Queensland Health

Specialist Outpatient Services Implementation Standard

Department of Health Standard

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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 facilities by providing best-practice waitlist management and scheduling 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 or community 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 delivered in a non-admitted setting.

The Specialist Outpatient Services Implementation Standard, commonly referred to as the SOSIS, provides minimum requirements for care for all patients requiring assessment within or access to specialist outpatient services, 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 (SODC) and Queensland Health Non-Admitted Patient Data Collection (QHNAPDC) Manuals.

The business rules, best practice and processes outlined in the Specialist Outpatient Services Implementation Standard apply to both New and Review appointments (initial and subsequent service events).

Unless covered by another guideline or implementation standard, the business rules, best practice and processes outlined in the Specialist Outpatient Implementation Standard should be used as a guide for management and delivery of the following services:

- Allied Health
- Diagnostic
- Maternity and midwifery.

Where a non-admitted procedural service patient journey is not able to be managed within the business rules, best practice and processes outlined in the Specialist Outpatient Services Implementation Standard, the management of non-admitted procedural services is considered to align with existing guidelines outlined within the Elective Surgical Services

Implementation Standard (ESSIS), and the Gastrointestinal Endoscopy Services Implementation Standards (GESIS).

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 will:

- have patients and carers as the primary focus
- be proactive, equitable and transparent in the management and delivery of services
- support patients to be seen as close to their home as possible, by the most appropriate clinician for the level of care, scope and timeframe required
- provide patients with the appropriate treatment option that will result in care as close as possible to their clinically recommended timeframe
- optimise continuity of care by facilitating patients being seen by the same clinician or team at each appointment wherever possible
- deliver coordinated care, clinical follow-up and appropriate discharge planning for patients and carers at the earliest possible convenience
- include the development of an agreed pathway of care and treatment plan, and discuss options for service delivery (e.g., Telehealth) during the initial consultation in partnership with the patient
- empower patients to participate in decision making and to make informed choices about their pathway of care, treatment, and timely return to the care of their general practitioner
- ensure the ordering of appropriate diagnostic tests/investigations to support diagnosis and inform appropriate treatment pathways
- ensure appropriate processes are in place to seek informed consent from the patient, guardian, or attorney prior to undertaking designated treatments or procedures
- provide information, education and support to patients and carers throughout the journey
- provide patients with information that identifies their rights and responsibilities and the process for lodging complaints and compliments
- be coordinated to promote the most effective use of available resources
- be the shared responsibility of the health service, treating general practitioner, and referring practitioner (and nominated general practitioner where not the same)
- maintain transparent, valid and reliable record keeping (electronic and/or written) and reporting
- ensure referrals for specialist outpatients services are clinically appropriate and facilitate the most suitable treatment for the patient's health care needs
- ensure communication with patients, referring practitioners, referring and/or nominated general practitioners where not the same occurs in a timely and efficient way that provides easy-to-understand information appropriate to the intended audience to facilitate optimum patient treatment
- exercise discretion to avoid disadvantaging patients in the case of hardship and other extenuating circumstances

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- consider the principles and requirements of the Specialist Outpatient Services Implementation Standard when entering collaborative arrangements with private 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 or community 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, or
- are compensable patients (note that charges will apply), or
- are patients referred by Prison Health Services, 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 may choose to direct Medicare ineligible patients to receive the required service at a private facility that provides the service, at the patient's own expense. HHSs should have appropriate processes in place for managing the treatment of and payment for Medicare ineligible patients accepted for service.

3.3 Access

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

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

- the geographic catchment (as defined by SA2 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 or is closer to

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the patient's usual place of residence, with the distance being calculated using the most direct transportation route (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 using a corporately endorsed referral management system. The patient and referring practitioner (and nominated general practitioner where not the same) are to be advised in writing of the redirection. The referral is not to 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.

Where a referral is received for an identified vulnerable population group, these referrals are to be prioritised according to the relevant Queensland Health Policy and / or Guideline. For example: The statement of intent for prioritisation of children and young people in the child protection system (QH-GDL-426:2021).

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.

HHSs 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 will be provided for patients with a valid referral (Refer to 3.6.3 *Referral validity*) and:

- with unresolved clinical problems relating to the reason 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/treatment plans
- who due to frailty require post care support by carer who resides at a different HHS as documented in the referral
- who are enlisted in a funded and approved research protocol.

Admitted patients with a scheduled specialist outpatient appointment should be reviewed and the consultation documented in the inpatient (ward) area and not in the outpatient setting 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 thirty (30) calendar days may result in activity being provided by 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 thirty (30) calendar days) or for the foreseeable future, within five (5) 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 will record all referrals received for discontinued services on a corporately endorsed referral management system from when Queensland Health receives the referral, but 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 facility where the patients are currently registered must:

- retain each patient on their 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 mitigates the risk of the patients becoming lost during the transfer process and to ensure that responsibility for the finalisation of the patients' care is retained by the referring facility
- 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 facility to allow the total days waiting for each patient on the receiving facility'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 facility 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 facility 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 corporately endorsed specialist outpatient waiting list and record each registration date as the date each patient was initially registered on the referring facility'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 facility has accepted patients for a specialist outpatient service 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 specialist outpatient waiting list located at the HHS where the outreach service will be provided. This is usually the HHS where the patient resides.

At the HHS where the outreach service is provided the outreach service is known as the visiting service for clear management of each aspect of clinical and administrative service provision.

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 thirty (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 clinically appropriate 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 (refer to section 3.6.2: *Internal referrals*) the duty of care solely lies with the HHS.

The HHSs duty of care towards a patient continues throughout the course of treatment until the patient is returned 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 lodgment of a written referral from a recognised referral source. Referrals received will be for an established pathway of care that is within the referring practitioner's scope of practice. Recognised referral sources include:

- General Practitioners
- Queensland Health employed Senior Medical Officers
- Queensland Health employed Visiting Medical Officers
- Privately employed Medical Officers
- Nurse Practitioners with a valid provider number
- Midwives with a valid provider number
- Allied Health practitioners with a valid provider number

HHSs may elect to accept referrals from nominated other sources where the model of care supports a specific referral pathway for the reason for referral. To be a valid referral source, the model of care and specific referral pathway for the reason for referral requires HHS Chief Executive endorsement.

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 and Medicare requirements. The order of treatment

should be based on a clinically appropriate identified timeframe for continued care and not be based on the public / private status of the patient.

(Refer to 3.6.3 *Referral validity* for a single course of treatment validity, and appropriate referrer timeframes regarding continued or extended care and referral requirements.)

3.6.2 Internal referrals

An internal referral is a new referral that is generated from within the same facility 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 facility until such time as the patient has commenced assessment / treatment. 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 generates a new referral to the appropriate specialist 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 reason for referral
- from a Queensland Health employed Allied Health practitioner, Nurse Practitioner, Midwife or source that supports a specific referral pathway for the reason for referral that is endorsed by the HHS Chief Executive.
- where a referral is from a Queensland Health employed Senior Medical Officer working in a General Practitioner role in a HHS owned general practice, Category 1 internal referrals will be accepted.

Category 2 and 3 referrals will not be classified as internal referrals and will be returned to the nominated general practitioner and referring general practitioner (where not the same) and managed as per standard referral pathways.

An internal referral does not include:

- referrals for admitted patients requiring an appointment for subsequent clinical review (inclusive of Allied Health and nursing outpatient services) following separation from an inpatient episode of care for the same reason for the admission. In this instance, a formal request for a review appointment must be submitted to the relevant specialist outpatient service and a copy must be included in the patient's clinical record. Such requests are considered 'discharge reviews'.
- Category 2 and 3 referrals received from a Queensland Health employed Senior Medical Officer working in a General Practitioner role in a HHS owned general practice.
- Referrals received from a Queensland Health employed Senior Medical Officer covering leave for a General Practitioner in a Privately owned General Practice will not be considered as internal referrals and will be managed as per standard referral pathways.

3.6.3 'Associated care referral' requests

Internal referrals also include 'associated care referral' requests where assessment, treatment and / or investigation is needed from another specialist / specialty within the facility to support diagnosis and / or treatment planning relating to the patient's existing reason for referral and pathway of care. 'Associated care referral' requests can only be made to another facility within the HHS if the facility at which the patient is receiving treatment does not provide the required service or the other facility is closer to the patient's residence.

'Associated care referral' requests are exempt from the thirty (30) calendar day rule as per other internal referral requirements. However, an 'associated care referral' request must be categorised as either category 1 or 2 only, based on the patient's clinical urgency to report findings and requirements to the requesting specialty.

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' appointment must occur in a timeframe before the elective request exceeds clinically recommended timeframes.

'Associated care referral' requests could include:

- referrals to another internal specialty 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 facility for which the outcome is required to inform or progress treatment planning for the same reason for referral
- referral for specialist consultation and assessment following transfer from another HHS directly for elective surgery.
- referral to a complimentary pathway of care (refer to section 3.8.2 *Alternate pathways of care and complimentary pathways of care*)

Decisions about whether to accept an internal referral and 'associated care referral' request 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 facility and HHS. All internal referrals and 'associated care referral' requests must comply with Clinical Prioritisation Criteria (CPC) (where CPC are available).

For all internal referrals and 'associated care referral' requests, the patient and the patient's nominated general practitioner and referring general practitioner (where not the same) must be informed that an internal referral or 'associated care referral' request has been made to a specialist outpatient service, with evidence of the communication retained in the patient's clinical 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.

3.6.4 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 service
- comply with Clinical Prioritisation Criteria (CPC) (where CPC are available)
- be received in writing via an endorsed electronic method. Referrals will be accepted in hard copy where access to an endorsed electronic method is not available.

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, reciprocal healthcare agreement or ineligible status
- patient's full permanent residential address, including whether patient resides at a residential aged care facility
- patient's telephone contact number – home, mobile and alternative
- patient's Aboriginal and/or Torres Strait and South Sea 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 next of kin and contact details
- 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, email, other messaging methods
- referring practitioner’s provider number
- signature of referring practitioner (either in hard copy or via an approved electronic method)
- date referral was raised/authored by the referring practitioner
- 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 CPC are 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, Ambulance transport required)

Referrals for specialist outpatient services including alternate and complementary pathways remain valid for a single course of treatment for specified periods (e.g., 3 months, 12 months, or indefinite) from the date the initial consultation occurs with the validity period appropriate to the referrer:

- 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 a specific timeframe or "indefinite" by the general practitioner.
- Referrals from a general practitioner for longer than twelve (12) months or for continuing care past the original referral validity period (referral continuation) should only be used where the patient's clinical condition specifically requires continuing care and management by a specialist. In these cases, the period for referral should clearly be expressed by the referring or nominated general practitioner as 'indefinite', 'ongoing' or 'requiring continuing care' to be appropriately identified for extended care or referral continuation additional to the initial validity period.

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 or nominated general practitioner as this is a Medicare requirement. Failure to receive a request for continuation of care may result in the patient's care being transferred to the referring or nominated general practitioner for management.

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 and comply with CPC (where CPC are available).

Where more than one (1) referral for different conditions has been received for the one (1) patient, every effort should be taken to combine or align appointment times where appropriate.

Standardised referral formats will be utilised to ensure the provision of adequate referral content by the referrer.

3.6.5 Declined referrals

Referrals received that do not meet referral criteria and/or CPC (where CPC are available) or are not suitable for treatment must be returned to the referring practitioner with suggestions for management, following clinical review of the referral.

Referrals received that following clinical review are suitable for alternate pathways of care, are to be reassigned to the alternate pathway.

Referrals received that following clinical review are suitable for complementary pathways of care are to be managed as an 'associated care referral' request internal referral for access to the complementary pathway of care (refer to section 3.6.2 *Internal referrals*).

These alternate and complementary pathways may include 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 (refer to section 3.8.2 *Alternate pathways of care and complementary pathways of care*).

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 and complementary 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 (refer to section 3.3 *Access*).

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 the decision. A record of the receipt of referral and non-acceptance of the referral must be maintained in the patient's clinical record and corporately endorsed 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:

- Entered into the corporately endorsed referral management system to process the receipt, registration, and categorisation of the referral. This includes incomplete, illegible, non-compliant, declined, or non-accepted referrals.
- Recorded on a corporately endorsed waiting list management system from the time that Queensland Health receives the referral until the patient has been removed from the waiting list.

Referrals received for services provided at Queensland Health reporting facilities must not be recorded (or transferred) to waiting lists at Queensland Health non-

reporting facilities as defined by the facility data set, Corporate Reference Data System (CRDS) referenced in the Specialist Outpatients Data Collection (SODC).

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 corporately endorsed specialist outpatient waiting list information system upon receipt. The information to be entered on the specialist outpatient waiting list information system upon registration must include:

- unique patient identifier (e.g., Unique Reference 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)
- patient's valid Medicare number, funding source / compensable details where relevant
- referral source type (refer to section 3.6.1: *Referral sources*)
- referring practitioner's details (name, address, contact numbers, refer to section 3.6.3 *Referral validity*)
- nominated general practitioner's details, if the nominated general practitioner is different from the referring practitioner (recorded on patient administration system, currently HBCIS)
- date the referral was created by the referring practitioner
- date the referral was received by Queensland Health (QH)
- clinical urgency category assigned to the referral upon acceptance (refer to section 3.7.4 *Urgency category assignment*)
- non-acceptance of the referral and reason for non-acceptance (refer to section 3.7 *Waiting list registration* and section 6 *Definitions*)
- clinic/service area the referral is allocated to (consultant/clinician name if known/applicable)
- allocated service provider
- reason for referral (provisional diagnosis and / or referred condition
- an indication of whether the booked appointment/s are to be provided in a group session or by multiple health providers.

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 corporately endorsed waiting list information system, are correct and up-to-date and that the patient has been advised that information regarding their care will 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 (NRFC) 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 facility 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 clinical record or referral must be undertaken by an appropriately qualified specialist (or their clinical delegate) at each facility 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 facility, the patient must be contacted to ascertain which waiting list they elect to remain on. A patient can only be registered on one (1) public 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 <u>and</u> it is within 50km of their nearest public facility, 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 facility 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 facility 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 / referral 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 facilities:

- 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 must not remain uncategorised by the triaging clinician for a period exceeding five (5) business days from receipt of referral to Queensland Health. Referrals received from triaging without an urgency category assigned must be returned to the triaging clinician on the grounds that they are incomplete.

3.7.4 Ready for care

A patient's waiting list status is classified as either 'ready for care' or 'not ready for care' (NRFC) 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 the identified service, and
- who are available to attend an appointment.

HHSs must ensure that the best interests of the patient take precedence over the interests of the facility or HHS when negotiating specific appointment dates and times, considering the patient and if relevant, their carers other commitments.

3.8 Waiting list management

It is the responsibility of the referred to 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 to the patient's place of residence.

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 to Queensland Health.

A record of notification of any changes to the urgency category of patients registered on the waiting list, or the decision not to change the patient's urgency category must be maintained in the patient's clinical record and the corporately endorsed 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.

HHSs 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 the service, facility or resources.

3.8.2 Alternate pathways of care and complementary pathways of care

Medical specialists may refer patients to an alternate or complementary pathway of care. HHS Chief Executive endorsed alternate and complementary pathways of care may be utilised for the management of referrals, including 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. Alternate and complementary pathways of care are established pathways of care that are provided by the HHS specialist outpatient service or through an established outreach or visiting service.

An alternate pathway of care is where an alternative mode of therapy or treatment intervention is provided to patients referred to specialist outpatient service for the reason for referral. When a patient is referred to an alternate pathway of care, the following actions should be undertaken:

- the alternate pathway of care provider must be notified of the referral
- following acceptance by the alternate pathway of care provider, the referral is removed from the corporately endorsed waiting list management system with the most appropriate referral removal reason and comment to identify the provider/ alternate pathway. Not ready for care (NRFC) periods are not to be applied
- if the patient commences an alternate pathway of care, and subsequently requires a further medical specialist consultation, the original referral is re-instated to the original specialty waiting list and / or specialty clinic. Additionally, if the alternate pathway of care was commenced following an initial specialist consultation appointment and the referral validity timeframe has expired, a new referral is required to be obtained from the patient's referring practitioner or nominated General Practitioner. The patient referral is reinstated applying Not ready for care (NRFC) – Staged
- if the patient is accepted for an alternate pathway of care, but subsequently does not commence the alternate pathway of care and is reinstated to the original specialty waiting list, the NRFC – clinical status should be applied such that the NRFC end date is the date the patient was reinstated

- patients who are on an alternate pathway of care waiting list that exceed the clinically recommended timeframe (365 days) are to be returned to the original specialty waiting list and must be appropriately booked for the next available specialist appointment or arrangements made for treatment at another public or private facility.

A complementary pathway of care is where complementary therapy or treatment intervention is provided to patients referred to specialist outpatient services. The complementary care is provided in addition to specialist treatment, to improve a patient's treatment outcomes. When a patient is referred to a complementary pathway of care, the following actions should be undertaken:

- the complementary pathway of care provider must be notified of the referral
- an 'associated care referral' request for the complementary pathway of care must be registered in the corporately endorsed waiting list management system
- the date the 'associated care referral' request was received by the complementary pathway of care provider will be recorded as the referral received date in the outpatient scheduling system
- the assigned urgency category of the complementary pathway of care referral must not be less (urgent) than the category assigned to the specialty waiting list category
- following acceptance by the complementary pathway provider, the patient's specialist outpatient referral will continue to remain on the specialist outpatient wait list and the patient will be offered a specialist appointment within (or where not possible, as close to) their clinically recommended timeframe.
- Not ready for care (NRFC) – Staged may be applied following clinical review for patients who are identified as not in a position to accept a specialist outpatient appointment as they are waiting for appointments or undergoing treatment for the complementary pathway of care
- if the patient is accepted for a complementary pathway of care, but subsequently does not commence the complementary pathway of care they remain waiting on the specialist outpatient waiting list and are managed as per standard referral pathways.

3.8.3 Not ready for care (NRFC)

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

Patients who are identified as 'not ready for care' (NRFC) can be classified as either:

- **Clinical** – Patients who require an outpatient appointment but are unable to accept or attend 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 specialty for a different reason for referral.

- **Personal (deferred)** – Patients who wish to defer their appointment for personal reasons including work or other commitments. Not ready for care (NRFC) – personal (deferred) can only be used for patients whose personal circumstances alter in such a way that it would prevent them from accepting or attending an appointment during the time that they are waiting.
- **Staged** – Patients who have been referred for or offered an appointment but are not able to accept as they are waiting for other appointments for a complementary pathway of care or undergoing treatment for a complementary pathway of care.

Patients who advise the HHS that they are not ready for care (NRFC) for personal reasons must be informed of the maximum periods for deferment and that exceeding these thresholds may result in removal from the specialist outpatient waiting list and associated corporately endorsed waiting list management system, with the care for their reason for referral returned to their referring practitioner or nominated general practitioner (where not the same).

3.8.4 Application and use of not ready for care (NRFC) periods

The use and application of not ready for care (NRFC) 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 (NRFC) for clinical reasons
- the decision, reason and timeframe for registering a patient as not ready for care (NRFC) –clinical should be documented and retained in the clinical record by the clinician
- where a patient notifies the facility that they are not ready for care (NRFC) due to illness (e.g., the flu) this will be recorded as NRFC – clinical and must be documented and retained in the patient's clinical 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 clinical 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 (NRFC) personal – (deferred) from the date

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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 (NRFC).

3.8.5 Not ready for care (NRFC) 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 (NRFC) for clinical, staged and / or personal (deferred) 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 not ready for care (NRFC) thresholds at the time of placement on the waiting list
- contact patients before they exceed the maximum deferment thresholds for not ready for care (NRFC), and
- advise the patient that they may be removed from the waiting list if they exceed the maximum not ready for care (NRFC) thresholds and review requirements.

If a formal case review and clinical audit (refer to section 3.13.1 *Clinical and administrative audits*) 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 clinical record and the corporately endorsed waiting list management 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 and clinical audit 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 referral and subsequent placement onto the specialist outpatient waiting list and entry into the corporately endorsed waiting list management system.

Patients who are removed from the specialist outpatient waiting list and corporately endorsed waiting list management system must receive written notification of their removal by the facility or HHS that clearly states:

- reason for removal

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

The facility or HHS 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.

The calculation of not ready for care (NRFC) thresholds for patients who have been re-categorised must follow the same premise as days waiting calculation for upgrades or downgrades of a patient's assigned urgency category:

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

Patients are entitled to appeal the decision to be removed from a public specialist outpatient waiting list or scheduling system through the HHS's complaint management process. Patients may also request reinstatement onto the specialist outpatient waiting list (refer to section 3.12.1 *Removing patients from the specialist outpatient waiting list or scheduling system*).

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 Queensland Health to a census date or the removal date, exclusive of the days the patient was not ready for care (NRFC) and 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. This includes all referrals transferred from another HHS.

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. Waiting time includes any period the patient waited for care within Queensland Health at both reporting and non-reporting facilities. Wait list status and total days wait must recorded in a Queensland Health corporately endorsed waiting list management system for the entire period.

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 (NRFC).

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 and clinically recommended timeframes.

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. This will result in the patient with the highest total days waiting count being seen first within their urgency category.

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
- the pathological process
- patient co-morbidities
- medication requirements
- the patient's social circumstances and community support
- patient access factors (e.g., distance of residence from the treating facility; availability of transport and accommodation).

3.9.2 Appointment scheduling and referral management systems

HHSs must utilise and maintain a corporately endorsed referral management system and corporately endorsed waiting list management system. The corporately endorsed referral management system and corporately endorsed waiting list management system must comply with the requirements of the Department of Health in the collection and collation of activity and performance data required to meet Queensland Government and Australian Government reporting obligations.

The requirement to use a corporately endorsed referral management system and corporately endorsed waiting list management system applies to both new / initial and review / subsequent appointments, and must:

- be used to record details of the referral from the time the referral is received to Queensland Health
- have the capability to capture information on patients who are booked for an appointment but have not yet been seen / commenced assessment or treatment
- record relevant details about the patient and their appointment/s, including dates of appointments and attendance history
- facilitate the immediate booking of 'urgent' patients within the accepted category 1 timeframe (thirty (30) calendar days) from when they are placed on the waiting list

- record the outcome of the consultation e.g., if a patient is subsequently placed on an elective surgery waiting list or scheduled for future/subsequent appointments
- have the capability to record the requirements for multidisciplinary clinics or group appointments as per the Queensland Health Non-Admitted Patient Data Collection (QHNAPDC) manual.

All records of the patient's referral and subsequent appointments will remain on the corporately endorsed referral management system and corporately endorsed waiting list management system for record and reporting purposes.

3.9.3 Appointment scheduling process

The initial responsibility for arranging appointments must be given to designated staff. Designated staff must arrange 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 care.

Patients should be booked into staggered appointment times (whether individual or group) and the process of booking block appointments for an outpatient clinic must 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 and available 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 to optimise patient throughput and reduce waiting times and cancellation rates
- 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 clinic template utilisation, including but not limited to:
    - ensuring all new case appointment slots are allocated and filled for each clinic session
    - allocating individual appointment times for patients on the clinic template that reflect the patient's urgency or clinical timeframe and clinical complexity (where known).

HHSs must ensure that the best interests of the patient take precedence over the interests of the facility or 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 or contemporary methods (e.g., App notifications)
- is able to participate in an appointment within the timeframe offered and resides within a reasonable travelling distance of the facility or able to suitably participate in virtual modes of care delivery where appropriate.

Patients on standby should be offered appointment dates based on the order they have been placed on the waiting list or closest to their clinically recommended timeframe to best optimise clinic utilisation.

A patient's inability to accept an offered standby appointment will not be managed as a declined offer of service (see section 3.9.7 *Management of declined offers*)

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 all medical staff including 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 (FTA) their confirmed appointment are in place. The following principles also apply to outsourced patients and providers.

For **category 1 and review patients** who fail to attend (FTA) the following principles should apply:

- verbal follow up within two (2) business days is required, and an agreement sought for another 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 clinical record and in the corporately endorsed waiting list management system
- if the patient nominates as not ready for care (NRFC), the patient will be recorded in the waiting list information system as not ready for care (NRFC) from the date of the failure to attend (FTA) until the date of the second appointment. The deferment period will not exceed not ready for care (NRFC) thresholds or clinically recommended timeframes (refer to 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 the failure to attend (FTA) or is unable to be contacted, the patient may be removed from the specialist outpatient waiting list at the direction of a clinician following a clinical audit of the patients referral or clinical record (refer to section 3.13.1 *Clinical and administrative audits*)
- a clinical review of the referral or patient's clinical record is to be undertaken and the patient's referring practitioner is to be notified
- if a patient fails to attend (FTA) 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 patient should be returned to the referring practitioner (and nominated general practitioner where not the

same) for ongoing care of the patient. The outcome of this decision must be recorded in the corporately endorsed waiting list management system and the patient's clinical record.
- 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, 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 requires referral to the specialist outpatient service for the same reason for referral in the future.

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

- written notification (or other appropriate communication measures as required) of failure to attend (FTA) for a booked appointment, together with the appropriate requested action, should be sent to the patient and the referring practitioner within five (5) business days of the failure to attend (FTA)
- patients are required to contact the HHS within fourteen (14) calendar days to re-book an appointment after initially failing to attend and a not ready for care (NRFC) date for a period of fourteen (14) calendar days can be applied during this period.
- if the patient fails to contact the HHS within this timeframe to notify of the reason for the failure to attend (FTA) and is unable to be contacted, the patient may be removed from the waiting list following clinical consultation and clinical audit (refer to section 3.13.1 *Clinical and administrative audits*)
- facilities should suspend the count of days waiting from the date that the patient fails to attend (FTA) until they confirm a second appointment by assigning a not ready for care (NRFC) status until the date of the second appointment, and the deferment period should not exceed not ready for care (NRFC) thresholds
- patients who re-book an appointment and fail to attend (FTA) a second confirmed appointment for the same reason for referral, should be removed from the 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 requires referral to the specialist outpatient service for the same reason for referral in the future
- removal from the waiting list or scheduling system for the same reason for referral/condition following a total of two (2) 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):

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- 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, SMS or approved contemporary method reminders of booked appointments 1-7 calendar days prior to the appointment date
- potential transfer of referrals to another facility that can provide the service closer to the patient's residential address (records must remain able to be reported by the treating facility for the entire period patient waited with Queensland Health)
- follow-up visits / subsequent appointments 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 or non- compliance/non-attendance
- regular administrative auditing and clinical review of patients on the waiting list (refer to section 3.13.1 *Clinical and administrative audits*)

3.9.7 Management of declined offers

Patients should only be offered a maximum of two (2) appointment offers for the same reason for referral for which they are waitlisted, or for a review appointment.

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 and corporately endorsed waiting list management system on the basis that they are not ready for care (NRFC), 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, alternate pathway of care or complementary pathway of care.

All appointment offers for a specialist outpatient service must be documented by the provider (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 return of their care to the referring practitioner and nominated general practitioner (where not the same).

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 of seven (7) days' notice for Category 1 and review appointment patients and a minimum fourteen (14) days' notice for Category 2 and 3 patients is 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 (NRFC) – personal (deferred) from the appointment date offered until they advise that they are available for care, acknowledging that this should not exceed the maximum threshold periods for not ready for care (NRFC).

Not ready for care (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 not ready for care (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 appointment for a reason that is related to the service and / or facility's inability to proceed with the appointment. When a hospital-initiated cancellation occurs, the service and / or facility must:

- notify the patient as soon as possible that their appointment has been cancelled
- notify all patients who have been advised of a partial booking date of the hospital-initiated cancellation and new partial booking date (where applicable)
- provide a new partial booking appointment date at or as soon as possible after the time of notification
- keep an accurate record of the hospital-initiated cancellation and the reason
- maintain the patient's status as ready for care on the waiting list.

Urgency category 1 patients who have already arrived at the facility 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 facility.

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 receipt of their referral and subsequent acceptance and placement on the specialist outpatient waiting list will accrue continuously, despite any hospital-initiated cancellations, until such time as the patient receives their appointment or is removed from the waiting list for an allowed reason for removal (as per section 3.12.1: *Removing patient from the waiting list or scheduling system*). HHSs must not suspend the count of days waiting by assigning a not ready for care (NRFC) period for hospital-initiated cancellations or for any period wait listed at a non-reportable facility 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 (2) occasions will be deemed to have declined treatment. A patient should be removed from the specialist outpatient waiting list and corporately endorsed waiting list management system if they decline a second appointment date or fail to attend (FTA) for a second confirmed appointment date for the same reason for referral.

The facility must send notification to the patient, referring practitioner (and nominated general practitioner where not the same), in writing, of the removal, within five (5) business days of removal, where the patient is classified as an urgency category 2, 3 or for a review appointment. The patient's treating specialist must also be notified of the patient's appointment cancellation. Appropriate clinical handover is required for the return of all patients, including review patients, to the referring and nominated general practitioner (where not the same).

Urgency category 1 patients must not be removed from the waiting list without the approval of the responsible / 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 facility should suspend the count of days waiting from the appointment date that was cancelled, by assigning a not ready for care (NRFC) status, until the date of the second appointment. Not ready for care (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 not ready for care NRFC thresholds or clinically recommended timeframes.

Removal from the waiting specialist outpatient waiting list and corporately endorsed waiting list management system for the same reason for referral following a total of two (2) 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 facility or HHS where the patient is waitlisted either by allocating additional clinic time or substituting clinic sessions with another specialist or clinically appropriate specialty
2. transferring care from one Queensland Health employed specialist to another within the same specialty and facility and / or HHS. HHSs will have the right to construct a single reportable 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 facility that provides the service and where a shorter waiting time for the appropriate 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 appropriate service is available. It is the responsibility of the contracting HHS 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:

- **Transfers**: where patients are referred from one public facility or service to another for treatment. Transferring occurs following registration, acceptance, and waitlisting on the specialist outpatient waiting list on the corporately endorsed referral management system and corporately endorsed waiting list management system.
- **Outsourcing**: where patients are referred from a public facility or service to a private facility for treatment. Outsourcing occurs following registration, acceptance, and waitlisting on the specialist outpatient waiting list on the corporately endorsed referral management system and corporately endorsed waiting list management system.

3.11.1 Principles for patient transfers and outsourcing

The following principles for patient transfers and outsourcing must be complied with:

- the best interests of the patient must take precedence over the interests of the referring and receiving facility with regard to any patient transfers or outsourcing
- wait list records must remain corporately reportable on a corporately endorsed specialist outpatient waiting list from the date of their receipt to Queensland Health until such time as the patient has completed their initial appointment regardless of whether this occurs within a public facility or through a private provider
- Category 1 patients should be excluded from transfer and outsourcing options and be treated in their original facility or service as a matter of priority within, or as close as possible to their clinically recommended timeframe
- patients who have commenced care for their reason for referral must be managed with the processes documented below in section 3.11.2 *Patients who permanently relocate from one HHS to another*, 3.11.3 *Patients who are transferred from one facility to another* and 3.11.4 *Transferring when transitioning from child to adult services* and 3.11.5 *Outsourcing patients to private facilities* with the processes for the corporately endorsed specialist outpatient waiting list being applied as applicable to the corporately endorsed waiting list management system at both the referring and receiving HHSs
- 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 facility within the HHS. The responsible officer at the referring facility / HHS must contact the responsible officer at the receiving facility / 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 clinical 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 clinical record
- the patient should be advised of indicative and comparative timeframes for treatment at each facility (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 facility, including the time it takes for the receiving 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 facility 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 (refer to 3.3 *Access*).
- 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 specialty, specialist and referring practitioner (and nominated general practitioner where not the same) by the referring facility
    2. documentation of the transfer in the patient's clinical record and corporately endorsed waiting list management system by the referring facility
    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 facility which is within 50km of the patient's nearest public facility 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 and an appropriate Not Ready For Care (NRFC) period applied. However, this should only be applied where all 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 receiving facility being offered compared to the expected waiting time should they choose to decline and remain at the referring facility, 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 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 Nor Ready for Care (NRFC) period applied should be from the appointment date offered at the alternate receiving facility until the next available appointment date at the originating facility (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 clinical record including:
    1. date the patient was contacted
    2. what information was provided to the patient (e.g., 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 specialist outpatient waiting list, who permanently relocate, are able to transfer to the nearest public facility regardless of their current waiting time provided there is a public facility closer to where they now permanently reside that has the service capability to safely deliver the care.

The nearest public facility 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 and remain reportable. 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 (refer to section 3.3 *Access*).

Patients who have commenced care for their reason for referral at a different HHS who permanently relocate are also able to transfer their care to the nearest public facility to where they reside, provided that facility has the service capability to safely deliver their care. These patients will continue their single course of treatment for their reason for referral and not be added to the specialist outpatient waiting list to recommence waiting at the nearest public facility following permanent relocation. These processes will be facilitated by the relevant HHS nominated responsible officer. This also applies to patients whose care is transferred between facilities within a HHS.

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

Where a patient is transferred from one public specialist outpatient waiting list to another due to permanently relocating, the days wait which the patient has already accrued must be carried over to the new facility including all time waiting at both Queensland Health reporting and non-reporting facilities.

Once the transfer is accepted, the receiving facility must back date the date received to match the date the patient referral was originally received by Queensland Health. Any prior periods of deferment, NRFC or category changes must also be recorded and reported in the corporately endorsed specialist outpatient waiting list management system at the receiving facility to allow the total days waiting for the patient to accurately reflect the original patient record.

Transfer to another public facility must be organised by the facility / HHS where the patient is registered at the time when the patient permanently relocates. The responsible officer at the referring facility or HHS is to communicate with the responsible officer at the receiving facility or HHS and provide the receiving facility / HHS (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 from the corporately endorsed patient administration system, 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.

The responsible officer at the referring facility will 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 facility must:

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

Where a patient is transferred from one public facility to another due to permanently relocating, they must not be removed from the referring facility's specialist outpatient 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 facility has accepted the patient, the patient's waiting list status in the corporately endorsed waiting list management system must be updated to 'transferred to other Queensland Health facility (Other HHS or Same HHS)' at the referring facility where the patient was originally waitlisted.

Following confirmation that the receiving public provider has accepted the patient, the patient must be contacted by the receiving facility 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 permanent relocation
3. updated contact details.

If the above information is not received within thirty (30) calendar days an administrative audit process must be commenced. If the patient fails to respond to

two (2) audit measures, the patient should be removed from the specialist outpatient waiting list (refer to section 3.13.1 *Clinical and administrative audits*).

3.11.3 Patients who are transferred from one public facility to another

Where a patient consents to being treated in another public facility, the HHS where the patient is currently registered must organise treatment in another public facility with the capability to provide the service. The referring public facility where the patient is registered must retain the patient on their reportable public specialist outpatient waiting list and corporately endorsed waiting list management system until such time as the receiving public provider has clinically reviewed the patient's clinical information and confirmed in writing that they will provide care for the patient and provided an appointment 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 facility. Upon confirmation that the receiving public facility provider has accepted the patient, the patient's specialist outpatient waiting list and corporately endorsed waiting list management system status will be updated to '*transferred to other Queensland Health facility (Other HHS or Same HHS)*' at the referring facility where the patient was originally waitlisted / scheduled.

The receiving public provider that agreed to accept the patient must register the patient on their appropriate reportable specialist outpatient waiting list and corporately endorsed waiting list management system and record the date that they were initially registered as received at the referring facility / HHS. In addition, the referring facility / HHS 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 at the receiving facility to accurately reflect the original patient record.

The responsible officer at the receiving facility must:

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

It is the responsibility of the responsible officer at the referring facility / HHS 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 Transferring when transitioning from Child to Adult Services

Patients who have been receiving services for chronic conditions from a paediatric service are to be transitioned to adult services with no break in continuity of care. The age for transitioning is sixteen (16) years. The exception to this is where there is an

established pathway for that service that documents transitioning to adult services at another specified age.

Management of the transition to adult services may be initiated prior to the patient turning sixteen (16) and should not be declined by the receiving service provided they will be of age at the time of their next required appointment.

The receiving service for the transitioning young adult may be in the same facility, or HHS or another HHS including where paediatric services have been provided by Children's Health Queensland. Clinical and administrative processes for the booking and provision of clinical handover is to be provided at both the referring and receiving facilities.

3.11.5 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 facility / HHS, the following actions must be undertaken until such time as there is a dedicated outsourcing capability in the reportable corporately endorsed specialist outpatient waiting list management 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 corporately endorsed waiting list management 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 waiting list using removal reason '*Patient Outsourced*'

Where a patient is outsourced, they must not be removed from the referring specialty and facility 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 facility, 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.

3.11.6 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 triaging clinician aligning with Clinical Prioritisation Criteria (CPC), (where CPC are 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 facility 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 decisions that could be perceived to be influenced by a conflict of interest are included in the patient's clinical record.

3.12 Removals and discharge

3.12.1 Removing patients from the specialist outpatient waiting list or scheduling system

Removal of a patient from the corporately endorsed specialist waiting list should only occur for the following reasons:

- A clinical review or administrative audit has determined that the appropriate service is no longer required
- The treating clinician requests removal of the patient for clinical reasons
- The patient no longer requires the care for the reason for referral
- The patient is deceased
- The patient has been seen for their initial appointment
- The patient has requested to be removed
- The patient has advised they have or will be attending elsewhere for treatment for the same reason for referral under their own arrangements
- The patient has accepted transfer to another public facility and the receiving facility has confirmed acceptance of the patient

- The patient has been outsourced to another private facility and has been treated
- The patient has commenced an alternate pathway of care, e.g., allied health or nursing outpatient services
- The patient has declined two (2) offers of appointment
- The patient has not responded to two (2) offers of appointment and cannot be located / contacted
- The patient has exceeded their NRFC threshold for their assigned category or clinically recommended timeframe, following clinical review
- The patient fails to attend (FTA), cancels and /or declines two (2) 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 (2) audit measures (clinical and / or administrative) within a minimum of 14 days from the second audit measure.

Where a patient is removed for failure to respond to two (2) 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 clinical record and corporately endorsed specialist outpatient information system at the time the patient is removed.

Where a patient has received treatment at another facility, 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 facility prior to removal.

When a patient is removed:

- the patient's referring practitioner (and nominated general practitioner where not the same) and the treating clinician 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 clinical records

Any patient who is removed 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.

A patient who has been removed and contacts the service within thirty (30) days of removal may be reinstated to their original position on the waiting list or scheduling system at the discretion of the HHS. Appropriate NRFC – personal (deferred) periods applicable for the patient's urgency category or clinical timeframe can be applied from the removal date to the date the patient requested reinstatement.

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 must commence at the initial encounter and 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 (2) or more specialist 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 / treatment 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., Primary Care, Allied Health practitioners and nurses) be developed and implemented.

3.13 Validation of waiting lists

HHSs must keep accurate and reportable records of 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 the corporately endorsed waiting list management system and the patient's clinical 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.

Where verbal notifications or communications with a patient or nominated next of kin (NOK) have taken place, a record of the conversation should be made in the clinical 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 (NRFC) periods
- information provided to patients regarding policy requirements (e.g., NRFC thresholds, FTA, cancellations, offers of transfer, outsourcing rules, audit measures, etc.)
- advice regarding estimated waiting or clinically recommended timeframes for care
- patient enquiries.

3.13.1 Clinical and administrative audits

HHSs must manage a system of administrative and clinical audits / review to ensure accurate records and reporting of patients waiting for appointments. Regular audits of all patients on the waiting list have been identified as an effective waiting list management tool, removing patients who no longer require care or have obtained care elsewhere.

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 facility's clinical records and utilising The Health Provider Portal (The Viewer)
- searches of the telephone directory or publicly listed contact details.

Removing a patient for failing to respond to two (2) audit measures should only occur after the patient has failed to respond within, a minimum of fourteen (14) days of the second audit measure.

Administrative audits of the 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 thirty (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 ninety (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 three hundred and sixty-five (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 requires contacting patients via telephone, letter, or another appropriate method to obtain the following information:

- current contact details

- details of current referring practitioner and nominated general practitioner (where not the same)
- confirmation that care is still required (i.e., care has not been received elsewhere)
- clarification that the patient is ready for care
- clarification regarding whether the patient is on a waiting list or receiving care at another facility or HHS for the same service / condition / reason for referral.

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 and corporate reporting requirements.

Clinical audits/reviews must also be undertaken in the following circumstances:

- on the request of the referring practitioner, nominated general practitioner or allocated treating specialty, specialist or non-admitted care provider.
- category 1 patients who have waited more than thirty (30) calendar days since last review, or are not ready for care (NRFC) for clinical or personal (deferred) reasons for more than fifteen (15) cumulative calendar days and who do not have a booking date
- category 2 patients who have waited more than ninety (90) calendar days since last review, or have been not ready for care (NRFC) for clinical or personal (deferred)l reasons for more than forty-five (45) cumulative calendar days and who do not have a booking date
- category 3 patients who have waited more than three hundred and sixty-five (365) calendar days since last review, or who have been not ready for care (NRFC) for clinical or personal (deferred) reasons for more than ninety 90 cumulative calendar days and who do not have a booking date.

The facility/HHS must ensure processes including audits are in place to conduct clinical review of patients on the waiting list and for patients who have exceeded an initial course of treatment without receiving an updated referral / clinical information from their referring practitioner or nominated general practitioner (where not the same). The information provided will assist to determine if these patients are to be retained in the specialist outpatient service establishing 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 and resulting change in priority and allocated urgency categorisation
- the urgency category and clinically recommended timeframe for care remains appropriate.
- the patient is fit to receive care and therefore ready for care
- the patient should be removed.

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 (F2F) and contemporary methods (e.g., web links and Apps)
- special needs – interpretation, translation, cultural differences.

3.14.1 Privacy requirements

HHS staff should refer to the relevant cyber security and information security policies and standards when determining appropriate communication modalities.

This includes, but is not limited to, responsibilities when emailing clinical and organisationally sensitive information.
(www.health.qld.gov.au/__data/assets/pdf_file/0025/1028293/qh-imp-484-3.pdf)

3.14.2 Communication with patients

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 facility of any changes to their nominated general practitioner and next of kin (NOK)
- the need for a written referral to gain access to and remain within services
- the need for a valid referral for continuation/extension of services further than the validity period of the initial referral.
- time, date, and location of appointment/s, and what to bring (e.g., x-rays, investigation results, medications, Medicare card, evidence of entitlements)
- 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 waiting list and clinically recommended timeframes
- 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
- NRFC maximum thresholds for deferment

- appointment confirmation, rescheduling and attendance processes
- changes to the patient's clinical urgency category
- removal for failing to attend, cancelling and / or declining two (2) offers of an appointment for the same reason for referral whether the appointments are consecutive or not
- removal including the reason, date of removal and what to do if treatment is still required.

3.14.3 Communication with referring practitioners and nominated General Practitioners (where not the same)

Communication with referring practitioners and nominated General Practitioners (where not the same) must occur in a timely manner to ensure patient safety in both primary and secondary care provision. Continued communication with the referring practitioner (and nominated general practitioner where not the same) must continue during the term of the consultative period (single course of treatment) to ensure that collaborative management of the patient is established and maintained.

Communication with the referring practitioner and nominated General Practitioner (where not the same) by the specialist about the results of consultation will be completed and communicated within five (5) working days. This will occur at a minimum:

- following the initial appointment
- at regular intervals in the patient's course of treatment
- where there is significant change in the patient's condition, or the treatment being provided.
- At transfer of care following completion of the single course of treatment to the referring practitioners and nominated General Practitioner where not the same.

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

- receipt of referral, expiration of referral or when further information is required
- confirmation of patient placement on the waiting list, including date of placement on the waiting list, name of allocated clinic and urgency categorisation and clinically recommended timeframes
- the need for regular clinical review of the patient by the referring practitioner or nominated general practitioner whilst awaiting an 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 and clinically recommended timeframe
- completion of the patient's single course of treatment
- removal of the patient including the reason and date of removal
- patient discharge / transfer of care and the reason for this.

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

- availability of service
- alternative and complementary 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 waiting lists
- types of specialties/services offered
- estimated waiting times
- special requirements (as applicable)
- supporting diagnostics and clinical information required for triaging
- Clinical Prioritisation Criteria (CPC), (where CPC are available), or relevant HHS referral guidelines
- treatment / intervention details.

3.14.4 Queensland Corrective Services

Patients from Queensland 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 appointment details.

Details of dates for appointments must be directly conveyed to the delegate from Queensland 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 lists, activity, dynamics and performance. This is to ensure a proactive approach to waiting list and scheduling 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). This includes all Queensland Health reporting and non-reporting facilities within HHSs:

- Number of long waits at census by category and by specialty
- Number of booked and un-booked 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 and patient review lists within services

- Proportion of patients treated within clinically recommended timeframes by category
- Number of patients treated from the waiting list by specialty
- Number of patients added to the waiting list by specialty
- Number of patients removed 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
- Number of patients who fail to attend (FTA) confirmed appointments
- List of patients who have or will exceed maximum NRFC thresholds.

3.16 Aboriginal and Torres Strait Islander considerations

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

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

4 Legislation

- Health Services Act 1991
  Health Services Act 1991 (legislation.qld.gov.au)
- Hospital and Health Boards Act 2011
  Hospital and Health Boards Act 2011 (legislation.qld.gov.au)

5 Supporting documents

Authorising policy and standards:

- Governance of Outpatient Services
  Governance of Outpatient Services Policy (health.qld.gov.au)

Procedures, guidelines and protocols:

- Clinical Prioritisation Criteria
  Clinical Prioritisation Criteria (CPC) - home page (health.qld.gov.au)

- Clinical records management policy and supporting standards and guidelines
  Clinical records management (health.qld.gov.au)

- Credentialing and defining the scope of clinical practice policy and guideline
  Credentialing and defining the scope of clinical practice (health.qld.gov.au)

- Data management policy and supporting standards and guideline
  https://www.health.qld.gov.au/__data/assets/pdf_file/0031/397237/qh-imp-279-1.pdf

- Elective Surgery Implementation Standard
  https://www.health.qld.gov.au/__data/assets/pdf_file/0027/397440/qh-imp-342-1.pdf

- Gastrointestinal and Endoscopy Services Implementation Standard
  https://www.health.qld.gov.au/__data/assets/pdf_file/0020/812450/qh-pol-461-2019.pdf

- Queensland Health informed consent
  https://www.health.qld.gov.au/consent

- Queensland Health Non-Admitted Patient Data Collection (QHNAPDC) manual

Queensland Health Non-Admitted Patient Data Collection (QHNAPDC) | Queensland Health

- Queensland Health records and privacy
  http://www.health.qld.gov.au/system-governance/records-privacy/health-personal/default.asp

- Specialist Outpatient Data Collection (SODC) manual
  Specialist Outpatient Data Collection Manual 2022-2023 | Clinical Excellence Queensland (health.qld.gov.au)

- Use of e-mail standard
  Use of Email standard (health.qld.gov.au)

Related documents:

- Australian Charter of Healthcare Rights
  Australian Charter of Healthcare Rights (second edition) - A4 Accessible | Australian Commission on Safety and Quality in Health Care

- Hospital and Health Service Agreements
  www.health.qld.gov.au/system-governance/health-system/managing/agreements-deeds

- Medical Board of Australia Good medical practice: a code of conduct for doctors in Australia
  Medical Board of Australia - Good medical practice: a code of conduct for doctors in Australiahttp://www.medicalboard.gov.au/Codes-Guidelines-Policies/Code-of-

- 2020 – 2025 National Health Reform Agreement (NHRA)
  2020–25 National Health Reform Agreement (NHRA) | Australian Government Department of Health and Aged Care

- National Safety and Quality Health Service Standards
  The NSQHS Standards | Australian Commission on Safety and Quality in Health Care

- Patient election to receive a public or private service
  Patient election to receive a public or private service | Australian Government Department of Health and Aged Care

- Private Practice Guidelines
  Private Practice Guidelines (health.qld.gov.au)

- Reciprocal Healthcare Agreements
  Reciprocal Health Care Agreements - Services Australia

- Referring and requesting Medicare services

  Referring and requesting Medicare services - Health professionals - Services Australia

- Scope of Publicly Funded Services Policy

  https://www.health.qld.gov.au/__data/assets/pdf_file/0026/396143/qh-pol-336.pdf

- Publicly Funded Services Guideline

  https://www.health.qld.gov.au/__data/assets/pdf_file/0030/397461/qh-gdl-336-1.pdf

6 Definitions

Term	Definition
Alternate pathway of care	An alternate pathway of care is where an alternative mode of therapy or treatment intervention is provided to patients referred to specialist outpatient service for the reason for referral. *Source*: 3.8.2 Alternate pathways of care and complementary pathways of care, Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
'Associated care referral' requests	Internal referrals also include 'associated care referral' requests where assessment, treatment and / or investigation is needed from another specialist within the facility to support diagnosis and / or treatment planning relating to the patient's existing reason for referral and pathway of care. 'Associated care referral' requests can only be made to another facility within the HHS if the facility at which the patient is receiving treatment does not provide the required service or the other facility is closer to the patient's residence. *Source*: 3.6.2 Internal Referrals, Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Census date	Date on which the organisation takes a point in time (census) count of and characterisation of patients on the waiting list. *Source*: METEOR Metadata Online Registry, Australian Institute of Health and Welfare: https://meteor.aihw.gov.au/content/270153
Clinical audit	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. *Source*: National Institute for Clinical Excellence (2002): www.nice.org.uk/media/default/About/what-we-do/Into-practice/principles-for-best-practice-in-clinical-audit.pdf
Clinical Record (also referred to as Health Record)	A collection of data and information gathered or generated to record clinical care and health status of an individual or group. Health records are made up of documents such as health record forms, clinical documents, legally authenticated documents and clinical referral letters received from clinical providers. This term includes paper-based health records, clinical records, medical records, digitised health records, EHRs, and healthcare records. *Source*: Australian Standard AS 2829.1-2012 as cited in QH-IMP- 279- 2:2013 Documentation of date and time in the paper-based health record: www.health.qld.gov.au/__data/assets/pdf_file/0026/397304/qh-imp-279-2.pdf *NB: in the context of the SOSIS, electronic patient administration systems (eg. HBCIS, ESM), do not constitute a clinical record.*
Clinical urgency	A clinical assessment of the urgency with which care, treatment or assistance is required.

	Source: METEOR Metadata Online Registry, Australian Institute of Health and Welfare: http://meteor.aihw.gov.au/content/269075
Compensable Patient	A compensable patient means an eligible person who is: receiving public hospital services for an injury, illness or disease; and entitled to receive or has received a compensation payment in respect of an injury, illness or disease; or if the individual has died. *Source*: National Health Reform Agreement: Microsoft Word - FINAL NHRA 2020-25 Addendum (consolidated version) - May 2020.DOCX (federalfinancialrelations.gov.au)
Complementary pathway of care	A complementary pathway of care is where complementary therapy or treatment intervention is provided to patients referred to specialist outpatient services. The complementary care is provided in addition to specialist treatment, to improve a patient's treatment outcomes. *Source*: 3.8.2 Alternate pathways of care and complementary pathways of care, Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Continuation of care referral	If a patient needs continuing care, GPs can write a referral beyond 12 months or for an indefinite period. Source: Services Australia, Australian Government: www.servicesaustralia.gov.au/referring-and-requesting-medicare-services)
Corporately endorsed patient administration system	Queensland Health's corporately endorsed patient administration system is HBCIS – Hospital Based Corporate Information System – Patient Information Module *Source*: HBCIS, eHealth Queensland, Queensland Health: qheps.health.qld.gov.au/ehealth/technology/systems/hbcis-online
Corporately endorsed referral management system	Queensland Health's corporately endorsed referral management systems is Smart Referrals. *Source*: Smart Referrals, Clinical Excellence Queensland, Queensland Health: www.health.qld.gov.au/clinical-practice/innovation/smart-referrals/smart-referrals-resources
Corporately endorsed waiting list management system	Queensland Health's corporately endorsed waiting list management systems are the ieMR ESM appointment scheduling and management module (ESM) and the Hospital Based Corporate Information System Appointment Scheduling Module (HBCIS APP) *Source*: HBCIS-APP: qheps.health.qld.gov.au/ehealth/technology/systems/hbcis-online. ieMR ESM: Integrated electronic medical record (ieMR) | Queensland Health
'Discharge reviews'	Referrals for admitted patients requiring an appointment for subsequent clinical review (inclusive of Allied Health and nursing outpatient services) following separation from an inpatient episode of care for the same reason for the admission. In this instance, a formal request for a review appointment must

	be submitted to the relevant specialist outpatient service and a copy must be included in the patient's clinical record. Such requests are considered 'discharge reviews'. *Source*: 3.6.2 Internal referrals, Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Endorsed electronic methods of referral receipt	The preferred endorsed electronic method of referral receipt is the corporately endorsed referral management system; GP Smart Referrals: Smart Referrals | Queensland Health Endorsed electronic methods of referral receipt also include: • Medical-Objects: www.medicalobjects.com • HealthLink: https://au.healthlink.net • and fax.
Facility identifier	The unique identifier of the facility providing the specialist outpatient Service is a valid code from the Corporate Reference Data System (CRDS) Facility Data Set. Records must be reported from and by the facility where the service request occurs; being the facility where the service is intended to occur, or has occurred. The Facility identifier therefore must be the identifier of that reporting facility. *Source:* 3.2.1 Data element: Facility identifier, Specialist Outpatient Data Collection (SODC) Manual: qheps.health.qld.gov.au/__data/assets/pdf_file/0027/2786040/sodc-manual-2022-23.pdf Corporate Reference Data System (CRDS): http://qheps.health.qld.gov.au/hsu/statstand/corporate-reference-data-system-crds
Health Provider Portal (HPP)	The Health Provider Portal (HPP) provides Queensland Eligible Health Practitioners (HPs) with secure online access to patient healthcare information from Queensland's public hospitals. Eligible Health Practitioners can include General Practitioners (GPs), Specialists, Nurses, Midwives, Paramedics and Pharmacists. This access bridges the information gap between Queensland HPs and public hospitals to help ensure patients receive consistent, timely and better coordinated care. The Health Provider Portal is also known as The Viewer within Queensland Health. *Source*: Health Provider Portal, eHealth, Queensland Health: www.health.qld.gov.au/clinical-practice/database-tools/health-provider-portal
Health Record	See Clinical Record
Internal Referral	An internal referral is a new referral that is generated from within the same facility 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. *Source*: 3.6.2 Internal referrals, Specialist Outpatient Services Implementation Standard (SOSIS):

	www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Medical Record	See Clinical Record
Nominated General Practitioner	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. *Source:* Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Non-admitted patient service event	An interaction between one or more healthcare provider(s) with one non-admitted patient, which must contain therapeutic/clinical content and result in a dated entry in the patient's medical record. *Source*: METEOR Metadata Online Registry, Australian Institute of Health and Welfare: Non-admitted patient service event (aihw.gov.au)
Not accept reason (Smart Referrals)	Does not meet service criteria, duplicate, exceeds treatment age limit, Internal referral - not cat 1, insufficient information, not a referral - correspondence, out of catchment, out of scope, referral from specialist required, treated as inpatient, service not available, redirect to alternate service, other, CPC minimun referral criteria not met *Source*: Smart Referrals: https://qheps.health.qld.gov.au/clinical-excellence/smart-referrals/resources and https://www.health.qld.gov.au/clinical-practice/innovation/smart-referrals/smart-referrals-resources
Not ready for care (NRFC) status	A not ready for care patient is: • a patient whose health status precludes them from accepting an appointment; or • a patient who for personal reasons wishes to defer their appointment. Each not ready for care period should be recorded in the source system, with the reason, start date and end date specified. The not ready for care period is inclusive of the start and end dates specified. *Source*: 1.10.4 Ready for care, Specialist Outpatient Data Collection (SODC) Manual: Specialist Outpatient Data Collection Manual 2022-2023 | Clinical Excellence Queensland (health.qld.gov.au)

Outpatient Clinic Service	An examination, consultation, treatment or other service provided in an outpatient setting in a specialty unit or under an organisational arrangement administered by a hospital. *Source*: METEOR Metadata Online Registry: Outpatient clinic service (aihw.gov.au) meteor.aihw.gov.au/content/684477
Outreach Service / Visiting Service	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. At the HHS where the outreach service is provided the outreach service is known as the visiting service for clear management of each aspect of clinical and administrative service provision. *Source:* 3.4.1 Outreach and visiting services, Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Outsource	Outsourcing is where patients are referred from a public facility or service to a private facility for treatment. Outsourcing occurs following registration, acceptance, and waitlisting on the specialist outpatient waiting list on the corporately endorsed referral management system and corporately endorsed waiting list management system. *Source*: 3.11 Transferring and outsourcing patients, Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Private Patient (non-admitted)	The National Health Reform Agreement (NHRA) – Addendum 2020-2025, Schedule G Business Rules, G19 states: An eligible patient presenting at a public hospital outpatient department will be treated free of charge as a public patient unless: a. there is a third party payment arrangement with the hospital or the State or Territory to pay for such services; or b. the patient has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient. To support the business rules and processes outlined in the SOSIS, interpreted from the NRHA business rules, the definition of a private non-admitted patient is: A patient who has been referred to a named medical specialist who is exercising a right of private practice and the patient chooses to be treated as a private patient. *Source*: G19, Schedule G Business Rules, Addendum, National Health Reform Agreement 2020-2025: Microsoft Word - FINAL NHRA 2020-25 Addendum (consolidated version) - May 2020.DOCX (federalfinancialrelations.gov.au)

Partial booking date	A partial booking date is when a booking for an appointment is created in the corporately endorsed waiting list management system, but the patient is not notified of the offer of appointment until six (6) prior to the appointment. This prevents the patient receiving multiple offers of appointment for different dates as appointments are internally rescheduled regularly and prevents the resulting confusion about what is the actual date of the appointment. *Source*: Specialist Outpatient Services Implementation Standard (SOSIS) www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Ready for Care	A ready for care patient is ready, both clinically and personally, to receive their appointment. *Source*: 1.10.4 Ready for care, Specialist Outpatient Data Collection (SODC) Manual qheps.health.qld.gov.au/__data/assets/pdf_file/0027/2786040/sodc-manual-2022-23.pdf
Reassign (referral)	Change the referral from the healthcare service nominated by the GP to a healthcare service (within the HHS) determined most appropriate to treat the patient. i.e. Change specialty, same facility (within the HHS) or change facility (within the HHS), same specialty or change specialty and facility (within the HHS) *Source*: Smart Referrals: https://qheps.health.qld.gov.au/clinical-excellence/smart-referrals/resources and https://www.health.qld.gov.au/clinical-practice/innovation/smart-referrals/smart-referrals-resources
Redirect (referral)	The HHS (HHS1) has deemed the received request as not appropriate for acceptance and has redirected the request to an appropriate HHS (HHS2). *Source*: Smart Referrals: https://qheps.health.qld.gov.au/clinical-excellence/smart-referrals/resources and https://www.health.qld.gov.au/clinical-practice/innovation/smart-referrals/smart-referrals-resources
Referral (for specialist treatment)	Patient referrals to a specialist or consultant physician for treatment, not including general practitioners, need to meet certain conditions. The referral must include all of the following: • relevant clinical information about the patient's condition for investigation, opinion, treatment and management • the date of the referral • the signature of the referring practitioner. Referrals don't need to be made out to a certain specialist or consultant physician. If you're referring a patient, you should let them choose where to present the referral. This also applies to electronic referrals.

	Source: Referring and requesting Medicare services, Services Australia: Referring and requesting Medicare services for health professionals - Health professionals - Services Australia
Referring practitioner	The referring practitioner is the person responsible for referring a patient to a service. NB. The referring practitioner may be the nominated general practitioner and the nominated general practitioner must be included all communication where the referring practitioner and nominated practitioner are not the same. *Source*: 3.6.1. Referral sources Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Reporting Hospital	32 public hospitals in Queensland Health are required to provide a submission to the SODC. This requirement is included in the Service Agreements between each HHS and the Department of Health. The full list of hospitals included in the scope of the collection is listed in the appendix. *Source*: Appendix 2 – SODC Reporting Hospitals, Specialist Outpatient Data Collection (SODC) Manual 2022-2023: Specialist Outpatient Data Collection Manual 2022-2023 | Clinical Excellence Queensland (health.qld.gov.au)
Responsible Officer (for transfer and outsourcing)	Each HHS is to nominate a responsible officer for coordinating patient transfers at each facility within the HHS. The responsible officer at the referring facility / HHS must contact the responsible officer at the receiving facility / HHS prior to initiating a patient transfer and / or outsourcing. *Source*: 3.11.1.1 Principles for patient transfers and outsourcing, Specialist Outpatient Services Implementation Standard (SOSIS): Specialist Outpatient Data Collection Manual 2022-2023 | Clinical Excellence Queensland (health.qld.gov.au)
SA2	Statistical Areas Level 2 (SA2s) are medium-sized general purpose areas built up from whole Statistical Areas Level 1 (SA1s). Their purpose is to represent a community that interacts together socially and economically. *Source*: Australian Statistical Geographical Standard (ASGS) Version 3 July 2022: https://www.abs.gov.au/statistics/standards/australian-statistical-geography-standard-asgs-edition-3/jul2021-jun2026/main-structure-and-greater-capital-city-statistical-areas/statistical-area-level-2 Hospital and Health Boards Regulation 2012: https://www.legislation.qld.gov.au/view/html/inforce/current/sl-2012-0024#
Single course of treatment	A referral covers a single course of treatment for the referred condition. A single course of treatment is an initial attendance at the specialist or consultant physician. It includes subsequent attendances for the continuing management until the patient is referred back to the referring practitioner.

	Source: Referring and requesting Medicare services, Services Australia: https://www.servicesaustralia.gov.au/referring-and-requesting-medicare-services?context=20#a2
Specialist outpatient service	Outpatient services are defined as an organisational unit or arrangement through which a Hospital and Health Service (HHS) 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 usually led by a specialist health practitioner. *Source:* 1.1 Introduction, Specialist Outpatient Data Collection (SODC) Manual 2022-2023: Specialist Outpatient Data Collection Manual 2022-2023 | Clinical Excellence Queensland (health.qld.gov.au)
Transfer	Transfer occurs where patients are referred from one public facility or service to another for treatment. Transferring occurs following registration, acceptance, and waitlisting on the specialist outpatient waiting list on the corporately endorsed referral management system and corporately endorsed waiting list management system. *Source*: 3.11 Transferring and outsourcing patients, Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Triaging Clinician	The triaging clinical assigns the urgency category to the within five (5) business days of receipt of the referral, complying with Clinical Prioritisation Criteria (CPC) where CPC are available, or as per endorsed local triage / referral guidelines. (CPC). The triaging clinician is the Clinical Director of the Specialty or assigned delegate. *Source*: 3.7.4 Urgency category assignment, Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf
Urgency category	A clinical assessment of the urgency with which a patient requires care and/or treatment following assessment of a service request at a specialist outpatient clinic *Source:* 3.3.7 Data element: Clinical urgency category, Specialist Outpatient Data Collection (SODC) Manual 2022-2023: Specialist Outpatient Data Collection Manual 2022-2023 | Clinical Excellence Queensland (health.qld.gov.au)
Visiting Service	See definition under Outreach Services *Source:* 3.4.1 Outreach and visiting services, Specialist Outpatient Services Implementation Standard (SOSIS): www.health.qld.gov.au/__data/assets/pdf_file/0029/164756/qh-imp-300-1.pdf

Waiting time	Waiting time is calculated as the total number of days from the start date (being the date a patient is placed on the specialist outpatient waiting list) to the end date (being either the date of removal or the census date) minus any days the specialist outpatient service request was awaiting further information, any days the patient was not ready for care, and also minus any days the patient waited with a less urgent clinical urgency category than their clinical urgency category at the end date. There may be a period of time between when the specialist outpatient referral is received and a clinician is able to assess the referral. This is referred to as an uncategorised period. An uncategorised period is counted in the patient's waiting time. *Source*: 1.10.5 Waiting time, Specialist Outpatient Data Collection (SODC) Manual 2022-2023: Specialist Outpatient Data Collection Manual 2022-2023 | Clinical Excellence Queensland (health.qld.gov.au)

7 Version control

Version	Date	Comments
1.0	01 February 2016	SOSIS published following OSIS revision, consultation and approval
2.0	13 November 2017	Updated SOSIS published following revision, consultation and approval. For detailed information on the changes made from version 1, please email OIP@health.qld.gov.au for a copy of the comparison document
3.0	06 February 2023	Updated SOSIS published following revision, consultation and approval. For detailed information on the changes made from 2 version, please email OIP@health.qld.gov.au for a copy of the comparison document

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