Outpatient Services Performance Improvement Programme

A Guide to Measurement & Data in Outpatient Services

Supporting Implementation of the Protocol for the Management of Outpatient Services

January 2014

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1. Introduction

The provision of outpatient services requires accurate information and data to measure and manage performance and assess the achievement of objectives set out in the protocol for the management of outpatient services.

Performance measurement information facilitates the allocation and prioritisation of resources and provides evidence to either confirm or change current policy or program directions to meet goals and to report on the success in meeting those goals.

Performance measurement asks:

- "Is progress being made toward desired goals?"
- "Are appropriate activities being undertaken to promote achieving those goals?"
- "Are there problem areas that need attention?"
- "Are there successful efforts that can serve as a model for others?"

The outpatient data collection process will therefore be enhanced and developed, building on data already collected, to provide meaningful support to the outpatient services performance improvement programme (OSPIP).

2. Enhancing the Data Environment in Outpatient Services

2.1. Activity data will be required across the full range of OP services including nurse and allied health-delivered/led services, diagnostics, and physiological measurement. Waiting lists will be developed for these services and for review patients.

2.2. A new data set will be maintained in relation to outpatient clinic capacity and governance and will be formally reported twice yearly to the BIU.

2.3. The outpatient programme of reform will see:

- The introduction of standardisation of service description
- Quantification of OP resources and capacity
- Description of governance of clinics/services
- A full range of activity waiting list data, including review patient waiting list data
- Extension of the data collected to include presenting complaint, patient experience, and outcome measures

2.4. The development of the enhanced data environment will take place in a phased manner to be notified to service-providers as required.

3. Items Measured & Quantified in Outpatient Services

3.1. Service Demand & Capacity

- Demand for services will be assessed through quantification of referrals/recommendations for new, review, planned consultations, and patient transfers to OP services.

- The capacity to provide outpatient services will be assessed twice yearly. This assessment will assess outpatient staff resources and provision of 'slots' for new urgent/routine patients, review patients, and planned consultations. Identified capacity will be aggregated to national level and will enable the setting of benchmark performance per resource available.

- The governance of services/clinics will be clearly set out in the service provision agreement. This will enable accurate description and quantification of the service, and the provision of reliable information to SORs and patients regarding services provided. This data will also enable accurate counting of activity and assignment of activity statistics to the person overseeing and delivering the care.

- The definitions for the management of outpatient services contained in this document provide detail regarding types of governance arrangements. Service-providers should ensure that each outpatient activity session is described and recorded as set out in the definitions.

3.2. Access Times

- Wait-time for access to consultant-led consultation clinics, allied health/clinical nurse specialist consultation clinics, procedure clinics, and stand-alone diagnostic clinics will all be quantified across the lifetime of the programme.

- All outpatient service-provision will be recorded on a PAS system under the four service types set out in this document.

- Presenting complaint will be developed in conjunction with the clinical programmes and will greatly enhance the system's ability to assess access to services.

- Wait-time for access per urgency category will be assessed. Wait times will be adjusted to reflect cancellation/rescheduling by service-provider or patient. Indicative date of appointment will be used to assess review patient and planned consultation wait-times.

- Private and public status will be recorded to ensure equal access to services for both categories of patient.

3.3. Resource Utilisation

- Activity will be measured through the collection of data for all groups providing outpatient services, including consultant-led, nurse-led and allied-health-led services.
- All modes of outpatient service-provision will be recorded as activity including telemedicine/virtual clinics, outreach services, home visits, and services delivered to non-admitted patients in various locations throughout the service-provider site, not previously counted as 'OPD'.
- The manner in which the service is delivered will be quantified under the headings of standard, shared, and joint clinic formats.
- Mode of delivery (consultant-led, nurse delivered, etc.) will be quantified.
- Resource under-utilisation will be assessed with reference to performance benchmarks set nationally and by quantification of patients rescheduled by the service-provider and those who fail to attend or reschedule their appointment.
- Episode duration and contacts per episode will be quantified as the programme develops.

3.4. Quality Measures

- A set of quality measures will be developed and implemented. Time to clinical prioritisation is currently collected and this will be refined.
- Patient experience time, diagnosis, outcomes, and patient satisfaction will be developed and measured as the data collection process is progressed.

4. Monitoring & Reporting Mechanisms in Outpatient Services

4.1. Outpatient management will monitor key activities on a daily and weekly basis and escalate in a timely manner, necessary actions when (i) capacity does not meet demand, (ii) where targets are being breached, and (iii) where protocol guidelines are not being adhered to/implemented.

4.2. Each directorate, specialty, and/or discipline will set out details of outpatient service-provision in the service-provision agreement. The service provision agreement will be aligned with the service-provider's service plan/service-level agreement. The agreement will be updated throughout the year, as required, when changes to services occur.

4.3. Each directorate and specialty/discipline will monitor provision of service capacity, access times, resource utilisation, and quality measures. Management will provide clinicians with the necessary information to enable clinical groups to monitor the quantum, timeliness, and quality of outpatient service-provision.

4.4. The clinical director/clinical lead will report service capacity, access times, resource utilisation and achievement of quality targets to senior management monthly in arrears in keeping with the HSE reporting time frames, indicating escalation procedures and action plans to achieve targets and quality service provision, where required.

4.5. Outpatient management are responsible for the following outpatient inputs to the monitoring and reporting system which will enable assessment of the status of key performance indicators:

Table 1: Data reporting requirements in outpatient services

Output	Frequency	To:
OP patient-level data extract	Weekly	NTPF
OP minimum data return	Monthly	BIU
OP capacity assessment	Twice yearly	BIU
Service provision agreement	December	OSPIP
Participation in random audits of implementation of protocol for management of OP services	Random audit	NTPF & Q&PS

4.5.1. Service-providers will ensure cover 52 weeks of the year in relation to provision of data at the times specified by the data collection agencies.

5. Metrics for Use in Outpatient Services

Each OP metric will have a defined purpose and life-span, with metrics being developed, rolled out, paused, retired, and re-instated, as required. The summary tables set out the metric number, description, and status.

Table 2: Metrics for use in outpatient services

Service Area	Metric Number	Data item	Data Output	Current Status
Demand & capacity	001	Number of referrals	Number of referrals per SOR to clinician/s, specialty/discipline, service-provider, per month, median referrals per SOR to clinician, specialty, service-provider	In progress
	002	Number of clinic hours	Number of clinic hours per clinician/s, specialty/discipline, service-provider, per month, median number of clinic hours per clinician, specialty/discipline, service-provider	In development
	003	Number of appointment slots	Number of appointment slots per clinic/service, per clinician/s, specialty/discipline, service-provider, per month	In progress
	004	Number of WTE clinicians	Number of WTE clinicians per specialty/discipline, service-provider, group, nationally	In progress
Access	005	Referral outcome	Proportion of referrals, per SOR, per clinician, specialty and service-provider assigned to each referral outcome option	In development
	006	Wait-times for consultation	Current and retrospective wait-time for first consultation with consultant-led, multidisciplinary-led and nurse-led services, for new urgent, new routine, review and planned consultations, per SOR, per clinician/s, specialty/discipline, service-provider, per month; Achievement of cancer access targets.	In progress
	007	Wait-times for outpatient treatment	Current and retrospective wait-time for outpatient treatment event per type, for consultant-led, multidisciplinary led, nurse-led services for new urgent, new routine and review patients	In development
	008	Wait-times for outpatient diagnostic/ report	Current and retrospective wait-time for outpatient diagnostic event per type, for consultant-led, multidisciplinary led, nurse-led services for new urgent, new routine and review patients; Proportion of planned diagnostics provided within five working days of the date; Proportion of review diagnostics provided within 20 working days of indicative date. Diagnostic report turn-around times.	In development
Resource Utilisation	019	Outpatient attendances	Attendances, new urgent, new routine, review, planned consultation per clinician/s, specialty/service, service-provider, per month; median new urgent, new routine, review, planned consultation per clinician/s, specialty/service, service-provider; Proportion of attendances delivered face-to-face, through telemedicine; new to review ratio	In progress
	010	Failure to attend	Number of new urgent, new routine, review, planned consultations failing to attend per SOR to clinician/s, specialty/service, service-provider per month; median new urgent, new routine review	In progress
	011	Number of episodes	Number of episodes of care in progress per clinician/s, specialty/service, service-provider per month; duration of episode of care; number of contacts per on-going and completed episodes of care	In development
	012	Completed episodes of care	Number of completed episodes of care per clinician/s, specialty/service, per service-provider, per month; Median completed episodes of care per clinician/s, specialty/service, service-provider; referral to completion ratio	In development
Quality Measures	013	Time to clinical prioritisation	Time to clinical prioritisation per SOR, per clinician/s, specialty/service, service-provider, per month; median referrals per SOR to clinician, specialty/service, service-provider	In progress
	014	Patient experience time	Time spent in the outpatient environment waiting to be seen, in consultation/treatment/diagnostics from registration to final administrative departure	In development
	017	Patient satisfaction	Patient's satisfaction with timeliness, quality and outcomes of referral	In development

Metrics will be calculated to assess performance on an on-going basis, with a sub-set chosen each year for the performance assurance reporting system. This sub-set is set out annually in the national service plan. The outpatient minimum data set describes the individual data items that will be required to enable calculation of this set of metrics (Guidance 006).

Definitions for the Management of Outpatient Services

	Term	Description	Business Rules
1	**Outpatient Service**	An organisational arrangement through which a health-service-provider delivers healthcare to non-admitted patients.	
2	**Outpatient Clinic**	The term 'clinic' describes various arrangements under which service-providers deliver specialist outpatient services to non-admitted, non-ED patients.	• Outpatient clinics are delivered in defined locations, at regular or irregular times, with one or more healthcare-provider delivering care to patients. • Scheduled outpatient clinics are counted in hours (or portions of an hour not less than 0.5).
3	**Outpatient Clinic Type** **(1, 2, 3, 4)**	The type of clinic provided, described in relation to the nature of activity delivered.	**Type of clinic:** (1) Procedure clinics (2) Medical consultation clinics (3) Stand-alone diagnostic clinics (4) Allied health/clinical nurse specialist clinics • Where mixed activity involving consultation and some procedures occur, these clinics are coded as (2) medical consultation clinics. *Health Pricing Office (Case Mix) definitions provide full description of clinic type.*
4	**Location of Clinic/Service**	The location of the clinic/service delivered.	**Select from:** • Main outpatient area • Hospital ward • Procedure room • Radiology • Diagnostic area (non-radiology) • Allied health service area • Telemedicine/virtual clinic • Telephone • Day centre • Home visit • Outreach location (specify) • Other service-provider location (specify)

	Term	Description	Business Rules
5	**Outpatient Clinic Delivery Mode**	**The manner in which clinicians deliver the outpatient clinic:**	
		Standard clinic: Typically a clinician and/or his or her team, provide consultations in an outpatient service.	• One clinician has overall responsibility for this clinic
		Shared clinic: Shared clinics occur where two or more clinicians see patients from a common waiting list during the same clinic session.	• One clinician has overall responsibility for the patient he/she sees
		Joint clinic: Joint clinics occur when two or more clinicians from different specialties provide care to patients within certain diagnostic categories during the same clinic.	• Each clinician who sees the patient has joint responsibility for that patient
6	**Consultant-Led Outpatient Service**	An element of the overall outpatient service led by a medical consultant. The medical consultant usually works with a team which includes non-consultant medical staff, nursing, allied health, and technical staff.	• One or a number of consultants lead the team, with the consultant/s ultimately accountable for delivery of the healthcare service to service-users.
			• The wait-time for a consultant-led service starts on the date the referral is received by the service-provider or on an indicative date in limited circumstances, and stops when the patient is seen by the consultant or an authorised member of the consultant's team.
			• Where a patient is seen by an authorised member of the consultant's team for the first visit, but requires review, follow-up or further assessment by the consultant or another member of his/her team, the patient is removed from the new waiting list and placed on the review waiting list to be seen within 28 days where urgent or by the indicative date of appointment where routine.

	Term	Description	Business Rules
7	**Consultant-Led Outpatient Service (Type 1)**	Consultant-led, medical-delivered.	• The consultant is scheduled to attend this clinic.
			• Patients can be seen by NCHDs in association with the consultant. In limited circumstances (e.g., illness, planned leave) where clear pathways of care and governance arrangements are stated, senior NCHDs may see patients on behalf of the consultant without his/her attendance.
			• Activity is returned for the consultant, with a sub-set to indicate which team member sees the patient.
			• Where a patient is seen by an authorised NCHD for the first visit, but requires review, follow-up or further assessment by the consultant or another member of his/her team, the patient is removed from the new waiting list and placed on the review waiting list, to be seen by the consultant within 28 days where urgent or by the indicative date of appointment where routine.
8	**Consultant-Led Outpatient Service (Type 2)**	Consultant-led nurse delivered.	• The consultant is not scheduled for this clinic but nursing staff may require occasional consultation with the consultant or other medical staff.
			• Activity is returned for the consultant, with a sub-set created to indicate nurse-delivered.
			• Where the patient is seen by a member of the nurse team and requires review, follow-up or further assessment by the consultant or another member of his/her team, the patient is removed from the new waiting list and placed on the review waiting list to be seen the consultant/team member within 28 days where urgent or by the indicative date of appointment where routine.
9	**Consultant-Led Outpatient Service (Type 3)**	Consultant-led allied health delivered (including technician).	• The consultant is not scheduled for this clinic but allied health professional staff may require occasional consultation with the consultant or other medical staff.
			• The activity is returned for the consultant, with a sub-set created to indicate allied health/technician-delivered.
			• Where the patient is seen by a member of the allied health team/technician and requires review, follow-up or further assessment by the consultant or another member of his/her team, the patient is removed from the new waiting list and placed on the review waiting list to be seen within 28 days where urgent or by the indicative date of appointment where routine.

	Term	Description	Business Rules
10	**Consultant-Led Outpatient Service (Type 4)**	Consultant-led multidisciplinary team delivering a service to patients with complex specified conditions, for example, a cystic fibrosis or obesity management multidisciplinary team.	• Care may be delivered by the consultant/s and/or any combination of multidisciplinary professionals, as set out in the specialty pathways of care and governance arrangements. • Activity is returned for the consultant/s, with a sub-set created to indicate multi-disciplinary/ nurse-delivered if appropriate. • Where the patient is seen by a member of the multidisciplinary team and requires review, follow-up or further assessment by the consultant or another member of the multidisciplinary team, the patient is removed from the new waiting list, placed on the review waiting list to be seen by the consultant/team member within 28 days where urgent and within the indicative date of appointment where routine.
11	**Allied Health-Led Outpatient Service**	An element of the overall outpatient service **led** by an allied health professional (advanced practitioner), for example a physiotherapist or dietician. In this arrangement, the allied health professional may work alone or as part of a team including other allied health professionals, nursing and technician staff.	• Allied health professionals delivering this type of service have the right to receive their own referrals, make clinical decisions, and discharge patients from their care. • Activity is returned for the allied health professional. • Ad-hoc consultation by allied health professionals with medical team members is permitted without affecting the definition of this type of clinic. These ad-hoc consultations or advisory sessions are not counted as separate activity. • Where patients are waiting for a consultation with an allied health professional as part of a consultant-led service the patient is counted as waiting for a consultant-led service Type 3 (consultant-led allied health delivered (including technician).
12	**Nurse-Led Outpatient Service**	An element of the overall outpatient service **led** by an advanced nurse practitioner (ANP). In this arrangement, the ANP may work alone or as part of a team including other nursing and technician staff.	• Nurses delivering this type of service have the right to receive their own referrals, make clinical decisions, and discharge patients from their care. • Activity is returned for the nurse. • Ad-hoc consultation by nurses with medical team members is permitted without affecting the definition of this type of clinic. These ad-hoc consultations or advisory sessions are not counted as separate activity. • Where patients are waiting for a consultation with a nurse as part of a consultant-led service the patient is counted as waiting for a consultant-led service Type 2 (consultant-led nurse delivered, e.g., diabetic nurse as part of endocrinology team).

	Term	Description	Business Rules
13	**Outpatient Clinician Status**	**Describes whether the clinician is:**	
		(i) Working within his/her main site	• Clinician is working within the main site with which he/she holds a contract of employment. Activity is returned by the main site.
		(i) Visiting	• Where a consultant 'visits' from another site. The consultant's obligation is split in specified proportions between another site and this site. Activity is returned by the 'visiting' site.
		(i) Providing an outreach service in a location other than the main service-provider site	• Outreach clinics are delivered by a service-provider in a location other than the main service-provider site, for example, a community-based location. Activity should only be returned by the main site. Activity is **not** returned by the outreach location.
14	**Outpatient Episode of Care***	A period of care for a specific healthcare problem or condition. It may be continuous or it may consist of a series of intervals marked by one or more **brief** separations. An episode of care is initiated with an initial assessment and acceptance by the organisation and is usually completed with discharge or appropriate referral.	• When the patient is discharged, transferred or leaves against medical advice, and **after 28 days** (brief period) requires further treatment for the same condition, this is a new episode of care.
			• When the patient is discharged, transferred or leaves against medical advice and the requirement for care occurs within 28 days or less, the previous episode of care may continue at the clinician's discretion.
			• The patient is counted as 'new' for the first attendance within the episode of care, and thereafter as a review patient.
15	**Outpatient Episode of Care Status**	Determination as to whether the episode of care is on-going, paused or terminated.	**Episode Status:** • On-going • Paused • Terminated
16	**Outpatient Event**	Relevant occurrences along the course of a patient's episode of care, for a specific healthcare problem or condition, linked to the overall episode of care.	

	Term	Description	Business Rules
17	**Outpatient Event Type**	Description of the type of outpatient event.	**Event Types:** • Episode initiation (receipt of referral) • Return of invalid referral to SOR • Episode re-confirmation (receipt of completed referral after return to SOR) • Referral re-route • Attendance for consultation • Attendance for stand-alone diagnostic • Attendance for treatment/procedure • Failure to attend for consultation • Failure to attend for stand-alone diagnostic • Failure to attend for treatment/procedure • Admission (day case or inpatient) relating to original referral • Cancellation or rescheduling by service-provider of scheduled appointment • Healthcare separation (death, discharge, sign out against medical advice, transfer) • Episode Re-instatement
18	**Outpatient Episode of Care Number**	A unique number assigned to one or a series of healthcare events related to an outpatient referral for a specific healthcare problem or condition.	• The episode of care number is assigned on receipt of referral and is linked to all events relating to that episode of care thereafter until the patient is discharged in relation to the condition for which the referral was made.
19	**Outpatient Event Number**	A unique number assigned to each event in the episode of care for a specific healthcare problem or condition, linked to the episode of care number.	• The outpatient event number is date and time stamped.
20	**Outpatient Episode of Care Initiation**	The commencement of an episode of care on receipt of referral and the upload of the patient's referral details on to the relevant patient administration system.	• The episode of care commences on the date of receipt of the patient's referral.
21	**Outpatient Episode of Care Pause**	A pause in the episode of care due to the submission of an invalid referral.	**Episode paused reason:** Receipt of invalid referral.
22	**Outpatient Episode of Care Re-Start**	The continuation of an episode of care that was paused due to receipt of an invalid referral.	• While the episode of care commences with the receipt of the original referral, the patient is not counted as waiting until the receipt of a valid referral.

	Term	Description	Business Rules
23	**Outpatient Episode of Care Termination**	An event that ends the patient's episode of care.	**Episode terminated reason:** • Discharge • Requested removal from waiting list • Removal from waiting list due to failure to attend • Removal from waiting list due to frequent rescheduling • Patient deceased • Patient re-routed/transferred to another service-provider (not including 'out-sourcing') • Referral rejected (not suitable to specialist care/this service-provider)
24	**Outpatient Episode of Care Re-Instatement**	The reinstatement of a terminated episode if the patient seeks, or is referred by SOR for further care within 28 days.	• Reinstatement requests that occur after 28 days require a new referral and generate a new episode of care.
25	**Healthcare Separation***	Separation from a healthcare facility/service occurs any time a patient leaves because of death, discharge, sign out against medical advice or transfer.	
26	**Outpatient Referral**	An outpatient referral occurs when an authorised health professional (SOR) requests advice/consultation, procedure/treatment, or diagnostic with an outpatient service-provider on behalf of his/her patient.	• Where a patient attends for a review/follow-up appointment and presents a new referral letter from his/her SOR regarding a separate condition, this referral is entered on the PAS system on the day of receipt as a new referral. • If the patient is subsequently seen on the day for this separate condition, he/she will accrue a zero day wait. If it is not possible to see the patient on the day of receipt, the referral is managed as normal.
27	**Invalid Outpatient Referral**	A referral that does not contain sufficient information to allow the service-provider to administer, clinically manage, and/or make decisions in relation to the patient's care.	• A valid referral contains, at a minimum, the data set out by HIQA (see Guidance 003)
28	**Outpatient Referral Status**	Determination as to whether the referral is valid or invalid.	**Select from:** • Valid new referral • Valid review referral • Valid planned consultation • Invalid new referral • Invalid review referral • Invalid planned consultation • No referral in progress

	Term	Description	Business Rules
29	**Outpatient Referral Return to SOR**	The return of a referral to the SOR with a request to provide the minimum amount of information required to administer and safely clinically prioritise the patient (as set out by HIQA, see Guidance 003).	• Incomplete referrals marked 'urgent' by the SOR should be completed by phone. • The episode of care is 'paused', with the patient not counted as waiting until a valid referral is received.
30	**Source of Referral (SOR)**	A health professional/health service-provider who, by agreement with the outpatient service, seeks a consultation/procedure/treatment/a diagnostic/ opinion/advice on behalf of a patient.	**Select From:** • GP • Dentist • Consultant same hospital • Consultant other (public) hospital • Consultant other (private) hospital • ED same hospital • ED other (public) hospital • ED other (private) hospital • Advanced nurse practitioner • Primary care team member • Allied health professional • Public health nurse • MAU/AMAU • Inpatient/day case services • Mental health services • Disability services • Older persons services • Consultant (this hospital) private rooms • Consultant (other hospital) private rooms • Private hospital clinic • Private hospital day case service • Private hospital inpatient service
31	**Preferred Consultant/Service-Provider**	The named professional to whom the SOR directs the referral.	• Use name and healthcare codes.
32	**Specialty/Discipline Pre Clinical Prioritisation**	The outpatient specialty/discipline to whom the patient is assigned by the receiving service-provider for clinical prioritisation.	• Use name and healthcare codes.
33	**Specialty/Discipline Post Clinical Prioritisation**	The outpatient specialty/discipline that the patient is assigned to after acceptance and clinical prioritisation.	• Use name and healthcare codes.

	Term	Description	Business Rules
34	**SOR Clinical Priority**	Determination by SOR as to whether the patient requires urgent or routine access to outpatient services.	**Select from:** • Urgent • Routine
35	**Referral Outcome**	Care pathway that the patient is placed on after the clinician assesses/clinically prioritises the referral.	**Select from:** • Accepted face-to-face consultation with consultant-led service • Accepted face-to-face consultation with allied health or nurse led service • Accepted, but requires stand-alone diagnostic prior to first consultation • Accepted to outpatient procedure clinic • Re-routed to other clinician/specialty/ANP/AHP same hospital • Re-routed to other clinician/specialty/ANP/AHP other hospital • Direct admission to day case service • Direct admission to in-patient service • Return to SOR with advice/care plan • Return to SOR (reject) (State reason)
36	**Outpatient Waiting List**	An ICT-held record of patients awaiting consultation / procedure / treatment / a diagnostic / opinion / advice in an outpatient setting.	• All waiting lists in public hospitals are 'common' and chronologically managed within the relevant urgency category. • The patient's private or public status has no bearing on the manner in which patients are appointed to clinic slots.
37	**Outpatient Waiting Time**	The time a patient spends waiting for access to an aspect of an outpatient service for a particular condition or healthcare need.	• Wait-time for a new consultation/procedure/diagnostic is from the date of receipt of referral or indicative date for certain specified conditions, until the patient sees the clinician/nurse/AHP or an authorised member of a clinical team, has a diagnostic (where no consultation is required) or procedure/treatment. • Waiting time for a review appointment is from the indicative date of appointment until the date the patient is seen. • Patients must be ready and fit to be seen for an outpatient appointment. The wait-time for patients, who are not currently fit to be seen, starts on the date when they are fit to be seen/an indicative date. For example, a patient has surgery on week 1 and requires chemotherapy at week 6. The patient is placed on the waiting list at week 1, but the clock does not start until week 6, that is, when the patient is ready/fit.

	Term	Description	Business Rules
38	**Waiting List Transfer**	An instance where a patient is transferred from one waiting list to another.	
		Transfer Type 1: As part of succession management when a consultant retires/resigns his/her position (patients can be (i) inherited by the new consultant or (ii) distributed across the remaining consultants).	• Patients waiting for new appointments on the previous clinician's waiting list are counted as new waiters on the replacement consultant's waiting list, retain the original referral date and wait-time, but are flagged as waiting list transfers and can be counted as a sub-set of that clinician's new waiting list.
			• Patients who are awaiting review appointments on the previous clinician's review waiting list are placed on the new clinician's review waiting list and are seen according to the indicative date given by the previous clinician, with the clock not starting until the indicative date is reached. Transferred review patients are flagged as transfers until the first review appointment occurs. These review patients should be scheduled for first review with the new clinician with slots appropriate in duration to reflect the fact that the patients are new to this particular clinician.
		Transfer Type 2: Where a service-provider/clinician brings an existing patient (new or review) on to a new or review waiting list from another service-provider site.	• The patient retains his/her status of new or review and the original referral date. The patient is flagged as a waiting list transfer with note taken of the transferring location. New patients are appointed chronologically according to the original wait-time in the previous service-provider site. Review patients are appointed chronologically in accordance with the indicative date of appointment set at the most recent consultation in the previous service-provider site.
		Transfer Type 3: Where child (<16 years of age) patients are transferred to adult services.	• Where a child patient (<16) has been awaiting a first appointment (new) and at 16 requires transfer to adult services, with the same or different consultant in the same or another hospital, he/she is counted as a new waiter but retains the original date of referral.
			• Where a child patient awaiting a review appointment is transferred at age 16, to his/her current clinician in the same or a different hospital, and the duration of time since the last consultation is within one year, the patient is counted as a review appointment, and appointed taking account of the indicative date of appointment set at the most recent consultation.
			• Where the child patient awaiting a review appointment is transferred at age 16 to his or her own clinician in the same or a different hospital, and the duration of time since the last consultation is greater than one year, the patient is counted as waiting for a planned consultation, and appointed taking account of the indicative date of appointment set at the most recent consultation.
			• Where the child patient awaiting a review appointment is transferred at age 16 to a new service-provider/clinician in the same or a different hospital, the patient is placed on the new waiting list of the new service-provider taking account of the indicative date of appointment set out by the previous service-provider.
			• Example: A paediatric endocrinologist transfers a patient to an adult endocrinologist's waiting list, and the patient requires a follow up appointment within three months. The patient is placed on the adult service-provider's new waiting list immediately but the clock does not start until the indicative date of appointment (three months' time). Where the date is greater than one year, the patient is placed on the service-provider's planned consultation waiting list, with the clock starting at the indicative date of appointment.
		Transfer Type 4: Where a patient is transferred (by request of original service-provider) from a publicly-funded hospital to another publicly-funded hospital.	• The patient is transferred from the original new/review/planned consultation waiting list to an equivalent waiting list with another service-provider, by request of the original service-provider. Patients awaiting a new/review/planned consultation are seen chronologically according to the original date of referral/indicative date of appointment with the original service-provider. Patient's awaiting new/ review/planned consultation or continuation of outpatient treatment are new to the new service-provider, but are counted as waiting from the original date of referral/indicative date of appointment set by the original service-provider in order to ensure continuity of care for the patient.

	Term	Description	Business Rules
39	**Reason for Removal from Waiting list**	The reason a patient was removed from a waiting list.	**Select from:** • Patient attended a scheduled appointment • Patient failed to attend for appointment (DNA) • Patient cancelled appointment and did not reschedule (CP) • Patient repeatedly re-schedules appointment • Patient admitted as inpatient, day case or attends an AMAU for the specified condition • Patient referral re-routed to another hospital/service- provider • Patient re-routed to another clinician same specialty • Patient re-routed to another specialty in the hospital/service-provider • Patient re-routed to a stand-alone advance nurse practitioner service • Patient re-routed to a stand-alone allied health service • Patient returned to SOR with advice/care plan • Patient discharged • Referral rejected • Patient deceased • Validation exercise • Data error
40	**Appointment Date**	The date the patient is scheduled to attend for appointment.	• Where patients are rescheduled due to CNA, DNA, and cancellation by service-provider, the date of each appointment must be noted.
41	**Patient Private/Public Status**	Private or public status of the patient at initiation of the episode of care.	• All patients are held on a 'common' waiting list and are seen in chronological order within urgency code, irrespective of public or private status.
42	**Outpatient Attendance**	Refers to any outpatient attendance at an outpatient clinic or service, or engagement with an outpatient service through telemedicine (including telephone and internet) or at home/other location.	• An attendance is counted for each person for whom a healthcare record is held. Where two or more persons attend a consultation (e.g., family therapy), the record is held for one individual within the family and this constitutes one attendance • Where a couple attend an appointment, both with, for example, an infectious disease, and two healthcare records are held, this constitutes two attendances. • Telephone and internet consultations (telemedicine) are counted as activity .Telemedicine consultations are used to assess, diagnose and/or treat the patient and provide the same set of outcomes for the patient as would be expected in a face-to-face consultation. • Interactions with the SOR prior to or during clinical prioritisation to complete referral information do not constitute telemedicine activity.

	Term	Description	Business Rules
43	**Outpatient Attendance Type**	Description of manner in which the service is delivered	**Type:** • Patient • Patient via telemedicine • Patient's SOR via telemedicine • Patient's SOR via care plan
44	**Outpatient Attendance (new)**	The first attendance in an episode of care for assessment and/or treatment for a healthcare condition.	• Patients can only be counted once as a 'new' attendance per episode of care. A single referral cannot generate more than one 'new' attendance. • Wait-time is calculated from the date of receipt of referral or indicative date in limited circumstances, until the patient is seen, fails to attend, reschedules his/her appointment or is removed from the waiting list for another valid reason. • Patients who have been seen in ED, who have not been seen by the relevant outpatient service clinician, or where further diagnostics/work-up is required by the relevant outpatient specialty clinician to determine the necessity for care, require a new appointment (including, but not limited, to fractures and trauma patients in the specialties of plastics, ENT and ophthalmology) • Patients who are in the care of a clinician in a particular specialty, who after first consultation are determined to require a consultation with another clinician in that specialty, or another specialty with a particular sub-specialisation, are placed on the new waiting list of the other/ sub-specialising consultant and appointed with an urgent or routine appointment as determined by the sub-specialising consultant during clinical prioritisation. The patient retains the original date of referral. • A patient whose first consultation in an episode of care is delivered via telemedicine is counted as 'new'. Telemedicine consultations are used to assess, diagnose and/or treat the patient and provide the same set of outcomes for the patient as would be expected in a face-to-face consultation. • Patients who are treated in an AMAU where a separate condition is detected or unexpected results warrant a further referral which does not relate to the condition for which the patient was admitted to the AMAU require a new appointment for the new condition. • Where a patient has been discharged from outpatients and re-presents with a new condition, this requires a new appointment regardless of occurrence within the 28 days. • Where a patient has been discharged from outpatients and re-presents after 28 days with the original condition, this is a new episode of care and requires a new appointment.

	Term	Description	Business Rules
45	**Outpatient Attendance (review)**	Attendance at an outpatient service by patients who have been treated: (i) At least once previously as an outpatient with the same condition/complaint and who have not been discharged. (ii) As an inpatient or day case by a specialty for that condition (iii) As a one day admission in an AMAU/MAU (iv) In ED by the relevant specialty/service clinician, resulting in the commencement of the episode of care. (Clinician satisfied that review appointment required). (v) Re-attendance by patients within 28 days after discharge, transfer, leaving against medical advice.	• All attendances after the first attendance are counted as review attendances. • Wait-time is calculated from the 'indicative' date of appointment until the patient is seen, fails to attend, reschedules his/her appointment or is removed from the waiting list for another valid reason. • Patients who have been seen in ED, where a diagnosis has been determined and agreed by the relevant **outpatient service clinician**, resulting in commencement of the patient's episode of care, require a review appointment for outpatients.· • Patients managed for the first attendance via telemedicine are counted as new for that telemedicine consultation and as review patients for any subsequent attendances in relation to the specific condition. • Where a patient has been discharged from outpatients and the patient returns with the same condition **within** 28 days the clinician can decide to re-start the previous episode of care if he/she is satisfied that the attendance is in relation to the previous condition. In this instance the patient requires a review appointment. • General review appointments scheduled more than one year away are counted as 'planned consultations', and require the reason for planned consultation to be stated by the clinician as set out in the planned consultation reasons in Item 47.
46	**Outpatient Attendance Planned Consultation**	Planned consultations are appointments that must occur on a particular date, on a planned schedule, or at a particular developmental milestone.	• Wait-time for planned consultations is calculated from the indicative date of appointment until the patient is seen, fails to attend, reschedules his /her appointment, or is removed from the waiting list for another valid reason. • In cases where a patient who is awaiting or is scheduled for a planned consultation requires transfer from one service-provider to another, Transfer Type 4 (page 17) rules apply.
47	**Planned Consultation Reason**	The reason a patient is scheduled for a planned consultation.	**Planned Consultation Reasons:** • Surveillance • Fitness for treatment issues • Developmental reasons • Phased/bilateral treatments • Time-stamped or series-dependent treatments
48	**New to Review Ratio**	The number of new patients that attend a service compared to the number of review patients that attend a service. Expressed by setting out for each new patient attendance, how many review patients attendances occur.	• The new to review ratio is calculated by dividing the number of outpatient review attendances by the number of outpatient new attendances.

	Term	Description	Business Rules
49	**Failure to Attend (DNA) (New or Review)**	Failure to attend for a new or review appointment at an outpatient service.	• The wait-time clock is re-set each time the patient DNAs. The time is re-set to the date of the DNA.
50	**Failure to Attend (DNA) Rate**	Describes the proportion of appointments booked that fail to attend.	• In calculating DNAs and CNAs, as a general rule they are additive, however, account must be taken of whether choice and reasonableness existed in each case. • The failure to attend (DNA) rate is calculated by dividing the number of failures to attend (DNAs) by the number of appointments made (attendances +DNAs).
51	**CNA (Cannot Attend, New or Review)**	An instance where a patient reschedules an appointment with an outpatient service and does not use the original booked appointment.	• Each time the patient reschedules the clock is re-set. The clock is re-set using the date of CNA.
52	**Cancellation by Patient (CP)**	An instance where the patient contacts the hospital to cancel the appointment and requires no further appointment or care from the hospital.	• The patient is removed from the waiting list.
53	**Cancellation by Patient Reason**	Reason the patient requires no further appointment.	**Cancellation by patient reasons:** • Patient seen elsewhere as public patient • Patient seen elsewhere as private patient • Patient recovered • Patient deceased • No reason specified • Other (specify)
54	**Cancellation/Postponement by Service-Provider (CPSP)**	An instance where the service-provider/clinician cancels/reschedules a patient's appointment.	**Reasons are:** • Consultant unavailable due to illness • Consultant unavailable due to other leave • Consultant unavailable due to on call rota/scheduling conflict • Consultant unavailable unspecified reasons • Non-consultant personnel unavailable due to illness • Non-consultant personnel unavailable due to other leave • Non-consultant personnel unavailable due to on call rota/scheduling conflict • Non-consultant unavailable unspecified reasons • Financial curtailment • Infrastructural reasons • Infection-control reasons

	Term	Description	Business Rules
55	**Indicative Date of Appointment**	An appointment date/ time- frame set by a clinician by which the patient must be seen.	• Indicative dates are typically set for review and planned consultations. • An indicative date can be set in limited circumstances for a new referral to nominate a date by which the patient is fit/ready for treatment, for example, for a patient commencing oncology post-surgery. **Example of wait time calculation:** • The patient is seen at an outpatient clinic and the clinician states that he/she should be reviewed in three months (the indicative date). • The patient is then appointed by four months (due to unavailability of slots). The wait-time starts at the indicative date, that is, in three months' time. The wait-time for this patient is therefore one month/four weeks. He/she waited four weeks longer than the indicative date of appointment.
56	**Activity Type**	Description of the type of activity reported after attendance.	**Activity Types:** • New Urgent • New Routine • Review Urgent • Review Routine • New Planned Consultation • Review Planned Consultation
57	**Clinic/Service Code Appointed To**	The unique code of the clinic/service to which the patient is appointed.	• Identification code assigned by service-provider to clinic .
58	**Service-Provider-Type Appointed To**	The type of provider with whom the patient is appointed.	**Select from:** • Consultant-led, medical delivered provider • Consultant-led, nurse delivered provider • Consultant-led, allied health delivered provider • Consultant-led, multidisciplinary delivered provider • Nurse-led provider • Allied health-led provider • Stand-alone diagnostics • Other provider (specify)

	Term	Description	Business Rules
59	**Governing Service-Provider Appointed To**	The unique code of the individual with responsibility for the service to whom the patient is appointed.	• Where the patient is appointed to a shared or joint clinic, indicate all codes
60	**Clinic /Service Code Seen In**	The unique code of the clinic/service in which the patient was seen.	• Identity code assigned by service-provider to clinic.
61	**Service-Provider-Type Seen In**	The type of service-provider the patient is seen in.	**Select from:** • Consultant-led, medical delivered provider • Consultant-led, nurse delivered provider • Consultant-led, allied health delivered provider • Consultant-led, multidisciplinary delivered provider • Nurse-led provider • Allied health-led provider • Stand-alone diagnostics • Other provider (specify)
62	**Governing Service-Provider Seen In**	The unique code of the individual who governs the service within which the patient is seen.	• For a standard service this is the governing clinician's code. • For a shared service this is the code of the governing clinician who oversees the patient's care (one clinician). • For a joint service, this is the code of each clinician who oversees the patient's care (one or more clinicians).

	Term	Description	Business Rules
63	**Service-Provider Seen By**	The unique code of the primary service-provider who sees the patient and delivers the substantive component of the attendance.	• For a consultant-led, medical-delivered service (Type 1), the primary service-provider is the consultant or NCHD. • For a consultant-led, nurse delivered service (Type 2) the primary service-provider is the nurse. • For a consultant-led, allied health delivered service (Type 3), the primary service-provider is the allied health professional. • For a consultant-led, multidisciplinary delivered service (Type 4), the primary service-provider/s is/are the professional /s delivering the substantive component/s of the patient's attendance (one or more professionals). • For a nurse-led service the primary service-provider is the nurse. • For an allied-health-led service the primary service-provider is the allied health professional. • For stand-alone diagnostics the primary-service-provider is the professional who conducts/runs the diagnostic.
64	**Attendance Registration Time**	The time the patient registers at a dedicated location for his/her attendance.	• All attendance times are recorded with the date (hh:mm dd/mm/YYYY)
65	**Attendance First Contact with Clinical Staff Time**	The time at which the patient has first contact with a clinical staff member (nurse, doctor, allied health professional, technician).	• All attendance times are recorded with the date (hh:mm dd/mm/YYYY)
66	**Attendance Primary Contact Time**	The time the patient has first contact with the primary service-provider for that attendance.	• All attendance times are recorded with the date (hh:mm dd/mm/YYYY)
67	**Attendance Departure Time**	The time the patient is administratively 'departed' at the end of the attendance.	• All attendance times are recorded with the date (hh:mm dd/mm/YYYY)

	Term	Description	Business Rules
68	**Clinic/Attendance Outcome**	The end-result of the patient's attendance in outpatient services.	**Outcomes:** • Review consultation • Diagnostic work-up and review • For scheduled consultation at specific time greater than 1 year as outpatient • For minor procedure as outpatient • For treatment/intervention as outpatient • For scheduled day case procedure • For scheduled inpatient procedure • Emergency admission • Refer on to another clinician • Repeat offer of appointment for clinical reasons post failure to attend (DNA) • Discharged

- *HIQA, National Standards for Better, Safer Healthcare, 2012*