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Department of **Health**

Outpatient Services Guideline

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Outpatient Services Guideline

About this Guideline

The Guideline information is accurate at the time of publication. Please check WA health resources and links for any updated processes or templates since the time of this publication.

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Disclaimer

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Using the term Aboriginal

Within Western Australia the term Aboriginal is used in preference to Aboriginal and Torres Strait Islander, in recognition that Aboriginal people are the original inhabitants of Western Australia. Aboriginal and Torres Strait Islander may be referred to in the national content and Indigenous may be referred to in the international context. No disrespect is intended to our Torres Strait Islander colleagues and community.

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1. Introduction

This guideline is to ensure high standards of patient care are consistent across WA health entities. By following the recommendations and framework provided in the guideline, public outpatient services can ensure patients receive timely and appropriate care, reduce the risk of complications, and enhance overall patient satisfaction and outcomes. This guideline is a valuable resource for healthcare providers, administrators, and patients to assist in navigating the complexities of outpatient services.

This guideline is non-mandatory, offering flexibility for health entities to develop policies and procedures to implement the recommendations locally.

1.1 Purpose of this guideline

The purpose of the Outpatient Services Guideline (the guideline) is to provide WA health entities and contracted health entities with additional information to support the implementation of MP 0191/25 *Outpatient Services Policy* (the policy). For ease of use, requirements within the policy may be repeated in the appropriate section. The only statements within the guideline that have the term 'must' or 'shall' are the requirements within the policy.

The guideline is intended to complement, not replace, clinical judgement and an individual's professional integrity and accountability, which are essential attributes to delivering high quality healthcare.

2. Management of referrals

2.1 Referral requirements

Referrals are considered a form of clinical handover. Ensuring the referral contains sufficient information assists in providing seamless patient care and optimal clinical outcomes.

2.1.1 Minimum requirements

Referrals must meet the minimum requirements, listed in Table 1: WA public outpatient referral minimum requirements, to ensure receiving clinicians have all the essential and necessary information to make informed decisions and provide timely, effective care.

Table 1: WA public outpatient referral minimum requirements

Description	Details
Patient demographic information	• Full name • Date of birth • Residential address including postcode • Telephone number(s) (mobile preferred) • Preferred method of communication (e.g. post, SMS, or phone call) • Sex recorded at birth • Gender • Marital status • Aboriginal status • Australian state or country of birth • Resident status

Description	Details
	• Medicare number, individual reference number and expiry date (if eligible) • Name of next of kin/carer/guardian along with contact details and relationship type • Interpreter requirements (if relevant)
Referring practitioner demographic information	• Full name • Practice name and address • Contact details, including telephone number(s) and fax number • Medicare provider number
Required referral information	• Date of referral • Evidence the patient has agreed to the referral and the sharing of their personal and health information to WA health • Urgency of the referral (immediate, urgent, or non-urgent)
Minimum clinical information	• Reason for referral to the outpatient service including the problem to be addressed and details of any associated medical conditions which may affect the presenting condition, or its treatment • Presenting symptoms including duration and evolution • Any relevant physical findings • Past medical history including, details of current and previous treatment, investigations including radiology, pathology, and other relevant results • Details of any current medications and dosage • Details of any known allergies and adverse reactions • Any mandatory information as detailed in the Referral Access Criteria (RAC) (where RAC apply)

2.1.2 Highly desirable requirements

Highly desirable requirements, listed in Table 2: WA public outpatient highly desirable referral requirements are additional information that, while not essential, significantly enhance the quality and usefulness of the referral. Any additional information included in referrals can assist in providing high-quality and timely public outpatient services.

Table 2: WA public outpatient highly desirable referral requirements

Description	Details
Patient information	• Patient's email address • Patient's postal address (if different to residential address) • Patient's pronouns • Hospital Unit Medical Record Number (UMRN) • Patient's financial classification or claim type • Patient's preferred modality of consultation (e.g. via virtual appointment or face-to-face) ○ If virtually, then the patient's virtual appointment capability (i.e. phone or video call enabled) and support

Description	Details
	requirements (e.g. appointment attendance through local clinic). ○ If the patient would benefit from a virtual consult (e.g. due to availability of captions, distance constraints, time constraints, cost constraints, mobility constraints) • The patient's usual general practitioner (GP) and practice name (if not the referrer)
Referring practitioner information	• The general practice's Electronic Data Interchange (EDI) code for secure electronic transmission
Referral information	• The name of the specialty to which the patient is being referred
Highly desirable clinical information	• Patient's height, weight, or BMI (or percentile if referring infant/child with weight gain/loss issues) • Any special care requirements or reasonable adjustments for disability • Patient's smoking/vaping status • Any highly desirable information as detailed in the RAC (if relevant)

2.1.3 Compliance with referral requirements

WA health entities should work in partnership with referrers to promote compliance with the policy's referral requirements so that all patients receive fair and equitable treatment. This may include:

- inform referring practitioners of the expected minimum referral requirements, including use of relevant templates
- encourage referring practitioners to meet referral requirements through regular written and verbal feedback processes
- promote the use of primary care information directories such as WA Primary Health Alliance (WAPHA) developed clinical support tools, to enhance referring practitioners' awareness of referral requirements
- identify inadequate or incomplete referrals and, where necessary, returning them to the referrer to supply more information prior to progressing the referral
- provide guidelines relating to investigations pertinent to the patient's condition prior to an outpatient appointment (e.g. RAC)
- encourage referrers to consult with outpatient services or the allocated provider if there is deterioration in the patient's condition which would warrant a change in the clinical urgency category or priority of a referral

In the event an outpatient service requires additional patient information to facilitate an informed assignment of clinical urgency, the outpatient service may directly contact the referrer. If the additional patient information identifies the treatment required is not offered by the service, then the outpatient service should organise appropriate reallocation of the referral to a provider that does offer the service, see 2.3.3 Reassignment .

2.1.4 Referral Access Criteria (RAC)

Where established, RAC are mandatory state-wide criteria that apply to all referrals to WA public medical-led outpatient services. RAC outline clinical criteria that identify what conditions and presentations are appropriate to refer for assessment and treatment in public medical-led outpatient services; and what mandatory information the referral must contain to be accepted.

RAC have been established for selected conditions and specialties. Where information is identified to be mandatory, referrals must contain the specified mandatory referral criteria. If there is missing mandatory information an explanation must be included in the body of the referral to facilitate acceptance into the WA health system. If a referral is missing mandatory information without an explanation, then the referral may not be accepted, and the referring practitioner must be notified.

Any other local hospital criteria should only be applied once the patient is accepted onto a waitlist. The relevant provider is therefore responsible for organising and collecting this additional clinical information with the referrer or patient directly, whichever is most appropriate.

2.2 Referral acceptance

WA health entities can exercise discretion in accepting a referral without all required referral information. The decision to not accept a referral is determined by clinical judgment and reason. The reason for not accepting a referral should be advised to the referrer.

For immediate referrals, the WA health entity should accept this referral and allocate it to the relevant provider even if some of the WA public outpatient referral minimum requirements are missing.

If RAC exist for the condition the referring practitioner is seeking an outpatient review and management for, any mandatory requirements as part of the RAC must be included in the referral. Where this is not possible, if clear written justification is included in the referral, the WA health entity can continue to allocate the referral to the appropriate provider.

2.2.1 Declined referrals

Referrals may be declined in the following circumstances:

- the patient does not meet the eligibility requirements outlined in the policy
- the referral does not meet the WA public outpatient referral minimum requirements outlined in the policy
- the referral is illegible
- the referral is a duplicate (see 2.4.7 Duplicate referrals)
- an external referral is older than 3 months at the time of receipt
- an internal referral is older than 4 weeks at the time of receipt.

In the instance a referral is declined the receiving provider should notify the referring practitioner, in writing, of the reason including any additional information required and options for alternate referral or care management. If the referral was initially processed and allocated to a hospital site by the Central Referral Service (CRS), the provider should advise the CRS the referral has been declined as part of the referral close-out process.

2.3 Referral processing and allocation

2.3.1 The Central Referral Service

The CRS is responsible for the receipt, processing, and allocation of outpatient referrals that are in-scope for initial public medical-led outpatient appointments and services. A full list of the specialties, services, referrers, and referral types in-scope for the CRS are available at the Department of Health: CRS website.

Immediate referrals and internal referrals are currently out of scope for the CRS. Out of scope referrals incorrectly received may be returned to the referrer for re-submission via the correct pathway.

Referrals processed by the CRS should follow these timeframes:

- Referrals received by the CRS are:
    - Opened, reviewed, and assigned a priority within 1 working day of receipt
- Referrals are then allocated to a provider:
    - Priority referrals within 1 working day of receipt
    - Non-priority referrals within 3 working days of receipt

The CRS allocates referrals to a provider based on:

- postcode of the patient's residence (geographical catchment area)
- postcode of the referring practitioner's address if the patient is of no fixed address
- patient acuity and level of care required (e.g. requirement for tertiary, specialist, or general hospital level care)
- specialty service availability (i.e. service capability information)
- patient ease of access (e.g. patient residing with family at another address, patient already attending other clinics or specialties at a particular hospital)
- referral guidelines for patients under the care of corrective services and child protection agencies.

The Department of Health guides geographical catchment areas, which vary depending on the specialty and level of service being requested. A patient's prior history with a provider or specialist should also be considered as part of referral allocation.

Referral allocation by the CRS is dependent on the services available at each provider which is known as service capability information. Providers can make updates to the service capability information database by following the CRS Service Capability Database Business Rules (available upon request via email) and submitting a request to the CRS.

2.3.2 Health Service Providers (HSPs)

Referrals listed as out of scope for the CRS are sent, by referrers, direct to the service providing the appropriate level of care within the HSP catchment area, closest to the patient's home. For referrals sent direct to a service, HSPs should verify that the patient has been allocated to the appropriate provider for their level of care and within the HSP catchment area.

Referrals processed by the HSPs should follow these timeframes:

- For urgent referrals, the receiving HSP should either accept, reassign, or decline the referral within 1 working day of receipt
- For non-urgent referrals, the receiving HSP should either accept, reassign, or decline the referral within 5 working days of receipt

Once a referral has been processed, allocated, and accepted, the triaging clinician should categorise all referrals to a clinical urgency category:

- Category 1 (urgent) – appointment required within 30 calendar days
- Category 2 (semi-urgent) – appointment required within 90 calendar days
- Category 3 (non-urgent) – appointment required within 365 calendar days

Electronic referrals (eReferrals) should be used by HSPs whenever possible. All referrals received, regardless of the outcome, should be registered on the HSP's outpatient referrals register, or system, to monitor and support the management of referrals.

The receiving HSP is responsible for notifying the referrer in writing if a referral has been received incorrectly. For instance, if a provider has received a referral that should have been sent to the CRS as per the Department of Health: CRS website or to a different provider, the provider should have a process in place to return the referral to the referrer and notify them to re-submit the referral to the CRS or to the correct provider.

2.3.3 Reassignment of referrals

Referrals may need to be reassigned to another outpatient service within the same hospital or to an outpatient service within a different hospital prior to the patient's first appointment, to ensure appropriate treatment is received. For patients who are reassigned between providers the following applies:

- If the allocated provider determines that treatment would be more appropriate by a different provider and:
    - the referral was processed by the CRS, the referral should be reassigned back to CRS for reallocation
    - the referral was not processed by the CRS, the referral should be managed between the sending and receiving providers
- For all other circumstances, the referral should be managed between the sending and receiving providers.

2.4 Referral sources and types

Public outpatient services are accessed through lodgement of a referral. The preferred method is by using a WA Health referral form template.

Patients may be referred to outpatient services through the following sources:

- General practitioner (GP)
- Healthcare provider within the hospital (e.g. Emergency Department, other outpatient services)
- Medical specialist's private rooms
- Healthcare providers in other hospitals

- Other healthcare providers from the community where appropriate (e.g. optometrists, dental practitioners, midwives, audiologists, Aged Care Assessment Teams (ACATs), nurse practitioners)
- Individual self-referral by the patient or referral by a carer or family member. This may occur in very limited circumstances. It is expected that referrals are generated by healthcare providers.

2.4.1 External referrals

An external referral is a referral generated from outside the WA health system to refer a patient to an outpatient service. This includes referrals from sources such as a GP, private specialist, community allied health practitioner or nurse. Refer to the Department of Health: CRS website for a full list of in-scope and out of scope referral sources. In-scope referrals should be sent to the CRS and should not be older than 3 months at the time of receipt. Out of scope referrals should be sent direct to the relevant provider in line with care closer to home principles.

2.4.2 Internal referrals

An internal referral is a referral generated from within the WA health system to refer a patient to an outpatient service, either within the same facility, or to a different facility. This includes referrals from other outpatient services, emergency departments and inpatient admissions.

Outpatient services should be based on clinical necessity, with no priority given to internal referrals over the waitlists. To ensure equitable access and meet clinical prioritisation and clinical triage requirements, internal referrals should not be older than 4 weeks at the time of receipt, and the WA public outpatient referral minimum requirements apply to referrals from internal sources.

Internal referrals should only be generated for:

- patients who require high priority access to services
- requests for associated care
- clinical review following an inpatient episode of care.

If the criteria are not met, the patient should not have an internal referral generated and instead, upon discharge, the treating clinician should advise the patient to return to their GP for appropriate care and referral, if required. The treating clinician should include this instruction within the discharge summary.

2.4.3 Associated care referrals

An associated care referral is a type of internal referral requesting support from another outpatient service, specialty, or sub-specialty relating to the patient's existing reason for referral and pathway of care. These include:

- requests for assessment, diagnostic tests, or investigation from another provider to support diagnosis and/or treatment planning
- referrals to another provider for preoperative review or clearance before surgery.

Associated care referrals are exempt from the high priority requirement applied to other internal referrals and are not considered to be a duplicate referral.

If the rationale for the referral is not related to the patient's existing reason for referral, then this is not classified as associated care and the patient should be advised by the treating clinician to return to their GP for appropriate care and management.

2.4.4 Immediate referrals

Immediate referrals are for patients requiring assessment within 7 days and rapid access to outpatient services. They are differentiated from emergency and urgent referrals.

Before an immediate referral is sent, the referring practitioner is required to initiate phone contact with the relevant consultant or on-call registrar to discuss and provide a verbal clinical handover. The referring practitioner clearly indicates 'immediate' on the referral and includes the name, position/role and site of the clinician they spoke with as well as any agreed clinical plan within the referral. The referral should also include the minimum referral requirements.

Immediate referrals are sent direct to the relevant provider by the referring practitioner and bypasses processing by the CRS. RAC should not be applied to immediate referrals as the receiving clinician is responsible for requesting the relevant clinical information from the referring practitioner during the verbal clinical handover.

2.4.5 Named referrals

A named referral is required for a Medicare-eligible patient to be treated as a private patient within WA public outpatient services. As part of this arrangement, the referral is addressed to a chosen medical specialist who holds rights to private practice. This enables salaried specialists to bill through the Medicare Benefits Schedule (MBS), provided they meet the requirements outlined in the MBS Billed Non-Admitted Services Manual.

When issuing a named referral, referring practitioners should clearly state the reason for directing the referral to a particular specialist, such as a specific skill set, a request for a second opinion, or the need for continuity of care. Holding a named referral does not grant the patient priority on the outpatient waitlist. Patients may still choose to be treated as public patients if they prefer.

A named referral is not required to access WA public outpatient services.

Referrals addressed to a chosen medical specialist for patients who do not hold private health insurance, or those courteously addressed for public outpatient services, do not qualify as named referrals.

Where a patient is seen as a private patient outside of the arrangement referenced here, then the private activity is not aligned to the requirements in supporting private activity of WA health medical staff. Referrals intended for a patient to be seen by a private specialist in a private healthcare setting must be sent direct to the private provider, not via CRS.

2.4.6 Multiple referrals

When a patient requires care from multiple disciplines for the same condition, a separate referral must be written for each service. The exception is when referring to a Multidisciplinary Team (MDT) clinic or a multidisciplinary service within the one specialty and referral, in which case, only one referral is required.

2.4.7 Duplicate referrals

A duplicate referral is where a carbon copy of an existing referral is received. That is, for the same patient, condition, specialty, and treatment from the same referring practitioner. If a further referral(s) is received for the same patient but differs in any way from the existing referral, then it is not considered to be a duplicate, but as an update or escalation to the previous referral.

Patients should only be registered at one public outpatient service for the same specialty. Acknowledging the electronic systems currently in use do not allow for cross-system checking and action, WA health entities should aim to prevent patients being listed at multiple HSPs and occupying a spot on a waitlist or appointment list unnecessarily.

Exceptions to this exist where duplicate referrals are located at two separate providers and to ensure continuity of care, these referrals should not be automatically rejected.

This includes:

- Sub-specialty and/or expertise required (associated care referral) but only offered at a different HSP
- Patients permanently relocating. This includes:
  - transitions from paediatric to adult care
  - transfer between different HSPs.

The CRS should check all referrals that are processed by the CRS for duplication to avoid sending duplicates to the provider. If duplicate referrals from the same source become common, the CRS should inform the referring practitioner(s) about the correct process. Where appropriate, duplicate referrals should be sent back to the referring practitioner.

HSPs should have processes to identify and manage duplicate referrals. Where duplicate referrals have been detected for two or more of the same outpatient services the referral relevant to the patient’s catchment area should be retained.

2.4.8 Updated referrals

An updated referral is where additional or updated information is provided for a patient who has not yet attended an initial appointment (new) and is currently on an outpatient waitlist. This is not considered to be a duplicate referral as the clinical content is not identical to the original referral. CRS and HSPs should have processes in place for managing updated referrals and ensure they are differentiated from duplicates.

3. Arranging and managing appointments

3.1 Equity of access

To create equity of access, patients are prioritised and allocated an appointment according to their clinical urgency. This can be based on:

- clinical information provided by the referring practitioner
- information within the RAC (where established)

- clinical judgment of the triaging clinician.

Developing local policies and guidelines that underpin this equity of access process will ensure that:

- clinical urgency categorisation is not influenced by current wait times or service availability
- patients have their outpatient appointment booked in order of receipt, when no clinical urgency differentiation exists.

WA health entities are responsible for ensuring that:

- regional residents are afforded equitable access to a public care pathway either via a local/regional public outpatient appointment or where this is not available, the referral must be allocated to a metropolitan HSP. Please refer to MP 0183/24 *Access to Care for Country Residents Policy.*
- people with disability, their families and carers have the same rights as others to access services, buildings and information within the community. Please refer to the local Disability Access and Inclusion Plan (DAIP).

3.2 Outpatient waitlist management

Outpatient waitlists are managed by a Responsible Officer(s). The Responsible Officer(s) can be any healthcare provider the HSP nominates at each site and is responsible for overseeing and organising the waitlist review activities conducted as part of business as usual for outpatient services. This includes managing the audits of outpatient waitlists to ensure patients are treated within clinically appropriate timeframes.

3.2.1 Waitlist registration

Once a referral has been accepted and assigned a clinical urgency category (triaged) by a triaging clinician, the patient is placed on a waitlist according to their clinical urgency. The waitlist start date is the date the referral was accepted by the HSP. For patients who are being transferred between providers, the waitlist start date is the date the original referral was accepted at the initial provider, not the date of the referral received by the new provider.

HSPs to ensure:

- receipt of all accepted referrals is recorded in the Patient Administration System (PAS)
- the CRS referral management system is updated (where applicable)
- the patient and referring practitioner are notified (via an approved secure means as per the MP 0067/17 *Information Security Policy*)

Patients remain on the waitlist when their first appointment is booked and while waiting for their initial visit. If the appointment is cancelled or rescheduled with adequate notice, they continue on the waitlist. Patients are removed from the waitlist once they have attended or did not attend (DNA) their first appointment.

After the first appointment, patients are placed on an appointment list for any follow-up appointments that are booked.

3.2.2 Waitlist auditing

HSPs should have processes in place to regularly audit waitlists to provide an accurate representation of patients waiting for outpatient appointments.

The audit process should aim to confirm:

- patient and GP or referring practitioner contact details are current
- the patient still requires an appointment
- if there is any change in condition or priority i.e. the assigned urgency category remains appropriate
- the patient is not on an outpatient waitlist for the same condition or receiving treatment at another provider (duplicate) acknowledging the current PAS and referral system capabilities within WA Health are constrained.

Other tasks that should be completed by HSPs include:

- an evaluation of the audit process
- identify and remove duplicate waitlist entries
- completion of missing details in the waitlist record
- review of cases with a previous booked appointment date who remain on the waitlist.

HSP audits may also involve contacting patients via a phone call, letter, SMS messaging or other communication methods including patient surveys.

Outpatient waitlists should be reviewed regularly to identify and prioritise unbooked patients who have exceeded, or are approaching, the clinically recommended timeframe for their urgency category. This includes at a minimum:

- A monthly audit of category 1 patients who have waited longer than 30 calendar days for an appointment and who do not have an initial appointment date.
- A quarterly audit of category 2 patients who have waited longer than 90 calendar days for an appointment and who do not have an initial appointment date.
- A 6-monthly audit of category 3 patients who have waited longer than 365 calendar days for an appointment and who do not have an initial appointment date.
- An annual audit of the complete waitlist identifying waitlist records that are incorrect.

3.3 Active life of a referral

Referrals for outpatient services remain valid for a single opinion or course of treatment for a defined period starting from the date of first attended appointment with the outpatient service.

- If referred by a clinician to another clinician within the WA health system (i.e. an internal referral), or by a private specialist, the active life of the referral is 3 months from the date of first attended appointment
- If referred by a practitioner outside the WA health system (e.g. a GP, nurse practitioner), the active life of the referral is 12 months from the date of first attended appointment, unless specified as indefinite

- Referrals for longer than 12 months should only be used where the patient's clinical condition requires continuing care and management by an outpatient service. In these cases, the period for referral must clearly be expressed as 'indefinite,' 'ongoing' or 'requiring continuing care'.

If a referral is approaching or has reached end of life (expired), treating clinicians should advise the patient that a new referral is required where ongoing treatment is indicated. This referral should be sent direct to the provider.

3.4 Booking outpatient appointments

Once an initial outpatient appointment has been booked on the service provider's PAS, the patient is notified by the provider. For immediate referrals requiring an appointment within 7 days and other bookings required within 14 days, the patient should be notified of the appointment date and time by telephone or SMS.

The appointment notification may also be viewed by patients, carers and next of kin on the Manage My Care (MMC) patient application (app) and web portal (if accessible and where a patient has downloaded and registered with the app).

3.4.1 Delivery modes

Outpatient appointments can be delivered either in-person or via virtual consultation (preferably by video or, if not possible, by phone).

Selection of the service delivery mode should be based on individual patient preference in consultation with their clinical care provider. Where clinically appropriate, virtual delivery methods are the preferred modality in ensuring an ongoing sustainable health system.

3.5 Cancellations and non-attendance

3.5.1 Did Not Attend (DNA) appointments

HSPs should establish protocols to identify and communicate with patients who miss their scheduled outpatient appointments. Following reasonable attempts to contact patients via verbal and written communication and support the patient to attend, patients should be removed from the waitlist or appointment list if they:

- decline care
- DNA a new appointment (without a valid reason)
- DNA two consecutive follow-up appointments without notice.

If a patient has provided prior notice and a valid reason for missing an appointment, they should not be automatically removed from the waitlist or appointment list.

HSPs should implement strategies to reduce DNA rates. These may include:

- inform the patient and the referring practitioner through written and verbal communication that the patient is registered on an outpatient waiting list
- Contact patients via a phone call or SMS with a reminder regarding their booked appointment, 1 to 7 calendar days prior to the appointment date
- undertake regular administrative auditing and clinical review of patients on the waitlist

- provide information about virtual care and video consult set up requirements, provide access to support for technical queries and encouraging a test call prior to the appointment
- encourage patients to download and use the MMC app and web portal. MMC provides patients visibility of their referrals and appointments, and enables attendance confirmation, and requests to reschedule or cancel (for Outpatient Direct-supported clinics), to prevent DNAs. If downloading the app or accessing the web portal is not possible, patients can be encouraged to reach out to Outpatient Direct or the provider clinic to assist in managing their appointments.

The removal from a waitlist should be clearly documented in the patient's medical record (where applicable) and the PAS.

3.5.2 Repeated reschedule appointments

A patient should be removed from the waitlist or appointment list if either of these occur without prior notice and a valid reason provided to the HSP:

- two confirmed, consecutive appointment deferrals
- patient indicates unavailability for treatment for more than 90 days

3.5.3 Management of provider-initiated cancellations

A provider-initiated cancellation is any cancellation of a patient's booked outpatient appointment for a reason that is related to the service's inability to proceed with the appointment.

When a provider-initiated cancellation occurs, the outpatient service should:

- notify the patient as soon as possible that their appointment has been cancelled
- advise the patient of the reason for cancellation and what they should do if their condition deteriorates
- provide a new booking appointment date at or as soon as possible after the time of notification
- ensure an accurate record of the provider-initiated cancellation and the reason in the PAS.

HSPs should have processes in place to manage planned leave for outpatient services' staff due to the critical impact that these staff have on the timely and quality provision of these services.

3.5.4 Management of patient-initiated cancellations

When a patient cancels an outpatient appointment for personal or clinical reasons, a patient-initiated cancellation should be recorded in the PAS and where applicable, the patient's medical record. The outpatient service should work with the patient to reschedule their appointment where required.

3.6 Timeliness of outpatient services

To ensure all patients are treated within clinically appropriate timeframes within outpatient services, HSPs should provide:

- Relevant and timely information to patients to support attendance at their outpatient appointment. At a minimum this includes the date, time, and location of their appointment, or the details of a virtual care appointment and any pre-appointment actions to be completed including information to be brought to the appointment.
- Regular communication with the referring practitioner and the usual GP if not the referring practitioner and ensure this occurs throughout the episode of care to maintain collaborative management of the patient. At a minimum this includes upon discharge.

A Responsible Officer(s) should be nominated by each HSP to undertake management of the waitlist review as part of business-as-usual outpatient activity. Over boundary cases should be tracked and promptly actioned. Auditing outpatient waitlists are essential to ensure patients are treated within clinically appropriate timeframes.

3.7 Removals

When removing any patient from the outpatient waitlist or appointment list, the HSP should exercise discretion on a case-by-case basis to avoid disadvantaging patients in the case of genuine hardship, cultural sensitivities, misunderstanding and other unavoidable circumstances.

A patient can be removed from a waitlist or appointment list if they:

- decline to receive treatment at their own choice
- DNA a new appointment or two consecutive follow-up appointments without valid reason and prior notice to the HSP
- defer two consecutive follow-up appointments without valid reason and prior notice to the HSP (repeated reschedule)
- have permanently relocated to another state or country
- are unavailable for treatment for an extended period (>90 days)
- receive treatment for the same condition at another provider (e.g. duplicate, see 2.4.7 Duplicate referrals)
- are deceased
- Cannot be contacted, provided the service has made reasonable attempts to contact the patient. This may include attempts to identify the patient’s correct contact details via the patient’s treating clinician, GP, provider medical records, the patient’s next of kin or a telephone directory search. Evidence of a reasonable effort to contact the patient must be included in the PAS at the time the patient is removed from the waitlist.

  OR
- if a clinical review or administrative audit has determined that the referred service is no longer required.

Before removing a Category 1 patient from the outpatient waitlist or appointment list, HSPs should consider the risk profile of the patient and could discuss the patient with the treating outpatient clinician or relevant Head of Department prior to removal.

Category 2 and 3 patients who meet the criteria for removal from the outpatient waitlist or appointment list may be automatically removed, with advice from the outpatient clinic to

contact their referring practitioner, GP, or the treating outpatient clinician if they wish to proceed with treatment later, or if their condition deteriorates.

All contactable patients who are removed from the outpatient waitlist or appointment list must receive written advice of their removal. The advice must clearly state:

- reason for the removal
- date of the removal
- contact person for the patient to contact if they have a query or concern.

Where practical, the provider should notify, in writing, the patient's referring practitioner, or usual GP when a patient is removed from the outpatient waitlist or appointment list and advise of the need to initiate a new referral if the patient still requires the service in the future, unless alternative re-referral is permitted by the HSP.

The removal of a patient from the outpatient waitlist or appointment list should be clearly documented in the PAS.

4. Financial classification

All eligible patients have equitable access to outpatient services. In addition, certain arrangements allow for private patients to be seen in public rooms and billed under the MBS, see MP 0191/25 *Outpatient Services Policy* section 3.4.2.

Patients referred to an outpatient service, will be assigned to a healthcare provider nominated by the HSP, except in the case where a valid named referral has been received, see 2.4.5 Named referrals. In this instance, the named referral must be directed to a salaried medical specialist who has the appropriate arrangement in place to enable them to exercise a right to private practice. See MP 0191/25 *Outpatient Services Policy* section 3.4.2.

Eligible war service veterans (Entitled Persons) can choose to be treated in a WA public health service, where funding is via an arrangement between the Department of Veterans' Affairs (DVA) and the State of Western Australia. Referrals for DVA patients will be assessed through the public referral pathway.

4.1 Compensable and Medicare ineligible patients

A compensable or Medicare ineligible patient is not eligible to access public funding for outpatient services.

Patients who are both compensable and Medicare eligible will be accepted for treatment via the public referral pathway.

A HSP can choose to accept a Medicare ineligible patient (e.g. most temporary visa holders) or a patient who is both compensable and Medicare ineligible into their outpatient service. The CRS will allocate referrals regardless of Medicare eligibility for HSPs to make the decision on whether they accept the referral. Where treatment is non-urgent, clinical staff should follow any local procedures and work with revenue staff, where required, to identify any potential financial risk posed by treating the patient and seek approval to provide care in line with the relevant authorisation and delegation schedule.

In all cases, to enable cost recovery opportunities from the relevant funding source, the patient's relevant financial classification should be recorded into their medical record and the PAS.

Refer to the WA Health Patient Fees and Charges Manual 2024/2025 for further guidance on provision of non-urgent or extended treatment and pricing policy.

5. Discharge from outpatient services

Outpatient services play a crucial role in managing patients with complex or rare conditions. However, for most patients, outpatient health care is necessary only for a limited duration. Once their specific needs have been addressed, a timely transition to other service providers, such as their GP or referring practitioner, becomes essential. Outpatient services should avoid routinely retaining care of patients when the patient can be appropriately managed in a different healthcare setting, such as primary medical care or community healthcare services.

Efficient and timely discharge of patients ensures the appropriate use of outpatient services, streamlines patient flow, and increases the capacity of outpatient clinics to treat new patients. By commencing discharge planning early and transferring ongoing management when a single course of treatment is complete, healthcare providers can optimise patient care and resource allocation.

5.1 Discharge planning

Discharge planning should commence during the initial outpatient service appointment and extend until the patient returns to primary care. This planning should involve evaluating the patient's ongoing care requirements in collaboration with caregivers and relevant providers. The goal is to identify discharge-related issues specific to each patient and take proactive steps to address them, thereby preventing any delays in discharge. Effective discharge planning ensures a smooth transfer of care between outpatient services and primary healthcare providers, enhancing patient outcomes.

5.2 Discharge criteria

Public outpatient services should develop specific discharge criteria and guidelines for individual specialties or services to promote consistency of discharge practice and expedite discharge from the service.

5.3 Documentation of discharge

To ensure timely delivery of the discharge summary or correspondence letter to the referring practitioner (and/or usual GP, if not the referrer), HSPs should aim for completion and submission of correspondence within 7-14 days of discharge and should align to MP 0095/18 *Clinical Handover Policy.*

Recommendations for ongoing care management or action plans that incorporate options for self-management or evidence-based management by alternative service providers (e.g. primary care, allied health practitioners and nurses) should be implemented into the discharge summary. This should clearly allocate responsibility for ongoing care to minimise premature or unnecessary re-referral.

5.4 Shared model of care

A "shared care" model is recommended in situations where a complete transition of care back to primary health is not feasible for the patient. In a shared care model, hospital healthcare providers and primary healthcare providers collaborate to deliver a shared service to the patient and ensure patients are not solely reliant on hospital specialists for their care.

To enhance integration with primary care, hospital healthcare providers should provide guidance and support to primary healthcare providers through frequent communication and all involved clinicians and carers should have clearly delineated roles and responsibilities to provide an individualised care plan for the patient.

6. Clinical communication and documentation

6.1 Clinical communication

HSPs are responsible for maintaining communication with referring practitioners and patients about whether a referral is accepted or declined, allocated appointments at the outpatient service, and care plans in the interest of fostering transparency and quality of care across all healthcare providers.

HSPs should also keep the patient's usual GP informed, if they are not the referring practitioner.

Where a HSP has received a referral from CRS, the HSP must update the CRS referral management system to reflect accurate and complete referral information for every patient. This will ensure the CRS are kept informed of any changes in the referral status.

HSPs should ensure that patients identified as culturally and linguistically diverse (CALD), and those with a disability or hearing impairment, are provided with information in an appropriate language or format wherever possible or offered the services of an interpreter as per MP 0051/17 *Language Services Policy*. Patients with hearing impairments must be made aware of the benefits of a virtual consult where captions are available.

Referrers and patients need to be kept informed of the various stages throughout the outpatient referral and booking process. Table 3: Notification stages for outpatient services, outlines the stage of the referral process notifications to be delivered, who they should be delivered to, and which systems need to be updated as a result of these notifications.

Table 3: Notification stages for outpatient services

Notifiable Stage	Referrer	Patient	CRS referral management system	PAS
Referral allocated	✓		✓	
Referral incorrectly received	✓		✓	
Referral declined	✓		✓	
Referral accepted (and waitlisted)	✓	✓	✓	✓
Appointment booked		✓		✓
DNA or cancellation		✓		✓

Internal referral generated	✓			✓
Removal from waitlist	✓	✓		✓
Discharge	✓	✓		✓

The patient must be notified of their appointment booking either by phone call, letter, or SMS, including the possibility of being removed from the waitlist or appointment list for failing to notify the provider of any changes to their contact details or repeatedly rescheduling or failing to attend an appointment.

Providers must advise patients of the circumstances in which a patient may be removed from the outpatient appointment list as part of the patient information and communication processes.

6.2 Clinical handover

Clear and well-defined procedures for clinical handover minimises clinical risk by promoting effective communication of patient care and a clear transfer of responsibility. This is essential to ensure standardisation between healthcare providers and enable continuity of care.

Information relevant to the patient’s continuing care whilst receiving outpatient services must be routinely shared with the patient’s usual GP or other nominated healthcare providers unless the patient specifically does not consent to sharing this information. This may include communication after the initial appointment, a change in condition, and upon discharge.

6.3 Clinical documentation

HSPs should establish local policies that clearly define clinical documentation requirements, including procedures for both paper-based and electronic records, frequency of entries, and any profession-specific guidelines. Documentation systems should ensure that all essential information related to a patient’s care is accurately captured in their healthcare record. This includes referrals and associated documents, such as referral letters, specialist reports, and follow-up communications. These should be consistently recorded to support continuity of care, inform clinical decision-making, and fulfill medico-legal and regulatory obligations.

Documentation to support safe, high-quality care should:

- define when documentation is required
- be clear, legible, concise, contemporaneous, progressive and accurate
- include information about assessments, action taken, outcomes, reassessment processes (if applicable), risks, complications and changes
- meet all necessary medico-legal requirements for documentation, such as record retention timeframes, date and time, or author’s name and designation
- ensure healthcare providers know how to gain access to the healthcare record, and the healthcare service’s templates, checklists or other tools and resources that support safe, high-quality documentation.

7. Governance, monitoring, and reporting

7.1 Information management

The management of data information is an imperative activity in preserving data quality and integrity. Health information is highly sensitive data and once captured, needs to be securely stored and protected as per MP 0145/20 *Information Storage Policy*. This includes ensuring that all patient information, medical records, accompanying documents and referrals are accurately recorded in the patient's medical record and the HSP's PAS, as per the Communicating for Safety Standard.

7.2 Evaluation and monitoring

In addition to Health Service Performance Reporting (HSPR), HSPs may consider using the following measures to monitor overall organisational performance in relation to outpatient service management:

- number of patient-initiated cancellations
- provider or clinician-initiated cancellations
- Waiting time for the first outpatient appointment
- Number of patients on the follow up appointment list who are waiting past preferred date, and mean wait time
- New to follow-up ratio of appointments
- New waitlist and follow-up appointment list over boundary status, median and 90th percentile delays
- Did not attend rates
- Attendance rates
- Discharge rates
- Timeframe from referral to first outpatient appointment
- Internal referral numbers
- Monitoring of complaints
- Number of young people transition to adult services who are aged over 18 years
- Number of unprocessed appointments with unknown outcome.

8. Definitions

This section provides a reference of key terms. The Australian Institute of Health and Welfare National Health Data Dictionary is recognised as the authoritative source of definitions and should be consulted in conjunction with this list.

Term	Definition
Central Referral Service (CRS)	A service which operates to provide a single point of entry for external referrals that are in scope for initial medical-led outpatient appointments across Perth metropolitan hospitals and select WA Country Health Service locations. The CRS manages the allocation of

	these referrals to the appropriate health service. Additionally, the service enables systemwide governance by monitoring, auditing, and reporting on these functions.
Clinician	A health professional that practices in the outpatient clinic setting, including doctors, nurses, midwives and allied health professionals.
Clinical handover	Clinical handover is the transfer of professional responsibility and accountability for some or all aspects of care for a patient, or group of patients, to another person or professional group on a temporary or permanent basis. The purpose of clinical handover (handover) is to achieve effective, high-quality communication of relevant clinical information that is understood and accepted by the receiver when responsibility for patient care is transferred.
Clinical review	Review of a patient to consider appropriateness of the assigned clinical urgency category, to assess the patient's clinical condition during the waiting period.
Clinical triage	Clinical triage is the process of determining the urgency of the patient's need for treatment based on the severity of their condition and includes the allocation of a clinical urgency category.
Clinical urgency	A clinical assessment of the urgency with which a patient requires care based on clinical need. • Category 1 (urgent): Assessments that are clinically indicated within 30 days. • Category 2 (semi-urgent): Assessments that are clinically indicated within 90 days. • Category 3 (non-urgent): Assessments that are clinically indicated within 365 days.
Discharge	Agreed separation of patient from outpatient services at completion of an episode of treatment.
Duplicate referral	A referral for WA Health public outpatient services that is exactly the same as an existing referral, i.e. for the same patient, condition, specialty, and treatment from the same referrer.
Episode of care	An episode of care is a patient's entire treatment needed for an illness or "episode". It includes all the services provided to a patient to treat a clinical condition or procedure. The services occur within a specific period of time and from a range of organisations that make up an integrated system.
External referral	A referral for WA health public outpatient services from a practitioner external to WA Health, such as a general practitioner or private specialist.
Follow-up	An appointment for an outpatient patient requiring review from an inpatient admission or following a patient's first 'new' outpatient attendance under the same specialty, clinician, or clinical team.
General Practitioner (GP)	A registered medical practitioner who: • is qualified and competent to provide general practice anywhere in Australia • has the skills and experience to provide patient-centred, continuing, comprehensive, coordinated primary care to individuals, families, and communities • maintains professional competence in general practice • may have Specialist General Practice registration.

Health Service	A service for maintaining, improving, restoring or managing people's physical and mental health and wellbeing. It may include: a. a service that is provided to a person at a hospital or any other place; b. a service dealing with public health, including a programme or activity for: i. the prevention and control of disease or sickness; or ii. the prevention of injury; or iii. the protection and promotion of health; c. a support service for a health service; d. the provision of goods for a health service.
Health Service Provider (HSP)	A Health Service Provider established by an order made under section 32(1)(b) of the *Health Services Act 2016* and may include North Metropolitan Health Service (NMHS), South Metropolitan Health Service (SMHS), Child and Adolescent Health Service (CAHS), WA Country Health Service (WACHS), East Metropolitan Health Service (EMHS), PathWest, Quadriplegic Centre and Health Support Services (HSS).
High priority	High priority access to services is required if the patient's care needs to be prioritised because their condition is deemed likely to result in an Emergency Department presentation or an unplanned readmission and they would therefore benefit from a review within 30 calendar days (Category 1/urgent).
Immediate referral	Denotes that a patient is to have an immediate outpatient review (within 7 days) and requires initial telephone contact to be made by the referrer to a specific clinician at the hospital site. These referrals are out of scope for the CRS.
Internal referral	A referral that is initiated during an emergency department visit, or an inpatient or outpatient episode. Internal referrals may be directed to the same specialty (e.g. inpatient to outpatient referral, or outpatient to outpatient referral for a different or new reason) or to a different specialty (e.g. outpatient to outpatient referral) within a particular provider or across other WA public providers. Internal referrals are out of scope for the CRS.
Medical specialist	Credentialed medical practitioner who has become specialised in a specific area of medicine and is recognised by the relevant professional college, board, or association.
Medicare Benefits Schedule	The Medicare Benefits Schedule (MBS) is a Commonwealth Department of Health (DoH) and Aged Care publication which contains a list of the Medicare services subsidised by the Australian Government. The MBS is part of the wider Medicare Benefits Scheme, managed by DoH and administered by Services Australia.
Non-admitted services	Health care provided to patients who do not undergo a formal admission process and do not require an overnight stay in a hospital. These services can be delivered in various settings, such as hospital outpatient clinics, community-based clinics, or in the patients' home. They cover a broad spectrum of healthcare activities, such as consultations, diagnostic tests, treatments, and follow-up care.
Non-urgent referral	Denotes that a patient is to have a non-urgent outpatient review or assessment (beyond 30 days). These referrals are in scope for CRS.

Outpatient clinic	An outpatient clinic is a specialty unit or organisational arrangement under which a hospital provides outpatient services. Outpatient clinics provide non-admitted services that require the focus of a healthcare provider to ensure the best outcome for the patient. These services are an important interface in the health system between acute admitted patients and primary care services. They provide access to: • Medical practitioners, nursing, midwifery and allied health professionals for assessment, diagnosis, and treatment • Ongoing specialist management of chronic and complex conditions in collaboration with community providers • Pre- and post-hospital care Related diagnostic services such as pathology, pharmacy, and diagnostic imaging.
Outpatient services	An examination, consultation, treatment, or other service provided in an outpatient setting by a healthcare provider who is recognised by the relevant professional college, board, or association. The scope of outpatient services includes medical, surgical, mental health, dental, allied health, nursing and midwifery clinics.
Over boundary	Term used to identify cases that have waited longer for their first appointment than the clinically recommended timeframe in their urgency category.
Provider	A person or entity that provides treatment or care to a patient.
Public Hospital	Public Hospital defined as a) a hospital controlled or managed by a Health Service Provider or the Department CEO; or b) a hospital declared to be a public hospital by the Minister.
Referral	A documented request for a service or consultation within the public outpatient system. Referrals may be external (i.e. from primary care to public outpatient services), or internal (from one public specialist to another).
Referral Access Criteria (RAC)	State-wide clinical criteria for public medical-led outpatient services which provide clear guidance regarding: • Examples of presenting issues under each condition which are indicated for referral to an outpatient service • Mandatory information which must be included in a referral by the referring practitioner • Highly desirable information which can be included in a referral at the referring practitioner's discretion • Transparent indicative clinical urgency categories • Useful information which can assist the referring practitioner in completing the referral • A list of conditions that are excluded or not routinely seen in public outpatient services, and, if applicable, existing alternative care pathways
Referrer	Any person who has referred a patient to an outpatient service, including patients who have self-referred.
Referring Practitioner	A health practitioner responsible for referring a patient to an outpatient service.

Responsible Officer	A Health Service Provider nominated person who is responsible for the management of the outpatient waitlists at each provider.
Transition	The process of planning, preparing, and moving from paediatric health care service to an adult health care service.
Triaging clinician	The designated clinician responsible for assigning an approved clinical urgency category to the patient, for their relevant service, within 5 business days of receipt of referral.
Urgent referral	Denotes that a patient is to have an urgent outpatient assessment or review (within 30 days). These referrals are in scope for CRS.
Valid referral	A referral that meets the minimum requirements for patient, referrer, and clinical information, to facilitate accurate and timely review and clinical triage.
Virtual care	Any health care interaction with the public health system between patients, their carers, and health professionals, who are in different locations, using technology.
WA health entities	WA health entities include: (i) health service providers as established by an order made under section 32 (1)(b) of the *Health Services Act 2016*. (ii) Department of Health as an administrative division of the State of Western Australia pursuant to section 35 of the *Public Sector Management Act 1994*.
WA health system	The WA health system is comprised of: (i) the Department of Health (ii) Health Service Providers (North Metropolitan Health Service, South Metropolitan Health Service, Child and Adolescent Health Service, WA Country Health Service, East Metropolitan Health Service, PathWest Laboratory Medicine WA, Quadriplegic Centre, and Health Support Services) (iii) contracted health entities, to the extent they provide health services to the State.

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