

PROTOCOL

THE MANAGEMENT OF OUTPATIENT SERVICES

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EDITION 1.0

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ABBREVIATIONS

AHP	Allied health professional
CNA	Could not attend (appointment)
DNA	Did not attend (appointment)
GP	General practitioner
HIQA	Health Information and Quality Authority
HSE	Health Service Executive
ICT	Information and communication technology
NCCP	National Cancer Control Programme
OPWL	Outpatient waiting list
OSMG	Outpatient Services Management Group
PAS	Patient administration system
PTL	Primary targeting list
SOR	Source of referral

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Issued as supplementary pack to this Protocol

Section 1

Introduction & Context

1.1. PURPOSE OF THE PROTOCOL

1.1.1. The Protocol for the Management of Outpatient Services sets out a suite of processes that will enable the provision of quality outpatient services. The protocol forms the core guidance of the Outpatient Services Performance Improvement Programme. When used in conjunction with the supporting material, the protocol will ensure that consistent management processes exist across all publically funded healthcare facilities providing outpatient services in Ireland.

1.2. SCOPE OF THE PROTOCOL

1.2.1. 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 publically funded outpatient services.

1.2.2. This edition of the protocol is designed specifically for use in consultant-led outpatient services, the majority of which are provided in acute hospital settings. However, the maximum waiting time guarantee for patients, and therefore this guidance, applies to any location where consultant-led outpatient services take place. Local implementation plans should be developed to take account of the specific requirements of non-hospital based consultant-led outpatient services. Future editions will address the broader elective outpatient pathway within the acute and other healthcare settings.

1.2.3. 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).

1.2.4. For the purpose of this protocol, PAS is taken to refer to all patient administration systems, whether manual or electronic.

1.3. STAFF DEVELOPMENT & TRAINING

- 1.3.1.** The effective delivery of the outpatient services programme of change and protocol objectives will depend on the competency of individuals and teams across all staff groups in outpatient services. The planned changes to processes and work practices will require all staff to develop new skills or enhance existing ones.
- 1.3.2.** All staff involved in the administration of outpatient waiting lists will ensure that the local policies and procedures relating to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on the PAS and the waiting lists for outpatient assessment.
- 1.3.3.** All staff involved in the implementation of this protocol, whether clinical, managerial, or clerical/administrative, will undertake training and regular annual updating.
- 1.3.4.** Service-providers should provide appropriate information and training to staff so they can make informed decisions when implementing and monitoring this protocol.
- 1.3.5.** Training will be cascaded at and by each clinical, managerial, or administrative tier within hospital/hospital group, providing the opportunity where required, for staff to work through operational scenarios. All staff involved in the administration of outpatient waiting lists will be expected to read and sign off this protocol.

1.4. INFORMATION & COMMUNICATION TECHNOLOGY (ICT)

- 1.4.1.** Implementation of the outpatient services performance improvement programme and delivery of the standards in this protocol will require modifications to existing hospital systems.
- 1.4.2.** Service-providers are expected to develop robust information systems to support the delivery of targets and protocol objectives. Daily management information should be available at both managerial and operational level so that staff

responsible for selecting persons for appointment are working with up-to-date and accurate information.

- 1.4.3.** Service-providers must develop and administer systems designed to maximise the proficient management of outpatient services enabling efficient registration, tracking, tracing, and management of the patient along the care pathway from initiation until discharge.

SECTION 2

UNDERPINNING PRINCIPLES

2.1 INTRODUCTION

- 2.1.1.** The provision of outpatient services must be built upon this set of underpinning principles. The full implementation of these principles is essential as each affects multiple parts of the outpatient journey.
- 2.1.2.** The administration and management of the outpatient pathway from receipt of referral until the end of the episode of care, within and across service-providers, must be consistent, easily understood, patient-focussed and responsive to clinical decision making.

2.2. CLINICAL PRIORITY & CHRONOLOGICAL MANAGEMENT

- 2.2.1.** Patients referred to outpatients should be treated based on clinical urgency, with urgent referrals seen and treated first. The definition of clinical urgency and associated maximum wait times will be agreed at specialty/condition level by the clinical programmes and agreed locally through the clinical programme governance structure.
- 2.2.2.** Patients of equal clinical priority will be selected for appointment in strict chronological order and service-providers will put systems in place to ensure that the relevant maximum waiting time standards are achieved.

2.3. CENTRALISED MANAGEMENT OF REFERRALS

- 2.3.1.** There will be a dedicated central referral service for the management of outpatient referrals per service-provider/group.
- 2.3.2.** The central referral service will act as the organisational hub for the receipt, management, tracking, administration, and closing of referrals. It will also be the central point of contact for sources of referral (SORs) and service-providers, should queries arise.

- 2.3.3.** The central referral service will also act as the central point of contact for patients wishing to cancel, reschedule, or enquire about appointments.
- 2.3.4.** In the future, service-providers will work towards a centralised model for both referral management and advanced booking.

2.4. POOLED REFERRALS TO SPECIALTIES

- 2.4.1.** As per HIQA recommendations (2011), outpatient referrals should be made by sources of referral to a specialty/service. As a minimum, all un-named referrals should be pooled. Referrals to individual or named clinicians should also be considered for pooling by specialty/service, sub-specialisation permitting.
- 2.4.2.** Reference to 'preferred consultant' on the HIQA minimum dataset for outpatient referrals facilitates service-user input and these wishes should be accommodated where clinically possible.
- 2.4.3.** As a general rule, service-providers should allocate referred patients to the appropriate clinician on the basis of clinical suitability, sub-specialty or expediency, keeping in mind at all times the best interests of the referred patients.

2.5. MAXIMUM WAITING TIME GUARANTEES

- 2.5.1.** The length of time a patient needs to wait for a first appointment with a consultant is an important quality issue and is a visible public indicator of the efficiency of the service.
- 2.5.2.** The successful management of patients awaiting outpatient assessment and diagnostic investigation is the responsibility of a number of key individuals within the healthcare-provider group. SORs, clinical staff, managers, and clerical/administrative staff have significant roles in ensuring access, quality, and efficient healthcare for potential users of outpatient services.
- 2.5.3.** The maximum waiting time guarantees for a first appointment with a Consultant are:

- **12 months by 30th November 2013**
- **26 weeks by 30th November 2014**
- **13 weeks by 30th November 2015**

2.5.4. These waiting time targets are the minimum standards with which every outpatient service-provider must comply. The expectation is that these standards are factored into plans at regional, local, specialty, and departmental levels as part of the normal business and strategic planning processes.

2.5.5. Site, specialty, and departmental managers are expected to produce implementation plans setting out the key steps required to ensure the delivery of wait time targets within the area(s) of their responsibility.

2.5.6. Ownership is essential in delivering quality of care. The importance of these targets as indicators of quality must be conveyed to all levels of staff within the service-provider/group. An accountable officer will be nominated by each service-provider/group and delegated responsibility for ensuring adherence to all aspects of the protocol.

2.5.7. Service-providers must ensure that all staff are conversant with the national outpatient wait time targets. They must be committed to training and developing staff and putting in place systems to ensure progressive improvement in care for service-users.

2.6. CAPACITY ANALYSIS & MANAGEMENT

2.6.1. It is important for service-providers to understand their baseline capacity, the make-up of the cohort of patients waiting, and the likely changes in demand that will impact on their ability to treat them and meet the relevant access and quality targets.

2.6.2. At departmental, specialty, and clinician level, managers are required to have, as a minimum (taking account of any standards set by the clinical programmes), an overview of core capacity including:

- Number of clinicians and contractual commitment.
- Number of clinic sessions.
- Session length.
- Average clinic slot time.

2.6.3. Similar information is required for diagnostic services related to the provision of outpatient services as this capacity currently forms a core component of outpatient service capacity.

2.6.4. Systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.

2.6.5. 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 targets. Specialty/service managers will be expected to initiate plans to expedite solutions and agree these through the regional performance management review process.

2.6.6. Approximately eight weeks prior to appointment, service-providers should calculate prospective slot capacity for each appointment type (new urgent, new routine and review) and escalate where capacity gaps exist.

2.6.7. Capacity should be linked to the service level agreement for outpatients and used to inform development, monitoring, and achievement of the outpatient plan. Key considerations will include resource requirements and escalation processes to ensure effective delivery.

2.6.8. There is a continual need to identify capacity constraints that could threaten the delivery of access targets and quality outcomes and to speed up the planning and delivery of extra capacity, where needed, to address these constraints.

2.6.9. There will need to be a co-ordinated approach to capacity planning taking into account local, group, and regional capacity available to the population of that particular region.

2.7. CLINIC TEMPLATE MANAGEMENT

- 2.7.1.** Clinic profiles/templates should be jointly agreed between clinicians and the outpatient services management group (OSMG). Clinic profiles/templates should reflect the level of demand associated with the service level agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees.
- 2.7.2.** Templates will identify the number of slots available for (i) new urgent (ii) new routine and (iii) review appointments. They will specify the time each clinic is scheduled to start and finish and identify the length of time allocated for each appointment slot (see implementation procedure for template redesign in [Appendix 1](#)).
- 2.7.3.** All requests for temporary or permanent template and clinic rule changes should be made in writing to the OSMG for authorisation, having due regard to the potential impact on capacity. A minimum of six (6) weeks notice is required for temporary or permanent clinic template changes to minimise the impact on patients (see clinic template alteration procedure in [Appendix 2](#)).

2.8. PROTECTING CAPACITY & CANCELLATION/REDUCTION OF CLINICS

- 2.8.1.** 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. Clinic cancellation and re-booking of appointments is an extremely inefficient way to use valuable resources.
- 2.8.2.** It is essential that planned medical and other clinical absence is organised in line with an agreed protocol and there should be clear medical and clinical commitment to this leave protocol.
- 2.8.3.** Medical and clinical staff must apply, in writing, to the clinical director, and the OSMG six (6) weeks in advance of their intended leave and clearly outline any clinic cancellations/temporary reductions (see implementation procedure for compliance with leave protocol in [Appendix 3](#)).

2.8.4. The leave protocol is designed to minimise the disruption to clinical activity as a result of short-notice of planned leave. It is accepted that short-notice cancellations/clinic reductions may occur due to illness or other unplanned events. However, the level of these cancellations/clinic reductions should be monitored by the OSMG and appropriate action taken to reduce the risks to clinical activity.

2.8.5. Escalation procedures must be put in place where, despite intervention by the OSMG, the practice of short-notice cancellation/reduction of clinics continues resulting in an inability to meet waiting time standards for urgent, routine or review outpatient appointments.

2.9. PROTECTING CAPACITY & THE MANAGEMENT OF CLINICAL LEAVE

2.9.1. Service-providers will have specific processes in place to manage planned leave for outpatient staff due to the critical impact that these staff have on the provision of outpatient services (see [Appendix 3](#)).

2.9.2. Service-providers are required to establish leave management processes (in accordance with industrial and HR requirements) in relation to all outpatient staff, underpinned by a communication strategy whereby:

- There is clear medical and clinical agreement and commitment to this HR policy.
- There is approval of leave by the relevant line manager a minimum of six (6) weeks in advance.
- Approval of leave requires notification to the accountable officer and OSMG a minimum of six (6) weeks in advance.
- There is proactive planning and approval of conference/CME leave.
- There is an ongoing review by the OSMG of the impact of staff leave on appointment schedules, with risk-management processes being put in place where necessary.

2.10. APPOINTMENT/BOOKING SYSTEMS

2.10.1. All of the principles in this section underpin the effective management of access to outpatient services. Fair access to outpatient services requires booking systems built on these principles 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. Advanced booking systems are not only more convenient for patients, but offer increased efficiency for outpatient services.

2.10.2. Moving to booking systems will require changes in working practices for all staff involved in the provision of outpatient services. Implementation of the principles and pathway guidance outlined in this protocol will provide the administrative foundation upon which successful booking systems can be built. It will also require technological change to information systems to enable provision of quality information to support the booking process.

2.10.3. The first step towards the development of advanced booking systems is to ensure consistent administration of fixed appointments and reduce variation in the current system. All service-providers should implement the “hold and treat” method of appointing patients. Implementation should focus on new patients in the first instance, followed by review patients (see hold and treat flowchart in [Appendix 4](#)).

2.10.4. The hold and treat system manages patients on the appropriate waiting list until the decision to appoint. The key principles of this approach are:

(a) New Urgent Patients

- Clinical Urgency will determine how quickly urgent patients need to be seen, and this will vary between and within specialties.
- Slots are identified on the clinic template for new urgent patients.
- Where the timeframe is less than four (4) weeks, it may not always be possible to provide the patient with a minimum of three (3) weeks’ notice, however, the principle of a reasonable period of notice applies.
- Where the urgent timeframe is greater than four (4) weeks, the hold and treat process for routine patients should be applied.

(b) New Routine Patients

- Slots are identified for new routine patients on the clinic template.
- Using the primary targeting list (PTL), routine patients should be selected for appointment approximately four to six (4-6) weeks before they are due to be seen.
- Routine patients are given a minimum of three (3) weeks' notice of their appointment, which ensures that they receive a 'reasonable' offer.
- Routine patients are not given appointments more than six (6) weeks into the future.

(c) Review Patients

- Those patients who are to be reviewed within six (6) weeks should negotiate their appointment before leaving the clinic.
- Review patients who require an appointment beyond six (6) weeks should be managed on a review waiting list on PAS, using the indicative date / month of treatment for listing.
- The process for routine patients should be applied.

2.10.5. The outpatient PTL must be used as the primary tool to select patients for appointment. The outpatient waiting list (OPWL) on PAS must not be used to select patients for appointment as this module does not adjust waiting times in the event of patient cancellations or DNAs, and does not facilitate robust chronological management.

2.10.6. The future vision for the outpatient services performance improvement programme is to progress the development of advanced booking systems. Further information on advanced booking is provided in **Appendix 5**. This will assist staff in understanding the way in which the outpatient system will develop during the programme of change. This material will also inform service-providers who currently operate booking systems that offer the patient choice of appointment date and time.

2.11. REASONABLE OFFERS

- 2.11.1.** As part of the commitment towards the introduction of booking systems which offer choice to patients, the principle of a reasonable offer applies.
- 2.11.2.** In the interim period, where fixed appointments are used, a reasonable offer is considered to be an appointment which provides a minimum of three (3) weeks' notice to the patient. It is recognised that the clinical timeframe for appointing some cohorts of urgent patients may not enable this period of notice to be given, however, the principle of a 'reasonable' period of notice should apply.
- 2.11.3.** If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.
- 2.11.4.** If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation.
- 2.11.5.** It is essential that service-providers have robust audit procedures in place to demonstrate compliance with the above. The implementation procedure on reasonableness can be found in [Appendix 6](#).

SECTION 3

THE MANAGEMENT OF THE OUTPATIENT PATHWAY

3.1 ACCESS TO OUTPATIENT SERVICES

- 3.1.1.** Access to outpatient services is via the submission of a written/electronic referral from a recognised referral source as outlined in the data definitions for use with the National Treatment Purchase Fund (NTPF) OPWL minimum data set for reporting waiting times.
- 3.1.2.** Service-providers should have arrangements in place to safely return referrals from sources other than those listed in the guidance.
- 3.1.3.** As the outpatient programme develops, a suite of specialty-specific forms will be introduced in tandem with the move to an electronic referral system.
- 3.1.4.** In the transition period, standardised referral formats will be utilised to facilitate the provision of adequate referral content. Sources of referral should therefore submit referrals using the HIQA standard referral form data set which provides the minimum data required for safe, efficient, administrative, and clinical management of referred patients (see [Appendix 7](#)).
- 3.1.5.** Referrals that do not contain the minimum amount of data required to accurately categorise the level of clinical urgency cannot be accepted and will be returned to the SOR for further clarification.
- 3.1.6.** Service-providers must work collaboratively with SORs to minimise the level of inappropriate referrals (for example, diagnostic referrals) on outpatient wait lists.

3.2. CALCULATION OF THE OUTPATIENT WAITING TIME

- 3.2.1.** The starting point for the waiting time of a new outpatient referral is the date the referral is received by the service-provider. All referral letters must be date stamped on the date received into the organisation.
- 3.2.2.** All time spent waiting, including the wait for clinical prioritisation and decision making is counted as part of the total wait time.

- 3.2.3.** As the outpatient services performance improvement programme develops, systems will be put in place to ensure that patients who require a diagnostic test to determine the appropriate clinical pathway are managed on an appropriate waiting list. Pending introduction of these systems, such patients will remain on the outpatient waiting list.
- 3.2.4.** Patients who cancel or re-schedule an appointment (CNA) will have their waiting time clock reset to the date the hospital was informed of the request.
- 3.2.5.** Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.
- 3.2.6.** Patients who request that an appointment is cancelled and not re-scheduled will be removed from the waiting list. Notification of reason for removal from the waiting list will be forwarded to the clinician/specialty, SOR, and patient.
- 3.2.7.** Patients who refuse a short-notice appointment (less than three weeks' notice) will not have their waiting time reset.
- 3.2.8.** Patients whose appointment is cancelled by the hospital/service will not have their waiting time reset.
- 3.2.9.** No patient will have their outpatient waiting time suspended. The use of this function should cease with immediate effect.

3.3. THE RECEIPT & CLINICAL PRIORITISATION OF REFERRALS

- 3.3.1.** All outpatient service referrals to service-providers will be received in a dedicated central referral service, registered on PAS, and added to the outpatient waiting list module within one working day of receipt. SOR priority status must be recorded at the point of registration to facilitate booking of urgent patients where the turnaround time for categorisation is not met.
- 3.3.2.** Where required, referrals will also be scanned to enable cross-site referral management.

- 3.3.3.** Where referrals bypass the centralised referral point (for example, sent directly to a consultant), a process should be in place to ensure that these are date stamped upon receipt and immediately forwarded to the central referral management point and registered with the date on the date stamp.
- 3.3.4.** A process should be in place to notify SORs that their referral has been received.
- 3.3.5.** Clinical priority must be identified for each patient. All referrals should be categorised and PAS updated with the outcome within five (5) working days of receipt of referral.
- 3.3.6.** Service-providers will work towards a system whereby the location of all referral letters can be tracked at all times throughout the episode of care. This system will ensure that referrals sent for clinical prioritisation that are not returned in the permitted time-frames can be identified and expedited.
- 3.3.7.** Arrangements should be put in place to facilitate cross-site clinical prioritisation of referrals (e.g., scanning) in order to ensure that the standard is met.
- 3.3.8.** Where clinics take place, or referrals are reviewed less frequently than weekly (five working days), a process must be put in place, agreed with clinicians, whereby SOR prioritisation is accepted in order to proceed with appointing urgent patients.
- 3.3.9.** Service-providers should ensure that arrangements are in place for categorisation of referrals during times of planned/unplanned clinical leave. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and categorised during their absence.
- 3.3.10.** Categorisation of referrals should allocate patients to one of two streams, that is, urgent or routine. The use of the 'soon' category should be phased out and will no longer be required as waiting times reduce. Clinic templates should be constructed to ensure enough capacity is available to treat each stream within agreed clinical and maximum waiting time guarantees.
- 3.3.11.** The consultant in charge of the specialty/service has overall responsibility for clinical prioritisation and categorisation of referrals, however, this may be delegated to a member of their team (for example, medical registrar, nurse or

AHP) where clearly defined service models and protocols have been agreed with the clinical programmes.

3.3.12. Compliance with the five (5) working day turnaround standard for clinical prioritisation and categorisation of referrals will be monitored by the OSMG. Monitoring will take place at clinician level on a weekly basis and local protocols should be developed to include escalation procedures where the standard is not routinely being met.

3.3.13. Where clinical prioritisation and categorisation is not determined within the five (5) working day standard, a process should be in place to initiate booking of urgent patients according to the SOR's categorisation.

3.4. THE MANAGEMENT OF URGENT NEW APPOINTMENTS

3.4.1. Patients categorised as urgent must be booked within the maximum wait times agreed locally with clinicians and the clinical programmes. The timeframe for appointing urgent patients should be made explicit to clerical/administrative staff/booking teams.

3.4.2. When administering patients who require urgent appointments, service-providers should ensure that the process is robust and that clinical governance requirements are met.

3.4.3. Service-providers must ensure that clinic templates are constructed to provide sufficient capacity for urgent patients to be appointed within the clinically indicated timeframe.

3.4.4. Service-providers must put systems in place to ensure that those categorised as suspected cancer or 'red-flag' are clearly identified on the waiting list and booked within the specified clinical timeframe.

3.4.5. Where it is not possible to appoint urgent patients within four (4) weeks or within timeframes set down by the clinical programmes, the principles of "hold and treat" should be applied. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately.

3.4.6. The booking of referred patients with suspected **cancer** and other conditions with '**red-flag**' signs and symptoms should be as follows:

- All suspected cancer referrals should be identified by SOR, expedited, and booked in line with the agreed clinical pathways locally, as set out by the clinical programmes and the NCCP.
- Conditions (not including cancer) for which the local clinician and the clinical programmes list specified 'red-flag' signs and symptoms should be identified by SOR, expedited, and booked, in keeping with the time-lines set out in the care pathway.
- Dedicated registration functions for suspected cancer and/or red-flag referrals should be in place within central referral offices.
- Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to ensure fast-tracked booking of this cohort of patients.
- Patients will be contacted by telephone twice (morning and afternoon).
- If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum timeframe as set out by the NCCP/clinical programmes.
- Systems should be established to allow the tracking of urgent and red-flag patient referrals.

3.5. THE MANAGEMENT OF ROUTINE NEW APPOINTMENTS

3.5.1. All routine new patients should be appointed within the maximum waiting time guarantee and service-providers should ensure that sufficient capacity is available at clinics to facilitate this.

- 3.5.2.** An acknowledgement letter should be sent to routine patients within five (5) working days of receipt of referral, that is, immediately following outcome of clinical prioritisation and categorisation.
- 3.5.3.** The estimated length of wait, along with information on how the patient will be booked, should be included on the acknowledgement letter (see guidance in **Appendix 8**).
- 3.5.4.** Routine patients will be selected from the PTL and appointed using the “hold and treat” system. Approximately six (6) weeks, but not less than three (3) weeks in advance, patients will be issued a letter of appointment. A minimum of three (3) weeks’ notice of appointment will be provided.
- 3.5.5.** Occasionally, appointment slots become available as a result of cancellation, and routine patients from the PTL may be contacted and offered a short-notice appointment (with less than 3 weeks’ notice). Where the patient refuses a short-notice offer, this will not constitute a patient initiated cancellation and their waiting time clock will not be reset.

3.6. THE MANAGEMENT OF REVIEW APPOINTMENTS

- 3.6.1.** All review appointments must be made within the time-frame specified locally by clinicians, taking account of any care pathway requirements set out by the clinical programmes.
- 3.6.2.** Patients who require an appointment within the following six (6) weeks should agree a date with the central referral service at the current appointment. Review slots should be clearly identified on the clinic template and sufficient capacity made available to meet the clinical needs of this cohort of patients.
- 3.6.3.** Patients who require a review appointment beyond six (6) weeks should be placed on a review wait list and appointed in line with the process outlined in Section 2.10.
- 3.6.4.** Service-providers must actively monitor patients on the review wait list to ensure that they do not go past their indicative month of treatment and escalate/initiate remedial action where required.

3.7. THE MANAGEMENT OF PATIENTS WHO DNA/CNA

- 3.7.1.** Where a patient is issued with a fixed appointment and fails to attend (DNA), they will be offered one more opportunity to attend. The patient's wait time will be reset to commence at the date of the failure to attend and the patient will be managed as per normal for his/her waiting list category (urgent/routine/review).
- 3.7.2.** If a patient DNAs a second appointment, they will be discharged back to the care of the SOR.
- 3.7.3.** Where patients fail to attend for cancer, red-flag or urgent appointments, every effort must be made to contact the patient and the SOR by phone to support successful management of this cohort.
- 3.7.4.** When a patient cancels or asks to reschedule a fixed appointment (CNA), they should be offered a second opportunity to attend, which ideally should be within six (6) weeks of the request to re-schedule. If the patient cancels on a second occasion, they will be discharged back to the SOR (see guidance on the management of cancellations and DNAs in [Appendix 9](#)).
- 3.7.5.** Under certain circumstances (for example, patient vulnerability or imminent clinical need) a clinician may decide not to discharge a patient after DNA/CNA. Additional steps in the pathway should be agreed in order to prioritise patient safety and this may include contacting the patient or the SOR/other relevant professional/s directly to discuss rather than issuing further fixed appointments. This will assist in understanding the reason for the DNA/cancellation, support appropriate booking arrangements for these patients, and maximise capacity.
- 3.7.6.** There may be instances for new or review patients where the clinician may wish to review notes prior to any action to remove the patient from the wait list. Service-providers should ensure that robust and locally agreed rules and processes are in place so that booking staff are clear about how to administer these patients.
- 3.7.7.** If a patient requests to be removed from the waiting list, or cancels an appointment and requests no further appointment, the reason for cancellation/removal should be recorded. It is good practice to request clinicians

to review the notes to confirm that the patient's healthcare needs are being met and that no identifiable risks are present. A letter of confirmation of removal should be sent to the clinician, SOR and patient.

3.8. CLINIC RECONCILIATION

- 3.8.1.** There may be a number of locations within and across sites where patients present for an outpatient consultation. This protocol applies to all outpatient areas, irrespective of that location.
- 3.8.2.** All patients will have their attendance registered on the relevant PAS system upon arrival at the clinic. The patient must verify their demographic and SOR details at every visit. This information must be cross-checked on PAS and the patient's healthcare record and any changes updated on the date of clinic.
- 3.8.3.** Where clinics take place at evenings or weekends, or have no reception cover, PAS must be updated on the next working day.
- 3.8.4.** When the consultation has been completed, and where there is a clear decision made on the next step of the care pathway, the patient outcome must be recorded on the date of the clinic. The use of a clinic reconciliation form is recommended (see guidance in [Appendix 10](#)).
- 3.8.5.** All outcomes, such as booking of diagnostics or the decision to treat as day case or inpatient must be administered (manually and PAS) within 24 hours of attendance at clinic.
- 3.8.6.** Clinic reconciliation forms must be signed and approved by the consultant/clinician or authorised team member on the day of clinic.

3.9. DISCHARGING PATIENTS FROM OUTPATIENT SERVICES

- 3.9.1.** Discharge planning will commence at the initial consultation and will continue through to the patient being returned to the care of their SOR.
- 3.9.2.** The consultant's team will work together to actively plan the discharge of patients and complete the episode of care. Consultants will support non-consultant medical staff in the appropriate discharging of patients from outpatient services.
- 3.9.3.** At the end of each new or review consultation, patients will be discharged unless the relevant clinical lead determines that expert specialist care, unavailable in primary care, is required.
- 3.9.4.** Standardised discharge information is to be provided to the SOR, in keeping with HIQA recommendations.

3.10. THE MANAGEMENT OF PATIENTS REQUIRING ONGOING SPECIALIST CARE

- 3.10.1.** A cohort of service-users will require ongoing specialist care in outpatient services, particularly those with complex, chronic, non-resolvable, or degenerative conditions. As the outpatient and relevant clinical programmes develop, protocols for the management of these patients will be implemented.
- 3.10.2.** In the transition period, care pathways should be developed for these patients that will ensure that the patient is being managed in the most appropriate location for their current level of illness.
- 3.10.3.** These care pathways should allow evidence-based schedules of review and fast-tracked review in outpatient services, where required.
- 3.10.4.** As a general rule, chronic disease pathway development should ensure that the care of the patient takes place seamlessly between the acute and community sectors.

3.11. VALIDATION OF OUTPATIENT WAITING LISTS

3.11.1. A continuous process of data quality validation should be in place to ensure data accuracy at all times. Data validation of waiting lists is a corporate requirement and should be undertaken weekly and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times (see data quality validation checklist in [Appendix 11](#)).

3.11.2. While fixed appointment systems are being used, a process of patient-level validation will be required and is a core task of individual departments managing outpatient services (see patient-level validation guidance in [Appendix 12](#)). As advanced booking processes are implemented, the need for patient-level validation will cease.

3.12. TRANSFERS BETWEEN HOSPITALS OR ALTERNATIVE PROVIDERS

3.12.1. Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to alternative providers. Transfers should not be a feature of an effective scheduled system.

3.12.2. Administrative speed and good communication are very important to ensure that this process runs smoothly. Detailed guidance for the PAS management of transferred patients will be developed as the outpatient programme progresses.

3.12.3. In the interim, the principles of this protocol apply to all patients, irrespective of the location or provider of their service. Transferred patients remain the operational responsibility of the transferring hospital and should be administered in line with the requirements of this protocol.

Section 4

SUMMARY LIST OF APPENDICES

PROVIDED AS SUPPLEMENTARY PACK TO THIS PROTOCOL

Appendix 1	Implementation Procedure for Clinic Template Redesign
Appendix 2	Clinic Template Alteration Procedure
Appendix 3	Implementation Procedure for Compliance with Clinical Leave
Appendix 4	Hold and Treat Flowchart
Appendix 5	Guidance for the Development of Advanced Booking Systems
Appendix 6	Implementation Procedure on Reasonableness
Appendix 7	HIQA Standard Referral Form
Appendix 8	Sample Acknowledgement Letter
Appendix 9	Guidance on the Management of Cancellations and DNAs
Appendix 10	Guidance on Clinic Outcome Management
Appendix 11	Guidance on Data Quality Validation
Appendix 12	Guidance on Patient Level Validation