosis and inform appropriate treatment pathways
10. ensure appropriate processes are in place to seek informed consent from the patient, guardian or attorney prior to undertaking designated treatments or procedures
11. provide information, education and support to patients and carers throughout the process
12. provide patients with information that identifies their rights and responsibilities and the process for lodging complaints and compliments
13. be coordinated to promote the most effective use of available resources
14. be the shared responsibility of the health service, specialist medical practitioner, and referring practitioner (and nominated general practitioner where not the same)
15. maintain transparent, valid and reliable record keeping (electronic and/or written) and reporting
16. ensure referrals for specialist outpatient services are clinically appropriate and facilitate the most suitable treatment for the patient’s reason for referral
17. ensure communication with patients, referring specialist medical practitioners, referring practitioners and nominated general practitioners occurs in a timely and efficient way that provides easy-to-understand information appropriate to the intended audience to facilitate optimum patient treatment
18. exercise discretion to avoid disadvantaging patients in the case of hardship and other extenuating circumstances
19. consider the principles and requirements of the Specialist Outpatient Services Implementation Standard when entering into collaborative arrangements with private specialist outpatient service providers.

3.2 Eligibility

Specialist outpatient services will be provided to those who:

- have a valid referral, **and**
- require assessment and management of conditions which require specialist opinion above that available within the primary health care setting, **and**
- assessed, where applicable, as meeting the minimum threshold to benefit from specialist outpatient assessment as specified in Clinical Prioritisation Criteria (CPC) or local referral guidelines for their condition, **and are either:**
  - Medicare eligible (including patients referred from the Department of Corrective Services), or
  - are compensable patients (note that charges will apply), or
  - are private patients who meet the above criteria and are referred to a nominated HHS staff specialist, visiting medical officer or health professional with right of private practice and who elect to receive treatment as a private patient. This may only occur when participation of staff in the private practice scheme in no way compromises or adversely affects the timeliness or quality of treatment of public patients.

Specialist outpatient services may be offered to Medicare ineligible patients (patients from another country where there is no reciprocal agreement but are holders of relevant health insurance policy - note that charges will apply) at the discretion of the HHS. HHSs should have appropriate processes in place for managing the treatment and payment of Medicare ineligible patients.

3.3 Access

Access to publicly funded specialist outpatient services is only possible through registration of the patient on the specialist outpatient waiting list of a HHS.

The responsibility of HHSs to provide specialist outpatient services is determined by:

- the geographic catchment or population for which that HHS is responsible for providing health services for, as articulated in their service agreement with the Department. In the case of state-wide specialist outpatient services, HHSs have a responsibility to provide services to the whole of Queensland
- The volume and type of activity that a HHS has agreed to provide is specified in the current Service Agreement with the Department. This may include activity that has historically flowed from one geographic catchment to another because a patient’s place of residence does not have the service capability to safely provide the service.
It is mandatory for HHSs to accept specialist outpatient service registrations for patients outside of their geographic catchment where the service is not provided in the patient’s usual place of residence (this information must be formally documented at the time of referral) and

- the relevant service is provided either by local staff, public-private partnerships or outreach/visiting specialists, or
- historical flows of activity have been incorporated into their Service Agreement with the Department or the flow of activity has been included in the estimated future activity of the HHS.

Where a service is not available within a patient’s usual place of residence and the nearest HHS that provides the service refuses to accept a specialist outpatient registration for that service, the HHS where the patient resides should notify the HHS Chief Executive (or their nominated delegate).

Where unable to be resolved the issue should be tabled for discussion at the Relationship Management Group meeting.

Where a referral is received for a patient who resides outside the HHS and the service is available within the patient’s HHS, the referral is to be redirected to the HHS where the patient resides. The referring practitioner (and nominated general practitioner where not the same) and patient are to be advised in writing of the redirection. The referral should not be returned to the general practitioner for redirection.

Any disputes regarding purchased activity should be managed in accordance with the dispute resolution section of the relevant Service Agreement.

In situations where specialist outpatient services are provided through a cooperative arrangement between facilities (e.g. outreach or telehealth services), a Service Agreement between HHSs should clearly identify the service with the responsibility for each aspect of clinical and administrative service provision.

The Department will annually assess the performance of each HHS in relation to the delivery of specialist outpatient services and determine if the current level of self-sufficiency is appropriate to meet the needs of the population that the HHS serves, using estimated future activity projections. Any changes in the volume or type of activity purchased will be negotiated with HHSs and incorporated into their service agreement with the Department.

HHS’s have a responsibility to regularly monitor their demand and capacity to ensure timely access to services is sustainable. Where it is identified that there is insufficient capacity to treat patients within clinically recommended waiting times, the HHS must investigate strategies to align demand and capacity either internally or seek alternative, suitable arrangements to provide specialist outpatient services in time.

Clinical follow-up in specialist outpatient services must only be provided for a defined period for patients:

- with unresolved clinical problems relating to the reasons for referral
- requiring monitoring of new and/or potentially harmful therapy that cannot be safely undertaken in other settings or by other services
- with complex conditions that are unable to be safely treated by another service
- requiring monitoring of commenced management plans
- who are enlisted in a funded and approved research protocol.
Admitted patients with a scheduled specialist outpatient appointment should be reviewed in the inpatient (ward) area and not in the outpatient service area where appropriate. Exceptions to this would include, for example, patients requiring access to procedural work that is only available in the outpatient service area as specialised equipment is situated there, and there is no risk of harm associated with transport. Each patient’s case should be considered individually with patient safety, dignity, privacy and comfort as the primary considerations.

3.4 Service continuity
HHSs must be able to demonstrate to the Department that they have taken all reasonable steps to maintain local continuity for services that they have agreed to deliver under the current Service Agreement. Deferment, suspension or discontinuation of these agreed services for periods greater than 30 calendar days may result in activity being transferred to another public or private provider with the appropriate capability to deliver the service, unless the HHS can demonstrate that they are negotiating with an alternate service provider with equivalent service capability and capacity to provide the service.

The HHS Chief Executive (or their nominated delegate) must notify the Department (via the Healthcare Purchasing and System Performance Division) in writing that a specialist outpatient service has or will cease temporarily (for a period exceeding 30 calendar days) or for the foreseeable future, within five business days of being notified internally, including details of the proposed management plan. The HHS Chief Executive (or their nominated delegate) must also notify, in writing, any other services likely to be impacted by the service discontinuation, such as those to which outreach services are provided within 5 business days. HHSs should also refer to the relevant service agreement between the HHS and the Department regarding cessation of service delivery.

HHSs must not register patients on the specialist outpatient waiting list for the discontinued service from the date that they notify the Department that the service has ceased until an alternate service provider with the required service capability can be secured, unless directed to do so by the Department.

HHSs that cease provision of specialist outpatient services must ensure treatment elsewhere within the clinically recommended timeframe for patients accepted onto the specialist outpatient waiting list prior to the date that services were suspended.

Where a HHS ceases or suspends a service and it has been agreed with the Department and another HHS that patients who were accepted onto the specialist outpatient waiting list prior to the service being discontinued are to be referred to the other HHS as negotiated, the following must be undertaken:

The hospital where the patients are currently registered must:

- retain each patient on their public hospital waiting list until such time as the receiving public provider has clinically reviewed the patient and confirmed in writing that they will provide care. This is done to mitigate the risk of the patients becoming lost in the transfer process and to ensure that responsibility for the finalisation of the patients’ care is retained by the referring hospital
- Update each patient’s waiting list status to ‘transferred to other Queensland Health facility (Other HHS or Same HHS)’ upon confirmation that the patient has been accepted
• provide details as described in section 3.11.2: *Patients who permanently relocate from one HHS to another*, to the receiving hospital to allow the total days waiting for each patient on the receiving hospital’s waiting list to accurately reflect the original patient record
• notify the patient and referring practitioner (and nominated general practitioner where not the same) of the outcome of the transfer request once confirmed.

The responsible officer at the receiving hospital must:
• provide confirmation of receipt of the transfer request within the timeframe negotiated with the Department and referring HHS
• arrange an appropriate review of the patient transfer request and notify the referring hospital regarding the decision to accept or reject the transfer within the timeframe negotiated with the Department and referring HHS
• (timeframes will be dependent on the volume of patients being transferred; however, should be expedited to reduce delays in patient care)
• register the patients on their specialist outpatient waiting list and record each registration date as the date each patient was initially registered on the referring hospital’s specialist outpatient waiting list
• ensure that Not Ready for Care (NRFC) periods are not applied for any period of the transfer process in accordance with section 3.8.3: *Not ready for care*.

Where the receiving hospital has accepted patients who have or will exceed clinically recommended waiting times from the HHS who has ceased or suspended the service, they should retain a record of such patients for reporting at the Relationship Management Group meeting.

### 3.4.1 Outreach and visiting services

Outreach services are services delivered in sites outside of the HHS area to meet or complement local service need. Outreach services include services provided from one HHS to another as well as statewide services that may provide services to multiple sites.

Patients must be placed on the waiting list located at the HHS where the outreach specialist outpatient service will be provided. This is usually the HHS where the patient resides. HHSs that manage specialist outpatient waiting lists for outreach/visiting services are responsible for ensuring that patients are only waitlisted for appointments at facilities where the schedule of visits is such that services can reliably be delivered within clinically recommended timeframes. Category 1 patients should not be waitlisted at facilities where the provider’s schedule between visits is 30 calendar days or more.

In the event where outreach services cannot be provided within clinically recommended timeframes, the originating HHS should investigate options to expedite care within clinically recommended timeframes.

For outreach and visiting services, a service agreement between HHSs should clearly identify the service with the responsibility for each aspect of clinical and administrative service provision.

### 3.5 Duty of care
Once a referral has been received by a HHS, the HHS assumes some duty of care towards the patient, although the primary duty of care remains with the patient’s referring practitioner and/or nominated general practitioner until the patient has completed their initial consultation. The HHS’s duty of care while a patient is on a waiting list includes taking reasonable efforts to provide specialist outpatient care within clinically recommended timeframes, communicating with patients, referring practitioners and nominated general practitioners, and responding to information regarding changes to the patient’s condition during this time appropriately.

For internal referrals (section 3.6.2: Internal referrals) the duty of care solely lies with the HHS.

The HHS’s duty of care towards a patient continues throughout the course of treatment until the patient is referred back to the care of the referring practitioner or nominated general practitioner (if different), or in the case of internal referrals, until such time as the patient has completed their initial consultation and the referring practitioner and nominated general practitioner (if different) have been advised of the outcome of the assessment.

### 3.6 Referral management

#### 3.6.1 Referral sources
Access to specialist outpatient services is only possible through the lodgement of a written referral from a recognised referral source. Recognised referral sources include:

- General Practitioners
- Queensland Health employed Senior Medical Officers
- Queensland Health employed Visiting Medical Officers
- Privately employed Medical Officers
- Nurse practitioners and eligible midwives with a valid provider number
- Allied health practitioners with a valid provider number
- Queensland Health employed allied health practitioners.

Patients may be referred to a public specialist outpatient service for continued treatment following an initial consultation in a private setting. HHSs should have appropriate processes in place to manage and record these occasions of service in accordance with relevant funding requirements. The order of treatment should not be based on the public / private status of the patient.

#### 3.6.2 Internal referrals
A new referral that is generated from within the same hospital to refer a patient to either:

- a different specialist outpatient service or
- the same specialist outpatient service but for a different/new reason for referral.

An internal referral should only be generated where the patient’s condition is deemed likely to result in an emergency department presentation or an unplanned readmission to an inpatient unit if they are not reviewed by a specialist within 30 calendar days (except associated care referral requests). Only Category 1 internal referrals will be accepted. The duty of care for patients referred internally is a shared responsibility between the referring and receiving specialist of the hospital until such time as the patient has been seen. Where an appointment is not required within 30 calendar days, the patient’s care is to be returned to the nominated general practitioner for assessment and management. If the patient still requires assessment
by a specialist, the nominated general practitioner is to send a new referral to the specialist outpatient service as per standard referral pathways.

An internal referral includes referrals:
- generated from an inpatient admission for a new issue not related to the original reason for admission and not consulted on whilst an inpatient
- from emergency department presentations
- from a specialist outpatient attendance to the same specialty for a different condition
- from a Queensland Health employed allied health practitioner.

Internal referrals also include ‘associated care referral’ requests where assessment, treatment and / or investigation is needed from another specialist within the hospital to support diagnosis and / or treatment planning relating to the patient’s pathways of care. ‘Associated care referral’ requests are exempt from the 30 calendar day rule as per other internal referral requirements. However, an ‘associated care referral’ request must be categorised as a category 1, 2 or 3 based on the patient's clinical urgency. The timeframe for this appointment should also not exceed the associated maximum Not Ready for Care (NRFC) thresholds for the category of the initial referral (refer to section 3.8.5: Not ready for care thresholds and review requirements).

NB: If the ‘associated care referral’ request is for a pre-op review prior to elective surgery for which the patient is waitlisted, the assigned urgency category of the referral must not be less (urgent) than the category assigned to the elective surgery waiting list episode. E.g.: If a patient is on the elective surgery waiting list as a Category 2 and requires pre-op review, the ‘associated care referral’ request must be either a Category 1 or 2.

‘Associated care referral’ requests could include:
- referrals to another specialist for pre-op review or clearance prior to surgery
- any requests for assessment, investigations or diagnostic tests from one specialist to another within the same hospital for which the outcome is required to inform or progress treatment planning for the same reason for referral.

An internal referral does not include:
- referrals for admitted patients requiring an appointment for clinical review (inclusive of allied health and nursing outpatient services) following separation from an inpatient episode of care. In this instance, a formal request for a review appointment must be sent to the relevant specialist outpatient service and a copy must be included in the patient’s medical record.

Decisions about whether to accept an internal referral should refer to sections 3.1: Guiding principles, 3.2: Eligibility and 3.6.3: Referral validity, with the best interests of the patient and carer taking precedence over the interests of the hospital and HHS. All internal referrals must comply with Clinical Prioritisation Criteria (CPC) where CPC are available.

For all internal referrals, the patient and the patient’s nominated general practitioner must be informed that an internal referral has been made to a specialist outpatient service, with evidence of the communication retained in the patient’s medical record. The correspondence should contain the following information:
- reason for referral
- name of the specialist outpatient service to which the patient has been referred and
- any other relevant information.
3.6.3 Referral validity

Referrals are considered to be a form of clinical handover and as such, must provide adequate information for safe transfer of care. In order to be accepted, the referral (both internal and external) must:

- contain adequate information to allow for informed categorisation of clinical urgency, prioritisation and direction of patients to the appropriate specialist outpatient service
- comply with Clinical Prioritisation Criteria where CPC are available
- be received in writing, either in hard copy or via an approved electronic method.

Referrals should capture all of the following information where applicable:

- patient’s full name (and aliases)
- patient’s date and country of birth
- patient’s Medicare number
- patient’s full address, including whether patient resides at an aged care facility
- patient’s telephone contact number – home, mobile and alternative
- patient’s Aboriginal and Torres Strait Islander status
- patient’s preferred language and interpreter requirements
- patient’s choice to be treated as a public or private patient
- patient’s compensable status (e.g. Department of Veteran’s Affairs, Work Cover, motor vehicle insurance etc.) where relevant
- name of the parent or caregiver (if appropriate)
- name of delegate and contact details (Department of Corrective Services)
- referring practitioner’s full name
- referring practitioner’s full address
- referring practitioner’s contact details – telephone, facsimile, email
- referring practitioner’s provider number
- signature of referring practitioner (either in hard copy or via an approved electronic method)
- nominated general practitioner’s details (if known), if the nominated general practitioner is different from the referring practitioner
- reason for referral to the specialist outpatient service (including the problem to be assessed, degree of loss of function, pain experienced) relevant information about the patient’s condition
- presenting symptoms (evolution and duration)
- physical findings
- details of previous treatment and outcome (include systemic and topical medications prescribed for the condition)
- all conservative options that have been pursued unsuccessfully prior to referral
- details of any associated physical factors which may affect the condition or its treatment (e.g. diabetes, Body Mass Index)
- patient’s current medications and dosages (include any drug allergies)
- a comprehensive capture of information in relation to CPC where available
- relevant psychological and social issues including impact on:
  - employment
  - education
  - home
  - activities of daily living functioning – low/medium/high
• any special care requirements where relevant (e.g. tracheostomy in place, oxygen required)
• date of referral.

Referrals for specialist outpatient services remain valid for a single course of treatment for specified periods (e.g. three months, 12 months or indefinite):

• If referred by a specialist or internal clinician to another clinician, the active life of the referral is three (3) months from the initial outpatient consultation.

• If referred by a general practitioner, the active life of the referral is twelve (12) months from the initial specialist outpatient consultation, unless specified as indefinite by the general practitioner.

• Referrals for longer than twelve (12) months should only be used where the patient’s clinical condition requires continuing care and management by a specialist. In these cases the period for referral should clearly be expressed as ‘indefinite’, ‘ongoing’ or ‘requiring continuing care’.

HHSs must ensure that if a single course of treatment exceeds the referral validity timeframe, a new referral for continuation of care must be received from the referring practitioner or nominated general practitioner.

The presentation of an unrelated illness or condition will initiate a new referral. This new referral will need to be categorised independently of the initial referral.

Where more than one referral for different conditions has been received for the one patient, every effort should be taken to combine or align appointment times.

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

3.6.4 Declined referrals

Referrals received that do not meet referral criteria and/or CPC (where available) or are not suitable for treatment within a medical specialty must be:

• redirected back to the referring practitioner with suggestions for management, following clinical review of the referral or
• redirected to another appropriately qualified allied health practitioner, nurse practitioner, advanced practice nurse or registered nurse employed or contracted by Queensland Health for further assessment and/or treatment, following clinical review. The referring practitioner and patient must be notified of this course of action in writing (letter/email) within five (5) business days of the decision. (refer to section 3.8.2: Alternate pathways of care).

Referrals should be declined by a HHS in the following circumstances:

• the patient does not meet the requirements of section 3.2: Eligibility
• the referral is illegible
• the referral does not contain sufficient information to accurately categorise the level of clinical urgency
referral information indicates that the patient can be more effectively managed in the primary healthcare setting
the referral is for a service that the HHS does not have the capability to provide and there is evidence that the HHS has not accepted purchased activity in relation to the service via the current Service Agreement negotiated between the Department and the HHS.

In any instance where a referral is declined, the referring practitioner must be notified in writing of the reason for non-acceptance and alternate referral options outlined for services not provided locally (either temporarily for periods greater than thirty (30) calendar days or for the foreseeable future) within five (5) business days of receipt of referral. A record of the receipt of referral and non-acceptance of the referral must be maintained in the patient’s medical record and outpatient services information system.

HHSs must 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) business days of the decision to decline the referral and that alternative arrangements for treatment will be required.

3.7 Waiting list registration
All referrals received by the HHS must be recorded on an electronic waiting list system from the time that the HHS receives the referral until the patient has been removed from the waiting list.

A referral received by a specialist outpatient service that is allocated an urgency category is referred to as an ‘accepted’ referral.

3.7.1 Waiting list registration information
The information to be entered on the specialist outpatient waiting list information system upon registration must include:

- unique patient identifier (for example (Unit Record Number (URN))
- patient’s demographic details (first and second name, family name, sex, date of birth, indigenous status)
- patient’s contact details (address including suburb and postcode, contact telephone numbers)
- referral source type (section 3.6.1: Referral sources)
- referring practitioner’s details (name, address, contact numbers – section 3.6.3: Referral validity)
- nominated general practitioner’s details, if the nominated general practitioner is different from the referring practitioner
- date of the referral
- date the referral was received by the hospital
- clinical urgency category assigned to the referral (section 3.7.4: Urgency category assignment)
- clinic/service area the referral is allocated to (consultant/clinician name if known/applicable)
- allocated service provider
- reason for referral (provisional diagnosis)
- date/s of any appointments booked against the referral
- an indication of whether the booked appointment/s are to be provided in a group session
The HHS must ensure appropriate processes are in place for confirming the details of the patient’s nominated general practitioner, which are registered on the waiting list information system, are correct and up-to-date and that the patient has been advised that information regarding the patient may be provided to their registered nominated general practitioner.

3.7.2 Waiting list registration exclusions
A patient cannot be registered on a specialist outpatient waiting list if they:

- are not ready for care for clinical or personal reasons at the time of the request for placement on the specialist outpatient waiting list, or
- are already known to be on a specialist outpatient waiting list at another hospital for management of the same reason for referral.

3.7.3 Duplicate referrals
In the event that a duplicate listing for the same patient is detected within or across HHSs, a clinical review of the patient’s medical record or referral must be undertaken by an appropriately qualified specialist (or their clinical delegate) at each hospital to confirm that the patient is waiting for the same condition.

If it is confirmed that the patient is waiting for management of the same reason for referral at more than one public hospital, the patient must be contacted to ascertain which hospital’s waiting list they should remain on. A patient can only be registered on one public hospital waiting list for the same reason for referral. In determining which waiting list the patient will remain on, the following should be applied:

1. The patient must be provided the treatment option that will result in an appointment within (or where not possible, as close as possible to) their clinically recommended timeframe and as close as possible to their place of residence.
2. If the patient declines the option that will enable their appointment within (or where not possible, as close as possible to) their clinically recommended timeframe and it is within 50km of their nearest public hospital, this should be considered a decline of an offer for an appointment and an appropriate NRFC applied – refer to section 3.11.3: Patients who are transferred from one public hospital to another.
3. If the patient has acquired a duplicate referral due to permanently relocating, refer to section 3.11.2: Patients who permanently relocate from one HHS to another.

At all times, consideration should be given to the patient’s social circumstances in relation to ongoing care and family support when determining at which hospital the patient should be waitlisted.

3.7.4 Urgency category assignment
All HHSs must implement procedures to manage referral urgency categorisation that include:

- registering receipt of all referrals received within one (1) business day of receipt
- clinical review of all referrals on the waiting list within two (2) business days of receipt
- urgency categorisation by a triaging clinician within five (5) business days of receipt of the referral.

The urgency category should be appropriate to the patient and their clinical situation and must comply with Clinical Prioritisation Criteria (CPC) where CPC are available, or as per endorsed...
local triage guidelines. Urgency categorisation must not be influenced by the perceived or actual availability of resources.

Assessment of a patient’s clinical situation should include consideration of their medical condition and the patient’s life circumstances (including issues related to activity limitations, restrictions in participation in employment and other life situations), carer responsibilities and access to carer and other supports.

The following urgency categories have been defined for use in specialist outpatient services undertaken in Queensland public hospitals:

- category 1 – Appointment required within 30 calendar days
- category 2 – Appointment required within 90 calendar days
- category 3 – Appointment required within 365 calendar days.

Referrals to specialist outpatients must not remain uncategorised by the triaging clinician for a period exceeding 5 business days from receipt of referral. Specialist outpatient referrals received without an urgency category assigned must be returned to the triaging specialist on the grounds that they are incomplete.

3.7.5 Ready for care
A patient’s waiting list 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 a specialist outpatient service.

In the context of specialist outpatient services, ‘ready for care’ patients are those:

- whose referral has been allocated an urgency category and have been placed on the waiting list for a specialist outpatient service, and
- who are available to attend a specialist outpatient appointment (with reasonable flexibility for negotiation on specific appointment dates).

3.8 Waiting list management

3.8.1 Urgency categorisation review and re-categorisation

Referring practitioners (and nominated general practitioners where not the same) should be notified of the need to monitor the patient’s clinical condition and communicate any changes to their condition, in writing, to the specialist outpatient service. If changes in the patient’s clinical condition occur, the triaging clinician will review the additional information and a determination regarding a change to the patient’s urgency category must be made within five (5) business days of receipt of information.

A record of notification of any changes to the urgency category of patients registered on the specialist outpatient waiting list, or the decision not to change the patient’s urgency category must be maintained in the patient’s medical record and the specialist outpatient information system and communicated, in writing, to the patient and the referring practitioner (and nominated general practitioner where not the same) within five (5) business days of the decision to re-categorise.

HHS’s must ensure that re-categorisation is not used as a tool to manage waiting times and that the urgency category is appropriate to the patient and their clinical situation and not influenced by the availability of hospital or specialist resources.
3.8.2 Alternate pathways of care

Medical specialists may refer patients to an alternate pathway of care. Alternate pathways of care may include allied health, nursing and non-medical specialist clinics as a first point of contact clinic for assessment and/or management of the reason for referral.

When a patient is referred to an alternate pathway of care, the following actions should be undertaken:

- Notify the alternative pathway provider that the referral is being transferred.
- Following acceptance by the alternate pathway provider, remove the specialist referral with the most appropriate referral removal reason and insert a comment stating ‘Transferred DD/MM/YY – provider/alternative pathway’ in the specialist outpatient information system.

If the patient is accepted for an alternate pathway of care, but is subsequently unable to be treated and is reinstated to the referring specialty waiting list, the NRFC – clinical status should be applied such that the NRFC end date is the date the patient was reinstated. The patient is to resume accruing days waiting from the NRFC end date.

It is the responsibility of the referring specialty where the patient is waitlisted to monitor waiting times and ensure that patients are offered the option that will enable access to care as close as possible to their clinically recommended timeframe and as close to the patient’s place of residence.

3.8.3 Not ready for care

Once registered on a specialist outpatient waiting list, the patient’s situation may change such that they are no longer ready for care for a defined period of time (due to personal, clinical or staged reasons). In this case, the patient should be assigned a not ready for care status on the specialist outpatient waiting list information system. The reason for the change in status must be retained in the patient’s medical record.

Patients who are identified as ‘not ready for care’ can be classified as either:

- **Clinical** – Patients who require an outpatient appointment, but are unable to accept an immediate offer of appointment until their clinical condition improves.

  This must not be used for patients who are waiting for an appointment in outpatients for treatment with a different specialist or specialty for a different reason for referral.

- **Personal (deferred)** - Patients who wish to defer their appointment for personal reasons including work or other commitments. NRFC - personal can only be used for patients whose personal circumstances alter in such a way that it would prevent them from accepting an appointment during the time that they are waitlisted.

- **Staged** – Patients who have been referred for an outpatient appointment but are not in a position to accept as they are waiting for other appointments for a complementary service or undergoing treatment for a complementary service.
Patients who advise the HHS that they are not ready for surgery for personal reasons must be informed of the maximum periods for deferment and that exceeding these thresholds may result in removal from the elective surgery waiting list.

3.8.4 Application and use of not ready for care periods

The use and application of not ready for care periods should only occur in the following circumstances:

- **Clinical**: must only be applied under the direction of a clinician involved in the patient’s care or where there is documented evidence (e.g. emergency department admission record) to indicate the patient was not ready for care for clinical reasons.

  The decision, reason and timeframe for registering a patient as Not Ready For Care – clinical should be documented and retained in the medical record by the clinician.

  Where a patient notifies the hospital that they are not ready for care due to illness (e.g. the flu) this may be recorded as NRFC – clinical and must be documented and retained in the patient’s medical record. Where appropriate, a clinical review should be offered to determine if the illness would prevent the patient’s care from progressing.

- **Personal (deferred)**: may be applied by both administrative and clinical staff on direction / advice from the patient regarding their ready for care status and/or where there is evidence that the patient was not available for care for personal reasons.

- **Staged**: must only be applied under the direction of a clinician involved in the patient’s care. The decision, reason and timeframe for registering a patient as not ready for care (NRFC) – staged must be documented and retained in the medical record by the clinician.

Additionally, patients who refuse a first offer of a booking date for an appointment should be assigned ‘not ready for care - deferred for personal reasons’ from the date that they refused the first offer until they advise that they are available for care, acknowledging that this should not exceed the maximum threshold periods for not ready for care.

3.8.5 Not ready for care thresholds and review requirements

HHSs must undertake a formal case review to determine if a patient should remain on the specialist outpatient waiting list, if a patient is not ready for care for clinical, staged and / or personal reasons, and the patient indicates non-availability for assessment for a period exceeding the following maximum number of cumulative days:

- 15 calendar days—urgency category 1
- 45 calendar days—urgency category 2
- 90 calendar days—urgency category 3.

HHSs should:

- notify patients of the maximum NRFC thresholds at the time of placement on the specialist outpatient waiting list
• contact patients before they exceed the maximum deferment thresholds for NRFC, and
• advise the patient that they may be removed from the specialist outpatient waiting list if they exceed the maximum NRFC timeframes.

If a formal case review has been undertaken and the decision has been made not to remove the patient from the specialist outpatient waiting list, the HHS must notate the date that the formal case review was undertaken in the patient’s medical record and the specialist outpatient information system. If it is determined that the patient is still not clinically or personally ready for care the HHS may, at their discretion, extend the not ready for care period for a further:

• 15 calendar days—urgency category 1
• 45 calendar days—urgency category 2
• 90 calendar days—urgency category 3.

If the patient is still not clinically or personally ready for care after the second formal case review has been undertaken, they should be removed from the specialist outpatient waiting list and a new referral initiated when they are clinically and/or personally ready for care. Days waited from the previous listing must not be carried forward and must not be included in the waiting time calculation for the new listing.

Patients who are removed from the waiting list must receive written notification of their removal by the hospital that clearly states:

• reason for removal
• date of removal
• who the patient should contact if they have a query or concern.

The hospital must notify the patient’s treating specialist and the patient’s referring practitioner (and nominated general practitioner where not the same) when a patient has been removed from the specialist outpatient waiting list.

The calculation of NRFC thresholds for patients who have been re-categorised must follow the same premise as days wait calculation for upgrades or downgrades of a patient’s assigned category:

• Where a patient is reclassified to a higher urgency category, not ready for care days accrued at the lower urgency category must not be included in the count of maximum, cumulative not ready for care days for case review and removal
• Where a patient is reclassified to a less urgent category, not ready for care days accrued at the higher urgency category must be carried over and included in the count of maximum, cumulative not ready for care days.

Patients are entitled to appeal the decision to be removed from a public hospital specialist outpatient waiting list through the HHS’s complaint management process.

3.8.6 Calculating waiting time

Waiting time is defined as the time elapsed (in calendar days) for a patient on the specialist outpatient waiting list from the date of receipt of the referral to a census date or the removal
date, exclusive of days the patient was not ready for care, any days where the referral was
deemed to be awaiting information (e.g. from the referring practitioner), and of any time the
patient was listed at a less urgent category.

For corporate reporting purposes and in respect to the urgency category at a census date or
removal date, any days the patient was waiting at a less urgent category must be excluded
from the total days waiting calculation. This means that any period a patient waited at a more
urgent category and any previous period waiting at the same urgency category must be
included in the total days waiting calculation method.

For patients outsourced to a private facility, the actions outlined in section 3.11.4: Outsourcing
patients to private facilities must be undertaken. This will result in the outsourced patient’s
waiting time being suspended for the period whereby the patient is made not ready for care.

3.9 Booking and scheduling management

3.9.1 Appointment prioritisation

Allocation of appointments for patients accessing specialist outpatient services is based on
prioritisation according to clinical urgency categories.

Patients within the same urgency category should be provided a service in the order they are
placed on the waiting list, when all other relevant factors are equal.

It is reasonable that some patients are seen more urgently within an urgency category
because of factors such as:

• the acuity of a patient’s condition
• pathological process
• patient co-morbidities
• medication requirements
• patient, social and community support
• patient access factors (e.g. distance of residence from the treating hospital; availability
  of transport and accommodation).

3.9.2 Appointment scheduling system

HHSs must utilise and maintain an electronic appointment scheduling system. The system
must comply with the requirements of the Department of Health in the collection and collation
of activity and performance data required to meet State and Australian Government reporting
obligations.

The requirement to use an appointment scheduling or booking system applies to both new and
review appointments, and must:

• be used to record details of the referral from the time the referral is accepted
• have the capability to capture information on patients who are booked for an
  appointment but have not yet been seen in a specialist clinic
• record relevant details about the patient and their appointment, including date of the
  appointment and attendance history
• facilitate the immediate booking of ‘urgent’ patients within the accepted timeframe (30 calendar days) from when they are placed on the specialist outpatient waiting list
• record the outcome of the consultation e.g. if a patient is subsequently placed on an elective surgery waiting list
• have the capability to record the requirements for multidisciplinary clinics as per the Queensland Health Non Admitted Patient Data Collection manual.

All records of the patient’s referral and subsequent appointments will remain on the electronic appointment scheduling system.

3.9.3 Appointment scheduling process

The initial responsibility for arranging specialist outpatient service appointments must be given to designated staff. The designated staff must arrange specialist outpatient service appointments within the clinically recommended timeframe for the patient’s assigned urgency category. If designated staff are unable to arrange appointments in the clinically recommended timeframe, a member of the executive management team (Director of Surgery, Executive Director of Medical Services or another appropriate delegate) under delegation of the HHS Chief Executive will assume responsibility for expediting access to specialist outpatient services.

Patients should be booked into staggered appointment times (whether individual or group) and the process of booking block appointments for an outpatient clinic should not be used.

Every effort should be taken to ensure appointments take place at, or as close as possible to the scheduled appointment time. Additionally, appointment times should be arranged to facilitate patients being seen by the same clinician or specialist team at each appointment where possible.

Where relevant, a system of patient confirmation of attendance should be implemented. Partial bookings should be used to record appointments until such time as they are confirmed.

Patients must be offered an appointment date up to and not more than six (6) weeks in advance.

If a patient does not confirm or fails to respond to the offer of appointment within fourteen (14) calendar days of the offer being made, the appointment should be allocated to the next appropriate patient. The patient who does not confirm their appointment may be offered a further appointment at the discretion of the treating clinician.

HHSs must implement processes and procedures that maximise the number of patients seen within clinically recommended timeframes by:
• ensuring processes are in place to support load sharing across facilities in an HHS for specialist outpatient services to optimise patient throughput and reduce waiting times
• actively monitoring the effectiveness of failure to attend (FTA) management strategies (section 3.9.6: Management of failure to attend (FTA) a confirmed appointment)
• implementing best practice processes in relation to specialist outpatient services templates, including but not limited to:
  - ensuring all new case appointment slots are filled for each clinic session
- allocating individual appointment times for patients on the clinic template that reflect the patient's urgency category and clinical complexity (where known).

HHSs must ensure that the best interests of the patient take precedence over the interests of the HHS. This includes not staggering appointments over a number of days when scheduling clinic appointments for more than one specialty and by coordinating appointments so they are on the same day whenever possible. Where a patient is booked for a multidisciplinary clinic appointment, HHSs must ensure that all care provided for the patient occurs in a single clinic appointment.

3.9.4 Standby patients

The HHS should identify patients who are willing to accept an offer of appointment at short notice by contacting patients and confirming that the patient:

- agrees to be contacted at short notice
- can be easily contacted (e.g. via telephone)
- has agreed to be contacted by SMS
- is able to arrive at the hospital for an appointment within the timeframe offered and resides within a reasonable travelling distance of the hospital.

Patients on standby should be offered appointment dates based on the order they have been placed on the specialist outpatient waiting list.

3.9.5 Leave management

HHSs must have specific processes in place to manage planned leave for specialist outpatient services staff due to the critical impact that these staff have on the timely and quality provision of these services, including:

- establishment of a leave management process that is in accordance with industrial and human resource standards and is underpinned by a communication strategy
- establishment of processes to review and develop management plans for affected patients and waiting lists
- notification by Staff Specialists of approved leave to the Director of Service, Executive Director of Medical Services or another appropriate delegate and designated specialist outpatient service staff no later than four (4) weeks in advance
- notification by Visiting Medical Officers of intended leave to the Director of Service, Executive Director of Medical Services or another appropriate delegate and designated specialist outpatient service staff no later than four (4) weeks in advance
- timely notification to the executive management team (Director of Service, Executive Director of Medical Services or another appropriate delegate) under delegation of the HHS Chief Executive about upcoming leave that will affect appointment and/or clinic lists.

3.9.6 Management of failure to attend (FTA) a confirmed appointment

HHSs must ensure procedures to identify and contact patients who fail to attend their confirmed specialist outpatient service appointment are in place. The following principles also apply to outsourced patients and providers.
For **category 1** patients who fail to attend the following principles should apply:

- a phone follow up within two (2) business days is required and an agreement sought for a new appointment date. Following patient consultation the reason for FTA and the new scheduled appointment date are to be documented and retained in the patient’s medical record and specialist outpatient waiting list information system

- if the patient nominates as ‘not ready for care’ (NRFC), the patient will be recorded in the specialist outpatient waiting list information system as ‘NRFC’ from the date of the FTA until the date of the second appointment and the deferment period should not exceed NRFC thresholds (See section 3.8.5: *Not ready for care thresholds and review requirements*).

- all efforts to contact the patient should be made; however, if the patient fails to contact the HHS or provider within fourteen (14) calendar days to notify of the reason for FTA or is unable to be contacted, the patient may be removed from the specialist outpatient waiting list following clinical consultation

- a clinical review of the referral is to be undertaken and the patient’s referring practitioner is to be notified

- if a patient fails to attend a second confirmed appointment for the same reason for referral, clinician guidance must be sought to determine if the patient will be offered a subsequent appointment or if the referral should be returned to the referring practitioner (and nominated general practitioner where not the same) for ongoing care of the patient

- the patient and referring practitioner (and nominated general practitioner where not the same) must be notified in writing of the decision to remove the patient from the waiting list, the decision to transfer responsibility for ongoing care to the referring practitioner (and nominated general practitioner where not the same) and the need to initiate a new referral if the patient still requires the service in the future.

For **category 2 and 3** patients that fail to attend the following principles should apply:

- written notification (or other appropriate communication measures as required) of FTA for a booked specialist outpatient appointment, together with the appropriate requested action, should be sent to the patient and the referring practitioner within five (5) business days of the FTA

- patients are required to contact the HHS within fourteen (14) calendar days to re-book an appointment after initially failing to attend

- if the patient fails to contact the HHS within this timeframe to notify of the reason for FTA and is unable to be contacted, the patient may be removed from the specialist outpatient waiting list following clinical consultation

- hospitals should suspend the count of days waiting from the date that the patient fails to attend until they confirm a second appointment by assigning a not ready for care status
until the date of the second appointment, and the deferment period should not exceed
NRFC thresholds

- patients who re-book an appointment and fail to attend a second confirmed
  appointment for the same reason for referral, should be removed from the specialist
  outpatient waiting list

- the patient, treating specialist and referring practitioner (and nominated general
  practitioner where not the same) must be notified in writing (or via appropriate
  communication measures) of the decision to remove the patient from the waiting list,
  the decision to transfer responsibility for ongoing care to the patient’s referring
  practitioner (and nominated general practitioner where not the same) and the need to
  initiate a new referral if the patient still requires the service in the future.

Removal from the specialist outpatient waiting list for the same reason for referral following a
total of two failures to attend a confirmed appointment applies whether the failure to attends
are consecutive or not.

HHSs must implement strategies to reduce FTA rates. These may include (but are not limited to):

- keeping the patient and the referring practitioner (and nominated general
  practitioner where not the same) informed through written and verbal communication that the
  patient is registered on a specialist outpatient waiting list
- implementing systems to have patients confirm offers of appointment
- telephone or SMS reminders of booked appointments 1-7 calendar days prior to the
  appointment date
- potential redirection of referrals to another HHS that can provide the service closer to
  the patient’s residential address
- follow-up visits only as clinically required and with the consent of the patient
- discharge of patients to the care of the referring practitioner (and nominated general
  practitioner where not the same) on completion of a single course of treatment
- regular administrative auditing and clinical review of patients on the waiting list.

3.9.7 Management of declined offers

Patients should only be offered a maximum of two appointment offers for the same reason for
referral for which they are waitlisted on the specialist outpatient waiting list.

This excludes offers made and withdrawn by the provider (i.e. hospital-initiated cancellations). Patients who refuse a second offer of an appointment should be removed from the specialist
outpatient waiting list on the basis that they are not ready for care, unless there are
extenuating circumstances which the HHS Chief Executive (or their nominated delegate)
agrees warrants offering the patient a third appointment offer for the same reason for referral.
This includes offers for care under an outsourcing arrangement.

All appointment offers for a specialist outpatient service must be documented by the provider
(either public or private where outsourced) who contacted the patient along with the reason for
any refusals. Patients must be advised verbally at the time that the first offer is declined that
declining a second offer for care will result in removal from the specialist outpatient waiting list.
An offer must only be considered as ‘declined’ where the HHS has received acknowledgement that the patient has received the offer with sufficient notice. E.g.: If a patient is sent an appointment letter by post but fails to receive the mail in time, this should not be considered a decline of an offer of appointment.

A minimum 7 days’ notice for Category 1 and a minimum 14 days’ notice for Category 2, 3 and review patients may be deemed sufficient before it is considered a decline of an offer.

Patients who refuse a first offer of a booking date for an appointment should be assigned ‘not ready for care - personal’ from the appointment date offered until the date of the second appointment. NRFC periods applied for management of declined offers must comply with section 3.8.5: Not ready for care thresholds and review requirements and not breach NRFC thresholds.

3.10 Cancellations

3.10.1 Management of hospital-initiated cancellations

A hospital-initiated cancellation is defined as any cancellation of a patient’s booked specialist outpatient appointment for a reason that is related to the hospital’s inability to proceed with the appointment. When a hospital-initiated cancellation occurs, the hospital must:

- notify the patient as soon as possible that their appointment has been cancelled
- provide an alternate appointment date at or as soon as possible after the time of notification
- keep an accurate record of the cancellation and the reason
- maintain the patient’s status as ready for care on the specialist outpatient waiting list.

Urgency category 1 patients who have already arrived at the hospital must not be cancelled without the approval of a member of the executive management team (Director of Surgery, Executive Director of Medical Services or another appropriate delegate) under delegation of the HHS Chief Executive.

Patients should not incur a second hospital-initiated cancellation of their appointment if it will cause the patient to wait longer than their clinically recommended timeframe. Where this is unavoidable, the patient must be appropriately booked for the next available appointment, or arrangements made for treatment at another public or private hospital.

When a hospital-initiated cancellation occurs, the patient must be advised of:

- the reason for cancellation and a rescheduled appointment date
- what to do if their condition deteriorates.

The count of the number of days that a patient has waited since their categorisation date will accrue continuously, despite any hospital-initiated cancellations, until such time as the patient receives their appointment. HHSs must not suspend the count of days waiting by assigning a NRFC period for hospital-initiated cancellations under any circumstances.

3.10.2 Management of patient-initiated cancellations

When a patient cancels a specialist outpatient appointment for personal or clinical reasons, a patient-initiated cancellation must be recorded.
Patients who decline an offer of an appointment date on two occasions will be deemed to have declined treatment. A patient should be removed from the specialist outpatient waiting list if they decline a second appointment date, or fail to arrive for a second confirmed appointment date for the same reason for referral.

The hospital must send notification to the patient’s treating specialist and referring practitioner (and nominated general practitioner where not the same), in writing, of the removal from the specialist outpatient waiting list, within five (5) business days of removal, where the patient is classified as an urgency category 2, 3 or review.

Urgency category 1 patients must not be removed from the specialist outpatient waiting list without the approval of the treating specialist or a member of the executive management team under the delegation of the HHS Chief Executive.

If a patient cancels an appointment for personal or clinical reasons, the hospital should suspend the count of days waiting from the appointment date that was cancelled, by assigning a not ready for care status, until the date of the second appointment. NRFC periods applied for patient-initiated cancellations must comply with section 3.8.5: Not ready for care thresholds and review requirements and not breach NRFC thresholds.

Removal from the specialist outpatient waiting list for the same reason for referral following a total of two patient-initiated cancellations of a confirmed appointment applies whether the patient-initiated cancellations are consecutive or not.

3.11 Transferring and outsourcing patients

It is expected that HHSs must proactively monitor waiting times and take decisive action to ensure patients are treated within the clinically recommended timeframe. Decisive action should include reviewing internal options prior to transferring or outsourcing patients.

Internal options should include, at minimum:
1. Increasing internal capacity at the hospital where the patient is waitlisted either by allocating additional clinic time or substituting clinic sessions with another specialist or specialty.

2. Transferring of care from one Queensland Health employed specialist to another within the same specialty and hospital and / or HHS. HHSs will have the right to construct a single specialty specialist outpatient waiting list through combining or pooling waiting lists for specialties or subspecialties and may allocate patients to any appropriately credentialed specialist with the required scope of practice to deliver the care.

Where internal options are not possible, options for transferring patients to other public facilities or outsourcing to private providers should be considered as below:

External Options:
1. The option for transfer to another public hospital that provides the service and where a shorter waiting time for the specialist outpatient service is available.

2. The option for outsourcing to a private facility with appropriate service capability to deliver the service and where a shorter waiting time for the specialist outpatient service is available. It is the responsibility of the contracting entity to establish and monitor the safety, quality and efficiency of agreements with private providers to enable the transfer of patients in a timely
manner.

For the purpose of clarity, the following terms are used quite distinctly to differentiate between:

1. **Transfers**: where patients are referred from one public hospital to another public hospital for treatment.

2. **Outsourcing**: where patients are referred from a public hospital to a private facility for treatment.

### 3.11.1 Principles for patient transfers and outsourcing:

- The best interests of the patient must take precedence over the interests of the referring and receiving hospital in regards to any patient transfers or outsourcing.

- The HHS should have defined governance processes for identifying and approving patients for transferring and outsourcing which should include, at minimum, notification to the treating specialist.

- Each HHS is to nominate a responsible officer for coordinating patient transfers at each hospital within the HHS. The responsible officer at the referring HHS must contact the responsible officer at the receiving HHS prior to initiating a patient transfer and/or outsourcing.

- The patient must be notified prior to arrangements being made for transfer or outsourcing.

- For outsourcing to the private sector, patients must provide consent prior to arrangements being made, including consent for transfer of relevant medical records and patient information between the public and private providers. Evidence of informed consent (written or verbal) must be documented and retained in the patient’s medical record.

- The patient should be advised of indicative and comparative timeframes for treatment at each hospital (referring and receiving) when an offer for transfer or outsourcing is made.

- The treatment option chosen should result in the patient receiving their care within or, where not possible, as close as possible to the clinically recommended timeframe for the patient’s urgency category. The option should take account of the time it typically takes to transfer the care of a patient to another public or private hospital, including the time it takes for the alternate provider to conduct a clinical review prior to accepting the care of the patient, as well as the typical time lag in securing a booking date with the provider.

- Where the receiving hospital has accepted patients who have or will exceed clinically recommended waiting times, they should retain a record of such patients for reporting at the Relationship Management Group meeting.
• Where a patient accepts an offer for transfer or outsourcing to another treating specialist or facility, appropriate arrangements will be made for:
  1. notification of changes to the initially allocated treating specialist and referring practitioner (and nominated general practitioner where not the same) by the referring hospital
  2. documentation of the transfer in the patient’s medical record and specialist outpatient information system by the referring hospital
  3. assessment of the patient by the newly appointed treating specialist who will undertake the care (where required).

• Where a patient declines an offer for transfer to another treating specialist or hospital which is within 50km of the patient’s nearest public hospital to enable treatment within (or, where not possible, as close as possible to) clinically recommended timeframes, this should be recorded as a decline of an offer for care and an appropriate Not Ready For Care (NRFC) period applied. However, this should only be applied where all of the following criteria are met:
  1. the patient was provided with the necessary information to make an informed decision regarding their wait for care. This includes being provided with the planned date for care in the alternate hospital being offered compared to the expected waiting time should they choose to decline and remain at the originating hospital, and
  2. the patient was notified at the time of placement on the waiting list that their treatment may be provided by another doctor and/or at another Queensland Health hospital or private facility contracted to provide public services, and
  3. the patient has been notified of the implications on their eligibility for the Patient Travel Subsidy Scheme (PTSS).

Where the above criteria have been met, the NRFC period applied should be from the appointment date offered at the alternate hospital until the next available specialist outpatient appointment date at the originating hospital (as at the time of the decision).

Details regarding offers of care at other public facilities should be clearly documented and retained in the patient’s medical record including:
  1. date the patient was contacted
  2. what information was provided to the patient (e.g., specialist outpatient appointment offered, estimated waiting times if declined etc)
  3. patient’s decision and outcome.

3.11.2 Patients who permanently relocate from one HHS to another

Patients should be provided the treatment option that will result in care within (or where not possible, as close as possible to) their clinically recommended timeframe and as close as possible to their place of residence.

Patients who are currently registered on a public hospital specialist outpatient waiting list, who permanently relocate, should be entitled to transfer to the nearest public hospital regardless of their current waiting time provided there is a public hospital closer to where they now permanently reside that has the service capability to safely deliver the care.

The nearest public hospital to the patient’s new permanent place of residence must not decline to accept the transfer and the patient’s waiting time must continue to accrue. If the patient has
been waiting longer than clinically recommended, the Chief Executive (or nominated delegate) of the receiving HHS must be notified by the responsible officer prior to the acceptance of the transfer.

However, if the patient’s appointment can be offered within (or where not possible, closer to) their clinically recommended timeframe at the original hospital where it is within 50km of their new nearest public hospital, the patient must be notified prior to transferring. If the patient declines the earlier offer of appointment at the original hospital, they can be made NRFC - personal for declining as per section 3.8.3: Not ready for care.

Where a patient is transferred from one public hospital specialist outpatient waiting list to another due to permanently relocating, the days wait which the patient has already accrued at the referring hospital must be carried over to the new hospital.

Once the transfer is accepted, the receiving hospital must backdate the date received to match the date the patient was originally added to the waiting list of the referring hospital. Any prior periods of deferment or category changes must also be recorded in the specialist outpatient information system at the receiving hospital to allow the total days waiting for the patient to accurately reflect the original patient record.

Transfer to another public hospital must be organised by the HHS where the patient is registered at the time of the request. The responsible officer at the referring hospital is to communicate with the responsible officer at the receiving hospital and provide the receiving hospital (at minimum) with:

1. a copy of the original referral to specialist outpatients
2. a copy of the patient contact details and registration screen details, including:
   referring practitioner (and nominated general practitioner where not the same) and next of kin details
3. confirmation of any NRFC periods (previous, current and future)
4. confirmation of any previous categorisation changes
5. details of any previous booking cancellations and / or FTAs.

It is the responsibility of the responsible officer at the referring hospital to notify the patient and referring practitioner (and nominated general practitioner where not the same) of the outcome of the transfer request.

The responsible officer at the receiving hospital must:
1. provide confirmation of receipt of the transfer request within 2 business days
2. arrange an appropriate clinical review of the patient transfer request and notify the referring hospital regarding the decision to accept or reject the transfer request within 10 business days.

Where a patient is transferred from one public hospital to another due to relocating, they must not be removed from the referring hospital’s waiting list until such time as the receiving public provider has reviewed the patient’s referral and confirmed in writing that they will provide care for the patient. Upon confirmation that the receiving public hospital has accepted the patient, the patient’s waiting list status must be updated to ‘transferred to other Queensland Health facility (Other HHS or Same HHS)’ at the referring hospital where the patient was originally waitlisted.
Following confirmation that the receiving public hospital provider has accepted the patient, the patient must be contacted by the receiving hospital to advise the patient of their responsibility to provide:

1. an updated referral
2. name and contact details for their nominated general practitioner at the new place of residence
3. updated contact details.

If the above information is not received within 30 calendar days an administrative audit process must be commenced. If the patient fails to respond to two audit measures, the patient should be removed from the specialist outpatient waiting list.

3.11.3 Patients who are transferred from one public hospital to another

Where a patient consents to being treated in another public hospital, the HHS where the patient is currently registered must organise treatment in another public hospital with the capability to provide the service. The referring public hospital where the patient is registered must retain the patient on their public hospital waiting list until such time as the receiving public provider has clinically reviewed the patient’s referral and confirmed in writing that they will provide care for the patient (ideally on a given date). This is done to mitigate the risk of the patient becoming lost in the transfer process and to ensure that responsibility for the finalisation of the patient’s care is retained by the referring hospital. Upon confirmation that the receiving public hospital provider has accepted the patient, the patient’s waiting list status will be updated to ‘transferred to other Queensland Health facility (Other HHS or Same HHS)’ at the referring hospital where the patient was originally waitlisted.

The receiving public provider that agreed to accept the patient must register the patient on their specialist outpatient waiting list and record the date that they were initially registered on the referring HHS specialist outpatient waiting list. In addition, the referring hospital must provide details as described above in section 3.11.2: Patients who permanently relocate from one HHS to another to allow the total days waiting for the patient on the receiving hospital’s waiting list to accurately reflect the original patient record.

The responsible officer at the receiving hospital must:

1. provide confirmation of receipt of the transfer request within 2 business days (48 hours)
2. arrange an appropriate review of the patient transfer request and notify the referring hospital regarding the decision to accept or reject the transfer request within 10 business days.

It is the responsibility of the responsible officer at the referring hospital to notify the patient and referring practitioner (and nominated general practitioner where not the same) of the outcome of the transfer request.

3.11.4 Outsourcing patients to private facilities

For outsourced services, a service agreement between the HHS and private provider should clearly identify the service with the responsibility for each aspect of clinical and administrative service provision.
Where a patient consents to being treated in a private facility, the HHS where the patient is currently registered must independently organise and pay for treatment in a private facility with the capability to provide the specialist outpatient service, using locally negotiated or state-wide contracts.

When a patient is outsourced to another facility at a cost to the referring hospital, the following actions must be undertaken until such time as there is a dedicated outsourcing capability in the specialist outpatient information system:

- Suspend the count of days waiting by changing the patient’s NRFC status to NRFC - clinical with NRFC comments stating ‘Outsourced DD/MM/YY – provider/facility’ in the specialist outpatients information system.
- Patients must only be assigned NRFC from the date that the patient is accepted for treatment by the outsourced provider (i.e. after the appointment confirmation at the outsourced facility).
- Upon confirmation that the outsourced provider has completed the initial consultation for which the patient was referred, the patient must be removed from the public hospital specialist outpatient waiting list using removal reason ‘Patient Outsourced’.

Where a patient is outsourced, they must not be removed from the referring hospital’s waiting list until confirmation that the patient has completed their initial consultation (with the actual date of appointment provided) or until sufficient evidence that the patient no longer requires care has been obtained.

If the patient is accepted for outsourcing but is subsequently unable to be treated and is returned to the referring hospital, the NRFC – clinical must be updated such that the NRFC end date is the date the patient was returned. The patient must resume accruing days waiting from the NRFC end date.

It is the responsibility of the referring HHS to monitor waiting times and ensure that patients are offered the option that will enable access to care as close as possible to their clinically recommended timeframe and as close to the patient’s place of residence.

### 3.11.5 Conflicts of interest

HHSs are responsible for monitoring and managing actual, or perceived, conflicts of interest in relation to the flow of publicly waitlisted patients to private providers including through direct contractual arrangements between the HHS and private providers.

Examples of evidence that may be considered when monitoring conflicts of interest may include:

- The urgency category assigned by the treating specialist aligns with Clinical Prioritisation Criteria (CPC), where available.
- The treating specialist has submitted to the HHS a proposed appointment date for care in the private sector which is earlier than the appointment date that the HHS could provide.
- Another publicly employed specialist within 50km of the patient’s nearest public hospital could not treat the patient within the clinically recommended timeframe or on a date prior to the date that the treating specialist could treat them in the private sector. It is recommended that documentation to support this is included in the patient’s medical
3.12 Removals and discharge

3.12.1 Removing patients from the specialist outpatient waiting list

Removal of a patient’s referral from the specialist outpatient waiting list should only occur for the following reasons:

- A clinical review or administrative audit, has determined that the specialist outpatient service is no longer required.
- The treating specialist requests removal of the patient from the waiting list for clinical reasons.
- The patient no longer requires the care for the reason for referral
- The patient is deceased
- The patient has:
  - has been seen for their initial appointment
  - requested to be removed
  - advised they have or will be attending elsewhere for treatment for the same reason for referral under their own arrangements
  - accepted transfer to another public hospital and the receiving hospital has confirmed acceptance of the patient onto their waiting list
  - been outsourced to another private facility and has been treated
  - commenced an alternate pathway of care; eg. allied health or nursing outpatient services
  - declined two offers of appointment
  - not responded to two offers of appointment and cannot be located
  - exceeded their NRFC threshold for their assigned category, following clinical review
  - the patient fails to attend, cancels and /or declines two confirmed offers of an appointment for the same reason for referral whether the appointments are consecutive or not
  - the patient failed to respond to two audit measures (clinical and / or administrative) within a minimum of 14 days from the second audit measure.

Where a patient’s referral is removed for failure to respond to two audit measures, evidence of reasonable efforts to contact the patient and referring practitioner (and nominated general practitioner where not the same) including use of The Viewer must be recorded in the patient’s medical record and specialist outpatient information system at the time the patient is removed from the waiting list.

Where a patient has received treatment at another hospital, the HHS should ensure that they have appropriate procedures and processes in place to adequately document and confirm with the patient (or their provider in the event of outsourcing and transfers) that they have received the awaited treatment at another hospital prior to removal from the waiting list.

When a patient’s referral is removed from the specialist outpatient waiting list:

- The patient’s referring practitioner (and nominated general practitioner where not the same) and the treating specialist must be notified including details of the reason for removal, date of removal and who to contact if they have any queries.
- Appropriate documentation must be maintained in the patient’s medical records.
Any patient who is removed from a HHSs specialist outpatient waiting list at their own request (without having undergone treatment at another health service) should be advised to contact their referring practitioner or nominated general practitioner to discuss the potential risks associated with not proceeding with treatment and options for alternative management.

3.12.2 Discharge/transfer of care
A patient’s ongoing management must be transferred from specialist outpatient services when the single course of treatment is completed, predetermined discharge criteria have been met or another health care provider can more appropriately provide the service.

Discharge / transfer of care planning should commence at the initial encounter and must continue through to the patient being referred to another service for ongoing care and / or to the care of the referring practitioner (and nominated general practitioner where not the same).

If a patient has attended two or more review appointments with a registrar, any subsequent appointments must include a review by a consultant to determine whether discharge may be appropriate.

A discharge / transfer of care summary must be provided to the referring practitioner (and nominated general practitioner where not the same) and an ongoing management / action plan must be included with the discharge summary in order to minimise premature re-referral.

It is recommended that care pathways incorporating options for self-management and / or evidence-based management by alternative service providers (e.g. allied health practitioners and nurses) be developed and implemented.

3.13 Validation of waiting lists
HHSs must keep accurate records of specialist outpatient waiting list information including any change to a patient’s clinical urgency category, ready for care status or scheduled appointment date. The records must also include the reasons for any changes, substantiating evidence where appropriate, and the name of the person who authorised the change.

Any change to a patient’s waiting list status must be recorded in their medical record including:
- a change to the patient’s ready for care status
- a change to the patient’s clinical urgency category
- removal of a patient from the hospital’s waiting list.

Where verbal notifications or communications with a patient or nominated next of kin have taken place, a record of the conversation should be made in the medical record and include:
- date and time of the conversation
- names of the people involved in the conversation
- key points of discussion.

This may include but is not limited to details of:
- declined offers of appointments and reasons for declining
- not ready for care periods
- information provided to patients regarding policy requirements (e.g. NRFC thresholds, FTA, cancellations, offers of transfer and outsourcing rules etc)
- advice regarding estimated waiting times for care
3.13.1 Clinical and administrative audits

HHSs must manage a system of administrative and clinical audits to ensure that the specialist outpatient waiting list provides an accurate record of patients waiting for appointments.

When undertaking audits, all reasonable efforts should be made to contact the patient including:

- contacting the patient’s referring practitioner (and nominated general practitioner where not the same)
- accessing the hospital’s medical records and utilising The Viewer
- searches of the telephone directory.

Removing a patient from the specialist outpatient waiting list for failing to respond to two audit measures should only occur after the patient has failed to respond within, a minimum, of 14 days of the second audit measure.

Administrative audits of the specialist outpatient waiting list should occur on a regular, ongoing rolling basis that includes, at minimum:

- a weekly audit of category 1 patients who have waited longer than 30 calendar days for an appointment and who do not have a booking date
- a monthly audit of category 2 patients who have waited longer than 90 calendar days for an appointment and who do not have a booking date
- a six-monthly audit of category 3 patients who have waited longer than 365 calendar days for an appointment and who do not have a booking date
- an annual audit of the complete waiting list identifying waiting list records that are incorrect.

The administrative audit of the specialist outpatient waiting list requires contacting patients via telephone, letter or another appropriate method to obtain the following information:

- current contact details
- details of current general practitioner
- confirmation that care is still required (i.e. has not had the care elsewhere)
- clarification that the patient is ready for care
- clarification regarding whether the patient is on a waiting list at another hospital for the same service.

A range of other administrative audits should be maintained to ensure waiting lists are up-to-date and accurate and that management practices are in accordance with this standard.

Clinical audits must also be undertaken in the following circumstances:

- on the request of the referring practitioner, nominated general practitioner or allocated treating specialist
- category 1 patients who have waited more than 30 calendar days since last review, or are not ready for care for personal or clinical reasons for more than 15 cumulative days and who do not have a booking date
- category 2 patients who have waited more than 90 calendar days since last review, or have been not ready for care for personal or clinical reasons for more than 45 cumulative days and who do not have a booking date
- category 3 patients who have waited more than 365 calendar days since last review, or who have been not ready for care for personal or clinical reasons for more than 90 cumulative days and who do not have a booking date.

The hospital must ensure processes including audits are in place to conduct clinical review of patients on the specialist outpatient waiting list to determine if:
- the care is still required (i.e. they have not been treated elsewhere or have declined to be treated)
- there is any change in clinical status, or change in priority
- the urgency category remains appropriate
- the patient is fit to receive care
- the patient should be removed from the specialist outpatient waiting list.

### 3.14 Communication requirements

HHSs are responsible for communicating with relevant clinicians and patients regarding all aspects of the patient’s interaction with specialist outpatient services. In circumstances where the referring practitioner is not the patient’s nominated general practitioner, HHSs should ensure that the patient’s nominated general practitioner is also kept informed regarding the patient’s condition.

The communication process and method of transmission should 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, SMS, video, face-to-face
- special needs – interpretation, translation, cultural differences
- privacy requirements - HHS staff should refer to the relevant cyber security and information security policies and standards when determining appropriate communication mediums. This includes, but is not limited to, responsibilities when emailing clinical and organisational sensitive information.

HHSs should provide general information to the patient including:
- 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)
- their responsibility to notify the hospital of any changes to their nominated general practitioner and next of kin
- the need for a written referral to gain access to outpatient services
- the need for a valid referral for continuation of services
- 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
- the time within which to confirm appointments
- placement on the specialist outpatient waiting list
- the need to visit the referring practitioner or nominated general practitioner for clinical review while awaiting an appointment
- the course of action to be followed if changes occur in clinical condition
potential reasons for removal from the specialist outpatient waiting list
NRFC maximum thresholds for deferment
appointment confirmation, rescheduling and attendance processes
changes to the patient’s clinical urgency category
removal from the specialist outpatient waiting list for failing to attend, cancelling and / or declining two offers of an appointment for the same reason for referral whether the appointments are consecutive or not
removal from the specialist outpatient waiting list including the reason, date of removal and what to do if treatment is still required.

HHSs should inform the referring practitioner (and nominated general practitioner where not the same), regarding:

• receipt of referral, invalidity of referral or when further information is required
• confirmation of patient placement on the specialist outpatient waiting list, including date of placement on waiting list, name of specialist outpatient clinic and urgency categorisation
• the need for regular clinical review of the patient by the referring practitioner or nominated general practitioner whilst awaiting a specialist outpatient appointment
• the responsibility of the referring practitioner (and nominated general practitioner where not the same) to continue to monitor the patient’s condition and notify the facility if there is a change in the patient’s condition
• date and nature of the appointment (and any changes or postponements)
• changes to the patient’s clinical urgency category
• confirmation of the patient’s completed single course of treatment
• removal of the patient from the waiting list including the reason and date of removal
• patient discharge / transfer of care and the reason for this.

Referring practitioners, nominated general practitioner and other relevant clinicians should also be informed about:

• availability of specialist outpatient services
• alternative pathways of care.

Designated HHS staff must respond to information requests made by referring practitioners (and nominated general practitioners where not the same) to support the achievement of timely clinical outcomes and effective referral practices. Referring practitioners (and nominated general practitioners where not the same) may request access to information regarding:

• status of specialist outpatient waiting lists
• types of specialties offered
• estimated waiting times
• special requirements (as applicable)
• supporting diagnostics and clinical information required for triaging
• Clinical Prioritisation Criteria (CPC), where available, or relevant HHS referral guidelines
• treatment / intervention details.

When clinically appropriate, continued contact with the referring practitioner (and nominated general practitioner where not the same) during the term of the consultative period (single course of treatment) should take place to ensure that collaborative management of the patient is established and maintained.
Department of Corrective Services

Patients from the Department of Corrective Services including correctional centres, watch houses and secure mental health facilities must be accorded the treatment available to all patients – however, for security reasons, the patient and their relatives must not be informed of specialist outpatient appointment details.

Details of dates for specialist outpatient appointments must be directly conveyed to the delegate from the Department of Corrective Services or appropriate authority.

3.15 Reporting requirements

In addition to the minimum reporting requirements that form part of HHS service agreements, HHSs should seek to undertake regular monitoring, review and analysis of waiting list activity, dynamics and performance. This is to ensure a proactive approach to waiting list management whereby capacity issues can be identified and acted on early to ensure waiting times remain appropriate and are sustainable.

Hence, it is recommended that at minimum, the following metrics should be reported and monitored by HHSs on a regular basis (census each month):

- Number of long waits at census by category and by specialty
- Number of booked and unbooked at-risk patients who are due for treatment over the following 30, 90 and 365 days to ensure there is sufficient capacity to manage existing waiting lists as well as additional referral trends
- Proportion of patients treated within clinically recommended timeframes by category
- Number of patients treated from the specialist outpatient waiting list by specialty
- Number of patients added to the specialist outpatient waiting list by specialty
- Number of patients removed from the specialist outpatient waiting list by specialty including:
  1. all removal reasons
  2. removals where treatment was not required
  3. removals where treatment was provided elsewhere.
- Hospital-initiated and patient-initiated cancellation rates
- List of patients who have or will exceed maximum NRFC thresholds.

4. Aboriginal and Torres Strait Islander considerations

Queensland public hospital services and staff recognise and commit to the respect, understanding and application of Aboriginal and Torres Strait Islander cultural values, principles, differences and needs when caring for Aboriginal or Torres Strait Islander patients.

Each individual HHS is responsible for achieving successful provision of culturally appropriate specialist outpatient services to and with Aboriginal and Torres Strait Islander individuals and their communities within the respective HHS catchment.

Equally, the respect and acknowledgement extended to Aboriginal and Torres Strait Islander people will be extended to all participants, irrespective of ethnic background or membership of community group.
5. Supporting documents

5.1 Legislation:
- Hospital and Health Boards Act 2011.

5.2 Authorising policy and standards:
- Hospital and Health Service Agreements
- Scope of Publicly Funded Services Policy - Queensland Health.

5.3 Procedures, guidelines and protocols:
- Clinical Prioritisation Criteria
- Clinical records management policy and supporting standards and guidelines
- Credentialing and defining the scope of clinical practice policy and guideline.
- Data management policy and supporting standards and guidelines
- Elective Surgery Implementation Standard
- Medical Board of Australia Good medical practice: a code of conduct for doctors in Australia
- Health Pathways – HHS Health Pathways internet site
- National Safety and Quality Health Service Standards
- Queensland Health informed consent
- Queensland Health Non-Admitted Patient Data Collection (QHNAPDC) manual
- Queensland Health records and privacy
- Specialist outpatient data collection manual
5.4 Forms and templates:
- Approved outpatient services letter suite

5.5 Related documents:
- Australian Charter of Healthcare Rights
- Evidence Based Practice for Health Practitioners
  http://qheps.health.qld.gov.au/ahwac/content/ebp.htm
- Private Patients and Queensland Health

6. Definitions

<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
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<tr>
<td>Census date</td>
<td>Date on which the hospital takes a point in time (census) count of and characterisation of patients on the waiting list. (Australian Institute of Health and Welfare – Metadata Online Registry)</td>
</tr>
<tr>
<td>Clinical audit</td>
<td>Clinical audit is a quality improvement process that seeks to improve patient care and outcomes through systematic review of care against explicit criteria and the implementation of change. (National Institute of Health and Clinical Excellence)</td>
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<tr>
<td>Clinical urgency</td>
<td>A clinical assessment of the urgency with which a patient requires elective hospital care, as represented by a code. (Australian Institute of Health and Welfare – Metadata Online Registry)</td>
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</table>
| Internal Referral | A new referral that is generated from within the same hospital to refer a patient to either:  
  • a different specialist outpatient service or  
  • the same specialist outpatient service but for a different/new reason for referral. |
| Medical Record | A collection of data and information gathered or generated to record the clinical care and health status of an individual or group.  
NOTES:  
1. This includes information such as assessment findings, treatment details, progress notes, registration and information associated with care and health status.  
2. The term ‘health record’ includes paper-based health records, clinical records, medical records, digitized health records, Electronic Health Records, healthcare records and personal health records.  
3. Personal health records have specific variations which should be taken into consideration when applying this Protocol. |

(Australian Standard AS 2829.1-2012 as referred to in QH-IMP-279-
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<td>2:2013 Documentation of date and time in the paper based health record)</td>
<td>NB: in the context of the SOSIS, electronic patient administration systems (eg. HBCIS, ESM), do not constitute a medical record.</td>
</tr>
<tr>
<td>Nombranated General Practitioner</td>
<td>The General Practitioner (GP) is the patient’s usual first point of contact in relation to a personal health issue and is responsible for coordinating the care of the patient. The nominated General Practitioner is the GP that the patient has nominated as their regular GP and is recorded as the General Practitioner in the patient’s registration details on the HHS’s patient administration system (e.g. HBCIS Registration Screen). NB: The nominated general practitioner may differ to the referring practitioner where a practitioner other than the patient’s usual GP has referred the patient to the specialist outpatient service. See definition for Referring practitioner.</td>
</tr>
<tr>
<td>Not ready for care status</td>
<td>Ready for care status is an indication of a patient’s readiness to receive a planned specialist outpatient clinic appointment. A patient is ready for care when a service request has been registered and the patient is available to attend a specialist outpatient appointment. A patient is not ready for care when a service request has been registered and the patient’s health status precludes them from accepting an appointment, or the patient defers the appointment for personal reasons. (Specialist outpatient data collection manual 2015 – 2016)</td>
</tr>
<tr>
<td>Referral</td>
<td>A specialist outpatient clinic referral is a written or electronic request from an approved referring practitioner to a specialist outpatient clinic for investigation and/or diagnosis, advice on or provision of treatment/management, and/or reassurance and second opinion for a patient. Referrals for a specialist outpatient service originate from outside the specialist outpatient clinic and initiate the specialist outpatient service request. (Specialist outpatient data collection manual 2015 – 2016)</td>
</tr>
<tr>
<td>Referring practitioner</td>
<td>The referring practitioner is the person responsible for referring a patient to a specialist outpatient service as listed in 3.6.1 Referral sources.</td>
</tr>
<tr>
<td>Specialist outpatient service</td>
<td>Outpatient services are defined as an organisational unit or arrangement through which a Hospital and Health Service provides healthcare services in an outpatient setting. Specialist outpatient services are a subset of outpatient services, defined as an outpatient service where the clinic is led by a specialist health practitioner. Clinics classified as a specialist service are defined by their Corporate Clinic Code. (Specialist outpatient data collection manual 2015 – 2016)</td>
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<td>Term</td>
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<tr>
<td>Urgency category</td>
<td>A clinical urgency category is applied based on a clinical assessment of the urgency with which a patient requires care and / or treatment, following assessment of a referral for service at a specialist outpatient clinic. (Specialist outpatient data collection manual 2015 – 2016)</td>
</tr>
<tr>
<td>Waiting time</td>
<td>Waiting time is a calculation that represents the time a patient actively waited to receive a specialist outpatient service. It is calculated as the total number of days a patient waited on a Specialist Outpatient Waiting List, from the date the referral was received to the date of removal from the waiting list or a census date, excluding any days the specialist outpatient service request required further information, the patient was waiting with a less urgent clinical urgency category and the patient was not ready for care. (Specialist outpatient data collection manual 2015 – 2016)</td>
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**Version Control**

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<tr>
<th>Version</th>
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<td>1.0</td>
<td>1 February 2016</td>
<td>SOSIS published following OSIS revision, consultation and approval</td>
</tr>
<tr>
<td>2.0</td>
<td>13 November 2017</td>
<td>Updated SOSIS published following revision, consultation and approval. For detailed information on the changes made from version 1, please email <a href="mailto:OIP@health.qld.gov.au">OIP@health.qld.gov.au</a> for a copy of the comparison document.</td>
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