CENTRAL REFERRALS

Central Referral Receipt and Pooled Waiting Lists

National Guidance Document

Scheduled Care Reform Initiatives

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CHAPTER 1: INTRODUCTION TO CR (Central Referrals)

Contents covered in this Chapter:

1.1: This Guidance Document

1.2 CR and Sláintecare

1.3 Purpose of CR

1.4 What is CR

1.5 Why implement CR

1.6 The principles of CR

1.7 Patients likely to benefit from CR

1.8 International Research to support the benefits of CR

Target Audience:

CR Team

Clinical Lead

Chapter 1: Introduction to CR (Central Referrals)

1.1: This Guidance Document

The purpose of this document is to outline the national approach to implement and deliver for Central Referrals in Ireland in identified hospital sites.

1.2 CR and Sláintecare

The 2017 Sláintecare Report highlights the need for long waiting lists to be addressed and commits to maximum wait time targets. In 2024, as the next step towards achieving the Sláintecare maximum waiting times, revised interim maximum waiting times have been defined in the 2024 HSE National Service Plan:

- Outpatient: 90% of patients should be waiting less than 15 months for an outpatient appointment
- Inpatient/Day Case: 90% of patients should be waiting less than 9 months for an inpatient or day case procedure
- GI Scopes: 95% of patients should be waiting less than 9 months for a GI scope

Central Referrals is a key strategic reform initiative outlined in the delivery of health services for New Patients and Review Patients in Ireland.

1.3 Purpose of CR

The purpose of implementing CR is to:

i. Enable referrals to be managed centrally (at RHA level).
ii. Ensure that patients are on the most appropriate care pathway.
iii. Ensure patients are seen as soon as possible.

1.4 What is CR

Central Referrals describes the process by which outpatient departments involves the centralised handling and processing of all patient referrals in outpatient departments. This system streamlines the process of:

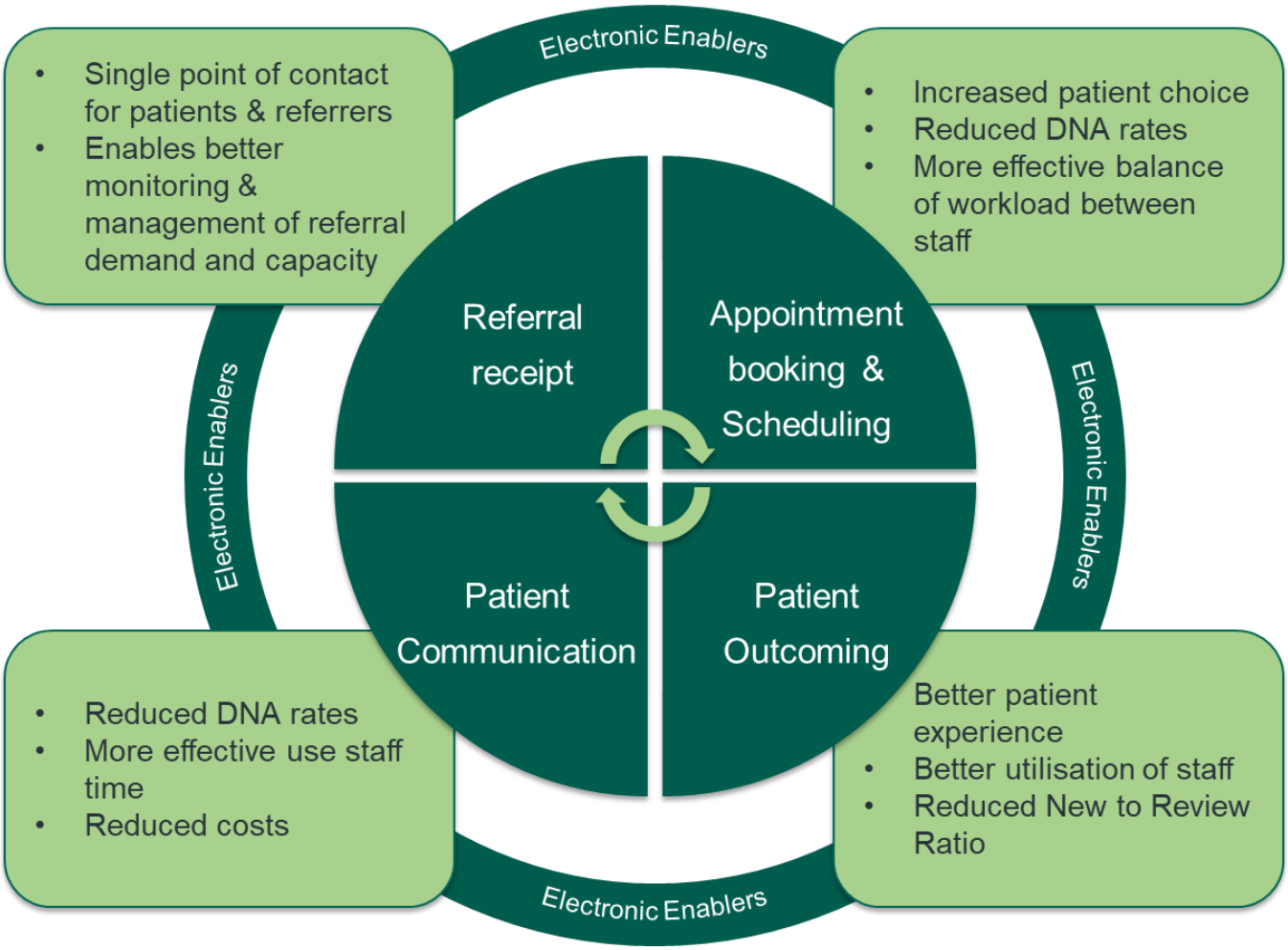
- Receiving and assigning patient referrals to appropriate healthcare professionals or departments.
- Scheduling and booking of patient appointments.
- Notifying patients of their appointments.
- Selecting the most appropriate discharge pathway and outcoming patients.

Central Referrals (CR) is a system for referrals from General Practitioners (GPs), Emergency Departments, Consultant to Consultant referrals, Inpatient referrals originating from an admission, Other Hospitals or Health Centres and National and regional specialist clinics including National Cancer Control Programme. The system outlines how to assess the referral and issue a priority based on clinical need and an appointment date is issued based on this priority.

CR encompasses the referral and booking processes from the decision to refer through to scheduling of first and subsequent appointments in the Acute Hospital and Community settings and ultimately the outcoming of the patient.

1.5 Why implement CR

Many benefits are achieved by implementing CR – both for the hospitals and the patients involved. A summary of the benefits identified for moving to CR are outlined below. Our targets are aligned to the National Outpatient Waiting List Management Protocol 2022.



1.6 The principles of CR

Key principles for CR include:

1. **Increased level of Centralisation**
   A hybrid approach to centralisation is most suitable for patient-centred booking arrangements in the Irish Health Service. Specifically, all administrative responsibilities are centralised at regional level (e.g. referral registration, assignment and booking) and all clinical responsibilities occur at Clinician/HSCP or specialty/CHN level (e.g. clinical prioritisation). CR will enhance centralisation by coordinating and collaborating with all administrative staff and implementing the to-be processes and sub-processes.

2. **Standardisation and Streamlining**
   The standardisation of care pathways is being taken forward through the wider Scheduled Care Reform Initiatives and will streamline access to care. CR will facilitate the implementation of these reformed scheduled care pathways, acting as the 'air traffic control centre' for referral, booking processes and discharge process where appropriate.

3. **Enhanced Patient / Service User Engagement**
   Processes are put in place to facilitate active patient engagement throughout the referral, booking and discharge processes where appropriate. Specifically, establishing a single point of contact (at the administrative level); partial booking where appointment choice is offered; clear, accurate and timely sharing of information; creating and reporting on KPIs to measure patient booking experience, specifically relating to patient-centred booking arrangements; and offering increased choice in relation to discharge pathways available.

1.7 Patients likely to benefit from CR

The following types of patients are most likely to benefit from the implementation of CR:

- Patients who are long waiters on the waiting list.
- Urgent patients, as the implementation of CR will ensure patients are scheduled an appointment within 28 days.
- Patients that require flexibility for appointment times with the introduction of partial booking.

1.8 International Research to support the benefits of CR

Extensive research has been undertaken to understand benefits of introducing elements of CR. A summary of the benefits identified through implementing CR internationally are outlined below.

Improved Patient Experience:

- NHS – quarterly patient feedback gathered through NHS Digital found that 72% of patients felt they were able to make choices that met their needs (across Q4 2018 and Q3 2019).
- Canada – 96% of patient respondents felt that eReferral led to an improved healthcare experience; 90% of patient respondents felt that eReferral was an easy process to follow; and 81% of patient respondents felt more informed about their care.

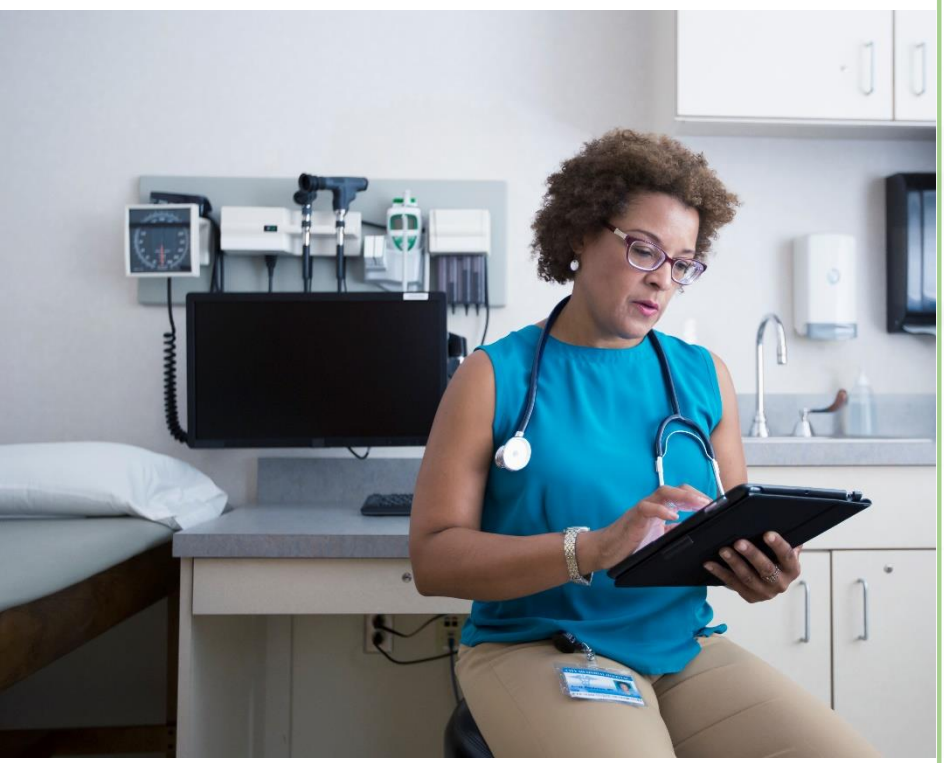
Enhanced Referral Management:

- New Zealand – Referral system decreased the number of days it takes referrals to be received and triaged by specialists from 8 days to 5 days (2008 study).
- Canada – reduced referral turnaround time (average 68 hours using a fax system to average 23 hours using electronic system), reduced wait times, improved patient safety and lowered costs.

Cost /Efficiency:

- New Zealand – 9,800 hours saved in New Zealand health service in 2019 using robotic eReferral processes.

CHAPTER 2: ESTABLISHMENT OF CR



Contents covered in this Chapter:

2.1 CR Establishment

2.1.1 CR Roles and Responsibilities

2.2 Selection of speciality

2.3 Clinical Governance

2.3.1 Clinical Lead Roles and responsibilities

2.4 Validation of the Waiting List

2.5 Pooling of Waiting List

Target Audience:

Scheduled Care Leads

CR Teams

Chapter 2: Establishment of CR

This chapter outlines the key activities to be delivered for the establishment of CR, the resourcing of key roles within CR, the selection of a speciality which CR will support, the establishment of clinical governance for the specialty's outpatient waiting list, validation of the waiting list and pooling of the relevant waiting lists.

2.1 CR Establishment

What is Central Referrals and why should hospitals move to this management system?

- Central Referrals aims to design and implement a central function for referrals to outpatient specialities. This function will manage the process from referral receipt to waiting list placement and appointment scheduling through to follow up or discharge.

How does CR support the National Model of Care?

The CR supports specialities to deliver safe and efficient outpatient services in line with their model of care through:

- Referral pooling
- Clinical integration
- New ways of working through Electronic Health Care
- Improved end-to-end Referral processing
- Alignment to best practices
- Reduced duplication of referrals

2.1.1 CR Roles and Responsibilities

There are three key non-clinical stakeholders whose roles and responsibilities are critical to the success of the end-to-end CR implementation including the CR Hospital Lead, the CR Officer, and Scheduled Care Reform Initiatives Support. In addition to these roles the CR Clinical Lead is critical in the implementation of CR. Detailed role descriptions are included below.

Role	Responsibilities	CR Phase
CR Hospital Lead	Co-ordinate all CR readiness activities	Pre-Implementation
	Manage relationships with stakeholders in the hospital to progress CR activities	All Phases
	Co-ordinate activities with the Clinical Lead for CR	All Phases
	Confirm staff for roles	Pre-Implementation

	Confirm training requirements for CR participants	Implementation
	Confirm that all entry criteria for CR implementation have been met	Implementation
	Ensure that the agreed to-be processes are followed	Post-Implementation
	Report on progress and status at scheduled calls with Acute Operations team	Post-Implementation
	Report on progress against the agreed metrics	Post-Implementation
	Report on risks that may impact CR and issues that have impacted delivery	Post-Implementation
	Support metrics gathering by requesting information from local teams where required	Post-Implementation
	Co-ordinate with the local iPMS/PAS team where required to support CR activities	All Phases
	Co-ordinate with the NTPF where required	All Phases
	Provide input into the Hospital site CR plans	All Phases

Role	Responsibilities	CR Phase
CR Clinical Lead	Provide clinical sign off on CR participation for the specialty	Pre-Implementation
	Encourage participation in CR among Clinician group	All Phases
	Co-ordinate activities with the CR Hospital Lead	All Phases
	Deliver training/share knowledge with clinicians as required	All Phases
	Provide input into the Hospital site CR plans	All Phases

Role	Responsibilities	CR Phase
CR Officer	Participate in training in advance of CR implementation commencement	Implementation

	Review referrals received to CR	Post-Implementation
	Record or stamp all referrals received into CR	Post-Implementation
	Confirm that all the required information is provided in the referral	Post-Implementation
	Contact SOR to request additional information if required	Post-Implementation
	Update iPMS/PAS at the following stages: ➢ Creation or update of patient record (where required) ➢ Creation of referral record ➢ Management of referral in wait list ➢ Update of referral with outcome of clinical review Closure of referral	Post-Implementation
	Print all referral related letters and issue to the patient/guardian of patient, GP and SOR where required	Post-Implementation
	Prepare referrals and associated information for clinical review	Post-Implementation
	Schedule appointments according to the clinical prioritisation category assigned by the Clinician	Post-Implementation
	Reject referrals where specific criteria are not met	Post-Implementation

Role	Responsibilities	CR Phase
Acute Access Team Support	Share To-Be processes	Pre-Implementation
	Develop the resources map	Pre-Implementation
	Develop the CR Hospital implementation plan with CR Hospital Lead	Pre-Implementation
	Design and develop education sessions for the CR team	Pre-Implementation
	Share the communications pack for the CR team in hospitals	Pre-Implementation
	Attend scheduled meetings with the CR Hospital lead and project team	All Phases

	Deliver regular status reports on the CR progress	All Phases

2.2 Selection of speciality

CR is now mandated among all clinical specialities. There are several critical questions and factors that must be considered when implementing CR. Four key categories to consider are noted below.

Clinical Buy in	Waitlist Optomistaion	Readiness	Model of Care
• This is key to engage with specialities in the hospital	• CR will help ensure that the waiting lists in specialists are optomised and there will be benefits to the clinicians and patients	• Does the proposed speciality already have CR in place? • What capacity is needed to support CR model?	• Ensure that the CR system is aligned to the Model of Care for the chosen specialty

2.3 Validation of the Waiting List

Validation is a process whereby patients are contacted to ensure they wish to remain on an Outpatient Waiting List. This can be completed either in house or administrative validation is facilitated by the NTPF (National Treatment Purchase Fund) for public hospitals. The process involves identifying and agreeing specific patients for validation in collaboration with the NTPF. These patients are then contacted. Validation ensures only patients who still require an appointment remain on the waiting list until offered an appointment.

It is good practice to ensure that a waiting list is data cleansed and validated prior to pooling.

2.4 Pooling of Waiting List

In 2011 (Protocol for the Management of Outpatient Referrals) HIQA recommended that referrals are made by a source of referral to a specialty/service where possible, rather than a named individual or named clinician. As a minimum all un-named or “Dear Doctor” referrals should be pooled. Generic referrals are good practice and should be encouraged from the source of referral. This will promote equity of access as waiting times will depend on next availability rather than specific clinician availability.

Prior to commencing pooling of the waiting lists, it is essential to ensure that the local Business Intelligence Units and facilitators of the extract file to the NTPF are aware that the lists are being pooled into one waiting list. This information should also be communicated to the NTPF.

2.4.1 Clinical Governance of a pooled Specialty/Service Outpatient Waiting List

Clinical Governance is defined as 'a framework through which the healthcare teams are accountable for the quality, safety and satisfaction of patients in the care they deliver'.

International best practice suggests that every patient on an Outpatient Waiting list must be allocated to a specific Clinician in terms of clinical responsibility. With a pooled waiting list, there must be a named Clinician who assumes responsibility for this patient until such a time as this patient is allocated an appointment in clinic under a specific Clinician.

The OSPIP Guidance document 005 'The Service Provision Agreement' (Table 1, No. 3) details the type and quantum of services which must be applied to an Outpatient Service, included within this service agreement is governance of a pooled waiting list decided at a hospital or regional level.

Table 1. Data items of Service Provision Agreement

1. Specialty/discipline name
2. Range of services provided, to indicate main focus of work and sub-specialism, as appropriate (set out per clinician)
3. Governance of service (who refers, admits, clinically prioritises, sees patient, discharges) and pooling arrangements
4. Description of specialty team to include consultants, junior medical staff, allied health professionals, nursing, technician, and support staff
5. Number of WTE staff as per above list
6. Description of clinic structure indicating whether standard, shared or joint delivery
7. Description of provision of telemedicine services
8. Proportion of new and review patients to be seen utilising:
    a. Face-to-face consultation with consultant-led service
    b. Face-to-face consultation with allied health or nurse led service
    c. Diagnostic prior to first consultation
    d. Direct access to outpatient procedure clinic
    e. Direct admission to day case service
    f. Direct admission to in-patient service
    g. Providing advice plan to SOR
9. Number of new referrals per month in current year (in tabular format) broken down by clinician and sub-specialty where appropriate
10. Number of patients on the waiting list for a new appointment broken down by clinician and sub-specialty where appropriate
11. Number of new urgent and routine clinic slots to be provided per month in coming year (in tabular format) broken down by clinician and sub-specialty where appropriate
12. Number of review patient slots to be provided per month in coming year (in tabular format) broken down by clinician and sub-specialty where appropriate
13. New to review ratio for the specialty, per clinician, broken down to sub-specialty where appropriate
14. Specialty-specific procedure for managing patients who fail to attend
15. Associated PAS clinic codes and wait list codes per clinician or group where shared/joint clinics are operated
16. Number of clinic hours provided per week per clinician (in tabular format)
17. Maximum wait time guarantee for new urgent patients, including suspect cancer patients
18. Maximum wait time guarantee for new routine patients
19. Set out procedure/plan for managing patients at risk of breaching maximum wait time guarantees
20. Set out procedure for management of referrals awaiting clinical prioritisation at risk of breaching the required five (5) day turn-around
21. Leave management process including application and notice process. Set out cover arrangement for clinical prioritisation when clinician is on leave and procedure for seeing patients within required timeframes who have been postponed and/or rescheduled
22. Set out succession management procedure

The following referral review and management activities are proposed for the CR implementation:

- The referral is received in a centralised location either manually or electronically.
- The referral is added to the PAS system and placed on a pooled waiting list within 24 hours of receipt.
- The referral is waitlisted under the named clinician (either the Clinical Director for the Speciality or the Clinical Lead for the specialty).
- The referral remains on the waiting list under the named clinician until transferred to a specific Clinician's clinic. At this stage, the referral becomes the responsibility of the Clinician under which the patient is now booked to see.

The patient should be allocated to the appropriate clinician from the pooled waiting lists on the basis of clinical suitability, subspeciality or expediency always keeping in mind the best interests of the patient.

CHAPTER 3: HIGH LEVEL CR PROCESSES

Contents covered in this Chapter:

3.1 High-Level CR Operating Model

3.2 CR Processes and Sub-Processes

Target Audience:

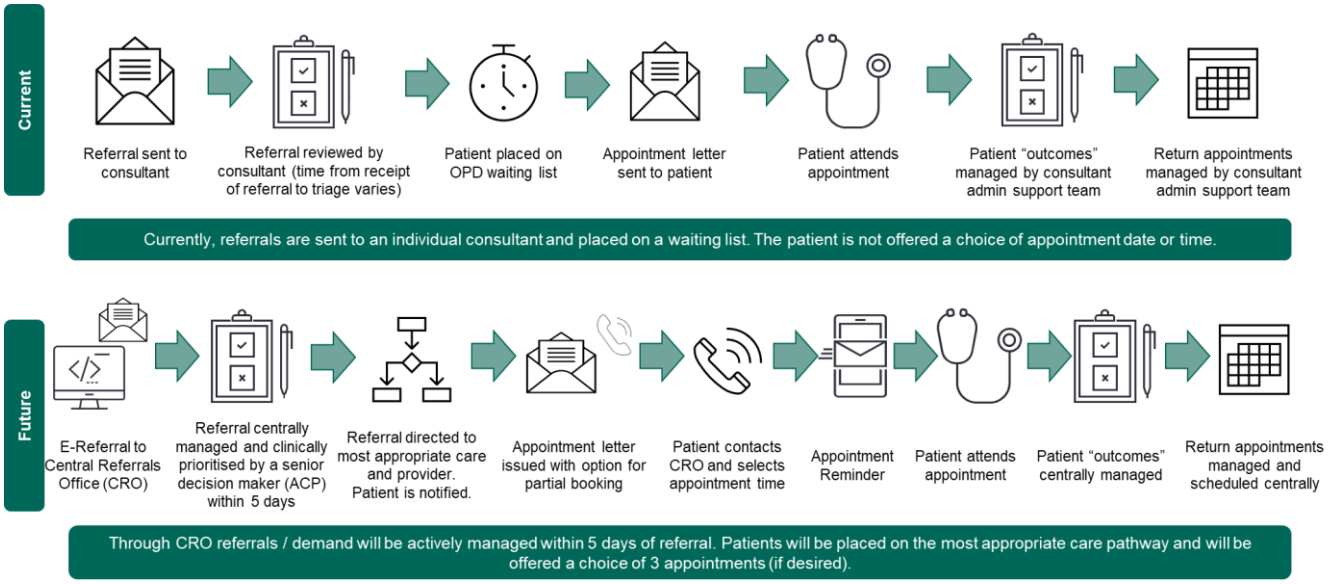
Scheduled Care Leads

CR Teams

Chapter 3: High-Level CR Processes

3.1 High-Level CR Operating Model

The high-level current and future view of the CR Operating Model is included below. This includes an overview of the current referral receipt, review and scheduling approach and an overview of the same activities delivered through CR.



This document includes centralised referral receipt and waiting list pooling only. For further information on the entire CR national guidance document, please contact the Acute Access team, who can provide further documentation on implementing an end-to-end CR operating model.

3.2 CR Processes and Sub-Processes

The end-to-end CR journey consists of 9 To-Be processes and sub-processes.

All of the processes have been developed to align with the HSE National Outpatient Waiting List Management Protocol 2022.

To-Be Processes have been drafted for CR to specify how activities should be delivered in each hospital implementing CR. These processes will be amended as required, taking into account the variability of technology available and existing efficient processes in place per hospital.

For each process, a process map has been defined with a summary of the steps and identified technology gaps. Detailed steps of the Central Referral Receipt and Pooling of Waiting Lists process and sub-process are captured within Chapter 6.

The To-Be Processes and Sub-processes include:

1. Referral receipt and registration, (ideally including specialty specific e-referral forms) and registration of referral
2. Referral assignment to Clinician and referral prioritisation
3. Reject referrals
4. Schedule appointments
5. Generate and Issue Letters
6. Attend Appointment
7. Can Not Attend/ Cancel Appointment
8. Follow up Appointment
9. Did Not Attend

CHAPTER 4: WAITING LIST MANAGEMENT

Contents covered in this Chapter:

4.1 CR Delivery – Wait List Management

4.2 CR Delivery – Clinic Management

4.3 CR Delivery – Letters and Communications

4.4 Policies, Procedures, Protocols and Guidelines (PPPGs)

4.5 Clinical Reconciliation / Outcome

Target Audience:

Scheduled Care Leads

CR Teams

Chapter 4: Waiting List Management

4.1 Wait List Management

Wait List Management is a key step in the establishment of CR. All required wait list management activities must be completed before CR can be implemented. These activities will be completed by the hospital's CR team with guidance provided by the Scheduled Care Reform Initiatives team.

Activities to be completed for Wait List Management

1. Assess current waiting list for specialty
2. Check validation status of the waiting list
3. Engage with Lead Clinician for the specialty in terms of merging all waiting lists into one generic pooled waiting list – identify governance.
4. Decide on name for pooled waiting list and set up appropriate session code and rules.
5. Contact the NTPF to inform them of the single merged waiting list for the specialty giving details of specific date and time on which this will occur.
6. Transfer all patients from individual waiting lists to pooled waiting list attached to the clinician responsible for triage.
7. Cross check all previous waiting lists to ensure they are now closed, and all patients have been safely transferred to the new pooled waiting list.
8. Provide training to all staff responsible for maintaining the waiting lists.
9. Initiate new waiting list and booking process

4.2 Clinic Management

Clinic Management is a key step in the establishment of CR and the steps below provide an outline of what is to be done. All required clinic management activities must be completed before CR can be implemented. These activities will be completed by the hospital's CR team with guidance provided by the Scheduled Care Reform Initiatives team.

Activities to be completed for Clinic Management

1. Review current clinic templates in terms of demand and capacity.
2. Evaluate if local categories are attached to the waiting list and that appropriate clinic codes are set up to facilitate local categories.
3. Identify booking slots for Urgent, Semi-Urgent and Non-urgent and ensure new CPCs (Clinical Prioritisation Pathways) are embedded into the triaging process.
4. Ensure patients are not booked beyond six (6) weeks in advance.
5. Ensure robust policy for implementation of leave is in place to ensure clinics are not cancelled without adequate notice.

4.3 Letters and Communications

Communications are issued at key stages during the patient booking processes. These are issued to patients, SORs and GPs. Letter templates have been developed and these can be customised. The Letter templates will be provided to the hospital and updated as required. Below is a list of the letters required for the Centralised Referral Receipt section of CR.

Letter	When to issue	Related process
1. Acknowledgement of Receipt of Referral (Patient Only)	This is issued when the referral has been checked by the CR officer and it has been added to the specialty wait list.	Process 2.1 – Referral Receipt and Registration
2. Referral Accepted and Placement on the Waiting List with CPC	This is issued to the SOR to inform them of the patient's clinical prioritisation.	Process 2.1 – Referral Receipt and Registration
3. Notification that the referral is redirected	This is issued to the SOR to inform them that the referral has been reviewed and has been redirected.	Process 2.2 – Referral assignment to Clinician and prioritisation
4. Notification that the referral is rejected	This is issued to the GP, SOR and patient when the referral is rejected.	Process 2.3 – Reject referral

The templates for the letters are included within Chapter 7. A full list of all letters and templates are included in the complete Central Referrals national guidance document.

4.4 Policies, Procedures, Protocols and Guidelines (PPPGs)

All PPPGs in relation to Outpatient Waiting lists should be updated to reflect the OP National Waiting List Protocol and to include reference to Central Referrals (CR). All hospital groups/hospitals much ensure they have an OP Waiting List Management SOP which aligns with the Outpatient (OP) Waiting List protocol. The CR end-to-end processes and implementation approach has been developed to align with the HSE National Outpatient Waiting List Management Protocol 2022.

CHAPTER 5: DATA AND REPORTING

Contents covered in this Chapter:

- Reporting Metrics
- Equity

Target Audience:

Scheduled Care Leads

Chapter 5: Data and Reporting

Reporting Metrics:

The following metrics will be utilised to measure the effectiveness of CR:

1. Central referrals maturity assessment score.
2. Number of specialities where central referrals is implemented.

Monitoring and reporting mechanisms should be implemented at each hospital rollout site to assess the feasibility and impact of the CR.

Equity:

The impact of CR on different patient groups should be considered across all evaluation metrics, including against protected characteristics, to ensure that the service is provided equitably by the introduction of mitigating actions if required.

CHAPTER 6: DETAILED CR PROCESSES

Contents covered in this Chapter:

- 6.0 Processes Overview
- 6.1 Process 2.1: Referral receipt and registration
- 6.2 Process 2.2: Referral assignment to Clinician and referral prioritisation
- 6.3 Process 2.3: Reject Referrals

Target Audience:

Scheduled Care Leads

Chapter 6: Detailed CR Processes

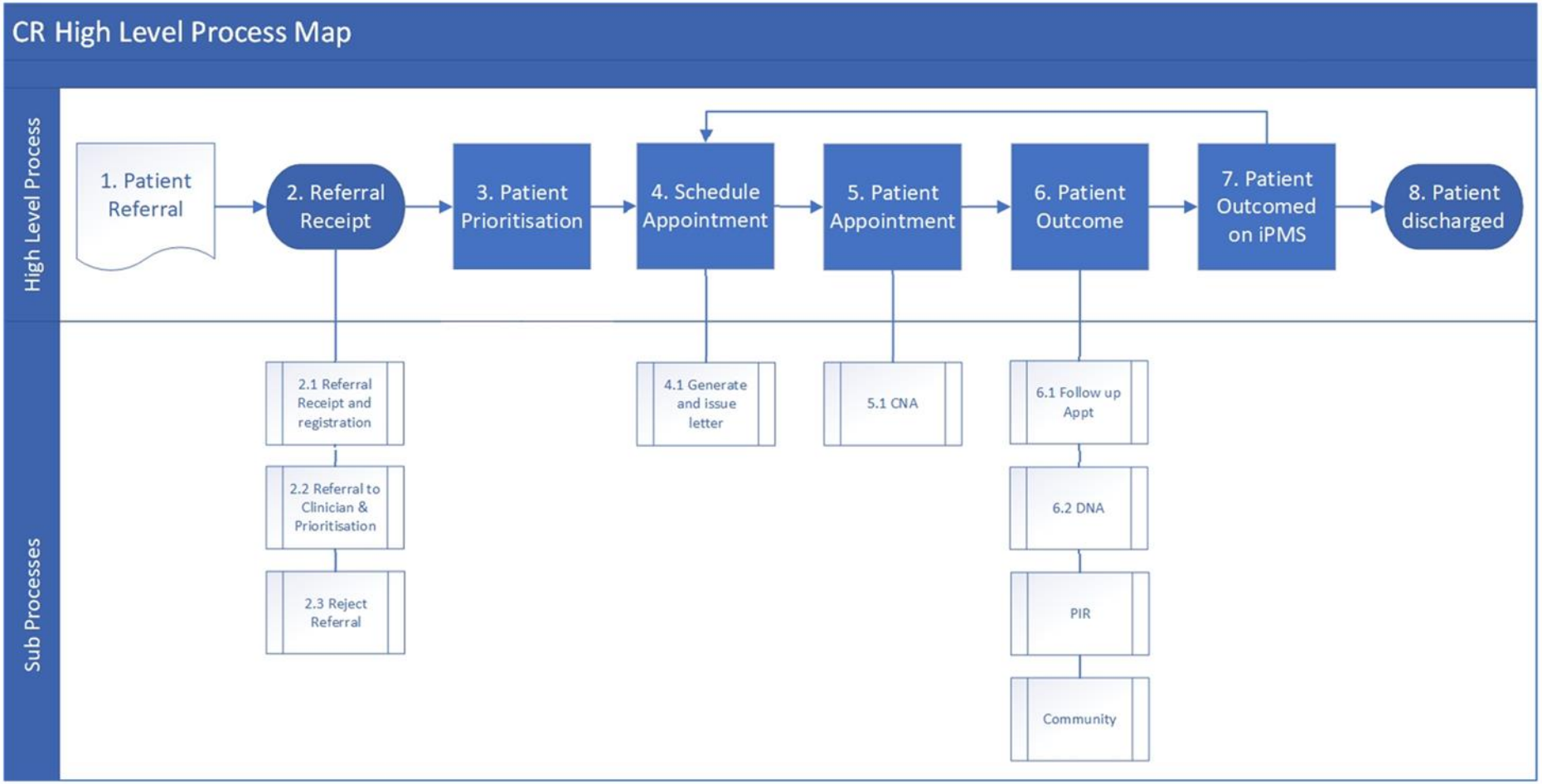
6.0 CR Processes Overview

The following sections include individual process maps for each process and sub-process, along with detailed steps per process to elaborate on the components within each map. A high-level overview of each process and sub-process is outlined in the process map and table below. The table is colour coded to align to the respective processes covered throughout the Chapter.

Process Name	High-Level Description	Page
2.1. Referral receipt and registration	The streamlined referral process includes all steps from the notification of a referral by the relevant Source of Referral (SOR) to the issuing of acknowledgement notifications to the patient / guardian of the patient, and the SOR.	26
2.2. Referral assignment to Clinician and referral prioritisation	The Referral assignment to Clinician and referral prioritisation process continues after the conclusion of the Referral Receipt and Registration process and includes all steps in the Clinician review and clinical prioritisation of referrals.	29
2.3. Reject Referrals	The Reject Referral process includes all steps to reject referrals.	34

For a complete list of all the processes and sub-processes please refer the complete CR national guidance document.

Process Map: CR High Level Process Map



6.1 CR Process Step 2.1: Referral receipt and registration

This section includes a table with detailed steps for the Referral receipt and registration process. Each step represents a component within the process map which is included under the table.

Step	Description	Technology Gap
1. Send referral to the CR team	The Source of Referral (SOR) submits a Referral as an electronic record through Healthlink or as a hard copy letter through the Post to the CR team. The SOR can be internal or external. Guidelines on the information to be included in the referral can be issued to the hospital if required.	C. 80% of GPs who represent the majority of external SORs use Healthlink.
2. Receive referral	The referral is received either as a Healthlink record or as a hard copy letter in the Post.	
3. Healthlink referral?	Decision point to confirm if the referral has been received from Healthlink or as a letter in the Post. If the referral has been received through Healthlink, the next step is Step 4. If the referral has been received through the Post, the next step is Step 5.	
4. Print letter from Healthlink	If the referral has been received through Healthlink, the letter is printed from Healthlink to facilitate the management of all Patient related records as hard copy files.	An E-HR solution could be utilised to manage all Patient data digitally.
5. Stamp letter	The letter is stamped with the date of receipt if it is a Postal letter and the date of creation of the referral on Healthlink if it was created in Healthlink.	i) If all referrals are reviewed and prioritised as eReferrals this step is not required. ii) Postal letters could be scanned and associated with the Patient record in a fully digitised solution.
6. Review letter	The letter is reviewed to ensure that the minimum administration information is included.	This can be done through Healthlink where a Healthlink referral is submitted.
7. Letter complete?	If the letter is not complete the next step is Step 8. If the letter is complete the next step is Step 14.	
8. Contact SOR to request required information	The SOR is contacted by the CR team to request the required information. This is currently done by telephone.	This information could be requested as an email or as a notification from a

Step	Description	Technology Gap
		system such as Healthlink (functionality to be confirmed).
9. Contact made within 48 hours of receipt?	If contact has been made within 48 hours, the next step is Step 10. If contact has not been made within 48 hours, the next step is Step 11.	

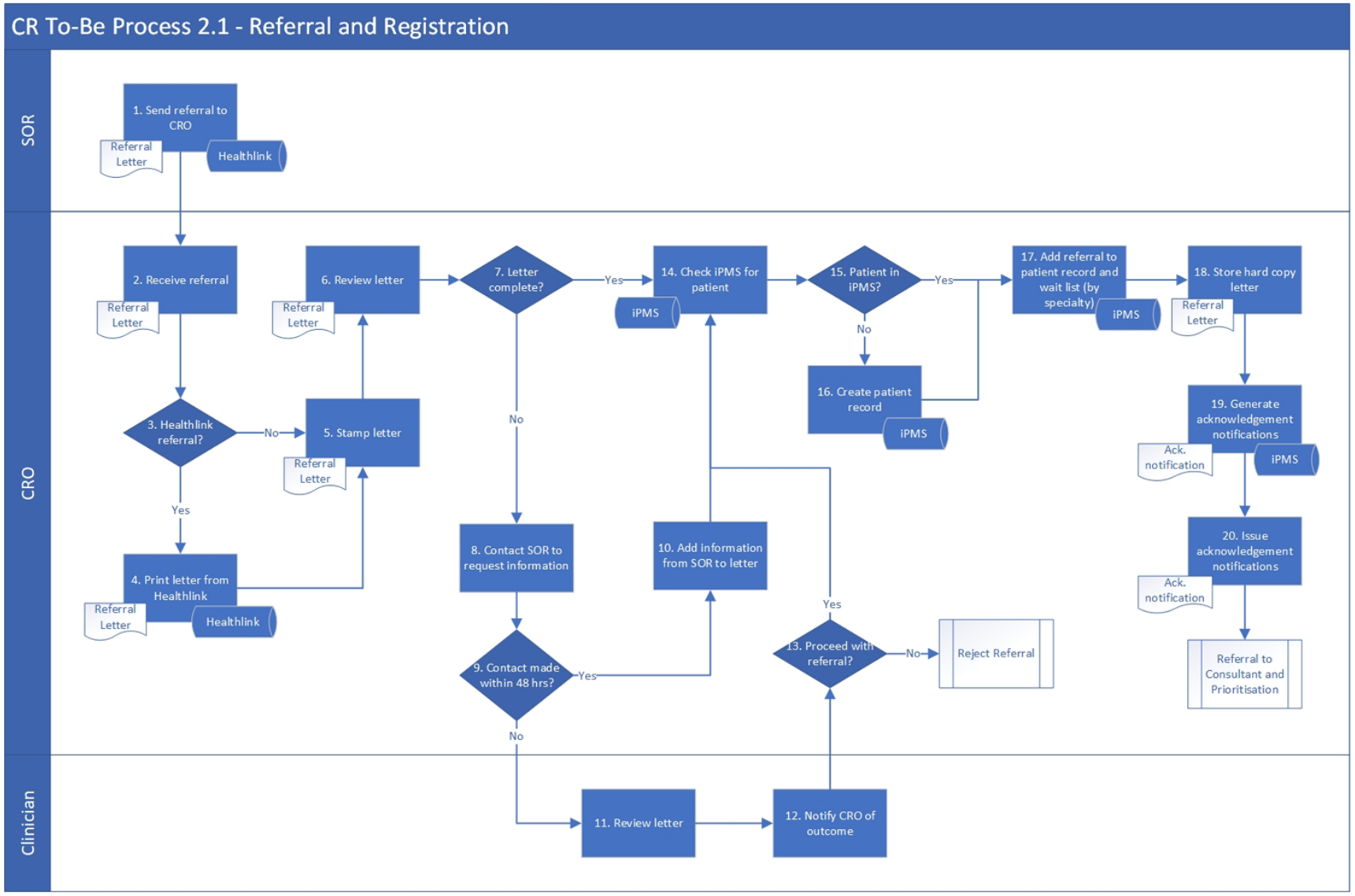
10. Add information supplied from SOR to Letter	The information is amended using the following approach:
	• Records shall not be erased or destroyed but shall be amended if incorrect
	• Correction fluids shall not be used. The original entry shall remain visible
	• Deletions or alterations shall be made by scoring out with a single line followed by:
	  • Signature (plus name in capitals) and counter signature, if appropriate
	  • Date and time of correct entry.
	  • Reason for amendment.
	  • Corrections shall be made as close to the original recording as possible.
		If a digital record of the referral is used then comments could be added immediately and retained as a permanent element of the referral record.

11. Review letter	The Clinician supporting review activities for the CR team will review the hard copy of the Letter.	The referral letter could be reviewed through a system such as Healthlink.
12. Notify the CR team of outcome	The Clinician informs the CR team of the outcome of their review of the referral letter.	The outcome of the review could be recorded in a system and the CR team would then be notified that this is available.
13. Proceed with referral?	If the referral will be proceeded with the next step is Step 14. If the referral will not be proceeded with the next step is the Reject Referral process which is a separate process (see pg. 37)	Confirm in system - checks could be included in system checklist.
14. Check iPMS/PAS for Patient in referral	Access iPMS/PAS and search for the patient record.	Patient records to be transferred from referral system to iPMS/PAS without manual intervention.
15. Patient in iPMS/PAS?	If there is a patient record for the patient in the referral the next step is Step 17. If there is no patient record for the patient in the referral the next step is Step 16.	
16. Create Patient record	Create a new record for the referral patient in iPMS/PAS using the data in the referral letter.	Patient records to be transferred from referral

Step	Description	Technology Gap
		system to iPMS/PAS without manual intervention.
17. Add referral to patient record and wait list	Record details of the referral in iPMS/PAS for the patient record and add to the wait list.	Patient records to be transferred from referral system to iPMS/PAS without manual intervention.
18. Store hard copy of letter	The letter is stored to facilitate the management of all Patient related records as hard copy files.	An E-HR solution could be utilised to manage all Patient data digitally.
19. Generate acknowledgement notifications (within 7 working days) for SOR and patient / guardian	The acknowledgement notification may be a letter or a Healthlink response or a SMS message to inform the patient/guardian and the SOR that the referral has been received. A Healthlink response is generated if the referral was received in Healthlink. If the notification is a letter this will be generated in iPMS/PAS and associated with the referral record. If the notification is a Healthlink response this is generated in Healthlink. If the notification is a SMS message this will be generated through the hospital's SMS messaging system.	Letter template in iPMS/PAS could be provided to automatically populate waiting times information. Notifications issued by SMS can be issued to the recipients immediately. Waiting time in the notification is to be automatically populated as these are not populated.
20. Issue acknowledgement notifications (within 7 working days) to SOR and to patient / guardian	The notification is sent as a letter by Post if a letter is generated in Step 19. If the notification is generated in Healthlink it is sent through Healthlink. If the notification is generated as a SMS message it is issued electronically.	The letters could be issued digitally as emails to the SOR and the patient / guardian.
Referral to Clinician and Prioritisation	The referral is transferred to the Referral to Clinician and Prioritisation process.	Detailed in the Referral to Clinician and Prioritisation process.

Table 6.1 – Detailed steps for the Referral Receipt and Registration process

6.1 CR Process Map Step 2.1: Referral receipt and registration



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6.2 CR Process Step 2.2: Referral assignment to Clinician and referral prioritisation

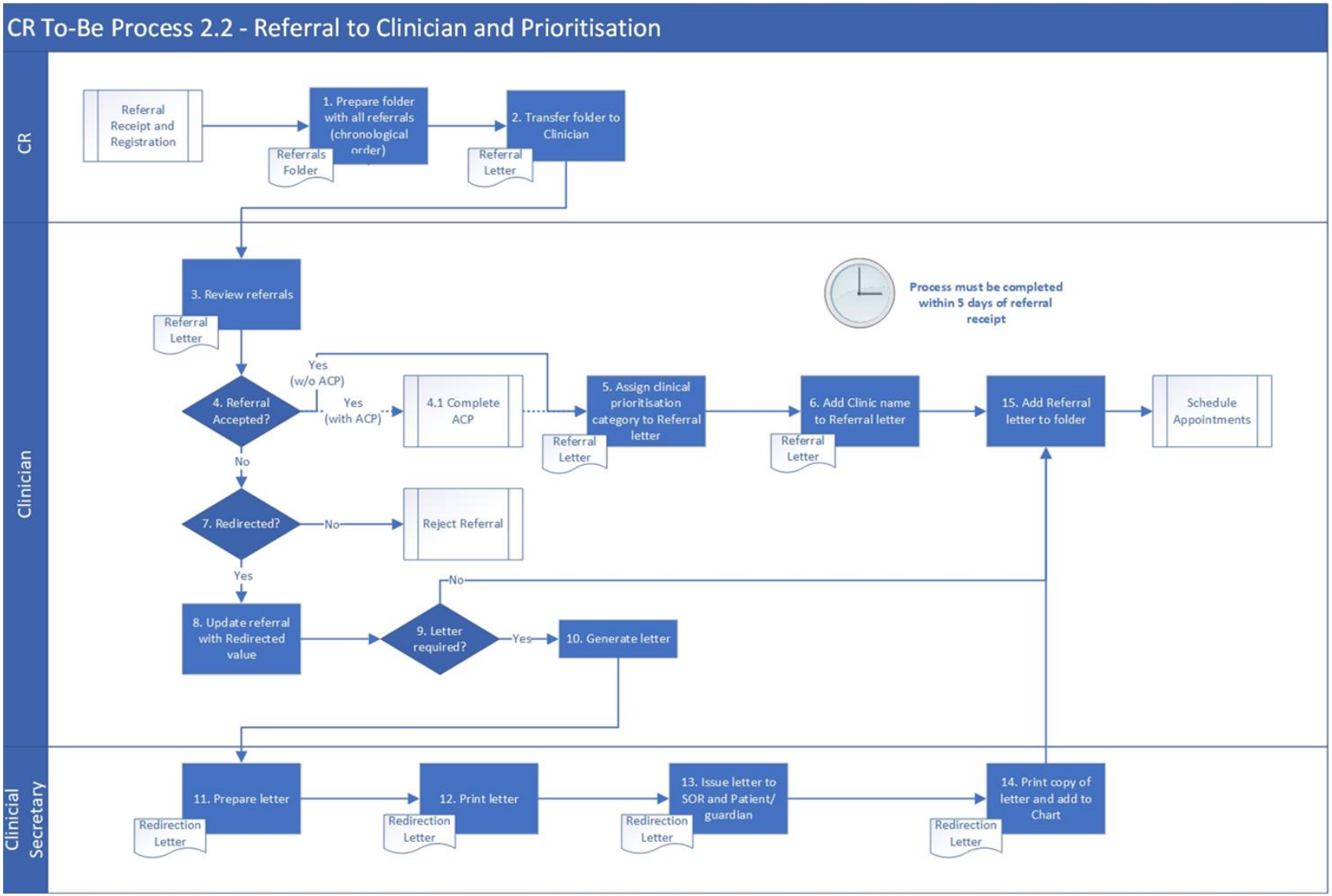
This section includes a table with detailed steps for the Referral assignment to Clinician and referral prioritisation process. Each step represents a component within the process map which is included under the table.

Step	Description	Technology Gap
1. Prepare folder with all referrals	The CR officer places referrals in date order with the first referral received in the previous process on top of the folder.	A digital folder could be created within iPMS to facilitate reviews *(this functionality is to be confirmed).*
2. Transfer folder to reviewing Clinician	The referral folder is provided to the Clinician who will review the referrals.	A system generated message could be sent to the Clinician when the referrals are ready for review.
3. Review referrals	The Clinician reviews the referrals that have been placed in the Folder by reviewing the hard copy referral documents.	The referrals could be reviewed in iPMS.
4. Referral accepted?	If the referral is accepted by the Clinician, the next step is Step 5. If the referral is not accepted by the Clinician, the next step is Step 7.	The review decision could be recorded digitally on iPMS.
4.1 ACP required? (OPTIONAL STEP)	If the Clinician determines that the referral meets the criteria for an Advanced Clinical Prioritisation (ACP) the next step is the Complete ACP process. If the referral is not accepted by the Clinician, the next step is Step 7. If ACP is not in place, the next step is Step 5	
5. Assign clinical prioritisation category to Referral letter	The Clinician assigns the clinical prioritisation category by ticking the appropriate box in the stamp that was applied to the referral letter in Process 2.1. Referral receipt and registration (see pg. 29)	The clinical prioritisation could be selected from a set list within iPMS for the referral record.
6. Add Clinic name to Referral letter	The Clinician notes the name of the clinic that the patient will be referred to directly on the referral letter.	The name of the clinic could be recorded with the referral record in iPMS.
7. Redirected?	If the Clinician determines that the referral is to be redirected the next step is Step 8. If the Clinician determines that the referral does not require redirection the	

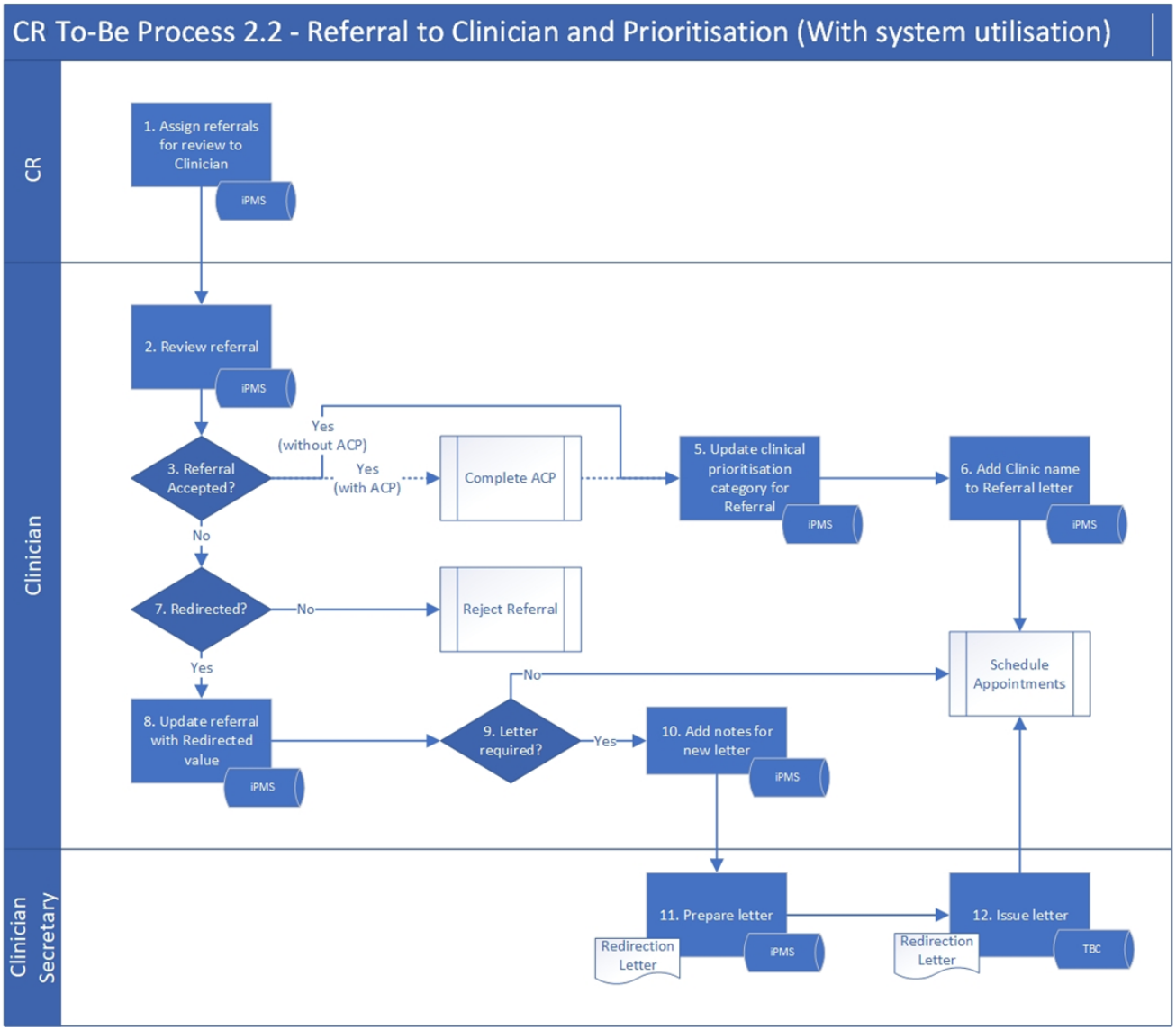
Step	Description	Technology Gap
	next step is the Reject Referral process which is a separate process (see pg. 37)	
8. Update referral with redirected value	The Clinician writes "Redirected" on the Referral letter or ticks a category on the stamp on the Referral letter.	The name of the Clinician could be recorded with the referral record in iPMS.
9. Letter required for redirection?	If a specific letter is required to facilitate the redirection of the referral the next step is Step 10. If a specific letter is not required to facilitate the redirection of the referral the next step is Step 10.	
10. Generate letter	The Clinician dictates notes for the new letter using a Dictaphone or TPro.	Notes for the letter could be recorded with the referral record in iPMS.
11. Prepare letter	The Clinician's Secretary types the new redirection letter in Microsoft Word.	The redirection letter could be generated in iPMS using the information entered by the Clinician in Step 11.
12. Print letter	The letter is printed from Microsoft Word.	The letters could be printed centrally as a scheduled batch job for the CR team. The letters could also be issued digitally to email addresses from iPMS.
13. Issue letter to SOR and to patient / guardian	The letter is sent to all recipients by Post.	The letters could be issued digitally as emails to the SOR and the patient / guardian.
14. Print copy of letter and add to Chart	The redirection letter is printed and added to the patient's paper chart.	i) The redirection letter could be stored with all of the patient data in a system. ii) The letter could be stored with the referral record in iPMS.
15. Add referral letter to folder	The referral letter is placed back in the folder, and this is then transferred back to the CR team.	The referrals could be progressed on an individual basis using iPMS rather than waiting for all referrals to be reviewed and placed back in the folder and transferred back to the CR team.

Table 6.2 – Detailed steps for the Referral assignment to Clinician and referral prioritisation process

6.2.1 CR Process Map Step 2.2: Referral assignment to Clinician and referral prioritisation



6.2.2 CR Process Map Step 2.2B: Referral assignment to Clinician and referral prioritisation (with system utilisation)



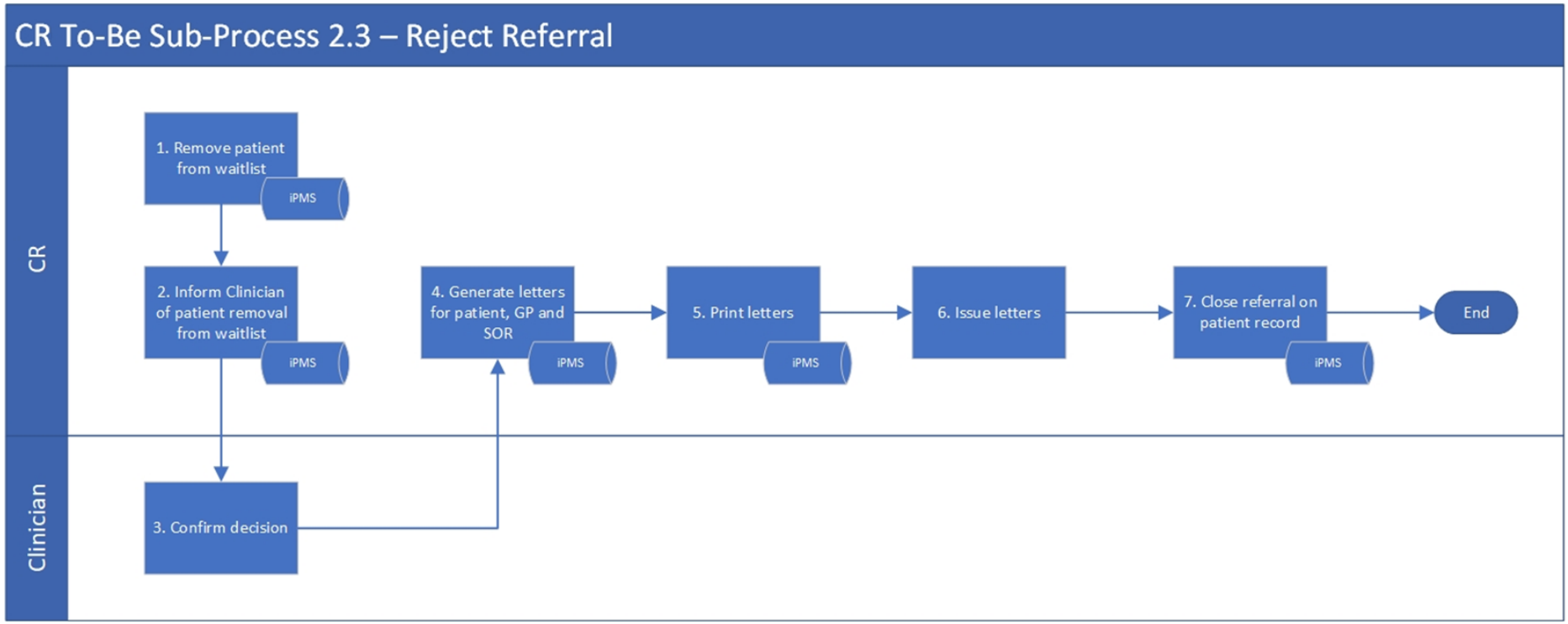
6.3 CR Process Step 2.3: Reject Referrals

This section includes a table with detailed steps for the Reject Referrals process. Each step represents a component within the process map which is included under the table.

Step	Description	Technology Gap
1. Remove patient from waitlist	The CR officer removes the patient record from the Clinician's waitlist.	
2. Inform Clinician of patient removal from waitlist	The CR officer informs the Clinician that the patient record has been removed from the wait list.	The request for the Clinician to review this decision could be recorded in a system and then sent to the Clinician.
3. Confirm decision	The Clinician reviews the referral and confirms this decision.	The Clinician could record their decision in a system.
4. Generate letters for patient and SOR	The CR officer generates letters to notify the patient/ patient guardian and the SOR that the patient has been removed from the waiting list.	The system could generate this letter automatically if the decision to reject the referral is recorded.
5. Print letters	The letter is printed from iPMS/PAS.	The letters could be printed centrally as a scheduled batch job for the CR team. The letters could also be issued digitally to email addresses from iPMS/PAS.
6. Issue letters	The letter is sent to all recipients by Post.	The letters could be issued digitally as emails to the patient / guardian.
7. Close referral on patient record	The CR officer closes the referral on the patient record in iPMS/PAS.	

Table 6.3 – Detailed steps for the Reject Referral process

6.3 CR Process Map Step 2.3: Reject Referrals



CHAPTER 7: CR LETTER & COMMS PACK

TO BE ADAPTED LOCALLY

Contents covered in this Chapter:

7.0 Overview

7.1 Acknowledgement of Receipt of Referral (Patient Only)

7.2 Referral Accepted and Placement on the Waiting List with CPC

7.3 Notification that the referral is redirected

7.4 Notification that the referral is rejected

Target Audience:

Scheduled Care Leads

CR Teams

Chapter 7: CR Letter and Communications Pack (to be adapted locally)

7.0 Overview

Central Referrals encompasses referral and booking processes from the decision to refer through to scheduling of first and subsequent appointments in the Acute Hospital and Community settings. As outlined in the Multi-Annual Waiting Lists Reduction Plan, the purpose of CR is to: (i) engage patients in decision making processes regarding planning their care and treatment, (ii) centralise referral and booking processes, (iii) ensure that patients are on the most appropriate care pathway and (iv) ensure that patients are seen as soon as possible.

Letters are issued at key stages during the CR processes. These are issued to patients or guardians of patients, Source of Referrals (SORs) and GPs. Letter templates have been developed and these can be customised. The letter templates are provided to the hospital and updated as required.

This document includes nine letter templates, which are to be populated accordingly and customised as required to the local hospital.

Letters

A number of letters have been defined and templates have been drafted for hospital use. Those pertaining to the referral receipt process are detailed in this section. For each letter, the text of the letter is included in this section. For the complete suite of letters for all element of the CR process please refer to the CR national guidance document.

An overview of the letters and the processes that are issued during the referral receipt process is included in the table below.

Letter	When to issue	Related process
1. Acknowledgement of Receipt of Referral (Patient Only)	This is issued when the referral has been checked by the CR officer and it has been added to the specialty wait list.	Process 2.1 – Referral Receipt and Registration
2. Referral Accepted and Placement on the Waiting List with CPC	This is issued to the SOR to inform them of the patient's clinical prioritisation.	Process 2.1 – Referral Receipt and Registration
3. Notification that the referral is redirected	This is issued to the SOR to inform them that the referral has been reviewed and has been redirected.	Process 2.2 – Referral assignment to Clinician and prioritisation
4. Notification that the referral is rejected	This is issued to the GP, SOR and patient when the referral is rejected.	Process 2.3 – Reject referral

7.1 Acknowledgement of Receipt of Referral (Patient Only)

<Insert Header>

< Date >

< Patient name >

< Patient address >

< Patient address >

Dear <Patient>,

Patient ID:	**<Healthcare Record Number>**
Name:	**< Patient Name>**
Date of Birth:	**<Date of Birth>**

I wish to confirm that we have received a <speciality> referral for you and this referral has been added to the <speciality>Outpatient waiting list.

If you receive an appointment elsewhere or you wish to be removed from the waiting list, we would be grateful if you contact us immediately on Ph: {insert phone no} or email: {insert email}

Thank you,

Yours sincerely,

< User Name >

_____

Central Referrals

Phone:

Email:

cc: < SOR name >, <GP>

7.2 Referral Accepted and Placement on the Waiting List with CPC

<Insert Header>

<Insert SOR/GP Information>

<Insert Date>

Dear Dr. ,

Reference:

Patient ID:

Patient Name:

Date of Birth:

We received a referral for the above patient. This patient has been added to the <Hospital Specialty> OPWL. The referral has been reviewed by a Consultant and graded <Urgent> <Semi-Urgent><Non-urgent>

If your patient has received an appointment elsewhere or now wishes to be removed from the waiting list, we would be grateful if you contact us immediately on Phone: {insert number} or email: {insert email address}

Yours sincerely,

_____

Central Referrals

Tel: {Insert Number}

Email: {Insert Email address}

c.c. <SOR>, <Patient or Parent/Guardian>

7.3 Notification that the referral is redirected

<Insert Header>

< Date >

< SOR/GP >

<Address>

Dear Dr,

Patient ID: **<Healthcare Record Number>**
Name: **< Patient Name>**
Date of Birth: **<Date of Birth>**

I wish to confirm that we have received a <speciality> referral from your service.

On review of the referral a clinical decision has been made to **redirect** this referral to a more appropriate service _____. We will forward on the letter of referral for clinician review and triage.

If you have any queries at all in relation to this, please do not hesitate to contact us:

Phone: {Insert Number} or Email: {Insert email address}

Thank you,

Yours sincerely,

< User Name >

_____

Central Referrals

Tel: {Insert Phone Number}

Email: {Insert email address}

cc: <Patient or Parent/Guardian>,<GP>

7.4 Notification that the referral is rejected

<Insert Header>

< Date >

< SOR name >

< SOR address >

Dear Dr,

Patient ID: **<Healthcare Record Number>**

Name: **< Patient Name>**

Date of Birth: **<Date of Birth>**

I wish to confirm that we have received a <speciality> referral from your service. On review of the referral a decision has been made to reject this referral. Referrals are rejected based on the following criteria:

- The referral has been deemed as an inappropriate referral (i.e. the service/speciality/procedure is not delivered by the hospital). ☐

OR

- The referral contains insufficient clinical information and we are therefore returning this referral to you. ☐

If you have any queries at all in relation to this, please do not hesitate to contact us:

Phone: {Insert Number} or Email: {Insert email address}

Thank you,

Yours sincerely,

< User Name >

_____

Central Referrals

Tel: {Insert Number}

Email: {Insert Email Address}

cc: <Patient or Parent/Guardian>, <GP>

CHAPTER 8: EDUCATION TOOLKIT

Contents covered in this Chapter:

- Education Toolkit for hospitals

Target Audience:

Clinical Leads

CR Hospital Leads

CR Teams

Chapter 8: Education Toolkit

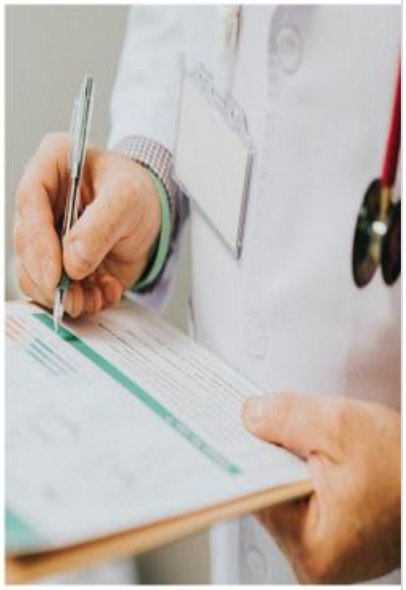
Central Referrals – Education toolkit for Hospitals

March 2024

Seirbhís Sláinte Nios Fearr á Forbairt | Building a Better Health Service

Purpose of this document

- What is Central Referrals (CR)
- Why do we need Central Referrals (CR)
- How to implement Central Referrals (CR)
- Roles and Responsibilities of Central Referrals (CR) teams
- Impact of Central Referrals (CR)
- Reporting of Central Referrals (CR)



Learning Objectives

After this training session you should be able to:

- Understand what CR is
- Understand why CR is important
- Understand what is required to implement CR
- Understand the roles and responsibilities of the CR team
- Understand the impact of CR
- Understand the reporting and metrics associated with CR

What is Central Referrals?

Central Referrals (CR) encompasses referral and booking processes from the decision to refer through to scheduling of first and subsequent appointments in the Acute Hospital and Community settings.

The aim of implementing CR is to:

i. Engage patients in decision making processes regarding planning their care and treatment

ii. Enable referrals to be managed centrally (at regional level)

iii. Ensure that patients are on the most appropriate care pathway

iv. Ensure patients are seen as soon as possible.

What are the Central Referrals Processes & key components?

To-Be Processes have been defined for CRs to specify how activities pilot should be delivered.

All of the processes align with the HSE National Outpatient Waiting List Management Protocol 2022 and have been developed by the CR team and verified through the ULHG CR pilot in November 2022 – May 2023.

The To-Be Processes that have been defined for CR include:

- Referral receipt and registration, including specialty specific e-referral forms and registration of referral
- Referral assignment to consultant and referral prioritisation
- Schedule appointments
- Review Wait List
- Reject referrals (sub-process)
- Generate and Issue Letters (sub-process)
- Cancel Appointment (sub-process)
- Did Not Attend (sub-process)
- Attend Appointment (sub-process)

Why do we need CROs?

The Reform programme aims to ensure:

1. A whole system model of care approach; ensuring patients needing schedule/planned care will receive the right care in the right place, at the right time
2. Clinical and cost-effective care delivery through high-reliability services focused on reducing variability and inequalities and improving clinical outcomes
3. A significant reduction in scheduled care waiting times across Acute and Community in order to achieve the maximum waiting times outlined within the Sláintecare report

Implementing a Central Referrals Office aims to:

- Engage patients in decision making processes regarding planning their care and treatment
- Enable referrals to be managed centrally (at CHO/ Hospital Group/ RHA level)
- Ensure that patients are on the most appropriate care pathway
- Ensure patients are seen as soon as possible.

How do we implement Central Referrals?

The pilot for CR took place in ULHG from mid November 2022 until mid May 2023.

The pilot included:

- Validation of the CR To-Be processes
- Advanced Clinical Prioritisation to support clinical review of referrals
- Patient Initiated Reviews

Learnings from the pilot will be used to deliver a national roll out of CRs from mid 2023. The following deliverables will be produced to support the rollout:

- National Standard Operating Procedure for the delivery of Central Referrals
- To-Be processes (validated in the ULHG pilot)
- Identified technology enablers
- A national implementation plan for the rollout

Roles and responsibilities of Central Referrals teams – what does it mean for the Central Referrals team?

Referral Receipt and Registration

- Review referrals received to CR
- Stamp all referrals received into CR
- Confirm that all of the required information is provided in the referral
- Contact SOR to request additional information if required
- Update iPMS at the following stages:
  - Creation or update of patient record (where required)
  - Creation of referral record
  - Management of referral in wait list

Referral assignment to consultant

- Prepare referrals and associated information for clinical review

Schedule Appointments

- Update of referral with outcome of clinical review
- Schedule appointments according to the clinical prioritisation category assigned by the Consultant
- Reject referrals where specific criteria are not met
- Closure of referral
- Print all referral related letters and issue to the patient/guardian of patient and SOR where required

Roles and responsibilities of Central Referrals teams – what does it mean for the Clinician?

Referral Receipt and Registration

- Review referral and provide guidance where required

Referral assignment to Consultant and Prioritisation

- Review referrals assigned for review with timelines required
- Confirm if referral is accepted, rejected or redirected
- Assign clinical prioritisation for each referral accepted

Ongoing Central Referrals staff training requirements locally

Staff Cohort	Training provided
Clinicians	• To-Be processes reviewed with lead clinician
CR Officer	• Service Meetings • Relevant IT Demos and processes • SOP circulated

Impact of Central Referrals

Anticipated benefits of introducing Central Referralss in Ireland

- Reduced DNA rates
- Capturing review appointment data
- Enhanced chronological scheduling creating equity for the patient
- A single point of contact for the patient/guardian/source of referral

Reporting of Central Referrals and key metrics

The following metrics will be utilised to measure the effectiveness of CR rollout.

1. Hospital Speciality Waiting List by Wait-time bands
2. Weekly additions to the Waiting List – by Clinical priority
3. Weekly additions to the Waiting List – by Consultant
4. Attendances - Attendances and New : Return ratio
5. Attendances – Did Not Attend
6. Attendances – Cancellations by type

THANK YOU

If you have any questions regarding CR, please contact a member of the Acute Access Team below and we will be happy to help!

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