THE MANAGEMENT OF OUTPATIENT SERVICES

Version 2.1

February 2014

Outpatient Services Performance Improvement Programme

Protocol

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Introduction

The health service in Ireland provides scheduled access for non-admitted patients to assessment, diagnosis, follow-up, and treatment of healthcare conditions. The Protocol for the Management of Outpatient Services provides a standardised set of processes that will drive and enable the provision of quality outpatient services while putting in place a framework against which to assess performance.

The protocol forms the core guidance for outpatient service reform as set out by the Outpatient Services Performance Improvement Programme. This version (2.0) supersedes version 1.0 and will be reviewed annually.

When used in conjunction with the supporting material issued in association with this document, or from time to time as required, the protocol will ensure that consistent management processes exist across all publicly-funded healthcare facilities providing outpatient services in Ireland.

The protocol seeks to enable service-providers to transition to an ICT-enabled, clinically driven, performance managed system of care that will ensure patients receive appropriate care, in a timely manner, utilising suitable resources.

This protocol applies to all HSE-funded healthcare facilities providing outpatient services. Compliance with this protocol is mandatory for all HSE employees, volunteers and contractors engaged in the delivery of publicly-funded outpatient services.

This document has been developed with due regard to the Health Information & Quality Authority's (HIQA) *Report and Recommendations on Patient Referrals from General Practice to Outpatients and Radiology Services, Including the National Standard for Outpatient Referral Information (2011)* and *The National Standard for Better Safer Healthcare (2012)*.

The protocol is accompanied by *A Guide to Measurement and Data in Outpatient Services, A Guide to Audit of the Management of Outpatient Services,* and a set of guidance documents relating to operational actions required in OP services.

1. Accessing Outpatient Services

1.1. Access to outpatient services is via the submission of a written/electronic referral from a recognised source of referral (SOR). Recognised SORs (agreed locally and/or set out by national/clinical programmes) are set out in Table 1:

Table 1. Approved Sources of Referral to Outpatient Services

- GP
- Dentist
- Consultant same hospital/service-provider
- Consultant other (public) hospital/service-provider
- Consultant other (private) hospital/service-provider
- ED same hospital
- ED other (public) hospital
- ED other (private) hospital
- Advanced nurse practitioner
- Allied health professional
- Public health nurse
- Other primary care team member
- MAU/AMAU
- Inpatient
- Day case services
- Mental health services
- Disability services
- Older persons services
- Consultant (same hospital/service-provider) private rooms
- Consultant (other hospital/service-provider) private rooms
- Private hospital/service-provider clinic
- Private hospital/service-provider day case service
- Private hospital/service-provider inpatient service

1.2. A standard referral form is used to facilitate the provision of sufficient information to enable safe assessment by the clinician. This referral must contain, at a minimum, the data set out by HIQA (2011) in ***OP Guidance 003, The HIQA Minimum Data Set for Outpatient Referrals***.

1.3. Outpatient referrals should be made by SORs to a specialty/service.

1.4. SORs will be contacted by phone or letter, as appropriate, to complete in full, referrals that do not contain the minimum data required to safely manage and clinically prioritise the patient.

1.5. SORs are expected to notify the service-provider of any clinically significant changes in the patient's condition.

1.6. Throughout the course of an episode of care, unrelated conditions noted by the clinician generate a new referral. Where necessary, the patient should be directed back to their SOR for management and onward referral of this new condition. Where the clinician determines that the condition requires urgent attention, this clinician should make the referral to the required service in order to prevent any delay, and copy to the SOR who will then take over management.

2. Receipt & Clinical Prioritisation of Referrals

2.1. Referrals are managed centrally to maximise efficiency and reduce duplication, enabling standardisation in keeping with the requirements of this protocol.

2.2. All outpatient service referrals are added to the PAS outpatient waiting list module within 24 hours of receipt. SOR priority status is recorded at the point of registration to facilitate booking of urgent patients where the five-day turnaround for clinical prioritisation is not met.

2.3. In the interest of providing equivalent access to all patients, referrals to individual or named clinicians should be pooled by specialty/service (sub-specialisation permitting). ‘Preferred consultant’ can only be accommodated if this is in the best interest of the patient, including adherence to the maximum wait-time guarantee.

2.4. The definition of clinical urgency and associated maximum wait-time will be agreed at specialty/condition level by the clinical programmes and agreed locally through the clinical programme governance structure.

2.5. Clinical prioritisation of referrals by the relevant clinician is completed within five (5) working days of receipt of referral. The SOR and patient are notified within seven (7) working days of receipt of the referral and the expected duration of wait to be seen. The SOR should be informed of the outcome of clinical prioritisation. ***Guidance 004*** sets out a ***Communication from Outpatient Services to Source of Referral and Patient***.

2.6. Clinical prioritisation of referrals allocates patients to one of two categories, that is, urgent or routine.

2.7. Service-providers must put systems in place to ensure that those categorised as suspected cancer, ‘red-flag’, or having complex clinical need, are identified daily by a dedicated registration function and placed on an urgent waiting list to facilitate appointment within urgent time frames.

2.8. Clinicians involved in management of referrals can select a number of referral outcome options, depending on the pathway of care put in place by the specialty and/or service-provider, as set out in Table 2:

Table 2. Outpatient Referral Outcomes

- Accepted face-to-face consultation with consultant-led service
- Accepted face-to-face consultation with allied health-led service
- Accepted face-to-face consultation with nurse-led service
- Accepted, but requires diagnostic prior to first consultation
- Accepted to outpatient procedure clinic
- Re-routed to other consultant/specialty/ANP/AHP same hospital/service-provider
- Re-routed to other consultant/specialty other hospital/service-provider
- Direct admission to day case service
- Direct admission to in-patient service
- Return to SOR with advice/care plan
- Return to SOR (reject)

2.9. Tracking systems should be put in place to monitor completion of clinical prioritisation. Referrals in breach of the five (5) day turnaround should be expedited until resolved.

2.10. The five (5) day turnaround is required of all clinicians and therefore cross-site clinical prioritisation should be enabled and cover/delegation arrangements put in place for clinicians on leave. These cover/delegation arrangements should be set out in the service provision agreement. The minimum data required in the service provision agreement is set out in ***Guidance 005, The Service Provision Agreement***.

3. Managing Outpatient Waiting Lists

3.1. Outpatient referrals result in a number of waiting lists as set out in Table 3:

Table 3. Outpatient Services Waiting Lists

1. New referrals to consultant-led services
2. New referrals to nurse-led services
3. New referrals to allied health-led services
4. New referrals for diagnostic assessment
5. Return/review referrals for review of condition
6. Return/review referrals for treatment clinic sessions
7. Return/review referrals for minor procedures
8. Referrals for planned consultation

3.2. Waiting lists are currently extracted in regard to new referrals to consultant-led services. ***OP Guidance 006*** sets out the ***Minimum Data Set for Outpatient Services***. Waiting lists will be established for the remaining types of referrals to outpatient services.

3.3. Patients are added to a waiting list only after receipt of a fully completed referral form (paper or electronic), with all patients referred to OP services being placed on the relevant waiting list.

3.4. All time spent waiting, including the wait for clinical prioritisation and decision-making is counted as part of the total wait-time. The patient is counted as waiting from date of referral until he/she is seen by the appropriate clinician in outpatient services.

3.5. Waiting time stops/re-starts where a patient reschedules his/her appointment, fails to attend for appointment, cancels an appointment, or is removed from the waiting list.

3.6. All outpatient waiting lists must be continuously validated as patients move from one wait category to another, to ensure both data accuracy (system-level) and continued requirement for the appointment (patient-level). Waiting lists may be validated by phone or letter as set out in ***Guidance 002, The Validation of Outpatient Waiting Lists***.

3.7. All patients are managed chronologically on the relevant outpatient waiting list, with the patient's private or public status having no bearing on position on that waiting list. Patients who commence outpatient assessment for a particular condition as a private patient, who subsequently require access to the public outpatient system in relation to that complaint, generate a new referral and are managed chronologically.

3.8. Removal of a patient from a waiting list should only occur for the reasons set out in Table 4:

Table 4. Reasons for Removal of Patient from an Outpatient Waiting List

- Patient attended the 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 rerouted to another specialty in the hospital/service-provider
- Patient rerouted to a stand-alone advance nurse practitioner service
- Patient rerouted 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

3.9. Patients who are transferred to another facility for outpatient services remain the responsibility of the original service-provider. The patient is not removed from the waiting list until the date that the patient is seen by the other service-provider. This is necessary to ensure accurate counting of the patient's full wait to be seen.

3.10. As a general rule, patients who fail to attend for appointment will not be offered a second appointment unless the clinician indicates high clinical or other need that requires immediate and/or special attention. ***Guidance 001*** sets out the procedure for the ***Management of Patients Who Fail to Attend for Outpatient Appointment.***

3.11. Service-providers will put in place a policy for the management of OP waiting lists where a clinician is due to retire, resign from a contract of employment, or go on extended leave of absence for illness or other reasons. This policy should ensure a seamless transfer of patients to an equivalent clinician's waiting list.

3.12. Succession management policies should ensure, through the distribution of patients waiting across the specialty/service that no patient is disadvantaged as a result of an individual clinician's departure. Where sub-specialty issues arise in regard to succession management, arrangements should be made with other service-providers to ensure equal, timely access to services for all patients.

3.13. From time to time, patients may require transfer from one service-provider to an equivalent service-provider elsewhere. Service-providers should ensure in all cases that the transfer of care is seamless and that waiting times are not accrued. The patient therefore retains the original date of referral (see transfer counting rules in the *Guide to Measurement & Data in Outpatient Services*).

4. The Provision & Scheduling of Appointments in Outpatient Services

4.1. The Provision of Appointment Slots:

a. All services provided on an outpatient basis should be set out in the service provision agreement, indicating quantum, frequency and expected output. This agreement sets out 'core capacity' at specialty/service, and clinician level.

b. Service-providers should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures where capacity gaps are identified, enabling solutions to be found in a timely manner to support operational booking processes and delivery of the relevant wait-time guarantees.

c. Clinic templates should be jointly agreed between clinicians and OP management. Templates should reflect the level of demand associated with the service-level agreement to ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum wait-time guarantees.

d. Clinic capacity lost due to cancelled or reduced clinics has negative consequences for patients and on the service-provider's ability to manage the appointment process. It is essential that planned clinical absence is organised in line with an agreed procedure. ***Guidance 007*** sets out requirements for ***The Management of Outpatient Staff Leave.***

e. Where patients are cancelled/rescheduled by the service-provider, urgent patients should be seen at clinic within one week and routine patients should be appointed and seen within three (3) weeks of the original date.

f. Appointment slots should be staggered and streamed by type.

4.2. The Timeliness of Appointment Slots:

a. Patients seeking access to outpatient services are guaranteed a maximum wait-time. The maximum wait-time guarantee for a first appointment is set out in the national service plan. This wait-time target is the <u>minimum standard</u> with which every outpatient service-provider must comply.

b. Providing sufficient appointment slots to allow achievement of wait-time guarantees requires co-operation between sites to determine provision of services across the groups/areas.

c. Clinic templates should be standardised within a range nationally to provide minimum levels of service for new urgent/routine referrals and reviews, including planned consultations.

4.3. Allocation of Appointments

a. Patients referred for outpatient services are treated according to clinical urgency, with urgent referrals to a specialty/service seen and treated before referrals categorised as routine.

b. Patients of equal clinical priority within a specialty/service will be selected for appointment in strict chronological order, sub-specialisation permitting.

4.4. Scheduling & Booking Process

a. Service-providers will move to a prospective, capacity planning model of outpatient service provision, whereby, demand is assessed, capacity determined and ring-fenced on a rolling basis.

b. This will ensure that patients are booked into known, ring-fenced capacity and therefore prevent cancellation by service-provider and subsequent reallocation of appointments out of chronological order.

c. Fair access to outpatient services requires booking systems that offer the patient choice in the date and time of their appointment, and the ability to agree their appointment as part of a reasonable process.

d. New urgent patients should be appointed in keeping with urgent time frames set by the clinical programmes.

e. New routine patients should be booked in chronological order within the maximum wait-time guarantee.

f. Review patients should be booked in keeping with the timeframes (indicative date) set by the relevant clinician.

g. Patients awaiting planned consultations should be booked as per planned consultation date.

h. Service-providers will closely monitor all patients at risk of breaching the relevant wait-time target and put plans in place to schedule appropriately. This process will ensure that no patient is overlooked while on a waiting list and that access to required services is prioritised on a patient by patient basis. ***Guidance 008*** sets out additional advice in regard to ***The Booking of New Urgent, New Routine and Review Patients in Outpatient Services.***

5. The Operation of the Outpatient Clinic

5.1. Patients are advised to attend for appointment no sooner than required, prior to the scheduled appointment time. On arrival, patients will register their arrival at a dedicated location.

5.2. Service-providers should provide for the specific needs of vulnerable patients, and ensure appropriate support during the outpatient consultation.

5.3. Specialties/services will set out in the service provision agreement the outpatient patient experience time guarantee for the various sub-sets of appointment types.

5.4. Individual patient experience time should be tracked during the consultation, with patients informed of the reasons for any delay beyond the outpatient experience time guarantee. Every effort will be made to expedite completion of the patient's consultation.

5.5. During healthcare record preparation for the clinic, the clinic reconciliation form is generated. This form records times for commencement of the patient's consultation, along with general outcomes and follow-up actions required. ***Guidance 009*** sets out ***A Minimum Data Set for the Outpatient Clinic Reconciliation Form.***

5.6. The clinic reconciliation form indicates attendance status and is used by clinical staff to indicate required outcomes, and by clerical administrative staff to organise these outcomes. The patient's PAS record is to be updated with all reconciliation form information and actions within 24 hours of the consultation.

5.7. Priority should be given to the ordering of patient diagnostics, tests, and procedures. Follow-up actions should be tracked by the service-provider and expedited, where required, to enable timely management of patients in need of care.

5.8. Clinic/attendance outcomes are set out in Table 5:

Table 5. Outpatient Clinic/Attendance 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

5.9. At the end of each new or review consultation, patients will be discharged unless the relevant clinical lead determines that on-going expert specialist care is required. A standardised report should be made to the SOR utilising relevant minimum data set items after every new consultation setting out the investigations, findings, and recommended treatment plan. After review consultation, any relevant updates relating to that episode of care will require an updated report.

5.10. Standardised discharge information is provided to the SOR utilising the relevant items (adjusted for OP use) from the HIQA National Standard for Discharging Patients. ***Guidance 010*** sets out ***A Minimum Data Set for SOR Report/Discharging Patients from Outpatient Services*** (based on the HIQA National Standard for Discharging Patients).

5.11. On completion of the consultation, a patient who requires a further appointment returns to the registration desk, whereby he/she is issued with another appointment if within six (6) weeks, or placed on a waiting list for review if the required consultation is greater than six (6) weeks.

Glossary of Terms

Term	Explanation
Cancellation by Patient (CP)	An instance where the patient contacts the service-provider to cancel the appointment and requires no further appointment or care from the service-provider.
Cannot Attend (CNA)	An instance where a patient reschedules an appointment with an outpatient service and does not use the original booked appointment.
Clinic Reconciliation Form	A form which records the major components of the patient's clinic attendance status and supports follow-up actions that result from the attendance.
Clinical Prioritisation (triage)	Process where a service-provider reviews a patient's referral and determines the urgency of the patient's requirement to be seen as either urgent or routine.
Clock Start	The beginning of the patient's wait to be seen.
Clock Stop	A termination or pause in the patient's wait to be seen in outpatient services.
Clock Restart	When the patient's wait-time re-commences after a clock stop.
Closed Clinic	An instance when a clinic is closed off on the PAS system resulting in no appointments being issued for this time. This typically occurs for known closures such as public/bank holidays, but may occur for other reasons such as planned renovations, agreed leave, etc.
Co-existing Morbidities	Previously existing healthcare conditions that exist alongside the conditions diagnosed during the current episode of care.
Complex Clinical Need	A patient who has needs beyond those expected with a specific condition as a result of co-existing morbidities, social circumstances, or significant disability.
Consultant Commitment	Consultant commitment to an outpatient service is the number of clinic hours (or part of an hour, not less than 0.5) committed to the service-provider, as set out in the consultant work schedule.
Failure to Attend (DNA)	Failure to attend for a new or review appointment at an outpatient service.
Healthcare separation*	Separation from a healthcare facility/service occurs anytime a patient leaves because of death, discharge, sign-out against medical advice or transfer.
Indicative Date of Appointment	An appointment date/ time frame set by a clinician by/within which the patient must be seen.
Maximum Wait-Time Guarantee	A guarantee that the service-provider gives to patients that he/she will wait no longer than a specified time to be seen.
New to Review Ratio	How many new patients attend clinics compared to review patients. Expressed by setting out for each new patient, how many review patients attend.
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.
Outpatient Clinic	The term 'clinic' describes various arrangements under which service-providers deliver specialist outpatient services to non-admitted, non-ED patients.
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.
Outpatient Experience Guarantee	A guarantee that service-providers make to patients that they will be seen in clinic within a specified timeframe.
Outpatient Experience Time	The amount of time the patient spends in outpatient services from registration until departure.
Outpatient Referral	An outpatient referral occurs when a health professional requests a consultation, procedure/treatment, or diagnostic with an outpatient service-provider on behalf of his/her patient.
Outpatient Service	An organisational arrangement through which a health-service-provider provides a healthcare service to a non-admitted patient.
Planned Consultation	Planned consultations are appointments that must occur on a particular date, on a planned schedule, or at a particular developmental milestone.
Presenting Complaint	The complaint for which the patient requires an appointment with outpatient services.
Rapid Access	An outpatient service arrangement that provides accelerated access to assessment/treatment within a timeframe set out by the clinical programmes/specialty. Where not specified by the clinical programmes/specialty, the maximum wait for rapid access is one week (5 working days).
Red Flag	A warning of danger. Red flag symptoms are set out by medical specialists and are used to identify conditions that require immediate attention.
Service Provision Agreement	A document setting out the nature and quantum of service provided to a patient population.
Service-Provider*	Any person, organisation, or part of an organisation delivering healthcare services, as described in the Health Act 2007 section 8(1)(b)(i)–(ii).

Term	Definition
Service-User*	The term service user includes: people who use healthcare services (this does not include service providers who use other services on behalf of their patients and service users, such as GPs commissioning hospital laboratory services); parents, guardians, carers and family, nominated advocates and potential users of healthcare services.
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 on behalf of a patient.
Staggered Appointment Slots	Appointment system where only one patient is assigned to an appointment slot for a specific time. The number of patients seen per time slot matches the number of clinicians available during that time slot. The opposite to a 'batched' appointment system where multiple patients are appointed to at the one time.
Standardised Discharge Report	A report which provides a minimum amount of healthcare information to the source of referral when the patient is discharged from outpatient services.
Standardised SOR Report	A report which provides a minimum amount of healthcare information to the source of referral after the patient's first visit in the episode of care, and after any subsequent visit where the patient's status or care plan requires updating.
Streamed Appointment Slots	Appointment slots streamed by type, for example, all new, all review, all procedure, all diagnostic.
Succession Management	A process of planning the management of a service in advance of planned staff changes.
Suspected Cancer Referral	A patient who requires immediate attention as symptoms suggest the possibility of a malignant neoplasm.

**HIQA, 2012*