Specialist clinics service improvement guide
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Acknowledgements

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Particular acknowledgment is made to the Welsh National Leadership Agency for Health Care. Some content from the publication A guide to good practice: elective services (2005) has been incorporated into this guide. Some content is also adapted from material developed by the United Kingdom's National Health Service (NHS) Institute for Innovation and Improvement. The institute has published extensively on the challenges faced by planned, non-emergency services in public hospitals, and has developed a suite of tools and resources for improving the quality and productivity of these services.
Introduction

Specialist clinics in Victoria’s public hospitals deliver planned services to non-emergency, non-admitted patients. They provide medical, obstetric and surgical assessment and treatment, as well as a range of specialised nursing and allied health services. Specialist clinics provide an interface between primary care (general practitioners (GPs) and community-based health services) and other parts of the health service. Public hospital specialist clinics are a major part of the healthcare system, delivering more than two million appointments to Victorians each year.

Specialist clinics have experienced strong growth in demand, driven by factors such as an ageing population, an increasing burden of chronic disease, reducing inpatient length of stay (and consequent increase in patient acuity) and rising community expectations.

In 2013 the Department of Health published Specialist clinics in Victorian public hospitals: access policy. The access policy outlines the department’s expectations of specialist clinic service delivery, including indicative timeframes for completing key processes. The access policy is available at <www.health.vic.gov.au/outpatients>.

This Specialist clinics service improvement guide is a companion document to the access policy. It contains information, templates, ‘real-world’ examples of good practice and resources to assist health services to undertake successful redesign work in the specialist clinics environment, as well as meet the requirements and principles of the access policy.

The service improvement guide consists of three main sections:

Section 1: Process redesign in specialist clinics
Outlines key process redesign concepts for reviewing current service provision and implementing improvement initiatives. This section provides example measures for health services to consider when undertaking redesign activities, as well as some examples of redesign projects undertaken.

Section 2: Improving clinic processes
Discusses opportunities for improving particular specialist clinic processes at key stages of the care pathway. For each stage the following are presented:

- key messages from a literature review and consultation with service providers
- strategies to improve service delivery related to that stage
- examples of good practice.

Section 3: Letter templates
This section provides letter templates and other example documents to support key clinic processes and communication.
Section 1: Process redesign in specialist clinics

Victoria’s public hospital specialist clinic services offer high standards of care, but there are well recognised opportunities to improve service delivery. To realise these opportunities, health services may consider undertaking process redesign. Many health services have redesign teams available to assist with process redesign activities. Process redesign is a formal approach to mapping, reviewing and redesigning the patient journey to maximise safety, effectiveness and efficiency of care. The key principles of redesign in healthcare are:

- the centrality of the consumer – adopt the patient’s eye view
- describe and redesign work processes
- measure components of the process
- recognise the expertise of the people who work on the frontline.

Commonly used process redesign methodologies are Lean Thinking, Six Sigma, Lean Six Sigma and the Theory of Constraints. Each methodology differs in theory, application, principles and focus.

The Department of Health’s Redesigning Hospital Care Program (RHCP) is a statewide initiative delivering significant health system improvements by applying process redesign methodologies in Victorian public hospitals. The RHCP website provides numerous resources relating to process redesign (see <www.health.vic.gov.au/redesigningcare>).

*Redesigning Hospital Care Program – an introduction to process redesign* (Department of Health 2012) (available at <www.health.vic.gov.au/redesigningcare>) provides an overview of process redesign. It is a useful resource for specialist clinics considering redesign and covers:

- key principles of process redesign
- redesign approaches
- phases of the redesign process
- defining the scope of work
- diagnosing the issues
- developing appropriate interventions
- evaluating the outcomes
- sustaining the improvement
- change management
- project management
- measurement for improvement.

Additional information is provided below relating to process mapping, flow modelling (as part of ‘diagnosing the issues’) and ‘measurement for improvement’ to assist health services considering, or in the initial stages of, a redesign project in specialist clinics.
1.1 Process mapping and flow modelling

Process mapping

Process mapping creates a map of each administrative and clerical stage of a patient’s journey through a specialist clinic. It can identify delays, unnecessary steps, waste, duplication of effort, illogical steps and common bottlenecks or constraints. Involving clinical, clerical and support staff from all relevant departments in process mapping will result in a more comprehensive map. An example process map for specialist clinics is shown in Figure 1.

A constraint is a factor that ultimately restricts the capacity of the system, for example, the number of consulting rooms, availability of medical specialists and availability of nursing staff skilled in particular procedures. Once identified, strategies can be implemented to remove the constraint or minimise the impact on service delivery. Often constraints are not easily removed without substantial investment in staffing or facilities.

By comparison, bottlenecks limit specialist clinic activity. Examples of bottlenecks in specialist clinics are delayed appointment bookings while triage staff are on leave and delayed clinic activity due to patients waiting to have investigations before their appointment. Often, resolving bottlenecks do not require the investment that resolving constraints can require.
Figure 1: Example process map for specialist clinics

Generic representation of processes for the specialist clinics high and detailed-level process map

<table>
<thead>
<tr>
<th>Action</th>
<th>Referral</th>
<th>Referral receipt and registration</th>
<th>Triage and referral acceptance</th>
<th>Scheduling and wait list management</th>
<th>In clinic</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral</td>
<td>Fax</td>
<td>Acknowledgement to GP/referent</td>
<td>Referral registered</td>
<td>Triage referral</td>
<td>Schedule appointment</td>
<td>Assessment review/treatment</td>
</tr>
<tr>
<td></td>
<td>Mail</td>
<td></td>
<td>Referral accepted</td>
<td>Patient waitlisted</td>
<td>Patient notified</td>
<td>Further treatment</td>
</tr>
<tr>
<td></td>
<td>Electronic</td>
<td></td>
<td>No</td>
<td></td>
<td></td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Referrer notified</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Make a referral</td>
<td></td>
<td>Check form details/follow up additional information</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Send refer to acknowledgement of receipt of referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>GP/consultant/ED/community/other hospitals staff/family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialist clinic team (clinical)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task</td>
<td></td>
<td>Prioritise referral (such as urgent or non-urgent)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check clinical/follow up where required</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pre-clinic work up X-ray/pathology</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Review waiting list</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Document care plan</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Discharge summary/plan for GP/referent</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Who?</td>
<td></td>
<td>GP/consultant/ED/community/other hospitals staff/family</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialist clinic team (clinical)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialist clinic team (clinical and/or clinical)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Specialist clinic team (clinical and/or clinical)</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

Guide for redesign measures for improvement for specialist clinics
Flow modelling builds on process mapping to analyse constraints and bottlenecks from the perspective of the service. Flow modelling enables work to be scheduled around identified constraints to maximise efficiency and increase capacity within existing resources. An example of flow modelling in specialist clinics is time-stamping the beginning and end of each step in the pathway to determine the duration of each step. A time-stamping example for a sample clinic of 10 patients with appointments scheduled 15 minutes apart is shown in Tables 1 and 2 and Figure 2.

### Table 1: Time stamps

<table>
<thead>
<tr>
<th>Patient</th>
<th>Patient arrival</th>
<th>Scheduled appointment</th>
<th>Registration complete</th>
<th>Imaging starts</th>
<th>Imaging complete</th>
<th>Consultation starts</th>
<th>Consultation complete</th>
<th>Check out complete</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>08:22</td>
<td>08:30</td>
<td>08:35</td>
<td>08:35</td>
<td>08:48</td>
<td>08:48</td>
<td>09:20</td>
<td>09:26</td>
</tr>
<tr>
<td>2</td>
<td>08:29</td>
<td>08:45</td>
<td>08:53</td>
<td>08:53</td>
<td>09:13</td>
<td>09:20</td>
<td>09:34</td>
<td>09:42</td>
</tr>
<tr>
<td>3</td>
<td>08:34</td>
<td>09:00</td>
<td>09:09</td>
<td>09:13</td>
<td>09:39</td>
<td>09:39</td>
<td>10:04</td>
<td>10:09</td>
</tr>
<tr>
<td>6</td>
<td>09:19</td>
<td>09:45</td>
<td>09:55</td>
<td>10:09</td>
<td>10:19</td>
<td>10:47</td>
<td>11:03</td>
<td>11:10</td>
</tr>
<tr>
<td>7</td>
<td>09:46</td>
<td>10:00</td>
<td>10:11</td>
<td>10:19</td>
<td>10:36</td>
<td>11:03</td>
<td>11:26</td>
<td>11:31</td>
</tr>
</tbody>
</table>
Table 2: Process step durations (minutes)

<table>
<thead>
<tr>
<th>Patient</th>
<th>Patient arrival</th>
<th>Wait for registration</th>
<th>Registration</th>
<th>Wait for imaging</th>
<th>Medical imaging</th>
<th>Wait for consultation</th>
<th>Consultation</th>
<th>Check out</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>08:22</td>
<td>00:08</td>
<td>00:05</td>
<td>00:00</td>
<td>00:13</td>
<td>00:00</td>
<td>00:23</td>
<td>00:10</td>
</tr>
<tr>
<td>2</td>
<td>08:29</td>
<td>00:16</td>
<td>00:08</td>
<td>00:00</td>
<td>00:20</td>
<td>00:07</td>
<td>00:14</td>
<td>00:08</td>
</tr>
<tr>
<td>3</td>
<td>08:34</td>
<td>00:26</td>
<td>00:09</td>
<td>00:04</td>
<td>00:26</td>
<td>00:00</td>
<td>00:25</td>
<td>00:05</td>
</tr>
<tr>
<td>4</td>
<td>09:01</td>
<td>00:14</td>
<td>00:08</td>
<td>00:16</td>
<td>00:14</td>
<td>00:11</td>
<td>00:24</td>
<td>00:04</td>
</tr>
<tr>
<td>5</td>
<td>09:19</td>
<td>00:11</td>
<td>00:11</td>
<td>00:12</td>
<td>00:16</td>
<td>00:19</td>
<td>00:19</td>
<td>00:09</td>
</tr>
<tr>
<td>6</td>
<td>09:19</td>
<td>00:26</td>
<td>00:10</td>
<td>00:14</td>
<td>00:10</td>
<td>00:28</td>
<td>00:16</td>
<td>00:07</td>
</tr>
<tr>
<td>7</td>
<td>09:46</td>
<td>00:14</td>
<td>00:11</td>
<td>00:08</td>
<td>00:17</td>
<td>00:27</td>
<td>00:23</td>
<td>00:05</td>
</tr>
<tr>
<td>8</td>
<td>10:02</td>
<td>00:13</td>
<td>00:05</td>
<td>00:16</td>
<td>00:10</td>
<td>00:40</td>
<td>00:21</td>
<td>00:10</td>
</tr>
<tr>
<td>9</td>
<td>10:26</td>
<td>00:04</td>
<td>00:09</td>
<td>00:07</td>
<td>00:12</td>
<td>00:49</td>
<td>00:09</td>
<td>00:07</td>
</tr>
<tr>
<td>10</td>
<td>10:28</td>
<td>00:17</td>
<td>00:10</td>
<td>00:03</td>
<td>00:20</td>
<td>00:38</td>
<td>00:12</td>
<td>00:06</td>
</tr>
</tbody>
</table>

Figure 2: Graphical representation of Tables 1 and 2 (white bars indicate periods when patients are waiting)

1.2 Measuring process redesign in specialist clinics

Measuring the impact of change is an essential step in service improvement. Measures can be used to identify and prioritise areas for improvement, to develop a baseline against which to measure change, and to demonstrate the impact of improvement initiatives. The choice of measures will depend on the focus of the redesign activity and the overall aims and priorities of the service.
Redesigning Hospital Care Program – guide to redesign measures for improvement for specialist clinics

Redesigning Hospital Care Program – guide to redesign measures for improvement for specialist clinics (Department of Health 2013) is an RHCP publication that provides information about measurement in specialist clinics process redesign including:

- why measurement is important
- different types of measures
- presentation of data
- example measures specific to specialist clinics redesign.

The example measures provided in the guide are neither prescriptive nor exhaustive. Health services are encouraged to consider measures most relevant to particular design projects, and adapt the example measures or create new measures as appropriate. The guide is available at <www.health.vic.gov.au/redesigningcare> and www.health.vic.gov.au/outpatients

A guide to using data for health care quality improvement (Department of Health 2008a) (available at <www.health.vic.gov.au/qualitycouncil>) is another useful resource when planning how to measure process redesign. It describes the fundamental concepts associated with data collection, analysis, interpretation and reporting, and how these relate to the various stages of the quality improvement cycle.

Table 3 is a reproduction of the key specialist clinic processes and associated timeframes as outlined in the access policy.

Table 3: Key specialist clinic processes and timeframes

<table>
<thead>
<tr>
<th>Process</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral screening (identifies referrals that are in the wrong place or missing required information, and therefore contact with referrers if necessary)</td>
<td>Within three working days of referral receipt</td>
</tr>
<tr>
<td>Closure of referrals pending further information and reconsideration (where the referral is retained by the health service)</td>
<td>Within 30 days of requesting additional referral information, where the referrer has not responded</td>
</tr>
<tr>
<td>Referral acceptance/rejection</td>
<td>Within five working days of receiving a referral containing necessary referral information</td>
</tr>
<tr>
<td>Referral acknowledgement</td>
<td>Within eight working days of referral receipt</td>
</tr>
<tr>
<td>The referral acknowledgment conveys information to the referrer about the referral outcome (for example, acceptance or rejection) or requests additional information</td>
<td></td>
</tr>
<tr>
<td>Clinical prioritisation</td>
<td>Within five working days of receipt of referral containing necessary referral information</td>
</tr>
<tr>
<td>Addition to waiting list, offer to book appointment or scheduling of urgent appointment</td>
<td>Within three working days of referral acceptance and clinical prioritisation</td>
</tr>
<tr>
<td>First appointment for urgent patients</td>
<td>Within 30 days of referral receipt</td>
</tr>
<tr>
<td>Patient notification of new appointment date where health service has cancelled scheduled appointment</td>
<td>Within five working days of cancellation</td>
</tr>
<tr>
<td>Communication with referrer about the findings of initial assessment/treatment*</td>
<td>Within five working days of completed initial assessment/treatment</td>
</tr>
<tr>
<td>Discharge summary sent to referrer and/or other provider*</td>
<td>Within five working days of discharge from the clinic</td>
</tr>
</tbody>
</table>

* The access policy outlines circumstances in which discretion may be applied to these requirements.
1.3 Managing change

Significant information has been published on organisational change management. One well-established change model was developed by John Kotter (2007). Kotter’s model describes eight critical success factors for leading ‘transformational’ change:

- establishing a sense of urgency
- forming a powerful guiding coalition
- creating a vision
- communicating the vision
- empowering others to act on the vision
- planning for and creating short-term wins
- consolidating improvements and producing still more change
- institutionalising new approaches.

Within Kotter’s model, the change process goes through a series of phases that often requires a considerable length of time; however, skipping steps rarely produces a satisfactory result.

Engagement and motivation

The uncertainty of change can provoke strong emotional responses in staff. The introduction of change in the specialist clinics environment should include anticipation of resistance and therefore strategies to acknowledge and respond to concerns. Effective staff engagement underpins each of Kotter’s steps and is fundamental to all models of organisational change.

It is particularly important that health services engage clinicians in change processes as clinicians make decisions that determine the quality and efficiency of care for individual patients, and also have the knowledge to help guide overall approaches to service delivery. Research in the United Kingdom (UK) and the United States has shown that higher levels of clinician engagement are associated with better financial, operational and clinical performance outcomes (Mountford & Webb 2009; Silow-Carrol & Lashbrook 2009).

Health services are expected to create cultures that encourage clinician input into policy, procedures and the management of resources. The Victorian clinical governance policy framework (Department of Human Services 2008b) (available at <www.health.vic.gov.au/clinrisk>) promotes a stronger role and capacity for clinical leadership in quality and safety and related activities such as staff supervision, professional development and credentialing. To support clinical engagement within health services, the department’s Statewide Quality Branch developed the Clinical Engagement Program. Details are available at <www.health.vic.gov.au/clinicalengagement>.

Communication

Clear channels of communication that convey vision and encourage staff engagement are essential to implementing change. Early consultation will prepare staff to participate in the change process, and encourage ownership of the project.

Communicating the evaluation of a change initiative is often essential to sustaining change. It is important to communicate successes, as well as failures and lessons learnt.

Continuous improvement

In addition to large, discrete improvement projects, smaller ongoing continuous improvement activities are also important to ensure delivery of high-quality specialist clinics services. The Plan, Do, Study, Act model promotes change as a normal and continuous process. Small changes are often more acceptable to staff and patients, and less disruptive to clinic operations than major redesign programs.
Engaging staff in generating ideas and piloting a new approach before it is fully embedded will reduce the barriers to change. Further information on the Plan, Do, Study, Act model can be found at the Australian Resource Centre for Healthcare Innovations website at <www.archi.net.au/home>.

1.4 Process redesign examples in Victorian specialist clinics

Department of Health – Specialist Clinics Redesign Demonstration Project

In 2009–10 the department funded the Specialist Clinics Redesign Demonstration Project as part of the RHCP. This was undertaken across four speciality areas (maternity, orthopaedics, gastroenterology and urology) at three health services.

The project interventions were:

- load levelling of referral management
  - reallocation of clerical work to ensure new referrals were processed within three days of receipt
  - collection of demand data to determine the resources required
  - redesign of processes to promote flow
  - assessment of first-time quality of referrals
- template alignment with actual start time
  - alignment of the booking template with medical staff start time
- communication hub (visual management system)
  - a whiteboard detailing clinic activity, team members, relevant changes or concerns, clinician arrival and departure times
- clinic kickstart
  - short team meetings at the beginning of the clinic at the communication hub
- activity report
  - a weekly report posted in a communication hub to show key metrics including planned capacity, actual capacity, activity and failure to attend (FTA) rates.

The project findings were:

- One site reduced referral receipting time from up to 120 days to less than three days.
- The number of patients seen within one hour of their appointment increased from 38 per cent to 71 per cent in one clinic.
- Although additional capacity existed within current resources, utilisation would require a significant change to current work processes.
- Redesign within specialist clinics is a significant task with unique complexities and challenges.
- The scope of a large redesign initiative should be defined after initial diagnostics are complete.
- Recruiting a stable internal team with sufficient redesign knowledge and capability, as well as adequate representation from the range of relevant work areas, is an important enabler of redesign work.

Figure 3 outlines a model for redesign projects in specialist clinics developed as part of the Specialist Clinics Redesign Demonstration Project. This model focuses on the steps and phases of redesign, rather than the specific changes to be implemented.
Figure 3: Model for redesign projects in specialist clinics

**Pre-redesign**
- Demonstrate commitment beyond a project
- Appreciate specialist clinic high level flows and the patient journey connections
- Fulfill pre-requisites, most importantly ensure operational/improvement leadership is in place.

**Diagnostics 1**
- High level observations of referral pathway & intra-clinic pathway
- Consider where the early opportunities for redesign exist e.g. clinical champions
- Agree on program scope for first 12 months

**Diagnostics 2**
- Determine current state of demand and capacity, and clinic metrics
- Track intra clinic patient journey and their experience
- Understand work flow and practices: clerical, nursing and medical - *who does what*

**Analyse & Synthesize**
- Considered analysis and synthesis of diagnostics
- Establish program measures and goal

**Improve 1**
- Stable and safe clinic environment (based on SCRDP experience) e.g, patients receipted and initial triage <3 days, load level the clinic week; visual management to support process & work flow; align template start with actual start time, ensure doctors start on time, safer, informed waiting room.

**Improve 2**
- Incrementally move towards *the right people doing the right work*
- Introduce Demand and Capacity Manager as a fundamental clinic role
- Increase capacity with template redesign, partial booking systems and customer focused booking.

**Measurement**
- Systematic weekly measures relating to high level flows
- Compare clinic agreed capacity (business rules), planned capacity for the clinic and actual
- Measure demand and capacity ratio regularly, use to guide further work.
Barwon Health – orthopaedic clinic reform

From 2005 Barwon Health undertook a series of reforms to its orthopaedic outpatient service to address the following issues: an increasing number of referrals, inefficient referral management and triage, long waiting times for non-urgent appointments, high rates of patients failing to attend their appointments and poor utilisation of conservative therapies before referral to a surgeon. Numerous improvement strategies were implemented including:

- an audit of waiting lists for first appointments to identify patients who did not need to be on the list (this resulted in 273 (24 per cent) of the 1,100 waiting patients being removed from the list)
- physiotherapy-led clinics and an orthopaedic lead nurse role
- adherence to a policy for managing patients who failed to attend their appointments
- development of triage guidelines to allow new referrals to be triaged by more junior clinicians
- introduction of a patient-focused appointment booking system, resulting in a reduction in FTA rates from 18 per cent to 7.9 per cent in surgeons’ clinics, and from 30 per cent to 7.4 per cent in physiotherapy-led clinics
- appointment of an additional orthopaedic surgeon.

Together these initiatives resulted in a 66 per cent reduction in waiting list numbers by mid-2011. There was also an 87 per cent reduction in waiting times from referral to first appointment over the same period.

Figure 4: Orthopaedic clinic patient numbers, 2004–05 to 2010–11
Barwon Health – redesigning specialist clinics

In November 2011 Barwon Health began a program of work to transform its delivery of specialist clinics in partnership with primary healthcare providers and consumers. While there appeared to be a mismatch between the demand for specialist care and the activity undertaken by specialist clinics, there was limited knowledge about the true demand, capacity and activity across public and private clinics. The absence of a consistent data collection and reporting mechanism was a key barrier to developing a shared understanding of specialist clinic work and defining clear goals for service improvement.

A comprehensive analysis of all medical and surgical specialist clinics was undertaken. It was agreed that effective stakeholder engagement, along with a rigorous data collection, would enable Barwon Health to better align the provision of specialist services with the needs of the community. Four key focus areas for improvement were identified: access, capacity, operating structure and data reporting.

A number of related performance measures were selected to monitor the success of improvement work:

- number of patients added to the waiting list
- number of new patients seen
- number of new patients on the waiting list
- ratio of new to review appointments
- ratio of attendances to FTAs
- ratio of referrals added to referrals closed
- waiting time from referral received to first appointment.

A range of ‘check’ measures were also chosen including:

- waiting list movement
- number of patients with an urgent referral who waited longer than 30 days for their first appointment.

Specific improvement initiatives identified as part of the redesign program include:

- a sophisticated information and communication (ICT) technology infrastructure (including an electronic queue management system) to support the core business of specialist clinics
- enhanced communication including revised patient correspondence templates, short message service (SMS) reminders for review appointments and using social media where appropriate
- care pathways, to be developed in collaboration with GPs, to promote a seamless transition of care on referral and discharge.

Each improvement initiative described above will be led by a member of the health service executive and supported by dedicated project resources.

Northern Health – redesign of outpatient diabetes services

Key drivers for quality improvement and service redesign at Northern Health’s outpatient diabetes services included long waiting times and high levels of FTA rates for both new and review appointments. Also, patients were frequently unaware of the rationale for the referral and not sure what to expect.

Northern Health adopted a Lean Six Sigma methodology, with the aim of delivering more timely access to specialist diabetes care. The program of work involved a multifaceted approach, including developing referral triage processes to ensure patients with the greatest clinical need were seen in an appropriate timeframe by the clinician with the most appropriate skill set.

At the outset of the project all referred patients were waitlisted to see an endocrinologist. This led to long delays to access first appointments with the diabetes service. Based on evidence that interventions led by nurses and allied health professionals, along with changes to the structure of care, can improve diabetes outcomes in outpatient settings, Northern Health redesigned its intake process so that, at the completion of the trial, only 42 per cent of all patients needed referral to the endocrinologist before hospital-based care could begin. This
care was able to be delivered by other suitably qualified health professionals working closely with the patients’ GPs.
Section 2: Improving clinic processes

2.1 Referral management

Referrals to specialist clinics are received from GPs, community-based healthcare providers and inpatient units of health services. Patients can also self-refer for some allied health and maternity clinics.

To enable prompt and accurate triage and management, referrals need to contain all relevant information relating to the patient and their condition, clearly state the patient’s needs, and be received by the correct clinic.

It is important that referrals to specialist clinics are processed within appropriate timeframes to maximise patient outcomes and minimise clinical risk. The specialist clinics access policy (available at <www.health.vic.gov.au/outpatients>) contains business rules for timing key referral management steps.

2.1.1 Messages from the consultation and literature review

Most referrals to specialist clinics contain adequate information to enable administrative processing and clinical triage; however, there is considerable variation in the quality of referrals. Commonly referrals fail to clearly convey the reason for referral and the desired outcome, and relevant demographic or clinical information may also be missing. Referrals may overstate the urgency of the condition in an attempt to expedite an appointment. Sometimes urgency is understated, potentially resulting in a risk to the patient. The absence of key information can hinder decisions about the urgency and most appropriate resources for that patient.

Historically, specialist clinics have not specifically defined, communicated or enforced referral standards. However, specialist clinics in Victoria and other jurisdictions are now increasingly implementing strategies to improve the quality and appropriateness of referrals.

There is wide variation in referral management processes both between and within health services. Hospitals often have multiple referral entry points and differing referral requirements for their specialist clinics.

Inability to receive and process referrals electronically has a significant impact on the efficiency of referral processing and timeliness of communication with referrers. Most health services cannot receive external referrals electronically due to system incompatibility with primary care services. Work in this area is progressing, with some health services accepting email referrals, and some introducing systems to manage referrals electronically once received.

A strong and consistent message from consultation with GPs and consumer representatives is that referrers and patients need information about the expected waiting time for an appointment.

2.1.2 Understanding the referral decision

GPs will vary in their practice of referring patients to specialist clinics, depending on factors such as clinical knowledge and experience with particular conditions, local community support services, likely waiting time for an appointment, duration of the consultation with the patient and patient expectations. Referrers must balance the benefits of providing reassurance to individual patients against the need to maintain cost-effectiveness at the system-wide level (Imison & Naylor 2010). This is a difficult task; however, there are opportunities for referrers, specialist clinics and patients to develop a shared understanding of whether a referral is primarily for diagnosis, investigation, treatment or reassurance (Imison & Naylor 2010).
Once a decision has been made to refer to a specialist clinic, the referrer needs to decide where to refer, and may consider:

- private and public specialist services
- local community health services
- alternative clinicians, such as a physiotherapist
- access issues such as waiting time and travel.

Avoidable specialist clinics referrals

While most referrals are necessary, there is some level of avoidable referral. Some conditions, such as back pain and headache, tend to be associated with a higher rate of referral to specialist clinics but do not require intervention by a medical specialist. A proportion of patients referred to public hospital specialist clinics could be seen in an alternative care setting. Consultation with hospital specialists in an out-of-hospital setting, GPs with a special interest and advanced-scope practitioners in the local community may be more appropriate than referral to hospital specialist services for some patients.

2.1.3 Supporting referrers

Providing support to referrers will benefit patients, referrers and specialist clinics by ensuring referrals are appropriate, contain all required information and are received by the correct service for the patient’s needs. The specialist clinics access policy stipulates that health services support referrers by providing information about specialist clinics services, referral requirements and a clear point of contact for enquiries about specialist clinic services and referrals.

Service information for referrers

The access policy states that user-friendly, up-to-date information about public hospital specialist clinics, including the scope of services, should be accessible from the home page of the health service's website. Section 5 of the access policy (Pre-referral communication) outlines information that health services may consider including. Health services may also like to provide information about alternative services that may be more appropriate for particular conditions.

The government’s planned publication of waiting times for specialist clinics will provide information about demand and waiting times for specialist clinics, allowing referrers to make informed referral decisions. This may reduce the practice of referring one patient to multiple specialist clinics for the same problem, which will in turn improve the efficiency at the statewide level. The Victorian Health Performance website can be accessed at <http://performance.health.vic.gov.au>.

Clinical advice for referrers

Ready access to specialist clinical advice can assist referrers in deciding if referral to specialist services is required, reducing inappropriate referrals. Strategies in Victoria or other jurisdictions to improve referrer access to advice include:

- a dedicated on-call specialist for telephone advice
- ‘hot’ clinics for on-the-day assessment and advice
- email advice for semi-urgent conditions
- specialist involvement in community settings, such as consulting or participating in case conferences within general practice
- telemedicine/technology to increase access to specialist assessment.

Specialist clinics can further assist referrers by providing feedback once the referral is received. Feedback may cover topics such as necessity of the referral, referral letter content or
expectations of pre-referral management. Such feedback is often welcomed by GPs and provides an effective educational tool to improve referral quality (Imison & Naylor 2010). Health service GP liaison services may provide assistance in this regard.

**Written referral guidelines**

Most Victorian health services have developed written guidelines for referrers to define the criteria for referral. Section 5 of the access policy (*Pre-referral communication*) suggests basic referral content for all referrals to specialist clinics. Referral guidelines currently in use vary considerably in style, content and availability between clinics. Referrers may have limited time to locate and read complex referral guidelines.

**Referral guideline template – Department of Health**

A referral guideline template is provided in Figure 5 and is available for download from [www.health.vic.gov.au/outpatients](http://www.health.vic.gov.au/outpatients)

Health services are encouraged to download and adapt this non-mandatory template to suit local needs. This template encourages health services to adopt a consistent style and format for referral guidelines across conditions and clinics. The template prompts health services to outline pre-referral advice for referrers, indications for specialist referral, required referral information, the outcome of the referral and contact information. Referral guidelines may be effective in changing referral behaviour in combination with feedback from specialists or other active support strategies such as proformas or standardised letters, risk factor checklists or electronic decision support tools (Imison & Naylor 2010).
Figure 5: Referral guideline template

**Specialist clinics – guidelines for referrers**

**Health service to insert name of condition**

**Pre-referral**

<table>
<thead>
<tr>
<th>GP work-up</th>
<th>GP management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health service to insert details of any pre-referral actions to be considered by the referrer including:</td>
<td>Health service to insert recommendations for GP management of this condition, where applicable</td>
</tr>
<tr>
<td>- checking for clinical indications/history</td>
<td>Health service to insert any presentations not seen in the specialist clinic, or seen only under certain conditions (for example, inadequate response to conservative treatment)</td>
</tr>
<tr>
<td>- physical examination</td>
<td></td>
</tr>
<tr>
<td>- tests and investigations</td>
<td></td>
</tr>
</tbody>
</table>

**Indications for specialist referral**

<table>
<thead>
<tr>
<th>Emergency department</th>
<th>Urgent specialist clinic referral (discuss with clinic coordinator – contact details overleaf)</th>
<th>Routine specialist clinic referral</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health service to insert details of any presentations to be referred to the emergency department</td>
<td>Health service to insert any presentations likely to be considered urgent by the clinic</td>
<td>Health service to insert indications for routine referral</td>
</tr>
</tbody>
</table>

**Required referral information**

<table>
<thead>
<tr>
<th>Reason for referral</th>
<th>Tests and investigations</th>
<th>Other clinical information</th>
<th>Demographic and referral details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your referral must address the following questions:</td>
<td>The following must accompany the referral:</td>
<td>Relevant medical history</td>
<td>Patient</td>
</tr>
<tr>
<td>- What are the main presenting symptoms and their duration?</td>
<td>Health service to insert details of any tests and investigations required with the referral</td>
<td>Relevant family history</td>
<td>- Full name</td>
</tr>
<tr>
<td>- What is your working diagnosis?</td>
<td></td>
<td>Relevant social history or special needs</td>
<td>- Name of parent or carer, if applicable</td>
</tr>
<tr>
<td>- What is the main purpose of this referral?</td>
<td></td>
<td>Allergies or warnings</td>
<td>- Address</td>
</tr>
<tr>
<td>o Diagnosis</td>
<td></td>
<td>Current medications</td>
<td>- Telephone numbers</td>
</tr>
<tr>
<td>o Diagnostic procedure</td>
<td></td>
<td></td>
<td>- Alternative contact</td>
</tr>
<tr>
<td>o Second opinion/care review</td>
<td></td>
<td></td>
<td>- Date of birth</td>
</tr>
<tr>
<td>o Shared care with GP</td>
<td></td>
<td></td>
<td>- Medicare number</td>
</tr>
<tr>
<td>o Patient management</td>
<td></td>
<td></td>
<td>- Indigenous status (if applicable)</td>
</tr>
<tr>
<td>- What is the impact of the problem on the patient? (Consider functional impairments, social and work impacts and impact on comorbidities)</td>
<td></td>
<td></td>
<td>- Interpreter (note language if applicable)</td>
</tr>
<tr>
<td>- What are the findings of your physical examination?</td>
<td></td>
<td></td>
<td>- Usual GP (if not referrer)</td>
</tr>
<tr>
<td>- How has the patient been managed to date and what was the response to treatment?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Referrer</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Name and address</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Contacts (phone, fax, email)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Provider number</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Referral</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Date of referral</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Specialist clinic requested</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>- Name of specialist, if applicable</td>
</tr>
</tbody>
</table>
Outcome of referral

All referrals are reviewed by a clinician according to the clinic’s referral triage process. Priority for an appointment is based on the information provided in the referral, and is relative to the needs of other patients referred to the clinic. Patients assessed as urgent are seen as required. Routine patients are offered the next available appointment. Please contact us if there is a significant change in your patient’s condition while waiting for an appointment.

Health service to insert any specific information about the referral outcome including:
- factors that will influence clinical prioritisation or acceptance of the referral
- alternative services to which the patient may be triaged (for example, a clinic led by allied health rather than a consultant in the first instance)

Specialist clinic contact information

<table>
<thead>
<tr>
<th>General contacts</th>
<th>Clinic coordinator (contact for urgent referrals)</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health service switch:</td>
<td>Name of clinic:</td>
<td>Health service to insert website details including link to referral guidelines and waiting time information, when available</td>
</tr>
<tr>
<td>Specialist clinics telephone enquiries:</td>
<td>Telephone:</td>
<td></td>
</tr>
<tr>
<td>Fax:</td>
<td>Fax:</td>
<td></td>
</tr>
<tr>
<td>Email:</td>
<td>Email:</td>
<td></td>
</tr>
</tbody>
</table>

Document management

Created by: Health service to insert details
Date: Health service to insert date guideline was created
Planned review date: Health service to insert planned review date

2.1.4 Screening referrals

Referral screening is an important process to ensure that referrals requiring additional information, clarification or immediate action are not unnecessarily delayed. Referral screening may be undertaken by administrative staff provided these staff members are adequately supported by training, protocols and access to clinical advice.

The access policy specifies that referrals should be screened within three working days of receipt. The following questions can be used as a referral screening checklist:

- Has the referral been received at the intended location?
- Have all pages been received?
- Is the referral legible?
- Is the referral a duplicate?
- Is the referral an addition/update to a previous referral?
- Does the health service provide the requested service?
- Does the referral meet the established service criteria?
- Does the referral contain the referrer’s details and the mandatory demographic information about the patient?
- Does the referral contain sufficient clinical information to enable triage, including the results of mandatory pre-referral investigations?
- Does the referral request emergency or urgent assessment?
- Should the opinion of a clinician (for example, clinic nurse or registrar) be sought about this referral?
Referral audit tool – Department of Health

Undertaking an audit of referrals allows of the quality of referrals to be evaluated. A sample referral audit tool is provided in Figure 6, and is available for download and adaption from <www.health.vic.gov.au/outpatients>

**Figure 6: Sample specialist clinics referral audit tool**

<table>
<thead>
<tr>
<th>Referrer details – were the following included in the referral?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Provider number</td>
</tr>
<tr>
<td>Address</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient details – were the following included in the referral?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
</tr>
<tr>
<td>Date of birth</td>
</tr>
<tr>
<td>Address</td>
</tr>
<tr>
<td>Medicare details</td>
</tr>
</tbody>
</table>

| Was contact with the patient or referrer required to complete referrer or patient information? | Y / N |

<table>
<thead>
<tr>
<th>Referral format</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referral form</td>
</tr>
<tr>
<td>GP template</td>
</tr>
<tr>
<td>Format</td>
</tr>
<tr>
<td>Legibility</td>
</tr>
<tr>
<td>Referral date included</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical details – were the following included in the referral?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relevant past history</td>
</tr>
<tr>
<td>Relevant psychosocial history</td>
</tr>
<tr>
<td>Medications</td>
</tr>
<tr>
<td>Allergies</td>
</tr>
<tr>
<td>History of condition referred for</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Clinical triage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Was the reason for referral clear?</td>
</tr>
<tr>
<td>What was the main reason for referral?</td>
</tr>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>GP second opinion</td>
</tr>
<tr>
<td>Patient request</td>
</tr>
<tr>
<td>Specific treatment</td>
</tr>
<tr>
<td>Was the requested service available at your health service?</td>
</tr>
<tr>
<td>Could the patient’s condition be more appropriately managed in another setting?</td>
</tr>
<tr>
<td>If ‘yes’, which other setting may have been more appropriate?</td>
</tr>
<tr>
<td>Different health service or hospital</td>
</tr>
<tr>
<td>General practice</td>
</tr>
<tr>
<td>Community health centre</td>
</tr>
<tr>
<td>Was contact with the referrer required to obtain further clinical information for triage?</td>
</tr>
</tbody>
</table>
2.1.5 Referral management centres

A number of Victorian health services have established centralised referral management centres. Some manage referrals across a number of clinical specialties, while others manage referrals for a particular specialty or condition. Most referral management centres undertake administrative triage of referrals (which may or not include an ability to reject or redirect referrals), with some also completing clinical triage of referrals. Some referral management centres may support patient choice in selecting specialist services. Table 4 outlines potential advantages and disadvantages of referral management centres that must be taken into account when considering establishing a referral management centre.

Table 4: Potential advantages and disadvantages of referral management centres

<table>
<thead>
<tr>
<th>Potential advantages</th>
<th>Potential disadvantages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consistent referral processing</td>
<td>Increased delay to access services due to addition of another step to the patient journey</td>
</tr>
<tr>
<td>Consistent data collection</td>
<td>Reduction in direct communication between referrers and specialists</td>
</tr>
<tr>
<td>Standardised practice for redirection of referrals</td>
<td></td>
</tr>
<tr>
<td>Development of a body of knowledge of local services</td>
<td></td>
</tr>
</tbody>
</table>

The clinical risks associated with referral management centres can be mitigated by clear and timely communication with referrers, maintaining an effective tracking system for referrals and ensuring staff are supported to make consistent and effective clinical prioritisation decisions. The letter templates in Section 4 include a series of letters designed to support referral management in a manner consistent with the requirements of the access policy. The referral acknowledgement letter template includes an estimate of waiting time. This gives referrers the opportunity to discuss alternative options if they are concerned about the waiting time for a particular patient.

2.1.6 Examples of good practice

MidCentral District Health Board – Non-contact First Specialist Assessment

In 2007 the MidCentral District Health Board in New Zealand introduced an innovative model called the Non-contact First Specialist Assessment (NcFSA) model to improve access to specialist advice for neurology patients. Prior to implementing the model, routine neurology patients were not being seen within a clinically appropriate timeframe and were at risk of not being seen at all.

Referrals are triaged into three basic groups:

1. patients with serious conditions who need an urgent face-to-face appointment
2. patients who require a routine face-to-face clinic appointment, including where there is uncertainty about the diagnosis
3. patients with minor/non-disabling conditions or a clear diagnosis who require management advice without full specialist assessment.

Patients in the third group (approximately 20–30 per cent of referrals) are offered a non-contact first specialist assessment. The consultant neurologist reviews the referral and available clinical notes and prepares a detailed letter and management plan, sent to the referring GP within one to two weeks of referral. A copy is sent to the patient. Where required, a diagnostic work-up is arranged to inform the specialist’s recommendations.

The NcFSA model has allowed all referred patients to receive a specialist’s opinion. Follow-up auditing did not reveal any significant clinical risk associated with the model.
Victorian Paediatric Orthopaedic Network website

The Victorian Paediatric Orthopaedic Network (VPON) aims to foster collaboration and coordination among providers of paediatric orthopaedic services. The network developed a comprehensive website designed to improve communication between the specialist paediatric orthopaedic providers (Barwon Health, Monash Children’s at Southern Health, The Royal Children’s Hospital and Western Health) and those referring to these providers. The website’s content includes:

• referring information, including referral guidelines for common orthopaedic conditions and referral forms
• fact sheets for parents
• a facility for making appointment enquiries
• clinic descriptions, schedules and locations.


Alfred Health: Improving the management of specialist clinics referrals

In 2009 Alfred Health redesigned how external referrals are managed to improve the ‘first time’ quality of referrals, establish a reliable method of tracking incoming referrals and acknowledge receipt of every referral in a timely manner.

Before the project began:

• Referral management was paper-based, with multiple entry points and handoffs.
• Up to six staff were involved from referral receipt to appointment scheduling.
• There was no mechanism for acknowledging receipt to the patient or referrer.
• There were long delays before referrals were registered electronically.
• Staff were unable to account for missing referrals.
• Approximately 50 duplicate referrals were processed each week.
• More than 1000 ‘work in progress’ referrals were being processed at any given time.

On completion of the project:

• All referrals were electronically registered within 24 hours.
• All referrals were acknowledged within three days of receipt.
• Approximately nine hours of administrative time was saved each week on processing duplicate referrals.

The reforms have been embedded in standard work practices through auditing, ongoing education and evaluating staff feedback.
2.2 Triage and clinical prioritisation

In the context of specialist clinics, triage is a process in which a clinician reviews all referrals to assess the patient’s needs and the clinic’s capacity to meet these needs. The triage process may result in acceptance of the referral, referral to another care provider (such as another specialist clinic or community care) or advising the referrer of strategies to manage the patient. Clinical prioritisation is an important component of triage, determining the urgency with which patients are allocated an appointment.

Clinical prioritisation aims to ensure that patients are treated equitably within clinically appropriate timeframes, and that priority is given to patients with an urgent clinical need to minimise clinical risk when patients have to wait for care. Clinical prioritisation relies on the clinical information contained in the referral and any existing knowledge of the patient’s condition.

2.2.1 Messages from the consultation and literature review

Current best practice advice for managing healthcare ‘queues’ suggests a two-part process. The first step to ensuring patients are treated within clinically appropriate timeframes is for health services to identify patients with an urgent clinical need. The second step is to ensure less urgent patients are treated according to waiting time or ‘in turn’ within their urgency category, wherever possible.

The utilisation of two statewide categories (urgent and routine) (see Box 1) is based on theory and evidence that the best form of prioritisation has the fewest possible categories. As soon as one patient is prioritised to receive treatment ahead of another, patients at the back of the queue have to wait longer.

However, while minimal prioritisation and treatment in turn will ensure equity and the shortest average waiting times for specialist care, it may have clinical risks for some patients. Therefore, a greater level of prioritisation may be required in practice.

As described in the next section, the Victorian Government has decided on an approach to clinical prioritisation based on the recommended ‘minimal prioritisation’; however, Victoria’s approach still leaves some flexibility for health services to use more categories at the local level if necessary.

2.2.2 Statewide clinical prioritisation approach

The access policy introduces a consistent statewide classification system for clinical prioritisation in specialist clinics based on the recommended ‘minimal prioritisation’. The proposed statewide approach:

- is a simple two-category (urgent versus routine) approach for data collection and statewide reporting (see Box 1)
- provides flexibility for health services to further prioritise within these categories if necessary (for example, for very urgent cases)
- encourages treatment in turn for non-urgent patients, where possible.
Box 1: Statewide clinical priority definitions

**Urgent**
Referrals should be categorised as urgent if the patient has a condition that has the potential to deteriorate quickly, with significant consequences for health and quality of life, if not managed promptly. These patients should be seen within 30 working days of referral receipt.

**Routine**
Referrals should be categorised as routine if the patient’s condition is unlikely to deteriorate quickly or have significant consequences for the person’s health and quality of life, if specialist assessment is delayed beyond one month.

*It is expected that all patients referred to specialist clinics will be assigned to one of these priority categories.*

In some specialties, it may be necessary to further categorise patients within the statewide ‘urgent’ or ‘routine’ categories to ensure appropriate management of clinical risks. Health services are encouraged to use the fewest number of categories possible to minimise excessively long waits for those with lower priority.

### 2.2.3 Developing guidelines for clinical prioritisation

Written clinical prioritisation guidelines provide consistency in priority decision making. Such guidelines should reflect current evidence and be easily accessible to staff responsible for triage and clinical prioritisation.

**Suggestions for clinical prioritisation guidelines**
- List conditions treated in the clinic.
- List conditions not treated in the clinic and alternative appropriate services.
- Use minimal prioritisation categories.
- Define the threshold for referral to emergency care if relevant.
- List an indicative timeframe for each clinical prioritisation category.
- Outline conditions treated by individual specialists, if relevant.
- Document when the guidelines were created and a timeframe for review.

### 2.2.4 Collecting additional triage information

The ability to accurately triage and prioritise referrals is determined by the quality of referral information. Providing information and support for referrers, along with an effective referral screening process, will minimise the need to collect additional information.

Pre-appointment review of diagnostic testing has been implemented in some clinics. This can ensure appropriateness of referrals and improve clinical prioritisation. Patient questionnaires can provide additional information to form a comprehensive picture of the patient’s needs and therefore enhance clinical prioritisation processes.

### 2.2.5 Staffing the triage function

Many different staffing models can be utilised for triage and clinical prioritisation. The most appropriate staffing model will often depend on the nature of the clinic. Clinics with high volumes of low-risk presentations and well-established urgency criteria may be well suited to allied health and nursing-led triage, whereas clinics with low volumes of rare or high-risk presentations might be better suited to consultant-led triage. While consultant-level staff may provide more accurate triaging decisions, sessional involvement with the clinic may prevent triage and clinical prioritisation within required timeframes.
Regardless of seniority, all staff undertaking these duties should be appropriately credentialed, and receive comprehensive orientation and ongoing support from senior specialists to ensure accurate outcomes. The considerable amount of time required for triage and clinical prioritisation should to be factored into clinic staff resourcing.

Some clinical assessment services led by speciality-specific nurses or allied health staff assess, triage and divert patients to the most appropriate care. These services may also provide some forms of treatment and care coordination, reducing onward referrals to high-demand medical or surgical services.

2.2.6 Examples of good practice

Flinders Medical Centre – shoulder assessment questionnaire

The upper limb outpatient clinic at Flinders Medical Centre experiences a high demand for new patient assessments. To minimise waiting times, a patient questionnaire was embedded in the triage process (supported by the appointment of a senior physiotherapist) to assist with clinical prioritisation and directing patients to the most appropriate stream of care. The questionnaire enabled treatment of patients first in order of clinical need and then in order of the date their referral was received. Post-implementation:

- the FTA rate dropped from 25 per cent to approximately 10 per cent
- waiting times reduced from 12 months to two months for urgent surgical treatment
- waiting times reduced from 12 months to five months for routine patients

Further information can be found at:

Eastern Health – centralised triage services

A centralised triage process has been developed at Eastern Health for referred clients with diabetes. All such referrals regardless of source are directed to a single point and are triaged according to clinical priority, as judged by standardised criteria adapted from the Risk assessment tool developed as part of the Improving the Diabetes Journey initiative. In addition, patients are distributed to the most appropriate environment given clinical priority, complexity and geographic location. This provides equity of access but also allows for waiting times and workload to be monitored in each of the seven diabetes clinic locations.

The above process is similarly reflected in the Eastern Health urology department, where clinic referrals are gathered centrally, triaged and then distributed to the most appropriate environment given clinical priority, complexity and geographic location.
2.3 Waiting list management

Waiting lists for specialist clinics need to be actively managed to ensure patients are treated equitably within clinically appropriate timeframes.

Section 8 of the access policy (Managing waiting patients) outlines the department’s expectations for managing patients placed on waiting lists prior to scheduling an appointment. This includes circumstances in which patients may be added to or removed from waiting lists, and requirements relating to waiting list record keeping and validation.

2.3.1 Messages from the consultation and literature review

Queuing theory

Queuing theory is a well-developed science in mathematics that can be applied to specialist clinic waiting lists. In theory, a single queue leading to multiple ‘windows’ will have shorter overall waiting times than a small queue in front of each window.

Reserving part of a resource for one group while reducing resource availability to another group is known as ‘carve out’ and creates multiple queues in front of multiple ‘windows’. This can lead to wasted capacity and reduced efficiency. ‘Carve out’ occurs in specialist clinics when there are multiple queues for different patient designations such as new, review, urgent, routine or post-operative.

Waiting list validation

Waiting lists for specialist clinic care at many Victorian hospitals are not subject to active management such as regular validation, often containing patients who no longer require assessment. This contributes to high FTA rates and longer waiting times for other waiting patients.

A number of Victorian and interstate health services found that appointing waiting list coordinators and undertaking regular validation of waiting lists has improved clinic efficiency and access to appointments. Pooling of waiting lists has also reportedly promoted more efficient use of available resources and greater cooperation within specialist clinics teams.

2.3.2 Adding patients to waiting lists

As stated in the access policy, urgent patients should be booked directly into an appointment and should not be placed on a waiting list.

In the context of applying queuing theory to specialist clinics, patients prioritised as non-urgent should be pooled into one waiting list and then treated in turn according to referral date to ensure the shortest average waiting time for an appointment. This prevents patients being added to the waiting list ahead of others already on the list, which causes patients at the back of the list to wait longer.

It is best to avoid carve out where possible; however, there are instances in the specialist clinic environment when a single queue is not appropriate and some carve out is necessary. This may occur when a specialist has expertise with a particular patient group. Scheduling for this patient group should be treated with the same priority as the pooled waiting list.

Best practice for adding patients to waiting lists is to pool non-urgent cases, and then treat in turn according to referral date.
2.3.3 Validating waiting lists

Validating waiting lists involves reviewing the list to ensure patients on the list are actively waiting for an appointment. Improved waiting list accuracy allows a more precise indication of the waiting time for a patient’s first appointment. A standardised approach to validating patients’ demographic information, clinical information and continued need for an appointment is recommended. An example waiting list validation process is outlined below:

- When adding patients to the waiting list:
  - ensure the patient is not already on the waiting list
  - ensure all necessary demographic information is captured.
- Create a waiting list validation letter for patients (see letter template 10 in Section 4 – Waiting list validation letter). This requests that patients contact the clinic via phone, email or return mail to confirm personal details and ongoing need for an appointment. If an appointment is no longer required, the reason is recorded.
- Create a script for telephone validation (see template 11 in Section 4 – Waiting list validation phone script) to encourage consistency.
- Patients remain on the waiting list if they confirm their need for an appointment. If a patient advises that their condition has worsened significantly since their original referral, they are re-triaged by the clinic and advised to return to their GP for further treatment or re-referral.
- Patients advising that they no longer need an appointment are removed from the waiting list and advised accordingly (see letter template 12 in Section 4 – Patient advice of post-validation removal from the waiting list). The patient’s referring clinician is advised that the patient has been removed from the waiting list and instructed to re-refer if necessary (see letter template 13 in Section 4 – Referrer advice of patient removal from the waiting list or clinic list).
- If there is no response to the waiting list validation letter after two weeks, the patient’s GP is contacted to confirm the patient’s contact details. One more attempt is made to contact the patient – via telephone or another waiting list validation letter.
- If the correct patient details cannot be obtained, or if a patient has not responded to two contact attempts, the patient is removed from the waiting list and the GP advised (see letter template 13 in Section 4 – Referrer advice of patient removal from the waiting list or clinic list). At the discretion of the health service, patients who have been removed from the waiting list may be reinstated without penalty if they contact the health service and provide a reasonable explanation of their failure to respond to communication.
- After the initial validation, repeat the process on a six-monthly basis for patients added within the previous six months as well as patients who have been on the list for more than 12 months at that time. If a patient has already been contacted on more than one occasion, future communication to confirm the need for an appointment is at the discretion of the service.

2.3.4 Communicating with waiting patients and referrers

The access policy requires that patients placed on waiting lists should be informed of their rights and responsibilities including:

- the specialist or clinical unit responsible for their care
- a contact person in the specialist clinic for further information
- their responsibility to notify the service if there is any change to their contact details, if the appointment is no longer required or if they are unable to attend a scheduled appointment
- what to do and who to contact if their clinical condition changes.

A responsive telephone, email or web-based service will encourage patients to update their contact details and contact the clinic if their situation changes, which will in turn improve the accuracy of waiting lists.
GPs often hold current and detailed information on a patient’s circumstances. Approaching waiting list management in partnership with GPs may assist hospitals to maintain an accurate record of the patient’s clinical priority and current demographic details. Engagement with GPs may also minimise FTA rates at both GP and specialist services.

It is good practice to advise patients and their referring practitioner about the expected waiting time for an appointment. GPs should be provided with sufficient information to support patients while they are waiting for their first appointment (National Health Service Scotland 2003). If appropriate, patients could also be provided with information to help manage their condition until their appointment.

About specialist clinics in public hospitals – information for patients
About specialist clinics in public hospitals – information for patients (Department of Health 2010a) addresses many frequently asked questions for patients. It is available for download in multiple languages from www.health.vic.gov.au/outpatients

2.3.5 Examples of good practice

Department of Health – waiting list validation project
In 2010–11 the Department of Health undertook a waiting list validation project. Twelve health services conducted a validation of specialist clinic waiting lists and estimated the waiting times for new patients to receive their first appointment in selected clinics.

The waiting list validation resulted in 17,525 patients being removed from waiting lists across participating hospitals. Estimates of waiting times for new appointments, based on clinic capacity and the number of waiting patients, were reduced by an average of 30 per cent.

2.4. Appointment scheduling and booking

High-quality appointment scheduling and booking systems are integral to maximising clinic capacity, controlling patient flow, reducing overbookings and reducing FTA rates.

Section 9 of the access policy (Appointment scheduling and booking) covers a range of scheduling and booking processes, including patient selection for appointments, information for booked patients and rescheduling of non-attended or postponed appointments.

The following section explores:
- managing clinic schedules
- understanding the impact of overbooking
- implementing patient-focused booking.

2.4.1 Messages from the consultation and literature review

Health services commonly report the following:
- Scheduling and booking processes vary between clinics at the same hospital.
- Some health services are introducing patient-focused booking, but many still allocate appointments without patient choice or confirmation of the need to see a specialist.
- Clinics schedules often do not reflect the true clinic capacity (a product of clinician time and rooms available).
- FTA rates are greater than 20 per cent in some clinics.
- FTA and cancellation rates are higher for review patients than new referrals.
Many clinics overbook to compensate for high FTA rates, which can then cause long waits for patients and increased workloads for staff.

Overbookings may comprise a higher proportion of review appointments due to a perception of higher clinical priority than new referrals.

Processes for booking ancillary services (such as patient transport and interpreters) are often cumbersome and poorly coordinated.

Best practice for patient scheduling and booking includes:

- process flow modelling techniques for clinic schedules that are optimally aligned to patient demand and clinic capacity
- minimal or no overbookings
- patient-focused booking systems based on finite booking periods (for example, no bookings until six weeks before the actual appointment date) and offering patients a choice of appointment time
- use of initiatives to reduce FTA rates such as SMS or telephone reminders and patient education
- adherence to policies for removing patients from waiting lists for patients who fail to attend
- treating patients in turn where possible.

2.4.2 Managing clinic schedules

To maximise clinic scheduling, it is important to first analyse historical rates of attendance and scheduling processes. Analysis should consider:

- actual attendance rather than the booking template
- minimum, median and maximum clinic volumes in addition to the average
- urgent and non-urgent demand.

Some suggestions for managing clinic schedules are:

- Allocate appointments for urgent patients within the booking template, rather than as overbookings.
- Utilise historical data to estimate the number of appointments that need to be allocated for urgent patients while minimising carve out as much as possible.
- Consider filling unallocated urgent appointments with routine patients close to the clinic date.
- Book patients from the waiting list by date of referral receipt.
- Seek input into scheduling from clinicians and administrative staff.
- Plan for foreseeable changes to staffing and other resources.
- Consider appropriateness of alternative clinic structures such as separate clinics for new appointments or registrar-led review clinics.

Pooling waiting lists on the day of clinic

Pooling waiting lists to reduce waiting time to first appointment is discussed above in section 2.3.2 Adding patients to waiting lists. Pooling can also be used on the day of the clinic to minimise average waiting times. The positive impact on in-clinic waiting times of a pooled patient list compared with individual clinician lists was evident in a demonstration project undertaken by the department in 2009–10. When a pooled list is used on the day of the clinic, patients are pulled from the list according to their appointment time not their arrival time.

Using modelling to improve specialist clinic appointment scheduling

Various forms of mathematical modelling have been used to study and improve specialist clinic appointment systems to maximise efficiency of the clinic. The following redesign project focusing on preadmission clinics illustrates the potential application of modelling techniques.
Edward et al. (2007) used simulation models to reduce access and waiting times. The two steps involved were:

- determining the number of appointments needed to reduce the access time from five weeks to 10 working days for 95 per cent of patients
- determining how long the consultation time should be, taking the American Society of Anesthesiologists (ASA) physical status of the patients into account, to reduce the maximum waiting time to 10 minutes for 95 per cent of patients.

The researchers found the actual capacity of the clinic (consultations per day) to be enough to meet demand. However, access time was currently five weeks due to an existing backlog. Temporary extra capacity was needed to eliminate this backlog. The study predicted that if the reserved consultation time was 18 minutes for patients with ASA class I or II and 30 minutes for patients with ASA class III or IV, the maximum waiting times would decrease to 10 minutes for 95 per cent of patients.

### 2.4.3 Implementing patient-focused booking

Patient-focused booking (see Box 2) empowers patients to take an active role in booking their specialist appointment, such as contacting the specialist clinic at their convenience to choose an appointment date and time within the clinic schedule. Ancillary services such as interpreters and transport may also be coordinated when booking the appointment. The access policy encourages health services to implement a formal patient-focused booking approach and requires health services to make appointment times in consultation with the patient, unless the patient is urgent and requires the first available appointment.

Patient-focused booking offers the following benefits to specialist clinics:

- maximised clinic capacity.
- better-controlled patient flow.
- reduced cancellation and FTA rates.
- reduced burden of rearranging appointments.
- improved patient satisfaction.
Box 2: Key elements of patient-focused booking

As outlined in the specialist clinics access policy, the key elements of patient-focused booking include the following.

• Acknowledgement of referral: When the specialist clinic accepts a referral, patients are sent a referral acknowledgement letter that confirms they are on the waiting list and explains they will be contacted nearer to the time they are due to attend to arrange their appointment. If a patient is to be seen within six weeks, they are asked to contact the health service immediately to book their appointment.

• Generating the clinic list: Each week, clerical staff plan clinics scheduled for four weeks ahead. For each clinic they calculate how many patients will be needed to fill the clinic to its capacity. Patients are then selected from the waiting list, first in order of clinical priority, then by date of referral receipt.

• Invitation for appointment letter: A letter is sent to the selected patients inviting them to telephone the specialist clinic to arrange their appointment. Appointment times are negotiated between the patient and specialist clinic within the clinic schedule.

• Managing variation in responses: Patient-focused booking is self-regulating. If too few patients respond to the invitation for an appointment in any one week, extra letters can be generated the following week. Conversely, if too many patients respond, bookings can be made into week five, and fewer patients invited for appointments in that fifth week.

• Patients who do not respond to the appointment letter: A reminder letter is generated for patients who do not respond to the invitation for appointment letter within a set timeframe. If the patient fails to respond to a subsequent reminder letter, and is unable to be contacted by telephone, a further letter is sent to the patient and their GP explaining that they have been removed from the waiting list.

• Adherence to a leave notification policy: Successful introduction of patient-focused booking relies on strict policies about notification of leave for any staff whose absence will affect specialist clinic bookings. Medical staff should provide notification of planned leave six weeks in advance. This allows the clinic template to be adjusted to match the predicted clinic capacity prior to patients being booked. Any necessary cancellations due to unplanned leave, such as staff illness, can be rescheduled into an empty clinic in five weeks’ time.

Successfully implementing patient-focused booking depends on a well-resourced telephone booking service for patients to access after receiving a letter of invitation to make an appointment. Where possible, the telephone service should operate for extended hours. An email or web-based communication tool may also offer convenience to both patients and staff.

To support the change process to patient-focused booking, it will be beneficial to communicate to clinic staff the benefits to both patients and staff. Supportive data on current FTA, cancellation and rebooking rates may strengthen support to change current practice.

Overbooking

The common practice of ‘overbooking’ clinics is used to compensate for the proportion of patients who will fail to attend their appointment. Many outpatient departments routinely overbook clinics based on an average FTA rate. Ideally, booking templates should not be built around predicted FTA rates (see Box 3).
Box 3: The impact of overbooking

A guide to good practice: elective services (National Leadership for Healthcare 2005) explores the impact of various overbooking and FTA scenarios in detail with graphical representations.

The scenarios are summarised below.

Scenario 1: Overbooking by 20 per cent, FTA rate 20 per cent
Outcome: Several long waits early in the clinic

Scenario 2: Overbooking by 20 per cent, FTA rate 40 per cent
Outcome: Unused clinician time

Scenario 3: Overbooking by 20 per cent, FTA rate 0 per cent
Outcome: Long waiting times

Scenario 4: No overbookings, no FTA
Outcome: Best utilisation of clinician and patient time

Booking review appointments

The management of follow-up (review) specialist clinic appointments should be as systematic as the management of new appointments. As discussed earlier, booking review appointments with the same clinician as was seen at the first appointment enhances continuity of care.

Section 2.2 outlined the process for triaging and prioritising new referrals (by clinical priority, then by date of referral receipt). In contrast, prioritising patients for review appointments involves selecting patients in order of clinical priority only. The requested review appointment date may be the sole determinant of clinical priority. However, where demand is greater than capacity, it may be necessary to further prioritise patients. One method of achieving this is calculating an acceptable range in time in which the appointment is to occur.

An example of how this can be achieved is provided in A guide to good practice: elective services (National Leadership Agency for Healthcare 2005), and adapted in Table 5 and Figure 7.
Table 5: Example of prioritisation structure for booking review appointments using patient-focused booking

<table>
<thead>
<tr>
<th>Priority</th>
<th>Definition</th>
</tr>
</thead>
</table>
| 1 (high) | The clinic date* is after the end date.**  
The appointment is overdue.          |
| 2        | The clinic date is within 14 days of the end date.  
The appointment will sit within the acceptable range if it is arranged promptly. |
| 3        | The clinic date is after the target date but not within 14 days of the end date.  
The appointment will sit within the acceptable range. |
| 4        | The clinic date is before the target date but after the start date.  
The appointment will sit within the acceptable range. |
| 5 (low)  | The clinic date is before the start date.  
It is too early to make an appointment for this patient. |

* The clinic date is the date for which the list is being generated, which is usually four weeks into the future.

** Calculate the end date using the following methodology:
1. Note the review request date: the date on which the clinician makes the appointment request.
2. Identify the target date: the date the clinician has nominated for a patient’s review appointment.
3. Calculate the appointment delay: the number of days between the review request date and the target date.
4. Identify the start date: the target date minus 20 per cent of the appointment delay – the start of the acceptable range.
5. Identify the end date: the target date plus 20 per cent of the appointment delay – the end of the acceptable range.
6. Calculate the acceptable range: the difference in days between the end date and the start date (the target date +/- 20 per cent of the appointment delay). Note that because a percentage is used, long-term review appointments (for example, 12 months) will have a greater acceptable range than short-term review appointments (for example, eight weeks).

Source: National Leadership Agency for Healthcare 2005

Figure 7: Graphical representation of Table 5 – Example of prioritisation structure for booking review appointments using patient-focused booking

Source: National Leadership Agency for Healthcare 2005
2.4.4 Managing failure to attend appointments

In general, a high FTA rate in a specialist clinic may indicate:

- long waiting times
- poor communication with patients including management of patient contact details
- patients unnecessarily referred for specialist assessment
- scheduling of unnecessary review appointments
- lack of opportunity for patient input on appointment time.

Analysis of FTA rates may be enlightening. Recurring themes may emerge, particularly in relation to specific clinics or patient groups. Such analyses may also identify opportunities to improve FTA rates.

Section 9 of the access policy (Appointment scheduling and booking) provides advice on managing patients who fail to attend an appointment, including the process for removing a patient from the waiting list if they fail to attend appointments.

Many health services are endeavouring to improve communication with patients about appointments, particularly through patient-focused booking strategies (see section 2.4.3) and appointment reminders.

Hospitals may consider setting target FTA rates as a percentage of total scheduled appointments, and provide regular feedback to clinics about their FTA rates. Specialty-specific targets may be considered.

Local ‘failure to attend’ policies

As stated in the access policy, a patient may be removed from the waiting list if they have failed to attend an agreed appointment on two consecutive occasions without adequate explanation, and the treating specialist has agreed to their removal.

In the case of patients who have declined, repeatedly rescheduled or failed to attend appointments, the health service has a duty of care to inform the patient of any risks to their health of not receiving treatment for their condition. It may also be appropriate to contact the referring practitioner in these circumstances.

Local policy relating to patients failing to attend appointments should ensure risks to the patient are managed and retaining a patient on a waiting list following repeated FTA is an explicit decision in keeping with local policy. Local policy relating to FTA may address:

- specific actions following an FTA
- circumstances in which a patient will be given another opportunity to attend
- recording of the FTA in the patient’s medical record
- communication with the patient and referrer regarding the FTA and removal from the waiting list if appropriate.

It may be necessary to consider individual specialties within a policy relating to FTA. There may be instances where it is not appropriate to discharge a patient who has failed to attend multiple appointments, such as a patient of an infectious diseases clinic if there is a public health imperative for monitoring the patient’s condition on an ongoing basis.
2.4.5 Examples of good practice

St Vincent’s Health – SMS appointment reminder pilot

In 2010 St Vincent’s Hospital piloted an SMS appointment reminder system to address an FTA rate of between 20 and 40 per cent across selected specialist clinics. Patients were informed at the time of arranging their appointment that an SMS reminder would be sent unless they opt out. SMS appointment reminders were sent one week before patients were scheduled to attend the orthopaedic, urology or gastroenterology clinics. As part of the pilot, a dedicated telephone line was provided for rescheduling or cancelling appointments. On average, the FTA rate decreased by 33 per cent.

In 2012 SMS messaging was commenced across all clinics. The FTA rate dropped to between five and 15 per cent, which was a reduction of up to 25 per cent prior to the SMS system being introduced. SMS will be rolled out to other like services, such as endoscopy, later in 2013. SMS has led to an increase in rescheduling of appointments, which is preferable to patients failing to attend.

Hutt Valley District Health Board (New Zealand) – patient-focused booking

Following a visit to the National Health Service (NHS) in the UK, the Hutt Valley District Health Board in New Zealand introduced patient-focused booking. Baseline data was collected on FTA rates, cancellation rates and administrative ‘rework’.

Patient-focused booking was then rolled out by specialty. This involved sending patients a letter inviting them to contact the health service to arrange a mutually agreeable appointment time. Two critical requirements were that appointments were not booked more than six weeks in advance, and that senior doctors be required to give six weeks’ notice of leave.

To assist the continued rollout an evaluation for each speciality was completed after implementation. Patient-focused booking was rolled out to all outpatient specialties. The reported benefits included:

• sustained reduction in FTA rates from 13–15 per cent to 7–8 per cent
• reduction in cancellations and administrative ‘rework’
• increased patient satisfaction.

Austin Health – reducing in-clinic waiting times in orthopaedic fracture clinic

Patients attending the orthopaedic fracture clinic at the Heidelberg Repatriation Hospital of Austin Health were experiencing long in-clinic waiting times. Manual data collection revealed suboptimal booking template practices including:

• The booking template commencing prior to medical staff arriving at the clinic.
• Patients for cast removal were all booked at the beginning of the clinic.
• The typical appointment duration for consultants, registrars and residents was not reflected in the booking template.
• Appointment slots were labelled new, review or ‘removal of plaster’, but the number of each in the booking template did not match demand.
• There was an absence of dedicated appointment slots for urgent patients, leading to consistent overbooking of the clinic.

A new booking template was designed to more closely align with the capacity and activity of the clinic. Day-of-clinic waiting times have reduced and patient flow through the clinic has improved. Patient complaints have reduced, and both patient and staff satisfaction has increased. Comprehensive training and education on the new booking template is provided to both specialist clinics and emergency department staff.
2.5 Care pathways

One of the overarching aims of the access policy is to improve and streamline patient flow through specialist clinics. In specialist clinics, patient flow refers to the flow of patients through the numerous steps in the specialist clinic pathway, such as referral, assessment, treatment and discharge. It also includes the movement of patients between departments, staff groups or organisations as part of the care pathway.

2.5.1 Messages from the consultation and literature review

Health services in Victoria and other jurisdictions have adopted care pathways to help define and streamline the patient journey through specialist clinics.

Generic care pathways (patient streaming) are based on theory and evidence that health services may achieve efficiencies through managing ‘like’ patients as part of the same service stream. Generic care pathways stream patients according to the likely length and nature of care required.

By comparison, clinical care pathways provide guidelines and protocols for particular conditions. Ideally a clinical care pathway incorporates a patient-centred, multidisciplinary team approach and adherence to evidence-based or locally agreed best practice. Clinical care pathways can facilitate upfront planning and allocation of resources. Some positive impacts of clinical care pathways have been documented including cost savings, improved clinical outcomes and reduced adverse events (Lugtenberg, Bergers & Western 2009). Some clinical experts have expressed concern that the blanket use of care pathways may inhibit the flexibility, innovative thought and experimentation necessary for the evolution of new and better treatments (Nanan, Poulton & Champion 2012).

The use of care pathways has grown rapidly since the 1980s. The UK’s Map of Medicine and New Zealand’s Canterbury Health Pathways each provide integrated outpatient and inpatient clinical care pathways for more than 300 conditions. While neither approach has been adopted in Victoria (or elsewhere in Australia) due to lack of proven cost-benefit, some Victorian health services and individual specialties have embraced the use of care pathways.

2.5.2 Application of care pathways

Generic care pathways (patient streaming)

Generic care pathways would stream specialist clinic patients according to the likely length and nature of their involvement with the clinic, and the clinical and administrative processes required. Generic care pathways may provide a basis for developing clinical care pathways. Allocation of a generic care pathway would occur at either triage or first clinical assessment.

Table 6 demonstrates potential generic stream definitions, adapted from recommendations from Sano Consultancy (2008) and outlined in Victorian public hospitals specialist clinics: discharge guidelines (Department of Health 2010b). The discharge guidelines are available at www.health.vic.gov.au/outpatients
Table 6: Potential generic stream definitions

<table>
<thead>
<tr>
<th>Stream</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>See, treat and advise</td>
<td>One visit only: relatively minor matters, patient given an opinion and/or minor treatment and discharged with advice, without review or follow-up. May be treated in nurse practitioner/allied health-led clinics. Discharged to GP.</td>
</tr>
<tr>
<td>Simple</td>
<td>Two-three visits: patient attends to receive diagnostic testing and specialist appointment for opinion and possible treatment. May attend a follow-up appointment before being discharged to a GP.</td>
</tr>
<tr>
<td>Complex</td>
<td>Multiple visits: patient who have complex conditions, rare conditions and/or complex co-morbidities and who may require multidisciplinary care and multiple reviews. May be discharged to GP once stabilised with preferential access to return to clinic. Some patients may never be discharged, although there may be a shared care arrangement between the specialist clinic and the GP.</td>
</tr>
</tbody>
</table>

Clinical care pathways

Some examples of clinical care pathways in the specialist clinic environment are outlined in section 2.5.3.
2.5.3 Examples of good practice

Barwon Health – care pathways

Barwon Health has developed a range of guidelines and pathways for particular patient groups including:

- a trauma pathway for trauma patients referred to specialist clinics from the emergency department
- surgical review guidelines in which particular surgical procedures are linked to target times for post-surgery review and discharge from the specialist clinics
- a process for review of arthroplasty patients, including a patient self-assessment questionnaire that is mailed or administered by phone.

Pathway for orthopaedic trauma patients referred from the Barwon Health emergency department

Prior to establishing pathways for orthopaedic trauma patients referred from the emergency department, the orthopaedic clinics were overbooked and had long waiting lists. Specialist clinic staff were reluctant to discharge patients due to being unaware of other appropriate services and were scheduling review appointments 'just in case'.

Communication between the clinics and GPs was poor. As a result, GPs were re-referring discharged patients or asking for additional appointments due to their uncertainty about management protocols. The purpose of each appointment was not adequately conveyed to patients, contributing to a high FTA rate.

In 2009 a standardised trauma care pathway was introduced that began from the emergency department presentation and concluded with discharge from a specialist clinic. This led to improved utilisation of available resources. Implementation of electronic referral from the emergency department resulted in 100 per cent of referrals being triaged within one day and booked in a clinically appropriate timeframe. Communication between the hospital and GPs was also enhanced, with 92 per cent of GPs receiving a documented care plan.

Waikato Hospital (New Zealand) – streamlining access to cataract surgery

Traditionally, patients for cataract surgery would be referred by a GP or optometrist, then have a long wait for assessment by an ophthalmologist. An ophthalmologist would usually confirm the need for surgery, with the patient added to the elective surgery waiting list.

To streamline this pathway, the Waikato Hospital introduced a direct access pathway to enable optometrists to refer patients directly to the elective surgery waiting list. A comprehensive referral form elicits the information required to make a valid judgement of the need for surgery. All referrals are reviewed by an experienced ophthalmologist who assesses the need for further information, adds patients directly to the surgical waiting list or recommends that the patient is seen in the clinic.

Patients referred through the direct access pathway are assessed by their surgeon at a preadmission appointment. Very few patients have had their surgery cancelled.

The direct access pathway reduced the delay between referral and date of treatment from 300 days in 2004 to 60 days in 2008. It also releases ophthalmology clinic appointments for patients with more complex or undiagnosed conditions.
2.6 Discharge practice

Effective discharge practices are another strategy to improve patient flow and create capacity for new patients. The specific requirements of the access policy relating to discharge practice include:

• beginning discharge planning early in the patient’s episode of care, ideally at the patient’s first specialist appointment
• completing a discharge plan for all patients who do not require further specialist intervention or who can be treated on a shared care basis with primary or community care providers
• sending discharge letters and other relevant information to the patient’s GP and/or other relevant healthcare providers within five working days of the patient being discharged from the specialist clinic.

The access policy recognises that there is a cohort of patients who will never be suitable for discharge from specialist clinic care due to the complex nature of their conditions.

2.6.1 Messages from the consultation and literature review

A consultancy commissioned by the department in 2011 found that support for GPs and better discharge practices are likely to be more effective in improving access to specialist clinics (by increasing capacity for assessment of new referrals) than strategies focused on referrals and service entry. There is strong anecdotal and consultation evidence that structural and cultural issues contribute to patients being given review appointments with hospital specialists when they could be appropriately managed by GPs and/or other primary healthcare providers. These issues include:

• absence of close working relationships between GPs and specialists
• delayed or inadequate discharge communication with referrers
• specialist and GP concern regarding timely re-access to specialist services if unexpected complications arise following discharge
• staffing models focusing on junior doctors who may lack the authority, support or confidence to discharge patients
• administrative barriers to discharge, such as complicated discharge procedures.

Some hospitals in Western Australia and Victoria have introduced mandatory specialist review at key points in the care pathway, based on evidence that an important factor in determining whether a patient is discharged or not is whether they are reviewed by medical staff with the authority and confidence to instigate or approve discharge.

2.6.2 Discharge guidelines

Victorian public hospitals specialist clinics: discharge guidelines

The Victorian public hospitals specialist clinics: discharge guidelines (Department of Health 2010b) (available at www.health.vic.gov.au/outpatients) discuss best practice and provide resources to help develop local health service discharge policies. Key points and examples from the discharge guidelines are reproduced below.

Strengthening links with community-based care

Access to a GP is often critical to a successful discharge from specialist clinics, as GPs and community-based healthcare providers play a key role in providing ongoing care to patients. Specialist clinics are encouraged to help patients access a local GP and community services.
Strengthening relationships between the acute and primary and community care sectors is a broad objective of the healthcare system. Specialist clinics can strengthen linkages with local primary and community providers by:

- providing education and ongoing support to enhance knowledge transfer
- ensuring clinic staff have knowledge of, and access to, community services
- maintaining effective processes for communicating information about care undertaken in the specialist clinic, including assessment and discharge
- being receptive to queries and feedback from primary and community service providers.

It is important that specialist clinics provide information to help manage patient expectations of the specialist service such as:

- the role of the GP as the primary carer
- the acute, specialist and time-limited nature of the specialist clinic intervention (if appropriate)
- the expected nature and outcome of the patient’s involvement with the clinic
- the reasons for discharge, when applicable.

**Patient-initiated follow-up**

In the UK, it has been shown that discharge alternatives to routine follow-up in hospital outpatient clinics have improved access and reduced outpatient attendance without adverse effects on quality of care (National Primary Care Research and Development Centre, and Centre for Public Policy and Management 2006). The alternatives include ‘no follow-up’, ‘patient-initiated follow-up’ or ‘follow-up in primary care’.

In Wales, many outpatient departments now use self-referral for follow-up rather than fixed appointments (National Leadership Agency for Healthcare 2005). These ‘SOS’ appointments have been very effective in reducing unnecessary review appointments and FTA rates. The SOS system is used in the following scenarios:

- **Recurrent problems**: This is the most common use of SOS appointments in Wales, allowing patients with conditions that flare up from time to time to have rapid access to an appointment when the problem recurs.
- **Procedure follow-up**: Informing the patient about the progression of recovery through a care pathway, and allowing the patient to make an appointment quickly if there is a deviation or if they are concerns. This reduces unnecessary reviews (where the patient attends to report no further problems). Patients on a normal recovery path do not take up clinic time, therefore improving clinic capacity to see those patients who are experiencing problems.
- **Chronic condition monitoring**: Some patients with chronic conditions are also allocated SOS appointments where monitoring can be undertaken in part by the patient. Less frequent review can then occur. To ensure that patients understand what events require specialist reassessment, laminated cards with the events that should lead to an SOS appointment and instructions on how to make the appointment are provided to the selected patients.

The selection of appropriate patients and conditions is essential to successful and safe implementation of SOS appointments and similar processes. Clinicians need to balance the benefits of such initiatives with the role that a periodic review appointment (or shared care structure) may have in reinforcing patient compliance with management and monitoring.

**Criteria-led discharge**

Many health services have developed criteria-led discharge guidelines for particular conditions without necessarily having a fully developed clinical care pathway from referral to discharge.
Criteria-led discharge guidelines assist staff, particularly junior medical, allied health and nursing staff, to identify the clinically appropriate period between review appointments, as well as when it is appropriate to discharge a patient from the specialist clinic service.

### 2.6.3 Enabling discharge

There is significant potential to improve discharge rates and practices from specialist clinics. Successful discharge strategies implemented by some Victorian specialist clinics include:

- **initiatives to inform and support specialist clinic staff**
  - *discharge awareness campaigns*
    At one Victorian health service, rates of discharge more than doubled following a sustained campaign on visual reminders about discharge and regularly providing data on referrals compared with discharges.
  - *formal and informal education and support for junior doctors*
    Some health services have established formal programs to educate junior doctors on the clinical criteria for discharge, aiming to give them the confidence and authority to appropriately discharge patients.
  - *allied-health and nursing-led discharge models*
    This may be appropriate for common presentations.

- **standardisation of discharge rates and processes**
  - a strategy adopted in some clinics is the introduction of new/review ratios or guidelines on the expected proportion of new patients seen
  - standardised templates for discharge plans and letters to GPs
  - processes and technology to simplify preparation and transmission of discharge documentation

- **service re-entry arrangements for recently discharged patients**
  - health services are encouraged to develop processes for streamlined re-access into specialist clinic services for recently discharged patients, and to communicate this information to GPs as part of the discharge process.
2.6.4 Examples of good practice

**Eastern Health – Integrated Diabetes Education and Assessment Service**

The endocrinology unit at Eastern Health has developed the Integrated Diabetes Education and Assessment Service (IDEAS) to optimise the management of patients with diabetes. This service is a collaborative approach between Eastern Health and Whitehorse Community Health Service (WCHS).

The innovative funding model uses Medicare Benefits Schedule (MBS)-funded specialist medical services and core community-health-funded health professionals working together in a seamlessly integrated multidisciplinary team. The consultant and registrar from the endocrinology clinic at Eastern Health attend the IDEAS at WCHS, where patients also have access to a range of healthcare professionals and health management education. The model encourages close links with GPs and facilitates diversion of people with diabetes from hospital-based specialist clinics, earlier discharge from specialist care and patient education in self-management.

**Southern Health – electronic distribution of specialist letters**

Southern Health implemented a pilot project to increase the electronic distribution of specialist clinics letters to GPs to enable timely and accurate communication, reduce clinical risk and enhance collaboration between specialists and GPs. The new system allows specialist letters to be transcribed and sent via a secure messaging system as encrypted HL7 messages that can be imported directly into the general practice software for GPs using any of the common GP clinical information systems.

Eighteen months post-implementation, electronic distribution of dictated GP letters has grown to approximately 45 per cent. The project initially involved 15 general practices and has expanded to all practices interested in receiving specialist clinics letters electronically.

The project involves the Southern Health Medical Transcription Service, a private medical transcription service, a secure messaging provider and the founding member of the South Eastern Melbourne Medicare Local (SEMML), Dandenong Casey General Practice Association (DCGPA).

**Barwon Health – re-referral process**

Barwon Health specialist clinics have a number of processes that allow streamlined re-referral of patients for the same condition. Prior to discharge, patients are provided a ‘window’ of time in which they can return to the clinic as a review patient for the same condition. The patient is discharged once this window has lapsed if they have not initiated a review.

**Alfred Health – orthopaedic clinic outcomes letter**

To reduce the burden of paperwork associated with the discharge process, and to encourage transfer of information to the GP, the orthopaedic clinic in the specialist consulting suites at The Alfred have introduced an outcomes letter that is completed by staff at the end of the medical consultation and faxed to the GP. The letter includes the progress note to avoid duplication of work. Discharge rates have shown an upward trend, and the letter format is now being developed for several other specialist units. A copy of the letter template is provided as Figure 8.
GP COPY

Dear Doctor,

Today, your patient had an ATTENDANCE AT ORTHOPAEDIC OUTPATIENT CLINIC Date: /

With the diagnosis of:

Notes for GP:

☐ Non weight bearing  ☐ Partial weight bearing  ☐ Full weight bearing  ----------- weeks

And the Management plan is:

☐ Review in: weeks / months (circle one) with:
  ☐ Bloods  ☐ MRI scan  ☐ X-ray  ☐ On the waiting list for
  ☐ CT scan  ☐ Interpreter  ☐ Discharge from the Orthopaedic Clinic back to your care

Seen by: signature: ___________________________  print name: ___________________________
2.7 The patient’s perspective in specialist clinics

Previous sections of this guide focus on ways health services can improve access to, and flow through, specialist clinics. This section explores the patient experience of specialist clinics, including methods to evaluate such experience and strategies to implement patient-focused service delivery.

2.7.1 Messages from the consultation and literature review

Several factors are consistently shown to shape patients' experiences of, and satisfaction with, specialist clinic services (Jackson et al. 1997) such as:

- service access, including waiting time for an appointment and in-clinic waiting
- interpersonal aspects of care, including the perceived interpersonal skills of administrative staff and clinicians
- the quality of communication from the health service about the appointment, the patient’s condition and treatment
- the quality of the environment, including physical amenities.

Long in-clinic waiting times are a common source of frustration for patients, and are of particular concern for un-well patients. In addition to appointment scheduling techniques such as overbooking, long clinic waiting times may be due to factors such as staff arriving late, unavailability of necessary patient information or medical equipment and difficulty accessing interpreters and patient transport services.

Better patient experiences and patient-centred care are associated with favourable clinical and operational outcomes such as:

- decreased mortality
- decreased readmission rates
- decreased healthcare-acquired infection rates
- reduced length of stay
- improved adherence to treatment regimens
- improved functional status
- lower costs per case
- improved liability claims experiences
- increased workforce satisfaction and retention rates.

2.7.2 Improving patient experience in specialist clinics

Wayfinding and signage

Finding a clinic’s location within a health service can be challenging, particularly in large health services with multiple sites. Clear information regarding how to find the clinic should be provided to patients in their appointment letter before their visit. A map (or instructions on how to obtain one) can also be of great assistance.

**Specialist clinics wayfinding guidelines**

Signs at the clinic site should be easy to read and displayed in prominent areas for visibility. The Specialist clinics wayfinding guidelines (available at <www.health.vic.gov.au/outpatients>) provide detailed advice to assist Victorian public hospitals with patient-friendly wayfinding and signage.
In-clinic waits

Many Victorian health services have attempted to address issues that cause long in-clinic waits as part of their service redesign work in specialist clinics. Some clinics have introduced a nursing role to monitor patients in the waiting area in clinics managing patients who are typically unwell.

Sometimes delays are unavoidable. Patients are less concerned about in-clinic waiting times if they are informed about the expected length of the wait and the reasons for the delay (Jackson et al. 1997). Communication to patients about their appointment should include information about the anticipated time the patient will spend at their clinic appointment.

Physical environment

A supportive clinic environment provides physical areas and furnishings appropriate to the needs of the clinic’s patient group. The *Review of Victorian public hospitals outpatient departments* (Department of Human Services 2007) (available at <www.health.vic.gov.au/outpatients>) provides a number of recommendations about physical amenities in specialist clinics. Small design modifications and improvements can have a positive impact on patient experience.

Improvements undertaken by health services in recent years include:

- modification to reception areas to improve privacy, communication and comfort
- improved seating, including special seating for older, obese and orthopaedic patients
- positive distracters such as televisions and reading materials
- designated areas and toys for children
- access to refreshments
- expanded space to reduce crowding
- lockers for patient belongings
- adjustable plinths in consultation and procedure rooms
- upgraded intercom systems
- software and pagers for automated queuing and call-back systems
- painting and artwork to enhance ambiance.

Health literacy

Health literacy is related to, but not the same as, general literacy. Health literacy can be defined as the ‘degree to which individuals can obtain, process and understand the basic health information and services they need to make appropriate health decisions’ (Berkman et al. 2011). Health literacy is influenced by the interaction between personal factors (general literacy, health status, emotional state and background knowledge) and service delivery factors (communication skills of health professionals and assumptions about a patient’s understanding).

Approximately 60 per cent of Australians have poor health literacy and are not able to effectively exercise their ‘choice’ or ‘voice’ in healthcare decisions (Australian Bureau of Statistics 2008). Only 33 per cent of people born overseas have adequate or good health literacy, with this figure dropping to 27 per cent for those who arrived in Australia in the past five years (Ethnic Communities’ Council of Victoria 2012).

Health literacy skills and health outcomes are linked, even when other factors such as socioeconomic status are taken into account. Patients with inadequate health literacy have poorer levels of knowledge and understanding about their condition, are less likely to attend appointments, are less adherent to medication regimens and health behaviour advice, make more medication errors and perform worse at self-care activities. The Australian Commission
Health services can improve patient access to and understanding of health information by:

- reducing the complexity of information by avoiding medical jargon
- simplifying quantitative information in easy-to-understand graphs
- supporting staff to improve their own health literacy, understand patients’ health literacy issues, and communicating in ways that support health literacy
- making information accessible (print, internet access, smartphone applications)
- providing information in a range of languages
- involving patients when developing and reviewing information
- providing access to interpreters
- building networks with key community organisations.

A communication training program for clinic staff, *Enhancing communication in outpatient departments*, was prepared for the department in 2008 and is available at <www.health.vic.gov.au/outpatients>.

### 2.7.3 Evaluating patient experience in specialist clinics

Most health services actively promote their interest in patient feedback and undertake regular surveys to understand and monitor patient experience and satisfaction. There are also established processes through which health services consult with consumer representatives. Anecdotally, however, processes for obtaining patient feedback are often not as well established in specialist clinics as in other areas of the hospital.

*The national safety and quality health service standards* (Australian Commission on Safety and Quality in Healthcare 2011) (see <www.safetyandquality.gov.au/our-work/accreditation>) require health services to establish mechanisms to ensure patients’ views and experiences are taken into account in service development, design and review.

Evaluation of patient experience in specialist clinics involves measuring patient experience, then analysing the results and communicating this information. Specialist clinics are encouraged to liaise with internal quality departments for support and resources regarding patient experience evaluation in specialist clinics (see Box 4).

#### Box 4: Coordination of patient experience measurement and reporting across the Victorian Department of Health

In 2011 a project titled ‘Coordination of patient experience measurement and reporting across the Victorian Department of Health’ was commissioned by the department. The final report made a number of recommendations including:

- specialised survey tools are used to measure patient experience, rather than patient satisfaction
- measurement of patient experience is expanded to include groups such as specialist clinics and paediatric populations
- a set of focus group questions and an interview process is developed for hard-to-reach survey populations.

The Department of Health has recently undertaken broad consultation with health services, community groups and other key stakeholders on the recommended changes to measuring patient experience in Victoria (see <www.health.vic.gov.au/patsat/consultation>).
Research methods

Many research methods can be used to gain feedback on patient experience in specialist clinics depending on the purpose of the information being gathered. If the information is being formally reported, it may be important to survey a representative sample using a reliable and valid questionnaire. If the information is simply to generate ideas about possible service improvements, less structured methods such as observational studies, focus groups or a small number of interviews may be appropriate. It is often desirable to use a combination of methods, for example, focus groups can be undertaken prior to developing a questionnaire. Data may be quantitative or qualitative. Some of the main research methods used by health services are outlined below.

Observation

Observational studies observe patient behaviour as it occurs, avoiding the reliance on recollection. Observation can be combined with other methods such as patient surveys to provide comprehensive information about services. For example, a specialist clinic may observe details about in-clinic waiting times such as arrival time in relation to the appointment and the waiting time for the appointment, and combine this with a survey asking patients to comment on their experience of their in-clinic waiting time.

Surveys

Survey research encompasses any approach to information collection that involves asking questions of respondents. A survey can be anything from a short paper-and-pencil feedback form to a series of intensive one-on-one in-depth interviews.

Extensive survey methodology information is available online from the following sources:
- NHS Surveys (www.nhssurveys.org/surveys)
- NHS Outpatient Department Survey 2011 (www.nhssurveys.org/surveys/568)
- Picker Institute US (www.pickerinstitute.org)
- Picker Institute Europe (http://www.pickereurope.org/picker-institute-europe)

Some points for consideration when undertaking surveys in specialist clinics include:
- undertaking surveys ‘in-house’ versus engaging an external contractor
- patient-completed questionnaire versus interview
- mail-out versus completion in clinic
- self-designed versus ‘ready-made’ templates
- length of the survey
- whether the sample group is representative of the whole clinic patient population.

Focus groups

A focus group is a planned discussion with a small group of invited participants. Most focus groups are conducted by a moderator whose role it is to ask questions and ensure all participants have the opportunity to contribute to the discussion.

Focus groups can provide in-depth information on a particular aspect of service provision, but normally only involve small numbers of participants rather than the larger numbers often involved in surveys, so may not represent the whole target group.

Incidents, complaints and suggestions

Tracking the rates and nature of incidents, complaints and suggestions can beneficial. The national safety and quality health service standards require health services to have formal arrangements for implementing a complaints management system that includes partnership with patients and carers.
**Analysing and reporting patient experience**

Patient experience information and data requires analysis and reporting to be meaningful. The method(s) chosen for analysis and reporting will depend on the type and purpose of the study, and the intended audience. A report for health service executive may be a brief summary highlighting key findings and prioritised recommendations, whereas poster or pamphlet presentation may be more appropriate for communication with consumers. A *guide to using data for health care quality improvement* (Department of Human Services 2008a) (available at [www.health.vic.gov.au/qualitycouncil](http://www.health.vic.gov.au/qualitycouncil)) describes the fundamental concepts associated with data collection, analysis, interpretation and reporting, and how these relate to the various stages of the quality improvement cycle.

Displaying key findings as graphics and pictures can convey key messages effectively without the need for detailed text. The Picker wheel is a practical means of displaying patient experience data based on the eight dimensions of patient-centred care. The Picker wheel was developed by the Picker Institute and Harvard Medical School (see [http://www.nrcpicker.com/member-services/eight-dimensions-of-pcc](http://www.nrcpicker.com/member-services/eight-dimensions-of-pcc)).

The Picker wheel in Figure 9 was used to display patient experience information collected from a specialist clinic in a Victorian redesign project in 2010 (ThincLean Consultancy 2010). The colours of the wedges in the wheel darken as more responses are received for that dimension of care.

**Figure 9: Example of using the Picker wheel to demonstrate patient feedback**
2.7.4 Examples of good practice

**Austin Health – self-check-in and electronic calling system**

In September 2012 Austin Health became the first Victorian public hospital to introduce a self-check-in for patients in specialist clinics. The self-check-in and electronic calling system has been designed to improve patient privacy, reduce the risks associated with delays in treatment and reduce complaints about excessive waiting times.

Under the new system, patients swipe their Medicare or Department of Veterans’ Affairs (DVA) card, or scan their appointment letter at the self-managed kiosk on arrival, following which they are provided with a ticket. When the clinician is ready, the patient’s ticket number is selected from the Queue Master dashboard (on the clinician’s desktop computer) and the ticket number and room number are displayed in the waiting room. The completion of the consultation is also captured in the program. These timestamps will provide data to support change management and improved scheduling for specialist clinics.

Reports from two health services in Queensland with similar systems have shown a reduction in patient waiting times by up to 50 per cent. A similar system has been implemented for the Olivia Newton-John Cancer and Wellness Centre, where patients are given a pager for callback and encouraged to use the centre’s facilities while waiting for their appointment.

**Department of Health – Talking with your doctor – a guide for older people**

Talking with your doctor – a guide for older people (Department of Health 2011) (available at <www.health.vic.gov.au/qualitycouncil>) was written to help older Victorians have more effective conversations with their doctor and get the most out of their visits.

**Western Health – OrthoAnswer**

OrthoAnswer.org is a patient-focused website created by the Western Health orthopaedic department and medical students from The University of Melbourne, as well as occupational therapists, physiotherapists, pharmacists and plaster technicians.

Hundreds of patients were surveyed in the development of best practice patient-focused information, written in Year 5–6 level English, with patients’ needs and experiences in mind. A patient information pamphlet has also been created so that treating doctors can recommend the website and also advise patients of the correct diagnosis and recommended treatment. The pamphlet has become part of the orthopaedic department’s standard consent process. The website receives more than 11,000 visitors per month. The OrthoAnswer website can be accessed at <www.orthoanswer.org>.

**Goulburn Valley Health – working with culturally diverse patients to improve women’s health outcomes**

In 2010–11 Goulburn Valley Health undertook an initiative to improve the attendance of culturally and linguistically diverse (CALD) patients in their gynaecology clinics. Women from CALD communities had a higher FTA rate and were experiencing a range of barriers to accessing services. The specific needs of local refugee groups were identified through greater collaboration between hospital specialists and relevant community stakeholders.

More appropriate patient communication was developed to reflect the health literacy levels and cultural norms of specific refugee groups, including hospital letters and envelopes presenting key information in pictorial format (see Figure 10). This has resulted in a reduction in FTA rates in this patient population.

A specific objective of the project was to provide culturally sensitive information to women to reinforce the need for regular pap smears. Targeted education sessions were provided for Arab, Congolese and Afghani women in community settings. Information was provided in relevant languages and visual displays and aids (such as pap smear equipment) assisted communication. The sessions were well received, with women reporting they were less fearful of attending the clinic.
Dear <Patient>,

An appointment has been made for you in the Gynaecology Clinic at GV Health (Hospital) - Specialist Consulting Suite.

Kupima njia ya uzazi

Clinic ________________

Doctor ________________

Time ________________

Date ________________

Interpreter ________________

Please bring your Medicare card

GV Health Specialist Consulting Suite
Phone 03 5832 3600   Fax 03 5831 6032
Graham Street, Shepparton Victoria 3631
2.8 Information and communication technology

Given the high volume of activity in specialist clinics, there is potential for significant efficiency gains through ICT applications that have been widely implemented in other industries to streamline communications, records management and scheduling processes. Such applications allow all written correspondence to be seamlessly embedded in the patient’s electronic medical records at both hospital and community care settings. It is important to maintain a telephone service to manage urgent appointment requirements and support patients who are unable to access the internet.

2.8.1 Messages from the consultation and literature review

Currently, many specialist clinics are burdened by cumbersome paper-based systems such as:

- receiving referrals by fax
- paper-based medical records
- paper-based medical records being transported to and from clinics by staff
- letters to the GP and referrers being dictated, typed and sent by mail
- appointment details being sent to patients by mail.

Paper-based systems also require staff resources to undertake tasks such as searching for missing referrals and medical records, photocopying, faxing investigation results and stuffing envelopes.

Some health services are embracing ICT applications such as telehealth to enable care to be delivered at a distance. A minority of clinics are sending SMS appointment reminders to patients as discussed earlier.

2.8.2 Enhancing use of ICT in specialist clinics

Increased uptake of ICT in specialist clinics may benefit patients by providing:

- better service access
  - shorter timeframes for referral management
  - less administrative burden on staff
  - reduced need for patients to travel
- better coordination of care
  - faster and easier communication with referrers
  - reliable access to patient records to inform clinical decision making
- better quality care
  - improved patient access to electronic information
  - robust monitoring of service delivery and patient outcomes.

Potential applications of ICT in specialist clinics

The following are potential applications of ICT in specialist clinics:

- electronic referrals generated by the referrer and transmitted securely to the hospital
- electronic referrals for existing patients of the hospital are embedded in the patient’s electronic medical record
- receipt of referral acknowledged by secure email
  - referrer advised whether the referral is accepted
  - additional information requested by secure email if required
- hospital specialists review incoming referrals remotely to identify urgency
• patients are sent a letter inviting them to connect to an e-portal to
  – track the progress of their referral
  – receive relevant information such as anticipated waiting time
  – confirm and update personal details and prepare for their first appointment
  – book appointments using an online clinic schedule
  – access appointment records, information about their condition and tools for managing
    their condition
• automated appointment reminders
• investigation results transmitted by secure email between the hospital, GP, medical imaging
  and pathology centres
• remote dictation services.

E-referral

The National e-Health Transition Authority (NEHTA) is responsible for developing the capacity
for e-referral (the electronic exchange of patient information between referring and receiving
providers) in the Australian healthcare sector. The NEHTA Electronic Referral Program is
developing the key specifications required for software vendors, GPs and specialists to
establish a national environment for standardised electronic referral exchange. This will enable
referrals to be sent securely and reliably to identified recipients, viewed by healthcare providers
and integrated into recipient clinical information systems.

A trial of e-referral between Eastern Health and local GPs was conducted in 2011–12.

Telehealth

Technologies that enable care to be delivered at a distance, for example, through
videoconferencing supported by digital transfer of clinical information, can increase patient
access to specialist assessment and care planning, improve management of patients in their
local communities, and reduce the need for patients to travel to see specialists. Use of these
technologies is expected to grow in the future, along with the use of home-based technologies
and social media applications that help patients and their carers manage long-term conditions
(Imison 2012).

2.8.3 Examples of good practice

Orbost Regional Health

Orbost Regional Health is a member of the Gippsland Health Alliance, which has enabled the
 provision of advanced technology and communications such as videoconferencing, VoIP (Voice
 over Internet Protocol) internet telephone systems and healthcare-specific software programs.
 This technology reduces travel time and supports integration with other regional providers.

GPs at Orbost Medical Clinic have embraced telehealth consultations with specialists. Patients
from Orbost consult with specialists around Australia using a dedicated consulting room with a
large computer monitor and high-resolution camera.

2012 Victorian Public Healthcare Awards

The 2012 Victorian Public Healthcare Awards highlight a number of examples of health
services utilising telehealth to support access to specialist services for those living in regional
and rural areas. Further information can be found at
2.9 Workforce innovation

Maximising workforce productivity and flexibility will be critical to achieving workforce sustainability in specialist clinics into the future. New approaches to fully utilise health professionals’ skills and build on these to broaden roles beyond traditional job boundaries will enable a highly skilled, efficient workforce in specialist clinics.

In 2008 the Council of Australian Governments signed the *National partnership agreement on hospital and health workforce reform*. This agreement, accompanied by a $1.5 billion funding package, identifies workforce development as a key enabler of a sustainable healthcare system for Australia. The partnership agreement emphasises workforce innovation as a way of responding to workforce shortages, changes in the composition of the workforce, and the health needs of the community.

2.9.1 Messages from the consultation and literature review

Specialist clinics deliver a diverse range of services across many locations, under multiple operational models. As such, specialist clinics services can be difficult to fit within traditional hospital structures; their role and function as part of the service delivery framework may not be clearly articulated. This can lead to a number of management challenges.

Managing specialist clinics is often the responsibility of a nurse unit manager, who may oversee the work of specialist clinic nurses and clerical staff but have minimal management responsibility for clinic medical staff. Feedback from specialist clinic staff suggests there is often a lack of strategic or supervisory leadership, and an absence of medical leadership. Medical and surgical clinicians attend specialist clinics on a sessional basis. Those not directly employed by the health service may have little appetite for service and staff development activities. Medical staff (particularly junior staff) often express frustration about the volume of activity, inadequate environment, cumbersome processes and lack of administrative support in specialist clinics.

Nursing activities and resourcing vary between clinics. In many clinics nurses spend significant amounts of time managing patient flow and undertaking administrative tasks rather than nursing duties. Role delineation between different nursing divisions (for example, division 1 and 2 nurses) may not be clear.

Despite the specialist clinic environment being heavily process-oriented and reliant on good administrative and business management skills, there are few higher level administrative roles in specialist clinics. Lack of a career pathway for clerical staff is frequently cited as contributing to the challenges of the specialist clinic environment. Charging relatively junior staff with responsibility for specialist clinics reduces the capacity to effect large-scale change. Variation in administration operations between clinics reduces the opportunity for administrative staff to move easily between clinics and health services. Better alignment of the attributes and skills of staff with the tasks they perform in the outpatient setting is improving business processes and culture in specialist clinics.

2.9.2 Using the workforce in new ways

In addition to growth in demand, specialist clinics are managing higher acuity patients and providing more complex clinical interventions. The specialist clinic workforce is evolving in response to this and to new technologies and ways of providing patient care. The department supports innovative approaches to developing and using Victoria’s health workforce through a range of programs and resources (see [www.health.vic.gov.au/workforce/skills](http://www.health.vic.gov.au/workforce/skills)) including the Better Skills, Best Care program, and other work to support innovation in health service delivery, such as the Redesigning Hospital Care Program (see [www.health.vic.gov.au/redesigningcare](http://www.health.vic.gov.au/redesigningcare)).
There may be opportunities to utilise the local specialist clinic workforce in alternative ways to further enhance the efficiency of specialist clinics services. Workforce redesign may involve:

- Vertical expansion. Transferring tasks or roles up or down an existing hierarchy. This can be within the traditional scope of practice but requiring expert knowledge, clinical skills and clinical reasoning competencies and/or experience. This may be referred to as ‘advanced scope of practice’). Alternatively, this expansion of roles may require expertise, skills and knowledge beyond the currently recognised scope of practice of the profession (known as ‘extended scope of practice’).
- Horizontal expansion. Horizontal expansion involves widening roles to encompass related tasks, or giving staff new responsibilities in response to emerging need.
- Creation of new or composite roles.

**Leadership and management**

Health services are increasingly recognising the need for roles that focus on higher level business management processes and service redesign initiatives in the specialist clinic environment such as:

- implementing efficient, customer-focused business processes relating to referral and waiting list management, clinical prioritisation, booking and discharge
- reviewing current service delivery
- developing strategies to improve demand management
- overseeing development of comprehensive performance management frameworks, including patient experience monitoring
- implementing communication strategies to share performance data with staff and key stakeholders.

The Department of Health has recently developed the Leadership, Innovation, Networks and Knowledge (LINK) in Health program to build the capability of existing and future leaders in Victoria’s public health sector. Further information is available at [www.health.vic.gov.au/linkinhealth](http://www.health.vic.gov.au/linkinhealth).

**Expansion of nursing and allied health roles in specialist clinics**

New roles for allied health and nursing/midwifery clinicians may extend beyond developing advanced clinical skills and knowledge to include responsibility for managing patients’ conditions. The roles may operate relatively autonomously with well-defined links to medical or surgical specialists for care beyond the nurse/midwife or allied health clinician's recognised scope of practice or the agreed service capability.

Increasingly, allied health and nursing/midwifery disciplines are being used in new ways to support delivery of specialist clinics services, many examples of which are provided below. Programs have been developed to expand the roles of nursing and allied health staff to include:

- surgical screening and preadmission (anaesthetic risk screening and triage).
- pre-operative and post-operative management and follow-up.
- case management for patients on waiting lists or particular groups of patients with complex health and support needs.
- care coordination to facilitate access between multiple clinics or care providers.
- triage, early assessment and treatment for patient groups rarely requiring assessment and treatment by a specialist, or those that would benefit from early intervention while awaiting specialist assessment. There is evidence of improved efficiencies, financial savings and patient benefits with such service delivery arrangements; however, some reviews suggest that ‘fast track’ assessment by non-specialists may lower the threshold for referrals and increase demand if not targeted to conditions known to benefit from early intervention (Hurst et al. 2000).
Strategies to maximise workforce redesign success:

- Consult with all internal and external stakeholders, including industrial representatives if appropriate.
- Map typical patient journeys in the service stream.
- Identify tasks and staff competencies required for mapped patient journeys.
- Recognise relevant organisational and professional regulatory requirements, and plan appropriate training to accompany any role changes.
- Cluster skills and abilities into new or altered work roles and configurations.
- Document new roles and configurations, and the competencies required.
- Assess and record the education and training needs for the new workforce roles and configuration, and develop and implement appropriate training.
- Trial the changed workforce roles and configurations before embedding them into practice.
- Evaluate the impact of the changes on patients, staff and the health service.
- Consider common challenges to workforce redesign such as current or potential for fragmented roles and responsibilities, regulatory requirements, funding and payment disincentives, entrenched attitudes and customs.

2.9.3 Examples of good practice

Osteoarthritis Hip and Knee Services in Victoria

The Osteoarthritis Hip and Knee Services (OAHKS) aims to better coordinate the management of patients with hip or knee osteoarthritis and prioritise patients on specialist clinic and elective surgery waiting lists according to clinical need.

Features of the OAHKS are:

- early and comprehensive assessment.
- multidisciplinary team involvement.
- conservative management.
- monitoring, review and reporting.
- equitable and appropriate prioritisation for surgery.

Through system and workforce change, the following benefits have been achieved:

- more appropriate use of specialist orthopaedic services, including deferral of patients not requiring surgery to conservative management.
- early comprehensive assessment resulting in fast-tracking to surgical assessment as appropriate and/or early referral for conservative management.
- active management of the elective surgery waiting list, including prioritisation to match patient need
- improved patient satisfaction.

Further information can be found at <www.health.vic.gov.au/oahks>.

Melbourne Health – rheumatology TNF nurse

The TNF rheumatology clinic provides care for patients with rheumatoid arthritis, psoriatic arthritis and ankylosing spondylitis who are receiving treatment with biological-disease-modifying antirheumatic drugs. These drugs are powerful immune suppressants with potentially life-threatening side effects and therefore their use requires careful monitoring.
The TNF nurse is the key point of contact for the clinic and coordinates the overall care and management of this complex patient group. The role of the TNF nurse is to:

- follow up patients and organise diagnostic tests for early detection, treatment and ongoing management of any complications.
- prioritise and book patients for consultant appointments.
- coordinate inpatient day treatment for patients requiring intravenous drug therapy.
- coordinate patient prescription and treatment requirements.
- provide advice and patient education in relation to the condition, including drugs, drug administration (intravenous or subcutaneous administration), self-management and symptom control, recognising complications and understanding the service system.
- monitor patients for longer term complications (such as malignancy).
- address psychosocial issues including referral to other services if required.

**The nurse practitioner role in Victoria**

A nurse practitioner is a registered nurse who has completed both advanced university study at a master’s degree level and extensive clinical training. Through training and expertise, nurse practitioners autonomously perform advanced assessment, order and interpret diagnostic tests, initiate referrals to relevant healthcare providers, and prescribe appropriate medications and other therapies. The role of a nurse practitioner is clearly defined by the scope or specialty area in which they practise. Endorsement by the Nursing and Midwifery Board of Australia is required before the title can be applied to a nursing staff member.

The first four nurse practitioners were endorsed in Victoria in 2004. As at the beginning of 2013, more than 100 nurse practitioners are endorsed in Victoria.

**The Royal Women’s Hospital – Well Women’s de-infibulation clinic**

The de-infibulation clinic provides health services to women affected by female genital mutilation/circumcision (FGM/C). The service recognises that increasing numbers of women are migrating to Australia from countries where FGM/C is practised. The de-infibulation clinic is part of Well Women’s Services, which provides a range of services to women from diverse cultural backgrounds, many of whom are marginalised and experience difficulties accessing and using mainstream health services.

The multidisciplinary de-infibulation clinic is led by women’s health nurses/midwives with expertise in women’s sexual health. The nurses assess, coordinate and manage the patient’s care and progress from admission to discharge. Where clinically appropriate, the women’s health nurse may also perform the de-infibulation procedure under local anaesthetic in an outpatient setting.

Benefits provided by the clinic include:

- quicker and more streamlined service access for women seeking de-infibulation.
- reduced need for de-infibulation procedures during birthing.
- integration with existing pathways for women requesting or requiring a general anaesthetic for the procedure.
- coordinated multidisciplinary approach to education, information, counselling and healthcare, improving patients’ experiences, outcomes and participation in care.

Eastern Health – obesity clinic nurse flow coordinator

Eastern Health has established a nurse flow coordination role as part of a multidisciplinary clinic responsible for reviewing clinic patients considering weight loss surgery. The clinic is run in conjunction with medical staff, nursing staff and a dietician. The flow nurse is the preliminary point of contact for all patients referred to the obesity clinic and is responsible for directing appropriate patients to the health service’s obesity information sessions, which are a prerequisite for a consultation in the obesity clinic.

Key responsibilities of the flow nurse are to:

• provide a point of information and advice for patients.
• organise and deliver formal information sessions about weight loss surgery.
• communicate with GPs regarding service access criteria, referral quality, waiting times and patient status.
• triage referrals, ensuring high-need patients are fast-tracked for consultant assessment.
• refer to other specialties and services as required.
• manage booking and scheduling for new and review specialist appointments.
• review triage status and reschedule appointments if patients’ needs change.
• act as a conduit between patients, GPs, clinical staff, clerical staff in clinics and surgery booking staff.
• undertake audits of service access and quality of care provided.
Section 3: Letter templates

The letter templates in this section have been developed to support key processes outlined in the *Specialist clinics in Victorian public hospitals: access policy*. They reflect significant consultation with patient representatives, GPs and operational managers of specialist clinics.

As well as supporting good practice in communication with patients and referrers, the templates are intended to promote greater consistency in style and format of specialist clinic letters.

The letter templates are not mandatory. Health services are encouraged to amend the text to reflect local operational processes, provided these changes do not conflict with the requirements of the access policy.

The letters have been written for a sample clinic, hospital, patient and referrer. Health services can customise the text to include clinic-specific information such as hours of operation, contact details or estimated waiting times for routine appointments.

Where required, notes on using the letters and references to key sections of the access policy are provided as footnotes to the individual templates.

The letters do not cover every scenario; health services may wish to create additional letters to support the full range of services.

In addition to the letter templates, some telephone conversation templates are included.
<table>
<thead>
<tr>
<th>Template</th>
<th>Subject</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Referrer acknowledgement of referral receipt (for a routine patient who is added to a waiting list)</td>
</tr>
<tr>
<td>2a</td>
<td>Referrer advice regarding incomplete referral – additional referral information required</td>
</tr>
<tr>
<td>2b</td>
<td>Referrer advice regarding incomplete referral – return of incomplete referral</td>
</tr>
<tr>
<td>3a</td>
<td>Referrer advice regarding unavailable service – requested service not available</td>
</tr>
<tr>
<td>3b</td>
<td>Referrer advice regarding unavailable service – requested service not available (aesthetic procedure)</td>
</tr>
<tr>
<td>4</td>
<td>Referrer request to reconsider referral</td>
</tr>
<tr>
<td>5</td>
<td>Patient advice regarding non-accepted referral</td>
</tr>
<tr>
<td>6</td>
<td>Patient advice regarding placement on waiting list</td>
</tr>
<tr>
<td>7</td>
<td>Patient notification of appointment (from referral)</td>
</tr>
<tr>
<td>8</td>
<td>Patient notification of appointment reschedule</td>
</tr>
<tr>
<td>9</td>
<td>Referrer notification of first patient appointment</td>
</tr>
<tr>
<td>10</td>
<td>Waiting list validation letter</td>
</tr>
<tr>
<td>11</td>
<td>Waiting list validation phone script</td>
</tr>
<tr>
<td>12</td>
<td>Patient advice of post-validation removal from the waiting list</td>
</tr>
<tr>
<td>13</td>
<td>Referrer advice of patient removal from the waiting list or clinic list</td>
</tr>
<tr>
<td>14</td>
<td>Patient invitation to book appointment</td>
</tr>
<tr>
<td>15</td>
<td>Patient reminder to book appointment</td>
</tr>
<tr>
<td>16</td>
<td>Patient confirmation of agreed appointment (from waiting list)</td>
</tr>
<tr>
<td>17</td>
<td>Patient advice of removal from the waiting list (after offer letter)</td>
</tr>
<tr>
<td>18</td>
<td>Referrer advice of patient removal from the waiting list (after offer letter)</td>
</tr>
<tr>
<td>19</td>
<td>Patient failure to attend – appointment reschedule</td>
</tr>
<tr>
<td>20</td>
<td>Patient failure to attend – removal from waiting list or clinic list</td>
</tr>
<tr>
<td>21</td>
<td>Patient confirmation of agreed appointment (review)</td>
</tr>
</tbody>
</table>
Acceptance of referral

Dear Dr Jones,

Re: Referral to the gastroenterology clinic for
Mr Paul Patient (DOB 16/4/1956)
UR 000000
Date of referral: 12/7/2013

This is to confirm acceptance of the above referral.

Based on the information provided in the referral, your patient has been assessed as requiring a routine appointment in the gastroenterology clinic. Current waiting times for routine appointments in this clinic are approximately \[\text{INSERT WAITING TIME ESTIMATE OR RANGE} \quad \text{– e.g.} \quad 3–6 \text{ MONTHS}\].

Please contact \[\text{INSERT DETAILS OF CLINIC CONTACT}\] if further information comes to hand or if there is a clinically significant change in your patient’s condition while waiting for this appointment.

Referral guidelines and other information about specialist clinics at Victoria’s Best Hospital are available on our website at <www.vbh/specialistclinics.org.au>.

Yours sincerely,

Head of Clinic
Dear Dr Jones,

Re: Referral to the gastroenterology clinic for
Mr Paul Patient (DOB 16/4/1956)
UR 000000
Date of referral: 12/7/2013

Your referral has not yet been accepted, as we need additional information in order to process it.

The required information is indicated below.

1. Patient demographic information:

2. Referrer details:

3. Referral details:

4. Clinical information:

Please provide the information requested above as soon as possible. This referral will be closed if we do not hear from you within 30 days.

The [INSERT DETAILS OF CLINIC CONTACT] can be contacted on [INSERT CONTACT DETAILS] if you have any queries about this letter.

Referral guidelines and other information about specialist clinics at Victoria's Best Hospital are available on our website at <www.vbh/specialistclinics.org.au>.

Yours sincerely,

Head of Clinic
2b: Referrer advice regarding incomplete referral – return of incomplete referral

Gastroenterology Clinic
Victoria’s Best Hospital

Phone: (03) 0000 0000 (GP priority line)
Fax: (03) 0000 0000
Email: vbh@specialistclinics.org.au
Website: www.vbh/specialistclinics/gpaccess.org.au

16 July 2013

Dr J Jones
00 Primary Street
Suburb 0000

Return of incomplete referral

Dear Dr Jones,

Re: Referral to the gastroenterology clinic for
Mr Paul Patient (DOB 16/4/1956)
UR 000000
Date of referral: 12/7/2013

We have returned your original referral because we need additional information in order to process it.

The required information is indicated below. [INSERT DETAILS OR TICK BOX LIST]

1. Patient demographic information:

2. Referrer details:

3. Referral details:

4. Clinical information:

Please send us a new referral, including the information listed above, as soon as possible.

The [INSERT DETAILS OF CLINIC CONTACT] can be contacted on [INSERT CONTACT DETAILS] if you have any queries about this letter.

Referral guidelines and other information about specialist clinics at Victoria’s Best Hospital are available on our website at <www.vbh/specialistclinics.org.au>.

Yours sincerely,

Head of Clinic
3a: Referrer advice regarding unavailable service – requested service not available

Gastroenterology Clinic
Victoria’s Best Hospital

Phone: (03) 0000 0000 (GP priority line)
Fax: (03) 0000 0000
Email: vbh@specialistclinics.org.au
Website: www.vbh/specialistclinics/gpaccess.org.au

16 July 2013

Dr J Jones
00 Primary Street
Suburb 0000

Requested service not available

Dear Dr Jones,

Re: Referral to the gastroenterology clinic for
Mr Paul Patient (DOB 16/4/1956)
UR 000000
Date of referral: 12/7/2013

The service you requested for your patient is not available at Victoria’s Best Hospital.
A directory of specialist clinics at Victoria’s Best Hospital and guidelines for referral are available on our website at <www.vbh/specialistclinics/gpaccess.org.au>.

Please contact [INSERT DETAILS OF CLINIC CONTACT] if you have any queries about this letter.

Yours sincerely,

Head of Clinic
Dear Dr Jones,

Re: Referral to the gastroenterology clinic for
Mr Paul Patient (DOB 16/4/1956)
UR 000000
Date of referral: 12/7/2013

The above referral has not been accepted because it requests an assessment for [INSERT NAME OF PROCEDURE]. This procedure is on the list of aesthetic procedures that are not provided in Victorian public hospitals without a specified medical indication being present.


If you believe your patient has the medical indications that allow this procedure to be performed in a public hospital, please send us a new referral containing relevant clinical details. Guidelines for referral are available on our website at <www.vbh/specialistclinics/gpaccess.org.au>.

Please contact [INSERT DETAILS OF CLINIC CONTACT] if you have any queries about this letter.

Yours sincerely,

Head of Clinic
Request to reconsider referral

Dear Dr Jones,

Re: Referral to the gastroenterology clinic for
Mr Paul Patient (DOB 16/4/1956)
UR 000000
Date of referral: 12/7/2013

Due to a high level of community demand, there are currently long waits for routine appointments in the gastroenterology clinic.

Your referral has not yet been accepted, and we request that you consider referring your patient to an alternative healthcare provider. Alternatives may include:

- referral to a specialist outpatient clinic at another public hospital, such as a hospital closer to the patient’s place of residence if applicable
- referral to a specialist in private practice.

If you believe there are no acceptable alternatives or there is a specific reason why this patient would be more appropriately treated at Victoria’s Best Hospital, please contact [INSERT DETAILS OF CLINIC CONTACT] to discuss the referral. This referral will be closed if we do not hear from you within 30 days.

We are working to reduce our waiting times and ensure all patients are assessed by a specialist in a reasonable timeframe.

Yours sincerely,

Head of Clinic

* To be used where there are excessive waiting lists such that the clinic cannot provide an appointment in a clinically appropriate timeframe and where there may be appropriate services closer to the patient’s home. Refer to section 6.3 (Referrals requiring further information or reconsideration) of the access policy. Approval from the head of clinic and the health service executive responsible for specialist clinics should be obtained before this letter template is used.
Dear Mr Patient,

Re: Referral to the gastroenterology clinic
Referring doctor: Dr J Jones
Patient UR Number: 000000

We recently received a referral letter from Dr Jones requesting an appointment for you to attend the gastroenterology clinic.

Unfortunately Victoria’s Best Hospital was unable to accept this referral because [INSERT REASON BELOW]

we need to obtain more information from Dr Jones before we can process the referral. Please contact Dr Jones if you wish to be re-referred to the gastroenterology clinic.

OR

the service requested is not available at Victoria’s Best Hospital at this time. We have notified Dr Jones that we are unable to accept the referral.

OR

there is currently a long waiting list for routine appointments the gastroenterology clinic. We have asked Dr Jones to consider alternative referral options. Please contact Dr Jones if you wish to discuss your referral.

Please contact us on (03) 0000 0000 between [INSERT TIMES/DAYS] if you have any queries about this letter.

If your condition changes, we recommend you contact your general practitioner (GP) or, in an emergency, attend the nearest hospital emergency department.

Yours sincerely,

Manager, Specialist Clinics

# To be used where the referrer has been advised of the need for more information (see letter templates 2a and 2b) and has not responded within 30 days.

## To be used where the referrer has been advised of an unavailable service (see letter templates 3a and 3b).

### To be used where there has been a request to reconsider the referral (see letter template 4) and the referrer has not contacted the clinic within 30 days.
6: Patient advice regarding placement on waiting list

Gastroenterology Clinic
Victoria's Best Hospital

Phone: (03) 0000 0000
Email: vbh@specialistclinics.org.au
Website: www.vbh/specialistclinics.org.au

16 July 2013

Mr P Patient
00 Smith Street
Suburb 0000

Dear Mr Patient,

Re: Referral to the gastroenterology clinic
Referring doctor: Dr J Jones
Patient UR Number: 000000

We recently received a referral letter from Dr Jones requesting an appointment for you at the gastroenterology clinic.

All referrals we receive are read by a specialist to identify people who need an urgent appointment.

Your referral has not been assessed as urgent and we have placed you on the gastroenterology clinic waiting list. The current waiting time for non-urgent appointments in this clinic is approximately [INSERT WAITING TIME ESTIMATE OR RANGE e.g. 3–6 MONTHS].

We will contact you when an appointment becomes available to arrange a suitable time and provide other information you will need for your visit.

If your condition changes, we recommend you contact your general practitioner (GP) or, in an emergency, attend the nearest hospital emergency department.

Please contact us on (03) 0000 0000 between [INSERT TIMES/DAYS] if:

- you change your name, address or phone number, or
- you no longer need an appointment.

Yours sincerely,

Manager, Specialist Clinics
7: Patient notification of appointment (from referral)

Gastroenterology Clinic
Victoria’s Best Hospital

Phone: (03) 0000 0000
Email: vbh@specialistclinics.org.au
Website: www.vbh/specialistclinics.org.au

16 July 2013

Mr P Patient
00 Smith Street
Suburb 0000

Dear Mr Patient,

Re: Referral to the gastroenterology clinic
Referring doctor: Dr J Jones
Patient UR Number: 000000

We recently received a referral letter from Dr Jones requesting an appointment for you at the gastroenterology clinic. We have made the following appointment for you:

When: 10 am Wednesday 1 August 2013
Where: Gastroenterology Clinic
Ground Floor
Health Building
Victoria’s Best Hospital

A map and directions are available on our website or can be sent to you.

We hope you understand that sometimes the specialist needs to respond to urgent situations, which could mean that your appointment is delayed. Please allow [INSERT TIME] hours for your appointment.

Please contact us on (03) 0000 0000 between [INSERT TIMES/DAYS] if:

- you need further information, a map or directions to the clinic
- you change your name, address or phone number
- you no longer need an appointment, or
- you are unable to keep your appointment and need to reschedule it.

Appointments in this clinic are in high demand. Patients who miss two appointments without contacting us may need a new referral before another appointment is offered.

Further information about specialist clinic services and what to expect when you arrive is available on our website at <www.vbh/specialistclinics.org.au> or can be sent to you on request.

Yours sincerely,

Manager, Specialist Clinics
8: Patient notification of appointment reschedule

Gastroenterology Clinic
Victoria’s Best Hospital
Phone: (03) 0000 0000
Email: vbh@specialistclinics.org.au
Website: www.vbh/specialistclinics.org.au

16 July 2013

Mr P Patient
00 Smith Street
Suburb 0000

Dear Mr Patient,

Re: Referral to the gastroenterology clinic
Referring doctor: Dr J Jones
Patient UR Number: 000000

In response to your request, your appointment at the gastroenterology clinic has been changed. Your new appointment details are:

**When:**
10 am Wednesday 1 August 2013

**Where:**
Gastroenterology Clinic
Ground Floor
Health Building
Victoria’s Best Hospital
A map and directions are available on our website or can be sent to you.

**What to bring:**
1. This letter
2. Medicare/DVA card
3. Test results (for example, blood tests, X-rays, scans)
4. Medication list or medications
5. A copy of the clinic map

OR

Due to unforeseen circumstances your appointment at the gastroenterology clinic on [INSERT DETAILS] has been cancelled. Please accept our apologies for any inconvenience this may cause. A new appointment has been made:

**When:**
10 am Wednesday 1 August 2013

**Where:**
Gastroenterology Clinic
Ground Floor
Health Building
Victoria’s Best Hospital
A map and directions are available on our website or can be sent to you.

**What to bring:**
1. This letter
2. Medicare/DVA card
3. Test results (for example, blood tests, X-rays, scans)
4. Medication list or medications
5. A copy of the clinic map
We hope you understand that sometimes the specialist needs to respond to urgent situations, which could mean that your appointment is delayed. Please allow [INSERT TIME] hours for your appointment.

Please contact us on (03) 0000 0000 between [INSERT TIMES/DAYS] if:

- you need further information, a map or directions to the clinic
- you change your name, address or phone number
- you no longer need an appointment, or
- you are unable to keep your appointment and need to reschedule it.

*Appointments in this clinic are in high demand. Patients who miss two appointments without contacting us may need a new referral before another appointment is offered.*

Further information about specialist clinic services and what to expect when you arrive is available on our website, www.vbh/specialistclinics.org.au, or can be sent to you on request.

Yours sincerely,

Manager, Specialist Clinics
Notification of first specialist clinic appointment

Dear Dr Jones,

Re: Gastroenterology clinic appointment
Mr Paul Patient (DOB 16/4/1956)
UR 000000
Date of referral: 12/7/2013

The following appointment has been arranged for your patient:

<table>
<thead>
<tr>
<th>Clinic</th>
<th>Gastroenterology Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>Dr G Specialist</td>
</tr>
<tr>
<td>Day</td>
<td>Wednesday 1 August 2013</td>
</tr>
<tr>
<td>Time</td>
<td>10 am</td>
</tr>
<tr>
<td>Location</td>
<td>Ground Floor Health Building</td>
</tr>
<tr>
<td></td>
<td>Victoria’s Best Hospital</td>
</tr>
</tbody>
</table>

Please contact [INSERT DETAILS OF CLINIC CONTACT] if there is a clinically significant change in your patient’s condition while waiting for this appointment.

Yours sincerely,

Head of Clinic
Dear Mr Patient,

Re: Referral to the gastroenterology clinic  
Referring doctor: Dr J Jones  
Patient UR Number: 000000

Gastroenterology Clinic Waiting List Survey

We received a referral letter on 10 January 2013 from Dr Jones requesting an appointment for you to attend the gastroenterology clinic. At that time, we added your name to the gastroenterology clinic waiting list because we were unable to offer you an appointment straight away.

We would like to confirm your current details and check whether you still need an appointment with us. Please complete the details below and return it in the enclosed envelope. If you need help completing the form, please contact us on (03) 0000 0000.

Step 1: Do we have your current details?

<table>
<thead>
<tr>
<th></th>
<th>Our records</th>
<th>Your current details (if different from our records)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mobile telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Work telephone</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Email</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP name</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP address</td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP phone number</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Step 2: Do you still need an appointment in the gastroenterology clinic?

*Please tick the correct box.*

<table>
<thead>
<tr>
<th>YES</th>
<th>NO</th>
<th>NO</th>
<th>NO</th>
<th>NO</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I have been seen in another public hospital clinic</td>
<td>I have been seen by a private specialist</td>
<td>My health condition has improved and I no longer need to see a specialist</td>
<td>I am on the clinic waiting list at another public hospital</td>
<td>I am waiting to see a private specialist</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>For another reason (please specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

_If we do not receive your reply by [INSERT DATE] and we are unable to contact you by telephone, your name may be removed from the gastroenterology clinic waiting list._

We recommend you contact your general practitioner (GP) if your condition changes or, in an emergency, attend the nearest hospital emergency department.

More information about the specialist clinics can be found on Victoria’s Best Hospital’s website at <www.vbh/specialistclinics.org.au>.

Thank you for taking the time to help us keep our records up to date.

Yours sincerely,

Manager, Specialist Clinics
11: Waiting list validation phone script

Gastroenterology Clinic
Victoria’s Best Hospital

Phone: (03) 0000 0000
Fax: (03) 0000 0000
Email: vbh@specialistclinics.org.au
Website: www.vbh/specialistclinics.org.au

Good morning/afternoon/evening.

May I please speak with Mr P Patient please?

My name is [insert name] and I work for Victoria’s Best Hospital in the specialist outpatient clinics.

*If language is an issue, advise that you will call back using the telephone interpreter service. It is advisable not to use a family member to act as the interpreter.*

*[IF PATIENT IS UNAVAILABLE]*

Do not give specific details (e.g. name of the clinic or the reason for the referral to anyone other than the patient) except where the patient has asked you directly to talk to their carer or family member.

Could you please ask Mr Patient to contact [insert name/details] at Victoria's Best Hospital. I'm ringing to check our patient records. Mr Patient can call back between [insert times/days] on (03) 0000 0000.

*OR*

Could you please let me know when the best time to speak with Mr Patient is and I will call back then. I’m ringing to check our patient records.

*[WHEN PATIENT IS ON THE LINE]*

I am calling you about your referral to [insert name/a specialist] at the Victoria’s Best Hospital Gastroenterology Clinic.

*[PROMPT IF NECESSARY]*

We received a referral letter on 12 July 2013 from Dr Jones requesting an appointment for you in the gastroenterology clinic.

At the time we received the referral we added your name to the gastroenterology clinic waiting list because we couldn’t make an appointment for you straight away. I am calling to make sure the information we have for you is [still] correct.

Can I start by confirming your current details?

<table>
<thead>
<tr>
<th>Could you please tell me your address?</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>What is your home telephone number?</td>
<td></td>
</tr>
<tr>
<td>What is your mobile telephone number?</td>
<td></td>
</tr>
<tr>
<td>Can we contact you by email?</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Answer</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Is [insert name] your current GP?</td>
<td></td>
</tr>
<tr>
<td><strong>If NO</strong></td>
<td></td>
</tr>
<tr>
<td>Who is your current GP/local doctor?</td>
<td></td>
</tr>
<tr>
<td>What is their address and phone number?</td>
<td></td>
</tr>
<tr>
<td>Do you still need an appointment to see [insert name/a specialist] in the gastroenterology clinic?</td>
<td></td>
</tr>
<tr>
<td><strong>[IF YES]</strong></td>
<td></td>
</tr>
<tr>
<td>I would like to reassure you that you are on the waiting list for an appointment.</td>
<td></td>
</tr>
<tr>
<td>The clinic is very busy but as soon as an appointment becomes available we will write to you and ask you to contact us to arrange a suitable time.</td>
<td></td>
</tr>
<tr>
<td>If your health problem changes in the meantime, we would ask you to visit your GP who can send us an updated referral.</td>
<td></td>
</tr>
<tr>
<td>Thank you for your time to help us keep your details up to date.</td>
<td></td>
</tr>
<tr>
<td><strong>[IF NO]</strong></td>
<td></td>
</tr>
<tr>
<td>Can you tell us the reason you don’t need an appointment anymore?</td>
<td></td>
</tr>
<tr>
<td><strong>[PROMPT IF NECESSARY]</strong></td>
<td></td>
</tr>
<tr>
<td>Has your health problem improved/recovered?</td>
<td></td>
</tr>
<tr>
<td><strong>If NO</strong> Have you already been seen by a gastroenterologist?</td>
<td></td>
</tr>
<tr>
<td><strong>If YES</strong> Was your appointment in another public hospital?</td>
<td></td>
</tr>
<tr>
<td><strong>If NO</strong> Did you see the gastroenterologist in his/her private rooms?</td>
<td></td>
</tr>
<tr>
<td><strong>If NO</strong> Are you on the waiting list for the gastroenterology clinic at another public hospital?</td>
<td></td>
</tr>
<tr>
<td><strong>If NO</strong> Are you waiting to see a private gastroenterologist?</td>
<td></td>
</tr>
<tr>
<td>Is there another reason that I haven’t mentioned?</td>
<td></td>
</tr>
<tr>
<td>Do you have any questions about our booking process or is there any other information I can help you with?</td>
<td></td>
</tr>
<tr>
<td>Thank you for your time to help us keep your details up to date.</td>
<td></td>
</tr>
<tr>
<td><strong>[IF PATIENT REPORTS THAT THEY NEED AN URGENT APPOINTMENT OR NEED TO DISCUSS THEIR HEALTH PROBLEM]</strong></td>
<td></td>
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<tr>
<td>I am not able to talk to you in detail about your health problem or the urgency of your referral. If your condition is urgent please visit your GP, who can send us an updated referral.</td>
<td></td>
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<tr>
<td>Thank you for your time to help us keep your details up to date.</td>
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</tbody>
</table>
16 July 2013

Mr P Patient
00 Smith Street
Suburb 0000

Dear Mr Patient,

Re: Removal from the gastroenterology clinic waiting list
Referring doctor: Dr J Jones
Patient UR Number: 000000

We received a referral letter on 10 January 2013 from Dr Jones requesting an appointment for you to attend the gastroenterology clinic at Victoria’s Best Hospital.

[INSERT AS APPROPRIATE]

It has not been possible to contact you by telephone or mail to confirm that you still require an appointment. Therefore your name has been removed from the gastroenterology clinic waiting list.

Please obtain a new referral from your general practitioner (GP) or another doctor if you still need an appointment in the gastroenterology clinic.

You recently let us know that you no longer require an appointment. We wish to advise you that your name has now been removed from the gastroenterology clinic waiting list.

If you have any further queries about the specialist clinics waiting list or booking procedures, please contact us on (03) 0000 0000 between [INSERT TIMES/DAYS].

Yours sincerely,

Manager, Specialist Clinics
Dear Dr Jones,

Re: Removal from the gastroenterology clinic waiting list
Mr Paul Patient (DOB 16/4/1956)
UR 000000
Date of referral: 10/1/2013

It has not been possible to contact your patient by telephone or mail to confirm that an appointment is still required.

Your patient has been removed from the waiting list.

Please contact [INSERT DETAILS OF CLINIC CONTACT] if you have updated contact details for this patient and are aware that the patient still requires an appointment with us.

We wish to advise that your patient has been removed from the gastroenterology clinic waiting list at their request.

Please contact [INSERT DETAILS OF CLINIC CONTACT] if you have any queries about this letter.
Our records indicate that your patient has failed to attend two appointments at the gastroenterology clinic.

In accordance with hospital policy, your patient has been discharged from the clinic.

We have written to your patient advising them to request a new referral if they need to see a specialist.

Please contact [INSERT DETAILS OF CLINIC CONTACT] if you have any queries about this letter.

Yours sincerely,

Head of Clinic
Dear Mr Patient,

Re: Gastroenterology clinic appointment available
Referring doctor: Dr J Jones
Patient UR Number: 000000

We received a referral letter on 10 January 2013 from Dr Jones requesting an appointment for you to attend the gastroenterology clinic. At that time, we added your name to the waiting list because we were unable to offer you an appointment straight away.

An appointment has now become available. If you still need an appointment in the gastroenterology clinic, please call (03) 0000 0000 between [INSERT TIMES/DAYS] to arrange a suitable time.

If you no longer need an appointment please let us know so we can remove your name from the waiting list.

More information about specialist clinics can be found on Victoria's Best Hospital's website at <www.vbh/specialistclinics.org.au>.

Yours sincerely,

Manager, Specialist Clinics
Dear Mr Patient,

Re: Gastroenterology clinic appointment available
Referring doctor: Dr J Jones
Patient UR Number: 000000

Reminder

We received a referral letter on 10 January 2013 from Dr Jones requesting an appointment for you to attend the gastroenterology clinic.

An appointment has now become available and we recently sent you a letter asking you to contact the specialist clinics to arrange a suitable time. This is a reminder to call us immediately on (03) 0000 0000 if you still need an appointment.

If you no longer need an appointment please let us know so we can remove your name from the waiting list. If we do not hear from you within two weeks your name will be removed from the gastroenterology clinic waiting list.

Yours sincerely,

Manager, Specialist Clinics
Dear Mr Patient,

Re: Gastroenterology clinic appointment  
Referring doctor: Dr J Jones  
Patient UR Number: 000000

Thank you for contacting the gastroenterology clinic to arrange an appointment. Your appointment details are:

**When:**  
10 am Wednesday 1 August 2013

**Where:**  
Gastroenterology Clinic  
Ground Floor  
Health Building  
Victoria’s Best Hospital  
A map and directions are available on our website or can be sent to you.

**What to bring:**
1. This letter  
2. Medicare/DVA card  
3. Test results (for example, blood tests, X-rays, scans)  
4. Medication list or medications  
5. A copy of the clinic map

We hope you understand that sometimes the specialist needs to respond to urgent situations, which could mean that your appointment is delayed. Please allow [INSERT TIME] hours for your appointment.

Further information about specialist clinic services and what to expect when you arrive is available on our website at <www.vbh/specialistclinics.org.au> or can be sent to you on request.

Please contact us on (03) 0000 0000 between [INSERT TIMES/DAYS] if:
- you need more information, a map or directions to the clinic
- you change your name, address or phone number
- you no longer need an appointment, or
- you are unable to keep your appointment and need to reschedule it.

Appointments in this clinic are in high demand. Patients who miss two appointments without contacting us may need a new referral before another appointment is offered.

Yours sincerely,

Manager, Specialist Clinics
16 July 2013

Mr P Patient
00 Smith Street
Suburb 0000

Dear Mr Patient,

Re: Removal from the gastroenterology clinic waiting list
Referring doctor: Dr J Jones
Patient UR Number: 000000

We received a referral letter on 10 January 2013 from Dr Jones requesting an appointment for you to attend the gastroenterology clinic at Victoria's Best Hospital. At that time we added your name to the waiting list because we were unable to offer you an appointment straight away.

We recently wrote to you to advise you that an appointment has now become available.

As we have not heard from you, we believe that you no longer require an appointment. Your name has been removed from the gastroenterology clinic waiting list.

If you wish to attend the clinic in the future, you will need a new referral from your general practitioner (GP) or another doctor.

Please contact us on (03) 0000 0000 between INSERT TIMES/DAYS] if you have any queries about this letter.

Yours sincerely,

Manager, Specialist Clinics
18: Referrer advice of patient removal from the waiting list (after offer letter)

Gastroenterology Clinic
Victoria’s Best Hospital

Phone: (03) 0000 0000 (GP priority line)
Fax: (03) 0000 0000
Email: vbh@specialistclinics.org.au
Website: www.vbh/specialistclinics/gpaccess.org.au

16 July 2013

Dr J Jones
00 Smith Street
Suburb 0000

Removal of patient from specialist clinic waiting list

Dear Dr Jones,

Re: Removal from the gastroenterology clinic waiting list
Mr Paul Patient (DOB 16/4/1956)
UR 000000
Date of referral: 10/1/2013

It is our usual process to write to wait-listed patients approximately six weeks before an appointment is available, and invite them to contact us to arrange a suitable appointment time.

We recently invited your patient to contact us to arrange an appointment. The patient has not contacted the clinic and has been removed from the waiting list.

Please contact [INSERT DETAILS OF CLINIC CONTACT] if you have updated contact details for this patient and are aware that they still require an appointment with us.

Yours sincerely,

Head of Clinic
Dear Mr Patient,

Re: Gastroenterology clinic missed appointment  
Referring doctor: Dr J Jones  
Patient UR Number: 000000

Our records indicate that you missed your appointment at the gastroenterology clinic on Tuesday 13 August.

It is important that your health condition is reviewed by a specialist. We have scheduled a new appointment as follows:

**When:**  
10 am Wednesday 5 September 2013

**Where:**  
Gastroenterology Clinic  
Ground Floor  
Health Building  
Victoria’s Best Hospital

A map and directions are available on our website or can be sent to you.

What to bring:
1. This letter  
2. Medicare/DVA card  
3. Test results (for example, blood tests, X-rays, scans)  
4. Medication list or medications  
5. A copy of the clinic map

Please contact us on (03) 0000 0000 between [INSERT TIMES/DAYS] if:

- you need to reschedule this appointment  
- you need information, a map or directions to the clinic  
- you change your name, address or phone number, or  
- you no longer need an appointment.

Appointments in this clinic are in high demand. Patients who miss two appointments without contacting us may need a new referral before another appointment is offered.
If you still need to see a specialist, please call (03) 0000 0000 between [INSERT TIMES/DAYS] to make another appointment.

*Appointments in this clinic are in high demand. Patients who miss two appointments without contacting us may need a new referral before another appointment is offered.*

If you have not responded to this letter within 30 days, you will be discharged from the gastroenterology clinic.

Yours sincerely,

Manager, Specialist Clinics
20: Patient failure to attend – removal from waiting list or clinic list

Gastroenterology Clinic
Victoria’s Best Hospital

Phone: (03) 0000 0000
Email: vbh@specialistclinics.org.au
Website: www.vbh/specialistclinics.org.au

21 August 2013

Mr P Patient
00 Smith Street
Suburb 0000

Dear Mr Patient,

Re: Gastroenterology clinic missed appointment
Referring doctor: Dr J Jones
Patient UR Number: 000000

Our records indicate that you did not attend two booked appointments at the gastroenterology clinic.

As we advised you in our appointment letter, patients who miss two appointments without contacting us will need a new referral before another appointment is offered.

In accordance with this policy we have [INSERT AS APPROPRIATE] removed you from the clinic waiting list.

OR

...discharged you from the clinic.

If you still wish to be seen in the clinic, please obtain a new referral from your general practitioner (GP) or another doctor.

A copy of Victoria’s Best Hospital’s Failure to attend policy can be found on our website at <www.vbh/specialistclinics.org.au> or sent to you on request.

If you have any queries about the specialist clinics booking procedures, please contact us on (03) 0000 0000 between [INSERT TIMES/DAYS].

Yours sincerely,

Manager, Specialist Clinics
Dear Mr Patient,

Re: Gastroenterology clinic appointment
Referring doctor: Dr J Jones
Patient UR Number: 000000

This letter confirms your review appointment:

**When:**
10 am Wednesday 1 August 2013

**Where:**
Gastroenterology Clinic
Ground Floor
Health Building
Victoria’s Best Hospital

A map and directions are available on our website or can be sent to you.

We hope you understand that sometimes the specialist needs to respond to urgent situations, which could mean that your appointment is delayed. Please allow [INSERT TIME] for your appointment.

Further information about specialist clinic services and what to expect when you arrive is available on our website at <www.vbh/specialistclinics.org.au> or can be sent to you on request.

Please contact us on (03) 0000 0000 between [INSERT TIMES/DAYS] if:
- you need more information, a map or directions to the clinic
- you change your name, address or phone number
- you no longer need an appointment, or
- you are unable to keep your appointment and need to reschedule it.

Appointments in this clinic are in high demand. Patients who miss two appointments without contacting us may need a new referral before another appointment is offered.

Yours sincerely,

Manager, Specialist Clinics
References


Department of Health 2013, *Redesigning Hospital Care Program – guide to redesign measures for improvement for specialist clinics*, State Government of Victoria, Melbourne.


National Primary Care Research and Development Centre, and Centre for Public Policy and Management 2006, *Outpatient Services and Primary Care – A scoping review of research into strategies for improving outpatient effectiveness and efficiency*, prepared for the NHS Service Delivery and Organisation R&D Programme, University of Manchester, Manchester.

