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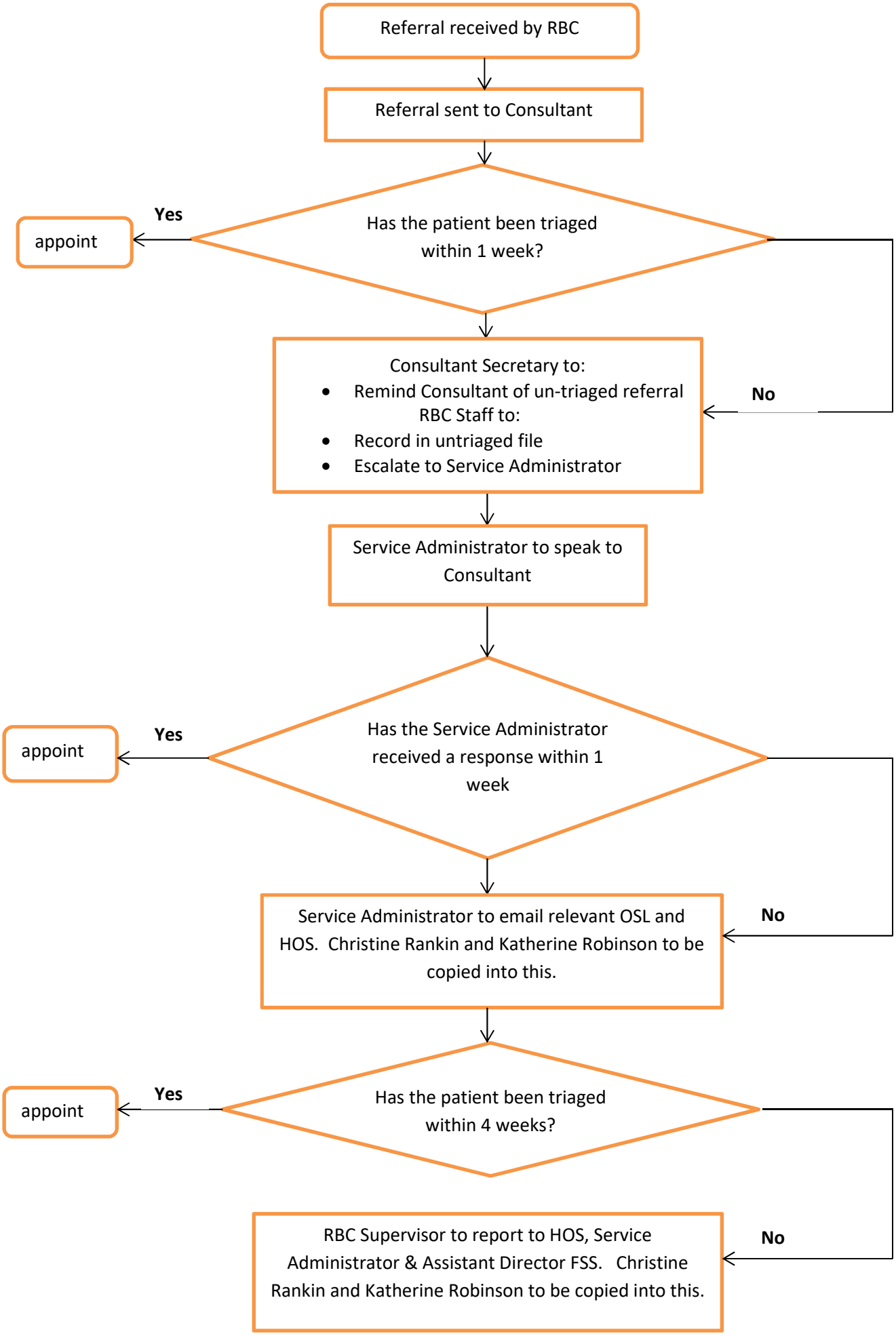
Thank you

Leanne Browne
Acting Supervisor – Gynae, Urology, Urology ICATS, Orthoptics Referral & Booking Centre Ramone Building
Craigavon Area Hospital Ext 3404

TRIAGE PROCESS



Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

Corrigan, Martina

From: Carroll, Ronan
Sent: 20 December 2016 23:05
To: Corrigan, Martina
Subject: FW: Concerns raised by an SAI panel
Attachments: sai panels concerns.pdf

Martina
As discussed this pm
Ronan

Ronan Carroll
Assistant Director Acute Services
ATICs/Surgery & Elective Care
Personal Information redacted by USI

-----Original Message-----
From: Boyce, Tracey
Sent: 16 December 2016 16:34
To: Carroll, Ronan; Gishkori, Esther
Cc: Stinson, Emma M
Subject: Concerns raised by an SAI panel

Hi Ronan and Esther
Could we have chat about this next week - I am at a regional strategy day on Monday - perhaps we could get together on Tuesday?

Kind regards

Tracey

Dr Tracey Boyce
Director of Pharmacy
Personal Information redacted by USI

-----Original Message-----
From: tracey.[Personal information redacted by USI]
Sent: 16 December 2016 16:30
To: Boyce, Tracey
Subject: Scan from YSoft SafeQ

Scan for the user Tracey Boyce (tracey.boyce) from the device CAH - Pharmacy Corridor - C308

Southern Health and Social Care Trust

15 December 2016

Dear Tracey

As you are aware the SAI review and report in relation to [redacted] reference number [redacted] complete.

The remit of [redacted] s Serious Adverse Incident was to fully investigate the circumstances which contributed to her clinical incident. The Review Team was comprised Mr Anthony Glackin Consultant Urologist, Dr Aaron Milligan Consultant Radiologist, Mrs Katherine Robinson Booking and Contact Centre Manager, and Mrs Christine Rankin Booking Manager. To provide context, part of the work included a look-back exercise for 7 Urology patients who managed in the same manner as [redacted] in October 2014. This was to satisfy the panel that there was a management plan in place and no harm had come to the other 7 patient (letters) which were not triaged on the week ending 30 October 2014. The manual look-back was done using the 6 available patient charts on 14 November 2016. These 6 patients all have been discharged or management plans in place. The 7th (patient initials [redacted] chart was not able to be found on Trust property at this time. [redacted] s chart arrived to the Governance office on week commencing 28 November 2016. The look-back exercise was completed on13 December 2016. There is clinical detail within the dictated letter in relation to the [redacted] s consultation which requires clinical validation. This has been given to Mr Anthony Glackin to review on 15 December 2016.

Upon conclusion, the Review Team agree there are a number of relevant and related issues/themes causing concern for the panel which have been exposed during the SAI investigation. The Panel would like to clarify that all relevant enquiries made while undertaking this report have been solely limited to the information which were independently provided by members of the Review panel in conjunction with Mrs Andrea Cunningham, Service Administrator. There have not been any approaches made directly to the Urology Clerical team, the Urology Head of Service or the Assistant Director of Surgery and Elective Care for any information or evidence of communication.

Issues and Themes of concern include:

- In May 2014, there was an informal process was implemented to monitor/manage Urology letters which had not been returned with management advice (not triaged). It appears that this process was created in an effort to limit risk of harm to the patient. The presence of this process implies that it was accepted that triage non-compliance was to be expected by a minority of consultants within the Urology specialty. On 6 November 2015, an email from the AD of Functional Service formally implementing this process. The Review Panel are anxious that the current process does not have a clear escalation plan which evidences inclusion of the Consultant involved. In addition, this process has not been effective in addressing triage non-compliance. From 28 July 2015 until 5 October 2016, there are 318 patient letters which were not triaged. Currently the Trust cannot provide assurance that the Urology non-triaged patient cohort are not being exposed to harm while waiting 74 weeks for a Routine appointment or 37 weeks for an urgent appointment.

- During the manual look-back exercise on 14 November 2016, Patient 99 [redacted]s patient chart could not be found on Trust premises. Patient 99 [redacted]'s chart did appear in the Acute Governance office the week commencing 28 November 2016. After informal queries, it is understood that patient notes are not transported via Trust vehicles to or from Dr 6's outlying clinics (inc SWAH). This could compound efforts to establish any chart location or outstanding dictation. The Review panel acknowledge that processes should not be drafted to address one issue with one specialist team. On balance, the Review team agree there is sufficient cause for concern that Trust documentation may be leaving Trust facilities and the process of record transportation for this Specialty does need urgently addressed.

- There is clear evidence that this patient Patient 99 [redacted]s letter was not triaged by week ending 30 October 2014. Personal information redacted by [redacted] was seen in SWAH by Dr 6 in Personal Information redacted by USI [redacted] The outpatient letter was dictated 11 November 2016 and typed 15 November 2016. The Review panel have grave concerns that there are other Urology patient letters not being dictated in a timely manner. Upon further investigation, the Panel have found that the Trust does monitor the number charts needing audio-typing of dictation but there does not appear to be a robust process to monitor if post-consultation patient dictation has been completed. This has the potential to be compounded if patient charts are leaving the Trust facilities. The SAI Panel are anxious that assurance is sought that there is reasonable compliance in relation to the timely dictation letters by Dr 6.

Southern Health and Social Care Trust

Incident Oversight Group

Tuesday 1st September 2020, 5:00pm

Via Zoom

AGENDA

No	Item	Documents
1	Apologies	
2	Review of Action Log	Attached to email
3	Update on Communications with PHA / HSCB / DoH	
4	Any Other Business	
5	Date of Next Meeting 8th September 2020	

Incident Management

ID	Element	Actions Required	Responsible	Date for Completion	Attachments	Complete
1	GMC Request for Information 27th July 2020	GMC Response issued, further update information required regarding patient notes for original 5 SAIs	M Corrigan / S Wallace	27th August	Response attached 4CA5AFA5.msg	In progress
2	MHPS Investigation (New)	Response from AOB solictor awaited regarding participation in the MHPS process. AOB is no longer professionally accountable to the SHSCT and Dr O'Kane is not responsible officer - this has been the case since 29th July 2020. DLS advice to be sought on continuing MHPS process	M O'Kane / S Hynds / S Wallace	8th September		In progress
3	Administration Review	Dr Rose McCullagh and Dr Mary Donnelly are conducting an administrative process review as specified in the 2018 MHPS review outcome. Report due to be presented to the Director of Acute Services	R McCullagh / M Donnelly	30th September		In progress
4	Screening of potential SAIs - Service User A - Service User B - Service User C - Service User D - Service User E - Service User F - Service User G	Three SAIs screened, (Service Users A, B and C). Further 4 cases to be screened	M Haynes / M Corrigan / P Kingsnorth	1st September	SAI Screening complete - 3 confirmed SAIs - clinical summaries \\svrfile11\users6$\stephen.wallace\Desktop\New \\svrfile11\users6$\stephen.wallace\Desktop\New \\svrfile11\users6$\stephen.wallace\Desktop\New	In progress
5	Communication with Service Users / Families	S Wallace / P Kingsnorth to discuss potential content of family communications with Jane McKimm. Further discussion with PHA / HSCB re approach also required	M Haynes / P Kingsnorth / S Wallace / J McKimm	8th September		In progress
6	Conducting SAIs	Leadership centre had been approached to identify a SAI chairperson to conduct the SAI's. This process was required to go to mini-competition and will be concluded next week. BAUS have been contacted via the RCS to identify both a subject matter expert with regard to the SAI's and to assist with identifying an appropriate IRS sample.	S Wallace / P Kingsnorth	10th September		In progress

7	Engagement of ISP to undertake waiting list work	Draft contract engagement document under development - pathways for service access to be mapped	M Haynes / M Corrigan	3rd September	Pathways under development	In progress
8	Lookback Scope	Contact with IRS re lookback scope who have suggested a sample taken over last five years. IRS potentially can carry out casenote review lookback during October- Nov. Realistically this will be a maximum of 80 patient charts Regional lookback policy reviewed, contact made with DoH (Jackie Johnston) who has advised that potential lookback scope should be discussed with PHA / HSCB in the first instance Data activity for 5 years for AOB collated. To consider all elements of practice 5 year activity being mapped for AOB -Inpatient Elective -Inpatient Emergency -Outpatients -Review Appointment - Cancer -Review Appointment - Non-Cancer	M McClements / M Haynes / S Wallace / M O'Kane / M Corrigan / R Carroll	1st September		In progress
9	Clinician Early Alert	M O'Kane / S Wallace to discuss Clinician Early Alert with DoH	Dr Maria O'Kane / S Wallace	27th August		
10	AOB work at other Trusts	To identify if AOB conducted sessions at other Trusts outside of SHSCT employment	S Wallace / M Corrigan	1st September	Preliniary enquries have not identified any addional sessional work directly with other regional Trusts	No
11	Copies of Patient Records (Service users A and B) to be provided to AOB)	Copies of notes to be sourced, copied and redacted	M Corrigan	7th August	Redaction of notes being completed 7th August, viability of electronic sharing of notes to be considered	Complete
12	Early Alert to DoH	Early Alert issued to DoH and HSCB	Dr Maria O'Kane / S Wallace	31st July	Early Alert issued to DoH and HSCB. Phone contact made from Dr O'Kane to Deputy CMO 6th August 2020	Complete
13	Information on Appraisal, Job Planning and Complaints	Information on apprisal, job planning and complaints collated	S Wallace	7th August	Information Collated - saved in shared folder	Complete
14	Incident Governance Oversight	Terms of reference developed - for agreement by oversight group / SMT CX	Dr Maria O'Kane / S Wallace	10th August	ToR Agreed	Complete

Southern Health and Social Care Trust

Quality Care - for you, with you

17th August 2020 Ref: MOK/ec

Via email [redacted]

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street,
Manchester

Dear Mr Brammall,

RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO. 1394911

Further to your email dated 30th July 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses and where required, attached items.

A copy of Mr O'Brien's job plan	Copies of the last two electronic job plans that are held in our job planning system for Mr O'Brien are attached in Appendix 1. Please note that they were not signed off by Mr O'Brien. These were previously sent to the GMC in response to this communication by Zoe Parks on 30th July 2020.
Any update that you may have about contacting the RCS for advice on the parameters of a possible lookback / patient recall exercise and information that	The Trust has hosted a discussion with the Royal College Surgeons Invited Review Service on the 28th July 2020 which explored the options for and extent of any potential lookback should this be required. A follow up call was conducted on 4th August with the

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [redacted] Email: [redacted]

may have arisen out of any review	Royal College of Surgeons Head of Invited Review manager where potential scale and scope of a lookback was discussed. The Trust will be discussing the potential for progressing with any lookback with the Department of Health over the next week.
An update about the new MHPS investigation that was being considered due to the additional concerns about Mr O'Brien that arose recently	The Trust has commenced preliminary enquiries in respect of the additional concerns which have now arisen under the MHPS Framework. Mr O'Brien's former clinical manager Mr Haynes, as Associate Medical Director, is the clinical manager co-ordinating preliminary enquiries under para 15 of Section I of MHPS. Mr O'Brien has been notified of this and a request has been made for his input to the preliminary enquiries process. A formal investigation has not been commenced at this point. Mr O'Brien is seeking advices in respect of his engagement in the MHPS preliminary enquires process and the Trust awaits his decision in this regard, via his solicitor.
Any updates concerning the SAI reviews for the following patients identified in the information originally sent to the GMC (if SAIs have been completed, please could you provide copies of these?): • Patient 14 (CAHE Personal Information redacted by USI) • Patient 11 (CAHE Personal Information redacted by USI) • Patient 13 (CAHE Personal Information redacted by USI) • Patient 12 (CAH Personal Information redacted by USI)	The Serious Adverse Incident Reviews for the listed patients have been completed. Copies of the review which was provided in a consolidated single report can be found attached in Appendix 2.

Any updates concerning the SAI reviews for service user A and service user B as identified in the new concerns that were recently sent to the GMC	Both Service User A and B have been screened and meets the requirement for a Serious Adverse Incident review and are being progressed as per regional and Trust processes. Since our last update a third case, Service User C has also been identified as meeting the requirement for a Serious Adverse Incident review.
Any data that you may hold for comparison purposes regarding the triage process and Mr O'Brien's peers (for example, any audit data / data gathered in relation to other urology consultants) in relation to patients who may have been mis-triaged	The Trust does not have formal data on the triage comparison between Mr O'Brien and his peers. All incidents have been identified by exception; no other triaging related incidents have been identified with any other Urology Consultant.
The outcome (or a copy of) the independent review into the administrative procedures that is due to be concluded by September 2020 (when this becomes available)	The review of administrative procedures is underway and will be shared following completion in September 2020 at which point a copy will be shared with the GMC.
Any guidance or protocols that were put in place for the urology department in terms of triaging incoming referrals using the three tier system and how this was shared with the urology consultants including Mr O'Brien	The Trust do not use the three tier system for triaging but follow the Northern Ireland Cancer Network (NICaN) referral guidance, which is based on NICE guidelines. Appendix 3 show the prostate and bladder guidance for triage (which is usually updated every year) and which is shared and used by all urology consultants in Northern Ireland.

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The relevant medical records for service user A and service user B as identified in the more recent concerns.	Copies of Service Users A and B redacted notes are attached as Appendix 4.
The relevant medical records for the following patients as identified in the concerns originally sent to the GMC. • Patient 10 (CAHE Personal Information redacted by USI) • Patient 14 (CAHE Personal Information redacted by USI) • Patient 11 (CAHE Personal Information redacted by USI) • Patient 13 (CAHE Personal Information redacted by USI) • Patient 12 (CAH Personal Information redacted by USI)	Copies of the patient will not be available until 24th August 2020 and will be forwarded following this.
Please could you provide details of the circumstances of the cancellation of the meeting in September 2018 and the lack of senior management availability in December 2018 including details of any plans that were put in place for Mr O'Brien / other consultants to raise their concerns to senior management	The meeting that was scheduled to take place between Urology Consultants and management in September 2018 was cancelled following the unexpected sickness absence of the Head of Service for Surgery. The Consultant body agreed that in the absence of the head of service the meeting should not progress. The meeting scheduled for December 2018 did not progress as 3 of the 6 Consultant Urology staff were unable to attend.

I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me.

Yours sincerely

Personal information redacted by USI

Dr Maria O'Kane
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI Email: Personal Information redacted by USI

Northern Ireland Cancer Network (NICaN) referral guidance

The Northern Ireland Cancer Network (NICaN) referral guidance issued in 2012 was informed by the NICE Referral Guidelines for Suspected Cancer 2005. NICE issued revised guidance, Suspected cancer: recognition and referral (NG12) in 2015 which sets out suspect cancer referral guidance for all cancers. The CRG recently undertook a review of the referral guidance for patients with suspect prostate cancer and proposed alternative guidance. Based on a review of other pathways across NHS England, HSE Ireland and considering evidence from the Prostate Cancer Risk Management Programme, Stockholm STHLM3 JNCI J National Cancer Institute 2016.

The revised guideline, whilst cognisant of the NICE recommendations, provides additional detail to help guide primary health care professionals in their decision making in relation to when to undertake PSA testing and when to refer patients as suspect cancer. The CRG completed a review of the Pre PSA Testing Advice leaflet given to patients by their GP and with the help of the NICaN Readers Panel updated this to ensure the information would offer the best advice to those who were considering having a PSA test. Pre-PSA Testing Advice Leaflet

The revised guidance has been approved by the NICaN Board, the HSCB and is supported by NIGPC: GP Suspect Prostate Cancer Referral Guidance Pathway Alongside the development of revised referral guidance for suspect prostate cancer the CRG is undertaken a review of the diagnostic pathway which is in the final stages of approval . This pathway will help navigate patients through the diagnostic pathway ensuring timely and appropriate investigations are completed to determine each patients treatment care plan.

Final Proposed Prostate Diagnostic Pathway December 2019

NICaN SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY

GP RED FLAG REFERRAL

Initial Assessment
- DRE
- Flow Rate (with moderate symptoms, IPSS >8)
- Residual volume
- Consider Assessment of Prostate volume / PSA Density
- ECOG status
- Charlson Co-morbidity index: https://www.mdcalc.com/charlson-comorbidity-index-cci

PSA <20 and ECOG ≥2 or CCI ≥5

Abnormal DRE
PSA >20
•Biopsy
•CT/ Bone Scan
•+/- MRI

ECOG <2 or CCI <5

DRE normal
And
PSAD (US/ DRE) <0.1

Abnormal DRE
Or
DRE Normal and
PSAD (US/DRE) >0.1
Or
PSADT (on PSA Monitoring) <4yrs

MRI prostate

MRI PSAD <0.15
And
MRI No Abnormality

MRI PSAD ≥0.15
Or
PIRADS 3/4/5 abnormality

MDM DISCUSSION
Malignant Diagnosis Only

PSA monitoring
(Education of patients regarding PSA monitoring, alert symptoms and access to services)

Prostate biopsy (TP or TRUS) + targeted biopsies of MRI abnormality
(Consider prostate volume as part of the initial assessment of a patient with a raised PSA and before MRI)

PIRADS 3 and PSAD <0.15 discuss options of PSA monitoring and biopsy, context of imaging and PSA history with patient and proceed according to

Watchful Waiting / Symptomatic management
(Refer to NICaN Watch and Wait Pathway)

Guidance Notes
To help men decide whether to have a prostate biopsy, discuss with them their prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors.
Prostate volume should form part of the discussion with a man about whether further investigation (eg MRI +/- biopsy) or monitoring.
Give men and their partners or carers information, support and adequate time to decide whether or not they wish to undergo prostate biopsy.

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	Date	Clinical Notes
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URINE Protein Sugar Acetone		
WEIGHT kg.		
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Age		
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URINE Protein Sugar Acetone		
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WEIGHT kg.		

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IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept
Address
Consultant

[redacted]
Personal Information redacted by USI

NOTES

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Out-Patient Use Only	Date	Clinical Notes
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IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

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Personal Information redacted by USI

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Out-Patient Use Only	Date	Clinical Notes
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Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

LPC 03/08/021

	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by the USI

NOTES

When used for in-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		
→		
Age		
URINE Protein		
Sugar		
Acetone		
WEIGHT		
kg.		

Personal Information redacted by the USI

LPC 03/08/021

	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

[redacted]
Personal Information redacted by USI

NOTES

When used for in-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

[redacted]
Personal Information redacted by the USI

LPC 03/08/021

	Date	Clinical Notes
→		

Personal Information redacted by the USI

Age

URINE Protein
Sugar
Acetone

WEIGHT

kg.

→

Age

URINE Protein
Sugar
Acetone

WEIGHT

kg.

→

Age

URINE Protein
Sugar
Acetone

WEIGHT

kg.

→

Age

URINE Protein
Sugar
Acetone

WEIGHT

kg.

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by USI

Personal Information redacted by USI

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

LPC 03/08/021

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

[redacted]
Personal Information redacted by USI

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		[redacted] Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

LPC 03/08/021

	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: 028 3756 1897
E mail: noleen.elliott@southerntrust.hscni.net
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear DR Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No:

Personal Information redacted by the USI

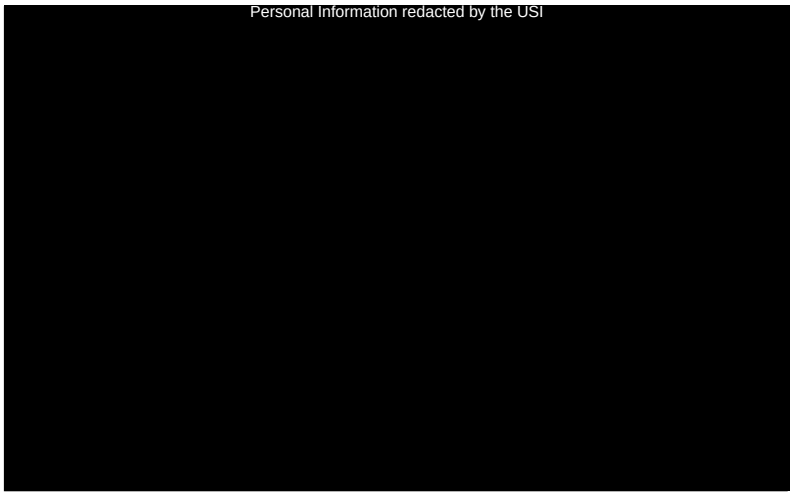
Southern Health and Social Care Trust

Personal Information redacted by the USI

CHART LJB

Personal Information redacted by the USI

Personal Information redacted by the USI


Personal Information redacted by the USI

CARDIOLOGY DEPARTMENT
Craigavon Area Hospital
Lurgan Road
Portadown, Co Armagh,
BT63 5QQ
Secretary: Personal Information redacted by USI
Telephone
Consultant

Personal Information redacted by the USI

Dear Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No:

Personal Information redacted by the USI


Personal Information redacted by the USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: noleen.elliott Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear DR Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by the USI HCN: Personal Information redacted by the USI

Personal Information redacted by the USI

CRAIGAVON CELLULAR PATHOLOGY

Surname [redacted]
Forename
Hosp. No.
DOB/Sex **Male**
Address

Source **CRAIGAVON AREA HOSPITAL**
Consultant **MR A O'BRIEN**

Ward/GP **WARD 1 WEST (ELECTIVE)**
CRAIGAVON AREA HOSPITAL

BT70 1QS **68 LURGAN ROAD**
PORTADOWN **BT63 5QQ**

[redacted]

CRAIGAVON CELLULAR PATHOLOGY

Surname Personal Information redacted by USI

Forename

Hosp. No.

DOB/Sex **Male**

Address

Source **CRAIGAVON AREA HOSPITAL**

Consultant **MR A O'BRIEN**

Ward/GP Personal Information redacted by USI **WARD 1 WEST (ELECTIVE) CRAIGAVON AREA HOSPITAL**

68 LURGAN ROAD
PORTADOWN **BT63 5QQ**

Personal Information redacted by the USI

[redacted]

Date of report print : 15 Mar 2019

CRAIGAVON CELLULAR PATHOLOGY

Surname [redacted]
Forename [redacted]
Hosp. No. [redacted]
DOB/Sex [redacted] Male
Address [redacted]

Source CRAIGAVON AREA HOSPITAL
Consultant MR A O'BRIEN
Ward/GP WARD 1 WEST (ELECTIVE)
[redacted] CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN BT63 5QQ

[redacted]

[redacted]

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: noleen.elliott Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

CONFIDENTIAL

Personal Information redacted by the USI

HCN: Personal Information redacted by USI

Personal Information redacted by the USI

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: [redacted]
E mail: noleen.elliott[redacted]
Secretary: Mrs N. Elliott

[redacted]
CONSULTANT ANAETHETIST
CRAIGAVON AREA HOSPITAL

Dear [redacted]

Re: Patient Name: [redacted]
D.O.B.: [redacted]
Address: [redacted]
Hospital No: [redacted] **HCN:** [redacted]

[redacted]

[redacted]

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: noleen.elliott Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

Dear DR Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.: Personal Information redacted by USI
Address: Personal Information redacted by USI
Hospital No: Personal Information redacted by USI HCN: Personal Information redacted by USI

Personal Information redacted by the USI

Personal Information redacted by the USI

HSC Southern Health and Social Care Trust

Anaesthetics, Theatres
Intensive Care Services

Preoperative Assessment Clinic
Craigavon Area Hospital
Department of Anaesthetics
68 Lurgan Road
Portadown
BT63 5QQ

Tel: Personal Information redacted by the USI

Personal Information redacted by the USI

Predicted Perioperative Risk:
P-POSSUM 30-Day Mortality: **10-18%**

30 Day Morbidity: **70-80%**

Mr A O'Brien
Consultant Urologist
Craigavon Area Hospital

Dear Aidan

Re: **Name:** Personal Information redacted by USI
DOB: Personal Information redacted by USI
Address: Personal Information redacted by the USI
Hospital No: Personal Information redacted by the USI **HCN:** Personal Information redacted by the USI

Personal Information redacted by the USI

[redacted]

Please remember these scores are a ***prediction*** of morbidity and mortality and the scores tend to slightly overpredict in the low-risk group and at the extremes of age.

MDM Report from Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI

Personal Information redacted by USI

(1)

DOB; Personal Information redacted by USI **Hospital Number:** Personal Information redacted by USI **, HCN:** Personal Information redacted by USI

Contact Tel: Personal Information redacted by USI

~~O'Brien office~~ AOP Took notes after clinic is/d

Noleen Elliott await Res

Personal Information redacted by the USI

MDM Report from Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI

Personal Information redacted by USI

DOB: Personal Information redacted by USI **Hospital Number:** Personal Information redacted by USI , **HCN:** Personal Information redacted by USI

Contact Tel: Personal Information redacted by the USI

Personal Information redacted by the USI

MDM Report from Urology MDM @ The Southern Trust

RE:	Personal Information redacted by USI
Contact Tel:	

Urology MDM @ The Southern Trust

Personal Information redacted by USI

RE: Personal Information redacted by USI

Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Dear Dr Personal Information redacted by USI

Personal Information redacted by the USI

Urology MDM @ The Southern Trust

Personal Information redacted by USI

RE: Mr [redacted]

Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Personal Information redacted by the USI

Urology MDM @ The Southern Trust

Personal Information redacted by USI

RE: Mr Personal Information redacted by USI

Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Personal Information redacted by the USI

MDM Plan:

Urology MDM @ The Southern Trust

[redacted]

RE: [redacted]

DOB: [redacted] Hospital Number: [redacted], HCN: [redacted]

[redacted]

MDM Report from Urology MDM @ The Southern Trust

Noleen Elliott - Awaiting Results

RE: Personal Information redacted by USI

Personal Information redacted by USI

DOB: Personal Information redacted by USI **Hospital Number:** Personal Information redacted by USI , HCN: Personal Information redacted by USI

Contact Tel: Personal Information redacted by the USI

Personal Information redacted by the USI

MDM Report from Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by the USI

DOB: Personal Information redacted by USI

Contact Tel: Personal Information redacted by the USI

Hospital Number: , HCN: Personal Information redacted by USI

Personal Information redacted by the USI

[redacted]

Urology MDM @ The Southern Trust

DR [redacted]
Personal Information redacted by USI
Personal Information redacted by USI

[redacted]
Personal Information redacted by the USI

Urology MDM @ The Southern Trust

Personal Information redacted by USI

RE: Personal Information redacted by USI

Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Personal Information redacted by the USI

Southern Health and Social Care Trust

Craigavon Area Hospital, Lurgan Road, Portadown, Craigavon, County Armagh, BT63 5QQ
Tel: 028 3861 3674/2952

Ward Tel:

Notes Copy

Personal Information redacted by USI

Date: Personal Information redacted by the USI 17:08
Discharge Id: Personal Information redacted by USI
Version: 17

505

Dear Personal Information redacted by USI

DISCHARGE NOTIFICATION

Personal Information redacted by the USI

Personal Information redacted by the USI

[redacted]

Personal Information redacted by the USI

Personal Information redacted by the USI

81/CA 51

OPERATION NOTES

Affix Label

HOSPITAL: CRAIGAVON AREA

Operations Performed: RIGHT RADICAL NEPHRECTOMY

Date:

Surgeon: AIDAN O'BRIEN

Anaesthetist:

Assistant: KEN HIGH

Sister: AIDAN CULLEN

Incision

Blood

Findings

Drains

Packs

PROCEDURE

RIGHT FLANK INCISION, RESECTING 11D OF SEVENTH RIB

LARGE RIGHT RENAL TUMOUR MASS EXTENDING TO RIGHT HEMIPELVIS

SINGLE RIGHT RENAL ARTERY & VEIN

RIGHT RADICAL NEPHRECTOMY PERFORMED

2 OF ROBINSON'S DRAIN

CLOSURE: LAYERED MUSCULAR USING

0/1 LOOP PDS x 2

3/0 SUBCUTICULAR MONOCRYL

LISTED FOR MDM DISCUSSION

AIDAN O'BRIEN

Signature of Surgeon: .....

WPH000378 Revised 03/13

OS17959

Personal Information redacted by the USI

MRV Inferior vena cava

Patient ID	Personal Information redacted by USI	Patient Name	Personal Information redacted by the USI
Sex	Male	Date Of Birth	
Time Performed	Personal Information redacted by the USI	Time Reported	
Requested by	Aidan O'Brien	Requested from	Urology Outpatients Craigavon
Order Number	Personal Information redacted by USI	Status	

Personal Information redacted by the USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
OUTPATIENT LETTER
Telephone: Personal Information redacted by the USI
E mail: noleen.elliott@ Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear Personal Information redacted by the USI

Re: Patient Name:
D.O.B.:
Address:
Hospital No:

Personal Information redacted by USI

HCN:

Personal Information redacted by USI

Personal Information redacted by the USI

[redacted]

Southern Health
and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: noleen.elliott Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by the USI

CONFIDENTIAL

Personal Information redacted by USI

HCN: Personal Information redacted by USI

Dear Personal Information redacted by USI

Personal Information redacted by the USI

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Radiology Report

South Tyrone Hospital
South Tyrone Hospital

Carland Road

BT71 4AU

Tel.:
Fax: Personal Information redacted by the USI

Personal Information redacted by USI

Personal Information redacted by USI

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth: Personal Information redacted by USI

Request no. Personal Information redacted by USI

Ref. clinician O'Brien, Aidan

Request date Personal Information redacted by the USI

Referral source
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Personal Information redacted by the USI

Radiology Report

South Tyrone Hospital
South Tyrone Hospital
Tel.:
Fax: Personal Information redacted by the USI

Carland Road

BT71 4AU

Personal Information redacted by USI

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth. Personal Information redacted by USI

Request no. Personal Information redacted by USI

Reason for referral

Personal Information redacted by the USI

Radiology Report

South Tyrone Hospital
South Tyrone Hospital

Tel.:
Fax: Personal Information redacted by the USI

Carland Road

BT71 4AU

Personal Information redacted by USI

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth Personal Information redacted by USI

Request no. Personal Information redacted by USI

Personal Information redacted by the USI

[redacted]

CT Chest with contrast W

Patient ID	Personal Information redacted by USI	**Patient Name**	Personal Information redacted by the USI
Sex	Male	**Date Of Birth**	
Time Performed	Personal Information redacted by the USI	**Time Reported**	
Requested by	Aidan O'Brien	**Requested from**	Urology Outpatients Craigavon
Order Number	Personal Information redacted by the USI	**Status**	Final

Report Final

Personal Information redacted by the USI

Clinical Info From Order Final

Personal Information redacted by the USI

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

Patient ID	Personal Information redacted by USI	**Patient Name**	Personal Information redacted by the USI
Sex	Male	**Date Of Birth**	
Time Performed	Personal Information redacted by the USI	**Time Reported**	
Requested by	Aidan O'Brien	**Requested from**	Urology Outpatients Craigavon
Order Number	Personal Information redacted by the USI	**Status**	Final

Personal Information redacted by the USI

UROLOGY RED FLAG TRIAGE SHEEET

Personal Information redacted by the USI

PATIENT NAME:

HOSPITAL NO:

HCN:

rf.appointment

From: AEreception
Sent: 13 December 2018 05:44
To: rf.appointment
Subject: Red Flag referral
Attachments: Personal Information redacted by USI

Please find Red Flag Haematuria referral for Personal Information redacted by USI

Many thanks,

Christine P.

From: [redacted]
Sent: 13 December 2018 06:49
To: AEreception
Subject: Message from Personal Information redacted by USI

HCN [redacted] Surname [redacted] Forename [redacted] Dob [redacted]
AE Number [redacted] [redacted]
GP [redacted] [redacted]
GP TEL. [redacted]

Diagnosis
1. haematuria ? uti
2.
3.

Investigations and Results
Hb 136 WCC 12

ED Discharge Plan
ABx. Review haematuria clinic

Patient to attend GP re:

Referred to Specialty Time

Admission Agreed By: DTA Time

Grade of Doctor Patient to make appt with GP

Prescription (Medicines on discharge)

Medicine	Dose	Route	Frequency	Duration	Signature	Supply required	Supply Checked by	Given by	Quantity
TRIMETHOPRIM	200 mg	po	BD	7 days	[signature]	T4	[initials]	TO	14 tabs

FINAL PLACEMENT

Admit to ward	GP (ticked)	other hospital OPD	Sign [signature]
CDU	ED Review	Did not wait/refuses Rx	Grade SHO
TNF to OH	Fracture Clinic	Died in ED	Breach Time 02:41
Home	CBYL Psych. Assess	CTMA	Exam Finish Time 0210
OPD (circled) Red flag haematuria. Emailed 13-12-18	ED Physio	Absconded	Departure Time

Discharge OBS

P	BP	RESP	TEMP	SPO2	GCS	CR	BM
86	155/75		37	96	15/15		

Transport booked · Time booked · Ref if NIAS
IV Cannula removed · Advice leaflet given · UNOCINI complete
CBYL given · GP letter given · Patient property returned

Breach Time 02:41

Time left department 02:35 Signature Nurse [signature]

FBP ☑ Coag ☐ Amylase ☐
U&E ☑ D-dimer ☐ Other:
CRP ☑ Troponin ☐ Time:
LFT's ☐ VBG ☐ Sign:
Cardiac ☐ Toxscreen ☐
INR 23:10 ECG ☑ EL

EM[...]AL [...]MENT
[...]5QQ
E[...] [...]scni.net

AE Number [redacted]		HCN [redacted]	Priority Code 3
Surname [redacted]	[redacted]	[redacted]	
Forename [redacted]			
Dob [redacted]	Age 88		
Sex M	MS W	BT70 1QS	
Occ. RETIRED		Tel 02887726844	
Casenote CAHE278515		Mobile/Other 07881580525	

Arrival Date/Time 12/12/2018 22:41	Prev Episodes 02 / 01	Adult Safeguarding Concerns Yes/No
Arrival Mode PR Incident Type NT	Triage Date/Time 12/12/2018 22:53	Social Work Involvement?
Source of Referral Out Of Hours	**Breach Time** 02:41	Current/Past/None/Not Applicable
Accompanied By	Nurse: [redacted]	Special Needs
NOK [redacted]	[redacted]	No Special Needs
Home: [redacted] Work: [redacted]	Tetanus Status: NOT REQUIRED	
Patient at risk of leaving Yes/No	Booster Given Yes/No	

Presenting Complaint ?UTI (ON WARFARIN) REQUESTING INR TEST
Presentation URINARY PROBLEMS
Discriminator FRANK HAEMATURIA
Triage Text NOTICED URINE RED THIS AM WITH SOME POSSIBLE CLOTS ALSO LOWER BACK PAIN

Medication

Anti-Coagulant WARFARIN — On Anti-Coagulant
Allergies NKDA

Signature

Pulse	B/P	RR	PFR	Temp	SaO2	GCS	CRT	BM	PERL	AVPU
76	170/89	18		37	96	15				A

Visual Acuity · Right Eye · Left Eye · Urine · Pregnancy Test · Weight

ECG required yes/no (< 10 minutes cardiac) · History · MRSA · CDIFF · Patient Location GREEN AREA · Pain Score 6 · Time 22:53 · Category 3 Infection

Commenced on NEWS/CNS/PEWS chart Yes No Signature

Nursing Assessment

MENTAL STATE	Yes	No	WASHING AND DRESSING	Yes	No	SOCIAL HISTORY	Yes	No
Alert and Orientated			Independent			Lives Alone		
Confused			Help Required			Lives With		
Agitated			Full Assistance Required			Relatives Present		
Aggressive			Pressure Areas Checked			Aware		
Drowsy			Commode required			Contacted by		
Trolley Sides in Situ			Pad Changed					
MOBILITY			FEEDING AND DIET			Relative Contact Number		
Independent			Dietary Requirements					
Walk with Help			Dentures top			Patient updated at regular intervals		
Walk with Aids			bottom			Yes		No

Personal Information redacted by the USI

[redacted]

Personal Information redacted by the USI

Date/ Time	Summary Of Events	Staff
	Personal Information redacted by the USI	
		AOB
		Nurse Kate ONeill
		AOB

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

[redacted]

Personal Information redacted by the USI

Date/ Time	Summary Of Events	Staff
Personal Information redacted by the USI		
		AOB
		AOB
		FY1
		Urology Registrar
		FY1
		AOB
		AOB

Personal Information redacted by the USI	
	Urology registrar
	JOD
	ED and M Haynes
	M Haynes/Mr Epanomeritakis

Personal Information redacted by the USI

Personal Information redacted by the USI

Date/ Time	Summary Of Events	Staff
	Personal Information redacted by the USI	
		Mr A O'Brien Consultant Urologist

Personal Information redacted by the USI

Dr S Vallely
Dr R McConville Consultant Radiologist
Dr R McKee Consultant Anaesthetist

Personal Information redacted by the USI

[redacted]

Mr A O'Brien
Consultant
Urologist

[redacted]
Personal Information redacted by the USI

Mr A O'Brien
Consultant
Urologist

Dr M Williams
Consultant
Radiologist

Personal Information redacted by the USI

Dr A Milligan
Consultant
Radiologist

Mr M Haynes
Consultant
Urologist

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

UROLOGY RED FLAG TRIAGE SHEEET

PATIENT NAME: Personal Information redacted by USI

HOSPITAL NO: Personal Information redacted by USI

HCN: Personal Information redacted by USI

Personal Information redacted by the USI

Personal Information redacted by USI

Personal Information redacted by USI

d69b86d1-c6fc-4838-b6b9-0ee5a6fe1f98

Personal Information redacted by the USI

Personal Information redacted by USI

BORN Personal Information redacted by USI GENDER Male

OHCP Personal Information redacted by USI

eReferral Triage

Last updated by Personal Information redacted by the USI

Triage Outcome

GP Priority	Red Flag
Triaged Priority	Red Flag
Triage Decision	Redirect

Redirect Referral

Redirect To	Craigavon Area Hospital - UROLOGY
Redirection Reason	Enniskillen pt

Red Flag	TRUS
Upgrade Red Flag	Flex. C/U
Urgent	Flow Rate
Routine	Ultrasound
Other	
Virtual	

Generated by Personal Information redacted by USI

For Trust use only: HCN: Personal Information redacted by USI	Referral Date: Personal Information redacted by the USI
Date Sent: Personal Information redacted by the USI	Surname: Personal Information redacted by USI

LAKESIDE MEDICAL PRACTICE

Practice address

Personal Information redacted by USI

Practice code: Z00564

Contact number(s)

Telephone: Personal Information redacted by USI

Fax:

Practice Email: Personal Information redacted by the USI

Referral to:	Omagh Hospital & PCC	**Referral Type:**	Out Patient
Specialty:	UROLOGY	**Nature of Request:**	Investigate
Urgency:	**RED FLAG**		
Cancer Site:	URC		
Electronic Attachment Present?:	No		
HCP Name:			
Designation:			

Practice Code:	Personal Information redacted by USI	**Registered GP:**	Personal Information redacted by USI	**Registered GP Cypher:**	Personal Information redacted by USI
Referring GP:		**Referring GP Cypher:**		**Referred by:**	Referring GP

HCN Number	Personal Information redacted by USI	**Title:**	Personal Information redacted by USI
Surname:		**Forenames:**	Personal Information redacted by USI
Previous Surname:		**Known as:**	-
DOB:		**Gender:**	Male
Registered Contact Details:			
Tel No:		**Mobile:**	Personal Information redacted by USI
Patient Email:			
Preferred Contact Details if different from above:		**Marital Status:**	(Not Known)

Special Needs or Requirements

Personal Information redacted by the USI

Reason for Referral/ History of Presenting Complaint

Description: raised psa

Comment: Date Consultation Text

Personal Information redacted by the USI

RELEVANT PAST MEDICAL HISTORY

Pre-existing conditions (High & medium priority - all)

Description	Comment	Date of onset	Date recorded

Personal Information redacted by the USI

Description	Comment	Date recorded

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

Family conditions (All priorities)

Description	Extension	Modifier	Relation to Patient	Date Recorded

Personal Information redacted by the USI

MEDICATION

Current medication (Active Repeat medication issued within the last 12 months)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration

Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by the USI

Recent medication (Any medication issued within last 168 days not shown above)

Drug name	Code	Formulation	Dosage	Frequency	Date started	Duration

Personal Information redacted by the USI

ALLERGIES & RISKS

Lifestyle risks

Personal Information redacted by the USI

Allergies

Description
Personal Information redacted by the USI

SMOKING STATUS

Description	Comment	Date Recorded
Personal Information redacted by the USI		

ALCOHOL INTAKE

Description	Comment	Date Recorded
Personal Information redacted by the USI		

BMI

BMI	Height	Weight	Date Recorded
Personal Information redacted by the USI			

Blood Pressure

Diastolic	Systolic	Date Recorded

SOCIAL HISTORY

OTHER PATIENT DATA

Personal Information redacted by the USI

Signature of referring doctor (or other professional)

Date

Personal Information redacted by USI

From: Personal Information redacted by USI
Sent: Personal Information redacted by the USI
To: referrals.rbc
Subject: FW:
Attachments: [Untitled].pdf

This e-mail is covered by the disclaimer found at the end of the message.

Morning

There are 2 referrals in the above attachment for your attention

Kind Regards

Personal Information redacted by USI
Urology Appointments
Personal Information

-----Original Message-----
From: ICATS Personal Information redacted by USI
Sent: 14 June 2019 10:52
To: Personal Information redacted by USI
Subject:

Please open the attached document. This document was digitally sent to you using an HP Digital Sending device.

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by USI

Personal Information redacted by USI

HCN

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	MR O'BRIEN UROLOGY Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

30723

	Date	Clinical Notes
Age URINE Protein Sugar Acetone WEIGHT kg.		Personal Information redacted by the USI
Age URINE Protein Sugar Acetone WEIGHT kg.		
Age URINE Protein Sugar Acetone WEIGHT kg.		Personal Information redacted by the USI
Age URINE Protein Sugar Acetone WEIGHT kg.		

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by USI

Personal Information redacted by USI

HCN

NOTES

When used for in-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		
Age		Personal Information redacted by the USI
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

30723

WPH000134

	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

CHART

FPN

Sheet Number NM/24

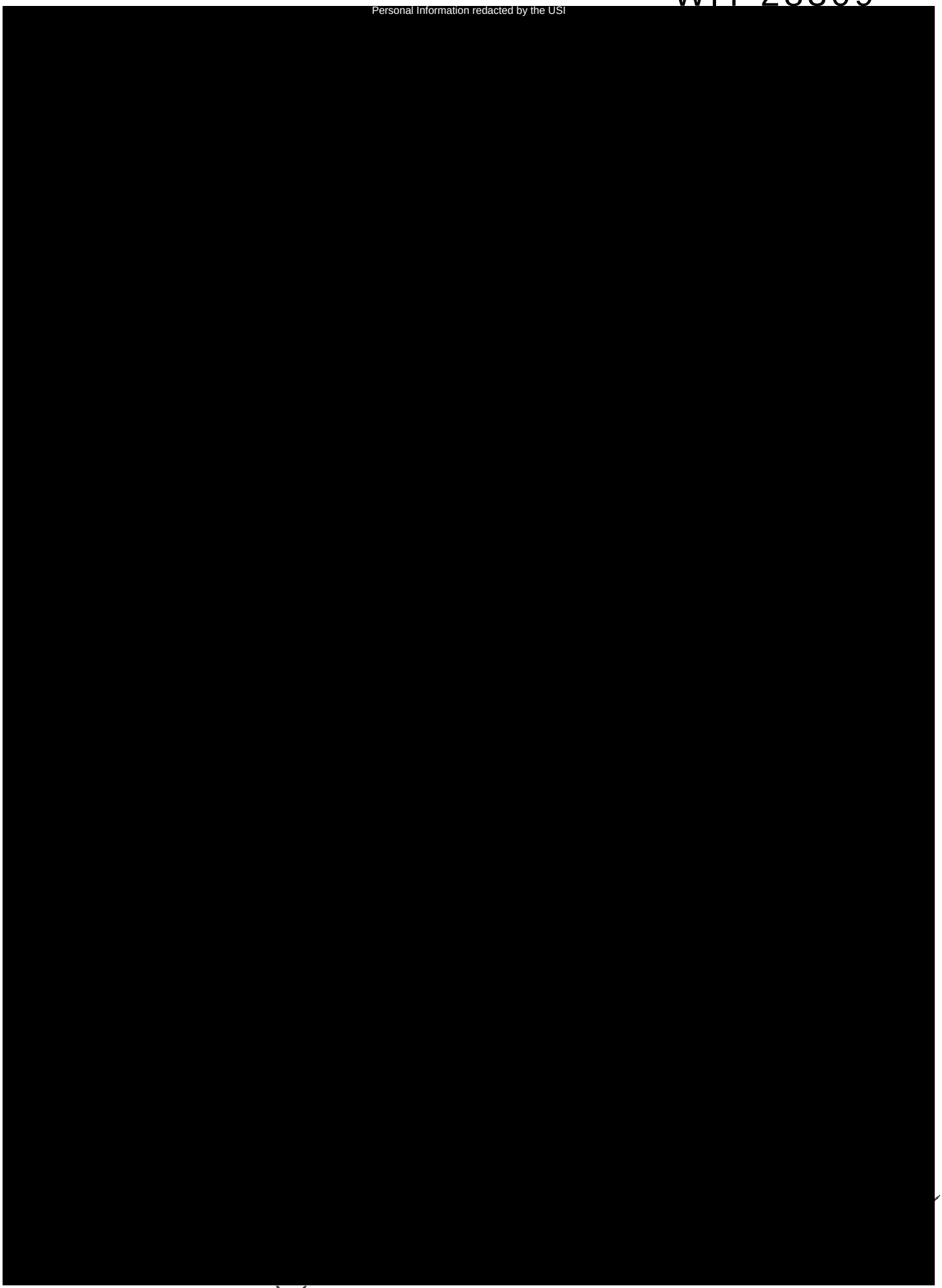
SURNAME (Block letters)	CHRISTIAN NAMES

Personal Information redacted by USI

Personal Information redacted by the USI

[redacted]

Personal Information redacted by USI



78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by USI

Personal Information redacted by USI
HCN

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	
		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT		
Age		
URINE Protein Sugar Acetone		
WEIGHT		kg.
Age		
URINE Protein Sugar Acetone		
WEIGHT		kg.

30723

	Date	Clinical Notes

Personal Information redacted by the USI

Age	
URINE Protein Sugar Acetone	
WEIGHT kg.	

Age	
URINE Protein Sugar Acetone	
WEIGHT k	

Age	
URINE Protein Sugar Acetone	
WEIGHT	

Age	
URINE Protein Sugar Acetone	
WEIGHT	

78/CA.2/1

IN-PATIENT FOLLOW-UP AND OUT-PATIENT NOTES

Affix Label or Enter in Block Letters
Full Name
Date of Birth
Unit No.
Ward/Dept.
Address
Consultant

Personal Information redacted by USI

Personal Information redacted by USI

HCN

NOTES

When used for In-patient follow-up ignore left-hand column

Out-Patient Use Only	Date	Clinical Notes
→		Personal Information redacted by the USI
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		
→		
Age		
URINE Protein Sugar Acetone		
WEIGHT kg.		

LPC 03/08/021

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

Personal Information redacted by the USI

CRAIGAVON CELLULAR PATHOLOGY

Surname Personal Information redacted by USI
Forename
Hosp. No.
DOB/Sex **Male**
Address Personal Information redacted by USI

Source **CRAIGAVON AREA HOSPITAL**
Consultant **MR A O'BRIEN**

Ward/GP **THORNDALE UNIT**
CRAIGAVON AREA HOSPITAL
BT74 5PU **68 LURGAN ROAD**
CRAIGAVON **BT63 5QQ**

Specimen

CLINICAL DETAILS

Personal Information redacted by the USI

PATHOLOGIST'S REPORT

Personal Information redacted by the USI

HISTOLOGY

Personal Information redacted by the USI

INVASION INTO FAT: no

Personal Information redacted by the USI

CRAIGAVON CELLULAR PATHOLOGY

Surname Personal Information redacted by USI

Forename Personal Information redacted by USI

Hosp. No.

DOB/Sex **Male**

Address Personal Information redacted by USI

Source **CRAIGAVON AREA HOSPITAL**

Consultant **MR A O'BRIEN**

Ward/GP **THORNDALE UNIT**
CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
CRAIGAVON **BT63 5QQ**

Specimen Personal Information redacted by the USI

PERINEURAL INVASION:

LYMPHOVASCULAR INVASION: Personal Information redacted by the USI

FURTHER COMMENTS:

Personal Information redacted by the USI

PROSTATE
NEEDLE CORE BIOPSY
ADENOCARCINOMA

Personal Information redacted by the USI

Personal Information redacted by the USI

Radiology Report

South West Acute Hospital

Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN

Tel.: Personal Information redacted by the USI
Fax:

Personal Information redacted by USI

Report recipient:
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth Personal Information redacted by USI

Request no. Personal Information redacted by the USI

Ref. clinician O'Brien, Aidan

Request date Personal Information redacted by the USI

Referral source
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Personal Information redacted by the USI

Requested examination(s) US Urinary tract

Clinical details

Personal Information redacted by the USI

Personal Information redacted by the USI

Reason for referral

Personal Information redacted by the USI

Radiology Report

South West Acute Hospital

Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN

Tel.: Personal Information redacted by the USI
Fax:

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Personal Information redacted by USI

Date of birth

Request no. Personal Information redacted by the USI

Personal Information redacted by the USI

Southern Health and Social Care Trust

PROSTATE BIOPSY CLINIC

Personal Information redacted by USI

Personal Information redacted by USI

HCN

Date:

Tel:

Personal Information redacted by the USI

Consultant: AOB

Doctor/Nurse performing procedure:

Personal Information redacted by USI

Current Medication including any [illegible]

Personal Information redacted by the USI

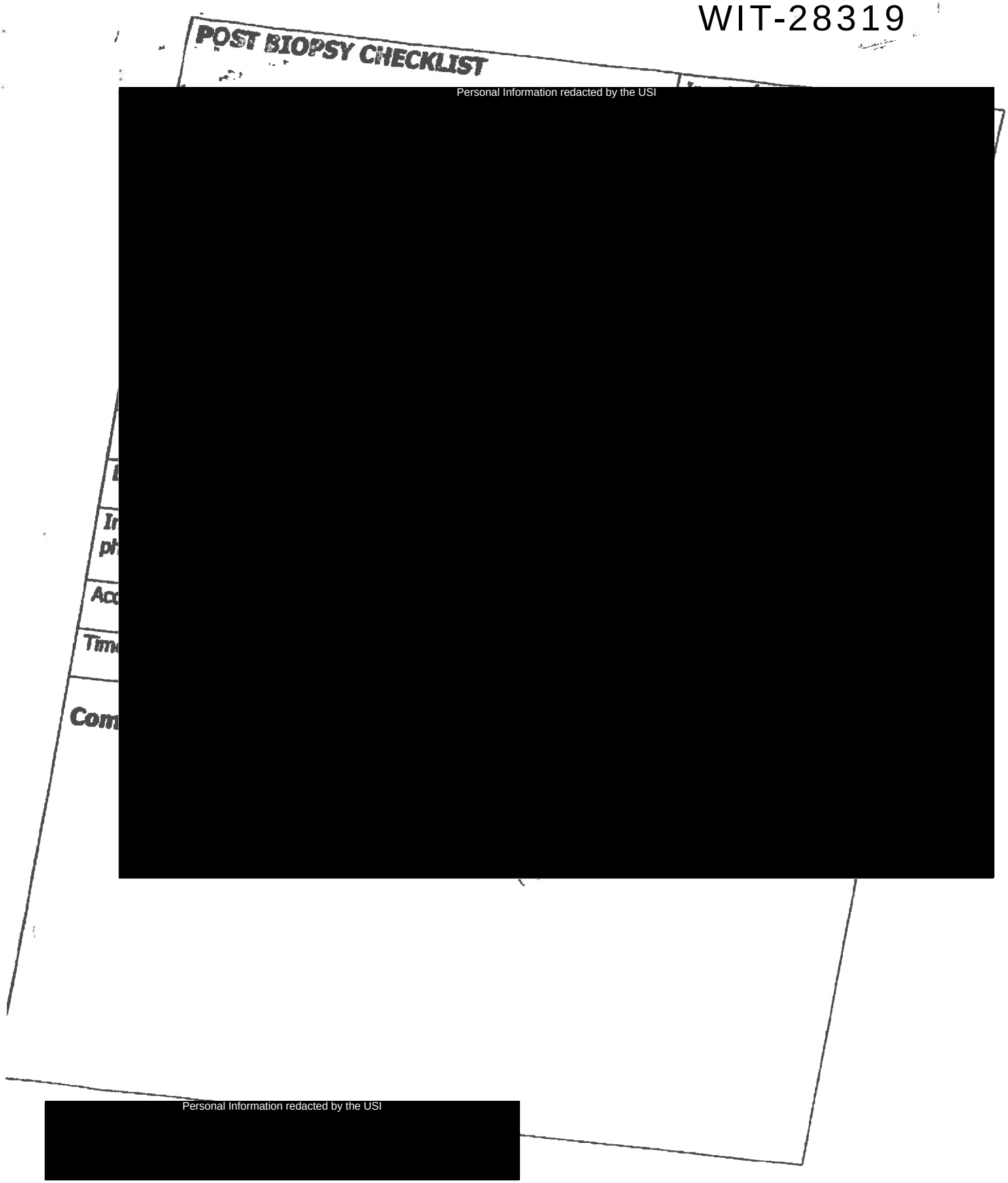
[redacted]

Personal Information redacted by the USI

[redacted]

Personal Information redacted by the USI

[redacted]


POST BIOPSY CHECKLIST
Personal Information redacted by the USI
Personal Information redacted by the USI
Lab Tube
Personal Information redacted by USI

TRUS biopsy of prostate

Department of Urology

Craigavon Area Hospital

Date Personal Information redacted by the USI

Consultant MR O'BRIEN

Patient Personal Information redacted by the USI

HCN

PSA ng/ml

DRE

Family History of Pro

Allergy

Operator Personal Information redacted by the USI

LA

Antibiotics

Prostate Volume

Cores

Follow up Personal Information redacted by the USI

Signed Personal Information redacted by USI

Personal Information redacted by the USI

AL PROSTATE SYMPTOM SCORE (I-PSS)

	Not At All	Less Than 1 Time In 5	Less Than Half The Time	About Half The Time	More Than Half The	Almost Always	YOUR SCORE
1. Incomplete Emptying Over the past month, how often have you had a sensation of not emptying your bladder completely after you finish urinating?							
2. Frequency Over the past month, how often have you had to urinate again less than two hours after you have finished urinating?							
3. Intermittency Over the past month, how often have you found you stopped and started again several times when you urinated?							
4. Urgency Over the past month, how often have you found it difficult to postpone urination?							
5. Weak Stream Over the last month, how often have you had a weak urinary stream?							
6. Straining Over the past month, how often have you had to push or strain to begin urination?							

Personal Information redacted by the USI

7. Nocturia Over the past month how many times did you most typically get up each night to urinate from the time you went to bed until the time you got up in the morning?	0	
Total I-PSS Score		

Quality of Life due to Urinary Symptoms	Delighte	
If you were to spend the rest of your life with your urinary condition just the way it is now, how would you feel about that?	0	

The I-PSS is based on the answers to seven questions concerning urinary symptoms. Each question is assigned points from 0 to 5 indicating increasing severity of the particular symptom. The total score can therefore range from 0 to 35 (asymptomatic to very symptomatic).

Although there are presently no standard recommendations into grading patients with mild, moderate or severe symptoms, patients can be tentatively classified as follows: **0 - 7 = mildly symptomatic; 8 - 19 = moderately symptomatic; 20 - 35 = severely symptomatic.**

The International Consensus Committee (ICC) recommends the use of only a single question to assess the patient's quality of life. The answers to this question range from "delighted" to "terrible" or 0 to 6. Although this single question may or may not capture the global impact of BPH symptoms on quality of life, it may serve as a valuable starting point for doctor-patient conversation.

HSS TRUST _____ | GP PRACTICE or other _____

Hospital Unit _____ | Primary Care Provider _____

FORM 3 – CONSENT FOR EXAMINATION, TREATMENT OR CARE

(Procedures where consciousness not impaired)

Personal details (or pre-printed label)

Surname/family name..... Personal Information redacted by USI

First names..... Personal Information redacted by USI

Date of Birth.....

☐ Male ☐ Female H+C No. (or other identifier) ..

Special requirements (language or other) .....

Statement of healthcare professional

Personal Information redacted by the USI

Statement of Interpreter (where appropriate)

I have interpreted the information above to the best of my ability and in a way which I believe s/he/they can understand.

Signed.....Date.....

Name (PRINT.....

Statement of person giving consent or with parental responsibility for child

I agree to the procedure or course of treatment described above.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that the procedure will/will not involve local anaesthesia.

Signature Personal Information redacted by the USI .....Date.. Personal Information redacted by the USI

Name (PRINT).....Relationship to child.....

Copy accepted Yes/ No (please circle)

WPH000203 Revised 01/13

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: noleen.elliott Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear Personal Information redacted by USI

Re: Patient Name: [redacted]
D.O.B.:
Address:
Hospital No: Personal Information redacted by USI **HCN:** Personal Information redacted by USI

Personal Information redacted by the USI

[redacted]

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by the USI
E mail: noleen.elliott@ Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Hospital No: Personal Information redacted by USI
HCN:

Dear Personal Information redacted by USI

Personal Information redacted by the USI

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Personal Information redacted by the USI

Radiology Report

South West Acute Hospital

Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN

Tel.: Personal Information redacted by the USI
Fax:

Personal Information redacted by USI

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Personal Information redacted by the USI

Date of birth Personal Information redacted by USI

Request no. Personal Information redacted by the USI

Personal Information redacted by USI

Ref. clinician O'Brien, Aidan

Request date Personal Information redacted by the USI

Referral source
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Personal Information redacted by the USI

Radiology Report

South West Acute Hospital

Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN

Tel.: Personal Information redacted by the USI
Fax:

Personal Information redacted by USI

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth Personal Information redacted by USI

Request no. Personal Information redacted by the USI

Referrer name: Aidan O'Brien
Referrer contact / bleep detail: Personal Information redacted by USI

Reason for referral

Personal Information redacted by the USI

Radiology Report

South West Acute Hospital

Radiology Department
124 Irvinestown Rd
Enniskillen
Co. Fermanagh
BT74 6DN

Tel.: Personal Information redacted by the USI
Fax:

Personal Information redacted by USI

Personal Information redacted by USI

Report recipient
Craigavaon Area Hosptial
Urology Department
68 Lurgan Road
CRAIGAVON

BT63 5QQ

Date of birth Personal Information redacted by USI

Request no. Personal Information redacted by the USI

Personal Information redacted by the USI

SERVICE USER C

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Direct Line: Personal Information redacted by USI
E mail: noleen.elliott Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear Personal Information redacted by the USI

Re: Patient Name: Personal Information redacted by the USI
D.O.B.:
Address:
Hospital No:

Personal Information redacted by the USI

Personal Information redacted by the USI

[redacted]

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

c.c. Personal Information redacted by USI

Date Dictated: Personal Information redacted by the USI

Personal Information redacted by USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

Direct Line: Personal Information redacted by the USI
E mail: noleen.elliott Personal Information redacted by the USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear Personal Information redacted by USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.: Personal Information redacted by USI
Address:
Hospital No: HCN: Personal Information redacted by USI

Personal Information redacted by the USI

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Personal Information redacted by the USI

Personal Information redacted by USI

CRAIGAVON CELLULAR PATHOLOGY

Surname [redacted]
Forename
Hosp. No.
DOB/Sex [redacted] Male
Address [redacted]

Source DAISY HILL HOSPITAL
Consultant MR A O'BRIEN

Ward/GP [redacted]

Specimen [redacted]

CLINICAL DETAILS

[redacted]

SPECIMEN – [redacted]

PATHOLOGIST'S REPORT

[redacted]

DIAGNOSIS:
PROSTATE
TURP
ADENOCARCINOMA

[redacted]

Secretary: [redacted]
Date: [redacted]

[redacted]

Southern Health and Social Care Trust

Daisy Hill Hospital, 5 Hospital Road, Newry, County Down, BT35 8DR
Tel: 028 3083 5000

Ward Tel:

Notes Copy

Personal Information redacted by USI

Personal Information redacted by the USI

564

Personal Information redacted by the USI

Personal Information redacted by the USI

Known Reactions to Allergies

Discharge Date Personal Information redacted by the USI **Discharge Time**

Arrangements For Follow-Up

Personal Information redacted by the USI

Further Detailed Discharge Letter To Follow: Personal Information redacted by the USI

Awaiting Further Results:

Patient Aware Of Diagnosis: Personal Information redacted by

Other Management Information For GP

Personal Information redacted by the USI

Discharge Prescription:

(POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route	GP Continue?
Admission drugs (unamended)					

Personal Information redacted by the USI

(Change Reason: .)

Personal Information redacted by the USI

Drugs prescribed since admission

Admission drugs (amended)

Stopped Medication: (POD = Patient's Own Drugs, PODH = Patient's Own Drugs at Home)

Drug	Dose	Frequency	Days	Route
Admission drugs (stopped)				

Personal Information redacted by the USI

Authorised Forms

Form	Authorised By	Date/Time
Adult Clinical Details (Elective-CMPM)	Personal Information redacted by the USI	

Prescribing Clinician: Personal Information redacted by the USI

Bleep No: Personal Information redacted by the USI

Discharged by:

Bleep No:

Personal Information redacted by the USI

Elliott, Noleen

From: O'Brien, Aidan
Sent: 01 June 2020 14:47
To: Elliott, Noleen
Subject: [redacted] Personal Information redacted by USI

Noleen,

Please place this man on CURWL for

- TURP
- Urgency 2 (Red Flag)
- Date of entry: 01 June 2020

I have dictated correspondence,

Thank you,

Aidan.

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

CONSULTANT: Mr A O'Brien, Consultant Urologist
SECRETARY: Mrs Noleen Elliott
TELEPHONE: Personal Information redacted by USI

Personal Information redacted by USI

Dear Personal Information redacted by USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by USI **HCN:** Personal Information redacted by USI

Personal Information redacted by the USI

Personal Information redacted by the USI

Yours sincerely,

DICTATED BUT NOT SIGNED BY:

AIDAN O'BRIEN FRCS
CONSULTANT UROLOGIST

Personal Information redacted by the USI

Personal Information redacted by the USI

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT

CONSULTANT: Mr A O'Brien, Consultant Urologist
SECRETARY: Mrs Noleen Elliott
TELEPHONE: Personal Information redacted by USI

01/06/20

CONFIDENTIAL

Personal Information redacted by USI

HCN: Personal Information redacted by USI

HOSPITAL NO:

Dear Personal Information redacted by USI

Personal Information redacted by the USI

Personal Information redacted by the USI

Yours sincerely,

DICTATED BUT NOT SIGNED BY:

AIDAN O'BRIEN FRCS
CONSULTANT UROLOGIST

Personal Information redacted by USI

PSA

Patient: Personal Information redacted by USI

Date Of Birth: Personal Information redacted by USI

HCN: Personal Information redacted by USI

Status: Filed

Recipient GP: Personal Information redacted by USI

Viewed: Personal Information redacted by USI

Taken: Personal Information redacted by the USI

Personal Information redacted by the USI

Personal Information redacted by USI

Specimen: UNSPECIFIED

PSA

(CD) - fao mr o'brien, cah urology

LPP Information redacted by the USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: noleen.elliott Personal Information redacted by USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear Personal Information redacted by USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address:
Hospital No: Personal Information redacted by USI HCN: Personal Information redacted by USI
Personal Information redacted by the USI

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Personal Information redacted by the USI

Personal Information redacted by USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: noleen.elliott Personal Information redacted by USI
Secretary: Mrs N. Elliott

[redacted]

Hospital No: Personal Information redacted by USI
HCN:

Dear Personal Information redacted by USI

Personal Information redacted by the USI

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Personal Information redacted by the USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: noleen.elliott Personal Information redacted by USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear Personal Information redacted by USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address: Personal Information redacted by USI Personal Information redacted by USI
Hospital No: Personal Information redacted by USI **HCN:** Personal Information redacted by USI

Personal Information redacted by the USI

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Personal Information redacted by the USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: noleen.elliott@ Personal Information redacted by USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Hospital No: Personal Information redacted by USI
HCN:

Dear Personal Information redacted by USI

Personal Information redacted by the USI

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Personal Information redacted by the USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: noleen.elliott Personal Information redacted by USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear DR Personal Information redacted by the USI

Re: Patient Name:
D.O.B.:
Address: Personal Information redacted by USI
Hospital No: HCN: Personal Information redacted by USI

Personal Information redacted by the USI

Personal Information redacted by the USI

Yours sincerely

Dictated but not signed by

Mr A O'Brien FRCS
Consultant Urological Surgeon

Personal Information redacted by the USI

Personal Information redacted by the USI

Southern Health and Social Care Trust

CRAIGAVON AREA HOSPITAL
68 LURGAN ROAD
PORTADOWN, BT63 5QQ

UROLOGY DEPARTMENT
Telephone: Personal Information redacted by USI
E mail: noleen.elliott@ Personal Information redacted by USI
Secretary: Mrs N. Elliott

Personal Information redacted by USI

Dear Personal Information redacted by USI

Re: Patient Name: Personal Information redacted by USI
D.O.B.:
Address: Personal Information redacted by USI
Hospital No: Personal Information redacted by USI **HCN:** Personal Information redacted by USI

Personal Information redacted by the USI

Clinical Nurse Specialist in Urology to:
Mr A O'Brien FRCS
Consultant Urological Surgeon

Personal Information redacted by the USI

Personal Information redacted by USI

MDM Report from Urology MDM @ The Southern Trust

~~Noleen elliott CHT clinic 20.08.19~~

RE: Personal Information redacted by the USI

Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Contact Tel: Personal Information redacted by USI

Library 2

Personal Information redacted by the USI

MDM Action

Personal Information redacted by the USI

MRI Findings

MDM Report from Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI
Personal Information redacted by USI
DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI
Contact Tel: Personal Information redacted by USI

Personal Information redacted by the USI

INDICATION:
Personal Information redacted by the USI

TECHNIQUE:
Personal Information redacted by the USI

COMPARISON:
None.

FINDINGS:
Personal Information redacted by the USI

MDM Report from Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI
Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Contact Tel: Personal Information redacted by USI

Urology MDM @ The Southern Trust

Personal Information redacted by USI

RE: Personal Information redacted by USI
Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Dear Dr

Personal Information redacted by the USI

MDM Update:

Personal Information redacted by the USI

MDM Plan:

Personal Information redacted by the USI

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI

Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Chairman of Urology MDM

Personal Information redacted by USI

Consultant Urologist

Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI

Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Dear Dr

Personal Information redacted by the USI

MDM Update:

Personal Information redacted by the USI

MDM Plan:

Personal Information redacted by the USI

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Personal Information redacted by the USI

[redacted]

Personal Information redacted by the USI

[redacted]

Time	Resp	SpO₂	Pulse	BP	O₂ deliv.	Temp	Drugs	Notes

HSS TRUST _____ | GP PRACTICE or other _____

Hospital Unit _____ | Primary Care Provider _____

FORM 1 – CONSENT FOR EXAMINATION, TREATMENT OR CARE

Personal details (or pre-printed label)

Surname/family name .....

First names .....

Date of Birth .....

❑ Male ❑ Female H+C No. (or other identifier) .....

Special requirements (language or other) .....

.....

Personal Information redacted by the USI

Statement of healthcare professional

Personal Information redacted by the USI

Contact details *(if patient wishes to discuss options later)* .....

Statement of interpreter (where appropriate)

I have interpreted the information above to the person giving consent to the best of my ability and in a way which I believe s/he can understand.

Signed .....Date .....

Name (Print) .....

Copy accepted by person giving consent Yes/No (please circle)

Statement of person giving consent

Please read this form carefully. If your treatment has been planned in advance, you shoul already have your own copy which describes the benefits and risks of the propose treatment. If not, you will be offered a copy now. If you have any further questions, do as - we are here to help you. You have the right to change your mind at any time, includin after you have signed the form.

I agree to the procedure or course of treatment described on this form.

I understand that you cannot give me a guarantee that a particular person will perform the procedure. The person will, however, have appropriate experience.

I understand that I will have the opportunity to discuss the details of anaesthesia with an anaesthetist before the procedure, unless the urgency of my situation prevents this. (This only applies to patients having general or regional anaesthesia).

I understand that any procedure in addition to those described on this form will only be carried out if it is necessary to save my life or to prevent serious harm to my health.

I have been told about possible additional procedures which may become necessary during my treatment I have listed below any procedures **which I do not wish to be carried out** without further discussion.

.....

.....

***I agree** that healthcare students, who will be supervised by healthcare professionals, may observe or assist in my care. ** You may remove this sentence without affecting your care.*

Personal Information redacted by the USI

Signature .....Date .....

Name **(Print)** .....

A witness should sign below if the person is unable to sign but has indicated his or her consent. Young people/children may also like a parent to sign here (see notes)

Signature .....Date .....

Name **(Print)**.....

Confirmation of consent (to be completed by a healthcare professional when the person is admitted for the procedure, if s/he has signed the form in advance). I have confirmed that s/he has no further questions and wishes the procedure to go ahead.

Signature .....Date .....

Name **(Print)** .....Job Title .....

Important notes: **(tick if applicable)**

☐ **See also advance directive/living will (eg Jehovah's Witness form)**

☐ **Person has withdrawn consent** .....Date.....

(ask person to sign/date here)

LPC 03/08/031

Urology MDM @ The Southern Trust

RE: Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Dear Dr

Personal Information redacted by the USI

Diagnosis: Personal Information redacted by the USI

Gleason Score

MDM Update:

RE: Personal Information redacted by USI

DOB: Personal Information redacted by USI Hospital Number: Personal Information redacted by USI , HCN: Personal Information redacted by USI

Personal Information redacted by the USI

Urology MDM @ The Southern Trust

RE: Mr [redacted]

DOB: [redacted] Hospital Number: CAH [redacted] , HCN: [redacted]

MDM Plan:

[redacted]

If you have any queries or require further information, please do not hesitate to contact us.

Yours sincerely,

Chairman of Urology MDM

[redacted]

Consultant Urologist

Southern Health and Social Care Trust.

This job plan started 01 April 2018.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	Locked down
Appointment	Full Time
Cycle	Rolling cycle - 12 weeks
Start Week	1
Report date	30 Jul 2020
Expected number of weeks in attendance	42 weeks
Usual place of work	Craigavon Area Hospital
Alternate employer	None Specified
Contract	New
Private practice	No

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		24 Apr 2018	Mr Zircadian Support
In ‘Discussion’ stage - awaiting doctor agreement		24 Sep 2018	Mr Colin Weir
In ‘Discussion’ stage - request cancelled		31 Oct 2018	Mr Colin Weir
In ‘Discussion’ stage - awaiting doctor agreement		31 Oct 2018	Mr Colin Weir
In ‘Discussion’ stage - request cancelled		31 Oct 2018	Mr Colin Weir
In ‘Discussion’ stage - awaiting doctor agreement		21 Nov 2018	Mr Colin Weir
Locked down		9 Dec 2019	Dr Edward James McNaboe

Hours Breakdown

	Main Employer PAs	Core PAs	APA PAs	Total PAs	Core hours	APA hours	Total hours
Direct Clinical Care (DCC)	10.271	10.271	0.000	10.271	41:03	0:00	41:03
Supporting Professional Activities (SPA)	1.462	1.462	0.000	1.462	5:51	0:00	5:51
Total	11.733	11.733	0.000	11.733	46:54	0:00	46:54

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
On-call Rota	Craigavon Area Hospital	5	5	A	5%	1.000

Type	Normal	Premium	Cat.	PA
			Total:	1.000
Predictable	n/a	n/a	DCC	0.000
Unpredictable	n/a	n/a	DCC	1.000

The total PAs arising from your on-call work is:	1.000
Your availability supplement is:	5% (based on the highest supplement from all your rotas)

On-call rota details

On-call Rota (PA entry)

General information	
What is your on-call activity?	On-call Rota
Where does your on-call rota take place in?	Craigavon Area Hospital
What is your on-call classification?	A
Weekday work	
What is the frequency of your weekday on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekday on-call work?	**0.000 1.000**
Weekend work (A weekend is classed as Saturday to Sunday for this rota)	
What is the frequency of your weekend on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekend on-call work?	**0.000 0.000**
Other information	
Which objective does this on-call work relate to?	
Comments	

Sign off

Role: Clinical Manager	Role: Clinical Director	Role: Board Member
Name: Dr McNaboe, Edward James (Con)	Name: Mr Haynes, Mark Dean (Con)	Name: Mr Carroll, Ronan
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Hot Activities

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 12:00 Week 6,12 (12 week cycle) Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)	Surgeon of the week 09:00 17:30 Week 1,7 (12 week cycle)		

Week 1

There are no activities this week

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Sub Specialty clinic 13:30 - 17:00		

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:30 - 13:00 Patient related admin (reports, results etc) 13:30 - 17:00	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Surgery MDT 13:15 - 17:15		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 13:30 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 6

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Sub Specialty clinic 13:30 - 17:00		

Week 7

There are no activities this week

Week 8

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:30 - 13:00 Patient related admin (reports, results etc) 13:30 - 17:00	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Surgery MDT 13:15 - 17:15		

Week 9

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 10

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Sub Specialty clinic 13:30 - 17:00		

Week 11

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 17:00	Day surgery 08:30 - 13:00 New patient Clinic 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Core SPA 09:00 - 12:00 Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Core SPA 13:30 - 17:00		

Week 12

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
	Core SPA 09:00 - 13:00 Core SPA 13:30 - 17:00	Pre-op ward round 08:30 - 09:00 Planned in-patient operating sessions 09:00 - 18:00 Post-op ward round 18:00 - 19:00	Surgery MDT 14:00 - 17:00	Sub Specialty clinic 09:00 - 13:00 Surgery MDT 13:15 - 17:15		

Activities

A Additional Programmed Activities
H Hot Activity
U Unaffected by hot activity
S Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
							Total:	Core APA	10.120 0.000	40:27 0:00
	Mon	08:30 - 13:00	wks 3, 8	New patient Clinic 30 minutes travel from Craigavon Area Hospital.	Southern Health and Social Care Tru..	Armagh Community Hospital	DCC	7	0.188	0:45
U	Mon	08:45		New patient	Southern Health and Social Care Tru..	Erne Hospital	DCC	12	0.625	2:30

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
		- 17:30		Clinic 75 minutes travel from Craigavon Area Hospital.						
S	Mon	09:00 - 17:00	wks 4, 9-11	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	12.19	0.580	2:19
H	Mon	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Mon	13:30 - 17:00	wks 3, 5, 8	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	9.14	0.190	0:46
S	Tue	08:30 - 13:00	wks 4-5, 9-11	Day surgery	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.67	0.446	1:47
S	Tue	09:00 - 13:00	wks 2-3, 6, 8, 12	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	16.67	0.397	1:35
H	Tue	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Tue	13:30 - 17:00	wks 4-5, 9-11	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.67	0.347	1:23
S	Tue	13:30 - 17:00	wks 2-3, 6, 8, 12	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	16.67	0.347	1:23
	Wed	08:30 - 09:00	wks 2-6, 8-12	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.104	0:25
H	Wed	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Wed	09:00 - 18:00	wks 2-6, 8-12	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	1.786	7:09
	Wed	18:00 - 19:00	wks 2-6, 8-12	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	35	0.208	0:50
H	Thu	09:00 - 12:00	wks 6, 12 12 wk cycle	Surgeon of the week Comments: Handover to oncoming Urologist of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.155	0:37
S	Thu	09:00 - 12:00	wks 2-5, 8-11	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	24.67	0.440	1:46
H	Thu	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Thu	14:00 - 17:00	wks 2-6, 8-12	Surgery MDT	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.595	2:23
S	Fri	09:00 -	wks 2-6,	Sub Specialty clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.33	0.794	3:10

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
		13:00	8-12							
H	Fri	09:00 - 17:30	wks 1, 7 12 wk cycle	Surgeon of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.67	0.438	1:45
S	Fri	13:15 - 17:15	wks 4, 8, 12	Surgery MDT Comments: Reconstruction MDM Lagan Valley Hospital 45 minutes travel from Craigavon Area Hospital. 45 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	Royal Victoria Hospital, Belfast	DCC	10	0.238	0:57
S	Fri	13:30 - 17:00	wks 2, 6, 10	Sub Specialty clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	10	0.208	0:50
S	Fri	13:30 - 17:00	wks 3, 5, 9, 11	Core SPA	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	13.33	0.278	1:07

No specified day

"( )" Refers to an activity that replaces or runs concurrently
A Additional Programmed Activities
H Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
						Total:	Core APA Replaced	0.613 0.000 (0.000)	6:27 0:00 (0:00)
	3:00	0:00	Surgery MDT Comments: MDT Chair preparation	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	13	0.232	0:56
	8:00	0:00	Triaging of new patients referrals	Southern Health and Social Care Trust.	Craigavon Area Hospital	DCC	8	0.381	1:31

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

No comments made

Southern Health and Social Care Trust.

This job plan started 01 April 2013 and ended 31 March 2018.

Job plan for Mr O'Brien, Aidan in Urology

Basic Information

Job plan status	Locked down
Appointment	Full Time
Cycle	Rolling cycle - 5 weeks
Start Week	1
Report date	30 Jul 2020
Expected number of weeks in attendance	42 weeks
Usual place of work	Craigavon Area Hospital
Alternate employer	None Specified
Contract	New
Private practice	No

Job plan stages

Job plan stages	Comment	Date stage achieved	Who by
In 'Discussion' stage		20 Mar 2013	Mr Malcolm Clegg
Locked down		16 Apr 2015	Mr Malcolm Clegg

Hours Breakdown

	Main Employer PAs	Total PAs	Total hours
Direct Clinical Care (DCC)	9.800	9.800	38:54
Supporting Professional Activities (SPA)	1.475	1.475	5:54
Total	11.275	11.275	44:48

On-call summary

Rota Name	Location	Weekday Freq	Weekend Freq	Category	Supplement	PAs
On-call Rota	Craigavon Area Hospital	5	5	A	5%	1.000

Type	Normal	Premium	Cat.	PA
			Total:	1.000
Predictable	n/a	n/a	DCC	0.000
Unpredictable	n/a	n/a	DCC	1.000

The total PAs arising from your on-call work is:	1.000
Your availability supplement is:	5% (based on the highest supplement from all your rotas)

On-call rota details

On-call Rota (PA entry)

General information	
What is your on-call activity?	On-call Rota
Where does your on-call rota take place in?	Craigavon Area Hospital

What is your on-call classification?	A
Weekday work	
What is the frequency of your weekday on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekday on-call work?	**0.000 1.000**
Weekend work (A weekend is classed as Saturday to Sunday for this rota)	
What is the frequency of your weekend on-call work?	1 in 5.00
	Predictable Unpredictable
How many PAs arise from your weekend on-call work?	**0.000 0.000**
Other information	
Which objective does this on-call work relate to?	
Comments	

Sign off

Role: Consultant	Role: Consultant	Role: Board Member
Name: Mr Hall, Samuel (Con)	Name: Mr Mackle, Edward (Con)	Name: Mrs Trouton, Heather
Signed:	Signed:	Signed:
Date:	Date:	Date:

Timetable

Week 1

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports, results etc) 09:00 - 13:00	Day surgery 08:30 - 13:00	Surgery MDT 09:00 - 11:00	Uroradiology meeting 08:30 - 09:30	Planned in-patient operating sessions 08:30 - 17:00		
Continuous professional development. 13:00 - 17:00	New patient Clinic 13:00 - 17:00	Urodynamics 11:00 - 12:30	Grand Round 10:00 - 12:00	Post-op ward round 17:00 - 17:30		
			Continuous professional development. 12:00 - 14:00			
			Surgery MDT 14:00 - 17:00			

Week 2

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Day surgery 07:15 - 13:00	New patient Clinic 13:00 - 17:00	Surgery MDT 09:00 - 11:00	Uroradiology meeting 08:30 - 09:30	New patient Clinic 09:00 - 13:00		
New patient Clinic 13:00 - 18:15		Urodynamics 11:00 - 12:30	Grand Round 10:00 - 12:00	Patient related admin (reports, results etc) 13:00 - 17:00		
		Pre-op ward round 12:30 - 13:00	Continuous professional development. 12:00 - 14:00			
		Planned in-patient operating sessions 13:00 - 20:00	Surgery MDT 14:00 - 17:00			
		Post-op ward round 20:00 - 20:30				

Week 3

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Patient related admin (reports,	Continuous professional	Surgery MDT	Uroradiology meeting	New patient Clinic		

results etc) 09:00 - 13:00 Continuous professional development. 13:00 - 17:00	development. 09:00 - 13:00 New patient Clinic 13:00 - 17:00	09:00 - 11:00 Continuous professional development. 11:00 - 12:30 Pre-op ward round 12:30 - 13:00 Planned in-patient operating sessions 13:00 - 20:00 Post-op ward round 20:00 - 20:30	08:30 - 09:30 Grand Round 10:00 - 12:00 Continuous professional development. 12:00 - 14:00 Surgery MDT 14:00 - 17:00	09:00 - 13:00		

Week 4

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
New patient Clinic 08:30 - 13:00 Continuous professional development. 13:00 - 17:00	Continuous professional development. 09:00 - 13:00 New patient Clinic 13:00 - 17:00	Surgery MDT 09:00 - 11:00 Urodynamics 11:00 - 12:30 Pre-op ward round 12:30 - 13:00 Planned in-patient operating sessions 13:00 - 20:00 Post-op ward round 20:00 - 20:30	Uroradiology meeting 08:30 - 09:30 Grand Round 10:00 - 12:00 Continuous professional development. 12:00 - 14:00 Surgery MDT 14:00 - 17:00	New patient Clinic 09:00 - 13:00 Patient related admin (reports, results etc) 13:00 - 17:00		

Week 5

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Emergency operating sessions 09:00 - 13:00 New patient Clinic 13:00 - 17:00	Emergency operating sessions 09:00 - 13:00 New patient Clinic 13:00 - 17:00	Emergency operating sessions 09:00 - 13:00 Day surgery 13:00 - 17:00	Uroradiology meeting 08:30 - 09:30 Pre-op ward round 09:30 - 10:00 Emergency operating sessions 10:00 - 14:00 Surgery MDT 14:00 - 17:00	Emergency operating sessions 09:00 - 13:00 Planned in-patient operating sessions 13:00 - 17:00 Post-op ward round 17:00 - 17:30		

Activities

A Additional Programmed Activities
H Hot Activity
U Unaffected by hot activity
S Shrunk by hot activity

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
								Total:	10.275	40:48
	Mon	07:15 - 13:00	wk 2	Day surgery 75 minutes travel from Craigavon Area Hospital.	Southern Health and Social Care Tru..	Erne Hospital	DCC	8.4	0.288	1:09
	Mon	08:30 - 13:00	wk 4	New patient Clinic 30 minutes travel from Craigavon	Southern Health and Social Care Tru..	Armagh Community Hospital	DCC	8.4	0.225	0:54

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
				Area Hospital.						
	Mon	09:00 - 13:00	wk 5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward Round, Emergency Operating, Triage and Virtual clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Mon	09:00 - 13:00	wks 1, 3	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.8	0.400	1:36
	Mon	13:00 - 17:00	wks 1, 3-4	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	25.2	0.600	2:24
	Mon	13:00 - 17:00	wk 5	New patient Clinic Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Mon	13:00 - 18:15	wk 2	New patient Clinic 75 minutes travel to Craigavon Area Hospital.	Southern Health and Social Care Tru..	Erne Hospital	DCC	8.4	0.263	1:03
	Tue	08:30 - 13:00	wk 1	Day surgery	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.225	0:54
	Tue	09:00 - 13:00	wk 4	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	8.4	0.200	0:48
	Tue	09:00 - 13:00	wk 5	Emergency operating sessions Comments: consultant of the week	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Tue	09:00 - 13:00	wk 3	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	8.4	0.200	0:48
	Tue	13:00 - 17:00	wks 1-4	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.6	0.800	3:12
	Tue	13:00 - 17:00	wk 5	New patient Clinic Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Wed	09:00 - 11:00	wks 1-4	Surgery MDT Comments: SURGERY MDT PREPARATION	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.6	0.400	1:36
	Wed	09:00 - 13:00	wk 5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward Round,	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
				Emergency operating, triage and virtual clinic						
	Wed	11:00 - 12:30	wk 1	Urodynamics	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.075	0:18
	Wed	11:00 - 12:30	wks 2, 4	Urodynamics	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.8	0.150	0:36
	Wed	11:00 - 12:30	wk 3	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	8.4	0.075	0:18
	Wed	12:30 - 13:00	wks 2-4	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	25.2	0.075	0:18
	Wed	13:00 - 17:00	wk 5	Day surgery Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Wed	13:00 - 20:00	wks 2-4	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	25.2	1.100	4:12
	Wed	20:00 - 20:30	wks 2-4	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	25.2	0.100	0:18
	Thu	08:30 - 09:30	wks 1-5	Uroradiology meeting	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	42	0.250	1:00
	Thu	09:30 - 10:00	wk 5	Pre-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.025	0:06
	Thu	10:00 - 12:00	wks 1-4	Grand Round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.6	0.400	1:36
	Thu	10:00 - 14:00	wk 5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Thu	12:00 - 14:00	wks 1-4	Continuous professional development.	Southern Health and Social Care Tru..	Craigavon Area Hospital	SPA	33.6	0.400	1:36
	Thu	14:00 - 17:00	wks 1-4	Surgery MDT	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	33.6	0.600	2:24
	Thu	14:00 - 17:00	wk 5	Surgery MDT Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.150	0:36
	Fri	08:30 - 17:00	wk 1	Planned in-patient operating sessions	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.425	1:42
	Fri	09:00 - 13:00	wk 5	Emergency operating sessions Comments: CONSULTANT OF THE WEEK - Ward round, Emergency Operating, Triage and Virtual clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48

Type	Day	Time	Weeks	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
	Fri	09:00 - 13:00	wks 2-4	New patient Clinic	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	25.2	0.600	2:24
	Fri	13:00 - 17:00	wk 5	Planned in-patient operating sessions Comments: CONSULTANT OF THE WEEK	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.200	0:48
	Fri	13:00 - 17:00	wks 2, 4	Patient related admin (reports, results etc)	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	16.8	0.400	1:36
	Fri	17:00 - 17:30	wk 1	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.025	0:06
	Fri	17:00 - 17:30	wk 5	Post-op ward round	Southern Health and Social Care Tru..	Craigavon Area Hospital	DCC	8.4	0.025	0:06

No specified day

"( )" Refers to an activity that replaces or runs concurrently
A Additional Programmed Activities
H Hot Activity

Type	Normal	Premium	Activity	Employer	Location	Cat.	Num/Yr	PA	Hours
You have not added any activities.									

Resources

Staff

Equipment

Clinical Space

Other

Additional information

Additional comments

No comments made

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APPENDIX 6

Revised November 2016 (Version 1.1)

Root Cause Analysis report on the review of a Serious Adverse Incident including Service User/Family/Carer Engagement Checklist

Organisation's Unique Case Identifier: Personal Information redacted by USI

Date of Incident/Event: January 2016 – September 2016

HSCB Unique Case Identifier: Personal Information redacted by USI

Service User Details: (*complete where relevant*)

Responsible Lead Officer: Dr J R Johnston

Designation: Consultant Medical Advisor

Report Author: The Review Team

Date report signed off: 22 May 2020

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1.0 EXECUTIVE SUMMARY

During an internal review in 2016, following an Index Case, the Trust identified a number of GP Urology referrals who were not triaged by one particular Consultant Urologist; 30 patients should have been red-flag referrals and of these 4 had cancer. A fifth patient Patient 15 discovered during an outpatient clinic, was included as he was also not triaged and subsequently had a cancer confirmed.

Patient 15 – a Personal Information redacted by USI male was referred to Urology Outpatients on 30 August 2015 for assessment and advice for an elevated Prostate specific antigen (PSA) (The blood level of PSA is often elevated in men with prostate cancer). The referral was marked Routine by the GP. The referral was not triaged on receipt. However, a second GP referral was received on 29 January 2016 marked Suspected Cancer Red Flag and had received a red flag appointment. Following this referral, he was seen in clinic on 8 February 2016 (D153). On day 166, Patient 15 was diagnosed with a confirmed cancer; a resultant 6-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 14 – a Personal Information redacted by USI male was referred to Urology Outpatients on 3 June 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review, the referral was upgraded to Red Flag and was seen in clinic on day 246. On day 304, the patient had a confirmed cancer diagnosis. There has been a resultant 10-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 11 – a Personal Information redacted by USI male was referred to Urology Outpatients on 28 July 2016 for assessment and advice for an elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of an internal review the referral was upgraded to Red Flag and seen in clinic on day 217. On day 258, Patient 11 was diagnosed with a confirmed cancer; a resultant 9-month delay in obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Patient 13 – a Personal Information redacted by USI male referred to Urology following an episode of haematuria on 28 July 2016. The referral was marked Routine by the GP. The letter was not triaged and Patient 13 was placed on a routine waiting list on 30 September 2016. As part of an internal review this patient's referral letter was upgraded to a Red Flag referral. Patient 13 was reviewed at OPD on 31January 2017. Subsequent investigations diagnosed with bladder and prostate cancer. Patient 13 has locally advanced bladder cancer. There has been a resultant 6-month significant delay in obtaining a diagnosis and a recommendation of treatment for his bladder cancer.

Patient 12 – a Personal Information redacted by USI male was referred to Urology Outpatients on 8 Sept 2016 for assessment and advice on lower tract symptoms and elevated PSA. The referral was marked Urgent by the GP. The referral was not triaged on receipt. As part of the internal review the referral was upgraded to Red Flag and was seen in clinic on day 152. On day 215, Patient 12 had a confirmed cancer diagnosis T3a with no nodal metastases. There has been a resultant 8-month delay in

obtaining diagnosis and a recommendation of treatment for a prostate cancer.

Causal Factors

1. Referral letters did not have their clinical priority accurately assigned by the GP. Referral letters were not triaged following receipt by the Hospital.

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely

manner.

Recommendation 8
The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

Recommendation 9
Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10
The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11
Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12
Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

2.0 THE REVIEW TEAM

Dr J R Johnston - Consultant Medical Adviser - Chair

Mr M Haynes - Consultant Urologist

Mrs K Robinson - Booking & Contact Centre Manager

Mrs T Reid - Acute Clinical & Social Care Governance Coordinator

3.0 SAI REVIEW TERMS OF REFERENCE

1. To undertake an initial investigation/review of the care and treatment of patients Patient 15, Patient 13, Patient 12, Patient 14 and Patient 11, in the period after referral to the SHSCT Urology service using

Southern Health and Social Care Trust

3.0 SAI REVIEW TERMS OF REFERENCE

National Patient Safety Agency root cause analysis methodology.

2. To determine whether there were any factors in the health & social care services interventions delivered or omitted to Patient 15, Patient 13, Patient 12, Patient 14 and Patient 11 that resulted in an unnecessary delay in treatment and care.
3. The investigation / Review Team will provide a draft report for the Director of Acute Services. This report will include the outcome of the Team's investigation/review, identifying any lessons learned and setting out their agreed recommendations and actions to be considered by the Trust and others.
4. The Trust will share or disseminate the outcomes of the investigation/review with all relevant parties internally and externally including the service user and relevant family member(s) (where appropriate).

4.0 REVIEW METHODOLOGY

The Review Team will undertake an analysis of the information gathered using RCA tools and may make recommendations in order that sustainable solutions can minimise any recurrence of this type of incident. The Review Team will request, collate, analyse and make recommendations on such information as is relevant under its Terms of Reference in respect of the incident outlined above.

Gather and review all relevant information

- Inpatient notes Craigavon Hospital.
- Information from the Northern Ireland Emergency Care Record (NIECR) and Patient Administration System.
- Information from laboratory systems.
- Information obtained from relevant medical, nursing and management staff.
- Review of Relevant Reports, Procedures, Guidelines.

Information mapping

- Timeline analysis
- Change analysis for problem identification and prioritisation of care delivery problems and service delivery problems as well as identifying contributory factors.

5.0 DESCRIPTION OF INCIDENT/CASE

5.1 Triage of GP referrals - background

The general public expect that, when they engage with their GP complaining of symptoms that are potentially due to a cancer, they will be referred to the appropriate secondary care services promptly and that they will respond, also promptly, to confirm or exclude the diagnosis of cancer.

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5.0 DESCRIPTION OF INCIDENT/CASE

The DHSSPSNI **Service Framework for cancer prevention, treatment and care** (Standard 13) of 2011 indicates, "*All people with signs and symptoms that might suggest cancer should be appropriately assessed by their GP and referred promptly on to hospital for further tests if needed*".

Cancer specialists, working in networks, have formulated lists of symptom and sign triggers which can signify the development of a cancer. Using these lists, primary care doctors can refer patients into secondary care; triaging a large number of patients by assigning them to different degrees of urgency (Routine, Urgent and Red-flag). If these are used as designed, this can provide an efficient referral system.

NICE have been instrumental in ensuring uniformity and the validity of these cancer recognition and referral lists of symptoms and signs. They have also formulated guidance regarding how safety nets should be setup to ensure patients are not missed. Local programmes, using this type of guidance, have been established, under the auspices of NICaN and the HSCB, to set up these triage pathways and safety nets.

5.2 Triage of GP referrals – Northern Ireland

NI Referral Guidance for Suspected Cancer (2012)

The Northern Ireland Referral Guidance for Suspected Cancer 2012 is based on the NICE clinical guideline, CG 27 - *Referral guidelines for suspected cancer,* published in June 2005. This has a section on Urological Cancer. It was introduced to GPs by HSCB correspondence (30/12/2012), revealing the new red-flag process and indicating in appendix A that, "*triaging will take place in a timely manner, within 72 hours of receipt of referral or the referral should continue with the GP Prioritisation".*

This is still the only set of referral guidance for suspected urological cancer available online on the NICaN website (last accessed 18/11/2018).

However, the 2005 CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* published in June 2015. This was endorsed by the Department of Health (NI) with HSC (SQSD) (NICE NG12) 29/15 on the 19th August 2015 which instructed the HSCB / PHA to send out the guidance to the appropriate Family Practitioners. This particular kind of guidance requires the HSCB to circulate regionally endorsed NICE guidelines to Trusts and GPs for implementation. Trusts are expected to review guidance against a base line assessment and provide HSCB with an assurance that the guidance has been implemented. If a Trust is unable to fully implement the guidance within the one-year period without regional co-ordination and/or additional resources, they should provide a formal assurance to HSCB, and this is to be managed as part of the risk management process. This assurance process does not however apply to primary care and GP's.

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5.0 DESCRIPTION OF INCIDENT/CASE

NICaN Urology Cancer Clinical Guideline (2016)

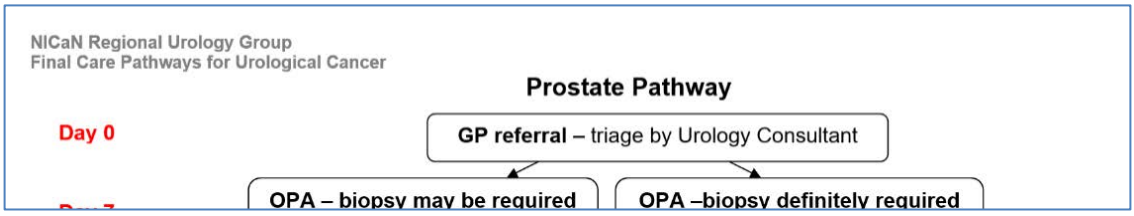
The NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016), was produced regionally to support the diagnosis, treatment and management of urological cancer. This version included amendments, to replace the previous red flag guidelines, with those from NICE NG12; the document was signed off on behalf of the NICaN by Consultant Urologist, Cons1.

The Review Team's evaluation of the advantages of NICE NG12 (2015) over the CG27 (2005) guidelines reveals fewer cases would be red-flagged for Urology, as a result of,

- a reduction in number of non-visible haematuria patients; and
- increases in age criteria of 45 years and over.

However, rollout of NG12 by the HSCB does not appear to have happened. The Review Team understands that the reason NG12 has not been implemented lies with ongoing discussions between the HSCB and GPs.

Appendix 2 of the NICaN Urology Cancer Clinical Guideline guidelines highlights the Urology Care pathways. Cons1 was present at the workshop discussing those on 02/10/2008. It clearly indicates that, for the Prostate pathway, the GP referral would be triaged by the Urology Consultant.



5.3 Triage of GP referrals – SHSCT

The process of Urology triage in CAH is based upon the NI Referral Guidance for Suspected Cancer of 2012 as described above i.e. it is based on the 2005 NICE CG27 guidelines and not the more up to date 2012 NG12. In CAH, triage of referrals is performed by the Consultant Urologist of the week.

The SHSCT Urological Cancer multi-disciplinary team (MDT) was led at the time by Consultant 1 (Cons1), who was also a joint chair.

Over a period of decades, within the SHSCT and Craigavon AH, there were occasions when triage was not performed; and this varied between consultants and specialities. Acute Services had a particular problem with this issue. Preliminary discussions by the Review Team revealed that triaging within Acute Services was a, "*very haphazard process going back for approximately 25 years. There were many Consultants who would not triage but Consultant 1 was the most persistent and there were multiple attempts to tackle this issue*".

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5.0 DESCRIPTION OF INCIDENT/CASE

Interview with Associate Medical Director (AMD1)

AMD1 first became aware of waiting list problems with Cons1 in 1996–8 when AMD1 was the lead clinician in outpatients. Cons1's OPD letters were being kept in a ring binder and were not on any waiting list. Once challenged, Cons1 would stop this practice and improve but would then slip back. There were further non-triage meetings with Cons1 when AMD1 was the Clinical Director of Surgery.

Interview with Director of Acute Services (DAS2)

In 2007, DAS2 (while in previous post in CAH) found a waiting list which was 10 years long. They worked on this with the Consultant, Cons1, and cleaned it up; they found no serious patient related issues.

Interview with Director of Acute Services (DAS1)

DAS1 indicated that the Urology Services were under various kinds of pressure during her time as Director. There was a regional transformation project in place for Regional Urology Services under Mr M. Fordham; this generated an element of pressure to modernise and change. Along with this and other issues, including the triage problem, Consultant 1 struggled to adapt to these changes and to comply with the other issues and triaging. DAS1 paints a picture of many issues with Cons1, triaging being only one of many issues but, in her opinion, not the most important issue.

Nevertheless, in April 2010, Consultant 1 (Cons1) was put under pressure to complete his triage list. The surgical Associate Medical Director (AMD1) brought concerns to DAS1. The other Urologists had been 'covering' triaging for Cons1; the Head of Service Surgery had informed AMD1 of this. They met Cons1 the next day. The European Association of Urology meeting was in Spain the following day and Cons1 wished to attend. DAS1 and AMD1 informed Cons1 he would not be attending the meeting unless he triaged all his referrals immediately. Cons1 duly addressed the triage backlog, completing them that evening. From that time on, AMD1 and the Head of Service (HoS1) monitored that Cons 1 was triaging the GP referral letters. However, DAS1 commented that the HoS1 had a difficult job managing Cons1.

Following interview with Head of Service (HoS1)

The Head of Service for Urology (HoS1) indicated that she inherited the problem upon appointment although she was aware that it was a long running issue, going back perhaps 25 years. She highlighted this was an ongoing issue with Cons1. He had the longest backlog and took longest to triage. There were issues with other Consultants who, on occasion, did not triage but Cons1 was the only one, when asked to triage, didn't do it. This came to head in 2010 (referred to above) and again in 2014.

Informal Default Triage (IDT) process

In May 2014, after escalation to HoS1, an Informal Default Triage (IDT) process was put in place by the Trust's booking centre. This process allowed the booking office to allocate

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5.0 DESCRIPTION OF INCIDENT/CASE

patients, who had not been triaged in time, to be allocated to a 'waiting list' using the GP triage category. Therefore, this IDT process of putting patients on the waiting list without triage meant that they did not get missed. However, some patients, who should have been triaged as a red flag, waited on the waiting list with their 'incorrect' GP triage category. After much discussion, this detailed process was formally circulated to all specialties on the 6th November 2015 by the Assistant Director of Support Services (ADSS1).

When questioned about this IDT process, the DAS2 was not aware of it even though it started during her time in post i.e. May '14. When asked about its potential problem of leaving incorrectly triaged (by their GP) patients on a waiting list she stated, "*Completely ridiculous, because would allow a cancer patient who should have been red flagged by their GP to go unchallenged by a Consultant triage process i.e. could have to wait for 11 months*".

5.4 Index case

In 2016, the SHSC Trust investigated (RCA ID Personal information redacted by USI), in what subsequently became an 'Index case' for the cases in this RCA, the treatment and care of Patient 10. Patient 10 was a patient who had had Personal information redacted by USI and then developed renal carcinoma. During review for her Breast Ca in June 2014, a CT Scan revealed that, previously noted, renal cysts had increased in size. Further investigation by a MRI scan was reported in a limited and incomplete fashion; resulting in a 'routine' referral GP letter on 29/10/2014.

During the investigation, the Review Team identified that Patient 10's GP referral letter had not been triaged; the Consultant Urologist with responsibility that week for triage duties was Cons1. This referral therefore waited as a 'new routine' referral till January 2016 to be seen by a Consultant Urologist.

The index case Review Panel agreed 3 main contributing factors led directly to Patient 10's delay in diagnosis. Firstly, the content of the MRI report; secondly a letter following a CT scan did not mention important information and thirdly, the opportunity to upgrade the referral to red flag was lost by the omission of triage; this resulted in a 64-week delay to diagnosis of a suspicious renal mass.

The index case Review Panel concluded in March 2017 that, ".... *a significant number of letters within Urology are not being triaged by the minority of the Team. It is clear that the default triage management process (*vide infra*) continues to be initiated secondary to the omission of Triage by individual members of the urology team and not the entire Urology Team*".

Of the 2 lessons learnt, one indicated that,

> "*Triage of GP referral letters remains a key element in validating appropriate utilisation of specialist services and ensuring patient safety. Triage also serves as an opportunity for early intervention for patients at risk of malignant disease or clinical deterioration.*"

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5.0 DESCRIPTION OF INCIDENT/CASE

This led to a recommendation that,

> "*This SAI has demonstrated that patients will be at an increased risk of harm when the opportunity for early intervention at Triage is omitted. The Review Panel recommend that the Trust reviews the process which enables the clinical triaging and escalation of triage non-compliance in accordance with the Integrated Elective Access Protocol (IEAP).*
>
> *In particular the fundamental issue of triaging GP referral letters remains a challenge within Urology. The Urology operational and medical management teams immediately need to address the issue of un-triaged referrals not being processed in accordance with IEAP.*"

The findings of this investigation, chaired by Consultant Urologist 2 (Cons2), were made available in December 2016 and formally signed off on the 15th March 2017. A letter highlighting a number of concerns was sent to the (then) lead for Acute Governance for Acute Services (AGAS1), on the 15th December 2016.

The letter pointed out that the IDT process implied that triage non-compliance was to be expected but that this process did not have a clear escalation plan to include the individual Consultant and, indeed, had not been effective in addressing triage non-compliance. Furthermore, the letter pointed out that, from July 2015 till October 2016, there were 318 non-triaged letters which the Trust could not provide assurance that patients were not being exposed to harm by waiting as a routine or urgent appointment i.e. when they should have been red-flagged.

It is not absolutely clear who wrote this letter as it has no signature, but it appears to have been written by, or on behalf of, Cons2. On the 10th January 2017, Cons2 was requested by the Medical Director (MD3) to share the report with the 2 key Consultants involved in the SAI. One of these was Cons1. Cons2 refused, stating that he was Cons1's colleague and not his manager.

This letter was escalated to the Director of Acute Services (DAS3) and the Assistant Director of Anaesthetics & Surgery. This was further escalated to the Chief Executive of the SHSCT.

Cons1 was written to by AMD1 on the 23rd March 2016, acknowledging his hard work as a Consultant Urologist but pointing out that there were governance and patient safety concerns with regard to untriaged letters dating back over 2 years, and other important issues. Cons1 was asked to respond with a commitment and immediate plan to address these issues.

The Review Panel also determined that there were 7 other patients who were not triaged that week along with Patient 10 [redacted]. They subsequently performed a 'look-back' exercise (number 1) of these referrals. Of the seven referrals, six charts were available and each patient had an appropriate

Southern Health and Social Care Trust

5.0 DESCRIPTION OF INCIDENT/CASE

management plan. One set of notes were missing and efforts were made to find them.

Cons1 provided his personal review, dated 25/01/2017, of the Index Case to the Chairman of this Review Team. It provides an argued retrospective rationale that a timely triage by himself would not have altered the referral grading. However, it does not provide a sound reason for his actual lack of triage. His report is consistent in arguing his view that he does not have time to perform both Consultant of the Week (CoW) duties and triaging of non-red flag referrals.

5.5 Look back exercise #2

Upon realisation that the 'look-back' exercise #1 had resulted from non-triage over the week beginning the 30/10/2014, further efforts were made to investigate the size of this non-triage issue and to find missing referral letters. Cons1 was contacted and the Head of Service for Urology (HoS1) obtained permission to look for missing GP referral letters in his filing cabinet. Cons1 stated that there were referral letters in a filing cabinet in his office. During interview, he stated that he kept the referrals to ensure they would not be missed or overlooked. The Head of Service for Urology retrieved these referral letters, which numbered over 700 along with the triage lists from the booking centre.

These referrals were then reviewed by the Urology Consultant Team revealing 30 patient referrals should have been red-flagged and four of these patients, following review, were diagnosed with cancer, becoming the subject of this review.

This (RCS Personal information redacted by USI) Review Team reviewed the clinical notes from these 4 patients and following discussion, under the Urological guidance of AMD1, detailed the clinical course and made the following conclusions.

Patient 14 03/06/2016 - Personal Information redacted by USI male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
09/08/2016 - added to W/L Urgent.
27/01/2017, as part of the internal review #2, the referral was upgraded to R/F and was seen in clinic on day 246. Therefore, this was an incorrect GP referral.
05/04/2017 (D304), following U/S guided biopsy, the patient obtained a confirmed cancer diagnosis and there was a recommendation for treatment of a prostate cancer by surveillance protocol.
Conclusions
Resultant 10-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 11 28/07/2016 - Personal Information redacted by USI male referred to Urology Outpatients by GP for assessment and advice, concerning elevated PSA.
The referral was marked Urgent by the GP.

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5.0 DESCRIPTION OF INCIDENT/CASE

The referral was not triaged on receipt.
30/09/2016 - added to W/L Urgent.
18/01/2017 - as part of an internal review #2, upgraded to R/F. Therefore, this was an incorrect GP referral.
20/02/2017 (D207) seen at R/F appointment. Sent for MRI and prostate biopsy.
11/04/2017 (D258) - diagnosed with a confirmed low risk prostate cancer and there was a recommendation for treatment of a prostate cancer by surveillance protocol.

Conclusions

Resultant 9-month delay in obtaining diagnosis.
Following Review Team consideration, deemed not to be a clinically significant delay.

Patient 13 [redacted] 28/07/2016 - Personal Information redacted by USI male referred to Urology by GP following an episode of haematuria.
The referral was marked Routine by the GP.
The letter was not triaged.
30/09/2016 - Patient 13 [redacted] was placed on a Routine waiting list.
19/01/2017 - As part of an internal review #2, upgraded to a R/F referral. Therefore, this was an incorrect GP referral.
31/01/2017 (188d) - reviewed at OPD and flexible cystoscopy.
22/02/2017 TURBT/TURP - diagnosed with bladder (locally advanced) and prostate cancer and there was a recommendation of treatment for his bladder cancer.

Conclusions

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is clinically significant; time will tell*.

* The Review Team referred to an expert for advice.
Delay in definitive surgical treatment beyond 12 weeks conferred an increased risk of disease-specific and all-cause mortality among subjects with stage II bladder cancer. He remains disease free as of September 2018.

1. John L. Gore, Julie Lai, Claude M. Setodji, Mark S. Litwin, Christopher S. Saigal, and the Urologic Diseases in America Project. Mortality increases when radical cystectomy is delayed more than 12 weeks. Results from a surveillance, epidemiology, and end results–Medicare analysis. Cancer March 1, 2009.
2. Nader M. Fahmy, Salaheddin Mahmud, Armen G. Aprikian. Delay in the surgical treatment of bladder cancer and survival: Systematic Review of the Literature. *European Urology 50 (2006) 1176–1182.*

Patient 12 [redacted] 08/09/2016 - Personal Information redacted by USI male was referred to Urology Outpatients on for assessment and advice on lower tract symptoms and elevated PSA.
The referral was marked Urgent by the GP.
The referral was not triaged on receipt.
27/01/2017 – further GP letter – please upgrade to R/F.
30/01/2017 - as part of the internal review #2, upgraded to R/F.

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5.0 DESCRIPTION OF INCIDENT/CASE

06/02/2017 - seen in clinic on day 152.
11/04/2017 (D215) - confirmed cancer diagnosis T3a with no nodal metastases – high risk and there was a recommendation of treatment for a locally advanced non-metastatic prostate cancer.

Conclusions

Resultant 8-month delay in obtaining diagnosis.
Following Review Team consideration, it is probable that the delay is not clinically significant.

At a later date, towards the end of 2018, another patient came to the attention of the Review Team – Patient 15. This patient could also have been one of those found in Cons1 filing cabinet but appeared at an outpatient clinic before the outworking of the look back exercise #2. A Consultant Urologist realised in the clinic that this was also a Cons1 non-triaged patient who was incorrectly referred by their GP.

Patient 15 30/08/2015 - Personal Information redacted by USI male referred to Urology Outpatients by GP for assessment and advice with a raised PSA.
The referral was marked Routine by the GP.
The referral was not triaged on receipt.
29/01/2016 2nd GP referral marked as Suspected Cancer – Red flag; Patient 15 was added to W/L R/F following this referral.
As part of the internal look back #2, the referral was noted.
Patient 15 had already received an appointment and was seen in clinic on day 153. Therefore, 1st GP referral was incorrect; the 2nd was a correct GP referral.
11/02/2016 (D166), following a prostate biopsy, the patient obtained a confirmed cancer diagnosis T3a and there was a recommendation for treatment of a prostate cancer.

Conclusions

Resultant 6-month delay in obtaining diagnosis.
Following Review Team consideration, it is felt that the delay is unlikely to be clinically significant.

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7.0 CONCLUSIONS

The Review Team interviewed a number of Trust staff including Directors (past and present), an Assistant Director, Head of Service and an Associate Medical Director as part of the review process. These interviews, along with clinical documents and health records systems, have helped inform the conclusions by providing the evidence and also corroboration where there appeared to be differences of opinion.

The Review Team and everybody interviewed, including Cons1, provided affirmation that a timely, efficient triage system which checked the initial GP referral was very important to patients. Comments made when interviewees were asked about the importance of triage and where the process of triaging a potential cancer patient ranked alongside other issues such as probity, patient experience and performance, were consistent,

"Very significant". Very high up the list in terms of importance".
"It is fundamental people are seen in the appropriate time".
"Very important" ... "Important for the patient".
"Vital" ... "Very significant .. patients are often anxious and depend on the system to work".

Cons1 replied,

"It is a serious issue, very important"..... "Number one ranking in overall scheme of things"

The Review Team established that there were factors in HSC service delivery to the 5 patients under examination that resulted in an unnecessary delay in treatment and care. In 4 patients the delay was thought not to be clinically significant but in 1 ([redacted]) there probably was a significant delay.

Consideration of the causative factors to the patients' delays reveal,

- Referral letters did not have the clinical priority accurately assigned by the GP; and
- Referral letters were not triaged following receipt by the Hospital.

7.1 Referral letters did not have the clinical priority accurately assigned by the GP.

Contributory factors

Task Factors (policy and guidelines)
The Review Team reviewed the GP referrals regarding the five patients listed above. They concluded, as judged from the Northern Ireland Cancer Network (NICaN) Referral Guidance for Suspected Cancer (December 2012), that all five patients should have been referred to Urology by the GP's as red flag referrals (suspected cancer) i.e. incorrect triage.

Task Factors (decision aids)
The current decision aid for GPs is the NI Referral Guidance for Suspected Cancer 2012 based on NICE CG 27 *Referral guidelines for suspected cancer* published in June 2005. It is clear that Secondary care, in the form of Consultant Urologists, should triage these GP referrals; by doing so, 11% of GP referrals are changed (from Review Team member). It is also clear that Cons1 would have been in no doubt as to his responsibilities; he was intimately

involved in setting this standard and signed off the NICaN clinical guidelines.

However, it is clear this very important and critical triage safety net, work can be considered onerous and other electronic methods which GPs can use might be more efficient and help to reduce that load.

According the HoS1, most patient referrals by GPs to Trusts for outpatient appointments are now made through the electronic Clinical Communication Gateway (CCG). However, some paper referrals are still received. CCG is a digital referral system for Primary care which can contain referral criteria that meet NICE and NICaN guidance. This would enable appropriate clinical triaging of referrals to be performed as part of the selection of referral reasons and/or symptom description.

Using the electronic CCG pathway, some clinical specialties, such as gynaecology, have worked closely with the Public Health Authority to develop a better GP referral tool e.g. using 'banner guidance' (a specialty specific banner, listing symptoms and signs) which complies with NICE/NICaN guidance. This 'banner guidance' helps by directing clinicians to use the NICE/NICaN referral criteria which allow for timely and appropriate triage of patients to clinically appropriate appointment types. It is possible when red flag symptoms are chosen that an immediate alert could go to the Red Flag booking team, to allow the appointment booking process to begin immediately. However, currently, the referral criteria fields are optional i.e. not mandatory, so opening up the possibility that fields are not completed, leading to error and delay.

NICE NG12
The reference CG27 guidance has been replaced by NICE Guideline NG12 *Suspected cancer: recognition and referral* but, despite being endorsed by the DHSSPSNI and accepted by the Regional Urologists, it has yet to be implemented. Its use as a triage standard should result in fewer red-flagged cases which should ease some of the pressure on waiting lists. Its adoption would take place in primary care and should form the basis of the electronic CCG referral tool.

There was a consistent medical staff view from the Review Team, the AMD1, and indeed Cons1, that GP's have a crucial and important responsibility in getting the referral criteria/urgency category correct. If the GP does not provide enough, or the correct information, the NI Electronic Care Record (NIECR) needs to be checked and that slows the whole triage process down. It was clear that the triage system works best when the initial GP referral is usually correct and the Secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

7.2 Referral letters were not triaged following receipt by the hospital.

Contributory factor

Task Factors (policy and guidelines)

The Integrated Elective Access Protocol (IEAP) (DHSSPS, April 2008) defines the roles and responsibilities of staff (in both primary and secondary care) when patients enter an elective care pathway. It states,

> '…*an Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to…. Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first*'.

The Principles for booking Cancer Pathway patients states,

> "Clinical *teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients*".

and,

> "*Referrals will be received, registered within one working day and forwarded to Consultants for prioritisation*".

However, the IEAP states,

> *"…if clinical priority is not received from Consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency".*

Following on from the IEAP of 2008, national and regional policies and guidelines, already referred to above, have been introduced which have outlined the detailed role of the Urology Consultant in triaging referrals that have come in from Primary care e.g.,

- Service Framework for cancer prevention, treatment and care (Standard 13) 2011;
- NI Referral Guidance for Suspected Cancer 2012; and
- NICaN Urology Cancer Clinical Guideline document, (version 1.3, March 2016).

These have provided agreed lists of the critical symptomatology of Urological cancers and the roles and responsibilities of Primary and Secondary care staff in ensuring patients receive prompt recognition and treatment of their cancer.

Review of Adult Urology Services in Northern Ireland

In March 2009, a *Review of Adult Urology Services in Northern Ireland - A modernisation and investment plan* was published. Its External Advisor was Mr Mark Fordham. SHSCT Consultant Urologists were represented on the committee.

Recommendation 4 states, "*Trusts must review the process for internal Consultant to Consultant referrals to Urology to ensure that there are no undue delays in the system".* Consultants indicated that they would routinely upgrade a significant number of routine and urgent referrals (GP) to urgent or red flag. It was noted that the development of agreed referral guidelines/criteria for suspected Urological cancers was a priority piece of work for the recently formed NICaN Group. That work was led by Cons1; see page 6.

Section 3.31 of the report indicates that, "*Consultant Urologists unanimously consider that referral triage should be led by Consultants. With over 40% of referrals being cancer related*

(and with many not red flagged or marked urgent) they believe that they are best placed and skilled to undertake the triage process. They also believe that despite the volume of referrals, this is not a particularly time consuming process."

Contributory factor

Staff factor

It is obvious from reading the documents referred to above that Cons1 has been aware of developments in this field and, indeed has been party to the discussions and signed some of them off. Cons1 was chair of NICaN (Urology) and was involved in drafting the NICaN regional Urology guidance, and therefore was very familiar with the requirement to triage GP referrals.

Despite all of this, and even though Cons1 agreed that this triaging role was, "*very important*", …. it was, "*a very serious matter not to be minimised, very serious"* he stated he would not triage non-red flag referrals.

When asked, *"Does triage still need done?"* Cons1 answered*, "a procedure is needed to highlight when it needs done and who does it".* When further asked, *"Who was involved in SHSCT Urology service in setting up triage"?* Cons1 answered for urological cancer, "*I was the Lead"*.

He felt triage of referral letters was too time consuming and the amount of time spent on triage, in his opinion, rendered inpatient care unsafe. He highlighted that he had previously escalated his concerns about work load to management teams and medical directors.

In relation to triage, Cons1 stated, '*I would love if we had a Trust Urology agreement on the type of triage to be conducted*'. When it was pointed out that, "*Consultant colleagues did triage for you. How did they do it?"* He stated, "*It depends on how you do it"* ..... "*Not all do advanced / enhanced triage, they compromise. It is a spectrum"... "They have not done it in the detail I felt it needed for routine/urgent non-red flag case".*

When questioned further, regarding his way of organising his own work load, Cons1 stated, '....*yes I did it my way – I wasn't cognisant of being unbending, I am very particular*'.

Cons1 highlighted to the Review Team that he currently takes annual leave each Friday and spends the weekend triaging. He stated that it is impossible to be Urologist of the Week and triage referrals appropriately. He stated he still can't do triage and everything else. He stated, '*I do triage entirely in my own time to allow me to do it properly'*.

When asked about using the NIECR - Electronic Referral using the Clinical Communication Gateway (CCG) method, Cons1 stated found the new CCG triage system*, "Very, very good, I wish all information was available on ECR. It is less time consuming. ECR makes it easier to check information".*

The Review Team concluded that there was a serious inconsistency between the guideline

standard that a Consultant should triage GP referrals (which Cons1 helped to construct) along with his stated view of the crucial importance of triage and Cons1's actual practice.

Cons1's chosen method of triage was beyond what is required. His triage is the equivalent of a virtual clinic where he reviews NIECR and books investigations for patients. While the Review Team recognised this was a detailed triage process, they concluded that his prioritisation of work and attention to detail meant that some patients got a higher standard of triage/care, while, crucially, others were not triaged, leading to a potentially critical delay in assessment and treatment for those patients. Cons1 is aware of this.

The Review Team concluded that Cons1's prioritisation of work and attention to detail led to some patients receiving a high standard of care, while others ran the real risk of having a cancer diagnosis delayed till it was dangerously late.

Contributory factor

Work load/scheduling

In 2008, when the IEAP was published, there was a maximum waiting time of 9 weeks for a first Outpatient appointment. On 30th September 2016, there were 2012 patients on the routine Urology outpatient waiting list, with 597 patients showing as waiting 52 weeks and over. The longest waiting time was 554 days (80 weeks). Therefore, if patient referrals are incorrectly referred, or not triaged and continue to use the GP's classification of urgency, there will be a significant wait. Cons1 is aware of this reality.

The Review Team considered the Consultant of the Week (CoW) work load, including ward rounds, clinics, emergency theatre sessions as a contributory factor. Cons1 has consistently argued that he cannot triage non-red flag referrals and carry out the duties of the CoW. He has not indicated who else should carry out the triage duties. However, the Review Team note that the other Consultant Urologists were able to manage this work load and triage referral letters in a timely fashion, with other members of the consultant team also ordering investigations, providing treatment recommendations and adding patients directly to waiting lists, similar to outcomes achieved from Cons1's 'advanced triage'.

Contributory factor

Organisational

The Review Team concluded that the non-triage of Urology referrals by Cons1 has been an ongoing problem in the Trust for many years, possibly decades. While there were pockets of non-compliance by other Consultants, when escalated, compliance improved. However, the Review Team note that Cons1 consistently did not return triage information on referrals thus not allowing the appropriate prioritisation of appointments by clinical need.

Interviews with 2 previous and the current Director of Acute Services, AMD1 and the Head of Surgery Service have highlighted that on many occasions, over a prolonged period, attempts had been made by the Trust's officers to address Cons1's non-compliance with triage. These

attempts encompassed both direct face to face conversations which were often heated, correspondence and, as in 2010, study leave refusal until there was compliance. These interventions all resulted in a familiar pattern of response; temporary improvement in compliance with triage, followed by a return to non-compliance.

In 2014, due to continuing non-compliance, the Trust implemented an 'Informal' Default Triage Process to manage the referrals which were not being triaged and returned to the Booking Centre. The Review Team considered the intention of this process was to prevent any delay in patients being added to the waiting list. However, this meant the 'non-return of triage' was not individually addressed with the non-compliant clinicians. Furthermore, and most importantly, it allowed patients, who should have been red-flagged, to remain on a waiting list until review.

In 2014, the Director of Acute Service 2 (DAS2) discussed non-compliance with Cons1 and agreed that Cons1 would no longer triage referral letters. Cons1 was heavily involved with formulating the NICaN Urology guidelines at the time and was grateful to the extent that he thanked DAS2.This task was delegated to other Urology Consultants for a time. However, Cons1 does not recollect having to formally stop triage. At interview, DAS2 was not aware that he had resumed those duties; she remembered that their Cancer performance figures improved when Cons1 was not triaging.

Escalation within Organisation
At every interview, questions were asked whether Cons1's consistent and prolonged non-compliance with triaging was referred upwards to executive level i.e. the Medical Director and Chief Executive.

Director DAS1 considered that the problem was being managed at Service level, although as it was only one of a series of issues and considered to be a 'minor' one, it did not predominate at higher level meetings with the Medical Director (MD1); to the extent that he may not have been aware of it.

Director DAS2 considered that the problem was dealt with by agreeing with Cons1 to stop triaging. There were other issues that were flagged up to MD2, but she was not able to remember whether MD2 was made aware of the triage problem.

During DAS3's current tenure Executive members certainly knew; at CAH Oversight meeting level and at the time of the look back exercise #2 which ultimately led onto this SAI and RCA process. The Medical Director (MD3) was directly involved in the RCA process and the CEO was aware. At Trust Board level, it is thought that a non-Executive member was asked to examine the situation which would indicate that it had also reached that level.

Overall, the Review Team in considering whether there was a satisfactory escalation of this 'non-triage' issue have concluded that there was no evidence of consistent and proactive escalation of 'non-return of triage' either to the Medical Director or the Chief Executive until the look back exercise #2 basically forced the seriousness of the issue out into the open. Indeed,

they do not appear to have appreciated the importance of triage, certainly from the patient's perspective. The Trust's officers made efforts to address Cons1's non-triage over time but were consistently thwarted by Cons1's refusal to comply. The Trust failed to put systems, processes and fail safes in place to ensure Cons1's consistently triaged patient referrals until 2017.

Systems and processes have now been put in place so that the Head of Service for Urology reviews Cons1's compliance with triage. HoS1 will check all Urology triage on an adhoc basis but, with Cons1, she will check daily when he is the Consultant of the Week. Any non-compliance with returning referrals without triage is addressed immediately. However, this process is heavily dependent on HoS1 who, when she is on leave, often has to recover non-triaged cases upon her return.

8.0 LESSONS LEARNED

1. The clinical urgency category allocated by GPs to 30 patients referred to Urology were incorrect. The referrals using NICaN guidance should have been referred as a Red Flag. Four (plus 1) of these patients were subsequently shown to have cancer.

2. The process of triaging Urology cancer referrals from Primary Care to Secondary Care, under the direction of the HSCB, appears to be less efficient than it could be, bearing in mind that NICE NG12 guidance has not been adopted and electronic referral using CCG is not being used as efficiently as it could.

3. GP's are not mandated to provide HSCB with an assurance that they comply with the most up to date NICE or other guidelines. Therefore, HSCB are unaware of any risks consequent upon the non-compliance with NICE and other guidance within GP practices.

4. GP's are not mandated to refer patients using CCG clinical criteria banners; this can lead to error and delay.

5. There is no Regional or Trust guidance or policy on what is expected of clinicians when triaging referral letters. Triage of patient referrals is obviously viewed as extremely important but does not seem to be at an equivalent level of importance when ranked alongside other clinical governance issues. Despite being an evident problem for decades and requiring considerable time and effort to find a solution, it only really surfaced within the Trust after an Index case forced the situation out into the open.

6. Despite it being absolutely clear to Consultant 1 (based upon his close proximity to the development and signing off of regional guidance) of the consequences of non-triage, he did not routinely triage referral letters. The Review Team consider that Cons1's refusal to triage to a level similar to other clinicians, led to patients not being triaged,

and this resulted in delays in assessment and treatment. This may have harmed one patient.

7. Cons1 confirmed that despite the Trust reminding him of the requirement to triage, he did not consistently triage referrals. He argued that, due to time pressures, he felt he was unable to perform the duties of the Consultant of the Week and his triaging duties. He has highlighted those views to Trust operational and management teams over a number of years.

8. The Trust made efforts to address Cons1's non-triage over time. However, the Trust failed to put systems, processes and fail safes in place to ensure Cons1 consistently triaged patient referrals until 2017. However, this safeguarding process is heavily dependent on the Head of Service checking triage is completed when Cons1 is Consultant of the Week.

9. The Informal Default Triage process allows patients who should be red flagged to remain on a waiting list of routine or urgent cases.

10. From examining the triaging issue over the length of time it has existed, it is obvious that there is an unwillingness or inability within the medical hierarchy to tackle its 'difficult colleague' problem. The reasons behind this probably include not taking ownership of its own problems and poor support from senior medical management perhaps resulting in issues not being referred upwards.

9.0 RECOMMENDATIONS AND ACTION PLANNING

HSCB

Recommendation 1

HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.

Recommendation 2

HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices.

Recommendation 3

HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.

HSCB, Trust and GPs

Recommendation 4

GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.

TRUST

Recommendation 5

Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.

Recommendation 6

The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.

Recommendation 7

The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.

Recommendation 8

The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.

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9.0 RECOMMENDATIONS AND ACTION PLANNING

Recommendation 9

Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.

Recommendation 10

The Trust must set in place a robust system within its medical management hierarchy for highlighting and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.

CONSULTANT 1

Recommendation 11

Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.

Recommendation 12

Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.

10.0 DISTRIBUTION LIST

In addition to the Review Team, the following.

Mr S Devlin, Chief Executive SHSCT.

Dr Maria O'Kane, Medical Director, SHSCT.

Mrs Melanie McClements Interim Director of Acute Services.

Health & Social Care Board (HSCB).

Chairs of Morbidity & Mortality Groups SHSCT.

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Checklist for Engagement / Communication with Service User[1]/ Family/ Carer following a Serious Adverse Incident

Reporting Organisation SAI Ref Number:	Personal Information redacted by USI	**HSCB Ref Number:**	**S** Personal Information redacted by USI

SECTION 1

INFORMING THE SERVICE USER[1] / FAMILY / CARER

1) Please indicate if the SAI relates to a single service user, or a number of service users. **Please select as appropriate (✓)**	**Single Service User**		**Multiple Service Users***	✓	
	Comment: 5 ***If multiple service users are involved please indicate the number involved**				
2) Was the Service User[1] / Family / Carer informed the incident was being reviewed as a SAI? **Please select as appropriate (✓)**	**YES**	✓	**NO**		
	If **YES**, insert **date informed**:19.2.18				
	If **NO**, please select **only one** rationale from below, for **NOT INFORMING** the Service User / Family / Carer that the incident was being reviewed as a SAI				
	a) No contact or Next of Kin details or Unable to contact				
	b) Not applicable as this SAI is not 'patient/service user' related				
	c) Concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user				
	d) Case involved suspected or actual abuse by family				
	e) Case identified as a result of review exercise				
	f) Case is environmental or infrastructure related with no harm to patient/service user				
	g) Other rationale				
	If you selected c), d), e), f) or g) above please provide further details:				
3) Was this SAI also a Never Event? **Please select as appropriate (✓)**	**YES**		**NO**		
4) If **YES**, was the Service User[1] / Family / Carer informed this was a Never Event? **Please select as appropriate (✓)**	**YES**	If **YES**, insert **date informed**: DD/MM.YY			
	NO	If **NO**, provide details:			
For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**					
Content with rationale?	**YES**		**NO**		

SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER

(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)

5) Has the Final Review report been shared with the Service User[1] / Family / Carer? **Please select as appropriate (✓)**	**YES**		**NO**	✓
	If **YES**, insert date informed:			
	If **NO**, please select **only one** rationale from below, for **NOT SHARING** the SAI Review Report with Service User / Family / Carer:			
	a) Draft review report has been shared and further engagement planned to share final report			
	b) Plan to share final review report at a later date and further engagement planned			✓

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SHARING THE REVIEW REPORT WITH THE SERVICE USER[1] / FAMILY / CARER *(complete this section where the Service User / Family / Carer has been informed the incident was being reviewed as a SAI)*		
	c) Report not shared but contents discussed ***(if you select this option please also complete 'l' below)***	
	d) No contact or Next of Kin or Unable to contact	
	e) No response to correspondence	
	f) Withdrew fully from the SAI process	
	g) Participated in SAI process but declined review report	
	(if you select any of the options below please also complete 'l' below)	
	h) concerns regarding impact the information may have on health/safety/security and/or wellbeing of the service user[1] family/ carer	
	i) case involved suspected or actual abuse by family	
	j) identified as a result of review exercise	
	k) other rationale	
	l) If you have selected **c), h), i), j), or k)** above please provide further details:	

For completion by HSCB/PHA Personnel Only (**Please select as appropriate (✓)**				
Content with rationale?	**YES**		**NO**	

SECTION 2							
INFORMING THE CORONERS OFFICE **(under section 7 of the Coroners Act (Northern Ireland) 1959)** *(complete this section for all death related SAIs)*							
1) Was there a Statutory Duty to notify the Coroner on the circumstances of the death? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						
2) If you have selected 'YES' to question 1, has the review report been shared with the Coroner? **Please select as appropriate (✓)**	**YES**		**NO**				
	If **YES**, insert **date report shared**:						
	If **NO**, please provide details:						
3) 'If you have selected 'YES' to question 1, has the Family / Carer been informed? **Please select as appropriate (✓)**	**YES**		**NO**		**N/A**		**Not Known**
	If **YES**, insert **date informed**:						
	If **NO**, please provide details:						

DATE CHECKLIST COMPLETED	**22.5.2020**

[1] *Service User or their nominated representative*

Incident Oversight Group

Tuesday 3rd November 2020, 4:30pm

Via Zoom

AGENDA

1	Apologies	
2	Review of Action Log	Urology Oversight Action Log 03.11.202
3	DoH Oversight Meeting Update (30th October 2020)	
4	Response from Tughans re Trust Letter	
5	**GMC Discussions** - Request for information	20201013_LtrGENERAL MEDICAL COUNCI Appendix D - Letter to Trust 9 September Appendix C - RP5593 Letter to Shane Dev Appendix B - Health MInister Statement 27 Appendix A - 25.10.20 Letter to Tu Appendix F - Summary of SAIs.pdf Appendix E - 2020 09 SEPT.29th.Respor
6	Administration Review Update	
7	Mileage Claims	
	Serious Adverse Incident (SAI) Reviews	
8	Process for Managing SAI's going forward	
9	Original SAI's – Deceased Service User Family Contact	
10	Initial Feedback from SAI Chair - MDM Processes - Oncology Attendance MDM	
11	Family Liaison Role	
	Management of Patient Reviews	
12	IPT for Review Process	IPT for urology required.msg
13	Additional Subject Matter Expertise / Consultant Reviews	Personal CV 2020.doc
14	Bicalutamide Patient Review	Clinical And Social Care Audit Registrati

15	Engagement of ISP to undertake waiting list work	
16	Telephone Support Service / Patient Triage Update	
Communications		
17	Ministerial Update Statement 10th November 2020	
18	Media / Assembly Questions	FAQs urology 02112020.docx
Any Other Business		
19	Any Other Business	
Date of Next Meeting		
20	Via Zoom – 10th November 2020	

Incident Management

ID	Element	Actions Required	Responsible	Date for Completion	Attachments	Complete
1	GMC Request for Information 8th October 2020	Further communication received from the GMC asking for update on issues. Draft corresepondence created for review. GMC to be advised of decision not to progress with MHPS review based on DoH advice.	M O'Kane / S Wallace	6th November		
2	MHPS Investigation (New)	AOB is no longer professionally accountable to the SHSCT and Dr O'Kane is not responsible officer - this has been the case since 29th July 2020. Response from AOB solictor 9th September stating that as MHPS did not start prior to AOB's retirement that there are no grounds for continuing the process. DLS advice has been dou on AOB solictor communcation. DoH have also advised that given AOBs retirement MHPS should not be followed. GMC to be updated	M O'Kane / S Hynds / S Wallace	30th September		Complete
3	Mileage Claims	AOB has submitted Personal for previous 8 years prior to retirement. AOB's contract states that this should be monthly submissions. SH stated that communications had been issued to staff at regular intervals to remind of the importance of prompt submission. Group agreed that April 2020 would be reasonable for consideration following verification.	M McClements / R Carroll / M Corrigan	20th October		In progress
4	Administration Review	Dr Rose McCullagh and Dr Mary Donnelly are conducting an administrative process review as specified in the 2018 MHPS review outcome. Group to be convened to progress wider aspects of the admin review. To consider additional quality assurance mechanisms	R McCullagh / M Donnelly	20th October		In progress
5	Screening of potential SAIs	Nine SAIs screened as meeting SAI criteria.	M Haynes / M Corrigan / P Kingsnorth	20th October		In progress
6	SAI Reviews	Required: - Communications with service users / families who are subject to SAIs - all nine new SAI service users / families contacted to inform of SAI progress. 4/5 original SAI service users contacted also - Discussion with DH to take place regarding progression of SAI's including discussions required with Trust staff, chair of MDM etc and ongoing family liaison arrangements.	M Haynes / M Corrigan / P Kingsnorth			
6	Trust External Communications	Jane to speak to David DoH on coordinated Communications strategy. - Trust to decide on public communicaions arrangements - HSCB offered Comms manager support - FAQ document to be developed to support media communications	Martina, Patricia and Ronan	3rd November		In progress
	Family Liaison	Family liaison person to be identified - MMcC has two persons who potentially can fulfil this role in mind. MMcC Discussions to take place with respective line managers to progress				
7	Additional Subject Matter Expertise	Further to this we have identified via RCS and BAUS another Subject Matter Expert Professor Krishna Sethia who is willing to engage with us.		20th October		In progress

8	Engagement of ISP to undertake waiting list work	Draft contract engagement document developed- pathways for service access are mapped. Documentation with contracts team for approval	M Haynes / M Corrigan	20th October		In progress
9	Review Scope	*Action plan to review key areas of concern developed by Urology Team - Review of stent removals Jan 2019 - June 2020 160 pts - Review of elective activity Jan 2019 - June 2020 352 pts - Review of pathology results Jan 2019 August 2020 168 pts - Review of Radiology requests Jan 2019 - August 2020 1028 pts episodes - Review of MDM episodes Jan 2019 - July 2020 271 pts Initial concerns found in a review of 270 patients has found issues with clinical skills where deviations from guideline based treatments. There is a requirement to understand the volume of patients who may be in this group. Additional SME Consultant Urologist Krishna Sethia has been identified as another avialable subject matter expert.	M McClements / M Haynes / M Corrigan / R Carroll	1st September		In progress
10	Bicalutamide Concerns	PK provided an update on SAI independent expert who has stated that Bicalutamide management in at least one case likely contributed to the death of one service user. The group discussed actions required to ensure that patient safety is maintained. The group dicussed the challenge with identifying patients who have been prescribed by AOB and those that are prescribed in secondary care. An update is being sought from Tracey Boyce and Joe Brogan to identify prescribing patterns. Group agreed this required addressing as a matter of urgency No information recieved from the PHA / HSCB re primary care prescribed Bicalutamide	M McClements / R Carroll			
10	Clinician Early Alert	M O'Kane / S Wallace to discussed Clinician Early Alert with DoH. DoH advised that informal communication with other Trust MDs and HRODs would be appropriate. MOK has completed this action.	Dr Maria O'Kane / S Wallace	20th October		Complete
12	Communication with DoH / Minister	Group agreed that date of 19th October 2020 for release should be postponed. Group suggested MD communicates with CMO to ask to postpone date.	M O'Kane	14th October		
14	Telephone Support Service	Telephone Support Service developed. Attached Powerpoint	M McClements / R Carroll / M Corrigan / M Haynes	20th October		
16	Early Alert to DoH	Early Alert issued to DoH and HSCB regarding Bicalutamide	Dr Maria O'Kane / S Wallace	16th October		Complete
17	Information on Appraisal, Job Planning, Litigation and Complaints	Information on apprisal, job planning and complaints collated	S Wallace	7th August	Information Collated - saved in shared folder	Complete

Southern Health and Social Care Trust

Quality Care - for you, with you

30th October 2020 Ref: MOK/ec

Via email [redacted]

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street,
Manchester

Dear Mr Brammall,

RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO. 1394911

Further to your email dated 8th October 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses and where noted, attached items. Further to the below information and attached items a verbal update was provided to Joanne Donnelly Employer Liaison Advisor, General Medical Council on the 23rd October 2020.

A copy of correspondence was issued via the Trust Directorate of Legal Services to Mr O'Brien's solicitor on 25th October 2020 and is attached as Appendix A, this provides additional information regarding:

- Information regarding media interest in the case
- Details of additional concerns raised regarding Mr O'Brien's practice including concerns regarding the prescribing on the anti-androgen Bicalutamide
- The Chief Medical Officer decision to issue a Professional Alert as per guidance found in DHSSPS Circular HSS (TC8) 6/98

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [redacted] Email: [redacted]

It is my opinion, that given the information known to date that the General Medical Council should consider implementing interim orders restricting Dr O'Brien's practice at the earliest opportunity.

Any update that you may have the possible RCS lookback / patient recall exercise and information that may have arisen out of any review	The Trust is continuing to progress with a review of Mr O'Brien's activity since January 2019 to identify any additional issues with the quality of care delivered. The Trust is liaising with the Department of Health Northern Ireland, Health and Social Care Board and Public Health Agency to guide the review process. The Trust has also consulted with the Royal College of Surgeons who have provided guidance on developing the review criteria. To date as a result of this review further issues have been identified which have required screening as potential Serious Adverse Incidents, in total nine of these incidents have been deemed as meeting Serious Adverse Incident criteria. The Trust has also been made aware of the scale Mr O'Brien's significant private practice activity via discussions with GPs in the Southern Area. Mr O'Brien's private practice was conducted from his home; therefore all records of this activity will solely be in his position. The Trust has no access or information on the scale of this activity, the Trust has made the Department of Health Northern Ireland, Health and Social Care Board and Public Health Agency aware of this area of activity. Given Mr O'Brien's residence being located close to the border with the Republic of Ireland, the Trust has concerns there may be private practice issues involving patients from this jurisdiction.

	In addition to this GP colleagues have commented that on occasion they have referred patients to the Southern Health and Social Care Trust to later receive correspondence from Mr O'Brien regarding the same patient on documentation referring to the individual as a private patient. The Northern Ireland Minister for Health has issued a written statement to the Northern Ireland Assembly on 27th October 2020 regarding this issue; this can be found attached as Appendix B. The concerns have also received media coverage via the Irish News and BBC Northern Ireland websites. Mr O'Brien has not been named in any public releases. The Minister for Health plans to make a statement in the Assembly on the 10th November. The Department of Health Northern Ireland has established an Departmental Oversight Group to provide assurance surrounding all elements of each ongoing process, a letter outlining this is attached as Appendix C.
An update about the new MHPS investigation that was being considered due to the additional concerns about Mr O'Brien that arose recently	The Trust sought advice from the Department of Health Northern Ireland regarding the new MHPS investigation. The Trust has been advised that as the process did not commence when Mr O'Brien was an employee that the investigation should not be pursed. The Trust is no longer his designated body and I am no longer his responsible officer. A response received from Mr O'Brien's solicitor (Appendix D) also indicates that Mr O'Brien will not engage with any Trust MHPS process as he is no longer employed by the Trust. The Trust response to this correspondence is attached as

	Appendix E.
Any updates concerning the SAI reviews for service user A and service user B as identified in the new concerns that were recently sent to the GMC	The Trust has discussed the identified Serious Adverse Incidents with the Department of Health Northern Ireland, Health and Social Care Board and Public Health Agency. As a result the Trust and PHA have appointed an independent chairperson to conduct these Serious Adverse Incident reviews with subject matter expert support provided by an independent Consultant Urologist nominated via the British Association of Urological Surgeons (BAUS). A wider review panel to support this has been appointed and work is preparing to commence. Further to this the Trust has identified a further seven Serious Adverse Incidents relating to patients on Mr O'Brien's caseload. Case summaries for these patients are attached as Appendix C. The Departmental Oversight Group is considering going forward whether all of these should progress as individual SAIs or become part of a different process such as an inquiry. During the initial stages of the Serious Adverse Incident reviews patient safety concerns have been raised by the chairperson in relation to the prescribing of Bicalutamide, an antiandrogen medication that is primarily used to treat prostate cancer, which should be prescribed at 150mg for a maximum of 8-10 weeks (and kept under review during that period) to patients prior to starting radiotherapy. The concern is with regard to patients that have been managed on Bicalutamide for extended periods, in

	excess of 8-10 weeks, without review during that period, and at 50mg, which is associated with making prostate cancer worse. It is also associated with a variety of harmful side-effects. The context is complex as Dr O'Brien would have advised the prescribing requirements, the GP would issue the prescription, and the pharmacist would dispense. The Trust is currently identifying those patients who are prescribed this medication and providing review appointments as a matter of urgency.
The outcome (or a copy of) the independent review into the administrative procedures that was due to be concluded by September 2020 (when this becomes available)	The independent review into administrative procedures commenced in August 2020. Further details on standard operating processes for administration of patient information has been requested to complete this work prior to acceptance of completion. This will be shared with the GMC on finalisation, this is expected 16th November 2020.

I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me.

Yours sincerely

Personal information redacted by USI

Dr Maria O'Kane
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
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Tughans

tughans.com

Ms Vivienne Toal
Southern Health & Social Care Trust

Our Ref: AFA/AK/9MP28112

Your Ref:

Date: 9 September 2020

BY EMAIL
[redacted]

Dear Ms Toal

MR AIDAN O'BRIEN

Thank you for your patience in waiting for this correspondence which, as you know, has been delayed due [redacted].

The Trust will be aware in the previous MHPS investigation Mr O'Brien did not accept that MHPS is incorporated within his contract. He maintains that position. There is no right under his contract to undertake any investigation, formal or informal, into performance or conduct following his retirement. The following comments are without prejudice to that position.

For the reasons we set out below, even if MHPS does apply, there is no contractual right thereunder to entitle the Trust to carry out any formal investigation into Mr O'Brien's conduct or performance, now that he has retired. In any event there is no purpose or rationale for such investigation intruding upon Mr O'Brien's retirement and taking up time and resources given the Trust has referred all matters which it might otherwise want to investigate to the GMC for its independent investigation.

Mr Haynes wrote to Mr O'Brien on 11 July 2020 enclosing a document entitled "Summary of Concerns". Mr Haynes noted in his covering correspondence the concerns were to be managed in line with MHPS and noted the Trust at that point to only be at the initial enquiry stage.

Even if contrary to our contention MHPS did apply under Section 1, paragraph 15 the Clinical Manager is to identify the nature of the problem or concern and assess the seriousness of the issue on the information available. It would appear, in accordance with that paragraph, Mr Haynes was only carrying out "preliminary enquiries" in order to decide whether an informal approach could address the issues he had identified or whether a formal investigation was required.

On 16 July 2020 I wrote to you indicating Mr O'Brien could not substantively comment to the issues raised without access to the underlying documentation the Summary of Concerns was based upon.

On 17 July 2020 Mr O'Brien's employment with the Trust came to an end. By that stage no steps had been taken under either the formal or informal processes referred to in MHPS.

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The Trust has provided to the GMC with the Summary of Concerns. The GMC is undertaking steps to investigate issues arising out of same. As I understand it, the GMC have requested the records for Service Users A and B, which have been separately provided to me by the Trust. The GMC are proposing to obtain expert evidence in relation to the care provided to Service Users A and B.

Therefore, there is no contractual basis under MHPS (even if incorporated) upon which to commence an investigation into the Summary of Concerns as Mr O'Brien's employment concluded prior to any formal or informal procedures having been commenced. Section IV of MHPS provides that an investigation should be taken to a final conclusion only where an employee leaves employment before formal procedures have been completed. However formal procedures were not commenced prior to Mr O'Brien's retirement, thus there are no such procedures to complete.

If a formal investigation had been commenced any investigation that would have been undertaken would only have resulted in a report to the Case Manager in accordance with Section 2, paragraph 38, of MHPS. One of the options open to the Case Manager in such a situation would be to refer the matters to the GMC. The Trust already has taken that step. There are no other referrals that would be required under Section II, paragraph 8 (such as to NCAS – Mr O'Brien has already has retired from medical practice) or under Section IV, paragraph 9 (to the Police or protection of children and vulnerable adults list).

As the GMC is carrying out an enquiry into Mr O'Brien, that is the appropriate forum for any investigation to continue in. The GMC is the appropriate authority to investigate any issues in relation to a Doctor's conduct and performance which may give rise to patient safety concerns or risk damage to public confidence in the medical profession. If urgent action is required the GMC has powers to request the Medical Practitioners Tribunal to consider an Interim Order. Mr O'Brien will liaise with the GMC in relation to any allegations the GMC consider need to be formally investigated against him.

Thus, given Mr O'Brien's retirement, and the ongoing investigation by the GMC, there is no purpose in the Trust undertaking an extra-contractual investigation nor requirement for Mr O'Brien to participate in the same, no formal investigation having been established.

A further reason for the Trust to defer to the GMC's investigation is the, as yet unresolved, Grievance Mr O'Brien submitted regarding the events giving rise to, and conduct of, the previous MHPS investigation. From the contents of that Grievance, it is clear that Mr O'Brien can neither have trust nor confidence in the Trust carrying out an investigation which would be fair to him.

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Thus, the Trust should provide such information it considers necessary to the GMC and Mr O'Brien will address matters in the context of the GMC's processes and not have his retirement troubled by unnecessary investigations.

Kind regards.

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From the Permanent Secretary and HSC Chief Executive

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

Castle Buildings
Upper Newtownards Road
BELFAST, BT4 3SQ

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Fax: Personal Information redacted by USI

Email: Personal Information redacted by USI

Shane Devlin
Chief Executive
Southern HSC Trust

Personal Information redacted by USI

Our ref: RP5593

Date: 22 October 2020

Dear Shane

CONFIDENTIAL EARLY ALERT 182/2020 – SOUTHERN TRUST CONSULTANT UROLOGIST

I refer to the above Early Alert which was notified to the Department on 31 July 2020, and the subsequent report submitted to the Department via the HSCB on 15 October 2020, summarising the Trust's ongoing scoping and management of the issues arising from it.

Whilst I fully appreciate the complexity of this task and the intensive efforts by Trust colleagues to date to quantify these issues and to ensure that no patients come to harm as a consequence, the Department's view is that this process will benefit at this stage from a commensurate level of external oversight and assurance. Further to our discussion today I have therefore attached at **Annex A** draft terms of reference for a Department-led assurance group which I will chair in order to review progress and guide the way forward in terms of the Trust's management plan. It is my intention that the Urology Assurance Group will begin to meet from next week in order to agree the terms of reference and discuss the immediate next steps. Michael O'Neill, Acting Director of General Healthcare Policy, will lead on this in the Department and provide secretariat for the group.

Yours sincerely

Personal information redacted by USI

RICHARD PENGELLY
ACCOUNTING OFFICER

cc.
CMO
CNO
Lourda Geoghegan
Naresh Chada
Jackie Johnston
David Gordon
Michael O'Neill
Ryan Wilson
Maria O'Kane, SHSCT
Sharon Gallagher, HSCB
Paul Cavanagh, HSCB
Olive MacLeod, PHA
Brid Farrell, PHA
Tony Stevens, RQIA
Emer Hopkins, RQIA

ANNEX A

UROLOGY ASSURANCE GROUP
DRAFT TERMS OF REFERENCE

Background

The Department received a confidential Early Alert (EA 182/20) from the Southern Health and Social Care Trust on 31 July 2020 regarding potential safety concerns that were initially raised on 7 June 2020 about a consultant urologist who retired at the end of June 2020.

The Trust took a number of initial actions relating to these concerns, including restricting the consultant's clinical practice and access to patient information, notifying the GMC and discussing the matters with the Royal College of Surgeons Invited Review Service to understand the scope and scale of any further independent review.

In order to fully define the areas for concern and quantify the number of patients potentially impacted, the Trust has undertaken an internal scoping exercise of all patients who were under the care of the consultant, initially for an 18 month period. This involves a review of all case notes to identify those which provide any cause for concern.

Officials from the Department, HSCB and PHA have participated in weekly progress update calls with the Trust since 10 September 2020. Upon request a report was provided to the Department on 15 October 2020 summarising the current position, including the quantity of patient case notes that need to be reviewed and progress so far, confirmed SAIs to date, and advising of additional patient safety concerns identified in the course of this exercise.

Objectives

In light of the concerns identified a Department-led Urology Assurance Group will provide external oversight of the various work streams arising from the ongoing scoping exercise Trust. Specifically the Group will:

- review the progress of the initial scoping exercise;
- consider emerging strategic issues;
- commission and direct further work as necessary;
- monitor the impact on urology and related services;
- ensure coordination with other associated reviews / investigations; and
- oversee communication across all stakeholder groups.

Membership

The Group will be chaired by the Permanent Secretary. Membership will include:

- Dr Michael McBride, Chief Medical Officer, DoH
- Sharon Gallagher, Interim Chief Executive, HSCB/PHA
- Jackie Johnston, Deputy Secretary Healthcare Policy Group, DoH
- Olive Macleod, Interim Chief Executive, PHA
- Paul Cavanagh, Director of Commissioning, HSCB
- Dr Brid Farrell, AD Service Development, Safety and Quality, PHA
- Dr Tony Stevens, Interim Chief Executive, RQIA
- Emer Hopkins, Interim Director of Improvement, RQIA
- Shane Devlin, Chief Executive, Southern Trust
- Maria O'Kane, Medical Director, Southern Trust

- Lourda Geoghegan, Deputy Chief Medical Officer, DoH
- David Gordon, Director of Communications, DoH
- Ryan Wilson, Acting Director of Secondary Care, DoH
- Michael O'Neill, Acting Director of General Healthcare Policy, DoH,
- Anne Marie Bovill, General Healthcare Policy

Support

Secretariat will be provided by General Healthcare Policy Directorate and meetings will initially be held fortnightly, but will be subject to review.

Department of Health
An Roinn Sláinte
Männystrie O Poustie
www.health-ni.gov.uk

URGENT WRITTEN STATEMENT TO THE ASSEMBLY BY HEALTH MINISTER ROBIN SWANN – TUESDAY 27 OCTOBER 2020 AT 12:00PM – CLINICAL CONCERNS WITHIN UROLOGY AT SOUTHERN HEALTH AND SOCIAL CARE TRUST

The Southern Health and Social Care Trust notified my Department on 31 July 2020 that it had identified clinical concerns in relation to the work of a consultant urologist who no longer works in the health service.

An internal exercise was immediately initiated by the Trust and is ongoing in order to ascertain the number of patients whose care may need to be reviewed. At this stage, a small number of patients have been contacted in this regard.

As Health Minister, I am extremely concerned about any issue that involves the potential for patients to come to harm within our Health and Social Care system. However, it is important to stress that the vast majority of urology patients in the Southern Trust will be unaffected by the issues that have come to light. I want to assure all patients and their families that the investigation into these matters will be comprehensive, and that anyone whose care needs to be reviewed will be contacted as quickly as possible.

My Department has been kept updated by the Southern Trust regarding progress with this exercise, and I intend to make an oral statement in the Assembly as soon as practicable in order to provide further details about this matter.

My Department's immediate priority is to ensure that the Southern Trust completes this initial phase of work in the weeks ahead in order to minimise and prevent any potential risk or harm to patients.

My Department has therefore established a Urology Assurance Group to provide external oversight to the Southern Trust's ongoing process, and the future management plan for the issues arising from it. The Assurance Group comprises senior officials from the Department of Health, Health and Social Care Board, Public Health Agency, Regulation and Quality Improvement Authority, as well as the Southern Trust. I will publish final terms of reference for the Assurance Group alongside my Assembly statement.

If any urology patient or their carer has concerns about their treatment and would like information they should contact the Southern Trust on 0800 4148520.

HSC Business Services Organisation

Directorate of Legal Services
Practitioners in Law to the
Health & Social Care Sector

2 Franklin Street, Belfast, BT2 8DQ

FAO: Andrew Anthony
Tughans
Marlborough House
30 Victoria Street
Belfast
BT1 3GG

Date: 25th October 2020 Our Ref: ERLS104/03 Your Ref: AFA/AK/9MP28112

Dear Sir,

RE: Your Client – Mr A O'Brien
Our Client – Southern HSC Trust

Thank you for taking my telephone call on Friday afternoon. As advised, the matter of my Client's ongoing review of your client's patient case load is now subject to media interest. As I explained, it is not known to my Client how the media has become aware of the concerns relating to your Client. The media interest was drawn to the attention of the Trust on Friday afternoon directly by The Irish News. The media outlet appeared to be aware of the relevant specialty, but your client was not mentioned by name. I explained that I was contacting you to advise you of this development as per your Client's request conveyed in your email of 16th July 2020 that the Trust should not correspond directly with your Client. However, my Client has made it clear that, given the very difficult circumstances which will undoubtedly result for your Client, including the potential for intense media interest, the Medical Director, Dr Maria O'Kane, would wish to speak directly with your Client. I trust that you will discuss this offer with your Client.

I also advised you yesterday of the increasing scale of concerns which continue to come to light as a result of the review exercise currently ongoing within the Trust regarding your client's practice.

A more detailed look back of your client's patient cases is still ongoing for the period 1st January 2019 to 30th June 2020. Mr Haynes' letter to your client dated 11th July 2020 included a summary of concerns following initial review of patient records for this period. I can confirm that the 2 potential Serious Adverse Incidents (SAI) identified in that summary, relating to Service User A

and Service User B, have since been screened, and having met the threshold, these are now being addressed as SAI reviews.

As a result of the detailed ongoing review, additional serious concerns relating to your client's practice have been identified, and these are summarised as follows:

Elective care – the review has identified that your Client had operated on 334 patients, and out of these 120 patients were found to have undergone delays in dictation of their discharge with a further 36 patients having no record of their discharge on the Trust's electronic care record (NIECR). **Of the 36 patients, there have been 2 incidents identified that meet the threshold for SAI reviews.**

Management of Pathology and Cytology Results – the review has identified 50 out of 168 patients that require review as a result of un-actioned Pathology or Cytology results. **Of the 50 patients requiring review there have been 3 incidents identified that meet the threshold for SAI reviews with a further 5 requiring a review follow-up to determine if these patients have come to harm.**

Management of Radiology Results – the review has identified 1536 radiology results which require review to ascertain if appropriate action was taken. A review of the 1536 cases is ongoing.

Actions required as a result of Multidisciplinary Team Meetings – there were 271 patients under your client's care whose cases were discussed at Multidisciplinary Team Meetings. A review of these patient records is being undertaken. To date there are currently **3 confirmed SAI's and a further 1 needing a review follow-up** to determine if these patients have come to harm. This exercise is ongoing.

Oncology Review Backlog – 236 review oncology outpatients will be seen face to face by a Urologist in the independent sector for review. To date there has been **one SAI confirmed** from this backlog as the patient presented to Emergency Department and he has been followed up as a result of this attendance.

Patients on Drug "Bicalutamide" - There are concerns regarding your Client's prescribing of androgen deprivation therapy outside of established NICE guidance regarding the diagnosis and management of prostate cancer[1].

Bicalutamide is an Anti-androgen that has a number of recognised short term uses in the management of prostate cancer. In men with metastatic prostate cancer NICE Guidance states;

> *'1.5.9 For people with metastatic prostate cancer who are willing to accept the adverse impact on overall survival and gynaecomastia with the aim of retaining sexual function, offer anti-androgen monotherapy with bicalutamide[6] (150 mg).* ***[2008]***
>
> *1.5.10 Begin androgen deprivation therapy and stop bicalutamide treatment in people with metastatic prostate cancer who are taking bicalutamide monotherapy and who do not maintain satisfactory sexual function.* ***[2008]'***

All patients currently receiving this treatment are being identified by a number of parallel processes utilising Trust and HSC / Primary Care systems in order to facilitate a review to ascertain if the ongoing treatment with this agent is indicated or if an alternative treatment / management plan should be offered.

In the interests of immediate patient safety, the Trust is requesting details of your Client's prescribing practices regarding anti-androgen therapy and specifically with regard to Bicalutamide. This can be undertaken in the form of a video discussion, telephone call or written format. Given the severity of this concern and the potential implications for affected patients, my Client asks that this is provided as a matter of urgency.

Summary table of Serious Adverse Incidents (SAI) confirmed to date

The following table contains the summary details of the SAI reviews required to date. The SAI process will be led by an external independent Chair, commissioned by the Trust and the Public Health Agency.

Element of Concern
Elective Exercise ** had a follow up CT scan of chest abdomen and pelvis performed on 17 December 2019 which was reported on 11 January 2020. The indicate for this was restaging of current renal cell carcinoma. ** had a right radical nephrectomy March 2019.The report noted possible sclerotic metastasis in L1 vertebral body. Result was not actioned. Patient contacted with result on 28 July 2020 and further

[1] Prostate cancer: diagnosis and management. National Institute for Health and Care Excellence. NICE guideline 131. May 2019.

assessment required
Elective Exercise Patient underwent TURP on 29/1/20. Pathology reported incidental prostate cancer. No follow-up or action from pathology result until picked up from elective exercise
Pathology Patient diagnosed with prostate cancer Gleason 7. MDM 08/08/19- Significant Lower urinary tract symptoms but declined investigations. On maximum androgen blockade - No onward oncology referral was made.
Pathology Diagnosed with penile cancer, recommended by cancer MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months.
Pathology Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy.
MDM CT renal report of 13/11/2019 unsigned on NIECR. No record of action taken recorded in NIECR. Case identified at urology MDM of 3/9/2020 following review of backlog
MDM *deceased **(previously notified in Mr Haynes' letter (11.7.20) as potential SAI – Service User A)** ** was diagnosed with locally advanced prostate cancer in August 2019. An MDT discussion on 31 October 2019 recommended androgen deprivation therapy (ADT) and external beam radiation therapy (EBRT). ** was not referred for ERBT and his hormone treatment was not as per guidance. In March 2020 ** PSA was rising and when restaged in June 2020 ** had developed metastatic disease
MDM/ Bicalutamide *deceased MDM outcome not followed and inadequate treatment given. MDM outcome = commence LHRHa. Started on low dose of bicalutamide (unlicensed and sub-therapeutic dosage), subsequently re-presented with local progression January 2020 and appropriate treatment (Degeralex) was given along with TUR and stent / nephrostomy. The evidence for LHRHa in context of metastatic disease is that it reduces the risk of local progression (renal failure and spinal cord compression). This man had inadequate treatment and experienced a complication likely as a result of this.
Review Op Backlog **(previously notified in Mr Haynes' letter (11.7.20) as potential SAI – Service User B)** In May 2019 ** had an assessment which indicated he had a malignant prostrate. ** was commenced on androgen deprivation therapy (ADT). Reviewed in July 2019 in outpatients and planned for repeat PSA and further review. Patient lost to review and attended Emergency Department in May 2020. Rectal mass investigated and diagnosed as locally advanced prostate cancer

I would reiterate that given the number of patient cases from this review period (January 2019 to June 2020), this review exercise continues to be ongoing, and the above information is the current position at this point in the review. I would advise that it is very likely that my Client will be required to undertake an incremental approach to the review of patients and further time periods prior to January 2019 will undoubtedly have to be considered in a similar way.

As a result of the concerns being identified, my Client issued an Early Alert to the Department of Health and has continued to update Departmental Officials on the extent of the emerging concerns. As you will appreciate, the matter is of significant concern to the Department and my Client has been advised of the Department's intention to have external oversight of various work streams arising from the ongoing review exercise being undertaken by my Client. It is expected that the Minister for Health will make a statement to the NI Assembly in the coming days in relation to the concerns and ongoing review by my Client. The Trust anticipates that the Department of Health/the Minister will need to consider whether your client should be referred to in the course of this statement.

In light of the concerns, the Chief Medical Officer has deemed that it is appropriate to issue a Professional Alert as per guidance found in DHSSPS Circular HSS (TC8) 6/98 (copy attached).

The General Medical Council has also been updated regarding the emerging position.

I will of course contact you as quickly as possible if or when my Client is made aware of any planned timescale for Assembly and / or media activity.

Yours faithfully,

Personal information redacted by USI

June Turkington
Assistant Chief Legal Adviser

Phone: Personal Information redacted by USI
Email: Personal Information redacted by USI

Att: Circular HSS (TC8) 6/98

Summary table of Serious Adverse Incidents (SAI) confirmed to date

The following table contains the summary details of the SAI reviews required to date. The SAI process will be led by an external independent Chair, commissioned by the Trust and the Public Health Agency.

Element of Concern
Elective Exercise ** had a follow up CT scan of chest abdomen and pelvis performed on 17 December 2019 which was reported on 11 January 2020. The indicate for this was restaging of current renal cell carcinoma. ** had a right radical nephrectomy March 2019.The report noted possible sclerotic metastasis in L1 vertebral body. Result was not actioned. Patient contacted with result on 28 July 2020 and further assessment required
Elective Exercise Patient underwent TURP on 29/1/20. Pathology reported incidental prostate cancer. No follow-up or action from pathology result until picked up from elective exercise
Pathology Patient diagnosed with prostate cancer Gleason 7. MDM 08/08/19- Significant Lower urinary tract symptoms but declined investigations. On maximum androgen blockade - No onward oncology referral was made.
Pathology Diagnosed with penile cancer, recommended by cancer MDM for CT scan of Chest, Pelvis and Abdomen to complete staging. Same delayed by 3 months.
Pathology Patient diagnosed with a slow growing testicular cancer (Seminoma) had delayed referral to oncology and therefore delay in commencing chemotherapy.
MDM CT renal report of 13/11/2019 unsigned on NIECR. No record of action taken recorded in NIECR. Case identified at urology MDM of 3/9/2020 following review of backlog
MDM *deceased **(previously notified in Mr Haynes' letter (11.7.20) as potential SAI – Service User A)** ** was diagnosed with locally advanced prostate cancer in August 2019. An MDT discussion on 31 October 2019 recommended androgen deprivation therapy (ADT) and external beam radiation therapy (EBRT). ** was not referred for ERBT and his hormone treatment was not as per guidance. In March 2020 ** PSA was rising and when restaged in June 2020 ** had developed metastatic disease
MDM/ Bicalutamide *deceased MDM outcome not followed and inadequate treatment given. MDM outcome = commence LHRHa. Started on low dose of bicalutamide (unlicensed and sub-therapeutic dosage), subsequently re-presented with local progression January 2020 and appropriate treatment (Degeralex) was given along with TUR and stent /

nephrostomy. The evidence for LHRHa in context of metastatic disease is that it reduces the risk of local progression (renal failure and spinal cord compression). This man had inadequate treatment and experienced a complication likely as a result of this.
Review Op Backlog **(previously notified in Mr Haynes' letter (11.7.20) as potential SAI – Service User B)** In May 2019 ** had an assessment which indicated he had a malignant prostrate. ** was commenced on androgen deprivation therapy (ADT). Reviewed in July 2019 in outpatients and planned for repeat PSA and further review. Patient lost to review and attended Emergency Department in May 2020. Rectal mass investigated and diagnosed as locally advanced prostate cancer

Southern Health and Social Care Trust

Quality Care - for you, with you

STRICTLY PRIVATE & CONFIDENTIAL

Mr. Andrew Anthony
Tughans

Via E-Mail only [redacted]

29 September 2020 **Our Ref:** VT/hm-c **Your Ref:** AFA/AK/9MP28112

Dear Mr. Anthony

Mr. Aidan O'Brien

I write further to your correspondence of 9 September 2020.

[redacted]

Your correspondence sets out clearly Mr. O'Brien's position in respect of his further engagement with any new MHPS process by the Trust. This position is noted by the Trust.

While I note Mr. O'Brien's view that during the previous MHPS process, MHPS was not incorporated within his employment contract, I would reiterate the Trust's position that MHPS was applicable to Mr. O'Brien during his employment with the Trust.

Given Mr. O'Brien's position in respect of any new MHPS process, the Trust will not be taking any further steps in connection with the preliminary enquiries or commencing any further process under MHPS. Preliminary enquiries will remain un-concluded as Mr. O'Brien's input has not been provided. Other internal Trust processes, including SAI processes and other processes relating to patient safety will continue.

Office of the Director of Human Resources & Organisational Development
Trust HQ, Craigavon Area Hospital
68 Lurgan Road, PORTADOWN BT63 5QQ
[redacted]

The matter is now in the hands of the GMC and the Trust will assist the GMC, as required, by providing any information or documents which it may seek.

Going forward, I would respectfully ask that should Mr. O'Brien need to raise matters in relation to his former employment, including any matter relating to his former patients, that these are raised by you directly to me via email. There should not be any reason for Mr O'Brien to make direct contact with any member of Trust staff in respect of any work related matter in connection with his former employment.

I thank you for your cooperation in this regard.

Yours sincerely

Personal information redacted by USI

VIVIENNE TOAL (MRS)
Director of Human Resources
& Organisational Development

Kelly, Elaine

From: McClements, Melanie
Sent: 03 November 2020 15:50
To: Cassells, Carol; Magwood, Aldrina; Wallace, Stephen; Carroll, Ronan; Corrigan, Martina; Haynes, Mark; Toal, Vivienne; Hynds, Siobhan; Kingsnorth, Patricia
Cc: O'Neill, Helen; OKane, Maria; Devlin, Shane
Subject: IPT for urology required

Hi Carol and Aldrina

At the DOH assurance group on Friday we were asked to do an IPT detailing the impact **financial and otherwise** of the Urology SAI etc. concerns to consider:

- **Pt impact to date**, stood down clinics, theatre lists etc.;
- **Future look** at impact as patients who would have been appointed next are likely to be displaced for reprioritised cases from this current review;
- **Clinical and operational** resource required to date and going forward – Urologist time, CNS,, HOS, admin, information line etc….
- Contracted **oncology reviews**;
- **SAI** resource;
- **Family liaison**;
- **Psychology** input;
- **3rd sector** support from **charities** etc.
- **Anything else you can think of…**
-

Can we discuss at urology meeting this afternoon?

Carol and Aldrina can you support us with this? Thanks Mel

Curriculum Vitae

Professor Krishna K Sethia

Consultant Urological Surgeon

Norfolk & Norwich NHS Trust
Colney
Norwich NR4 7UZ

1 February 2020

NAME		Krishna Kumar **SETHIA**
ADDRESS	HOME	Personal Information redacted by USI
	WORK	Norfolk & Norwich NHS University Trust Colney Norwich NR4 7UZ
TELEPHONE	HOME MOBILE	Personal Information redacted by USI Personal Information redacted by USI
Email		Personal Information redacted by USI
NATIONALITY		Personal Information redacted by the USI
DATE OF BIRTH		Personal Information redacted by USI
MARITAL STATUS		Personal Information redacted by USI
GENERAL MEDICAL COUNCIL		Full Registration No 2496223
MEDICAL DEFENCE		Medical Protection Society

QUALIFICATIONS	MA (Oxford)	1986
	MBBS (London)	1979
	FRCS (England)	1984
	DM (Oxford)	1988
	FRCSEd	2006

EDUCATION

Eton College, Windsor, Berks

Exeter College, Oxford

Guys Hospital Medical School, London SE1

PRESENT APPOINTMENTS

Consultant Urologist
Norfolk & Norwich NHS Trust
Colney
Norwich NR4 7FP

Honorary Professor
University of East Anglia, Norwich

Chairman
British Journal of Urology International

PREVIOUS APPOINTMENTS

Medical Director, Norfolk & Norwich University NHS Trust (2009-2015)

Hon Treasurer, British Association of Urological Surgeons (2003-2006)

Director of Surgical Division, Norfolk & Norwich University NHS Trust (2003-2007)

Manpower Planning Officer, British Association of Urological Surgeons (2000-2006)

Member of and Examiner for the Intercollegiate Board in Urology (2000-2008)

Vice-Chairman of Specialist Advisory Committee in Urology, Royal College of Surgeons (2003-2006)

Clinical Director, Urology & Nephrology, Norfolk & Norwich University NHS Trust (1997-2002)

Member of Council, British Association of Urological Surgeons (1997-2002)

Honorary Lecturer, Institute of Urology (1996-1999)

Norwich District Ethics Committee (1994-1998)

R& D Committee, Norfolk & Norwich NHS Trust (1996-1998)

Lead Doctor in Urology, Waveney Cancer Centre (1998 -2003)

Senior Registrar in Urology, Freeman Hospital, Newcastle (1988-1990)

EXPERIENCE

1. Clinical

Having completed training posts in Oxford and Newcastle I was appointed to a Consultant Urologist post in Norwich in 1990. As well as providing a general urological service I developed special interests in urological cancers (especially bladder and prostate) and andrology and during the 1990's I developed the Norwich unit into a tertiary referral centre for both these subspecialties. I also established the superregional service for the management of patients with cancer of the penis.

Together with the specialist urological cancer nursing team for which I secured the initial funding I set up a local patient support group for men with prostate cancer and their families.

My clinical commitments inevitably decreased when I became Medical Director but since relinquishing that post in I have increased my clinical practice. I continue to develop the urological cancer services in Norwich. My current main interests are in the management of superficial bladder tumours, penile cancers and the diagnosis of prostate cancer. I continue to run the specialist andrology service for the region.

2. Hospital Management

a. Director of Surgery (2003-2007)

As Director of Surgery I was responsible for the organisation of surgical services, clinical governance in surgery and ensuring that access targets were met. My specific achievements in my 4 year tenure were;

1. Reorganisation of the theatre schedules and surgeon timetables to create 25% more operating time in the week and increased theatre utilisation to over 90%.
2. Introducing centralised pre-operative assessment for all surgical patients.
3. Building of a unit to ensure that all patients were admitted on the day of surgery rather than the night before.
4. Achieving all access targets.
5. Increasing day-case surgical rates to the best quartile in the country.
6. Achieving cost-savings to plan.

b. Medical Director (2009 to 2015)

1. Clinical Governance

In my time as Medical Director I was involved in two reorganisations of clinical governance the second of which was designed to take account of all the Francis, Keogh and Berwick reports and CQC requirements. I was chairman of the Clinical Safety and Clinical Effectiveness Sub-Boards and of meetings of all Directorate Governance Leads.

2. Quality Improvement.

Five years ago I instigated a programme of annual safety improvement projects based on IHI methodology. Over 250 clinicians were eventually involved and significant changes to practice have resulted. Projects I have led or been involved in with other Executive Directors by 2015 had achieved significant improvements including

a. No hospital-acquired MRSA bacteraemias for 3 years
b. 85% reduction in C difficile infection over 3 years
c. Significant reduction in medication prescribing errors
d. Compliance with the WHO checklist
e. Compliance with thromboprophylaxis assessment. Hospital granted exemplar status.
f. Improved Early Warning Score completion and response to triggers.
g. Declining cardiac arrest calls outside critical care
h. Central line infection rates of under 1/1000 hospital days

c. Operational

As Medical Director

a. I shared responsibility for day-to-day operational performance.
b. I led a project to enlarge and redesign the emergency areas of the NNUH. We have established a regular GP presence in the emergency department.
c. I completed a review of critical care capacity and formulated plans for an increase thereof.
d. I regularly met and represented the hospital with the local Clinical Commissioning Groups and played an active role in contract negotiations.

d. Revalidation

a. I was Responsible Officer for over 800 doctors working at the Norfolk & Norwich Hospital.
b. I was responsible for introducing the policies and processes for enhanced appraisal and, with the help of a Revalidation Lead, ensured that the Trust was prepared for medical revalidation.

e. University

a. In 2009 together with the Medical School I instigated a strategy to increase research activity in the hospital by appointing a series of clinical academics with focussed areas of interest.
b. I established a Joint Research Committee which includes doctors, nurses, allied health professionals and university staff.
c. I helped establish a joint research office with UEA for managing clinical research.
d. Together with the Dean of Health I have supervised the development of the Norwich Clinical Trials Unit and Clinical Research facilities which now have full NIHR registration.
e. I promoted joint projects involving the hospital and other Institutes on the Norwich Research Park. I was the hospital representative on the NRP Scientific Board.
f. I supported the UEA project to obtain a new Medical School Building (BCRE) including a Biorepository.
g. In 2013, I was author of and together with the CEO led the Norfolk & Norwich Hospital successful bid to host the NIHR Eastern Clinical Research Network
h. I was involved with the Norwich bid to build a new Institute for Food and Health to include clinical gastroenterology.
i. I represented the hospital on the UEA/NNUH Joint Board University/NNUH (chaired by the Vice-Chancellor and Trust CEO)

f. Other hospitals

I have actively encouraged clinical collaborations with neighbouring hospitals (Kings Lynn and James Paget). To date this has resulted in an **i**ncreasing number of consultant joint appointments. I was instigated and was involved with projects to

a. Standardise clinical guidelines between the Trusts
b. Establish joint formularies
c. Establish a single Drugs, Therapeutics and Medicines Management Committee
d. Integrate clinical teams

3. National Associations / Committees

i. British Association of Urological Surgeons

a. Council Member (1997-2002)
b. Manpower Planning Officer (200-2007)
c. Treasurer (2005-2008)

For the past 18 years I have contributed to the development of BAUS and British Urology. Particular achievements have been:

1. As a major contributor to the development of different types of Consultant Urologists trained to have skills matching service need.
2. Regular liaison with National Workforce Planning Groups to ensure training numbers correct.
3. Responsibility for the reorganisation of BUAS into a charitable company limited by guarantee.
4. Rewriting of the M&A's and Rules of the Association.
5. Rewriting of all protocols for Governance within the organisation.
6. Establishing the budgeting process for the Association.
7. Creating a Strategic Plan for the Association.

ii. SAC in Urology (2000-2006), Vice-Chairman (2003-2006)

Apart from the normal duties of an SAC member I have made a particular contribution in:

i. The revision of the curricula in Urology
ii. Supervision and planning of urological manpower.
iii. Review of section 14 applications to PMETB

iii Examiner for Intercollegiate Board in Urology (2000 to 2008)
Member of Intercollegiate Board in Urology (2003 -2008)
Examiner for International Urology exam (2018- present)

As a member of the Intercollegiate Board I was responsible for exam design, standard-setting and ensuring educational validity. I personally rewrote over 25% of the then clinical question bank. In 2018 I was again appointed an examiner for the joint colleges international exam in urology.

4. British Journal of Urology International (BJUI)

Having been a Trustee for 7 years I was appointed Chairman of the BJUI in 2015.

For the past 5 years I have led the development of a comprehensive educational on-line programme which will serve international CPD and CME requirements. This involves collaboration with the Urological Societies of Australia and New Zealand, Hong Kong, Canada, India, Indonesia, Malaysia, Korea and the Republic of Ireland. The education programme was launched in January 2016 and has accreditation from the Edinburgh College of Surgeons (RCSEd). It has been now used by all UK urological trainees and widely in Asia and Australasia. We are working with the GMC and urology SAC to establish it as the standard for knowledge for all trainees.

5. Teaching experience

In the 1990's I was responsible for Higher Surgical Training in Urology in Norwich. I established and ran an annual residential regional teaching course which has remained an important part of our specialist registrar programme and is consistently highly-rated by trainees. I continue to contribute to this.
For the past 60 months I have been working with the RCSEd to develop a surgical training programme for Myanmar. This is being expanded to involve all the surgical specialties in the country.

6. Research experience

Following appointment as a consultant I was PI in several clinical trials within the Urology department.
For most of my career my other research activity has involved facilitating researchers in collaborations with University departments.
I took responsibility for establishing and organising the Norwich contribution to the national 100,000 Genome project.
In the past 12 years I have been involved in supervising 3 PhD and one MD student.

8. Medicolegal

For the past 17 years I have provided medicolegal opinions. I have been instructed by solicitors for acting both for the plaintiff and the defence (current ration 30:70). I currently provide approximately 80 reports per year. I am prepared to travel anywhere in the UK to see patients. I regularly attend case conferences with barristers and I have experience of giving expert evidence in Court.

9. Other

In the past 7 years I have been invited to perform 3 major reviews of urology department's performance and organisation in the UK.
I am experienced in reviewing serious incidents which I have done both for the Royal College of Surgeons and when requested by individual Trusts.

PUBLICATIONS

Sethia K.K., Darke S.G. Long Saphenous incompetence as a cause of venous ulceration. Br J Surg (1984) 71:154-755

Sethia K.K., Berry A.R., Morrison J.D., Collin J., Murie J.A., Morris P.J. The changing pattern of lower limb amputation in peripheral vascular disease. Br J Surg (1986) 73:701-703

Sethia K.K., Smith J.C. Non-invasive measurement of intravesical pressure. Br J Urol 1986) 58:657-658

Sethia K.K., Skelton J.B., Turner C.M., Berry A.R., Kettlewell M.G., Gough M.H. A prospective randomised controlled trial of suprapubic vs urethral catheterisation in patients undergoing general surgical procedures. Br J Surg (1986) 74:624-625

Speakman M.J., Sethia K.K., Fellow G.J., Smith J.C. A study of pathogenesis, urodynamic assessment and outcome of detrusor instability associated with bladder outflow obstruction. Br J Urol (1987) 60:516-518

Sethia I.K., Smith J.C. The effects of pH on detrusor function. Proc ICS, Bristol (1987) 177-178

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Crawford R.A.F., Sethia K.K., Fawcett D.P. Unusual presentation of urachal remnant. Br J Urol (1989) 64:315-316

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Mills R.D., Sethia K.K. Limited sub-coronal incision for insertion of semirigid penile prostheses. Br J Urol (1997) 79:802

Kirby R.S., Chapple C.R., Sethia K.K., Flannigan M., Milroy E.J.G., Abrams P. Mornign vs evening doxasosin in benign prostatic hyperplasia: efficacy and safety. Prost.Cancer (1998) 1:1630171

Mills R.D., Sethia K.K. Maximisation of the erectile response in the investigation of impotence. Int J Impot Res (1999) 11:29-32

Mitchell S.M., Sethia K.K. Hazards of aspirin withdrawal prior to transurethral prostatectomy. Br J Urol (1999) 84:101

Probert JL, Mills R, Persad RA, Sethia KK. Imaging assessment of uncomplicated bladder outflow obstruction. Int J Clin Pract. (2000) Jan-Feb;54:22-4

Szemere J.C., …Sethia K.K., Ball R.Y., Bardsley A. A surgical technique to the conservative management of urethral melanoma. Br J Plast Surg (2001) 45:361-3

Chitale S.V, Peat D, Lonsdale R, Sethia K.K. Xanthoma of the urinary bladder. Int.Urol.Nephrol (2002) 34: 507-509

Riddick A.C.P…..Sethia K.K., Edwards D.R, Ball R.Y. Banking of fresh-frozen prostate tissue: methods, validation and use. Br J Urol (2003) 91:315

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Riddick ACP, …….Sethia KK, Edwards DR Identification of degradome components associated with prostate cancer progression by expression analysis of human prostatic tissues. Br J Cancer (2005) 92:2171-2180

Sethia KK. Screening for prostate cancer. Ann.RCS Eng (2005) 87:88

Shukla CJ, Edwards D, Sethia KK Laser capture microdissection in prostate cancer research: establishment and validation of a powerful tool for the assessment of tumour - stroma interactions. BJUI (2008) 101:765-774

Viswanath S, Zelhof B, Ho E, Sethia K, Mills R. Is routine urine cytology useful in the haematuria clinic?
Ann R Coll Surg Engl. (2008) Mar; 90(2):153-5.

Sethia KK. Why I do not have a robot. Ann R Coll Surg Engl (2010) 92:5-8

Bayles AC, Sethia KK. The impact of Improving Outcomes Guidance on the management and outcomes of patients with carcinoma of the penis. Ann R Coll Surg Engl (2010) 92:44-45

Chitale S, Morsey M, Swift L, Sethia K. Limited shock wave therapy vs sham treatment in men with Peyronie's disease: results of a prospective randomized controlled double-blind trial. BJU Int. (2010) 106:1352-6

Chitale S, Morsey M, Sethia K. Is penile shortening part of the natural history of Peyronies Disease? Urol Nephrol J (2010)3:16-20

Manson-Bahr D, Ball R, Sethia K……Cooper C. Mutation Detection in Formalin Fixed Prostate Cancer Biopsies at the Time of Diagnosis Using Next Generation DNA Sequencing. Prostate. J Clin Pathol. 2015 Mar;68(3):212-7. doi: 10.1136/jclinpath-2014-202754

Kumar VK, Sethia KK. A prospective study comparing videoendoscopic radical inguinal lymph node dissection with open radical inguinal lymph node dissection for penile cancer over an 8 year period. BJU International 2016 (accepted for publication).

Luca BA……..Sethia KK….. Cooper C. DESNT: a poor prognosis category of human prostate cancer. European Urology Focus (2017) S2405-4569(17)30025-1

BOOKS

Parkhouse H., Sethia K.K. (eds) Illustrated Case Histories in Urology. Mosby-Wolfe. London (1996)

Eardley I., Sethia K. Erectile Dysfunction. Mosby-Wolfe 1998

Eardley I., Sethia K. Erectile Dysfunction for General Practitioners. Mosby-Wolfe 1999

OTHER

Models and Mechanisms of Detrusor Instability - Bard Silver Medal, British Association of Urological Surgeons, 1988

The Pathophysiology of Detrusor Instability. D.M. Thesis, University of Oxford.

EDITORIAL ACTIVITY

I am a regular reviewer for the British Journal of Urology International, Current Opinions in Urology, the Journal of Clinical Urology and the Journal of Sexual Medicine.

Clinical and Social Care Audit Registration Form

Audit Title: Audit of Prescribing of anti-androgen medicine 'Bicalutamide'

Directorate: Acute Services ■ Children & Young People ☐ Older Persons & Primary Care ☐
Mental Health & Disability ☐ Corporate request ☐

Division:

Auditor's name: Mr Mark Haynes **Contact details: (email)** Personal Information redacted by USI	**Audit Supervisor's Name : Not Applicable**

Is this a: National audit ☐ Regional audit ☐ Trust audit ■ International audit ☐

Proposed audit commencement date 27th October 2020 Proposed audit completion date …/…/….

Audit Aims

To ensure that the anti-androgen medicine 'Bicalutamide' has been prescribed as licensed and in line with NICE guideline NG131 Prostate Cancer: Diagnosis and Management

Audit Objectives

- To ensure that where Bicalutamide is prescribed only where indicated and as per licensed usage
- To ensure that where Bicalutamide is prescribed this is prescribed in the correct therapeutic dosages
- To ensure that patients prescribed Bicalutamide is appropriately reviewed as part of the patients ongoing care
- To ensure that any deviations from prescribing guidance is based on sound evidence based clinical rationale

Audit Standards

The following audit standards obtained from NICE guideline [NG131] Prostate cancer: diagnosis and management

Published date: 09 May 2019.

Audit Criteria	Target	Exceptions	Source of Evidence
Bicalutamide prescribed as per indicated conditions in NICE NG131	100%	Clinical rationale for deviation from guidance	NICE guideline NG131 Prostate Cancer: Diagnosis and Management
Therapeutic doses of anti-androgen monotherapy with bicalutamide are prescribed at recommended dose (150 mg).	100%	Discussions with patient / Clinical rationale	NICE guideline NG131 Prostate Cancer: Diagnosis and Management

Audit Methodology

The following audit methodology will be followed:

- HSCB to provide information on primary care prescriptions of the medication Bicalutamide
- Southern Health and Social Care Trust patients to be identified and a consultant led review of prescribing to take place to identify prescribing of Bicalutamide that is outside of that prescribed in NICE guideline NG131 Prostate Cancer: Diagnosis and Management

Rationale for the audit (please tick all that apply)

Topic is included in the Directorate's clinical audit work-plan ☐ Compliance with standards & guidelines ■

Clinical and Social Care Audit Registration Form

National Healthcare Quality Improvement Partnership (HQIP) audit	☐	Regional RQIA/GAIN audit	☐
Other national / international audit	☐	Trust based audit topic important to team/division	■
Clinical risk	■	Recommendation from national / regional report	☐
Serious Adverse Incident or Adverse Incident review	■	Clinician / personal interest	☐
Incident reporting	☐	Educational audit	☐

Other – please specify ……

Level 1 ☐ **Level 2** ■ **Level 3** ☐ **Level 4** ☐

Has this audit been approved based on the priority level? Yes ■ No ☐

Level 1 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum
Level 2 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum
Level 3 – Approval required by Supervising Consultant
Level 4 – Approval required by Supervising Consultant
Please be advised that the audit cannot proceed without approval as above.

Please Note: The Information Team have advised they will not release data to the requestor unless the clinical audit has been approved as above.
The clinical audit team will also advise contact with Information Governance for any advice required.

The clinical audit team can be contacted via:
Email: clinical.audit@southerntrust.hscni.net
Tel:

Raymond Haffey
Terri Harte
Sandra McLoughlin
[redacted]
Mary Markey
Roisin Feely
Philip Sullivan
Personal information redacted by USI
Personal information redacted by USI
Personal information redacted by USI

In submitting this audit registration form, I agree to share the audit findings, recommendations and audit summary template with:the Audit Supervisor, appropriate Divisional/Directorate Committee and the Trust's Clinical audit team

Please submit your audit registration form to: *clinical.audit@southerntrust.hscni.net*

Priority levels for clinical audit

Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	• National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires	1
Level 2 audits, other national audits and 'internal must dos'	• National audits not contained within the HQIP list, or other clinical audits arising from: • Clinical risk • Serious untoward incident / internal reviews • National Institute of Clinical Excellence Standards & Guidelines • Complaints • Re-audit • Regional audits initiated by RQIA / GAIN	2
Level 3 audits, 'divisional priorities'	• Local topics important to the division	3
Level 4 audits	• Clinician / personal interest • Educational audits	4

FAQs Urology October 2020

Why has the Southern Trust decided to look back at Urology patients?

Clinical concerns were raised regarding the work of one Consultant Urologist in June 2020 when two patients were identified has having not been listed on to the Trust Patient Administration System in a timely manner. This was alerted as a potential patient safety issue due to potential delays in treatment and prompted a wider review of the Consultant's workload to establish if there were additional service impacts.

What happened when concerns were raised?

Following the identification of clinical concerns, the Trust provided information about the Consultant's practice to the General Medical Council. In addition to this, restrictions were placed on the Consultant's practice by the Trust so they could no longer undertake clinical work and could not access patient information. The Department of Health were provided with details of the case via the 'Early Alert' mechanism.

A further review of the Consultant's workload over an 18 month period - January 2019 to June 2020 – has been on-going since June, with expert independent advice sought to inform the scope and scale of the work.

Why is the Trust only looking at cases between January 2019 and June 2020?

The Trust has agreed with the Health and Social Care Board, Public Health Agency and Department of Health to a chronological and incremental approach when reviewing the Consultants workload. In the first instance the Trust has reviewed cases in this 18 month period. The scope and scale of any further review may be extended. This will be based on our internal review of patient records and advice from the Royal College of Surgeons.

What issues have the Trust now identified?

The Trust has reviewed all of the Consultants elective and emergency activity that occurred between January 2019 and June 2020. The review has progressed to diagnostic testing conducted including radiology, pathology and cytology to ensure appropriate action has been taken on each result. Of these patients who have been reviewed, there have been **nine** cases which are now part of an independently chaired Serious Adverse Incident Review process.

The Trust has also recently identified concerns regarding medication prescribing, as a result 26 patients have been reviewed by our Urology team.d

How many patients are involved in the review process?

Were all the patients treated by the same doctor?

All the patients included in this review were under the care of the same Consultant.

Have all patients who are affected been told?

The initial review of paper records identified concerns regarding **11 cases**. These patients have been advised, clinical management plans are in place, and urgent issues actioned.

A further 236 oncology patients are being reviewed by an independent Urology consultant to ensure that their management plans and treatments are in line with guidance. These patients have been/are being contacted directly.

Have patients come to harm?

There are **nine cases** which are now part of a Serious Adverse Incident Review. A review of each of the **nine** patients care has been commissioned and is being led by an Independent Chair supported by a Consultant Urologist Expert. Each of these patients has been contacted by the Trust to inform them of the review process, arrangements have been made for patients in this group who need review appointments.

How will patients affected by this be notified?

Patients who have been identified as requiring review were contacted directly by the Trust as soon as issues with their care were identified.

Can the Trust reassure patients that the Urology service is safe, and that patients are receiving appropriate care?

Yes, our Urology team based in Craigavon Area Hospital provide care for thousands of patients each year and the current review is focused on a small proportion of these cases.

Have concerns previously been raised about this consultant

Part of the review process will look at all aspects of care provided, including a review of complaints received.

How many patients have been identified as potentially being affected?

To date the Trust review has identified **nine** patients that elements of their care require a Serious Adverse Incident review to take place. As the Trust review progresses there may be additional cases identified.

Have any of these patients died or been harmed as a result of being this doctor's patient?

The Serious Adverse Incident review process will seek to identify issues with the care provided to each patient to ascertain if harm occurred and what actions require to be taken to prevent this recurring in future.

Why hasn't the Trust identified the doctor involved?

The Trust has provided information regarding the doctor's identity to relevant professional and government agencies.

Is the doctor still working for the Trust?

The doctor is no longer working for the Trust or employed in Health and Social Care Services.

How long did this doctor work for the Trust?

The Doctor was employed by the Southern Health and Social Care Trust for 28 years.

Will this doctor face disciplinary or legal action as a result of this review?

The doctor is no longer an employee of the Trust therefore and future action would be the responsibility of the General Medical Council.

Will there be a PSNI investigation into this?

The remit of the review is to examine care provided by the Consultant using a chronological and incremental approach when reviewing the Consultants workload. This review is review in line with Department of Health, Public Health Agency and Health and Social Care Board processes.

Were any concerns raised about this doctor before the dates being looked at in this review i.e. before January 2019?

The General Medical Council are currently investigating professional aspects of the Consultants practice, an outcome will be provided by the General Medical Council in due course.

What action(s) were taken as result of these concerns?

As above

Will the Trust now review all patient care provided by this doctor to all patients during his employment at The Trust?

Any potential extension of the Trust review will be based on the outcomes of the current January 2019 to June 2020 review. A decision on this will be made in agreement with the Health and Social Care Board, Public Health Agency and Department of Health and will consider specialist advice from The Royal College of Surgeons.

Kelly, Elaine

From: Carroll, Ronan
Sent: 07 October 2020 10:36
To: Kingsnorth, Patricia; Corrigan, Martina
Subject: FW: IEAP referral
Attachments: Integrated Elective Access Protocol - April 2008.pdf; Integrated Elective Access Protocol Draft30June - OSL comments 01.07.20.doc

Update

2.3 NEW REFERRALS

2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.

2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

Ronan Carroll
Assistant Director Acute Services
Anaesthetics & Surgery
Mobile Personal Information redacted by USI

From: Clayton, Wendy
Sent: 07 October 2020 10:34
To: Carroll, Ronan
Subject: IEAP referral

IEAP April 2008 – Page 34 3.4.5

IEAP June (this is only draft can't find final one) – 2.3.4 page 23

Thanks

Regards

Wendy Clayton
Acting Head of Service for Trauma & Orthopaedics
Ext: Personal Information redacted by USI
Mob: Personal Information redacted by USI

Angela Muldrew
RISOH Implementation Officer/Service Administrator
Tel. No. Personal Information redacted by USI

Urology Oversight Group Minutes

Tuesday 3rd November 2020, 4:30pm

Via Zoom

	Item	Actions
1	**In Attendance** Stephen Wallace — Melanie McClements Martina Corrigan — Mark Haynes Damian Gormley — Jane McKimm Siobhan Hynds — Ronan Carroll Vivienne Toal — Maria O'Kane Patricia Kingsnorth	
2	**Apologies** None	
3	**Review of Action Log** Group agreed	
4	**DoH Oversight Meeting Update (30th October 2020)** Melanie updated on the DoH assurance meeting that took place on the 30th October. Meeting will be 2 weekly; this was chaired this week by Jackie Johnson. The Trust was commended on good work to date and progress. Group felt the Thursday meeting should continue to meet with current membership and will inform the DoH assurance group. The group felt the SAI process was not the best process moving forward. The focus of this incident is not the best process going forward. DoH / PHA to come back with a decision. The group felt external views on the process would be crucial. The group asked if there was any opportunities to act earlier in the summer by the Trust. Group discussed private practice and the challenges surrounding this. Dr O'Kane referenced MDM issues that were faced. It has been confirmed that the Minister will be making a statement to the assembly on the 10th November 2020. The group also required to consider family liaison roles. This is including psychology support. The status of impact to date included services that were stood down to conduct the review. The Trust has been asked to develop an IPT to state impact of incident. David Gordon felt we are moving towards a wider recall. Question was asked regarding who will front the media communications. Mark Haynes referenced the clinical review process suggested at the meeting and how that will interface with the current work ongoing and what outputs. The group discussed what are reasonable timescales for conducting processes such as triage, Mark Haynes stated these should be discussed with the external experts in the first instance to ascertain what is reasonable and what delay is reasonable.	**Martina / Stephen to contact Bernie Owens to form Trust oversight team** **Thursday meeting to discuss clinical review process** **Mark Haynes to discuss reasonable triage and administration response times with external experts**
	Professional Governance	
4	**Response from Tughans re Trust Letter** Vivienne Toal discussed the letter received from Tughans. The letter largely forms a request for information. Stephen and Vivienne to draft a response to the Tughans response. Jane McKimm asked has the solicitors contacted the DoH directly, group unsure.	**Stephen and Vivienne to draft a response**
5	**GMC Discussions** Dr O'Kane referred to the attached correspondence. Dr O'Kane has advised that the GMC have been asked explicitly to consider interim orders.	20201013_LtrGENERAL MEDICAL COUNCI

	Dr O'Kane explained that a conversation was had with Dr Fitzpatrick, NHS Resolutions to update on the case progression. Dr Fitzpatrick advised that NHS Resolutions would end at this stage. Dr O'Kane also advised that the chair and legal team of the Neurology Inquiry had been contacted to discuss potential early learning from the neurology review that can be incorporated into strengthening our assurance processes.	
6	**Administration Review Update** Martina Corrigan advised a meeting to review the administration review will be meeting tomorrow to progress. Melanie McClements asked for a summary document to be brought back for next week, with a plan for the final report to be issued on GMC. Mark Haynes referenced the work required regarding MDM processes and the importance of improving these. Dr O'Kane stated that she would be happy to endorse any improved processes for MDM that could be created. Patricia Kingsnorth stated that breast care have a failsafe nurse to ensure that actions to not get dropped. Melanie McClements stated that there is potential for regional learning from SAIs to improve processes.	**Melanie McClements to present summary report next week** **Mark Haynes to identify model for MDM improvement**
7	**Mileage Claims** Vivienne stated claims have been validated and payments are being processed via payroll currently, circa 270 miles.	
	Serious Adverse Incident (SAI) Reviews	
8	**Process for Managing SAI's going forward** Melanie McClements asked what process should govern new SAI's. Dr O'Kane stated that there is a requirement from the PHA and HSCB to indicate what process should be followed going forward new SAIs. Melanie McClements asked is the 3 month timescale achievable; Patricia Kingsnorth felt this was possible. Dr O'Kane stated that if there is a move outside of process PHA need to provide written confirmation.	**Thursday meeting to discuss clinical review process**
9	**Original SAI's – Deceased Service User Family Contact** Mark Haynes stated that the decision to inform to the final family could be guided by the process to notify patients who are part of the review process, e.g. if there care had an adverse outcome they would be told, if there was not an adverse outcome they would be told.	
10	**Initial Feedback from SAI Chair** Discussed under item 6	
11	**Family Liaison Role** Melanie McClements stated that Patricia had informed that family liaison requirement was low at this stage. Patricia stated that some families will require psychological support especially those that are being spoken to about medication errors. Mark Haynes stated that each service user was required to be told of incidents face to face, Dr O'Kane suggested that a leaflet would be required to assist with sharing of information. Group discussed the potential of contracting Inspire to offer additional support for both staff and patients.	**Vivienne to follow up with Inspire re additional support**
	Management of Patient Reviews	
12	**IPT for Review Process** Mark Haynes stated the impact is difficult to quantify with lack of clinic space and disruption to services. Melanie McClements asked how many of the 2336 patients identified to date how many patients have been identified that will require review. Martina Corrigan was unsure as this work is ongoing. Mark Haynes stated that if we are	 IPT for urology required.msg **Ronan /**

	required to arrange face to face for all patients who AOB has saw this would be enormous. If these were triaged by exception, those which there are concerns regarding this is much more manageable.	**Martina to follow up with Aldrina Magwood and Carol Cassells**
13	**Additional Subject Matter Expertise / Consultant Reviews** Mark Haynes to contact Professor Sethia to arrange additional subject matter expertise.	KS CV 2020.doc
14	**Bicalutamide Patient Review** Mark Haynes has started reviewing patients on Monday. Mark Haynes confirmed that the patient identified by the spotter practice as a long term bicalutamide prescription was prescribed appropriately	Clinical And Social Care Audit Registratic
15	**Engagement of ISP to undertake waiting list work** Work continuing, 26 patients has refused as they did not wish to travel.	
16	**Telephone Support Service / Patient Triage Update** Five calls this week, 147 in total, 5 have been required to be reviewed. One required reviewed. Martina Corrigan stated that more backup will be required following the ministerial statement which potentially could increase call volume.	**Martina / Melanie to discuss before next week**
	Communications	
17	**Ministerial Update Statement 10th November 2020** Date noted by the group. Jane McKimm stated it was still unknown what the Minister will include in his statement, hopefully this will be clearer on Thursday / Friday	
18	**Media / Assembly Questions**	FAQs urology 02112020.docx
	Any Other Business	
19	**Any Other Business**	
	Date of Next Meeting	
20	**Via Zoom – 10th November 2020**	

Southern Health and Social Care Trust

Quality Care - for you, with you

30th October 2020 Ref: MOK/ec

Via email [redacted]

Chris Brammall
Investigation Officer
General Medical Council
3 Hardman Street,
Manchester

Dear Mr Brammall,

RE: GENERAL MEDICAL COUNCIL - MR AIDAN O'BRIEN GMC NO. 1394911

Further to your email dated 8th October 2020 requesting further information regarding concerns raised in relation to Mr Aidan O'Brien, Consultant Urologist employed by the Southern Health and Social Care Trust, please see below itemised responses and where noted, attached items. Further to the below information and attached items a verbal update was provided to Joanne Donnelly Employer Liaison Advisor, General Medical Council on the 23rd October 2020.

A copy of correspondence was issued via the Trust Directorate of Legal Services to Mr O'Brien's solicitor on 25th October 2020 and is attached as Appendix A, this provides additional information regarding:

- Information regarding media interest in the case
- Details of additional concerns raised regarding Mr O'Brien's practice including concerns regarding the prescribing on the anti-androgen Bicalutamide
- The Chief Medical Officer decision to issue a Professional Alert as per guidance found in DHSSPS Circular HSS (TC8) 6/98

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: [redacted] Email: [redacted]

It is my opinion, that given the information known to date that the General Medical Council should consider implementing interim orders restricting Dr O'Brien's practice at the earliest opportunity.

Any update that you may have the possible RCS lookback / patient recall exercise and information that may have arisen out of any review	The Trust is continuing to progress with a review of Mr O'Brien's activity since January 2019 to identify any additional issues with the quality of care delivered. The Trust is liaising with the Department of Health Northern Ireland, Health and Social Care Board and Public Health Agency to guide the review process. The Trust has also consulted with the Royal College of Surgeons who have provided guidance on developing the review criteria. To date as a result of this review further issues have been identified which have required screening as potential Serious Adverse Incidents, in total nine of these incidents have been deemed as meeting Serious Adverse Incident criteria. The Trust has also been made aware of the scale Mr O'Brien's significant private practice activity via discussions with GPs in the Southern Area. Mr O'Brien's private practice was conducted from his home; therefore all records of this activity will solely be in his position. The Trust has no access or information on the scale of this activity, the Trust has made the Department of Health Northern Ireland, Health and Social Care Board and Public Health Agency aware of this area of activity. Given Mr O'Brien's residence being located close to the border with the Republic of Ireland, the Trust has concerns there may be private practice issues involving patients from this jurisdiction.

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI Email: Personal Information redacted by USI

	In addition to this GP colleagues have commented that on occasion they have referred patients to the Southern Health and Social Care Trust to later receive correspondence from Mr O'Brien regarding the same patient on documentation referring to the individual as a private patient. The Northern Ireland Minister for Health has issued a written statement to the Northern Ireland Assembly on 27th October 2020 regarding this issue; this can be found attached as Appendix B. The concerns have also received media coverage via the Irish News and BBC Northern Ireland websites. Mr O'Brien has not been named in any public releases. The Minister for Health plans to make a statement in the Assembly on the 10th November. The Department of Health Northern Ireland has established an Departmental Oversight Group to provide assurance surrounding all elements of each ongoing process, a letter outlining this is attached as Appendix C.
An update about the new MHPS investigation that was being considered due to the additional concerns about Mr O'Brien that arose recently	The Trust sought advice from the Department of Health Northern Ireland regarding the new MHPS investigation. The Trust has been advised that as the process did not commence when Mr O'Brien was an employee that the investigation should not be pursed. The Trust is no longer his designated body and I am no longer his responsible officer. A response received from Mr O'Brien's solicitor (Appendix D) also indicates that Mr O'Brien will not engage with any Trust MHPS process as he is no longer employed by the Trust. The Trust response to this correspondence is attached as

	Appendix E.
Any updates concerning the SAI reviews for service user A and service user B as identified in the new concerns that were recently sent to the GMC	The Trust has discussed the identified Serious Adverse Incidents with the Department of Health Northern Ireland, Health and Social Care Board and Public Health Agency. As a result the Trust and PHA have appointed an independent chairperson to conduct these Serious Adverse Incident reviews with subject matter expert support provided by an independent Consultant Urologist nominated via the British Association of Urological Surgeons (BAUS). A wider review panel to support this has been appointed and work is preparing to commence. Further to this the Trust has identified a further seven Serious Adverse Incidents relating to patients on Mr O'Brien's caseload. Case summaries for these patients are attached as Appendix C. The Departmental Oversight Group is considering going forward whether all of these should progress as individual SAIs or become part of a different process such as an inquiry. During the initial stages of the Serious Adverse Incident reviews patient safety concerns have been raised by the chairperson in relation to the prescribing of Bicalutamide, an antiandrogen medication that is primarily used to treat prostate cancer, which should be prescribed at 150mg for a maximum of 8-10 weeks (and kept under review during that period) to patients prior to starting radiotherapy. The concern is with regard to patients that have been managed on Bicalutamide for extended periods, in

	excess of 8-10 weeks, without review during that period, and at 50mg, which is associated with making prostate cancer worse. It is also associated with a variety of harmful side-effects. The context is complex as Dr O'Brien would have advised the prescribing requirements, the GP would issue the prescription, and the pharmacist would dispense. The Trust is currently identifying those patients who are prescribed this medication and providing review appointments as a matter of urgency.
The outcome (or a copy of) the independent review into the administrative procedures that was due to be concluded by September 2020 (when this becomes available)	The independent review into administrative procedures commenced in August 2020. Further details on standard operating processes for administration of patient information has been requested to complete this work prior to acceptance of completion. This will be shared with the GMC on finalisation, this is expected 16th November 2020.

I trust this provides the necessary detail required. Should you have any queries, please do not hesitate to contact me.

Yours sincerely

Personal information redacted by USI

Dr Maria O'Kane
Medical Director

Southern Trust Headquarters, Craigavon Area Hospital, 68 Lurgan Road, Portadown, BT63 5QQ
Tel: Personal Information redacted by USI Email: Personal Information redacted by USI

Kelly, Elaine

From: McClements, Melanie
Sent: 03 November 2020 15:50
To: Cassells, Carol; Magwood, Aldrina; Wallace, Stephen; Carroll, Ronan; Corrigan, Martina; Haynes, Mark; Toal, Vivienne; Hynds, Siobhan; Kingsnorth, Patricia
Cc: O'Neill, Helen; OKane, Maria; Devlin, Shane
Subject: IPT for urology required

Hi Carol and Aldrina

At the DOH assurance group on Friday we were asked to do an IPT detailing the impact **financial and otherwise** of the Urology SAI etc. concerns to consider:

- **Pt impact to date**, stood down clinics, theatre lists etc.;
- **Future look** at impact as patients who would have been appointed next are likely to be displaced for reprioritised cases from this current review;
- **Clinical and operational** resource required to date and going forward – Urologist time, CNS,, HOS, admin, information line etc….
- Contracted **oncology reviews**;
- **SAI** resource;
- **Family liaison**;
- **Psychology** input;
- **3rd sector** support from **charities** etc.
- **Anything else you can think of…**
-

Can we discuss at urology meeting this afternoon?

Carol and Aldrina can you support us with this? Thanks Mel

Curriculum Vitae

Professor Krishna K Sethia

Consultant Urological Surgeon

Norfolk & Norwich NHS Trust
Colney
Norwich NR4 7UZ

1 February 2020

NAME		Krishna Kumar **SETHIA**
ADDRESS	HOME	Personal Information redacted by USI
	WORK	Norfolk & Norwich NHS University Trust Colney Norwich NR4 7UZ
TELEPHONE	HOME MOBILE	Personal Information redacted by USI Personal Information redacted by USI
Email		Personal Information redacted by USI
NATIONALITY		Personal Information redacted by the USI
DATE OF BIRTH		Personal Information redacted by USI
MARITAL STATUS		Personal Information redacted by USI
GENERAL MEDICAL COUNCIL		Full Registration No 2496223
MEDICAL DEFENCE		Medical Protection Society

QUALIFICATIONS	MA (Oxford)	1986
	MBBS (London)	1979
	FRCS (England)	1984
	DM (Oxford)	1988
	FRCSEd	2006

EDUCATION

Eton College, Windsor, Berks

Exeter College, Oxford

Guys Hospital Medical School, London SE1

PRESENT APPOINTMENTS

Consultant Urologist
Norfolk & Norwich NHS Trust
Colney
Norwich NR4 7FP

Honorary Professor
University of East Anglia, Norwich

Chairman
British Journal of Urology International

PREVIOUS APPOINTMENTS

Medical Director, Norfolk & Norwich University NHS Trust (2009-2015)

Hon Treasurer, British Association of Urological Surgeons (2003-2006)

Director of Surgical Division, Norfolk & Norwich University NHS Trust (2003-2007)

Manpower Planning Officer, British Association of Urological Surgeons (2000-2006)

Member of and Examiner for the Intercollegiate Board in Urology (2000-2008)

Vice-Chairman of Specialist Advisory Committee in Urology, Royal College of Surgeons (2003-2006)

Clinical Director, Urology & Nephrology, Norfolk & Norwich University NHS Trust (1997-2002)

Member of Council, British Association of Urological Surgeons (1997-2002)

Honorary Lecturer, Institute of Urology (1996-1999)

Norwich District Ethics Committee (1994-1998)

R& D Committee, Norfolk & Norwich NHS Trust (1996-1998)

Lead Doctor in Urology, Waveney Cancer Centre (1998 -2003)

Senior Registrar in Urology, Freeman Hospital, Newcastle (1988-1990)

EXPERIENCE

1. Clinical

Having completed training posts in Oxford and Newcastle I was appointed to a Consultant Urologist post in Norwich in 1990. As well as providing a general urological service I developed special interests in urological cancers (especially bladder and prostate) and andrology and during the 1990's I developed the Norwich unit into a tertiary referral centre for both these subspecialties. I also established the superregional service for the management of patients with cancer of the penis.

Together with the specialist urological cancer nursing team for which I secured the initial funding I set up a local patient support group for men with prostate cancer and their families.

My clinical commitments inevitably decreased when I became Medical Director but since relinquishing that post in I have increased my clinical practice. I continue to develop the urological cancer services in Norwich. My current main interests are in the management of superficial bladder tumours, penile cancers and the diagnosis of prostate cancer. I continue to run the specialist andrology service for the region.

2. Hospital Management

a. Director of Surgery (2003-2007)

As Director of Surgery I was responsible for the organisation of surgical services, clinical governance in surgery and ensuring that access targets were met. My specific achievements in my 4 year tenure were;

1. Reorganisation of the theatre schedules and surgeon timetables to create 25% more operating time in the week and increased theatre utilisation to over 90%.
2. Introducing centralised pre-operative assessment for all surgical patients.
3. Building of a unit to ensure that all patients were admitted on the day of surgery rather than the night before.
4. Achieving all access targets.
5. Increasing day-case surgical rates to the best quartile in the country.
6. Achieving cost-savings to plan.

b. Medical Director (2009 to 2015)

1. Clinical Governance

In my time as Medical Director I was involved in two reorganisations of clinical governance the second of which was designed to take account of all the Francis, Keogh and Berwick reports and CQC requirements. I was chairman of the Clinical Safety and Clinical Effectiveness Sub-Boards and of meetings of all Directorate Governance Leads.

2. Quality Improvement.

Five years ago I instigated a programme of annual safety improvement projects based on IHI methodology. Over 250 clinicians were eventually involved and significant changes to practice have resulted. Projects I have led or been involved in with other Executive Directors by 2015 had achieved significant improvements including

a. No hospital-acquired MRSA bacteraemias for 3 years
b. 85% reduction in C difficile infection over 3 years
c. Significant reduction in medication prescribing errors
d. Compliance with the WHO checklist
e. Compliance with thromboprophylaxis assessment. Hospital granted exemplar status.
f. Improved Early Warning Score completion and response to triggers.
g. Declining cardiac arrest calls outside critical care
h. Central line infection rates of under 1/1000 hospital days

c. Operational

As Medical Director

a. I shared responsibility for day-to-day operational performance.
b. I led a project to enlarge and redesign the emergency areas of the NNUH. We have established a regular GP presence in the emergency department.
c. I completed a review of critical care capacity and formulated plans for an increase thereof.
d. I regularly met and represented the hospital with the local Clinical Commissioning Groups and played an active role in contract negotiations.

d. Revalidation

a. I was Responsible Officer for over 800 doctors working at the Norfolk & Norwich Hospital.
b. I was responsible for introducing the policies and processes for enhanced appraisal and, with the help of a Revalidation Lead, ensured that the Trust was prepared for medical revalidation.

e. University

a. In 2009 together with the Medical School I instigated a strategy to increase research activity in the hospital by appointing a series of clinical academics with focussed areas of interest.
b. I established a Joint Research Committee which includes doctors, nurses, allied health professionals and university staff.
c. I helped establish a joint research office with UEA for managing clinical research.
d. Together with the Dean of Health I have supervised the development of the Norwich Clinical Trials Unit and Clinical Research facilities which now have full NIHR registration.
e. I promoted joint projects involving the hospital and other Institutes on the Norwich Research Park. I was the hospital representative on the NRP Scientific Board.
f. I supported the UEA project to obtain a new Medical School Building (BCRE) including a Biorepository.
g. In 2013, I was author of and together with the CEO led the Norfolk & Norwich Hospital successful bid to host the NIHR Eastern Clinical Research Network
h. I was involved with the Norwich bid to build a new Institute for Food and Health to include clinical gastroenterology.
i. I represented the hospital on the UEA/NNUH Joint Board University/NNUH (chaired by the Vice-Chancellor and Trust CEO)

f. Other hospitals

I have actively encouraged clinical collaborations with neighbouring hospitals (Kings Lynn and James Paget). To date this has resulted in an **i**ncreasing number of consultant joint appointments. I was instigated and was involved with projects to

a. Standardise clinical guidelines between the Trusts
b. Establish joint formularies
c. Establish a single Drugs, Therapeutics and Medicines Management Committee
d. Integrate clinical teams

3. National Associations / Committees

i. British Association of Urological Surgeons

a. Council Member (1997-2002)
b. Manpower Planning Officer (200-2007)
c. Treasurer (2005-2008)

For the past 18 years I have contributed to the development of BAUS and British Urology. Particular achievements have been:

1. As a major contributor to the development of different types of Consultant Urologists trained to have skills matching service need.
2. Regular liaison with National Workforce Planning Groups to ensure training numbers correct.
3. Responsibility for the reorganisation of BUAS into a charitable company limited by guarantee.
4. Rewriting of the M&A's and Rules of the Association.
5. Rewriting of all protocols for Governance within the organisation.
6. Establishing the budgeting process for the Association.
7. Creating a Strategic Plan for the Association.

ii. SAC in Urology (2000-2006), Vice-Chairman (2003-2006)

Apart from the normal duties of an SAC member I have made a particular contribution in:

i. The revision of the curricula in Urology
ii. Supervision and planning of urological manpower.
iii. Review of section 14 applications to PMETB

iii Examiner for Intercollegiate Board in Urology (2000 to 2008)
Member of Intercollegiate Board in Urology (2003 -2008)
Examiner for International Urology exam (2018- present)

As a member of the Intercollegiate Board I was responsible for exam design, standard-setting and ensuring educational validity. I personally rewrote over 25% of the then clinical question bank. In 2018 I was again appointed an examiner for the joint colleges international exam in urology.

4. British Journal of Urology International (BJUI)

Having been a Trustee for 7 years I was appointed Chairman of the BJUI in 2015.

For the past 5 years I have led the development of a comprehensive educational on-line programme which will serve international CPD and CME requirements. This involves collaboration with the Urological Societies of Australia and New Zealand, Hong Kong, Canada, India, Indonesia, Malaysia, Korea and the Republic of Ireland. The education programme was launched in January 2016 and has accreditation from the Edinburgh College of Surgeons (RCSEd). It has been now used by all UK urological trainees and widely in Asia and Australasia. We are working with the GMC and urology SAC to establish it as the standard for knowledge for all trainees.

5. Teaching experience

In the 1990's I was responsible for Higher Surgical Training in Urology in Norwich. I established and ran an annual residential regional teaching course which has remained an important part of our specialist registrar programme and is consistently highly-rated by trainees. I continue to contribute to this.
For the past 60 months I have been working with the RCSEd to develop a surgical training programme for Myanmar. This is being expanded to involve all the surgical specialties in the country.

6. Research experience

Following appointment as a consultant I was PI in several clinical trials within the Urology department.
For most of my career my other research activity has involved facilitating researchers in collaborations with University departments.
I took responsibility for establishing and organising the Norwich contribution to the national 100,000 Genome project.
In the past 12 years I have been involved in supervising 3 PhD and one MD student.

8. Medicolegal

For the past 17 years I have provided medicolegal opinions. I have been instructed by solicitors for acting both for the plaintiff and the defence (current ration 30:70). I currently provide approximately 80 reports per year. I am prepared to travel anywhere in the UK to see patients. I regularly attend case conferences with barristers and I have experience of giving expert evidence in Court.

9. Other

In the past 7 years I have been invited to perform 3 major reviews of urology department's performance and organisation in the UK.
I am experienced in reviewing serious incidents which I have done both for the Royal College of Surgeons and when requested by individual Trusts.

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EDITORIAL ACTIVITY

I am a regular reviewer for the British Journal of Urology International, Current Opinions in Urology, the Journal of Clinical Urology and the Journal of Sexual Medicine.

FAQs Urology October 2020

Why has the Southern Trust decided to look back at Urology patients?

Clinical concerns were raised regarding the work of one Consultant Urologist in June 2020 when two patients were identified has having not been listed on to the Trust Patient Administration System in a timely manner. This was alerted as a potential patient safety issue due to potential delays in treatment and prompted a wider review of the Consultant's workload to establish if there were additional service impacts.

What happened when concerns were raised?

Following the identification of clinical concerns, the Trust provided information about the Consultant's practice to the General Medical Council. In addition to this, restrictions were placed on the Consultant's practice by the Trust so they could no longer undertake clinical work and could not access patient information. The Department of Health were provided with details of the case via the 'Early Alert' mechanism.

A further review of the Consultant's workload over an 18 month period - January 2019 to June 2020 – has been on-going since June, with expert independent advice sought to inform the scope and scale of the work.

Why is the Trust only looking at cases between January 2019 and June 2020?

The Trust has agreed with the Health and Social Care Board, Public Health Agency and Department of Health to a chronological and incremental approach when reviewing the Consultants workload. In the first instance the Trust has reviewed cases in this 18 month period. The scope and scale of any further review may be extended. This will be based on our internal review of patient records and advice from the Royal College of Surgeons.

What issues have the Trust now identified?

The Trust has reviewed all of the Consultants elective and emergency activity that occurred between January 2019 and June 2020. The review has progressed to diagnostic testing conducted including radiology, pathology and cytology to ensure appropriate action has been taken on each result. Of these patients who have been reviewed, there have been **nine** cases which are now part of an independently chaired Serious Adverse Incident Review process.

The Trust has also recently identified concerns regarding medication prescribing, as a result 26 patients have been reviewed by our Urology team.d

How many patients are involved in the review process?

Were all the patients treated by the same doctor?

All the patients included in this review were under the care of the same Consultant.

Have all patients who are affected been told?

The initial review of paper records identified concerns regarding **11 cases**. These patients have been advised, clinical management plans are in place, and urgent issues actioned.

A further 236 oncology patients are being reviewed by an independent Urology consultant to ensure that their management plans and treatments are in line with guidance. These patients have been/are being contacted directly.

Have patients come to harm?

There are **nine cases** which are now part of a Serious Adverse Incident Review. A review of each of the **nine** patients care has been commissioned and is being led by an Independent Chair supported by a Consultant Urologist Expert. Each of these patients has been contacted by the Trust to inform them of the review process, arrangements have been made for patients in this group who need review appointments.

How will patients affected by this be notified?

Patients who have been identified as requiring review were contacted directly by the Trust as soon as issues with their care were identified.

Can the Trust reassure patients that the Urology service is safe, and that patients are receiving appropriate care?

Yes, our Urology team based in Craigavon Area Hospital provide care for thousands of patients each year and the current review is focused on a small proportion of these cases.

Have concerns previously been raised about this consultant

Part of the review process will look at all aspects of care provided, including a review of complaints received.

How many patients have been identified as potentially being affected?

To date the Trust review has identified **nine** patients that elements of their care require a Serious Adverse Incident review to take place. As the Trust review progresses there may be additional cases identified.

Have any of these patients died or been harmed as a result of being this doctor's patient?

The Serious Adverse Incident review process will seek to identify issues with the care provided to each patient to ascertain if harm occurred and what actions require to be taken to prevent this recurring in future.

Why hasn't the Trust identified the doctor involved?

The Trust has provided information regarding the doctor's identity to relevant professional and government agencies.

Is the doctor still working for the Trust?

The doctor is no longer working for the Trust or employed in Health and Social Care Services.

How long did this doctor work for the Trust?

The Doctor was employed by the Southern Health and Social Care Trust for 28 years.

Will this doctor face disciplinary or legal action as a result of this review?

The doctor is no longer an employee of the Trust therefore and future action would be the responsibility of the General Medical Council.

Will there be a PSNI investigation into this?

The remit of the review is to examine care provided by the Consultant using a chronological and incremental approach when reviewing the Consultants workload. This review is review in line with Department of Health, Public Health Agency and Health and Social Care Board processes.

Were any concerns raised about this doctor before the dates being looked at in this review i.e. before January 2019?

The General Medical Council are currently investigating professional aspects of the Consultants practice, an outcome will be provided by the General Medical Council in due course.

What action(s) were taken as result of these concerns?

As above

Will the Trust now review all patient care provided by this doctor to all patients during his employment at The Trust?

Any potential extension of the Trust review will be based on the outcomes of the current January 2019 to June 2020 review. A decision on this will be made in agreement with the Health and Social Care Board, Public Health Agency and Department of Health and will consider specialist advice from The Royal College of Surgeons.

Incident Management

ID	Element	Actions Required	Responsible	Date for Completion	Attachments	Complete
1	GMC Request for Information 8th October 2020	Further communication received from the GMC asking for update on issues. Draft corresepondence created for review. GMC to be advised of decision not to progress with MHPS review based on DoH advice.	M O'Kane / S Wallace	6th November		
2	MHPS Investigation (New)	AOB is no longer professionally accountable to the SHSCT and Dr O'Kane is not responsible officer - this has been the case since 29th July 2020. Response from AOB solictor 9th September stating that as MHPS did not start prior to AOB's retirement that there are no grounds for continuing the process. DLS advice has been dou on AOB solictor communcation. DoH have also advised that given AOBs retirement MHPS should not be followed. GMC to be updated	M O'Kane / S Hynds / S Wallace	30th September		Complete
3	Mileage Claims	AOB has submitted Personal information redacted by USI for previous 8 years prior to retirement. AOB's contract states that this should be monthly submissions. SH stated that communications had been issued to staff at regular intervals to remind of the importance of prompt submission. Group agreed that April 2020 would be reasonable for consideration following verification.	M McClements / R Carroll / M Corrigan	20th October		In progress
4	Administration Review	Dr Rose McCullagh and Dr Mary Donnelly are conducting an administrative process review as specified in the 2018 MHPS review outcome. Group to be convened to progress wider aspects of the admin review. To consider additional quality assurance mechanisms	R McCullagh / M Donnelly	20th October		In progress
5	Screening of potential SAIs	Nine SAIs screened as meeting SAI criteria.	M Haynes / M Corrigan / P Kingsnorth	20th October		In progress
6	SAI Reviews	Required: - Communications with service users / families who are subject to SAIs - all nine new SAI service users / families contacted to inform of SAI progress. 4/5 original SAI service users contacted also - Discussion with DH to take place regarding progression of SAI's including discussions required with Trust staff, chair of MDM etc and ongoing family liaison arrangements.	M Haynes / M Corrigan / P Kingsnorth			
6	Trust External Communications	Jane to speak to David DoH on coordinated Communications strategy. - Trust to decide on public communicaions arrangements - HSCB offered Comms manager support - FAQ document to be developed to support media communications	Martina, Patricia and Ronan	3rd November		In progress
	Family Liaison	Family liaison person to be identified - MMcC has two persons who potentially can fulfil this role in mind. MMcC Discussions to take place with respective line managers to progress				
7	Additional Subject Matter Expertise	Further to this we have identified via RCS and BAUS another Subject Matter Expert Professor Krishna Sethia who is willing to engage with us.		20th October		In progress

8	Engagement of ISP to undertake waiting list work	Draft contract engagement document developed- pathways for service access are mapped. Documentation with contracts team for approval	M Haynes / M Corrigan	20th October	Document	In progress
9	Review Scope	*Action plan to review key areas of concern developed by Urology Team - Review of stent removals Jan 2019 - June 2020 160 pts - Review of elective activity Jan 2019 - June 2020 352 pts - Review of pathology results Jan 2019 August 2020 168 pts - Review of Radiology requests Jan 2019 - August 2020 1028 pts episodes - Review of MDM episodes Jan 2019 - July 2020 271 pts Initial concerns found in a review of 270 patients has found issues with clinical skills where deviations from guideline based treatments. There is a requirement to understand the volume of patients who may be in this group. Additional SME Consultant Urologist Krishna Sethia has been identified as another avialable subject matter expert.	M McClements / M Haynes / M Corrigan / R Carroll	1st September		In progress
10	Bicalutamide Concerns	PK provided an update on SAI independent expert who has stated that Bicalutamide management in at least one case likely contributed to the death of one service user. The group discussed actions required to ensure that patient safety is maintained. The group dicussed the challenge with identifying patients who have been prescribed by AOB and those that are prescribed in secondary care. An update is being sought from Tracey Boyce and Joe Brogan to identify prescribing patterns. Group agreed this required addressing as a matter of urgency No information recieved from the PHA / HSCB re primary care prescribed Bicalutamide	M McClements / R Carroll			
10	Clinician Early Alert	M O'Kane / S Wallace to discussed Clinician Early Alert with DoH. DoH advised that informal communication with other Trust MDs and HRODs would be appropriate. MOK has completed this action.	Dr Maria O'Kane / S Wallace	20th October		Complete
12	Communication with DoH / Minister	Group agreed that date of 19th October 2020 for release should be postponed. Group suggested MD communicates with CMO to ask to postpone date.	M O'Kane	14th October		
14	Telephone Support Service	Telephone Support Service developed. Attached Powerpoint	M McClements / R Carroll / M Corrigan / M Haynes	20th October		
16	Early Alert to DoH	Early Alert issued to DoH and HSCB regarding Bicalutamide	Dr Maria O'Kane / S Wallace	16th October		Complete
17	Information on Appraisal, Job Planning, Litigation and Complaints	Information on apprisal, job planning and complaints collated	S Wallace	7th August	Information Collated - saved in shared folder	Complete

Incident Oversight Group

Tuesday 8th December 2020, 4:00pm

Via Zoom

AGENDA

1	Apologies	
2	Minutes	MINUTES - Incident Group 01.12.2020 DF
3	DoH Oversight Meeting Update (4th December 2020)	
4	Private Practice - Private Practice Audit - Private Practice Patients transferred to HSC	
5	Update on Radiology and MDM Review	
6	IPT for Review Process	Urology Inquiry IPT - draft 7 (8 december
7	Additional Subject Matter Expertise - British Association of Urological Surgeons - British Association of Urological Nurses	Independent Consultant Urology S
8	Royal College of Surgeons Engagement	Terms of Reference CLINICAL RECORD RI
9	Bicalutamide Patient Review	Clinical And Social Care Audit Registrati
10	Engagement of ISP to undertake waiting list work	
11	Telephone Support Service / Patient Triage Update	
Professional Governance		
12	GMC Discussions	
13	Litigation / DLS Update	
14	Grievance Process	
15	Professional Alert Letter	
16	Administration Review Update	
Serious Adverse Incident (SAI) Reviews		
17	Update on Current SAI Progress	
18	Initial SAI Recommendations	Action plan Personal Information docx
19	Structured Judgement Review Process	
20	Family Liaison Role	
Communications		
21	Media / Assembly Questions	
Any Other Business		

22	Coronial Processes	
23	Letter to Staff re AOB Patient Reviews	07.12.2020 - Memo - Identification of Varia UROLOGY PATIENT REVIEW FORM v1.do
24	Declaration re CURE	DECLARATION OF INTERESTS FORM.do
25	Securing Records for Public Inquiry	
Date of Next Meeting		
23	Via Zoom – 15th December 2020	

Urology Oversight Group Minutes

Tuesday 8th December 2020, 4:00pm

Via Zoom

	Item	Actions
1	**In Attendance** Stephen Wallace — Melanie McClements Martina Corrigan — Dr Maria O'Kane Dr Damian Gormley — Jane McKimm Siobhan Hynds — Mr Mark Haynes Patricia Kingsnorth	
2	**Apologies** Vivienne Toal Ronan Carroll	
3	**Weekly DoH Update** Melanie updated on the meeting. Main update was to suggest that the SJR methodology would be a potentially viable vehicle going forward. Public Inquiry isn't likely to commence until March 2021. DOH meetings will now be two weekly. Prof Krishna to quality assure work to date. Second victim discussion regarding supports required.	
	Management of Patient Reviews	
4	**Private Practice** Martina updated on another case identified via GP practice. DLS have identified that AOB has still been liaising with DLS regarding medico-legal cases. Further information on this has been sought.	**DLS to update on AOB work**
5	**Update on Radiology and MDM Review** No update this meeting, to follow next week	**Update next meeting**
6	**IPT for Review Process** Martina reviewed IPT with the HSCB and costed at 2.3 million for 15 months. Costs in year to be met with 200k urology funding. Further funding required for 2021/22 via IPT process.	**To be discussed at HSCB meeting**
7	**Additional Subject Matter Expertise** Group reviewed the role description and agreed content.	
8	**Royal College of Surgeons Engagement** Group reviewed the terms of reference, broadly agreed content. Sampling strategy to be agreed. Group felt 5 years may be appropriate.	
9	**Bicalutamide Patient Review** No further update	
10	**Engagement of ISP to undertake waiting list work** Martina and Mark to speak to Patrick Keane to agree if he will be willing to engage beyond December.	**Martina / Mark to discuss with**

		Mr Keane
11	**Information Telephone Line** Martina stated that the information line has been quiet this week. Martina referenced a recent communication from a patient who received a letter from an unknown source regarding the care provided by AOB asking to contact the information line, this was not issued by the SHSCT. Group discussed producing a holding letter to patients regarding those patients who will not be part of the review going forward. Group agreed holing letters should be issued.	**Holding letter to patients to be issued**
	Professional Governance	
12	**GMC Discussions** Maria updated on the meeting with the GMC ELA. AOB will be going to interim orders on 15th December 2020.	
13	**Litigation / DLS Update** Next meeting – update covered in item 4	
14	**Grievance Process** Next meeting	
15	**Professional Alert Letter** Next meeting	
16	**Administration Review Update** Next meeting	
	Serious Adverse Incident Reviews	
17	**Update on Current SAIs** Communications are ongoing, a letter has been drafted to AOB via Tughans to invite AOB to take part. Summary position is expected on Friday. Maria asked that for responses are to be submitted by set deadlines.	**Patricia to write to AOB on SAI Chair behalf**
18	**Initial SAI Recommendations** Recommendations are in progress, update to be provided at a future meeting	**SJR model to be discussed with the HSCB**
19	**Structured Judgement Review Process** Next meeting	
20	**Family Liaison Role** Liaison role closes on Friday this week.	
	Communications	
21	**Media / Assembly Questions** No update this week	
	Any Other Business	
22	**Coronial Processes** Next meeting	
23	**Letter to Staff re AOB Patient Reviews** Letter agreed	
24	**Declaration re CURE**	
25	**Securing Records for Public Inquiry**	
	Date of Next Meeting	
26	**Via Zoom – 15th December 2020**	

Urology Oversight Group Minutes

Tuesday 1st December 2020, 4:00pm

Via Zoom

	Item	Actions
1	**In Attendance** Stephen Wallace — Melanie McClements Martina Corrigan — Dr Maria O'Kane Dr Damian Gormley — Ronan Carroll Siobhan Hynds Vivienne Toal Patricia Kingsnorth	
2	**Apologies** Jane McKimm Mr Mark Haynes	
3	**Ministerial Statement Update** Melanie updated that AOB solicitor has advised due to a [redacted] that no communications will be received for 10 days. A report was also issued to the DoH meeting updating on weekly Trust progress.	
	Management of Patient Reviews	
4	**Private Practice** Melanie advised that a letter had been issued to AOB requesting information however a response has not been received [redacted]	
5	**Update on Radiology Review** Engagement with Subject Matter Experts to be progressed to support radiology review work	**Role description for SME to be developed**
6	**IPT for Review Process** Martina referred to the £200k for an additional consultant. Group discussed the potential for this to be diverted to Inquiry IPT.	**To be discussed at HSCB meeting**
7	**Additional Subject Matter Expertise / Royal College of Surgeons Engagement** Meeting took place with the RCS on 30th November to discuss potential engagement and invited review. Trust to outline terms of reference for consideration by HSCB / DoH then onward submission to RCS.	**Terms of reference to be developed**
	Bicalutamide Patient Review Engagement with Subject Matter Experts to be progressed to quality assure bicalutamide audit	**Role description for SME to be developed**
	Engagement of ISP to undertake waiting list work Group discussed Mr Keane's availability to undertake additional work beyond the oncology reviews.	**Martina / Mark to discuss with Mr Keane**
	Information Telephone Line Martina provided an update on this work, group discussed the need for additional clinical input to support this. Group discussed calls from MLAs that went through directly to CX office regarding urology incident. Group to speak to Jane McKimm to	**Standardised communication to be developed**

	agree a communication to MLA's to standardize methods of contact.	
	Professional Governance	
8	**GMC Discussions** Stephen advised that the final set of requested information is being issued to the GMC this week. A meeting with the new GMC ELA is being arranged for Dr O'Kane and Stephen.	**Stephen to issue information to the GMC**
9	**Administration Review Update** Martina and Anita meeting with Denise Lynd tomorrow, update to be provided next meeting	**Update for next meeting**
	Serious Adverse Incident Reviews	
12	**Process for Managing SAI's** Dr O'Kane referred to the model of Structured Judgement Reviews and its potential applicability in the absence of a formal SAI process while the Public Inquiry commences. Proposal to be discussed with the HSCB	**SJR model to be discussed with the HSCB**
13	**Initial Feedback from SAI Chair** Patricia advised that the chair had requested information regarding NIMDTA surveys / feedback. Patricia to go back and clarify the rationale / reason for information. Chair also proposed a meeting with AOB, group agreed the route would be via AOB solicitors, questions are to be set by Subject Matter Expert prior to engagement.	**Patricia to contact chair to discuss**
14	**Family Liaison Role** Post to be advertised for 6 months temporary via EOI process.	
	Communications	
17	**Media / Assembly Questions** Stephen referred the FAQ, asked the group to review prior to submission to the DoH	
	Any Other Business	
19	**Any Other Business** Vivienne asked for Grievance Appeal to be added to agenda.	
	Date of Next Meeting	
20	**Via Zoom – 8th December 2020**	

Southern Health and Social Care Trust

Quality Care - for you, with you

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Staffing Support Requirement for Serious Adverse Incident /Inquiry - Urology

3 December 2020

1.0 Introduction

There have been significant clinical concerns raised in relation to Consultant A which require immediate and coordinated actions to ensure patient safety is maintained. Comprehensive plans need to be put into place to undertake the following:

- Review of professional governance arrangements
- Liaison with professional bodies
- Review of patient safety and clinical governance arrangements
- Commencement of operational support activities including
  - Offering additional clinical activity
  - Provide complaints resolution
  - Media queries, Assembly Questions responses
  - Managing the volume of patients who require to be reviewed
  - Patient Support (Psychology / Telephone Support / Liaison)
  - Staff Support
  - Claim handling / medico-legal requests

This proposal identifies the staffing requirements and costs required to support the Serious Adverse Incident (SAI) Investigation/Inquiry for Urology in the Southern Trust.

This proposal will require revision as demands change over time.

2.0 Needs Assessment

A comprehensive review of patients who have been under the care of Consultant A will be required and this may likely number from high hundreds to thousands of patients.

Following discussions with the Head of Service the following clinics have initially been proposed and have been estimated in the first instance to continue for one year.

Clinics will commence in December 2020 and continue throughout 2021. A putative timetable has been included. We will require that consultants have access to records, have reviewed the contents and results and are familiar with each patient's care prior to face to face review where required. Each set of patient records will require 10-30 minutes to review depending on complexity. In addition, each of the patients reviewed will require 45 minute consultant urologist appointments to include time for administration/ dictation in addition to 15 mins preparation time on average. That is 8 patients require 8hrs Direct Clinical Contact (DCC) Programmed Activity (PA). 800 patients require 800 hours of Direct Clinical and so on. (Each consultant DCC PA is 4hrs).

The purpose of the clinical review is to ascertain if the:

1. diagnosis is secure
2. patient was appropriately investigated
3. Investigations, results and communications were requested in a timely fashion
4. Investigations, results and communications were responded to/ processed in a timely fashion
5. Patient was prescribed / is receiving appropriate treatment
6. Overall approach taken is reasonable
7. Patient has, is or likely to suffer harm as a result of the approach taken.

In addition, it will be expected that where there are concerns in relation to patient safety or inappropriate management that these will be identified and a treatment plan developed by the assessing consultant and shared with the urology team for ongoing oversight or with the patient's GP.

Table 2-1 Suggested timetable

Day	Clinic Session	Number of Patients
Monday	AM	8
Monday	PM	8
Tuesday	AM	8
Tuesday	PM	8
To be confirmed	AM	8
To be confirmed	PM	8
Total no of patients per week		48

3.0 Staffing Levels Identified

3.1 Information Line – First Point of Contact

An information line will be established for patients to contact the Trust to speak with a member of staff regarding any concerns they may have and will operate on Monday to Friday from 10am until 3pm. A call handler will receive the call and complete an agreed Proforma (appendix 1) with all of the patient's details and advise that a colleague will be in contact with them. The PAS handler will take the information received and collate any information included on PAS/ECR and this will be examined in detail by the Admin/Information Handler. The following staff have been identified as a requirement for this phase. It must be noted that the WTE is an estimate and will be adjusted dependent on the volume of calls received. Costs are included in Appendix 1.

Table 3-1 – Information Line Initial Staffing Requirements

Title	Band	WTE
Call Handlers	4	2
Admin Support for identifying notes/ looking up NIECR etc	4	2
Admin/Information Handler	5	1

3.2 Clinic Requirements

To date a clinical process audit has been carried out in relation to aspects of the Consultant's work over a period of 17 months.

In addition to this 236 urology oncology patients are being rapidly and comprehensively reviewed in the private sector. (Patients returned with management plan are included in Table 3.2/Table 3.4)

A further 26 urology oncology patients have been offered appointments or reviewed in relation to their current prescription of Bicalutamide.

Given the emerging patterns of concerns from these reviews and Multi-Disciplinary Meetings (MDMS) which have resulted in 9 patients' care meeting the standard for SAI based on this work to date, it is considered that a comprehensive clinical review of the other patients is required. The Royal College of Surgeons has advised that this includes 5 years of clinical activity in the first instance.

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The numbers and clinical prioritisation will be identified collectively by the Head of Service, Independent Consultant and the Clinical Nurse Specialist either face to face or via virtual clinics. The volume of patients is 2327 for 18 months in the first instance and the number of DCC PA has been identified as **. The staffing required to operate these clinics is detailed below. This work will be additionality and should not disrupt usual current urology services. It must be noted that again this is an estimate and will be dependent on the volume of patients involved. .

Clinic Requirements Staffing – 6 sessions as detailed in Section 2. Costs are included in Appendix 1.

Table 3-2 – Clinic Staffing Requirements

Title	Band	WTE
Outpatient Manager	7	0.7
Medical Secretarial Support	4	0.5
Booking clerk	3	0.7
Audio Typist	2	0.7
Medical Records	2	0.7
Nursing staff	5	0.7
Nurse Clinical Specialist	7	0.7
Health Care Assistant	3	0.7
Receptionist	2	0.7
Consultant		DCC
Pharmacist	8a	0.7
Psychology Band 8B and above		1 present per clinic
Domestic Support	2	0.7

3.3 Procedure Requirements

If the outcome of the patient review by the Independent consultant urologist is that the patient requires further investigation, this will be arranged through phlebotomy, radiology, day procedure, and pathology / cytology staff. The provision will be dictated by clinical demand. The following staffing levels have been identified as below for each 1 day sessions. Costs are included in Appendix 1.

Table 3-3 – Procedure Staffing Requirements

Title	Band	WTE
Secretary	4	
Reception	2	
Nurses	5	0.64

Title	Band	WTE
Health Care Assistant	3	0.22
Sterile Services	3	0.22
Consultant - locum		2 PAs
Anaesthetic cover		1 PA
Domestic Support	2	0.22

3.4 Multi-Disciplinary Weekly Meetings Requirements

In order to monitor and review the number of patients contacting the following multi-disciplinary team has been identified as a requirement. Costs are included in Appendix 1.

Table 3-4 -–Staffing Requirements for Multi-Disciplinary Meetings (weekly)

Title	Band	WTE
Cancer Tracker	4	0.4
Nurse Clinical Specialist	7	0.1
Consultant Urologist x 2		2 PAS
Consultant Oncologist		1 PA
Consultant Radiologist		1 PA
Consultant Pathologist		1 PA

3.5 Serious Adverse Incident Requirements

Work has commenced on 9 SAI's and the following staff have been identified as a requirement to support the SAI and the Head of Service to enable investigative work to take place and to enable current provision to continue. Costs are included in Appendix 1.

Table 3-5 -Additional staffing and Services required to support SAI

Title	Band	WTE
Head of Service (Acute) – SAI backfill	8b	1
Chair of Panel	N/A	sessional
Band 5 admin support	5	1
Governance Nurse/ Officer	7	2
Admin support to the panel	3	1
Psychology support	Inspire	sessional
Family Liaison SLA	7	1

3.6 Inquiry Requirements

Costs are included in Appendix 1.

Table 3-6 - Additional staffing and Services required to Support Inquiry

Title	**Band**	**WTE**
Head of Service Backfill	8b	1
Clinical Nurse Specialist	7	1
Admin Support for HOS	4	1
Admin Support to respond and collate requests for information for inquiry team	5	2
Health records staff to prepare notes for Inquiry Team	2	4
Urology Experts – WL Initiative Funding £138 per hour	Consultant	Sessional
Media queries, Assembly Questions responses	8a (uplift from Band 7's)	2
Admin Support for media queries/Assembly questions	4	1

3.7 Professional and Clinical Governance Requirements to Support the SAI/ Inquiry

Investigations involving senior medical staff are resource intensive due to the many concerns about patient safety, professional behaviours, demands on comprehensive information and communications with multiple agencies. In particular this case has highlighted the need for clinical and professional governance processes across clinical areas within the Trust, to develop these systems and to embed and learning from the SAIs and Inquiry. This work should be rigorous and robust and develop systems fit for the future.

This strand will have responsibility for undertaking activities to ensure embedding of learning, improvement and communication of Trust response to the Urology incidents. This includes providing assurance that improvement efforts are benchmarked outside the Trust from both a service development and national policy perspective and the acquired learning process and may include:

- Revision of Appraisal and Revalidation processes
- Quality Assurance of information processes in relation to Appraisal and Revalidation
- Development of systems and processes that marry professional and clinical governance
- Embedding and providing assurance regarding learning, improvement and communication
- Provide support on Trust communications regarding incident response
- Support triangulation of clinical and social care governance and professional governance information to improve assurance mechanisms
- Support the benchmarking of Trust service developments against regional and national perspectives
- Support liaison and communications with PHA / HSCB and Department of Health on matters relating to the urology incidents

- Support for corporate complaints department

Costs are included in Appendix 1.

Table 3-7 - Professional Governance, Learning and Assurance

Title	Band	WTE
AD Professional Governance, Learning and Assurance	8c	1
Project Lead	7	1
Administrative Support	4	1

Table 3-8 – Claims Management / Medico – Legal Requests (DLS 20%)

It is anticipated that the number of medico-legal requests for patient records and the number of legal claims will significantly increase as a result of the patient reviews and SAIs. This will require support for claims handling, responses to subject access requests and redaction of records.

Title	Band	WTE
Head of Litigation (uplift from band 7)	8a (uplift from band 7)	1
Specialist Claims Handler	7	1
Claims Administrative Support	4	1
Medico – Legal Admin Support	3	1
Service admin support – redaction	4	1
Support Health Professional for redaction – Clinical Nurse Specialist	7	1
2 x Solicitor Consultants (DLS)	sessional	

4.0 Identified Risks

Risk Identified	Mitigation Measure
• Recruitment of experienced staff –	• Complete recruitment documentation as soon as possible • Liaise with Human Resources
• Staff Backfill	• Complete recruitment

Risk Identified	Mitigation Measure
	documentation as soon as possible • Liaise with Human Resources
• Securing Funding	• Liaise with PHA and HSCB regarding additional funding required to support the SAI/Inquiry.
• Volume of calls received by the information line will exceed expectations leading to further complaints	• Monitoring of call volumes • Extending the operational hours to receive calls • Increasing the number of call handlers
• Number of clinics is insufficient to cope with the demand for review appointments	• Monitoring the number of review appointments required • Monitoring clinics and virtual clinics • Increasing the number of virtual clinics
• Current Service Provision will be impacted by the additional clinics being taken forward and Waiting Lists will continue to grow.	• Current provision continues • Utilise independent resources • Provide evening/weekend clinics
• Red flag appointments will not be seen within the required timeframe	• Monitor all current referrals and red flag appointments
• Reputation of Trust	• Provide a response within an agreed timeframe

5.0 Monitoring

Monitoring and reporting will continue throughout the investigation period and will be provided on a weekly basis. Meetings are scheduled on a weekly basis.

Southern Health and Social Care Trust

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ROLE DESCRIPTION

JOB TITLE	Independent Consultant Urology Subject Matter Expert
REPORTS TO OPERATIONALLY	Melanie McClements, Acute Director
REPORTS TO PROFESSIONALLY	Dr Maria O'Kane, Medical Director
TIME COMMITMENT	Sessional Work on an ongoing basis

ROLE SUMMARY

To support the ongoing review of urology patients the Southern Health and Social Care Trust requires an independent Consultant Urologist to undertake a range of clinical review and quality assurance processes. The Subject Matter Expert will report operationally to the Director of Acute Services and Professionally to the Medical Director.

ROLE DUTIES

1. To review and quality assure the Trust audit of patients prescribed the medication Bicalutamide taking into account the audit methodology employed, audit findings and where appropriate the proposed changes in medication.

2. To chair a weekly extraordinary Multidisciplinary Team Meeting (MDT) to discuss and review patients which have been identified by independent Consultant Urologist as requiring MDT discussion. MDT will be supported by one additional Consultant Urologist, Consultant Oncologist and where required Consultant Radiologist / Pathologist.

3. To review radiology results (1028 patients) held on Electronically (NIECR System) to ascertain if appropriate action has been taken in response to the radiology results.

4. To review MDT meeting outcomes (271 patients) held on Electronically (NIECR System) to ascertain if appropriate action has been taken in response to the MDT discussions.

5. To quality assure the outcomes and conclusions for all patients that have been reviewed at clinic as part of the urology review to date from all identified workstreams.

6. To assist in the development on parameters for use when triaging patients who contact the patient information line including identification of what constitutes a potential delay in actioning treatments, reviews, referrals and reviews.

Southern Health and Social Care Trust

Clinical and Social Care Audit Registration Form

Audit Title: Audit of Prescribing of anti-androgen medicine 'Bicalutamide'

Directorate: Acute Services ■ Children & Young People ☐ Older Persons & Primary Care ☐
Mental Health & Disability ☐ Corporate request ☐

Division:

Auditor's name: Mr Mark Haynes **Contact details: (email)** Personal Information redacted by USI	**Audit Supervisor's Name : Not Applicable**

Is this a: National audit ☐ Regional audit ☐ Trust audit ■ International audit ☐

Proposed audit commencement date 27th October 2020 Proposed audit completion date …/…/….

Audit Aims

To ensure that the anti-androgen medicine 'Bicalutamide' has been prescribed as licensed and in line with NICE guideline NG131 Prostate Cancer: Diagnosis and Management

Audit Objectives

- To ensure that where Bicalutamide is prescribed only where indicated and as per licensed usage
- To ensure that where Bicalutamide is prescribed this is prescribed in the correct therapeutic dosages
- To ensure that patients prescribed Bicalutamide is appropriately reviewed as part of the patients ongoing care
- To ensure that any deviations from prescribing guidance is based on sound evidence based clinical rationale

Audit Standards

The following audit standards obtained from NICE guideline [NG131] Prostate cancer: diagnosis and management

Published date: 09 May 2019.

Audit Criteria	Target	Exceptions	Source of Evidence
Bicalutamide prescribed as per indicated conditions in NICE NG131	100%	Clinical rationale for deviation from guidance	NICE guideline NG131 Prostate Cancer: Diagnosis and Management
Therapeutic doses of anti-androgen monotherapy with bicalutamide are prescribed at recommended dose (150 mg).	100%	Discussions with patient / Clinical rationale	NICE guideline NG131 Prostate Cancer: Diagnosis and Management

Audit Methodology

The following audit methodology will be followed:

- HSCB to provide information on primary care prescriptions of the medication Bicalutamide
- Southern Health and Social Care Trust patients to be identified and a consultant led review of prescribing to take place to identify prescribing of Bicalutamide that is outside of that prescribed in NICE guideline NG131 Prostate Cancer: Diagnosis and Management

Rationale for the audit (please tick all that apply)

Topic is included in the Directorate's clinical audit work-plan ☐ Compliance with standards & guidelines ■

Clinical and Social Care Audit Registration Form

National Healthcare Quality Improvement Partnership (HQIP) audit	☐	Regional RQIA/GAIN audit	☐
Other national / international audit	☐	Trust based audit topic important to team/division	■
Clinical risk	■	Recommendation from national / regional report	☐
Serious Adverse Incident or Adverse Incident review	■	Clinician / personal interest	☐
Incident reporting	☐	Educational audit	☐

Other – please specify ……

Level 1 ☐ **Level 2** ■ **Level 3** ☐ **Level 4** ☐

Has this audit been approved based on the priority level? Yes ■ No ☐

Level 1 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum
Level 2 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum
Level 3 – Approval required by Supervising Consultant
Level 4 – Approval required by Supervising Consultant
Please be advised that the audit cannot proceed without approval as above.

Please Note: The Information Team have advised they will not release data to the requestor unless the clinical audit has been approved as above.
The clinical audit team will also advise contact with Information Governance for any advice required.

The clinical audit team can be contacted via:
Email: clinical.audit@southerntrust.hscni.net
Tel:

Raymond Haffey
Terri Harte
Sandra McLoughlin

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Mary Markey
Roisin Feely
Philip Sullivan

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Personal information redacted by USI
Personal information redacted by USI

In submitting this audit registration form, I agree to share the audit findings, recommendations and audit summary template with:the Audit Supervisor, appropriate Divisional/Directorate Committee and the Trust's Clinical audit team

Please submit your audit registration form to: *clinical.audit@southerntrust.hscni.net*

Priority levels for clinical audit

Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	• National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires	1
Level 2 audits, other national audits and 'internal must dos'	• National audits not contained within the HQIP list, or other clinical audits arising from: • Clinical risk • Serious untoward incident / internal reviews • National Institute of Clinical Excellence Standards & Guidelines • Complaints • Re-audit • Regional audits initiated by RQIA / GAIN	2
Level 3 audits, 'divisional priorities'	• Local topics important to the division	3
Level 4 audits	• Clinician / personal interest • Educational audits	4

Action Plan Urology [Personal Information redacted by USI]

Reference number	Recommendations	Designated responsible person	Action required	Date for completion / timescale	Date recommendation completed with evidence
1	HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.	HSCB	See recommendation 5		
2	HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices	HSCB			
3	HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.	HSCB			
4	GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.	HSCB			

5	**TRUST** Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.	AD surgical/ AMD Primary Care	The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care.		NiCan pathway.  Bladder Cancer Pathway March 2020  Revised Prostate Diagnostic Pathway D  Female Lower Urinary Tract Sympto  Female Urinary Tract Infection.docx  Male Lower Urinary Tract Symptoms.docx  male urinary tract infections.docx
6	The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.	AD Surgery/ AMD Surgery	Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD	Jan 2021	

7	The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.	AD surgery	Currently the IEAP protocol is followed The current regional protocol is being updated.	Jan 2021	 Integrated Elective Access Protocol - Apr  Integrated Elective Access Protocol Draft  FW IEAP referral.msg  Booking Centre SOP manual.doc  TRIAGE PROCESS 2. lmca.docx
8	The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.	AD Surgery		Nov 2020	
9	Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.	AD surgery	Reports will be sent to AD and AMD/ CD	Nov 2020	
10	The Trust must set in place a robust system within its medical management hierarchy for highlighting	MD			

	and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.				
11	Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.	MD			
12	Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.	MD			

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NICaN SUSPECT BLADDER CANCER REFERRAL AND DIAGNOSTIC PATHWAY

Day 0/62

GP RED FLAG REFERRAL
(CCG Proforma completed: Meets NG12 red flag referral criteria :
>45 unexplained visible haematuria with no UTI
Visible haematuria persists / recurs after UTI treatment
≥60 with u/e non-visible haematuria +/- dysuria/WCC

Imaging requested at time of referral (USS/CT)

Day 7/62

Initial Assessment/ One Stop Haematuria Clinic
Clinical examination
Flexible cystoscopy +/- Upper Tract

Upper Tract

Bladder Tumour Visible

TURBT
(Pathology reported ≤ 7days
If T2 disease patient tracker flags report to referring Consultant)

Day 28

LOCAL AND REGIONAL MDM DISCUSSION
Malignant Diagnosis Only

Laser/ local Excision/ Nepho - Ureterectomy

Non- muscle invasive (Stage pTa- pT1)

Muscle Invasive (Stage T2+)

Low Grade Papillary (pTa)

High Grade (pT1)

Day 31

Follow Up Repeat Cystoscopy (3months)

Repeat Cystoscopy +/- TURB BCG

Outpatient Review DECISION TO TREAT

Suitable for surgery

Unsuitable for surgery

Specialist OP Review

Oncology Review

Radical Cystectomy +/- neo-adjuvant therapy

Radiotherapy Chemotherapy Palliation

Day 62

Follow Up

Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

Final Proposed Prostate Diagnostic Pathway December 2019

NICaN SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY

GP RED FLAG REFERRAL

Initial Assessment
- DRE
- Flow Rate (with moderate symptoms, IPSS >8)
- Residual volume
- Consider Assessment of Prostate volume / PSA Density
- ECOG status
- Charlson Co-morbidity index: https://www.mdcalc.com/charlson-comorbidity-index-cci

PSA <20 and ECOG ≥2 or CCI ≥5

Abnormal DRE
PSA >20
•Biopsy
•CT/ Bone Scan
•+/- MRI

Benign DRE and PSA >20: **MRI**
OR
Benign DRE and PSA >40: **Biopsy**

ECOG <2 or CCI <5

DRE normal
And
PSAD (US/ DRE) <0.1

Abnormal DRE
Or
DRE Normal and PSAD (US/DRE) >0.1
Or
PSADT (on PSA Monitoring) <4yrs

MRI prostate

MRI PSAD <0.15
And
MRI No Abnormality

MRI PSAD ≥0.15
Or
PIRADS 3/4/5 abnormality

MDM DISCUSSION
Malignant Diagnosis Only

PSA monitoring
(Education of patients regarding PSA monitoring, alert symptoms and access to services)

Prostate biopsy (TP or TRUS) + targeted biopsies of MRI abnormality
(Consider prostate volume as part of the initial assessment of a patient with a raised PSA and before MRI)

PIRADS 3 and PSAD <0.15 discuss options of PSA monitoring and biopsy, context of imaging and PSA history with patient and proceed according to

Watchful Waiting / Symptomatic management
(Refer to NICaN Watch and Wait Pathway)

Guidance Notes
To help men decide whether to have a prostate biopsy, discuss with them their prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors.
Prostate volume should form part of the discussion with a man about whether further investigation (eg MRI +/- biopsy) or monitoring.
Give men and their partners or carers information, support and adequate time to decide whether or not they wish to undergo prostate biopsy.

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Female Lower Urinary Tract Symptoms

History;

- Storage symptoms – Frequency, Urgency, Nocturia, Incontinence
- Voiding symptoms – Hesitancy, Poor flow, Straining, Stop-start void.
- Assessment of Fluid intake

Examination;

- Abdomen
    - Palpable bladder?
- External Genitalia/Pelvic Examination
    - Atrophic Vaginitis
    - Pelvic Organ Prolapse

Investigations;

- Urine Dipstick
    - Glucose
    - Nitrite and Leukocytes
    - Haem
- Blood test
    - Renal profile
    - Glucose (found on Dipstick)
- USS Urinary tract
    - Hydronephrosis?
    - Residual Volume?
    - Pelvic organs?

Primary Care management;

- Lifestyle advice
    - Reduce Caffeine
    - Timing of fluid intake
- Palpabable Bladder
    - refer to Urology
- Atrophic Vagintis
    - Consider oestrogens therapy
- Pelvic Organ Prolapse
    - Refer to Gynae
- Leukocytes
    - manage infection as per Guidelines.
- If Renal Impairment
    - see Nephrology Guidelines

- Ultrasound Urinary tract
    - Hydronephrosis - refer to Urology
    - Residual Volume >150ml – refer to Urology
- Incontinent, residual volume <150ml, storage symptoms
    - If incontinent consider Anticholinergic treatment
    - Symptom review after 3/12 treatment

    If urinary incontinent,

    - If mainly stress incontinent, refer to community
    - Consider anticholinergice treatment – and reassessment after three months

- Others – patients who do not fit into the above two categories
    - Refer to Urology
    - Treat with topical oestrogens.
    - Hydronephrosis → Refer Urology
    - Residual Volume ≥ 300ml → Refer Urology
    - Residual volume 150ml – 300ml → Refer community continence team

Referral;

- Abnormal findings as above
- No symptomatic improvement after 3/12 of medical treatment refer to Urology

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Female Urinary Tract Infection

History;

- First, recurrent or persistent UTI
- Symptoms suggestive of sepsis
- Cystitis (lower UTI) or pyelonephritis (upper UTI)?

Examination;

- Sepsis - Temperature? Heart Rate? Respiratory Rate? Blood Pressure?
- Abdomen – Is the bladder palpable?
- External Genitalia - consider the possibility of
    - Atrophic Vaginitis
    - Urethral pathology
- Pelvic Examination - consider the possibility of
    - Pelvic Mass
    - Cervix
    - Pelvic Organ Prolapse

Investigations;

- MSU for all patients suspected of having UTI.
- USS Urinary tract for recurrent or persistent UTI
    - Hydronephrosis? Residual Volume? Pelvic Organs?

Primary Care treatment;

- UTI with Sepsis
    - Refer to secondary care for admission
- Simple, Single Lower UTI
    - Antibiotics as per microbiology guidelines.
    - Repeat MSU 2/52 post treatment.
- Recurrent Lower UTI
    - 7 day course antibiotics as per microbiology guidance followed by 3 month course of low dose antibiotics.
    - Repeat MSU after 1/12 of treatment.
- Upper UTI no sepsis
    - 14 day course antibiotics as per microbiology guidance

Referral to Urology;

- Abnormal findings as above
- UTI with Sepsis
    - Refer to secondary care for admission
- Upper UTI no sepsis
    - Refer to Urology 'Hot clinic'
- Recurrent Lower UTI
    - Further UTI while on low dose antibiotics.
    - 3rd UTI within 12 months of first presentation.

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Male Lower Urinary Tract Symptoms

History

Storage symptoms – Frequency, Urgency, Nocturia

Voiding symptoms – Hesitancy, poor flow, straining, intermittent stream

Incontinence

Comorbidities – constipation, review of relevant medication

Consider IPSS record and frequency / volume chart.

Examination

External genitalia specifically foreskin and meatus

Abdomen specifically to exclude a palpable bladder

DRE

Investigation

Urine Dipstick test for glucose, haem and nitrites/leucocytes

MSU if indicated

Blood tests – renal function, (glucose if indicated by dipstick test)

- PSA if 40+yrs, abnormal DRE, concern re prostate cancer

Ulrasound Urinary Tract specifically pre and post void bladder volumes and prostate volume

Refer if:

urinary incontinence

suspect urological cancer – raised PSA, abnormal DRE

palpable post void bladder

bothersome phimosis, meatal stenosis

haematuria (see Red Flag guidelines)

recurrent or persisting UTI

Hydronephrosis or bladder residual more than 200mls

Renal impairment if suspected if relating to lower urinary tract dysfunction

Primary care management

Lifestyle advice : - Timing / content of fluid intake (eg evening time fluids and caffeine)

o Co-morbidity issues (eg constipation)

Medication : Initial 3 month prescription (and continue if symptomatic improvement)

- Alpha blocker
- Consider 5-Alpha reductase inhibitor if prostate more than 30cc volume or PSA more than 1.4ng/ml (these medications can be given in combination)
- Consider anticholinergic medication if frequency / urge symptoms continue after trial of alpha blocker medication.

Refer if :

Initial concerns met

Lack of response to initial management plan

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Male Urinary Tract Infection

History;

- Red Flag symptoms? – See Red Flag Guidance
- Lower UTI or Upper UTI?
- 'Normal' lower Urinary tract symptoms?

Examination;

- Sepsis Response – Temperature? Heart Rate? Respiratory Rate? Blood Pressure?
- Abdomen – Is the bladder palpable?
    - Palpable bladder → Refer Urology
- External Genitalia – Foreskin, Glans / Meatus
    - Phimosis, Meatal stenosis → Refer Urology
- Digital Rectal Examination – Prostate
    - Malignant feeling prostate → Refer (see red flag guidance)
    - Tender Prostate without sepsis → Refer Urology 'Hot' clinic

Investigations;

- MSU – All patients suspected of having UTI.
- Blood – Renal profile and glucose.
- USS Urinary tract – Hydronephrosis? Residual Volume?
    - Hydronephrosis >> Refer Urology
    - Residual Volume ≥ 300ml >> Refer Urology
    - Residual volume 150ml – 300ml ??

Primary Care treatment;

- UTI with Sepsis;
- Lower UTI;
    - 7 day course antibiotics as per microbiology guidelines.
    - Repeat MSU 2/52 post treatment.
- Upper UTI no sepsis;
    - 14 day course antibiotics as per microbiology guidance.

Referral;

- Abnormal findings as above
- UTI with Sepsis;
    - Refer acutely to on-call team
- Upper UTI no sepsis;
    - Refer to Urology 'Hot clinic'
- Lower UTI;
    - Refer to Urology.

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

www.dhsspsni.gov.uk

INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008

DOCUMENT CONTROL INTEGRATED ELECTIVE ACCESS PROTOCOL			
Authors	Michelle Irvine – Programme Director, Elective Workstream Maria Wright – Associate Director, Outpatients Rosemary Hulatt – Associate Director, Diagnostics		
Issue Date **1st Draft**	Wednesday 20th February 2008		
Comments by	Close of Play - Friday 7th March 2008		
2nd Draft	27th March 08		
Final Protocol **Date Approved**	30th April 08		
Issue Date	Friday 9th May 2008		
Screened By	Service Delivery Unit, DHSSPSNI		
Approved By		**Signature**	
Distribution	Trust Chief Executives; Directors of Planning and Performance; Directors of Acute Care; DHSSPS		
Review Date	April 2009		

CONTENTS

ABBREVIATIONS

AHP	Allied Health Professional
BCC	Booking and Contact Centre (ICATS)
CNA	Could Not Attend (Admission or Appointment)
DHSSPSNI	Department of Health, Social Services and Public Safety
DNA	Did Not Attend (Admission or Appointment)
DTLs	Diagnostic Targeting Lists
ERMS	Electronic Referrals Management System
GP	General Practitioner
HIC	High Impact Changes
HROs	Hospital Registration Offices
ICATS	Integrated Clinical Assessment and Treatment Services
ICU	Intensive Care Unit
LOS	Length of Stay
PAS	Patient Administration System
PTLs	Primary Targeting Lists
SDU	Service Delivery Unit
TCI	To Come In (date for patients)

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

1.1.6 The DHSSPSNI has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.

1.1.8 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.

1.1.10 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.

1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

administration systems, whether in a hospital or community setting, or an electronic or manual system.

1.1.13 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on PAS and the waiting times for treatment. All staff involved in the implementation of this protocol, clinical and clerical, will undertake initial training and regular annual updating. Trusts will provide appropriate information to staff so they can make informed decisions when implementing and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2 UNDERPINNING PRINCIPLES

1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.

1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.

1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

1.2.5 Change No 1 within the publication "10 High Impact Changes for Service Improvement and Delivery"[1] focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.

1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.

1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.

1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.

1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.

1.2.10 This "bottom up" approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.

1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

[1] "10 High Impact Changes for Service Improvement and Delivery" – September 2004, NHS Modernisation Agency, www.modern.nhs.uk/highimpactchanges

1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.

1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.

1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.

1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.

1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

1.3.4 Trusts must be committed to training and developing staff and providing the supporting systems to ensure that together we can bring about the improvement in patient care.

1.4 REGIONAL TARGETS

1.4.1 The targets in respect of elective treatments are:

- A maximum waiting time of 13 weeks for inpatient and daycase admissions by March 2009
- A maximum waiting time of 9 weeks for a 1st outpatient appointment by March 2009
- A maximum waiting time of 9 weeks for a diagnostic test by March 2009
- A maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009
- By March 2009, sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis
- By March 2009, 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days

1.5 DELIVERY OF TARGETS

1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.

1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

and strategic planning processes. Divisional, specialty and departmental managers will be expected to have produced implementation plans setting out the key steps they need to take to ensure the delivery of the Trust and Departmental protocol objectives within the area(s) of their responsibility. Trusts will manage implementation through a regular review of "local" divisional, specialty and departmental plans for the implementation of waiting and booking targets.

1.5.3 It is expected that Trusts will develop robust information systems to support the delivery of these targets. Daily management information should be available at both managerial and operational level so that staff responsible for selecting patients are working from up to date and accurate information. Future developments should also look towards a clinic management system which will highlight the inefficiencies within the outpatient setting.

1.6 CAPACITY

1.6.1 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets.

1.6.2 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions
- Session length
- Average procedure / slot time
- Average length of stay

1.6.3 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients and diagnostics at service level.

1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.

1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.

1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.

1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.

1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

to expedite solutions and agree these through the accountability review process.

1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.

1.7.2 Offering the patient choice of date and time is essential in agreeing and booking appointments with patients. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them. This takes away the uncertainty of not knowing how long the wait will be as patients are advised of their expected wait. Advanced booking in this way also gives patients notice of the date so that they can make any necessary arrangements, such as child care or work arrangements.

1.7.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.

1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.

1.7.6 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.7.7 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

1.7.9 There are 3 main patient appointment types to be booked. Booking systems for these appointments should be designed around an agreed patient pathway and accepted clinical practice. They are:

a) New Urgent patients (including suspected cancer)
b) New Routine patients
c) Review patients

1.7.10 Clinic templates should be constructed to ensure that sufficient capacity is carved out to meet the local and maximum waiting time guarantees for new patients, and the clinical requirements of follow-up patients.

1.7.11 Principles for booking Cancer Pathway patients

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral
b) Dedicated registration functions for red flag and suspected cancer referrals should be in place within centralised HROs
c) Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients
d) Patients will be contacted by telephone twice (morning and afternoon)
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of 3 days of receipt of referral
f) Systems should be established to ensure the Patient Tracker / MDT Co-ordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient

1.7.12 Principles for booking Urgent Pathway patients

a) Local agreements should be in place with consultants to determine the timeframe within which urgent patients should be booked, and made explicit to booking teams

b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency
d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.7.13 Principles for booking Routine Pathway patients

a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments
b) Referrals will be received, registered within one working day at HRO's and forwarded to consultants for prioritisation
c) Patients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow
d) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified
e) Patients should be selected for booking in chronological order from the PTL
f) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment

1.7.14 Principles for Booking Review Patients

a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list
c) Patients will be added to the review waiting list with an indicative date of treatment and selected for booking according to this date
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment

1.7.15 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey. Examples of this include:

a) midwives contacting patients directly by telephone to arrange their appointment
b) clinical genetics services where family appointments are required
c) mental health or vulnerable children's services where patients may need additional reminders or more than one professional contacted if patients fail to make an appointment.

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 **(Appendix 1).**

2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.

2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.

2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.

2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).

2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting**.**

2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.

2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.

2.2.7 Data collection should be accurate, timely, complete and subject to regular audit and validation.

2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.

2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.

2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

2.3.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.

2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.

2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.

2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

Flowcharts illustrating the Triage Outcomes Process can be found in **Appendix 2.**

2.5 BOOKING

2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.

2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.

2.5.3 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

2.6 REASONABLE OFFERS

2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.

2.6.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

2.6.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date the service was notified of the cancellation, as the patient has entered into an agreement with the Trust.

2.6.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

2.7 MANAGEMENT OF PATIENTS WHO CANCELLED OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

2.7.1 If a patient DNAs their first ICATS appointment the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

2.7.2 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.

2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4.**

2.8 MAXIMUM WAITING TIME GUARANTEE

2.8.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen. This will ensure that all patients waiting for an appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.

2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.

2.10.2 Changes in the patient's details must be updated on ERMS and the medical records on the date of clinic.

2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

2.11.1 All review appointments must be made within the time frame specified by the ICATS practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the ICATS practitioner.

2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

2.12.1 Templates should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.

2.12.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5.**

2.13 VALIDATION

2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.

2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6.**

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.

3.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.

3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.

3.2.2 In cases where referrals bypass the dedicated HRO's, (e.g. sent directly to a consultant), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the HRO and registered at the date on the date stamp.

3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.2.3 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

3.3 KEY PRINCIPLES

3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.

3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7.**

3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

3.3.4 Maximum waiting times for urgent patients should be agreed locally with clinicians, and made explicit to staff booking these patients to ensure that they are appointed within the clinical timeframe indicated by the consultant and capacity issues quickly identified and escalated.

3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.

3.3.6 Data collection should be accurate, timely, complete and subject to regular audit and validation.

3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.

3.3.8 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

3.4 NEW REFERRALS

3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.

3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.

3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.

3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**

3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9.**

3.5 URGENT AND ROUTINE APPOINTMENTS

3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.

3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

how the patient will be booked, should be included on the acknowledgement letter.

3.5.4 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients refusing short notice appointments (i.e. less than three weeks' notice) will not have their waiting time reset, in line with guidance on reasonable offers.

3.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

3.6 BOOKING

3.6.1 All new and review consultant led outpatient clinics should be able to book their appointment. This will entail patients having an opportunity to contact the hospital and agree a convenient date and time for their appointment. The use of the Patient Choice field on PAS is mandatory. The only fields that should be used are 'Y' to indicate that the appointment has been booked or 'N' to indicate that an appointment has not been booked. No other available field should be used as compliance with booking requirements will be monitored via the use of the Patient Choice field. For non-ISOFT and manual administration systems, Trusts should ensure that they are able to record and report patients who have been booked.

3.7 REASONABLE OFFERS

3.7.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.7.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

3.7.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

3.7.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

3.8 MANAGEMENT OF PATIENTS WHO CANCELLED (CNA) OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

3.8.1 If a patient DNAs their outpatient appointment, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

3.8.2 There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to partial booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

3.8.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

3.8.4 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

3.8.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

3.8.6 The Implementation Procedure on DNAs and Cancellations can be found in **Appendix 4.**

3.9 MAXIMUM WAITING TIME GUARANTEE

3.9.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen in the Outpatient Clinic. This will ensure that all patients waiting for an outpatient appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

3.10 COMPLIANCE WITH LEAVE PROTOCOL

3.10.1 Capacity lost due to cancelled or reduced clinics at short notice has negative consequences for patients and on the Trust's ability to successfully

implement booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.

3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10.**

3.11 CLINIC OUTCOME MANAGEMENT

3.11.1 There are a number of locations within Trusts where patients present for their outpatient consultation. This protocol applies to all outpatient areas. It is the responsibility of the PAS user managing the attendance to maintain data quality.

3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.

3.11.3 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

3.11.4 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic. The implementation procedure for the Management of Clinic Outcomes can be found in **Appendix 11.**

3.12 REVIEW APPOINTMENTS

3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.

3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

3.13.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees for patients.

3.13.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

3.13.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5.**

3.14 VALIDATION

3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6.**

3.14.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.15.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

3.15.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Outpatient Transfers can be found in **Appendix 15a.**

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

4.1.2 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.

4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14.** All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.

4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

4.2.3 Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.2.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

4.3 KEY PRINCIPLES

4.3.1 Trusts must have in place arrangements for pooling all referrals unless there is specific clinical information which determines that the patient should be seen by a particular consultant with sub-specialty interest.

4.3.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list, and patients managed in 2 streams, i.e. urgent and routine. Session or clinic templates should be constructed to ensure enough capacity is available to treat each stream within the maximum waiting time guarantees outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

4.3.3 Data collection should be accurate, timely, complete and subject to regular audit and validation.

4.3.4 Staff should be supported by appropriate training programmes.

4.3.5 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there may be services which require alternative processes.

4.4 NEW DIAGNOSTIC REQUESTS

4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.

4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.

4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.

4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.

4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

4.4.7 Inappropriate and inadequate requests should be returned to the referral source. Minimum referral criteria is being developed to ensure the referral process is robust.

4.5 URGENT AND ROUTINE APPOINTMENTS

4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.

4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.

4.5.4 A minimum of three weeks notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients who refuse short notice appointments (i.e. less than three weeks notice) will not have their waiting time reset in line with guidance on reasonable offers.

4.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

4.6 CHRONOLOGICAL MANAGEMENT

4.6.1 Patients of equal clinical priority will be selected for appointment in chronological order and Trusts must ensure that regional standards and targets in relation to waiting times and booking requirements are met. The process of selecting patients for diagnostic investigations is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources.

4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

4.7.1 Booking will enable patients to have an opportunity to contact the service and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

4.8 REASONABLE OFFERS

4.8.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

4.8.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

4.8.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

4.9 PATIENT CANCELLATIONS (CNAS) AND DID NOT ATTENDS (DNAS)

4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

4.9.2 There may be instances for follow-up patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

4.9.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

4.9.4 If a patient cancels their appointment, the following process must be implemented.

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

4.9.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

4.10 TRANSFERS BETWEEN HOSPITALS

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

4.10.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly.

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

4.11.1 One of the major issues regarding the operation of healthcare services is the capacity lost due to cancelled or reduced clinics at short notice. This has negative consequences for patients and on the ability to successfully implement booking requirements. Clinic or session cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.

4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.

4.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

4.12 SESSION OUTCOME MANAGEMENT

4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.

4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.

4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.

4.12.4 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

4.13.1 DIAGNOSTIC TEST OUTCOME

4.13.1 The outcome of the diagnostic test must be available to the referrer without undue delay. A standard for the reporting turnaround time of tests will be introduced during 2008 and Trusts will be expected to monitor and report compliance to the standard.

4.14 FOLLOW UP APPOINTMENTS

4.14.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

4.15.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

4.15.2 Templates will identify the number of slots available for new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

4.15.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for session template changes.

4.15.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

4.16 VALIDATION

4.16.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times.

4.16.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

4.16.3 For patients in specialties which still issue fixed appointments, they will be contacted to establish whether they require their appointment.

4.16.4 Until follow-up and planned appointments are booked, the validation process will apply to follow up appointments.

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

4.17.1 Trusts should ensure that the relevant standards in the Elective Admissions section of this document are adhered to.

4.18 PLANNED PATIENTS

4.18.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

4.18.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

4.18.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.19 HOSPITAL INITIATED CANCELLATIONS

4.19.1 No patent should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.

4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.

4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

4.19.4 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.19.5 Where patients are cancelled on the day of a test as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.19.6 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of hospital initiated reasons, i.e. equipment failure, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

4.20.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

4.20.2 Where different clinicians are working together will perform more than one test at one time the patient should be added to the waiting list of the clinician for the priority test with additional clinicians noted, subject to local protocols.

4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

4.20.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.

5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.

5.1.3 For the purposes of this section of the protocol, the generic term ‘clinic’ will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

5.2.1 Trusts should ensure that there is a systematic approach to modernising AHP services which will help to improve access to services and quality of care for patients. This section should be read within the overall context of both the IEAP and the specific section governing the management of hospital outpatient services.

5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.

5.2.3 Booking will enable patients to have an opportunity to contact the hospital and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

5.3 CALCULATION OF THE WAITING TIME

5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.

5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12.**

5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.

5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.

5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.

5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.

5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.

5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.

5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

necessary information. If this cannot be gained, the referral should be returned to the referral source.

5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.

5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.

5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.

5.5.3 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered an earlier appointment. Patients refusing short notice appointments (i.e. less than three weeks notice) will not have their waiting time clock reset, in line with guidance on reasonable offers.

5.5.4 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

5.6 CHRONOLOGICAL MANAGEMENT

5.6.1 Patients, within each clinical priority category, should be selected for booking in chronological order, i.e. based on the date the referral was received. Trusts should ensure that local administrative systems have the capability and functionality to effectively operate a referral management and booking system that is chronologically based.

5.7 CAPACITY PLANNING AND ESCALATION

5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

5.8.3 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of cancellation as the patient has entered into an agreement with the Trust.

5.8.3 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

5.9 AHP SERVICE INITIATED CANCELLATIONS

5.9.1 No patent should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable appointment date, ideally at the time of cancellation, and no more than 6 weeks in advance. The Trust must ensure that the new appointment date is within the maximum waiting time guarantee.

5.9.2 The patient should be informed of the reason for the cancellation and the date of the new appointment. This should include an explanation and an apology on behalf of the Trust.

5.9.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.9.4 AHP service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of AHP service initiated reasons, i.e. equipment failure, staff sickness, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.10 MAXIMUM WAITING TIME GUARANTEE

5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.

5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.

5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

5.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

5.12 CLINIC OUTCOME MANAGEMENT

5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.

5.12.2 When the assessment/treatment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.13 REVIEW APPOINTMENTS

5.13.1 All review appointments must be made within the time frame specified by the practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the practitioner. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the practitioner.

5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

5.13.3 If domiciliary review appointment is required within 6 weeks, the appointment date should be agreed with the patient and confirmed in writing by the booking office. Where a domiciliary review appointment is required outside 6 weeks, the patient should be managed on a review waiting list, within the indicative date recorded, and booking in line with the booking principles outlined.

5.14 CLINIC TEMPLATE MANAGEMENT

5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

5.14.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.

5.14.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.15 ROBUSTNESS OF DATA / VALIDATION

5.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure Primary Targeting Lists are accurate and robust at all times.

5.15.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

6.1 INTRODUCTION

6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.

6.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

6.2 COMPUTER SYSTEMS

6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.

6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.

6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.

6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

6.3.3 Patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs). Any periods of suspension are subtracted from the patients overall waiting time.

6.4 STRUCTURE OF WAITING LISTS

6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.

6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking “is this patient suitable for day case treatment?” towards a default position where they ask “what is the justification for admitting this patient?” The Trust’s systems, processes and physical space should be redesigned and organized on this basis.

6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.

6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.

6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.

6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.

6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.

6.6.3 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

6.7.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner and confirmed in writing.

6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.

6.7.4 If the patient is offered an admission within a shorter notice period and it is refused, the waiting time cannot be recalculated.

6.7.5 If the patient however accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of that admission as the patient has entered into an agreement with the Trust.

6.7.6 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

6.8 SUSPENDED PATIENTS

6.8.1 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for social or

medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc).

- A maximum period not exceeding 3 months.

6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.

6.8.3 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

6.8.4 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

6.8.5 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

6.8.6 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for surgery.

6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.

6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

6.8.9 Trusts should ensure that due regard is given to the guidance on reasonableness in their management of suspended patients.

6.9 PLANNED PATIENTS

6.9.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria (e.g. check cystoscopy).

6.9.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

6.9.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13.**

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If a second admission offer is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

6.10.2 Patients who DNA

If a patient DNAs their first admission date, the following process must be implemented:

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

6.10.3 In a period of transition where fixed TCIs are still being issued, patients should have two opportunities to attend.

6.10.4 Following discharge patients will be added to the waiting list at the written request of the referring GP and within a four week period from date of discharge. Patients should be added to the waiting list at the date of the written request is received.

6.10.5 It is acknowledged that there may be exceptional circumstances for those patients identified as being ‘at risk’ (children, vulnerable adults).

6.10.6 No patient should have his or her operation cancelled prior to admission. If Trusts cancel a patient’s admission/operation in advance of the anticipated TCI date, the waiting time clock (based on the original date to admit) will not be reset and the patient will be offered an alternative reasonable guaranteed future date within a maximum of 28 days.

6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.

6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

6.10.9 Trusts will make best efforts to ensure that a patient's operation is not cancelled a second time for non clinical reasons.

6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.

6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:

- Be agreed with the patient
- Be recorded in the patient's notes
- Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.

6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.

6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.

6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.

6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.

6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.

6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.

6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNA THEIR PRE OPERATIVE ASSESSMENT

6.14.1 Please refer to the guidance outlined in the Outpatient section.

6.15 VALIDATION OF WAITING LISTS

6.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis, and ideally on a weekly basis as waiting times reduce. This is essential to ensure the efficiency of the elective pathway at all times.

6.15.2 As booking processes are implemented and waiting times reduce, there will no longer be the need to validate patients by letter. For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their admission.

6.15.3 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

6.16.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

6.16.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

6.16.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

6.17.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

6.17.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Inpatient Transfers can be found in **Appendix 15b.**

INTEGRATED ELECTIVE ACCESS PROTOCOL

June 2020

Integrated Elective Access Protocol

Protocol Summary -

The purpose of this protocol is to outline the approved procedures for managing elective referrals to first definitive treatment or discharge.

Version	**2.0** This guidance replaces the Integrated Elective Access Protocol, 30th April 2008.
Status	Draft for approval
Date	30 June 2020

Integrated Elective Access Protocol

Version

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

Integrated Elective Access Protocol Review Group

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Integrated Elective Access Protocol

Document control

The current and approved version of this document can be found on the Department of Health website https://www.health-ni.gov.uk and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	1 April 2021

Monitoring compliance with protocol

Monitoring compliance with the processes in this document should be part of Trusts internal audit processes.

Contents

Abbreviations

AHP	Allied Health Professional
CCG	Clinical Communication Gateway
CNA	Could Not Attend (appointment or admission)
DNA	Did Not Attend (appointment or admission)
DOH	Department of Health
CPD	Health and Social Care Commissioning Plan and Indicators of Performance Direction,
E Triage	An electronic triage system
GP	General Practitioner
HR	Human Resources (Trusts)
ICU	Intensive Care Unit
IEAP	Integrated Elective Access Protocol
IS	Independent Sector (provider)
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
LOS	Length of Stay
MDT	Multidisciplinary Team
NI	Northern Ireland
PAS	Patient Administration System, which in this context refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting.
PTL	Primary Targeting List
SBA	Service and Budget Agreement
TCI	To Come In (date for patients)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied help professional (AHP) bookings, including cancer pathways and waiting list management.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.

1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

- Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Increase the number of patients with a booked outpatient or in-patient / daycase appointment, thereby minimising Did Not Attends (DNAs), cancellations (CNAs), and improving the patient experience.
- Reduce the number of cancelled operations for non-clinical reasons.

1.1.5 This protocol aims to ensure that a consistent approach is taken across all Trusts. The principles can be applied to primary and community settings, however it is recommended that separate guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.6 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic, inpatient and AHP waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for treatment.

1.1.7 This protocol will be reviewed regularly to ensure that Trusts' policies and procedures remain up to date and that the guidance is consistent with good practice and changes in clinical practice, locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.2 METHODOLOGY

1.2.1 The Department of Health (DOH) has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.2.4 For the purposes of this protocol, the term;

- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
- elective admissions refer to inpatient and daycase admissions,
- inpatient refers to inpatient and daycase elective treatment,
- diagnostic refers to patients who attend for a scan / test or investigation,
- AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
- partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
- fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
- virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
- PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.

1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.

1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.

1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.

1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in (TCI).

1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.

1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.

1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.

1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.

1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient’s information.

1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified

and prioritised at the point of referral and appropriate arrangements made. Trusts must have mechanisms in place to identify such cases.

Have we anything in place for 1.3.10

1.3.11 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.4.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.4.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.4.6 The definition of a booked appointment is:

a) The patient is given the choice of when to attend or have a virtual appointment.
b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
d) Patients will be contacted by telephone twice (morning and afternoon).
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.4.8 Principles for booking Urgent Pathway patients:

a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.

c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.

d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.

e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.

b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.

c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
Rotas are not normally available 8 weeks out (annual leave/study leave notification period is 6 weeks. What escalation policy is being followed and where are the capacity gaps being escalated to? If this is an already known and accepted capacity gap, eg, through discussions with HSCB, vacant posts, do we always have to escalate?

d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).

e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.
c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.4.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

Is there any provision to change date required if patient does not accept reasonable offer?

1.5 VIRTUAL ACTIVITY

1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.

1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.
Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.

1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

1.6.3 The protocol should require a **minimum** of **six** weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes **six** weeks in advance.

1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

Have we anything set up for the ongoing clinical validation

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.

2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.

2.1.4 Fixed appointments should only be used in exceptional circumstances.

2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

Is there anything we need to have n place here?

2.2 KEY PRINCIPLES

2.2.1 Referrals into Trusts should be pooled where possible within specialties.

2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.

1. Red flag (suspect cancer),
2. urgent and
3. routine.

No other clinical priority categories should be used for outpatient services. There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes that would make sense

2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

2.2.4 Patient appointments for new and review should be **partially booked.** **In the case of red flag appointments and 14 day target, it is not always possible to partial book appointments. The principles in section 1 are applied, ie the 2 attempts at telephone contacts and 1 fixed appointment.**

2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

2.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

2.2.10 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.

2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

2.3 NEW REFERRALS

2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.

2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

2.5 REASONABLE OFFERS

2.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

2.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

2.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

2.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

2.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

2.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

2.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

2.6 REVIEW APPOINTMENTS

2.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

2.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

2.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

2.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

2.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

2.7.1 DNAs – New Outpatient

If a patient DNAs their new outpatient appointment the following process must be followed:

2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

2.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

2.7.1(d) *Where patients are discharged from the waiting list (ref. 2.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

2.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.

2.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2 DNAs – Review Outpatient

If a patient DNAs their review outpatient the following process must be followed:

2.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

2.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

2.7.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks*

of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.

2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

2.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2(h) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

Is there any provision to change date required if patient does not accept reasonable offer/DNA or the consultant changes plan following review of notes?

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

If a patient cancels their outpatient appointment the following process must be followed:

2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

2.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

2.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

2.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

2.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

2.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

2.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

2.8.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

2.9 CLINIC OUTCOME MANAGEMENT

2.9.1 Changes in the patient's details must be updated on PAS and the medical records on the date of the clinic.

2.9.2 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

2.10 CLINIC TEMPLATE CHANGES

2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

2.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

2.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

2.12.1 Registrations that have been opened on PAS should **not** be left open. When a patient referral for a new outpatient appointment has been opened on PAS, and their referral information has been recorded correctly, the patient will appear on the waiting list and will continue to do so until they have been seen or discharged in line with the earlier sections of this policy.

2.12.2 When a patient has attended their new outpatient appointment their outcome should be recorded on PAS within **three** working days of the appointment. The possible outcomes are that the patient is:

- added to appropriate waiting list,
- discharged,
- booked into a review appointment or
- added to a review waiting list.

If one of the above actions is not carried out the patient can get lost in the system which carries a governance risk.

2.13 TIME CRITICAL CONDITIONS

2.13.1 All referrals for new patients with time critical conditions, should be booked in line with the agreed clinical pathway requirement for the patient and within a maximum of the regionally recognised defined timescale from the receipt of the referral (e.g. for suspect cancer (red flag) and rapid access angina assessment the timescale is 14 days).

2.13.2 Patients will be contacted by phone and if telephone contact cannot be made, a fixed appointment will be issued.

2.13.3 If the patient does not respond to an offer of appointment (by phone and letter) the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.

2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.

2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.

2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re;

- Acute activity definitions.
- Effective Use of Resources policy.

2.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage)
- Biologic therapies activity.
- Cancer related information.
- Centralised funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Outpatients who are to be treated for Glaucoma.
- Management of referrals for outpatient services.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

3.1 INTRODUCTION

3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.

3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

3.1.3 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations.** Local booking polices should be developed accordingly.

3.2 KEY PRINCIPLES

3.2.1 Referrals into Trusts should be pooled as the norm where possible.

3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for diagnostic services.

3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable)**.** Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.

3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.

3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.

3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

3.2.11 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there will be services which require alternative processes.

3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.

3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.

3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.

3.3.3 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.

3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.

3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

3.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointments, and
- at least **one** offer must be within Northern Ireland (NI), except in those cases where there are no alternative providers within NI.

The IT Systems currently being used for the management of the majority of diagnostics do not facilitate partial booking, however, the fixed appointment letters do ask patients to confirm and are issued with 3 weeks' notice where appropriate. The diagnostic booking teams follow this up with telephone calls to patients to confirm attendances.

3.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

3.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

3.5.5 Providers should have robust audit procedures in place to demonstrate compliance with the above.

3.5.6 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

3.6 FOLLOW UP APPOINTMENTS

3.6.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a session appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable follow up date should be discussed and agreed with the clinician.

3.6.2 Patients must be recorded on the IT system as requiring to be seen within a clinically indicated time. Trusts should actively monitor follow up patients on the review list to ensure that they do not go past their indicative time of treatment.

3.6.3 Follow up patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.

3.6.4 Follow up patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with management guidance for follow up pathway patients.

3.7 PLANNED PATIENTS

3.7.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

3.7.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

3.7.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

3.8.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

3.8.2 Where different clinicians working together perform more than one test at one time, the patient should be added to the waiting list of the clinician for the priority test (with additional clinicians noted) subject to local protocols.

3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

3.8.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

There would be concern that a patient is only added to one waiting list, eg, a patient could require a number of different diagnostic tests to reach diagnosis and treatment plan, with varying waiting times for these tests, eg, a patient could be referred for a CT examination but also be added to the waiting list for an endoscopy procedure. A patient on cancer pathway could require PET and CT – these are different radiology modalities with different waiting lists. Cardiac patients could be listed for different examinations, eg, echo, stress test etc with varying waiting times.

The concern would be the risk that the patient would be closed off the system after the initial investigation or before all tests completed if only added to one waiting list.

3.9 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

3.9.1 <u>DNAs – Diagnostic Appointment</u>

If a patient DNAs their diagnostic appointment the following process must be followed:

3.9.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should be offered.

3.9.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

3.9.1(d) *Where patients are discharged from the waiting list (ref. 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

3.9.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(f) Where a patient DNAs a fixed diagnostic appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

If a patient DNAs their follow up diagnostic appointment the following process must be followed:

3.9.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

3.9.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

3.9.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patients GP, where they are not the referring clinician) should also be informed of this.

3.9.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*

3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.2(f) Where a patient DNAs a fixed follow up appointment, including virtual appointments, where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

3.9.2(g) There may be instances for follow up patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

If a patient cancels their diagnostic appointment the following process must be followed:

3.9.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

3.9.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

3.9.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

3.9.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

3.10.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

3.10.2 The patient should be informed of the cancellation and the date of the new appointment.

3.10.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

3.10.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

3.11 SESSION OUTCOME MANAGEMENT

3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.

3.11.2 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of session.

3.12 SESSION TEMPLATE CHANGES

3.12.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

3.12.2 Templates will identify the number of slots available for new red flag, new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

3.12.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for session template changes.

3.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.13.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

3.13.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with PAS technical guidance (see also Reasonable Offers, ref. 3.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

3.14 TECHNICAL GUIDANCE

3.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

3.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).

- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

4.1 INTRODUCTION

4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.

4.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

Have we anything in place for this?

4.2 KEY PRINCIPLES

4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.

1. active,
2. planned and
3. suspended.

4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for inpatient and daycase services.

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes this would make sense

4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.

4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

4.2.5 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
Is this relevant to elective? Consultants normally select cases based on clinical priority etc.

4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.

4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.

4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.

4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.

4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.

4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.

4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.

4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

4.5.3 A reasonable offer is defined as:

- an offer of admission, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a choice of **two** TCI dates, and
- at least **one** of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

The majority of elective procedures are fixed appointments, based on when consultants are available for theatre sessions, availability of ICU capacity if required, volume of predicted in-patient beds etc. This is a complex booking process which can be difficult to adapt with partial booking.
Does there need to be a guidance for fixed elective offers?

4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.

4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional

exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.

4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.

4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.

4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within **two** working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.

4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.

4.7.2 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).
- A recommended maximum period not exceeding **three** months.

4.7.3 No patient should be suspended from the waiting list without a suspension end date.

4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.

4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

4.7.9 Recommended practice is that no more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

4.8 PLANNED PATIENTS

4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.

4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.

4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

4.9.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

4.10 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR ADMISSION

DNAs – Inpatient/Daycase

4.10.1 If a patient DNAs their inpatient or daycase admission, the following process must be followed:

4.10.1(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second date should be offered or whether the patient can be discharged.

4.10.1(b) Where the clinical decision is that a second admission should be offered, the admission date must be agreed with the patient. Trusts should put in place local agreements with clinicians regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

4.10.1(c) Patients who DNA and are not discharged but offered a second date will have their waiting time clock reset to the date of the DNA.

4.10.1(d) Where the clinical decision is that a second date should not be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

4.10.1(e) *Patients being discharged from the list should be advised to contact the Trust if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original date, a clinical decision may be made to offer a second date. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

Is there a process in place for this the same as outpatients were a letter is sent to the patient and they phone in ?

4.10.1(f) If the patient DNAs the second admission offered then the above steps should be followed.

4.10.1(g) Where a patient DNAs a fixed admission date (i.e. they have not had the opportunity to agree/ confirm the date and time of their admission), they should be offered another date.

4.10.1(h) If the patient DNAs this second fixed admission, they will be removed from the waiting list and the steps in 4.10.1(e) should be followed.

4.10.1(i) Where a patient DNAs a pre-assessment appointment they will be offered another date. If they DNA this second pre-assessment appointment, they will be removed from the waiting list and the above steps in 4.10.1(e) should be followed.

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

If a patient cancels their inpatient/ daycase admission the following process must be followed:

4.10.2(a) Patients who cancel an agreed reasonable offer will be given a second opportunity to book an admission, which should ideally be within **six weeks** of the original admission date.

4.10.2(b) If a second agreed offer of admission is cancelled, the patient will not be offered a **third** opportunity.

4.10.2(c) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second admission, the Trust may exercise discretion to offer a third admission - this should include seeking a clinical review of the patient's case where this is appropriate.

4.10.2(d) Where a decision is taken not to offer a further admission, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

4.10.2(e) Where a patient CNAs a pre-assessment appointment they should be offered another date. If they CNA this second pre-assessment appointment, the above steps should be followed, as per 4.10.1(h).

4.10.2(f) Patients who cancel their procedure (CNA) will have their waiting time clock reset to the date the Trust was informed of the cancellation.

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.

4.11.3 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.11.4 Where patients are cancelled on the day of an admission/operation as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.

4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

4.13.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Recording inpatients who need to be added to the 28 day cardiac surgery waiting list.
- Recording paediatric congenital cardiac surgery activity.
- Centralised Funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Patients who are added to a waiting list with a planned method of admission.
- Pre-operative assessment clinics.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Patients waiting for a review outpatient appointment.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

GUIDANCE FOR MANAGEMENT OF ELECTIVE ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services, including those patients whose referral is managed virtually.

5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.

5.1.3 The administration and management of the AHP pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

5.1.4 For the purposes of this section of the protocol, the generic term ‘clinic’ will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people’s own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.

5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.

5.1.7 Fixed appointments should only be used in exceptional circumstances.

5.1.8 In all aspects of the AHP booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

5.2 KEY PRINCIPLES

5.2.1 All referrals, appointments and AHP waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list and allocated according to urgency of the treatment. Trusts will manage new patients in two priorities, i.e.

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.

5.2.3 Patient appointments for new and review should be **partially booked.** Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.

5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.

5.2.6 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

5.2.7 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

5.2.8 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

5.2.9 Trusts should **not** use manual administration systems to record and report patients who have been booked.

5.2.10 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

5.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

5.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

5.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

5.3.5 Following prioritisation, referrals must be actioned on PAS or the relevant electronic patient administration system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

5.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

5.4 CALCULATION OF THE WAITING TIME

5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.

5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.

5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

5.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

5.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

5.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.6 REVIEW APPOINTMENTS

5.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

5.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

5.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

5.7.1 DNAs – New AHP Appointments

If a patient DNAs their new appointment, the following process must be followed:

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(b) Under exceptional circumstances the AHP professional may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with AHP professionals, regarding those referrals or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

5.7.1(d) *Where patients are discharged from the waiting list (ref. 5.7.1(a)) they should be advised to contact the Trust booking office within* ***four*** *weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the* ***four*** *week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the* ***four*** *week period they cannot be reinstated*.

5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.

5.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.2 DNAs – Review Appointments

If a patient DNAs their review appointment the following process must be followed:

5.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

5.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.

5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.

5.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

5.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.3 **CNAs –** Patient initiated cancellations (new and review)

If a patient cancels their AHP appointment the following process must be followed:

5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

5.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring professional (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

5.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

5.7.4 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

5.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

5.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

5.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.8.4 Service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.9 CLINIC OUTCOME MANAGEMENT

5.9.1 There are a number of locations within Trusts where patients present for their AHP consultation. This protocol applies to all AHP areas. It is the responsibility of the PAS/ IT system user managing the attendance to maintain data quality.

5.9.2 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

5.9.3 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.10 CLINIC TEMPLATE CHANGES

5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

5.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers.

5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref. 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

5.12 TECHNICAL GUIDANCE

5.12.1 See also Public Health Agency; https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015 re Guidance for monitoring the Ministerial AHP 13 week access target.

5.12.2 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

5.12.3 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage).
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020).
- AHP Virtual Consultation Guidance (to be issued).

Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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INTEGRATED ELECTIVE ACCESS PROTOCOL
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CONTENTS

ABBREVIATIONS

AHP	Allied Health Professional
BCC	Booking and Contact Centre (ICATS)
CNA	Could Not Attend (Admission or Appointment)
DHSSPSNI	Department of Health, Social Services and Public Safety
DNA	Did Not Attend (Admission or Appointment)
DTLs	Diagnostic Targeting Lists
ERMS	Electronic Referrals Management System
GP	General Practitioner
HIC	High Impact Changes
HROs	Hospital Registration Offices
ICATS	Integrated Clinical Assessment and Treatment Services
ICU	Intensive Care Unit
LOS	Length of Stay
PAS	Patient Administration System
PTLs	Primary Targeting Lists
SDU	Service Delivery Unit
TCI	To Come In (date for patients)

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

1.1.6 The DHSSPSNI has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.

1.1.8 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.

1.1.10 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.

1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

administration systems, whether in a hospital or community setting, or an electronic or manual system.

1.1.13 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on PAS and the waiting times for treatment. All staff involved in the implementation of this protocol, clinical and clerical, will undertake initial training and regular annual updating. Trusts will provide appropriate information to staff so they can make informed decisions when implementing and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2 UNDERPINNING PRINCIPLES

1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.

1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.

1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

1.2.5 Change No 1 within the publication "10 High Impact Changes for Service Improvement and Delivery"[1] focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.

1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.

1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.

1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.

1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.

1.2.10 This "bottom up" approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.

1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

[1] "10 High Impact Changes for Service Improvement and Delivery" – September 2004, NHS Modernisation Agency, www.modern.nhs.uk/highimpactchanges

1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.

1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.

1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.

1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.

1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

1.3.4 Trusts must be committed to training and developing staff and providing the supporting systems to ensure that together we can bring about the improvement in patient care.

1.4 REGIONAL TARGETS

1.4.1 The targets in respect of elective treatments are:

- A maximum waiting time of 13 weeks for inpatient and daycase admissions by March 2009
- A maximum waiting time of 9 weeks for a 1st outpatient appointment by March 2009
- A maximum waiting time of 9 weeks for a diagnostic test by March 2009
- A maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009
- By March 2009, sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis
- By March 2009, 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days

1.5 DELIVERY OF TARGETS

1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.

1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

and strategic planning processes. Divisional, specialty and departmental managers will be expected to have produced implementation plans setting out the key steps they need to take to ensure the delivery of the Trust and Departmental protocol objectives within the area(s) of their responsibility. Trusts will manage implementation through a regular review of "local" divisional, specialty and departmental plans for the implementation of waiting and booking targets.

1.5.3 It is expected that Trusts will develop robust information systems to support the delivery of these targets. Daily management information should be available at both managerial and operational level so that staff responsible for selecting patients are working from up to date and accurate information. Future developments should also look towards a clinic management system which will highlight the inefficiencies within the outpatient setting.

1.6 CAPACITY

1.6.1 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets.

1.6.2 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions
- Session length
- Average procedure / slot time
- Average length of stay

1.6.3 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients and diagnostics at service level.

1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.

1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.

1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.

1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.

1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

to expedite solutions and agree these through the accountability review process.

1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.

1.7.2 Offering the patient choice of date and time is essential in agreeing and booking appointments with patients. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them. This takes away the uncertainty of not knowing how long the wait will be as patients are advised of their expected wait. Advanced booking in this way also gives patients notice of the date so that they can make any necessary arrangements, such as child care or work arrangements.

1.7.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.

1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.

1.7.6 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.7.7 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

1.7.9 There are 3 main patient appointment types to be booked. Booking systems for these appointments should be designed around an agreed patient pathway and accepted clinical practice. They are:

a) New Urgent patients (including suspected cancer)
b) New Routine patients
c) Review patients

1.7.10 Clinic templates should be constructed to ensure that sufficient capacity is carved out to meet the local and maximum waiting time guarantees for new patients, and the clinical requirements of follow-up patients.

1.7.11 Principles for booking Cancer Pathway patients

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral
b) Dedicated registration functions for red flag and suspected cancer referrals should be in place within centralised HROs
c) Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients
d) Patients will be contacted by telephone twice (morning and afternoon)
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of 3 days of receipt of referral
f) Systems should be established to ensure the Patient Tracker / MDT Co-ordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient

1.7.12 Principles for booking Urgent Pathway patients

a) Local agreements should be in place with consultants to determine the timeframe within which urgent patients should be booked, and made explicit to booking teams

b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency
d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.7.13 Principles for booking Routine Pathway patients

a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments
b) Referrals will be received, registered within one working day at HRO's and forwarded to consultants for prioritisation
c) Patients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow
d) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified
e) Patients should be selected for booking in chronological order from the PTL
f) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment

1.7.14 Principles for Booking Review Patients

a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list
c) Patients will be added to the review waiting list with an indicative date of treatment and selected for booking according to this date
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment

1.7.15 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey. Examples of this include:

a) midwives contacting patients directly by telephone to arrange their appointment
b) clinical genetics services where family appointments are required
c) mental health or vulnerable children's services where patients may need additional reminders or more than one professional contacted if patients fail to make an appointment.

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 **(Appendix 1).**

2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.

2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.

2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.

2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).

2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting**.**

2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.

2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.

2.2.7 Data collection should be accurate, timely, complete and subject to regular audit and validation.

2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.

2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.

2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

2.3.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.

2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.

2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.

2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

Flowcharts illustrating the Triage Outcomes Process can be found in **Appendix 2.**

2.5 BOOKING

2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.

2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.

2.5.3 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

2.6 REASONABLE OFFERS

2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.

2.6.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

2.6.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date the service was notified of the cancellation, as the patient has entered into an agreement with the Trust.

2.6.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

2.7 MANAGEMENT OF PATIENTS WHO CANCELLED OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

2.7.1 If a patient DNAs their first ICATS appointment the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

2.7.2 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.

2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4.**

2.8 MAXIMUM WAITING TIME GUARANTEE

2.8.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen. This will ensure that all patients waiting for an appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.

2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.

2.10.2 Changes in the patient's details must be updated on ERMS and the medical records on the date of clinic.

2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

2.11.1 All review appointments must be made within the time frame specified by the ICATS practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the ICATS practitioner.

2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

2.12.1 Templates should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.

2.12.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5.**

2.13 VALIDATION

2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.

2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6.**

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.

3.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.

3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.

3.2.2 In cases where referrals bypass the dedicated HRO’s, (e.g. sent directly to a consultant), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the HRO and registered at the date on the date stamp.

3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.2.3 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

3.3 KEY PRINCIPLES

3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.

3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7.**

3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

3.3.4 Maximum waiting times for urgent patients should be agreed locally with clinicians, and made explicit to staff booking these patients to ensure that they are appointed within the clinical timeframe indicated by the consultant and capacity issues quickly identified and escalated.

3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.

3.3.6 Data collection should be accurate, timely, complete and subject to regular audit and validation.

3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.

3.3.8 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

3.4 NEW REFERRALS

3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.

3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.

3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.

3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**

3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9.**

3.5 URGENT AND ROUTINE APPOINTMENTS

3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.

3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

how the patient will be booked, should be included on the acknowledgement letter.

3.5.4 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients refusing short notice appointments (i.e. less than three weeks' notice) will not have their waiting time reset, in line with guidance on reasonable offers.

3.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

3.6 BOOKING

3.6.1 All new and review consultant led outpatient clinics should be able to book their appointment. This will entail patients having an opportunity to contact the hospital and agree a convenient date and time for their appointment. The use of the Patient Choice field on PAS is mandatory. The only fields that should be used are 'Y' to indicate that the appointment has been booked or 'N' to indicate that an appointment has not been booked. No other available field should be used as compliance with booking requirements will be monitored via the use of the Patient Choice field. For non-ISOFT and manual administration systems, Trusts should ensure that they are able to record and report patients who have been booked.

3.7 REASONABLE OFFERS

3.7.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.7.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

3.7.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

3.7.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

3.8 MANAGEMENT OF PATIENTS WHO CANCELLED (CNA) OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

3.8.1 If a patient DNAs their outpatient appointment, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

3.8.2 There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to partial booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

3.8.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

3.8.4 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

3.8.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

3.8.6 The Implementation Procedure on DNAs and Cancellations can be found in **Appendix 4.**

3.9 MAXIMUM WAITING TIME GUARANTEE

3.9.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen in the Outpatient Clinic. This will ensure that all patients waiting for an outpatient appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

3.10 COMPLIANCE WITH LEAVE PROTOCOL

3.10.1 Capacity lost due to cancelled or reduced clinics at short notice has negative consequences for patients and on the Trust's ability to successfully

implement booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.

3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10.**

3.11 CLINIC OUTCOME MANAGEMENT

3.11.1 There are a number of locations within Trusts where patients present for their outpatient consultation. This protocol applies to all outpatient areas. It is the responsibility of the PAS user managing the attendance to maintain data quality.

3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.

3.11.3 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

3.11.4 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic. The implementation procedure for the Management of Clinic Outcomes can be found in **Appendix 11.**

3.12 REVIEW APPOINTMENTS

3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.

3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

3.13.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees for patients.

3.13.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

3.13.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5.**

3.14 VALIDATION

3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6.**

3.14.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.15.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

3.15.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Outpatient Transfers can be found in **Appendix 15a.**

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

4.1.2 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.

4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14.** All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.

4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

4.2.3 Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.2.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

4.3 KEY PRINCIPLES

4.3.1 Trusts must have in place arrangements for pooling all referrals unless there is specific clinical information which determines that the patient should be seen by a particular consultant with sub-specialty interest.

4.3.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list, and patients managed in 2 streams, i.e. urgent and routine. Session or clinic templates should be constructed to ensure enough capacity is available to treat each stream within the maximum waiting time guarantees outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

4.3.3 Data collection should be accurate, timely, complete and subject to regular audit and validation.

4.3.4 Staff should be supported by appropriate training programmes.

4.3.5 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there may be services which require alternative processes.

4.4 NEW DIAGNOSTIC REQUESTS

4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.

4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.

4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.

4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.

4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

4.4.7 Inappropriate and inadequate requests should be returned to the referral source. Minimum referral criteria is being developed to ensure the referral process is robust.

4.5 URGENT AND ROUTINE APPOINTMENTS

4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.

4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.

4.5.4 A minimum of three weeks notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients who refuse short notice appointments (i.e. less than three weeks notice) will not have their waiting time reset in line with guidance on reasonable offers.

4.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

4.6 CHRONOLOGICAL MANAGEMENT

4.6.1 Patients of equal clinical priority will be selected for appointment in chronological order and Trusts must ensure that regional standards and targets in relation to waiting times and booking requirements are met. The process of selecting patients for diagnostic investigations is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources.

4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

4.7.1 Booking will enable patients to have an opportunity to contact the service and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

4.8 REASONABLE OFFERS

4.8.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

4.8.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

4.8.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

4.9 PATIENT CANCELLATIONS (CNAS) AND DID NOT ATTENDS (DNAS)

4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

4.9.2 There may be instances for follow-up patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

4.9.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

4.9.4 If a patient cancels their appointment, the following process must be implemented.

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

4.9.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

4.10 TRANSFERS BETWEEN HOSPITALS

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

4.10.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly.

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

4.11.1 One of the major issues regarding the operation of healthcare services is the capacity lost due to cancelled or reduced clinics at short notice. This has negative consequences for patients and on the ability to successfully implement booking requirements. Clinic or session cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.

4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.

4.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

4.12 SESSION OUTCOME MANAGEMENT

4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.

4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.

4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.

4.12.4 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

4.13.1 DIAGNOSTIC TEST OUTCOME

4.13.1 The outcome of the diagnostic test must be available to the referrer without undue delay. A standard for the reporting turnaround time of tests will be introduced during 2008 and Trusts will be expected to monitor and report compliance to the standard.

4.14 FOLLOW UP APPOINTMENTS

4.14.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

4.15.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

4.15.2 Templates will identify the number of slots available for new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

4.15.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for session template changes.

4.15.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

4.16 VALIDATION

4.16.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times.

4.16.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

4.16.3 For patients in specialties which still issue fixed appointments, they will be contacted to establish whether they require their appointment.

4.16.4 Until follow-up and planned appointments are booked, the validation process will apply to follow up appointments.

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

4.17.1 Trusts should ensure that the relevant standards in the Elective Admissions section of this document are adhered to.

4.18 PLANNED PATIENTS

4.18.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

4.18.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

4.18.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.19 HOSPITAL INITIATED CANCELLATIONS

4.19.1 No patent should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.

4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.

4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

4.19.4 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.19.5 Where patients are cancelled on the day of a test as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.19.6 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of hospital initiated reasons, i.e. equipment failure, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

4.20.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

4.20.2 Where different clinicians are working together will perform more than one test at one time the patient should be added to the waiting list of the clinician for the priority test with additional clinicians noted, subject to local protocols.

4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

4.20.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.

5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.

5.1.3 For the purposes of this section of the protocol, the generic term ‘clinic’ will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

5.2.1 Trusts should ensure that there is a systematic approach to modernising AHP services which will help to improve access to services and quality of care for patients. This section should be read within the overall context of both the IEAP and the specific section governing the management of hospital outpatient services.

5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.

5.2.3 Booking will enable patients to have an opportunity to contact the hospital and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

5.3 CALCULATION OF THE WAITING TIME

5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.

5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12.**

5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.

5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.

5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.

5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.

5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.

5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.

5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

necessary information. If this cannot be gained, the referral should be returned to the referral source.

5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.

5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.

5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.

5.5.3 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered an earlier appointment. Patients refusing short notice appointments (i.e. less than three weeks notice) will not have their waiting time clock reset, in line with guidance on reasonable offers.

5.5.4 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

5.6 CHRONOLOGICAL MANAGEMENT

5.6.1 Patients, within each clinical priority category, should be selected for booking in chronological order, i.e. based on the date the referral was received. Trusts should ensure that local administrative systems have the capability and functionality to effectively operate a referral management and booking system that is chronologically based.

5.7 CAPACITY PLANNING AND ESCALATION

5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

5.8.3 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of cancellation as the patient has entered into an agreement with the Trust.

5.8.3 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

5.9 AHP SERVICE INITIATED CANCELLATIONS

5.9.1 No patent should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable appointment date, ideally at the time of cancellation, and no more than 6 weeks in advance. The Trust must ensure that the new appointment date is within the maximum waiting time guarantee.

5.9.2 The patient should be informed of the reason for the cancellation and the date of the new appointment. This should include an explanation and an apology on behalf of the Trust.

5.9.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.9.4 AHP service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of AHP service initiated reasons, i.e. equipment failure, staff sickness, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.10 MAXIMUM WAITING TIME GUARANTEE

5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.

5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.

5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

5.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

5.12 CLINIC OUTCOME MANAGEMENT

5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.

5.12.2 When the assessment/treatment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.13 REVIEW APPOINTMENTS

5.13.1 All review appointments must be made within the time frame specified by the practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the practitioner. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the practitioner.

5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

5.13.3 If domiciliary review appointment is required within 6 weeks, the appointment date should be agreed with the patient and confirmed in writing by the booking office. Where a domiciliary review appointment is required outside 6 weeks, the patient should be managed on a review waiting list, within the indicative date recorded, and booking in line with the booking principles outlined.

5.14 CLINIC TEMPLATE MANAGEMENT

5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

5.14.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.

5.14.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.15 ROBUSTNESS OF DATA / VALIDATION

5.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure Primary Targeting Lists are accurate and robust at all times.

5.15.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

6.1 INTRODUCTION

6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.

6.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

6.2 COMPUTER SYSTEMS

6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.

6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.

6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.

6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

6.3.3 Patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs). Any periods of suspension are subtracted from the patients overall waiting time.

6.4 STRUCTURE OF WAITING LISTS

6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.

6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking “is this patient suitable for day case treatment?” towards a default position where they ask “what is the justification for admitting this patient?” The Trust’s systems, processes and physical space should be redesigned and organized on this basis.

6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.

6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.

6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.

6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.

6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.

6.6.3 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

6.7.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner and confirmed in writing.

6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.

6.7.4 If the patient is offered an admission within a shorter notice period and it is refused, the waiting time cannot be recalculated.

6.7.5 If the patient however accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of that admission as the patient has entered into an agreement with the Trust.

6.7.6 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

6.8 SUSPENDED PATIENTS

6.8.1 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for social or

medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc).

- A maximum period not exceeding 3 months.

6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.

6.8.3 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

6.8.4 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

6.8.5 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

6.8.6 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for surgery.

6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.

6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

6.8.9 Trusts should ensure that due regard is given to the guidance on reasonableness in their management of suspended patients.

6.9 PLANNED PATIENTS

6.9.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria (e.g. check cystoscopy).

6.9.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

6.9.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13.**

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If a second admission offer is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

6.10.2 Patients who DNA

If a patient DNAs their first admission date, the following process must be implemented:

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

6.10.3 In a period of transition where fixed TCIs are still being issued, patients should have two opportunities to attend.

6.10.4 Following discharge patients will be added to the waiting list at the written request of the referring GP and within a four week period from date of discharge. Patients should be added to the waiting list at the date of the written request is received.

6.10.5 It is acknowledged that there may be exceptional circumstances for those patients identified as being ‘at risk’ (children, vulnerable adults).

6.10.6 No patient should have his or her operation cancelled prior to admission. If Trusts cancel a patient’s admission/operation in advance of the anticipated TCI date, the waiting time clock (based on the original date to admit) will not be reset and the patient will be offered an alternative reasonable guaranteed future date within a maximum of 28 days.

6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.

6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

6.10.9 Trusts will make best efforts to ensure that a patient's operation is not cancelled a second time for non clinical reasons.

6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.

6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:

- Be agreed with the patient
- Be recorded in the patient's notes
- Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.

6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.

6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.

6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.

6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.

6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.

6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.

6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNA THEIR PRE OPERATIVE ASSESSMENT

6.14.1 Please refer to the guidance outlined in the Outpatient section.

6.15 VALIDATION OF WAITING LISTS

6.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis, and ideally on a weekly basis as waiting times reduce. This is essential to ensure the efficiency of the elective pathway at all times.

6.15.2 As booking processes are implemented and waiting times reduce, there will no longer be the need to validate patients by letter. For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their admission.

6.15.3 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

6.16.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

6.16.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

6.16.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

6.17.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

6.17.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Inpatient Transfers can be found in **Appendix 15b.**

INTEGRATED ELECTIVE ACCESS PROTOCOL

June 2020

Integrated Elective Access Protocol

Protocol Summary -

The purpose of this protocol is to outline the approved procedures for managing elective referrals to first definitive treatment or discharge.

Version	**2.0** This guidance replaces the Integrated Elective Access Protocol, 30th April 2008.
Status	Draft for approval
Date	30 June 2020

Integrated Elective Access Protocol

Version

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

Integrated Elective Access Protocol Review Group

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Integrated Elective Access Protocol

Document control

The current and approved version of this document can be found on the Department of Health website https://www.health-ni.gov.uk and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	1 April 2021

Monitoring compliance with protocol

Monitoring compliance with the processes in this document should be part of Trusts internal audit processes.

Contents

Abbreviations

AHP	Allied Health Professional
CCG	Clinical Communication Gateway
CNA	Could Not Attend (appointment or admission)
DNA	Did Not Attend (appointment or admission)
DOH	Department of Health
CPD	Health and Social Care Commissioning Plan and Indicators of Performance Direction,
E Triage	An electronic triage system
GP	General Practitioner
HR	Human Resources (Trusts)
ICU	Intensive Care Unit
IEAP	Integrated Elective Access Protocol
IS	Independent Sector (provider)
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
LOS	Length of Stay
MDT	Multidisciplinary Team
NI	Northern Ireland
PAS	Patient Administration System, which in this context refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting.
PTL	Primary Targeting List
SBA	Service and Budget Agreement
TCI	To Come In (date for patients)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied help professional (AHP) bookings, including cancer pathways and waiting list management.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.

1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

- Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Increase the number of patients with a booked outpatient or in-patient / daycase appointment, thereby minimising Did Not Attends (DNAs), cancellations (CNAs), and improving the patient experience.
- Reduce the number of cancelled operations for non-clinical reasons.

1.1.5 This protocol aims to ensure that a consistent approach is taken across all Trusts. The principles can be applied to primary and community settings, however it is recommended that separate guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.6 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic, inpatient and AHP waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for treatment.

1.1.7 This protocol will be reviewed regularly to ensure that Trusts' policies and procedures remain up to date and that the guidance is consistent with good practice and changes in clinical practice, locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.2 METHODOLOGY

1.2.1 The Department of Health (DOH) has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.2.4 For the purposes of this protocol, the term;

- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
- elective admissions refer to inpatient and daycase admissions,
- inpatient refers to inpatient and daycase elective treatment,
- diagnostic refers to patients who attend for a scan / test or investigation,
- AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
- partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
- fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
- virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
- PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.

1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.

1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.

1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.

1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in (TCI).

1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.

1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.

1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.

1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.

1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient’s information.

1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified

and prioritised at the point of referral and appropriate arrangements made. Trusts must have mechanisms in place to identify such cases.

Have we anything in place for 1.3.10

1.3.11 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.4.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.4.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.4.6 The definition of a booked appointment is:

a) The patient is given the choice of when to attend or have a virtual appointment.
b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
d) Patients will be contacted by telephone twice (morning and afternoon).
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.4.8 Principles for booking Urgent Pathway patients:

a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.

c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.

d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.

e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.

b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.

c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
Rotas are not normally available 8 weeks out (annual leave/study leave notification period is 6 weeks. What escalation policy is being followed and where are the capacity gaps being escalated to? If this is an already known and accepted capacity gap, eg, through discussions with HSCB, vacant posts, do we always have to escalate?

d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).

e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.
c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.4.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

Is there any provision to change date required if patient does not accept reasonable offer?

1.5 VIRTUAL ACTIVITY

1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.

1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.
Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.

1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

1.6.3 The protocol should require a **minimum** of **six** weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes **six** weeks in advance.

1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

Have we anything set up for the ongoing clinical validation

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.

2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.

2.1.4 Fixed appointments should only be used in exceptional circumstances.

2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

Is there anything we need to have n place here?

2.2 KEY PRINCIPLES

2.2.1 Referrals into Trusts should be pooled where possible within specialties.

2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.

1. Red flag (suspect cancer),
2. urgent and
3. routine.

No other clinical priority categories should be used for outpatient services. There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes that would make sense

2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

2.2.4 Patient appointments for new and review should be **partially booked.** **In the case of red flag appointments and 14 day target, it is not always possible to partial book appointments. The principles in section 1 are applied, ie the 2 attempts at telephone contacts and 1 fixed appointment.**

2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

2.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

2.2.10 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.

2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

2.3 NEW REFERRALS

2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.

2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

2.5 REASONABLE OFFERS

2.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

2.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

2.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

2.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

2.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

2.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

2.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

2.6 REVIEW APPOINTMENTS

2.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

2.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

2.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

2.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

2.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

2.7.1 DNAs – New Outpatient

If a patient DNAs their new outpatient appointment the following process must be followed:

2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

2.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

2.7.1(d) *Where patients are discharged from the waiting list (ref. 2.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

2.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.

2.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2 DNAs – Review Outpatient

If a patient DNAs their review outpatient the following process must be followed:

2.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

2.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

2.7.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks*

of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.

2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

2.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2(h) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

Is there any provision to change date required if patient does not accept reasonable offer/DNA or the consultant changes plan following review of notes?

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

If a patient cancels their outpatient appointment the following process must be followed:

2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

2.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

2.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

2.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

2.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

2.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

2.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

2.8.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

2.9 CLINIC OUTCOME MANAGEMENT

2.9.1 Changes in the patient's details must be updated on PAS and the medical records on the date of the clinic.

2.9.2 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

2.10 CLINIC TEMPLATE CHANGES

2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

2.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

2.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

2.12.1 Registrations that have been opened on PAS should **not** be left open. When a patient referral for a new outpatient appointment has been opened on PAS, and their referral information has been recorded correctly, the patient will appear on the waiting list and will continue to do so until they have been seen or discharged in line with the earlier sections of this policy.

2.12.2 When a patient has attended their new outpatient appointment their outcome should be recorded on PAS within **three** working days of the appointment. The possible outcomes are that the patient is:

- added to appropriate waiting list,
- discharged,
- booked into a review appointment or
- added to a review waiting list.

If one of the above actions is not carried out the patient can get lost in the system which carries a governance risk.

2.13 TIME CRITICAL CONDITIONS

2.13.1 All referrals for new patients with time critical conditions, should be booked in line with the agreed clinical pathway requirement for the patient and within a maximum of the regionally recognised defined timescale from the receipt of the referral (e.g. for suspect cancer (red flag) and rapid access angina assessment the timescale is 14 days).

2.13.2 Patients will be contacted by phone and if telephone contact cannot be made, a fixed appointment will be issued.

2.13.3 If the patient does not respond to an offer of appointment (by phone and letter) the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.

2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.

2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.

2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re;

- Acute activity definitions.
- Effective Use of Resources policy.

2.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage)
- Biologic therapies activity.
- Cancer related information.
- Centralised funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Outpatients who are to be treated for Glaucoma.
- Management of referrals for outpatient services.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

3.1 INTRODUCTION

3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.

3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

3.1.3 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations.** Local booking polices should be developed accordingly.

3.2 KEY PRINCIPLES

3.2.1 Referrals into Trusts should be pooled as the norm where possible.

3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for diagnostic services.

3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable)**.** Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.

3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.

3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.

3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

3.2.11 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there will be services which require alternative processes.

3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.

3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.

3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.

3.3.3 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.

3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.

3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

3.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointments, and
- at least **one** offer must be within Northern Ireland (NI), except in those cases where there are no alternative providers within NI.

The IT Systems currently being used for the management of the majority of diagnostics do not facilitate partial booking, however, the fixed appointment letters do ask patients to confirm and are issued with 3 weeks' notice where appropriate. The diagnostic booking teams follow this up with telephone calls to patients to confirm attendances.

3.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

3.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

3.5.5 Providers should have robust audit procedures in place to demonstrate compliance with the above.

3.5.6 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

3.6 FOLLOW UP APPOINTMENTS

3.6.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a session appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable follow up date should be discussed and agreed with the clinician.

3.6.2 Patients must be recorded on the IT system as requiring to be seen within a clinically indicated time. Trusts should actively monitor follow up patients on the review list to ensure that they do not go past their indicative time of treatment.

3.6.3 Follow up patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.

3.6.4 Follow up patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with management guidance for follow up pathway patients.

3.7 PLANNED PATIENTS

3.7.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

3.7.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

3.7.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

3.8.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

3.8.2 Where different clinicians working together perform more than one test at one time, the patient should be added to the waiting list of the clinician for the priority test (with additional clinicians noted) subject to local protocols.

3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

3.8.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

There would be concern that a patient is only added to one waiting list, eg, a patient could require a number of different diagnostic tests to reach diagnosis and treatment plan, with varying waiting times for these tests, eg, a patient could be referred for a CT examination but also be added to the waiting list for an endoscopy procedure. A patient on cancer pathway could require PET and CT – these are different radiology modalities with different waiting lists. Cardiac patients could be listed for different examinations, eg, echo, stress test etc with varying waiting times.

The concern would be the risk that the patient would be closed off the system after the initial investigation or before all tests completed if only added to one waiting list.

3.9 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

3.9.1 <u>DNAs – Diagnostic Appointment</u>

If a patient DNAs their diagnostic appointment the following process must be followed:

3.9.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should be offered.

3.9.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

3.9.1(d) *Where patients are discharged from the waiting list (ref. 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

3.9.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(f) Where a patient DNAs a fixed diagnostic appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

If a patient DNAs their follow up diagnostic appointment the following process must be followed:

3.9.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

3.9.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

3.9.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patients GP, where they are not the referring clinician) should also be informed of this.

3.9.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*

3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.2(f) Where a patient DNAs a fixed follow up appointment, including virtual appointments, where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

3.9.2(g) There may be instances for follow up patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

If a patient cancels their diagnostic appointment the following process must be followed:

3.9.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

3.9.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

3.9.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

3.9.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

3.10.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

3.10.2 The patient should be informed of the cancellation and the date of the new appointment.

3.10.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

3.10.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

3.11 SESSION OUTCOME MANAGEMENT

3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.

3.11.2 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of session.

3.12 SESSION TEMPLATE CHANGES

3.12.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

3.12.2 Templates will identify the number of slots available for new red flag, new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

3.12.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for session template changes.

3.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.13.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

3.13.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with PAS technical guidance (see also Reasonable Offers, ref. 3.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

3.14 TECHNICAL GUIDANCE

3.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

3.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).

- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

4.1 INTRODUCTION

4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.

4.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

Have we anything in place for this?

4.2 KEY PRINCIPLES

4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.

1. active,
2. planned and
3. suspended.

4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for inpatient and daycase services.

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes this would make sense

4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.

4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

4.2.5 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
Is this relevant to elective? Consultants normally select cases based on clinical priority etc.

4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.

4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.

4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.

4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.

4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.

4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.

4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.

4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

4.5.3 A reasonable offer is defined as:

- an offer of admission, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a choice of **two** TCI dates, and
- at least **one** of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

The majority of elective procedures are fixed appointments, based on when consultants are available for theatre sessions, availability of ICU capacity if required, volume of predicted in-patient beds etc. This is a complex booking process which can be difficult to adapt with partial booking.
Does there need to be a guidance for fixed elective offers?

4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.

4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional

exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.

4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.

4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.

4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within **two** working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.

4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.

4.7.2 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).
- A recommended maximum period not exceeding **three** months.

4.7.3 No patient should be suspended from the waiting list without a suspension end date.

4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.

4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

4.7.9 Recommended practice is that no more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

4.8 PLANNED PATIENTS

4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.

4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.

4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

4.9.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

4.10 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR ADMISSION

DNAs – Inpatient/Daycase

4.10.1 If a patient DNAs their inpatient or daycase admission, the following process must be followed:

4.10.1(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second date should be offered or whether the patient can be discharged.

4.10.1(b) Where the clinical decision is that a second admission should be offered, the admission date must be agreed with the patient. Trusts should put in place local agreements with clinicians regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

4.10.1(c) Patients who DNA and are not discharged but offered a second date will have their waiting time clock reset to the date of the DNA.

4.10.1(d) Where the clinical decision is that a second date should not be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

4.10.1(e) *Patients being discharged from the list should be advised to contact the Trust if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original date, a clinical decision may be made to offer a second date. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

Is there a process in place for this the same as outpatients were a letter is sent to the patient and they phone in ?

4.10.1(f) If the patient DNAs the second admission offered then the above steps should be followed.

4.10.1(g) Where a patient DNAs a fixed admission date (i.e. they have not had the opportunity to agree/ confirm the date and time of their admission), they should be offered another date.

4.10.1(h) If the patient DNAs this second fixed admission, they will be removed from the waiting list and the steps in 4.10.1(e) should be followed.

4.10.1(i) Where a patient DNAs a pre-assessment appointment they will be offered another date. If they DNA this second pre-assessment appointment, they will be removed from the waiting list and the above steps in 4.10.1(e) should be followed.

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

If a patient cancels their inpatient/ daycase admission the following process must be followed:

4.10.2(a) Patients who cancel an agreed reasonable offer will be given a second opportunity to book an admission, which should ideally be within **six weeks** of the original admission date.

4.10.2(b) If a second agreed offer of admission is cancelled, the patient will not be offered a **third** opportunity.

4.10.2(c) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second admission, the Trust may exercise discretion to offer a third admission - this should include seeking a clinical review of the patient's case where this is appropriate.

4.10.2(d) Where a decision is taken not to offer a further admission, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

4.10.2(e) Where a patient CNAs a pre-assessment appointment they should be offered another date. If they CNA this second pre-assessment appointment, the above steps should be followed, as per 4.10.1(h).

4.10.2(f) Patients who cancel their procedure (CNA) will have their waiting time clock reset to the date the Trust was informed of the cancellation.

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.

4.11.3 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.11.4 Where patients are cancelled on the day of an admission/operation as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.

4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

4.13.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Recording inpatients who need to be added to the 28 day cardiac surgery waiting list.
- Recording paediatric congenital cardiac surgery activity.
- Centralised Funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Patients who are added to a waiting list with a planned method of admission.
- Pre-operative assessment clinics.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Patients waiting for a review outpatient appointment.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

GUIDANCE FOR MANAGEMENT OF ELECTIVE ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services, including those patients whose referral is managed virtually.

5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.

5.1.3 The administration and management of the AHP pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

5.1.4 For the purposes of this section of the protocol, the generic term ‘clinic’ will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people’s own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.

5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.

5.1.7 Fixed appointments should only be used in exceptional circumstances.

5.1.8 In all aspects of the AHP booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

5.2 KEY PRINCIPLES

5.2.1 All referrals, appointments and AHP waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list and allocated according to urgency of the treatment. Trusts will manage new patients in two priorities, i.e.

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.

5.2.3 Patient appointments for new and review should be **partially booked.** Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.

5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.

5.2.6 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

5.2.7 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

5.2.8 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

5.2.9 Trusts should **not** use manual administration systems to record and report patients who have been booked.

5.2.10 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

5.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

5.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

5.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

5.3.5 Following prioritisation, referrals must be actioned on PAS or the relevant electronic patient administration system and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

5.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

5.4 CALCULATION OF THE WAITING TIME

5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.

5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.

5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

5.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

5.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

5.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.6 REVIEW APPOINTMENTS

5.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

5.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

5.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

5.7.1 DNAs – New AHP Appointments

If a patient DNAs their new appointment, the following process must be followed:

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(b) Under exceptional circumstances the AHP professional may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with AHP professionals, regarding those referrals or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

5.7.1(d) *Where patients are discharged from the waiting list (ref. 5.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.

5.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.2 DNAs – Review Appointments

If a patient DNAs their review appointment the following process must be followed:

5.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

5.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.

5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.

5.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

5.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.3 **CNAs –** Patient initiated cancellations (new and review)

If a patient cancels their AHP appointment the following process must be followed:

5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

5.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring professional (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

5.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

5.7.4 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

5.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

5.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

5.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.8.4 Service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.9 CLINIC OUTCOME MANAGEMENT

5.9.1 There are a number of locations within Trusts where patients present for their AHP consultation. This protocol applies to all AHP areas. It is the responsibility of the PAS/ IT system user managing the attendance to maintain data quality.

5.9.2 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

5.9.3 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.10 CLINIC TEMPLATE CHANGES

5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

5.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers.

5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref. 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

5.12 TECHNICAL GUIDANCE

5.12.1 See also Public Health Agency; https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015 re Guidance for monitoring the Ministerial AHP 13 week access target.

5.12.2 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

5.12.3 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage).
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020).
- AHP Virtual Consultation Guidance (to be issued).

Administrative & Clerical Standard Operating Procedure

No:

TITLE	**Procedures for Referral & Booking Centre**	
S.O.P.		
Version Number	**1.0**	**Supersedes:**
Author	**Katherine Robinson, Helen Forde, Marie Loughran/Leeanne Browne**	
Page Count	**11**	
Date of implementation	**1.1.10**	
Date of Review	**1.1.12**	
Approved by	**A&C Implementation Group**	

Standard Operating Procedure (S.O.P)
Referral and Booking Centre Procedures

Introduction

This SOP outlines the procedures followed by the Referral and Booking Centre from initial receipt of referral letters to booking the appointment.

It also highlights the procedures which need to be followed should a clinic need to be cancelled or reduced.

Implementation

This procedure is already effective and in operation in the Referral and Booking Centre.

Referral Letters

There are 3 deliveries of post to the post room each day

Morning
Lunchtime
Afternoon

Post room staff open the post and sort.

Electronic Referrals

There are referrals now coming from some GP practices electronically. These are currently opened in the post room and printed. Red flag referrals are redirected to the Mandeville Unit/DHH. This project is in initial stages.

New Referrals

Date stamp the letter with the current date.

The post is then sorted out into the relevant teams and left in the appropriate trays in the RBC. Each team within the Booking Centre has responsibility for booking certain specialties.

If there are any discrepancies or queries with hospital numbers these referral letters should be placed in the registration tray in the RBC for registering on PAS. Hospital numbers should always be written in Red on the top right hand corner of the referral.

Triaged Referrals

Referrals received back following triage should be sorted into team specialties and put in appropriate trays for Add to Waiting List in RBC, **with the exception of Urology letters which are handed to directly to that team.**

ORE'ing

Priority is given to ORE'ing the referral letters – all members of the team ORE and the supervisor will monitor the flow. Referral letters should be ore'd within 24 hrs. The function set required is DWA – ORE.
You are required to ORE in site related to referral e.g, STH address has to be ORE'd in STH site. Relevant hospital number related to site is also required. All referrals are to be ORE'd to GP Specification, i.e. Urgent – GPU, priority type 2.

Creating an Episode

The function on PAS to be used when creating an episode is ORE. You will need to know which consultant code/speciality code to use – each team has a table of instructions which contains information relating to the codes and any special instructions, eg optician. You will need to check this each time you create an episode until you become familiar with the consultant's requirements.

When you have recorded the patient on PAS you then need to send the referral letters up to the consultant for triage (grading of the letter into routine / urgent).

For most specialities in Daisy Hill Hospital (DHH), South Tyrone Hospital (STH) and Armagh Community Hospital (ACH) referral letters are scanned and e-mailed to relevant secretaries for triage. In CAH referral letters are sent by post or delivered by hand.

Letters returned from Triage

When the letter is returned from the consultant they are ready to be added to the Waiting List. Each team is responsible for their own specialities. Check if:

Priority has been changed, eg from urgent to routine
The patient has been assigned to a named consultant in same speciality – previously an unnamed referral

Changes like this will mean you have to go into PAS and amend the OP REG using the function RBA which will allow you to make the amendments and also add to W/L) ensuring the correct hospital number.

To add to the Waiting List if there are no amendments to the OP REG – use the function OWL select your OP REG and then get the Waiting List code from the table of instructions and add in. Also add in additional details to the Procedure Field such as Bowels, Gastro, x-ray needed.

During this updating of PAS you must check to ensure that the date of the OP REG is the same as the date stamp on the letter and the same as the date on list on PAS.

For Dermatology ICATS and Urology ICATS the original episode needs discharged on PAS – function OD with reason code CICT.
Referral is then re-ored using relevant ICATS specification.

Selecting from Waiting List

Each month there is a “big select”. Before you do your “big select” you will need to:

- Check the front of the Select file for guidance/clinic instructions
- Check the back of the file to see what instructions are recorded on the calendar – if clinics are to be cancelled or reduced check PAS to make sure that this has been done
- Phone the consultant’s secretary to double check all holidays/reduced clinics are correct, and that there are no changes to the information
- Check that the cancelled clinic details are recorded on the cancelled clinic spreadsheet

To determine how many slots you have for NR (New Routine) patients use the function CBK and look at each individual clinic and see how many NR slots there are for the time period you are working on and this will let you know the number of patients you can send for.
The same procedure above applies for NU (New Urgent) and R (review) patients.

You’re now ready to select your patients so using SWO select the appropriate number of patients and on PAS record in the comment field:

- PB1,
- the date it was sent (todays date) and
- the code of the clinic that the patient is to be booked to, and the consultant or clinician code if appropriate eg Ortho Icats and Paeds staff grade clinics.
- the month they have to be booked into.

Patients must be selected in chronological order – your SWO screen and your PTL will guide you with this.

Only one person per speciality will work on the selection at a time to avoid duplication.

When you have completed your select you must then record the patient details etc on the SELECT SHEET You should also remove all the referral letters that you’ve selected and keep them with this list at the front of the select file.

In two weeks’ time when you’re checking to see who needs to have a PB2 sent you can use this check together with SWO to ensure that all patients have been actioned. You may also check function EPI to see if patients have responded to their PB1 letter.

When sending out the PB2 letters remember to update the comment field with your appropriate PB2 code, todays date, the clinic code/consultant code if appropriate to be booked into, and also the month the patient is to be seen in.

PB1 letter sent – if no response within 14 days from the date in the comment field the PB2 letter is sent. PB2 letter is sent – if no response within 7 days from the date in the comment field the patient is discharged and a letter sent to the patient and the GP.

Discharging a Patient

Before you can discharge a patient on PAS you must do a check on their address – phone their GP to confirm address. If this is different from what is recorded on PAS then you must get in contact with the patient to offer them an appointment – this is usually done by telephoning the patient.
If no contact can be made by telephone then the PB1 will be re-issued to the correct address.

If the address is correct then you can discharge the patient, issue a letter to the patient and to the GP, and forward the referral letter to the consultant. There are however exceptions where you need to email the secretary details of the non-responders and forward the referral letter.

Children – you cannot discharge a child (child = under 17 years and 364 days old). Fill in “Under 18’s O/P Discharge” form and forward to the consultant with the referral letter. They must inform you of the follow up action, eg discharge, send for again.

Primary Target Lists (PTL’s)

Every Monday you will get a new PTL (can be requested more frequently if required). When you get your PTL you will need to:

Look for any blanks (ie patient episodes where the W/L code is not entered)
Are there any episodes where a PB2 is now required
Are there any PB2’s that now need to be closed
Check, using CBK and SWO, if there is capacity in any of your clinics
Check, using CBK and SWO, if there is a shortfall in any of your clinics

Diary

Each team has a diary which is used as a checking mechanism. The diary is date stamped with the following headings and also includes the codes of the clinics that are held on that day:

Completed Clinic
PB1
PB2
PBG

Example

Today's date is Tuesday 19th April – the diary entry will look like this:

Completed Clinic	**26/04/11**	(this is one week in advance)
PB1	**31/05/11**	(this is 6 weeks in advance)
PB2	**05/04/11**	(this is 2 weeks previously)
PBG	**29/03/11**	(this is 3 weeks previously)

Completed Clinic

Today is the 19th April, so you want to check the clinics held on the 26th April to make sure they are all fully booked. The clinic codes are all on this page for reference.

PB1

Today you want to send out your PB1 letters for the clinics that are 6 weeks away – so you will be checking the clinics on the 31st May to check their capacity and then selecting your patients to send. The clinic codes are all on this page for reference.

PB2

Today you want to check who needs a PB2 letter sent – so you want to check the clinics that are held on a Friday that have had a PB1 sent on the 05/04/11 and that haven't responded, as they now require the PB2 letter. Use both the list at the front of the select file and also the function SWO.

PBDG

Today you want to check who has received a PB2 letter on the 29/03/11 and who have not responded – use the list at the front of the select file and also the function SWO. These patients now need discharged on PAS (except if they are a child).

Booking an appointment

When a patient phones up to make their appointment having received their letters you use function BWL.

You have to remember here:

- Breach Codes – being aware of target dates i.e. 9/17/21/26/41 weeks
- Letter codes – remember to use the relevant letter codes depending on the clinic, this gives information to patients what to expect at the clinic.
- Letter options i.e. U6/DB/VA

You may also have to use function RBA if the patient has come of an unnamed list, the consultant will have to be changed from unnamed to named. You have to ensure that when using RBA that you use the correct hospital number for the appointment.

Resetting

If a patient has an appointment for the 2nd July and phones up on the 23rd June to cancel the appointment then the date that they are reset on the PTL will be 23/6/09 – in other words PAS will always take the reset from the date the appointment was cancelled, not the date of the clinic. Their new date will be calculated to 23/6/09 by the PTL. Do not ever change the date on list for New Patients EXCEPT SFA following NRPB – no response to Partial Booking.

Cancelling a clinic

You may only cancel a clinic if you are in receipt of an e-mail containing a cancel clinic proforma from the consultant or their secretary giving the details of the clinic to be cancelled and confirming that you should now proceed and cancel same.
If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.
If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

Some clinics are set up on PAS to build well into the future (on screen) while others are set up to build a few weeks into the future (not on screen).

Do a CBK, enter in clinic code and check if this date is built on PAS. At this stage make a note of the number of NU, NR, RF, REV slots on the clinic as you will need to record this information on a spreadsheet*.

<u>Built on PAS</u>

Function Set = ODM and Function = CCL (cancelled clinic)
Enter in clinic code and date of clinic to be cancelled.
If there are patients booked onto this clinic a Rebook List will be automatically produced. It is best practice to phone the patients on the Rebook List and cancel the appointment, giving them a new appointment if possible.

If you do not have capacity to rebook the patients into the correct month then this should be escalated to your supervisor/referral and booking centre manager.

- Now go to the cancelled clinic *spreadsheet and fill in the clinic details including the number of slots cancelled by category.
- Record the cancelled clinic details on the calendar at the back of the Select File.
- Record the cancelled clinic details in the diary.
- File the e-mail in the cancelled clinics team folder.

<u>Not Yet Built on PAS</u>

If the date of the clinic you have to cancel is not built on PAS then you need to:

- Record the information on the calendar at the back of the Select File
- Record the information in the diary
- File the e-mail in the cancelled clinic team folder

Reducing a Clinic

You may only reduce a clinic if you are in receipt of an e-mail containing a proforma to reduce the relevant clinic from the consultant or their secretary giving the details of the clinic to be reduced and confirming that you should now proceed and reduce same.
If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.
If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

CBK – get details of the timeslots as you need to record the reduced clinic details on the cancelled clinic spreadsheet.

Some clinics are manned by one doctor while other clinics are manned by several doctors, some occur once a week, and some once a day. Therefore you need to know your clinic set up so when you get confirmation that a clinic is to be reduced you need to check:
Follow relevant instructions per consultant template.

- How many doctors are at this clinic?
- How many patients would need cancelled?
- What types of appointments should be cancelled – eg NR or Rev?

To reduce the clinic use the function TBO – this will allow you to view the clinic and see what the timeslots are and how they are set up, eg every 10 minutes, with 2 NR and 1 Rev at each timeslot.

Example of a clinic set up (using only NR and Rev as the categories)

Timeslot	NR	REV
9.00	2	1
9.10	2	1
9.20	2	1
9.30	2	1
9.40	2	1
9.50	1	1
10.00	1	1

If you were asked to reduce this clinic by 4 NR and 3 R as there will be one doctor on leave from the clinic then you need to make sure that the reductions

you make still ensure patient flow, ie you don't have all the reductions at the start of the clinic, leaving the 2 remaining doctors with no patients at 9 am. The reductions should be spread throughout the clinic. It's also important to consider the category of the patient, ie a doctor can generally see a review patient in a shorter time than a new patient.
Function set required is ODM – MS

Remember not to take away new patients from the start of an afternoon clinic to allow for ambulance patients.

- Record on PAS that the clinic is reduced to xx amount of patients, and any other instructions you have received, eg no NR patients after 10.30 am.

- Record the information in the calendar at the back of the Select File.

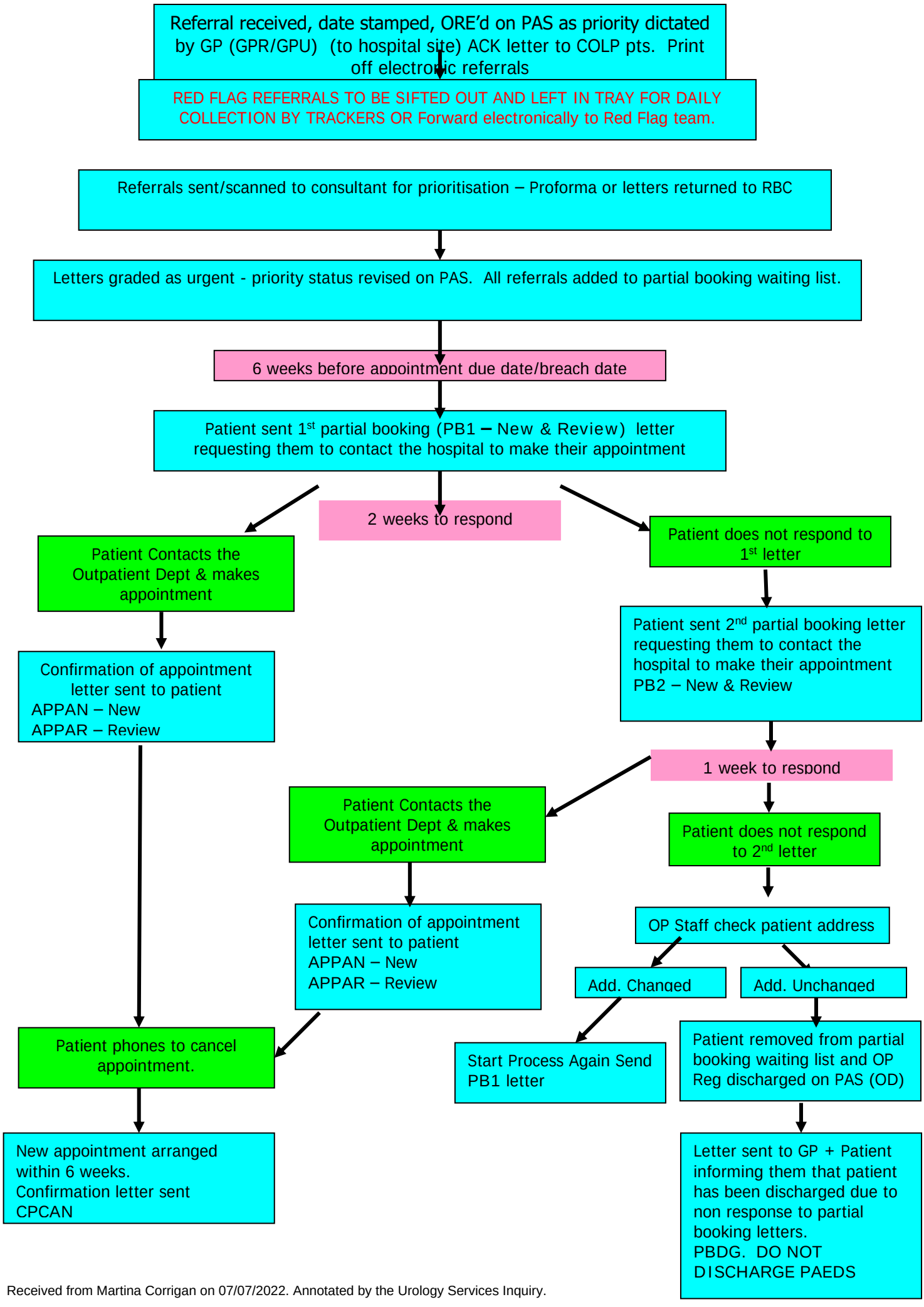
- Record the information in the diary.

- Record the information in the cancelled clinic spreadsheet.

- File the e-mail in the cancelled clinic team folder.

- Make the necessary reductions to the clinic.

PARTIAL BOOKING ROUTINE APPOINTMENTS – RBC

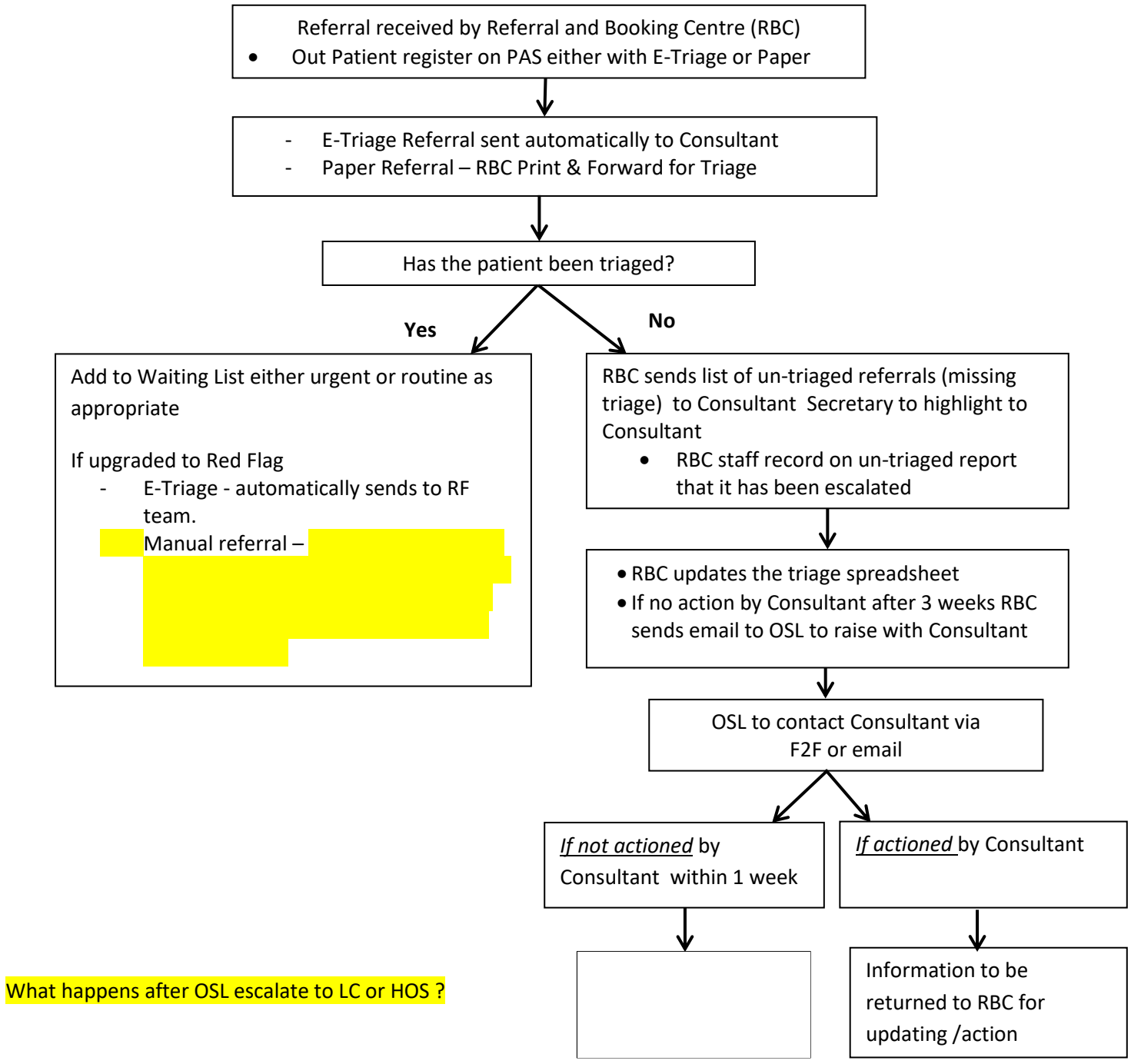


TRIAGE PROCESS

- **Red Flag referrals should be returned from Triage within 24hrs**
- **Urgent referrals should be returned from Triage within 72hrs**
- **Routine referrals should be returned from Triage within week.**

PURPOSE OF TRIAGE

- Consultant triage is to confirm that the speciality is appropriate and the clinical urgency is appropriate.
- It also serves a purpose to direct the referral to an appropriate service within the speciality (e.g. to vascular surgeons etc.)
- It allows the Consultant to request any investigations which the patient will require prior to outpatient attendance
- The Consultant can return referrals with advice and no outpatient attendance where appropriate.



What happens after OSL escalate to LC or HOS ?

Please Note: This process will incur a minimum of 7 weeks in total if referral is un-triaged within the target times which means that if the referral is upgraded to Red Flag it is in excess of 14 day Red Flag turnaround.

It is the responsibility of the Consultant to ensure Triage is done within the appropriate timescales detailed above

Southern Health and Social Care Trust

Medical Directorate

Memorandum

To:	All Trust Urology Team Members
c.c.	Melanie McClements, Interim Director Acute Services; Mr Mark Haynes, AMD Surgery and Elective Care
From:	Dr Maria O'Kane, Medical Director
Date:	7th December 2020
Subject:	**Identification of Variation of Diagnoses / Prescribed Treatments**

Dear Colleagues,

I would like to extend my thanks and appreciation to each of you regarding exemplary commitment to delivery of high quality services through what has been the most challenging of years for Health and Social Care Services. Without doubt the previous weeks have been significantly difficult for members of the Urology team in particular following the Ministerial announcement regarding the public inquiry regarding the practice of a former colleague, Mr O'Brien.

As part of the Trust response to ensuring patient safety each of you may be reviewing patients who were previously under the care of Mr O'Brien. As with all routine patient reviews any appointment may result in changes in prescribed treatment or may revise diagnoses based on new evidence or changes in the patient's condition.

Although this is part of routine practice I would ask that you identify **any patient previously under the care of Mr O'Brien** whom you have reviewed since his departure from the Trust on the 17th July 2010 and identify any:

- Inappropriate or incomplete investigations carried out / to be carried out
- Prescribing of treatments that are inconsistent with evidence based practice
- Any diagnoses that may be insecure
- Any clinical management approaches that appear unreasonable
- Any unexplained delays with any aspect of care (reviews, prescribing, diagnostics etc)

- An patient that may have suffered harm as a result of any of the above

I ask that as well as taking appropriate clinical follow up actions regarding any of the above that you pass the details of the same to Martina Corrigan, Head of Service to ensure we can use this information to direct our patient safety reviews moving forward.

We have developed a template to help capture this information (attached).

Finally I would like to again extend my appreciation for the work you are conducting under the most difficult of circumstances, as a Trust we recognise the vital contribution of each team member to ensure our services remain of the highest quality.

Yours sincerely

DR MARIA O'KANE
MEDICAL DIRECTOR

Southern Health and Social Care Trust

UROLOGY PATIENT REVIEW FORM

This form is to be completed for each patient previously under the care of Mr O'Brien reviewed by the Southern Trust Urology team since Mr O'Brien's departure on 17th July 2020. This form is to be retained in the patient notes and copied to Martina Corrigan, Head of Service.

Patient Details

Appointment Details

Presenting Condition	
Summary of Appointment	

While under Mr O'Briens care please answer the following to the best of your knowledge

Question	Y/N	Details
Where appropriate investigations carried out?		
Was the prescribed treatment appropriate at the time / is it appropriate now?		
Was the diagnosis secure?		
What the clinical management approach taken reasonable?		
Was there unexplained delays with any aspect of care (reviews, prescribing, diagnostics etc)		
Did the patient suffer harm as a result?		

Clinical Professional Reviewing Care

Name	
Title	
Date of Appointment	

Incident Oversight Group

Tuesday 2th February 2021, 1:00pm

Via Zoom

AGENDA

1	Apologies	
2	Minutes	MINUTES - Incident Group 08.12.2020.dc
3	Team Working - Maxine Williamson	
4	Private Practice - Private Practice Audit - Private Practice Patients transferred to HSC	
5	Update on Radiology and MDM Review	
6	IPT for Review Process	Urology Inquiry IPT - draft 8 15.12.2020.c
7	Additional Subject Matter Expertise - British Association of Urological Surgeons - British Association of Urological Nurses	RE Subject Matter Expertise.msg
8	Royal College of Surgeons Engagement - Terms of Reference - Team Membership - Selection of Records - Costing	Draft Terms of Reference CLINICAL RCS Review Team.txt RE CONFIDENTIAL - Urology Assurance Gı
9	Bicalutamide Patient Review	Clinical And Social Care Audit Registratic
10	Engagement of ISP to undertake waiting list work	
11	Telephone Support Service / Patient Triage Update	
12	MDM Processes	
	Professional Governance	
13	GMC Discussions	
14	Litigation / DLS Update	
15	Grievance Process	
16	Administration Review Update	
	Serious Adverse Incident (SAI) Reviews	
17	Update on Current SAI Progress	
18	Initial SAI Recommendations	Action plan 69120.docx
19	Structured Judgement Review Process	
20	Family Liaison Role	
	Communications	
21	Media / Assembly Questions	

22	Personal information redacted by USI	Personal information redacted by USI
23	Coronial Processes	
24	Letter to Staff re AOB Patient Reviews	07.12.2020 - Memo - Identification of Personal Informatio UROLOGY PATIENT REVIEW FORM v1.do
25	Declaration re CURE	
26	Securing Records for Public Inquiry	Letter to Chief Executives - Pubic In(
27	Urology Timeline for the HSCB	SHSCT Urology Timeline 2 Feb 21 MC
Date of Next Meeting		
28	Via Zoom – 10th February 2021	

Urology Oversight Group Minutes

Tuesday 8th December 2020, 4:00pm

Via Zoom

	Item	Actions
1	**In Attendance** Stephen Wallace — Melanie McClements Martina Corrigan — Dr Maria O'Kane Dr Damian Gormley — Jane McKimm Siobhan Hynds — Mr Mark Haynes Patricia Kingsnorth	
2	**Apologies** Vivienne Toal Ronan Carroll	
3	**Weekly DoH Update** Melanie updated on the meeting. Main update was to suggest that the SJR methodology would be a potentially viable vehicle going forward. Public Inquiry isn't likely to commence until March 2021. DOH meetings will now be two weekly. Prof Krishna to quality assure work to date. Second victim discussion regarding supports required.	
	Management of Patient Reviews	
4	**Private Practice** Martina updated on another case identified via GP practice. DLS have identified that AOB has still been liaising with DLS regarding medico-legal cases. Further information on this has been sought.	**DLS to update on AOB work**
5	**Update on Radiology and MDM Review** No update this meeting, to follow next week	**Update next meeting**
6	**IPT for Review Process** Martina reviewed IPT with the HSCB and costed at 2.3 million for 15 months. Costs in year to be met with 200k urology funding. Further funding required for 2021/22 via IPT process.	**To be discussed at HSCB meeting**
7	**Additional Subject Matter Expertise** Group reviewed the role description and agreed content.	
8	**Royal College of Surgeons Engagement** Group reviewed the terms of reference, broadly agreed content. Sampling strategy to be agreed. Group felt 5 years may be appropriate.	
9	**Bicalutamide Patient Review** No further update	
10	**Engagement of ISP to undertake waiting list work** Martina and Mark to speak to Patrick Keane to agree if he will be willing to engage beyond December.	**Martina / Mark to discuss with**

		MK Keane
11	**Information Telephone Line** Martina stated that the information line has been quiet this week. Martina referenced a recent communication from a patient who received a letter from an unknown source regarding the care provided by AOB asking to contact the information line, this was not issued by the SHSCT. Group discussed producing a holding letter to patients regarding those patients who will not be part of the review going forward. Group agreed holing letters should be issued.	**Holding letter to patients to be issued**
	Professional Governance	
12	**GMC Discussions** Maria updated on the meeting with the GMC ELA. AOB will be going to interim orders on 15th December 2020.	
13	**Litigation / DLS Update** Next meeting – update covered in item 4	
14	**Grievance Process** Next meeting	
15	**Professional Alert Letter** Next meeting	
16	**Administration Review Update** Next meeting	
	Serious Adverse Incident Reviews	
17	**Update on Current SAIs** Communications are ongoing, a letter has been drafted to AOB via Tughans to invite AOB to take part. Summary position is expected on Friday. Maria asked that for responses are to be submitted by set deadlines.	**Patricia to write to AOB on SAI Chair behalf**
18	**Initial SAI Recommendations** Recommendations are in progress, update to be provided at a future meeting	**SJR model to be discussed with the HSCB**
19	**Structured Judgement Review Process** Next meeting	
20	**Family Liaison Role** Liaison role closes on Friday this week.	
	Communications	
21	**Media / Assembly Questions** No update this week	
	Any Other Business	
22	**Coronial Processes** Next meeting	
23	**Letter to Staff re AOB Patient Reviews** Letter agreed	
24	**Declaration re CURE**	
25	**Securing Records for Public Inquiry**	
	Date of Next Meeting	
26	**Via Zoom – 15th December 2020**	

Southern Health and Social Care Trust

Quality Care - for you, with you

Strictly Confidential

Staffing Support Requirement for Serious Adverse Incident /Inquiry - Urology

3 December 2020

1.0 Introduction

There have been significant clinical concerns raised in relation to Consultant A which require immediate and coordinated actions to ensure patient safety is maintained. Comprehensive plans need to be put into place to undertake the following:

- Review of professional governance arrangements
- Liaison with professional bodies
- Review of patient safety and clinical governance arrangements
- Commencement of operational support activities including
  - Offering additional clinical activity
  - Provide complaints resolution
  - Media queries, Assembly Questions responses
  - Managing the volume of patients who require to be reviewed
  - Patient Support (Psychology / Telephone Support / Liaison)
  - Staff Support
  - Claim handling / medico-legal requests

This proposal identifies the staffing requirements and costs required to support the Serious Adverse Incident (SAI) Investigation/Inquiry for Urology in the Southern Trust.

This proposal will require revision as demands change over time.

2.0 Needs Assessment

A comprehensive review of patients who have been under the care of Consultant A will be required and this may likely number from high hundreds to thousands of patients.

Following discussions with the Head of Service the following clinics have initially been proposed and have been estimated in the first instance to continue for one year.

Clinics will commence in December 2020 and continue throughout 2021. A putative timetable has been included. We will require that consultants have access to records, have reviewed the contents and results and are familiar with each patient's care prior to face to face review where required. Each set of patient records will require 10-30 minutes to review depending on complexity. In addition, each of the patients reviewed will require 45 minute consultant urologist appointments to include time for administration/ dictation in addition to 15 mins preparation time on average. That is 8 patients require 8hrs Direct Clinical Contact (DCC) Programmed Activity (PA). 800 patients require 800 hours of Direct Clinical and so on. (Each consultant DCC PA is 4hrs).

The purpose of the clinical review is to ascertain if the:

1. diagnosis is secure
2. patient was appropriately investigated
3. Investigations, results and communications were requested in a timely fashion
4. Investigations, results and communications were responded to/ processed in a timely fashion
5. Patient was prescribed / is receiving appropriate treatment
6. Overall approach taken is reasonable
7. Patient has, is or likely to suffer harm as a result of the approach taken.

In addition, it will be expected that where there are concerns in relation to patient safety or inappropriate management that these will be identified and a treatment plan developed by the assessing consultant and shared with the urology team for ongoing oversight or with the patient's GP.

Table 2-1 Suggested timetable

Day	Clinic Session	Number of Patients
Monday	AM	8
Monday	PM	8
Tuesday	AM	8
Tuesday	PM	8
To be confirmed	AM	8
To be confirmed	PM	8
Total no of patients per week		48

3.0 Staffing Levels Identified

3.1 Information Line – First Point of Contact

An information line will be established for patients to contact the Trust to speak with a member of staff regarding any concerns they may have and will operate on Monday to Friday from 10am until 3pm. A call handler will receive the call and complete an agreed Proforma (appendix 1) with all of the patient's details and advise that a colleague will be in contact with them. The PAS handler will take the information received and collate any information included on PAS/ECR and this will be examined in detail by the Admin/Information Handler. The following staff have been identified as a requirement for this phase. It must be noted that the WTE is an estimate and will be adjusted dependent on the volume of calls received. Costs are included in Appendix 1.

Table 3-1 – Information Line Initial Staffing Requirements

Title	Band	WTE
Call Handlers	4	2
Admin Support for identifying notes/ looking up NIECR etc	4	2
Admin/Information Handler	5	1

3.2 Clinic Requirements

To date a clinical process audit has been carried out in relation to aspects of the Consultant's work over a period of 17 months.

In addition to this 236 urology oncology patients are being rapidly and comprehensively reviewed in the private sector. (Patients returned with management plan are included in Table 3.2/Table 3.4)

A further 26 urology oncology patients have been offered appointments or reviewed in relation to their current prescription of Bicalutamide.

Given the emerging patterns of concerns from these reviews and Multi-Disciplinary Meetings (MDMS) which have resulted in 9 patients' care meeting the standard for SAI based on this work to date, it is considered that a comprehensive clinical review of the other patients is required. The Royal College of Surgeons has advised that this includes 5 years of clinical activity in the first instance.

The numbers and clinical prioritisation will be identified collectively by the Head of Service, Independent Consultant and the Clinical Nurse Specialist either face to face or via virtual clinics. The volume of patients is 2327 for 18 months in the first instance and the number of DCC PA has been identified as **. The staffing required to operate these clinics is detailed below. This work will be additionality and should not disrupt usual current urology services. It must be noted that again this is an estimate and will be dependent on the volume of patients involved. .

Clinic Requirements Staffing – 6 sessions as detailed in Section 2. Costs are included in Appendix 1.

Table 3-2 – Clinic Staffing Requirements

Title	Band	WTE
Outpatient Manager	7	0.7
Medical Secretarial Support	4	0.5
Booking clerk	3	0.7
Audio Typist	2	0.7
Medical Records	2	0.7
Nursing staff	5	0.7
Nurse Clinical Specialist	7	0.7
Health Care Assistant	3	0.7
Receptionist	2	0.7
Consultant		DCC
Pharmacist	8a	0.7
Psychology Band 8B and above		1 present per clinic
Domestic Support	2	0.7

3.3 Procedure Requirements

If the outcome of the patient review by the Independent consultant urologist is that the patient requires further investigation, this will be arranged through phlebotomy, radiology, day procedure, and pathology / cytology staff. The provision will be dictated by clinical demand. The following staffing levels have been identified as below for each 1 day sessions. Costs are included in Appendix 1.

Table 3-3 – Procedure Staffing Requirements

Title	Band	WTE
Secretary	4	
Reception	2	
Nurses	5	0.64

Title	Band	WTE
Health Care Assistant	3	0.22
Sterile Services	3	0.22
Consultant - locum		2 PAs
Anaesthetic cover		1 PA
Domestic Support	2	0.22

3.4 Multi-Disciplinary Weekly Meetings Requirements

In order to monitor and review the number of patients contacting the following multi-disciplinary team has been identified as a requirement. Costs are included in Appendix 1.

Table 3-4 -–Staffing Requirements for Multi-Disciplinary Meetings (weekly)

Title	Band	WTE
Cancer Tracker	4	0.4
Nurse Clinical Specialist	7	0.1
Consultant Urologist x 2		2 PAS
Consultant Oncologist		1 PA
Consultant Radiologist		1 PA
Consultant Pathologist		1 PA

3.5 Serious Adverse Incident Requirements

Work has commenced on 9 SAI's and the following staff have been identified as a requirement to support the SAI and the Head of Service to enable investigative work to take place and to enable current provision to continue. Costs are included in Appendix 1.

Table 3-5 -Additional staffing and Services required to support SAI

Title	Band	WTE
Head of Service (Acute) – SAI backfill	8b	1
Chair of Panel	N/A	sessional
Band 5 admin support	5	1
Governance Nurse/ Officer	7	2
Admin support to the panel	3	1
Psychology support	Inspire	sessional
Family Liaison SLA	7	1

3.6 Inquiry Requirements

Costs are included in Appendix 1.

Table 3-6 - Additional staffing and Services required to Support Inquiry

Title	**Band**	**WTE**
Head of Service Backfill	8b	1
Clinical Nurse Specialist	7	1
Admin Support for HOS	4	1
Admin Support to respond and collate requests for information for inquiry team	5	2
Health records staff to prepare notes for Inquiry Team	2	4
Urology Experts – WL Initiative Funding £138 per hour	Consultant	Sessional
Media queries, Assembly Questions responses	8a (uplift from Band 7's)	2
Admin Support for media queries/Assembly questions	4	1

3.7 Professional and Clinical Governance Requirements to Support the SAI/ Inquiry

Investigations involving senior medical staff are resource intensive due to the many concerns about patient safety, professional behaviours, demands on comprehensive information and communications with multiple agencies. In particular this case has highlighted the need for clinical and professional governance processes across clinical areas within the Trust, to develop these systems and to embed and learning from the SAIs and Inquiry. This work should be rigorous and robust and develop systems fit for the future.

This strand will have responsibility for undertaking activities to ensure embedding of learning, improvement and communication of Trust response to the Urology incidents. This includes providing assurance that improvement efforts are benchmarked outside the Trust from both a service development and national policy perspective and the acquired learning process and may include:-

- Revision of Appraisal and Revalidation processes
- Quality Assurance of information processes in relation to Appraisal and Revalidation
- Development of systems and processes that marry professional and clinical governance
- Embedding and providing assurance regarding learning, improvement and communication
- Provide support on Trust communications regarding incident response
- Support triangulation of clinical and social care governance and professional governance information to improve assurance mechanisms
- Support the benchmarking of Trust service developments against regional and national perspectives
- Support liaison and communications with PHA / HSCB and Department of Health on matters relating to the urology incidents

- Support for corporate complaints department

Costs are included in Appendix 1.

Table 3-7 - Professional Governance, Learning and Assurance

Title	Band	WTE
AD Professional Governance, Learning and Assurance	8c	1
Project Lead	7	1
Administrative Support	4	1

Table 3-8 – Claims Management / Medico – Legal Requests (DLS 20%)

It is anticipated that the number of medico-legal requests for patient records and the number of legal claims will significantly increase as a result of the patient reviews and SAIs. This will require support for claims handling, responses to subject access requests and redaction of records.

Title	Band	WTE
Head of Litigation (uplift from band 7)	8a (uplift from band 7)	1
Specialist Claims Handler	7	1
Claims Administrative Support	4	1
Medico – Legal Admin Support	3	1
Service admin support – redaction	4	1
Support Health Professional for redaction – Clinical Nurse Specialist	7	1
2 x Solicitor Consultants (DLS)	sessional	

4.0 Identified Risks

Risk Identified	Mitigation Measure
• Recruitment of experienced staff –	• Complete recruitment documentation as soon as possible • Liaise with Human Resources
• Staff Backfill	• Complete recruitment

Risk Identified	Mitigation Measure
	documentation as soon as possible • Liaise with Human Resources
• Securing Funding	• Liaise with PHA and HSCB regarding additional funding required to support the SAI/Inquiry.
• Volume of calls received by the information line will exceed expectations leading to further complaints	• Monitoring of call volumes • Extending the operational hours to receive calls • Increasing the number of call handlers
• Number of clinics is insufficient to cope with the demand for review appointments	• Monitoring the number of review appointments required • Monitoring clinics and virtual clinics • Increasing the number of virtual clinics
• Current Service Provision will be impacted by the additional clinics being taken forward and Waiting Lists will continue to grow.	• Current provision continues • Utilise independent resources • Provide evening/weekend clinics
• Red flag appointments will not be seen within the required timeframe	• Monitor all current referrals and red flag appointments
• Reputation of Trust	• Provide a response within an agreed timeframe

5.0 Monitoring

Monitoring and reporting will continue throughout the investigation period and will be provided on a weekly basis. Meetings are scheduled on a weekly basis.

Royal College of Surgeons of England

TERMS OF REFERENCE FOR CLINICAL RECORDS REVIEW

Review of Urology clinical records at Southern Health and Social Care Trust under the Invited Review Mechanism.

Background

The review team will consider the standard of care provided to patients in a sample of clinical records provided by Southern Health and Social Care Trust for patients that had been under the care of a Trust Consultant Urologist.

Review

The review will involve:

- A clinical record review of up to 100 cases who were under the care of the Consultant between the period January 2015 – December 2015 put forward by the Southern Health and Social Care Trust

Terms of Reference

In conducting the review, the review team will consider the standard of care demonstrated in the clinical records provided by the Southern Health and Social Care Trust including with specific reference to:

- Assessment including history taking, examination and diagnosis;
- Investigations and imaging undertaken;
- Treatment including clinical decision-making, case-selection, operation or procedures and prescribing practices;
- Communication with the patient, their family and patient consent;
- Communication with General Practitioners;
- Team working including communication with other members of the care team, MDT discussions and working with colleagues;
- Follow-up action on the patient care (for example, ordering diagnosis/onward referral to other specialties (oncology etc).
- Actions taken as a result of Multidisciplinary Meeting recommendations
- Administration in connection to the patients episode

Conclusions and recommendations

The review team will, where appropriate:

- Raise any immediate patient safety issues that are identified during the course of the engagement with the Medical Director of Southern Health and Social Care Trust

- Form conclusions as to the standard of care provided and whether there is a basis for concern in light of the findings of the review.

- May make recommendations for the consideration to the Medical Director of Southern Health and Social Care Trust as to courses of action which may be taken to address any specific areas of concern which have been identified or otherwise improve patient care.

The above terms of reference were agreed by the College, the healthcare organisation and the review team on [date].

Dear Dr O’Kane,

I hope you are well.

I am writing with further information about the invited review that you have commissioned from the Royal College of Surgeons of England.

The invited review team
The team appointed to undertake this review is as follows:

- Clinical Reviewer: Mr David Jones FRCS
- Clinical Reviewer: Mr Jonathan Glass FRCS
- Clinical Reviewer: Mr Mark Speakman FRCS
- Clinical Reviewer: Mr Brian Birch FRCS

With best wishes,
Jessica

Jessica Govier-Spiers
Invited Review Coordinator

Royal College of Surgeons of England
35-43 Lincoln's Inn Fields
London WC2A 3PE

T: Personal information redacted by USI
E: Personal information redacted by USI
W: www.rcseng.ac.uk

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35-43 Lincoln's Inn Fields
London WC2A 3PE

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W: www.rcseng.ac.uk

Kelly, Elaine

From: Wallace, Stephen
Sent: 28 January 2021 11:58
To: 'O'Neill, Michael (DoH)'
Subject: RE: CONFIDENTIAL - Urology Assurance Group Meeting - Friday 8th January 2021

Area	Number of Charts
All Penile, testicular and renal	6 Cases in total
Prostate	15
Invasive Bladder	10
Raised PSA (Out Patients)	15
Haematuria (Out Patients)	15
Female Lower UTI	10
Male Lower UTI	10
Ureteric Colic	10
Andrology	10

Clinical and Social Care Audit Registration Form

Audit Title: Audit of Prescribing of anti-androgen medicine 'Bicalutamide'

Directorate: Acute Services ■ Children & Young People ☐ Older Persons & Primary Care ☐
Mental Health & Disability ☐ Corporate request ☐

Division:

Auditor's name: Mr Mark Haynes **Contact details: (email)** mark.haynes [redacted]	**Audit Supervisor's Name : Not Applicable**

Is this a: National audit ☐ Regional audit ☐ Trust audit ■ International audit ☐

Proposed audit commencement date 27th October 2020 Proposed audit completion date …/…/….

Audit Aims

To ensure that the anti-androgen medicine 'Bicalutamide' has been prescribed as licensed and in line with NICE guideline NG131 Prostate Cancer: Diagnosis and Management

Audit Objectives

- To ensure that where Bicalutamide is prescribed only where indicated and as per licensed usage
- To ensure that where Bicalutamide is prescribed this is prescribed in the correct therapeutic dosages
- To ensure that patients prescribed Bicalutamide is appropriately reviewed as part of the patients ongoing care
- To ensure that any deviations from prescribing guidance is based on sound evidence based clinical rationale

Audit Standards

The following audit standards obtained from NICE guideline [NG131] Prostate cancer: diagnosis and management

Published date: 09 May 2019.

Audit Criteria	Target	Exceptions	Source of Evidence
Bicalutamide prescribed as per indicated conditions in NICE NG131	100%	Clinical rationale for deviation from guidance	NICE guideline NG131 Prostate Cancer: Diagnosis and Management
Therapeutic doses of anti-androgen monotherapy with bicalutamide are prescribed at recommended dose (150 mg).	100%	Discussions with patient / Clinical rationale	NICE guideline NG131 Prostate Cancer: Diagnosis and Management

Audit Methodology

The following audit methodology will be followed:

- HSCB to provide information on primary care prescriptions of the medication Bicalutamide
- Southern Health and Social Care Trust patients to be identified and a consultant led review of prescribing to take place to identify prescribing of Bicalutamide that is outside of that prescribed in NICE guideline NG131 Prostate Cancer: Diagnosis and Management

Rationale for the audit (please tick all that apply)

Topic is included in the Directorate's clinical audit work-plan ☐ Compliance with standards & guidelines ■

Clinical and Social Care Audit Registration Form

National Healthcare Quality Improvement Partnership (HQIP) audit	☐	Regional RQIA/GAIN audit	☐
Other national / international audit	☐	Trust based audit topic important to team/division	■
Clinical risk	■	Recommendation from national / regional report	☐
Serious Adverse Incident or Adverse Incident review	■	Clinician / personal interest	☐
Incident reporting	☐	Educational audit	☐

Other – please specify ……

Level 1 ☐ **Level 2** ■ **Level 3** ☐ **Level 4** ☐

Has this audit been approved based on the priority level? Yes ■ No ☐

Level 1 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum
Level 2 - Approval required by Associate Medical Director or Clinical Director or Directorate Governance Forum
Level 3 – Approval required by Supervising Consultant
Level 4 – Approval required by Supervising Consultant
Please be advised that the audit cannot proceed without approval as above.

Please Note: The Information Team have advised they will not release data to the requestor unless the clinical audit has been approved as above.
The clinical audit team will also advise contact with Information Governance for any advice required.

The clinical audit team can be contacted via:
Email: clinical.audit@southerntrust.hscni.net
Tel:

Raymond Haffey
Terri Harte
Sandra McLoughlin

Personal Information redacted by USI

Mary Markey
Roisin Feely
Philip Sullivan

Personal Information redacted by USI

In submitting this audit registration form, I agree to share the audit findings, recommendations and audit summary template with:the Audit Supervisor, appropriate Divisional/Directorate Committee and the Trust's Clinical audit team

Please submit your audit registration form to: *clinical.audit@southerntrust.hscni.net*

Priority levels for clinical audit

Level	Audit type - projects identified through	
Level 1 audits, "external must dos" (where the service is applicable to SHSCT)	• National audits (NHS England Quality Accounts List (HQIP), including the National Confidential Enquiry into Patient Outcomes and Deaths (NCEPOD) / Other Confidential Inquires	1
Level 2 audits, other national audits and 'internal must dos'	• National audits not contained within the HQIP list, or other clinical audits arising from: • Clinical risk • Serious untoward incident / internal reviews • National Institute of Clinical Excellence Standards & Guidelines • Complaints • Re-audit • Regional audits initiated by RQIA / GAIN	2
Level 3 audits, 'divisional priorities'	• Local topics important to the division	3
Level 4 audits	• Clinician / personal interest • Educational audits	4

Action Plan Urology 69120

Reference number	Recommendations	Designated responsible person	Action required	Date for completion / timescale	Date recommendation completed with evidence
1	HSCB should link with the electronic Clinical Communication Gateway (CCG) implementation group to ensure it is updated to include NICE/NICaN clinical referral criteria. These fields should be mandatory.	HSCB	See recommendation 5		
2	HSCB should consider GP's providing them with assurances that the NICE guidance has been implemented within GP practices	HSCB			
3	HSCB should review the implementation of NICE NG12 and the processes surrounding occasions when there is failure to implement NICE guidance, to the detriment of patients.	HSCB			
4	GPs should be encouraged to use the electronic CCG referral system which should be adapted to allow a triaging service to be performed to NICE NG12 and NICaN standards. This will also mean systems should be designed that ensure electronic referral reliably produces correct triaging e.g. use of mandatory entry fields.	HSCB			

5	**TRUST** Work should begin in communicating with local GPs, perhaps by a senior clinician in Urology, to formulate decision aids which simplify the process of Red-flag, Urgent or Routine referral. The triage system works best when the initial GP referral is usually correct and the secondary care 'safety-net' is only required in a minority of cases. Systems should be designed that make that particular sequence the norm.	AD surgical/ AMD Primary Care	The urology service hold the view that to enable the referral process to be efficient and effective, the CCG form requires to have mandatory fields which require it to be completed prior to referral from Primary Care.		NiCan pathway. Bladder Cancer Pathway March 2020 Revised Prostate Diagnostic Pathway D Female Lower Urinary Tract Sympto Female Urinary Tract Infection.docx Male Lower Urinary Tract Symptoms.docx male urinary tract infections.docx
6	The Trust should re-examine or re-assure itself that it is feasible for the Consultant of the Week (CoW) to perform both triage of non-red flag referrals and the duties of the CoW.	AD Surgery/ AMD Surgery	Time needs to be made available in consultant job plans to undertake the task of triaging referral letters. Discussions are ongoing with MD and AD	Jan 2021	

7	The Trust will develop written policy and guidance for clinicians on the expectations and requirements of the triage process. This guidance will outline the systems and processes required to ensure that all referrals are triaged in an appropriate and timely manner.	AD surgery	Currently the IEAP protocol is followed The current regional protocol is being updated.	Jan 2021	Integrated Elective Access Protocol - Apr Integrated Elective Access Protocol Draft FW IEAP referral.msg Booking Centre SOP manual.doc TRIAGE PROCESS 2. lmca.docx
8	The current Informal Default Triage (IDT) process should be abandoned. If replaced, this must be with an escalation process that performs within the triage guidance and does not allow Red-flag patients to wait on a routine waiting list.	AD Surgery		Nov 2020	
9	Monthly audit reports by Service and Consultant will be provided to Assistant Directors on compliance with triage. These audits should be incorporated into Annual Consultant Appraisal programmes. Persistent issues with triage must be escalated as set out in recommendation 10.	AD surgery	Reports will be sent to AD and AMD/ CD	Nov 2020	
10	The Trust must set in place a robust system within its medical management hierarchy for highlighting	MD			

	and dealing with 'difficult colleagues' and 'difficult issues', ensuring that patient safety problems uncovered anywhere in the organisation can make their way upwards to the Medical Director's and Chief Executive's tables. This needs to be open and transparent with patient safety issues taking precedence over seniority, reputation and influence.				
11	Consultant 1 needs to review his chosen 'advanced' method and degree of triage, to align it more completely with that of his Consultant colleagues, thus ensuring all patients are triaged in a timely manner.	MD			
12	Consultant 1 needs to review and rationalise, along with his other duties, his Consultant obligation to triage GP referrals promptly and in a fashion that meets the agreed time targets, as agreed in guidance which he himself set out and signed off. As he does this, he should work with the Trust to aid compliance with recommendation 6.	MD			

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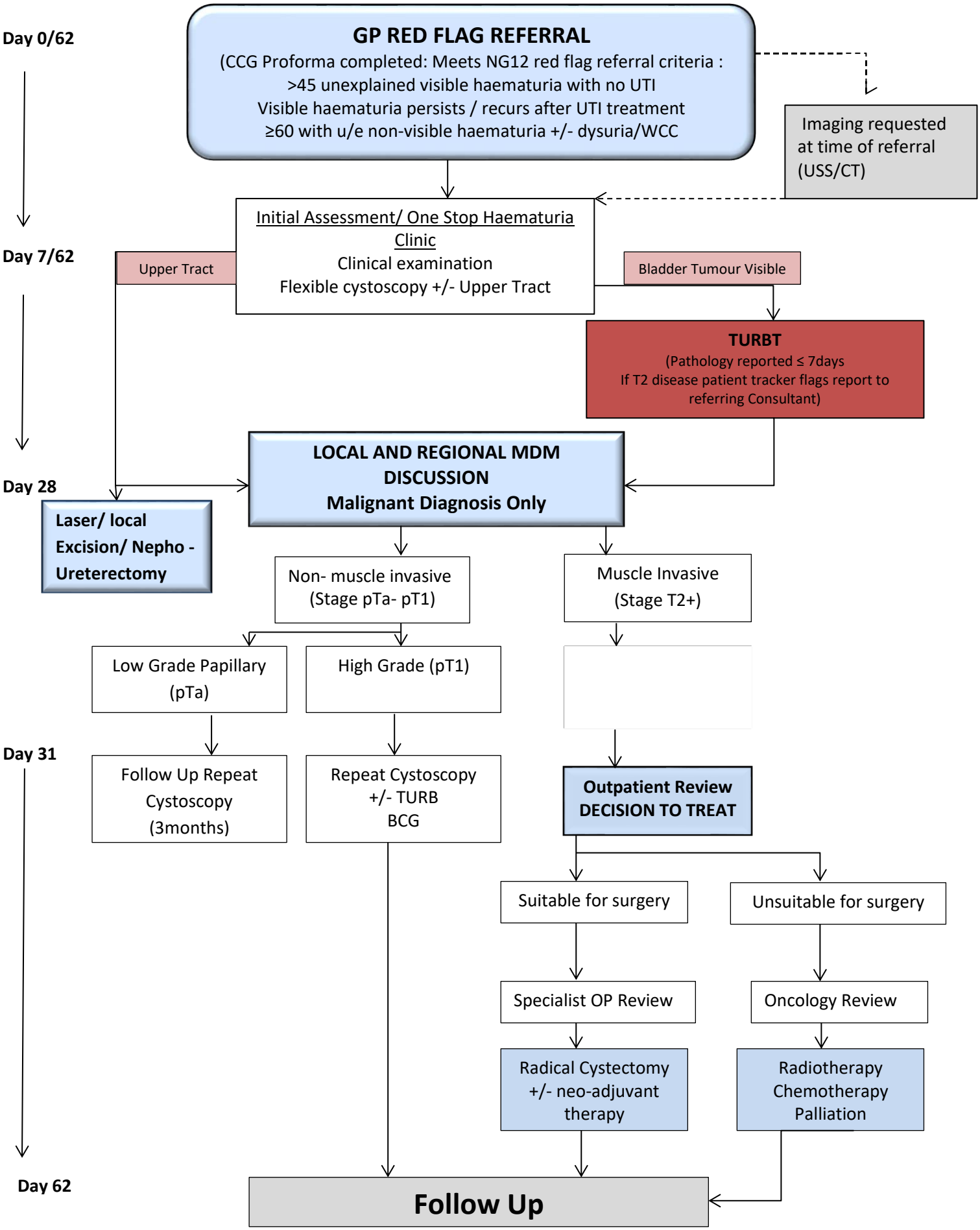
NICaN SUSPECT BLADDER CANCER REFERRAL AND DIAGNOSTIC PATHWAY



Received from Martina Corrigan on 07/07/2022. Annotated by the Urology Services Inquiry.

Final Proposed Prostate Diagnostic Pathway December 2019

NICaN SUSPECT PROSTATE CANCER DIAGNOSTIC PATHWAY

GP RED FLAG REFERRAL

Initial Assessment
- DRE
- Flow Rate (with moderate symptoms, IPSS >8)
- Residual volume
- Consider Assessment of Prostate volume / PSA Density
- ECOG status
- Charlson Co-morbidity index: https://www.mdcalc.com/charlson-comorbidity-index-cci

PSA <20 and ECOG ≥2 or CCI ≥5

Abnormal DRE
PSA >20
•Biopsy
•CT/ Bone Scan
•+/- MRI

Benign DRE and PSA >20: **MRI**
OR
Benign DRE and PSA >40: **Biopsy**

ECOG <2 or CCI <5

DRE normal
And
PSAD (US/ DRE) <0.1

Abnormal DRE
Or
DRE Normal and PSAD (US/DRE) >0.1
Or
PSADT (on PSA Monitoring) <4yrs

MRI prostate

MRI PSAD <0.15
And
MRI No Abnormality

MRI PSAD ≥0.15
Or
PIRADS 3/4/5 abnormality

MDM DISCUSSION
Malignant Diagnosis Only

PSA monitoring
(Education of patients regarding PSA monitoring, alert symptoms and access to services)

Prostate biopsy (TP or TRUS) + targeted biopsies of MRI abnormality
(Consider prostate volume as part of the initial assessment of a patient with a raised PSA and before MRI)

PIRADS 3 and PSAD <0.15 discuss options of PSA monitoring and biopsy, context of imaging and PSA history with patient and proceed according to

Watchful Waiting / Symptomatic management
(Refer to NICaN Watch and Wait Pathway)

Guidance Notes
To help men decide whether to have a prostate biopsy, discuss with them their prostate-specific antigen (PSA) level, digital rectal examination (DRE) findings (including an estimate of prostate size) and comorbidities, together with their risk factors.
Prostate volume should form part of the discussion with a man about whether further investigation (eg MRI +/- biopsy) or monitoring.
Give men and their partners or carers information, support and adequate time to decide whether or not they wish to undergo prostate biopsy.

Southern Health and Social Care Trust

Quality Care - for you, with you

Female Lower Urinary Tract Symptoms

History;

- Storage symptoms – Frequency, Urgency, Nocturia, Incontinence
- Voiding symptoms – Hesitancy, Poor flow, Straining, Stop-start void.
- Assessment of Fluid intake

Examination;

- Abdomen
    - Palpable bladder?
- External Genitalia/Pelvic Examination
    - Atrophic Vaginitis
    - Pelvic Organ Prolapse

Investigations;

- Urine Dipstick
    - Glucose
    - Nitrite and Leukocytes
    - Haem
- Blood test
    - Renal profile
    - Glucose (found on Dipstick)
- USS Urinary tract
    - Hydronephrosis?
    - Residual Volume?
    - Pelvic organs?

Primary Care management;

- Lifestyle advice
    - Reduce Caffeine
    - Timing of fluid intake
- Palpabable Bladder
    - refer to Urology
- Atrophic Vagintis
    - Consider oestrogens therapy
- Pelvic Organ Prolapse
    - Refer to Gynae
- Leukocytes
    - manage infection as per Guidelines.
- If Renal Impairment
    - see Nephrology Guidelines

- Ultrasound Urinary tract
    - Hydronephrosis - refer to Urology
    - Residual Volume >150ml – refer to Urology
- Incontinent, residual volume <150ml, storage symptoms
    - If incontinent consider Anticholinergic treatment
    - Symptom review after 3/12 treatment

    If urinary incontinent,

    - If mainly stress incontinent, refer to community
    - Consider anticholinergice treatment – and reassessment after three months

- Others – patients who do not fit into the above two categories
    - Refer to Urology
    - Treat with topical oestrogens.
    - Hydronephrosis → Refer Urology
    - Residual Volume ≥ 300ml → Refer Urology
    - Residual volume 150ml – 300ml → Refer community continence team

Referral;

- Abnormal findings as above
- No symptomatic improvement after 3/12 of medical treatment refer to Urology

Southern Health and Social Care Trust

Quality Care - for you, with you

Female Urinary Tract Infection

History;

- First, recurrent or persistent UTI
- Symptoms suggestive of sepsis
- Cystitis (lower UTI) or pyelonephritis (upper UTI)?

Examination;

- Sepsis - Temperature? Heart Rate? Respiratory Rate? Blood Pressure?
- Abdomen – Is the bladder palpable?
- External Genitalia - consider the possibility of
    - Atrophic Vaginitis
    - Urethral pathology
- Pelvic Examination - consider the possibility of
    - Pelvic Mass
    - Cervix
    - Pelvic Organ Prolapse

Investigations;

- MSU for all patients suspected of having UTI.
- USS Urinary tract for recurrent or persistent UTI
    - Hydronephrosis? Residual Volume? Pelvic Organs?

Primary Care treatment;

- UTI with Sepsis
    - Refer to secondary care for admission
- Simple, Single Lower UTI
    - Antibiotics as per microbiology guidelines.
    - Repeat MSU 2/52 post treatment.
- Recurrent Lower UTI
    - 7 day course antibiotics as per microbiology guidance followed by 3 month course of low dose antibiotics.
    - Repeat MSU after 1/12 of treatment.
- Upper UTI no sepsis
    - 14 day course antibiotics as per microbiology guidance

Referral to Urology;

- Abnormal findings as above
- UTI with Sepsis
    - Refer to secondary care for admission
- Upper UTI no sepsis
    - Refer to Urology 'Hot clinic'
- Recurrent Lower UTI
    - Further UTI while on low dose antibiotics.
    - 3rd UTI within 12 months of first presentation.

Southern Health and Social Care Trust

Quality Care - for you, with you

Male Lower Urinary Tract Symptoms

History

Storage symptoms – Frequency, Urgency, Nocturia

Voiding symptoms – Hesitancy, poor flow, straining, intermittent stream

Incontinence

Comorbidities – constipation, review of relevant medication

Consider IPSS record and frequency / volume chart.

Examination

External genitalia specifically foreskin and meatus

Abdomen specifically to exclude a palpable bladder

DRE

Investigation

Urine Dipstick test for glucose, haem and nitrites/leucocytes

MSU if indicated

Blood tests – renal function, (glucose if indicated by dipstick test)

- PSA if 40+yrs, abnormal DRE, concern re prostate cancer

Ulrasound Urinary Tract specifically pre and post void bladder volumes and prostate volume

Refer if:

urinary incontinence

suspect urological cancer – raised PSA, abnormal DRE

palpable post void bladder

bothersome phimosis, meatal stenosis

haematuria (see Red Flag guidelines)

recurrent or persisting UTI

Hydronephrosis or bladder residual more than 200mls

Renal impairment if suspected if relating to lower urinary tract dysfunction

Primary care management

Lifestyle advice : - Timing / content of fluid intake (eg evening time fluids and caffeine)

o Co-morbidity issues (eg constipation)

Medication : Initial 3 month prescription (and continue if symptomatic improvement)

- Alpha blocker
- Consider 5-Alpha reductase inhibitor if prostate more than 30cc volume or PSA more than 1.4ng/ml (these medications can be given in combination)
- Consider anticholinergic medication if frequency / urge symptoms continue after trial of alpha blocker medication.

Refer if :

Initial concerns met

Lack of response to initial management plan

Southern Health and Social Care Trust

Quality Care - for you, with you

Male Urinary Tract Infection

History;

- Red Flag symptoms? – See Red Flag Guidance
- Lower UTI or Upper UTI?
- 'Normal' lower Urinary tract symptoms?

Examination;

- Sepsis Response – Temperature? Heart Rate? Respiratory Rate? Blood Pressure?
- Abdomen – Is the bladder palpable?
    - Palpable bladder → Refer Urology
- External Genitalia – Foreskin, Glans / Meatus
    - Phimosis, Meatal stenosis → Refer Urology
- Digital Rectal Examination – Prostate
    - Malignant feeling prostate → Refer (see red flag guidance)
    - Tender Prostate without sepsis → Refer Urology 'Hot' clinic

Investigations;

- MSU – All patients suspected of having UTI.
- Blood – Renal profile and glucose.
- USS Urinary tract – Hydronephrosis? Residual Volume?
    - Hydronephrosis >> Refer Urology
    - Residual Volume ≥ 300ml >> Refer Urology
    - Residual volume 150ml – 300ml ??

Primary Care treatment;

- UTI with Sepsis;
- Lower UTI;
    - 7 day course antibiotics as per microbiology guidelines.
    - Repeat MSU 2/52 post treatment.
- Upper UTI no sepsis;
    - 14 day course antibiotics as per microbiology guidance.

Referral;

- Abnormal findings as above
- UTI with Sepsis;
    - Refer acutely to on-call team
- Upper UTI no sepsis;
    - Refer to Urology 'Hot clinic'
- Lower UTI;
    - Refer to Urology.

Administrative & Clerical Standard Operating Procedure

No:

TITLE	**Procedures for Referral & Booking Centre**	
S.O.P.		
Version Number	**1.0**	**Supersedes:**
Author	**Katherine Robinson, Helen Forde, Marie Loughran/Leeanne Browne**	
Page Count	**11**	
Date of implementation	**1.1.10**	
Date of Review	**1.1.12**	
Approved by	**A&C Implementation Group**	

Standard Operating Procedure (S.O.P)
Referral and Booking Centre Procedures

Introduction

This SOP outlines the procedures followed by the Referral and Booking Centre from initial receipt of referral letters to booking the appointment.

It also highlights the procedures which need to be followed should a clinic need to be cancelled or reduced.

Implementation

This procedure is already effective and in operation in the Referral and Booking Centre.

Referral Letters

There are 3 deliveries of post to the post room each day

Morning
Lunchtime
Afternoon

Post room staff open the post and sort.

Electronic Referrals

There are referrals now coming from some GP practices electronically. These are currently opened in the post room and printed. Red flag referrals are redirected to the Mandeville Unit/DHH. This project is in initial stages.

New Referrals

Date stamp the letter with the current date.

The post is then sorted out into the relevant teams and left in the appropriate trays in the RBC. Each team within the Booking Centre has responsibility for booking certain specialties.

If there are any discrepancies or queries with hospital numbers these referral letters should be placed in the registration tray in the RBC for registering on PAS. Hospital numbers should always be written in Red on the top right hand corner of the referral.

Triaged Referrals

Referrals received back following triage should be sorted into team specialties and put in appropriate trays for Add to Waiting List in RBC, **with the exception of Urology letters which are handed to directly to that team.**

ORE'ing

Priority is given to ORE'ing the referral letters – all members of the team ORE and the supervisor will monitor the flow. Referral letters should be ore'd within 24 hrs. The function set required is DWA – ORE.
You are required to ORE in site related to referral e.g, STH address has to be ORE'd in STH site. Relevant hospital number related to site is also required. All referrals are to be ORE'd to GP Specification, i.e. Urgent – GPU, priority type 2.

Creating an Episode

The function on PAS to be used when creating an episode is ORE. You will need to know which consultant code/speciality code to use – each team has a table of instructions which contains information relating to the codes and any special instructions, eg optician. You will need to check this each time you create an episode until you become familiar with the consultant's requirements.

When you have recorded the patient on PAS you then need to send the referral letters up to the consultant for triage (grading of the letter into routine / urgent).

For most specialities in Daisy Hill Hospital (DHH), South Tyrone Hospital (STH) and Armagh Community Hospital (ACH) referral letters are scanned and e-mailed to relevant secretaries for triage. In CAH referral letters are sent by post or delivered by hand.

Letters returned from Triage

When the letter is returned from the consultant they are ready to be added to the Waiting List. Each team is responsible for their own specialities. Check if:

Priority has been changed, eg from urgent to routine
The patient has been assigned to a named consultant in same speciality – previously an unnamed referral

Changes like this will mean you have to go into PAS and amend the OP REG using the function RBA which will allow you to make the amendments and also add to W/L) ensuring the correct hospital number.

To add to the Waiting List if there are no amendments to the OP REG – use the function OWL select your OP REG and then get the Waiting List code from the table of instructions and add in. Also add in additional details to the Procedure Field such as Bowels, Gastro, x-ray needed.

During this updating of PAS you must check to ensure that the date of the OP REG is the same as the date stamp on the letter and the same as the date on list on PAS.

For Dermatology ICATS and Urology ICATS the original episode needs discharged on PAS – function OD with reason code CICT.
Referral is then re-ored using relevant ICATS specification.

Selecting from Waiting List

Each month there is a “big select”. Before you do your “big select” you will need to:

- Check the front of the Select file for guidance/clinic instructions
- Check the back of the file to see what instructions are recorded on the calendar – if clinics are to be cancelled or reduced check PAS to make sure that this has been done
- Phone the consultant’s secretary to double check all holidays/reduced clinics are correct, and that there are no changes to the information
- Check that the cancelled clinic details are recorded on the cancelled clinic spreadsheet

To determine how many slots you have for NR (New Routine) patients use the function CBK and look at each individual clinic and see how many NR slots there are for the time period you are working on and this will let you know the number of patients you can send for.
The same procedure above applies for NU (New Urgent) and R (review) patients.

You’re now ready to select your patients so using SWO select the appropriate number of patients and on PAS record in the comment field:

- PB1,
- the date it was sent (todays date) and
- the code of the clinic that the patient is to be booked to, and the consultant or clinician code if appropriate eg Ortho Icats and Paeds staff grade clinics.
- the month they have to be booked into.

Patients must be selected in chronological order – your SWO screen and your PTL will guide you with this.

Only one person per speciality will work on the selection at a time to avoid duplication.

When you have completed your select you must then record the patient details etc on the SELECT SHEET You should also remove all the referral letters that you’ve selected and keep them with this list at the front of the select file.

In two weeks’ time when you’re checking to see who needs to have a PB2 sent you can use this check together with SWO to ensure that all patients have been actioned. You may also check function EPI to see if patients have responded to their PB1 letter.

When sending out the PB2 letters remember to update the comment field with your appropriate PB2 code, todays date, the clinic code/consultant code if appropriate to be booked into, and also the month the patient is to be seen in.

PB1 letter sent – if no response within 14 days from the date in the comment field the PB2 letter is sent. PB2 letter is sent – if no response within 7 days from the date in the comment field the patient is discharged and a letter sent to the patient and the GP.

Discharging a Patient

Before you can discharge a patient on PAS you must do a check on their address – phone their GP to confirm address. If this is different from what is recorded on PAS then you must get in contact with the patient to offer them an appointment – this is usually done by telephoning the patient.
If no contact can be made by telephone then the PB1 will be re-issued to the correct address.

If the address is correct then you can discharge the patient, issue a letter to the patient and to the GP, and forward the referral letter to the consultant. There are however exceptions where you need to email the secretary details of the non-responders and forward the referral letter.

Children – you cannot discharge a child (child = under 17 years and 364 days old). Fill in “Under 18’s O/P Discharge” form and forward to the consultant with the referral letter. They must inform you of the follow up action, eg discharge, send for again.

Primary Target Lists (PTL’s)

Every Monday you will get a new PTL (can be requested more frequently if required). When you get your PTL you will need to:

Look for any blanks (ie patient episodes where the W/L code is not entered)
Are there any episodes where a PB2 is now required
Are there any PB2’s that now need to be closed
Check, using CBK and SWO, if there is capacity in any of your clinics
Check, using CBK and SWO, if there is a shortfall in any of your clinics

Diary

Each team has a diary which is used as a checking mechanism. The diary is date stamped with the following headings and also includes the codes of the clinics that are held on that day:

Completed Clinic
PB1
PB2
PBG

Example

Today's date is Tuesday 19th April – the diary entry will look like this:

Completed Clinic	**26/04/11**	(this is one week in advance)
PB1	**31/05/11**	(this is 6 weeks in advance)
PB2	**05/04/11**	(this is 2 weeks previously)
PBG	**29/03/11**	(this is 3 weeks previously)

Completed Clinic

Today is the 19th April, so you want to check the clinics held on the 26th April to make sure they are all fully booked. The clinic codes are all on this page for reference.

PB1

Today you want to send out your PB1 letters for the clinics that are 6 weeks away – so you will be checking the clinics on the 31st May to check their capacity and then selecting your patients to send. The clinic codes are all on this page for reference.

PB2

Today you want to check who needs a PB2 letter sent – so you want to check the clinics that are held on a Friday that have had a PB1 sent on the 05/04/11 and that haven't responded, as they now require the PB2 letter. Use both the list at the front of the select file and also the function SWO.

PBDG

Today you want to check who has received a PB2 letter on the 29/03/11 and who have not responded – use the list at the front of the select file and also the function SWO. These patients now need discharged on PAS (except if they are a child).

Booking an appointment

When a patient phones up to make their appointment having received their letters you use function BWL.

You have to remember here:

- Breach Codes – being aware of target dates i.e. 9/17/21/26/41 weeks
- Letter codes – remember to use the relevant letter codes depending on the clinic, this gives information to patients what to expect at the clinic.
- Letter options i.e. U6/DB/VA

You may also have to use function RBA if the patient has come of an unnamed list, the consultant will have to be changed from unnamed to named. You have to ensure that when using RBA that you use the correct hospital number for the appointment.

Resetting

If a patient has an appointment for the 2nd July and phones up on the 23rd June to cancel the appointment then the date that they are reset on the PTL will be 23/6/09 – in other words PAS will always take the reset from the date the appointment was cancelled, not the date of the clinic. Their new date will be calculated to 23/6/09 by the PTL. Do not ever change the date on list for New Patients EXCEPT SFA following NRPB – no response to Partial Booking.

Cancelling a clinic

You may only cancel a clinic if you are in receipt of an e-mail containing a cancel clinic proforma from the consultant or their secretary giving the details of the clinic to be cancelled and confirming that you should now proceed and cancel same.
If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.
If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

Some clinics are set up on PAS to build well into the future (on screen) while others are set up to build a few weeks into the future (not on screen).

Do a CBK, enter in clinic code and check if this date is built on PAS. At this stage make a note of the number of NU, NR, RF, REV slots on the clinic as you will need to record this information on a spreadsheet*.

<u>Built on PAS</u>

Function Set = ODM and Function = CCL (cancelled clinic)
Enter in clinic code and date of clinic to be cancelled.
If there are patients booked onto this clinic a Rebook List will be automatically produced. It is best practice to phone the patients on the Rebook List and cancel the appointment, giving them a new appointment if possible.

If you do not have capacity to rebook the patients into the correct month then this should be escalated to your supervisor/referral and booking centre manager.

- Now go to the cancelled clinic *spreadsheet and fill in the clinic details including the number of slots cancelled by category.
- Record the cancelled clinic details on the calendar at the back of the Select File.
- Record the cancelled clinic details in the diary.
- File the e-mail in the cancelled clinics team folder.

<u>Not Yet Built on PAS</u>

If the date of the clinic you have to cancel is not built on PAS then you need to:

- Record the information on the calendar at the back of the Select File
- Record the information in the diary
- File the e-mail in the cancelled clinic team folder

Reducing a Clinic

You may only reduce a clinic if you are in receipt of an e-mail containing a proforma to reduce the relevant clinic from the consultant or their secretary giving the details of the clinic to be reduced and confirming that you should now proceed and reduce same.
If the clinic is to be within 6 weeks then clearance is required from the heads of service before any action can be taken.
If the clinic is 6 weeks or beyond then clearance is not required and relevant action can be taken.

CBK – get details of the timeslots as you need to record the reduced clinic details on the cancelled clinic spreadsheet.

Some clinics are manned by one doctor while other clinics are manned by several doctors, some occur once a week, and some once a day. Therefore you need to know your clinic set up so when you get confirmation that a clinic is to be reduced you need to check:
Follow relevant instructions per consultant template.

- How many doctors are at this clinic?
- How many patients would need cancelled?
- What types of appointments should be cancelled – eg NR or Rev?

To reduce the clinic use the function TBO – this will allow you to view the clinic and see what the timeslots are and how they are set up, eg every 10 minutes, with 2 NR and 1 Rev at each timeslot.

Example of a clinic set up (using only NR and Rev as the categories)

Timeslot	NR	REV
9.00	2	1
9.10	2	1
9.20	2	1
9.30	2	1
9.40	2	1
9.50	1	1
10.00	1	1

If you were asked to reduce this clinic by 4 NR and 3 R as there will be one doctor on leave from the clinic then you need to make sure that the reductions

you make still ensure patient flow, ie you don't have all the reductions at the start of the clinic, leaving the 2 remaining doctors with no patients at 9 am. The reductions should be spread throughout the clinic. It's also important to consider the category of the patient, ie a doctor can generally see a review patient in a shorter time than a new patient.
Function set required is ODM – MS

Remember not to take away new patients from the start of an afternoon clinic to allow for ambulance patients.

- Record on PAS that the clinic is reduced to xx amount of patients, and any other instructions you have received, eg no NR patients after 10.30 am.

- Record the information in the calendar at the back of the Select File.

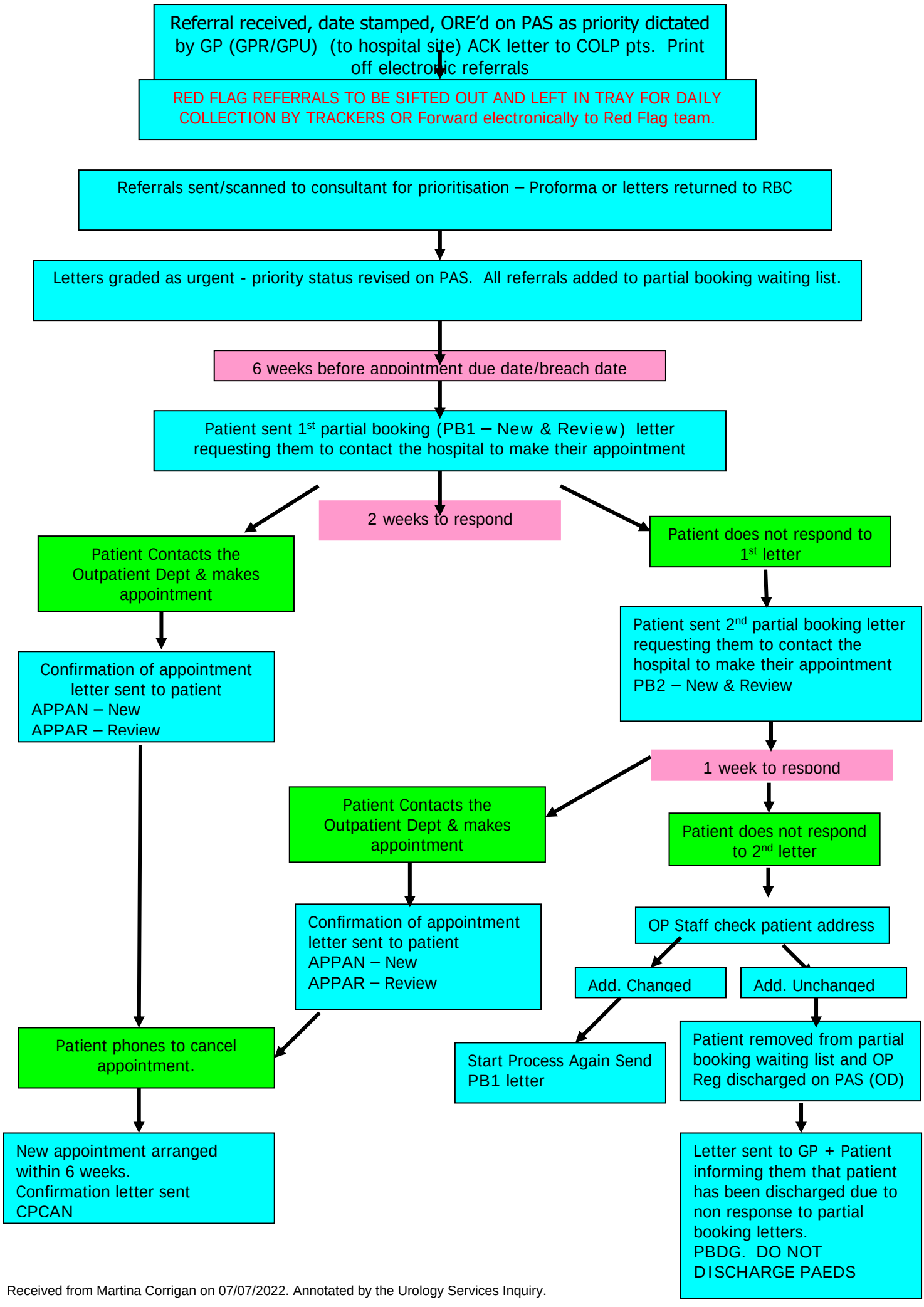
- Record the information in the diary.

- Record the information in the cancelled clinic spreadsheet.

- File the e-mail in the cancelled clinic team folder.

- Make the necessary reductions to the clinic.

PARTIAL BOOKING ROUTINE APPOINTMENTS – RBC



Department of
Health, Social Services and Public Safety

An Roinn
Sláinte, Seirbhísí Sóisialta agus Sábháilteachta Poiblí

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INTEGRATED ELECTIVE ACCESS PROTOCOL
30th April 2008

DOCUMENT CONTROL INTEGRATED ELECTIVE ACCESS PROTOCOL			
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CONTENTS

ABBREVIATIONS

AHP	Allied Health Professional
BCC	Booking and Contact Centre (ICATS)
CNA	Could Not Attend (Admission or Appointment)
DHSSPSNI	Department of Health, Social Services and Public Safety
DNA	Did Not Attend (Admission or Appointment)
DTLs	Diagnostic Targeting Lists
ERMS	Electronic Referrals Management System
GP	General Practitioner
HIC	High Impact Changes
HROs	Hospital Registration Offices
ICATS	Integrated Clinical Assessment and Treatment Services
ICU	Intensive Care Unit
LOS	Length of Stay
PAS	Patient Administration System
PTLs	Primary Targeting Lists
SDU	Service Delivery Unit
TCI	To Come In (date for patients)

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to encompass the elective pathway within a hospital environment. The principles can be applied to primary and community settings, however it is recommended that guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations and elective inpatient or day case treatment is the responsibility of a number of key individuals within the organisation. General Practitioners, commissioners, hospital medical staff, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time guarantees, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communications with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic and inpatient waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for hospital treatment.

1.1.4 This protocol will be updated, as a minimum, on an annual basis to ensure that Trusts' polices and procedures remain up to date, and reflect best practice locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.1.5 This protocol will be available to all staff via Trusts' Intranet.

1.1.6 The DHSSPSNI has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.1.7 There is an imperative to identify capacity constraints that could threaten the delivery of these key access targets and speed up the planning and delivery of extra capacity, where it is needed, to address these constraints. The health community will need to develop a co-ordinated approach to capacity planning taking into account local capacity on a cross Trust basis and independent sector capacity on an on-going partnership basis.

1.1.8 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.1.9 The intention is that this protocol will be further developed to consider all aspects of access to a range of quality healthcare at a date and time of the patients' choice.

1.1.10 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.1.11 Delivery of this protocol will require a step change in the way Trusts function. Trusts will need to transform themselves and this can only be achieved through a change in the way its staff approach their work on a day-to-day basis. Through this protocol, Trusts will aspire to work with patients and staff to raise expectations basing them not on where we are but on where we need to be.

1.1.12 For the purposes of this protocol, the term inpatient refers to inpatient and day case elective treatment. The term 'PAS' refers to all patient

administration systems, whether in a hospital or community setting, or an electronic or manual system.

1.1.13 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on PAS and the waiting times for treatment. All staff involved in the implementation of this protocol, clinical and clerical, will undertake initial training and regular annual updating. Trusts will provide appropriate information to staff so they can make informed decisions when implementing and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2 UNDERPINNING PRINCIPLES

1.2.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined specifically by specialty / procedure / service.

1.2.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.2.3 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient - they are fit, ready, and able to come in.

1.2.4 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures, not the norm. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving day case surgery to outpatient care, and outpatient care to primary care or alternative clinical models where appropriate.

1.2.5 Change No 1 within the publication "10 High Impact Changes for Service Improvement and Delivery"[1] focuses on day surgery and the document provides Trusts with tools and resources to help implement this high impact change.

1.2.6 Trusts will introduce booking systems aimed at making hospital appointments more convenient for patients. Booking systems are chronologically based and will move Trusts onto a system of management and monitoring that is chronologically as opposed to statistically based.

1.2.7 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority with immediate effect. The intention is to provide patients with certainty and choice enabling them to access services that are sensitive to their needs.

1.2.8 This will require changes in working practices. It will also require technological change to information systems to enable provision of quality information to support the booking process.

1.2.9 There is a need to balance the flow of patients from primary care through outpatients and on to booking schedules should they need elective admission. It follows that the level of activity in the Service and Budget Agreements and the level of provision of outpatient and inpatient capacity must be linked. If one changes, all should change.

1.2.10 This "bottom up" approach is based on the belief that services need to be built on firm clinical foundations. Trusts need a clinical vision built up specialty by specialty and department by department through debate and agreement between clinicians across the health community as to the best way to meet patient needs locally.

1.2.11 It is essential that patients who are considered vulnerable for whatever reason have their needs identified at the point of referral.

[1] "10 High Impact Changes for Service Improvement and Delivery" – September 2004, NHS Modernisation Agency, www.modern.nhs.uk/highimpactchanges

1.2.12 All relevant information must be recorded to ensure that when selecting a vulnerable patient for admission, their needs are identified early and appropriate arrangements made. This information should be recorded in detail in the episodic comment field of PAS relating to the listing. The patient master index comment field should not be used due to confidentiality issues.

1.2.13 Communication with this patient group will recognise their needs and, where appropriate, involve other agencies.

1.2.14 An operational process should be developed by Trusts to ensure that children and vulnerable adults who DNA or CNA their outpatient appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.2.15 In implementing this protocol the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.3 OWNERSHIP

1.3.1 Ownership is key to delivering quality of care. Trusts must ensure that all staff are conversant with the Departmental targets and standards and are comfortable with the local health communities' approach to their delivery.

1.3.2 These targets and standards must be seen to be core to the delivery of all aspects of care provision by all levels of staff within the Trust.

1.3.3 This is a major change agenda requiring significant commitment and investment at corporate and individual level. An Executive Director will take lead responsibility for ensuring all aspects of this Protocol are adhered to.

1.3.4 Trusts must be committed to training and developing staff and providing the supporting systems to ensure that together we can bring about the improvement in patient care.

1.4 REGIONAL TARGETS

1.4.1 The targets in respect of elective treatments are:

- A maximum waiting time of 13 weeks for inpatient and daycase admissions by March 2009
- A maximum waiting time of 9 weeks for a 1st outpatient appointment by March 2009
- A maximum waiting time of 9 weeks for a diagnostic test by March 2009
- A maximum waiting time of 13 weeks from referral to treatment by an Allied Health Professional (AHP) by March 2009
- By March 2009, sustain the target where 98% of patients diagnosed with cancer should begin treatment within a maximum of 31 days of the diagnosis
- By March 2009, 95% of patients with suspected cancer who have been referred urgently should begin their first definitive treatment within a maximum of 62 days

1.5 DELIVERY OF TARGETS

1.5.1 The waiting time targets are based on the “worst case” i.e. they reflect the minimum standards with which every Trust must comply.

1.5.2 The expectation is that these targets are factored into plans at Trust Board, divisional, specialty and departmental levels as part of the normal business

and strategic planning processes. Divisional, specialty and departmental managers will be expected to have produced implementation plans setting out the key steps they need to take to ensure the delivery of the Trust and Departmental protocol objectives within the area(s) of their responsibility. Trusts will manage implementation through a regular review of “local” divisional, specialty and departmental plans for the implementation of waiting and booking targets.

1.5.3 It is expected that Trusts will develop robust information systems to support the delivery of these targets. Daily management information should be available at both managerial and operational level so that staff responsible for selecting patients are working from up to date and accurate information. Future developments should also look towards a clinic management system which will highlight the inefficiencies within the outpatient setting.

1.6 CAPACITY

1.6.1 It is important for Trusts to understand their baseline capacity, the make-up of the current cohort of patients waiting and the likely changes in demand that will impact on their ability to treat patients and meet the Departmental Targets.

1.6.2 To manage at specialty and departmental level it is anticipated that managers will have, as a minimum, an overview of their core capacity including:

- Number of clinic and theatre sessions
- Session length
- Average procedure / slot time
- Average length of stay

1.6.3 It is expected that similar information will be available at consultant level. For inpatients this is at procedure level, and for outpatients and diagnostics at service level.

1.6.4 This information will enable Trusts to evaluate its waiting/booked lists in terms of theatre sessions (time in hours) and length of stay (time in bed days).

1.6.5 Each specialty should understand its elective bed requirements in terms of both inpatients and daycases, setting challenging daycase and LOS targets and agreeing plans to deliver them. In addition, systems must be developed to ensure assessment can be made of available capacity and flexible working arrangements developed accordingly.

1.6.6 Theatre sessions should be seen as corporate resources and used flexibly to ensure the delivery of waiting list and waiting time targets across consultants within the same specialty and specialties within the same Trust. This ties in with the Real Capacity Paper which also requires commissioners to demonstrate that they have used capacity flexibly across Trusts. The expectation is that divisions and/ or specialties will be able to demonstrate that they have optimised the use of existing capacity to maximise the treatment of patients within existing resources.

1.6.7 Trusts will treat patients on an equitable basis across specialties and managers will work together to ensure consistent waiting times for patients of the same clinical priority.

1.6.8 Trusts will set out to resource enough capacity to treat the number and anticipated casemix of patients agreed with commissioners. The Real Capacity Planning exercise will support this process locally.

1.6.9 Divisions/specialties will monitor referrals and additions to lists in terms of their impact on clinic, theatre time, bed requirements and other key resources e.g. ICU facilities, to ensure a balance of patients in the system and a balance between patients and resources.

1.6.10 When the balance in the system is disturbed to the extent that capacity is a constraint, divisional/specialty managers will be expected to produce plans

to expedite solutions and agree these through the accountability review process.

1.6.11 It is important for all services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

1.6.12 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

1.6.13 In summary, the intention is to link capacity to the Service and Budget Agreement i.e. to agree the plan, put in place the resources to achieve the plan, monitor the delivery of the plan and take corrective action in the event of divergence from the plan proactively. The existing arrangements whereby patients are added to waiting lists irrespective of whether Trusts have the capacity to treat them must change.

1.7 BOOKING PRINCIPLES

1.7.1 These booking principles have been developed to support all areas across the elective pathway where appointment systems are used.

1.7.2 Offering the patient choice of date and time is essential in agreeing and booking appointments with patients. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them. This takes away the uncertainty of not knowing how long the wait will be as patients are advised of their expected wait. Advanced booking in this way also gives patients notice of the date so that they can make any necessary arrangements, such as child care or work arrangements.

1.7.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.7.4 Booking development work within Trusts should be consistent with regional and local targets, which provide a framework for progress towards ensuring successful and consistent booking processes across the health community in Northern Ireland.

1.7.5 All booking processes should be underpinned with the relevant local policies and procedures to provide clarity to operational staff of the day to day requirements and escalation route, for example: management of patients who cancel / DNA their appointment, process for re-booking patients, and monitoring of clinical leave and absence.

1.7.6 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.7.7 The definition of a booked appointment is:

a) The patient is given the choice of when to attend.
b) The patient is advised of the total waiting time during the consultation between themselves and the healthcare provider / practitioner or in correspondence from them.
c) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment
d) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within 2 weeks if cancer is suspected.
e) The patient may choose to agree a date outside the range of dates offered or defer their decision until later

1.7.8 Booking Process

1.7.9 There are 3 main patient appointment types to be booked. Booking systems for these appointments should be designed around an agreed patient pathway and accepted clinical practice. They are:

a) New Urgent patients (including suspected cancer)
b) New Routine patients
c) Review patients

1.7.10 Clinic templates should be constructed to ensure that sufficient capacity is carved out to meet the local and maximum waiting time guarantees for new patients, and the clinical requirements of follow-up patients.

1.7.11 Principles for booking Cancer Pathway patients

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral
b) Dedicated registration functions for red flag and suspected cancer referrals should be in place within centralised HROs
c) Clinical teams must ensure triage is undertaken daily, irrespective of leave, in order to initiate booking patients
d) Patients will be contacted by telephone twice (morning and afternoon)
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of 3 days of receipt of referral
f) Systems should be established to ensure the Patient Tracker / MDT Co-ordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient

1.7.12 Principles for booking Urgent Pathway patients

a) Local agreements should be in place with consultants to determine the timeframe within which urgent patients should be booked, and made explicit to booking teams

b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation
c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the GP's classification of urgency
d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.
e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.7.13 Principles for booking Routine Pathway patients

a) Patients should be booked to ensure appointment within the maximum waiting time guarantees for routine appointments
b) Referrals will be received, registered within one working day at HRO's and forwarded to consultants for prioritisation
c) Patients will receive an acknowledgement from the Trust indicating their expected length of wait and information on the booking process they will follow
d) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified
e) Patients should be selected for booking in chronological order from the PTL
f) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment

1.7.14 Principles for Booking Review Patients

a) Patients who need to be reviewed within 6 weeks will agree their appointment before they leave the clinic

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list
c) Patients will be added to the review waiting list with an indicative date of treatment and selected for booking according to this date
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment

1.7.15 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey. Examples of this include:

a) midwives contacting patients directly by telephone to arrange their appointment
b) clinical genetics services where family appointments are required
c) mental health or vulnerable children's services where patients may need additional reminders or more than one professional contacted if patients fail to make an appointment.

SECTION 2

GUIDANCE FOR MANAGEMENT OF ICATS SERVICES

2.1 INTRODUCTION

2.1.1 The administration and management of ICATS referrals and ICATS requests for diagnostics must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.2 ICATS services are managed in accordance with the Data Definitions and Guidance Document for Monitoring of ICATS Services Sept 2007 **(Appendix 1).**

2.1.3 The level of functionality available on the Electronic Referral Management System to support the administration of patients in an ICATS setting is developmental. Achievement of the standards outlined will be where functionality permits.

2.1.4 Referrals will be managed through a centralised registration process in the nominated Hospital Registration Offices (HRO's) within Trusts to receive, register and process all ICATS referrals. The Trust should ensure that a robust process is in place to ensure that referrals received outside the HRO are date stamped, forwarded to the HRO and registered onto ERMS according to the date received by the Trust.

2.1.5 All new patients should be able to book their appointment in line with the guidance outlined in Booking Principles Section 1.7 The expectation is that follow up patients should also be offered an opportunity to choose the date and time of their appointment.

2.2 KEY PRINCIPLES

2.2.1 Where ICATS is in place for a specialty, all referrals should be registered and scanned onto Electronic Referral Management System (ERMS) within 24 hours of receipt.

2.2.2 Each ICATS must have a triage rota to ensure that every referral is triaged and the appropriate next step is confirmed, according to the clinically agreed

rules, within three working days of receipt in any Hospital Registration Office (HRO). Triage rotas must take multi-site working into account. A designated officer in ICATS should oversee the triage arrangements.

2.2.3 The outcome of the triage will be confirmed by letters to the GP and patient within a further two working days of triage (five working days in total from receipt).

2.2.4 ICATS clinical staff will be aware of all exclusions that prevent patients from being assessed or treated within the ICATS setting**.**

2.2.5 Patients of equal clinical priority will be selected for booking in chronological order in order to meet the maximum waiting time guarantee for patients and local access standards.

2.2.6 All patients deemed appropriate will be offered an ICATS appointment within six weeks from the triage date.

2.2.7 Data collection should be accurate, timely, complete and subject to regular audit and validation.

2.2.8 Staff should be supported by appropriate training programmes.

2.3 CALCULATION OF THE WAITING TIME

2.3.1 The waiting time clock for ICATS starts after the triage decision has been taken that an appointment in ICATS clinic is the appropriate next step.

2.3.2 The ICATS clock stops when the patient attends for first appointment or when the patient has been discharged from ICATS.

2.3.3 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the

verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

2.3.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

2.3.4 No patient should have his or her appointment cancelled. If the ICATS service cancels a patient's appointment, the patient's waiting time clock will not be reset and the patient should be offered another appointment, ideally at the time of the cancellation, and which is within six weeks of the original appointment date.

2.4 NEW REFERRALS

2.4.1 All ICATS referrals will be registered and scanned onto ERMS within 24 hours of receipt. All referrals forwarded for ICATS triage must be triaged or assessed to make a clear decision on the next step of a referral within three working days of the referral being logged by the HRO onto ERMS.

2.4.2 Within five working days of the referral being recorded onto ERMS, the GP and patient must be issued with written confirmation of the next stage of the patient's treatment.

2.4.3 Where there is insufficient information for the professional to make a decision, they have the option to either return the referral to the referrer requesting the necessary information or contact the referrer in the first instance to access the necessary information. If this cannot be gained, the referral should be returned to the referrer requesting the necessary information and a new referral may be initiated.

2.4.4 Those patients identified for outpatients and diagnostic services following triage will be managed in line with the relevant sections of this IEAP.

Flowcharts illustrating the Triage Outcomes Process can be found in **Appendix 2.**

2.5 BOOKING

2.5.1 All patients requiring an appointment in an ICATS will have the opportunity to agree the date and time of their appointment, in line with the booking principles outlined in Section 1.7.

2.5.2 If a patient requests an appointment beyond the six week ICATS standard the patient will be discharged and told to revisit their GP when they are ready to be seen at the ICATS clinic. This will ensure that all patients waiting for an ICATS appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate recalculation of the patient's waiting time and to facilitate booking the patient into the date they requested.

2.5.3 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

2.6 REASONABLE OFFERS

2.6.1 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the second appointment date declined.

2.6.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

2.6.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date the service was notified of the cancellation, as the patient has entered into an agreement with the Trust.

2.6.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

2.7 MANAGEMENT OF PATIENTS WHO CANCELLED OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

2.7.1 If a patient DNAs their first ICATS appointment the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

2.7.2 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

2.7.3 If a patient has been referred back to their referring clinician and the referrer still wishes a patient to be seen in ICATS, a new referral is required.

2.7.4 The Implementation Procedure for the Management of Patients who DNA or Cancel can be found in **Appendix 4.**

2.8 MAXIMUM WAITING TIME GUARANTEE

2.8.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen. This will ensure that all patients waiting for an appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

2.9 COMPLIANCE WITH TRUST LEAVE PROTOCOL

2.9.1 It is essential that leave/absence of ICATS practitioners is organised in line with Trusts' notification of leave protocol. It is also necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of ICATS clinics.

2.9.2 The protocol should require a minimum of six weeks' notification of intended leave. A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

2.10 CLINIC OUTCOME MANAGEMENT

2.10.1 There are a number of locations within Trusts where patients present for their ICATS consultation. This protocol applies to all ICATS locations. It is the responsibility of the ERMS user managing the attendance to maintain data quality.

2.10.2 Changes in the patient's details must be updated on ERMS and the medical records on the date of clinic.

2.10.3 When the assessment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on ERMS.

2.11 REVIEW APPOINTMENTS

2.11.1 All review appointments must be made within the time frame specified by the ICATS practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the ICATS practitioner.

2.11.2 As previously stated, the Booking Centres will be responsible for partially booking all new appointments. Booking Centres will also book review appointments that are required to be more than 6 weeks in the future. ICATS administration staff will make bookings directly with the patient at the clinic for any further appointments needing to occur within 6 weeks.

2.12 TEMPLATE CHANGES

2.12.1 Templates should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

2.12.2 Templates will identify the number of slots available for new and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated to each appointment slot.

2.12.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

2.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for management of Clinic Template Changes can be found in **Appendix 5.**

2.13 VALIDATION

2.13.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. Trusts should ensure that all relevant data fields are completed in ERMS. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce.

2.13.2 The data validation process will apply to both new and follow up appointments. The Implementation Procedure for data validation can be found in **Appendix 6.**

SECTION 3

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

3.1 INTRODUCTION

3.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of outpatient services.

3.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

3.1.3 There will be dedicated Hospital Registration Offices (HROs) within Trusts to receive, register and process all outpatient referrals. The HROs will be required to register and scan referrals (where appropriate) onto the Electronic Referrals Management System (ERMS) and PAS.

3.1.4 There will be dedicated booking functions within Trusts and all new and review outpatients should have the opportunity to book their appointment. The booking process for non-routine groups of outpatients or those with additional service needs should be designed to identify and incorporate the specific pathway requirements of these patients.

3.2 CALCULATION OF THE WAITING TIME

3.2.1 The starting point for the waiting time of an outpatient new referral is the date the clinician's referral letter is received by Trusts. All referral letters, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received into the organisation.

3.2.2 In cases where referrals bypass the dedicated HRO’s, (e.g. sent directly to a consultant), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the HRO and registered at the date on the date stamp.

3.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the hospital was informed of the cancellation. Patients who

refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.2.3 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

3.3 KEY PRINCIPLES

3.3.1 Referrals into Trusts should be pooled where possible within specialties. Referrals to a specific consultant by a GP should only be accepted where there are specific clinical requirements or stated patient preference. As a minimum, all un-named referrals should be pooled.

3.3.2 All referrals, appointments and waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list, allocated according to urgency of the treatment. Trusts will manage patients in 2 streams, i.e. urgent and routine. Templates should be constructed to ensure enough capacity is available to treat each stream within agreed maximum waiting time guarantees. The Implementation Procedure for Template Redesign can be found in **Appendix 7.**

3.3.3 The regional target for a maximum OP waiting time is outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

3.3.4 Maximum waiting times for urgent patients should be agreed locally with clinicians, and made explicit to staff booking these patients to ensure that they are appointed within the clinical timeframe indicated by the consultant and capacity issues quickly identified and escalated.

3.3.5 Patients of equal clinical priority will be selected for booking in strict chronological order. Trusts must ensure that Department waiting and booking targets and standards are met.

3.3.6 Data collection should be accurate, timely, complete and subject to regular audit and validation.

3.3.7 Trusts should provide training programmes for staff which include all aspects of this IEAP and its Implementation Procedures. It is expected that training will be cascaded at and by each clinical, managerial or administrative tier within Trusts, providing the opportunity where required, for staff to work through operational scenarios.

3.3.8 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

3.4 NEW REFERRALS

3.4.1 All outpatient referrals sent to Trusts will be received at the dedicated HRO's and registered within one working day of receipt. GP priority status must be recorded at registration.

3.4.2 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and which are not returned can be identified.

3.4.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for referrals to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

3.4.5 All outpatient referrals letters will be prioritised and returned to the HRO within 3 working days. It will be the responsibility of the health records

manager or departmental manager to monitor this performance indicator. Monitoring will take place by consultant on a monthly basis. Following prioritisation, referrals must be actioned on PAS and appropriate correspondence issued to patients within 1 working day.

3.4.6 Where clinics take place, or referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby GP prioritisation is accepted in order to proceed with booking urgent patients.

3.4.7 Inappropriate and inadequate referrals should be returned to the referral source. A minimum referral criteria dataset has been agreed and is outlined in **Appendix 8**

3.4.8 An Effective Use of Resources Policy is in place for some services and Trusts should ensure that this is adhered to. The policy is included for reference in **Appendix 9.**

3.5 URGENT AND ROUTINE APPOINTMENTS

3.5.1 All consultant led outpatient appointments where the patient attends the Trust should be booked. The key requirements are that the patient is directly involved in negotiating the appointment date and time, and that no appointment is made more than six weeks into the future.

3.5.2 All routine patients must be booked within the maximum waiting time guarantee. Urgent patients must be booked within the maximum wait agreed locally with clinicians, from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

3.5.3 Acknowledgment letters will be sent to routine patients within five days of receipt of the referral. The estimated length of wait, along with information on

how the patient will be booked, should be included on the acknowledgement letter.

3.5.4 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients refusing short notice appointments (i.e. less than three weeks' notice) will not have their waiting time reset, in line with guidance on reasonable offers.

3.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

3.6 BOOKING

3.6.1 All new and review consultant led outpatient clinics should be able to book their appointment. This will entail patients having an opportunity to contact the hospital and agree a convenient date and time for their appointment. The use of the Patient Choice field on PAS is mandatory. The only fields that should be used are 'Y' to indicate that the appointment has been booked or 'N' to indicate that an appointment has not been booked. No other available field should be used as compliance with booking requirements will be monitored via the use of the Patient Choice field. For non-ISOFT and manual administration systems, Trusts should ensure that they are able to record and report patients who have been booked.

3.7 REASONABLE OFFERS

3.7.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.7.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

3.7.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

3.7.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

3.8 MANAGEMENT OF PATIENTS WHO CANCELLED (CNA) OR DID NOT ATTEND (DNA) THEIR APPOINTMENT

3.8.1 If a patient DNAs their outpatient appointment, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

3.8.2 There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to partial booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

3.8.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

3.8.4 If a patient cancels their outpatient appointment the following process must be implemented:

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.

- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

3.8.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

3.8.6 The Implementation Procedure on DNAs and Cancellations can be found in **Appendix 4.**

3.9 MAXIMUM WAITING TIME GUARANTEE

3.9.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their GP when they are ready to be seen in the Outpatient Clinic. This will ensure that all patients waiting for an outpatient appointment are fit and ready to be seen. It is accepted that local discretion may be required where short periods of time are involved, for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

3.10 COMPLIANCE WITH LEAVE PROTOCOL

3.10.1 Capacity lost due to cancelled or reduced clinics at short notice has negative consequences for patients and on the Trust's ability to successfully

implement booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

3.10.2 It is essential that planned medical and other clinical leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments. There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

3.10.3 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed HR policies.

3.10.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit. The Implementation Procedure for Compliance with Leave Protocol can be found in **Appendix 10.**

3.11 CLINIC OUTCOME MANAGEMENT

3.11.1 There are a number of locations within Trusts where patients present for their outpatient consultation. This protocol applies to all outpatient areas. It is the responsibility of the PAS user managing the attendance to maintain data quality.

3.11.2 All patients will have their attendance registered on PAS upon arrival in the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS and the medical records.

3.11.3 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

3.11.4 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic. The implementation procedure for the Management of Clinic Outcomes can be found in **Appendix 11.**

3.12 REVIEW APPOINTMENTS

3.12.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the consultant. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative month of treatment and take the necessary action to ensure capacity is available for this cohort.

3.12.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the department and PAS updated. Patients requiring an appointment outside six weeks will be placed on a review waiting list, with the indicative appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

3.13 CLINIC TEMPLATE CHANGES

3.13.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement and ensure that there is sufficient capacity allocated to enable each appointment type to be booked in line with clinical requirements and maximum waiting time guarantees for patients.

3.13.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

3.13.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for clinic template changes.

3.13.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager. The Implementation Procedure for the management of Clinic Template Changes can be found in **Appendix 5.**

3.14 VALIDATION

3.14.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times. The Implementation Guidance for Data Validation can be found in **Appendix 6.**

3.14.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

3.14.3 For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their appointment.

3.15 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.15.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

3.15.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Outpatient Transfers can be found in **Appendix 15a.**

SECTION 4

PROTOCOL GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

4.1 INTRODUCTION

4.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of diagnostic waiting lists. Where possible, the principles of good practice outlined in the Outpatient and Elective Admissions Section of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

4.1.2 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

4.1.3 There will be a centralised registration process within Trusts to receive, register and process all diagnostic referrals. It is expected that this will be in a single location, where possible.

4.1.4 The Trust should work towards introducing choice of the date and time of tests to all patients. The Booking Principles outlined in Section 1 of this document should be considered in the development of this strategy.

4.2 CALCULATION OF THE WAITING TIME

4.2.1 The starting point for the waiting time of a request for a diagnostic test is the date the clinician's request is received into the department, in line with the guidance on Completing Diagnostic Waiting Times Collection (Definitions Document), September 2007. This can be found in **Appendix 14.** All referral letters and requests, including faxed, emailed and electronically delivered referrals, will be date stamped on the date received.

4.2.2 Patients who cancel an appointment will have their waiting time clock reset to the date the service was informed of the cancellation.

4.2.3 Patients who refuse a reasonable offer of an appointment will also have their waiting time clock reset to the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.2.4 Patients who fail to attend their appointment without giving prior notice (DNA) will have their waiting time clock reset to the date of the DNA.

4.3 KEY PRINCIPLES

4.3.1 Trusts must have in place arrangements for pooling all referrals unless there is specific clinical information which determines that the patient should be seen by a particular consultant with sub-specialty interest.

4.3.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list, and patients managed in 2 streams, i.e. urgent and routine. Session or clinic templates should be constructed to ensure enough capacity is available to treat each stream within the maximum waiting time guarantees outlined in Section 1.4. Maximum waiting times for urgent patients should be agreed locally with clinicians.

4.3.3 Data collection should be accurate, timely, complete and subject to regular audit and validation.

4.3.4 Staff should be supported by appropriate training programmes.

4.3.5 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there may be services which require alternative processes.

4.4 NEW DIAGNOSTIC REQUESTS

4.4.1 All diagnostic requests sent to Trusts will be received at a single location within the specialty Department. Trusts should explore the setting of one centralised diagnostic registration centre.

4.4.2 All requests will be registered on PAS / relevant IT system within one working day of receipt. Only authorised staff will have the ability to add, change or remove information in the outpatient module of PAS or other diagnostic system.

4.4.3 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system and that letters sent for prioritisation and not returned can be identified. Trusts should consider the introduction of clinical tracking systems similar to that used in patient chart tracking.

4.4.4 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians will be responsible for ensuring that cover is provided for requests to be read and prioritised during their absence. A designated officer should oversee this and a protocol will be required for each department.

4.4.5 All requests will be prioritised and returned to the central registration point within 3 working days. It will be the responsibility of the health records manager or departmental manager to monitor this performance indicator. Monitoring on a consultant level will take place by consultant on a monthly basis. Following prioritisation, requests must be actioned on PAS / IT system and appropriate correspondence issued to patients within 1 working day.

4.4.6 Where clinics take place, or requests can be reviewed less frequently than weekly, a process must be put in place and agreed with clinicians whereby the GP's priority is accepted in order to proceed with booking urgent patients.

4.4.7 Inappropriate and inadequate requests should be returned to the referral source. Minimum referral criteria is being developed to ensure the referral process is robust.

4.5 URGENT AND ROUTINE APPOINTMENTS

4.5.1 All requests must be booked within the maximum waiting time guarantee. The key requirement is that the patient is directly involved in negotiating the date and time of the appointment and that no appointment is made more than six weeks in advance.

4.5.2 Urgent requests must be booked within locally agreed maximum waits from the date of receipt. It is recognised that there will be exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Trusts should ensure that when accommodating these patients, the appointment process is robust and clinical governance requirements met.

4.5.3 All routine patients must be booked within the maximum waiting time guarantee. Acknowledgement letters will be issued to routine patients within 5 working days of receipt of request. The estimated wait, along with information on how the patients will be booked should be included on the acknowledgement letter.

4.5.4 A minimum of three weeks notice should be provided for all routine patients. This does not prevent patients being offered earlier appointment dates. Patients who refuse short notice appointments (i.e. less than three weeks notice) will not have their waiting time reset in line with guidance on reasonable offers.

4.5.5 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

4.6 CHRONOLOGICAL MANAGEMENT

4.6.1 Patients of equal clinical priority will be selected for appointment in chronological order and Trusts must ensure that regional standards and targets in relation to waiting times and booking requirements are met. The process of selecting patients for diagnostic investigations is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources.

4.6.2 It is expected that Trusts will use two prioritisation categories; urgent and routine.

4.7 BOOKING METHODS

4.7.1 Booking will enable patients to have an opportunity to contact the service and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

4.8 REASONABLE OFFERS

4.8.1 For patients who have been able to book their appointment, a reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks' notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

4.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

4.8.3 If the patient however accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the Trust.

4.8.4 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above. The Implementation Procedure on Reasonableness can be found in **Appendix 3.**

4.9 PATIENT CANCELLATIONS (CNAS) AND DID NOT ATTENDS (DNAS)

4.9.1 If a patient DNAs their diagnostic test, the following process must be implemented.

- Where a patient has had an opportunity to agree the date and time of their appointment, they will not normally be offered a second appointment. These patients will be referred back to the care of their referring clinician.
- Under exceptional circumstances a clinician may decide that a patient should be offered a second appointment. The second appointment must be booked.

4.9.2 There may be instances for follow-up patients where the clinician may wish to review notes prior to any action to remove a patient because of DNA or failure to respond to booking invitation letters. Trusts should ensure that robust and locally agreed rules and processes are in place so that booking clerks are clear about how to administer these patients.

4.9.3 In a transition period where fixed appointments are still being issued, patients should have two opportunities to attend.

4.9.4 If a patient cancels their appointment, the following process must be implemented.

- The patient will be given a second opportunity to book an appointment, which should be within six weeks of the original appointment date.
- If a second appointment is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

4.9.5 Following discharge, patients will be added to the waiting list at the written request of the referring GP and within a four week period from the date of discharge. Patients should be added to the waiting list at the date the written request is received.

4.10 TRANSFERS BETWEEN HOSPITALS

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

4.10.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly.

4.11 COMPLIANCE WITH TRUST LEAVE PROTOCOL

4.11.1 One of the major issues regarding the operation of healthcare services is the capacity lost due to cancelled or reduced clinics at short notice. This has negative consequences for patients and on the ability to successfully implement booking requirements. Clinic or session cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

4.11.2 It is therefore essential that leave/absence is organised in line with the Trust's Human Resources leave protocol. It is necessary for Trusts to have robust policies and procedures that minimise the cancellation/reduction of diagnostic sessions and the work associated with the rebooking of appointments. Where cancelling and rebooking is unavoidable the procedures used must be equitable and comply with clinical governance principles.

4.11.3 The local absence/leave protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed policies.

4.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

4.12 SESSION OUTCOME MANAGEMENT

4.12.1 There are a number of locations within Trusts where patients present for their diagnostic tests. This protocol applies to all diagnostic services. It is the responsibility of the PAS / relevant system user administrating the clinic to maintain data quality.

4.12.2 All patients will have their attendance registered on PAS / IT system upon arrival at the clinic. The patient must verify their demographic details on every visit. The verified information must be cross-checked on PAS / IT system and the medical record.

4.12.3 Changes in the patient's details must be updated on PAS / IT system and the medical record on the date of clinic.

4.12.4 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

4.13.1 DIAGNOSTIC TEST OUTCOME

4.13.1 The outcome of the diagnostic test must be available to the referrer without undue delay. A standard for the reporting turnaround time of tests will be introduced during 2008 and Trusts will be expected to monitor and report compliance to the standard.

4.14 FOLLOW UP APPOINTMENTS

4.14.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

4.14.2 Where follow up appointments are not booked, patients who require a review within six weeks will negotiate the date and time of this appointment before leaving the department and PAS / IT system updated. Patients requiring an appointment outside six weeks will have their appointment managed through a 'hold and treat' system. They will be managed on a review waiting list, with an indicative date of treatment and sent a letter confirming their appointment date six weeks in advance.

4.15 TEMPLATE CHANGES

4.15.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

4.15.2 Templates will identify the number of slots available for new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

4.15.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of six weeks notice will be provided for session template changes.

4.15.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

4.16 VALIDATION

4.16.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis and ideally on a weekly basis as waiting times reduce. This is essential to ensure PTLs are accurate and robust at all times.

4.16.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

4.16.3 For patients in specialties which still issue fixed appointments, they will be contacted to establish whether they require their appointment.

4.16.4 Until follow-up and planned appointments are booked, the validation process will apply to follow up appointments.

4.17 PLANNED PATIENTS AND DIAGNOSTICS TESTS CLASSIFIED AS DAY CASES

4.17.1 Trusts should ensure that the relevant standards in the Elective Admissions section of this document are adhered to.

4.18 PLANNED PATIENTS

4.18.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

4.18.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

4.18.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.19 HOSPITAL INITIATED CANCELLATIONS

4.19.1 No patent should have his or her admission cancelled. If Trusts cancel a patient's admission, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity, which should must be within the maximum waiting time guarantee.

4.19.2 Trusts should aim to have processes in place to have the new proposed admission date arranged before that patient is informed of the cancellation.

4.19.3 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

4.19.4 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.19.5 Where patients are cancelled on the day of a test as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.19.6 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of hospital initiated reasons, i.e. equipment failure, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.20 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

4.20.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

4.20.2 Where different clinicians are working together will perform more than one test at one time the patient should be added to the waiting list of the clinician for the priority test with additional clinicians noted, subject to local protocols.

4.20.3 Where a patient requires more than one test carried out on separate occasions by different (or the same) clinician, the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

4.20.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

SECTION 5

GUIDANCE FOR MANAGEMENT OF ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 Allied Health Professionals work with all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors. This guidance provides an administrative framework to support the management of patients waiting for AHP services.

5.1.2 Although it is written primarily for services provided in Trusts, it is recognised that there are a number of AHPs who provide services for children with physical and learning disabilities within special schools and with special educational needs within mainstream schools. Operational practices in these settings should be in line with the principles of the IEAP and provide consistency and equity for patients. Trusts should collaborate with colleagues within the Department of Education and the relevant schools to harmonise practices and ensure that children are able to access services equitably and within the maximum waiting time guarantees. A robust monitoring process will be required.

5.1.3 For the purposes of this section of the protocol, the generic term ‘clinic’ will be used to reflect AHP activity undertaken in hospital, community or domiciliary settings as it is recognised that AHPs provide patient care in a variety of care locations.

5.2 KEY PRINCIPLES

5.2.1 Trusts should ensure that there is a systematic approach to modernising AHP services which will help to improve access to services and quality of care for patients. This section should be read within the overall context of both the IEAP and the specific section governing the management of hospital outpatient services.

5.2.2 When looking at the experience of the patient it is important to consider the whole of their journey, with both the care and administrative pathways designed to support the patient's needs at each stage. The wait to receive outpatient therapy is likely to be one of many they experience in different parts of the system. It is the responsibility of all those involved to ensure that the patient wastes as little time as possible waiting and is seen by the right person as quickly as possible.

5.2.3 Booking will enable patients to have an opportunity to contact the hospital and agree a convenient time for their appointment. As outlined in paragraph 4.1.4, booking strategies should be developed in line with these Booking Principles. In the interim period, while fixed appointments are being issued, Trusts should ensure that the regional guidance is followed in the management of patients.

5.3 CALCULATION OF THE WAITING TIME

5.3.1 The waiting time clock for an AHP referral commences on the date the referral letter is received by the AHP service within the Trust. All referral letters, including faxed, emailed and electronically received referrals, will be date stamped on the date received.

5.3.2 The waiting time clock stops when the first definitive AHP treatment has commenced or when a decision is made that treatment is not required. Further information on definitions and sample patient pathways is contained in the Data Definitions and Guidance Document for AHP Waiting Times and can be found in **Appendix 12.**

5.3.3 As booking systems are introduced, patients should be made a reasonable offer, where clinically possible. Patients who refuse a reasonable offer of treatment, or fail to attend an AHP appointment, will have their waiting time clock re-set to the date the service was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs).

5.4 NEW REFERRALS

5.4.1 All AHP referrals will be registered on the relevant information system within 1 working day of receipt.

5.4.2 Trusts should work towards a system whereby all AHP referrals sent to the Trust are received at a dedicated registration function (s). Trusts should ensure that adequate systems are in place to deal with multiple referrals for the same patient regarding the same condition from a number of sources.

5.4.3 All referrals must be triaged or assessed to make a clear decision on the next step of a referral and clinical urgency (urgent or routine) clearly identified and recorded. All referrals will be prioritised and returned to the registration point with 3 working days.

5.4.4 Trusts must ensure that protocols are in place to prevent unnecessary delay from date stamping / logging of referrals to forwarding to the AHP department responsible for referral triage and/or initiation of treatment. It will be the responsibility of the relevant manager to monitor this performance indicator.

5.4.5 A robust system should be in place to ensure that cover is provided for referrals to be read and prioritised during practitioners' absence. A designated officer should oversee this and a protocol will be required for each service.

5.4.6 Where referrals can be reviewed less frequently than weekly, a process must be put in place and agreed with AHPs whereby the referrer's prioritisation is accepted in order to proceed with booking patients.

5.4.7 Following prioritisation, referrals must be updated on the relevant information system and appropriate correspondence issued to patients within 1 working day. Where there is insufficient information for the AHP to make a decision, they should contact the originating referrer in the first instance to access the

necessary information. If this cannot be gained, the referral should be returned to the referral source.

5.4.8 Trusts will work towards a system whereby the location of all letters can be tracked at all times through the referral and appointment system, and that letters sent to be prioritised and letters which are not returned can be identified.

5.4.9 If at the referral stage the patient / client is identified as being clinically or socially unfit to receive the necessary service the referral should not be accepted (not added to a waiting list) and returned to the originating referrer with a request that they re-refer the patient / client when they are clinically or socially fit to be treated.

5.5 URGENT AND ROUTINE APPOINTMENTS

5.5.1 All routine patients should be appointed within the maximum waiting time guarantee. Urgent patients must be booked within locally agreed maximum waits from the date of receipt. Local booking process should be based upon the principles outlined in Section 1.7.

5.5.2 For routine waiting list patients, an acknowledgement letter will be sent to patients within 5 working days of receipt of the referral, which should provide information to patients on their anticipated length of wait and details of the booking process.

5.5.3 A minimum of three weeks' notice should be provided for all routine patients. This does not prevent patients being offered an earlier appointment. Patients refusing short notice appointments (i.e. less than three weeks notice) will not have their waiting time clock reset, in line with guidance on reasonable offers.

5.5.4 Trusts must ensure that all communication to patients is clear, easily understood and complies with all relevant legislation.

5.6 CHRONOLOGICAL MANAGEMENT

5.6.1 Patients, within each clinical priority category, should be selected for booking in chronological order, i.e. based on the date the referral was received. Trusts should ensure that local administrative systems have the capability and functionality to effectively operate a referral management and booking system that is chronologically based.

5.7 CAPACITY PLANNING AND ESCALATION

5.7.1 It is important for AHP services to understand their baseline capacity, the make-up of the cohort of patients waiting to be treated and the likely changes in demand that will impact on their ability to initiate treatment and meet the maximum waiting time guarantees for patients.

5.7.2 Trusts should ensure that robust prospective capacity planning arrangements are in place, with clear escalation procedures to facilitate capacity gaps to be identified and solutions found in a timely manner to support operational booking processes and delivery of the targets.

5.8 REASONABLE OFFERS

5.8.1 As booking systems are introduced, patients should be offered reasonable notice, where clinically possible. A reasonable offer is defined as an offer of appointment, irrespective of provider, that gives the patient a minimum of three weeks notice and two appointments. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused. To ensure a verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.8.2 If the patient is offered an appointment within a shorter notice period and it is refused, the waiting time cannot be recalculated.

5.8.3 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of cancellation as the patient has entered into an agreement with the Trust.

5.8.3 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

5.9 AHP SERVICE INITIATED CANCELLATIONS

5.9.1 No patent should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable appointment date, ideally at the time of cancellation, and no more than 6 weeks in advance. The Trust must ensure that the new appointment date is within the maximum waiting time guarantee.

5.9.2 The patient should be informed of the reason for the cancellation and the date of the new appointment. This should include an explanation and an apology on behalf of the Trust.

5.9.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.9.4 AHP service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment as a result of AHP service initiated reasons, i.e. equipment failure, staff sickness, a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.10 MAXIMUM WAITING TIME GUARANTEE

5.10.1 If a patient requests an appointment date that is beyond the maximum waiting time guarantee, the patient will be discharged and advised to revisit their referrer when they are ready to be seen. This will ensure that all patients waiting for an AHP appointment / treatment are fit and ready to be seen.

5.10.2 There will undoubtedly be occasions and instances where local discretion is required and sensitivity should be applied when short periods of time are involved; for example, if patients are requesting dates up to a week over their breach date. Trusts should ensure that reasonableness is complied with to facilitate re-calculation of the patient's waiting time, and to facilitate booking the patient into the date they requested.

5.11 COMPLIANCE WITH LEAVE PROTOCOL

5.11.1 Capacity lost due to cancelled or reduced clinics or visits at short notice has negative consequences for patients and on the Trust's ability to successfully implement robust booking processes. Clinic cancellation and rebooking of appointments is an extremely inefficient way to use such valuable resources.

5.11.2 It is therefore essential that AHP practitioners and other clinical planned leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of AHP clinics and the work associated with rebooking patient appointments. There should be clear practitioner agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient and comply with clinical governance principles.

5.11.3 The protocol should require a minimum of six weeks' notification of planned leave, in line with locally agreed HR policies.

5.11.4 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

5.12 CLINIC OUTCOME MANAGEMENT

5.12.1 All patients will have their attendance recorded or registered on the relevant information system upon arrival for their appointment. The patient must verify their demographic details on every visit. The verified information must be cross-checked on information system and the patient records. Any changes must be recorded and updated in the patient record on the date of the clinic.

5.12.2 When the assessment/treatment has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.13 REVIEW APPOINTMENTS

5.13.1 All review appointments must be made within the time frame specified by the practitioner. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the practitioner. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the practitioner.

5.13.2 Review patients who require an appointment within six weeks will negotiate the date and time of the appointment before leaving the service and PAS / information system updated. Patients requiring an appointment outside six weeks should be managed on a review waiting list, with the indicative date recorded when appointment is required and booked in line with the booking principles outlined.

5.13.3 If domiciliary review appointment is required within 6 weeks, the appointment date should be agreed with the patient and confirmed in writing by the booking office. Where a domiciliary review appointment is required outside 6 weeks, the patient should be managed on a review waiting list, within the indicative date recorded, and booking in line with the booking principles outlined.

5.14 CLINIC TEMPLATE MANAGEMENT

5.14.1 Clinic templates should be agreed between the practitioner and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement.

5.14.2 Templates will identify the number of slots available for new urgent, new routine and follow up appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.14.3 All requests for template and temporary clinic rule changes will only be accepted in writing to the relevant service manager. A minimum of six weeks notice will be provided for clinic template changes.

5.14.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.15 ROBUSTNESS OF DATA / VALIDATION

5.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a weekly basis and continually reviewed as waiting times reduce. This is essential to ensure Primary Targeting Lists are accurate and robust at all times.

5.15.2 As booking processes are implemented and waiting times reduce, there is no longer the need to validate patients by letter.

5.15.3 For patients in AHP services that are not yet booked, they will be contacted to establish whether they will still require their appointment.

SECTION 6 PROTOCOL GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

6.1 INTRODUCTION

6.1.1 The following protocol is based on nationally recommended good practice guidelines to assist staff with the effective management of elective waiting lists.

6.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

6.2 COMPUTER SYSTEMS

6.2.1 To ensure consistency and the standardisation of reporting with Commissioners and the Department, all waiting lists are to be maintained in the PAS system.

6.2.2 Details of patients must be entered on to the computer system within two working days of the decision to admit being made. Failure to do this will lead to incorrect assessment of waiting list size when the daily / weekly downloads are taken.

6.2.3 As a minimum 3 digit OPCS codes should be included when adding a patient to a waiting list. Trusts should work towards expanding this to 4 digit codes.

6.3 CALCULATION OF THE WAITING TIME

6.3.1 The starting point for the waiting time of an inpatient is the date the consultant agrees with the patient that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is medically fit to undergo such a procedure.

6.3.2 The waiting time for each inpatient on the elective admission list is calculated as the time period between the original decision to admit date and the date

at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

6.3.3 Patients who refuse a reasonable offer of treatment, or fail to attend an offer of admission, will have their waiting time reset to the date the hospital was informed of the cancellation (CNAs) or the date the patient failed to attend (DNAs). Any periods of suspension are subtracted from the patients overall waiting time.

6.4 STRUCTURE OF WAITING LISTS

6.4.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided into a limited number of smaller lists, differentiating between active waiting lists, planned lists and suspended patients.

6.4.2 Priorities must be identified for each patient on the active waiting list, allocated according to urgency of the treatment. The current priorities are urgent and routine.

6.5 INPATIENT AND DAY CASE ACTIVE WAITING LISTS

6.5.1 Inpatient care should be the exception in the majority of elective procedures. Trusts should move away from initially asking “is this patient suitable for day case treatment?” towards a default position where they ask “what is the justification for admitting this patient?” The Trust’s systems, processes and physical space should be redesigned and organized on this basis.

6.5.2 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to admit, i.e. if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in.

6.5.3 All decisions to admit will be recorded on PAS within two working days of the decision to admit being taken.

6.5.4 Robust booking and scheduling systems will be developed to support patients having a say in the date and time of their admission. Further guidance will be provided on this.

6.5.5 Where a decision to admit depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure the result of the investigation is timely and in accordance with the clinical urgency required to admit the patient.

6.5.6 The statements above apply to all decisions to admit, irrespective of the decision route, i.e. direct access patients or decisions to directly list patients without outpatient consultation.

6.6 COMPLIANCE WITH TRUST HR LEAVE PROTOCOL

6.6.1 Trusts should have in place a robust protocol for the notification and management of medical and clinical leave and other absence. This protocol should include a proforma for completion by or on behalf of the consultant with a clear process for notifying the theatre scheduler of leave / absence.

6.6.2 The protocol should require a minimum of six weeks' notification of intended leave, in line with locally agreed consultant's contracts.

6.6.3 A designated member of staff should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

6.7 TO COME IN (TCI) OFFERS OF TREATMENT

6.7.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner and confirmed in writing.

6.7.2 Patients should be made reasonable offers to come in on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

6.7.3 All patients must be offered reasonable notice. A reasonable offer is defined as an offer of admission, irrespective of provider, that gives the patient a minimum of three weeks' notice and two TCI dates. If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date of the refused admission.

6.7.4 If the patient is offered an admission within a shorter notice period and it is refused, the waiting time cannot be recalculated.

6.7.5 If the patient however accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of that admission as the patient has entered into an agreement with the Trust.

6.7.6 It is essential that Trusts have robust audit procedures in place to demonstrate compliance with the above.

6.8 SUSPENDED PATIENTS

6.8.1 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for social or

medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc).

- A maximum period not exceeding 3 months.

6.8.2 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or social reasons. These patients should be suspended from the active waiting list until they are ready for admission. All patients who require a period of suspension will have a personal treatment plan agreed by the consultant with relevant healthcare professionals. One month prior to the end of the suspension period, these plans should be reviewed and actions taken to review patients where required.

6.8.3 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

6.8.4 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

6.8.5 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

6.8.6 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for surgery.

6.8.7 No patient should be suspended from the waiting list without a review date. All review dates must be 1st of the month to allow sufficient time for the patient to be treated in-month to avoid breaching waiting times targets.

6.8.8 No more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

6.8.9 Trusts should ensure that due regard is given to the guidance on reasonableness in their management of suspended patients.

6.9 PLANNED PATIENTS

6.9.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or surgical investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria (e.g. check cystoscopy).

6.9.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

6.9.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

6.9.4 Ideally, children should be kept under outpatient review and only listed when they reach an age when they are ready for surgery. However, where a child has been added to a list with explicit clinical instructions that they cannot have surgery until they reach the optimum age, this patient can be classed as planned. The Implementation Procedure for Planned Patients can be found in **Appendix 13.**

6.10 CANCELLATIONS AND DNA'S

6.10.1 Patient Initiated Cancellations

Patients who cancel a reasonable offer will be given a second opportunity to book an admission, which should be within six weeks of the original admission date. If a second admission offer is cancelled, the patient will not normally be offered a third opportunity and will be referred back to their referring clinician.

6.10.2 Patients who DNA

If a patient DNAs their first admission date, the following process must be implemented:

- Where a patient has had an opportunity to agree the date and time of their admission, they will not normally be offered a second admission date.

- Under exceptional circumstances a clinician may decide that a patient should be offered a second admission. The second admission date must be agreed with the patient.

6.10.3 In a period of transition where fixed TCIs are still being issued, patients should have two opportunities to attend.

6.10.4 Following discharge patients will be added to the waiting list at the written request of the referring GP and within a four week period from date of discharge. Patients should be added to the waiting list at the date of the written request is received.

6.10.5 It is acknowledged that there may be exceptional circumstances for those patients identified as being ‘at risk’ (children, vulnerable adults).

6.10.6 No patient should have his or her operation cancelled prior to admission. If Trusts cancel a patient’s admission/operation in advance of the anticipated TCI date, the waiting time clock (based on the original date to admit) will not be reset and the patient will be offered an alternative reasonable guaranteed future date within a maximum of 28 days.

6.10.7 Trusts should aim to have processes in place to have the new proposed admission date arranged before the patient is informed of the cancellation.

6.10.8 The patient should be informed in writing of the reason for the cancellation and the date of the new admission. The correspondence should include an explanation and an apology on behalf of the Trust.

6.10.9 Trusts will make best efforts to ensure that a patient's operation is not cancelled a second time for non clinical reasons.

6.10.10 Where patients are cancelled on the day of surgery as a result of not being fit for surgery / high anaesthetic risk, they will be suspended, pending a clinical review of their condition either by the consultant in outpatients or by their GP. The patient should be fully informed of this process.

6.10.11 Hospital-initiated cancellations will be recorded and reported to the relevant department on a monthly basis.

6.11 PERSONAL TREATMENT PLAN

6.11.1 A personal treatment plan must be put in place when a confirmed TCI date has been cancelled by the hospital, a patient has been suspended or is simply a potential breach. The plan should:

- Be agreed with the patient
- Be recorded in the patient's notes
- Be monitored by the appropriate person responsible for ensuring that the treatment plan is delivered.

6.11.2 The listing clinician will be responsible for implementing the personal treatment plan.

6.12 CHRONOLOGICAL MANAGEMENT

6.12.1 The process of selecting patients for admission and subsequent treatment is a complex activity. It entails balancing the needs and priorities of the patient and the Trust against the available resources of theatre time and staffed beds.

6.12.2 The Booking Principles outlined in Section 1.7 should underpin the development of booking systems to ensure a system of management and monitoring that is chronologically as opposed to statistically based.

6.12.3 It is expected that Trusts will work towards reducing the number of prioritisation categories to urgent and routine.

6.13 PRE-OPERATIVE ASSESSMENT

6.13.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-operative assessment. This can be provided using a variety of methods including telephone, postal or face to face assessment. Please refer to the Design and Deliver Guide 2007 for further reference.

6.13.2 Pre operative assessment will include an anaesthetic assessment. It will be the responsibility of the pre-operative assessment team, in accordance with protocols developed by surgeons and anaesthetists, to authorise fitness for surgery.

6.13.3 If a patient is unfit for their operation, their date will be cancelled and decision taken as to the appropriate next action.

6.13.4 Only those patients that are deemed fit for surgery may be offered a firm TCI date.

6.13.5 Pre-operative services should be supported by a robust booking system.

6.14 PATIENTS WHO DNA THEIR PRE OPERATIVE ASSESSMENT

6.14.1 Please refer to the guidance outlined in the Outpatient section.

6.15 VALIDATION OF WAITING LISTS

6.15.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis, and ideally on a weekly basis as waiting times reduce. This is essential to ensure the efficiency of the elective pathway at all times.

6.15.2 As booking processes are implemented and waiting times reduce, there will no longer be the need to validate patients by letter. For patients in specialties that are not yet booked, they will be contacted to establish whether they will still require their admission.

6.15.3 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

6.16 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

6.16.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

6.16.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

6.16.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

6.17 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

6.17.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to Independent Sector Providers. Transfers should not be a feature of an effective scheduled system.

6.17.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant. Administrative speed and good communication are very important to ensure this process runs smoothly. The Implementation Procedure and Technical Guidance for Handling Inpatient Transfers can be found in **Appendix 15b.**

INTEGRATED ELECTIVE ACCESS PROTOCOL

June 2020

Integrated Elective Access Protocol

Protocol Summary -

The purpose of this protocol is to outline the approved procedures for managing elective referrals to first definitive treatment or discharge.

Version	**2.0** This guidance replaces the Integrated Elective Access Protocol, 30th April 2008.
Status	Draft for approval
Date	30 June 2020

Integrated Elective Access Protocol

Version

Version	Date of issue	Summary of change	Author
1.0	25 August 2006	New Regional Guidance: Integrated Elective Access Protocol	M Irvine M Wright S Greenwood
2.0	30 April 2008	Protocol refresh to encompass guidance on all aspects of the elective care pathway	M. Irvine, M. Wright, R. Hullat
3.0		Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

Integrated Elective Access Protocol Review Group

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Integrated Elective Access Protocol

Document control

The current and approved version of this document can be found on the Department of Health website https://www.health-ni.gov.uk and on the Health and Social Care Board and Trusts intranet sites.

Document:	Integrated Elective Access Protocol 3.0
Department:	Department of Health
Purpose:	To advise and inform patients and clinical, administrative and managerial staff of the approved processes for managing patients access to outpatient, diagnostic, elective and elective Allied Health Professional (AHP) services.
For use by:	All clinical, administrative and managerial staff who are responsible for managing referrals, appointments and elective admissions.
This document is compliant with:	Northern Ireland Health and Social Care (NI HSCC) and Department of Health (DOH) Information Standards and Guidance and Systems Technical Guidance. https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Home.aspx
Screened by:	
Issue date:	
Approval by:	
Approval date:	
Distribution:	Trust Chief Executives, Directors of Planning and Performance, Directors of Acute Care, Department of Health.
Review date:	1 April 2021

Monitoring compliance with protocol

Monitoring compliance with the processes in this document should be part of Trusts internal audit processes.

Contents

Abbreviations

AHP	Allied Health Professional
CCG	Clinical Communication Gateway
CNA	Could Not Attend (appointment or admission)
DNA	Did Not Attend (appointment or admission)
DOH	Department of Health
CPD	Health and Social Care Commissioning Plan and Indicators of Performance Direction,
E Triage	An electronic triage system
GP	General Practitioner
HR	Human Resources (Trusts)
ICU	Intensive Care Unit
IEAP	Integrated Elective Access Protocol
IS	Independent Sector (provider)
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
LOS	Length of Stay
MDT	Multidisciplinary Team
NI	Northern Ireland
PAS	Patient Administration System, which in this context refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting.
PTL	Primary Targeting List
SBA	Service and Budget Agreement
TCI	To Come In (date for patients)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied help professional (AHP) bookings, including cancer pathways and waiting list management.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.

1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

- Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Increase the number of patients with a booked outpatient or in-patient / daycase appointment, thereby minimising Did Not Attends (DNAs), cancellations (CNAs), and improving the patient experience.
- Reduce the number of cancelled operations for non-clinical reasons.

1.1.5 This protocol aims to ensure that a consistent approach is taken across all Trusts. The principles can be applied to primary and community settings, however it is recommended that separate guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.6 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic, inpatient and AHP waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for treatment.

1.1.7 This protocol will be reviewed regularly to ensure that Trusts' policies and procedures remain up to date and that the guidance is consistent with good practice and changes in clinical practice, locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.2 METHODOLOGY

1.2.1 The Department of Health (DOH) has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.2.4 For the purposes of this protocol, the term;

- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
- elective admissions refer to inpatient and daycase admissions,
- inpatient refers to inpatient and daycase elective treatment,
- diagnostic refers to patients who attend for a scan / test or investigation,
- AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
- partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
- fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
- virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
- PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.

1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.

1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.

1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.

1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be "fit, ready, and able" to come in (TCI).

1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.

1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.

1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.

1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.

1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.

1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. It is essential that patients who are considered at risk for whatever reason have their needs identified

and prioritised at the point of referral and appropriate arrangements made. Trusts must have mechanisms in place to identify such cases.

Have we anything in place for 1.3.10

1.3.11 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

1.3.12 Trusts must ensure that the needs of ethnic groups and people with special requirements should be considered at all stages of the patient's pathway.

1.4 BOOKING PRINCIPLES

1.4.1 These booking principles will support all areas across the elective and AHP pathways where appointment systems are used.

1.4.2 Offering the patient choice of date and time where possible is essential in agreeing and booking appointments with patients through partial booking systems. Trusts should ensure booking systems enable patients to choose and agree hospital appointments that are convenient for them.

1.4.3 Facilitating reasonable offers to patients should be seen within the context of robust booking systems being in place.

1.4.4 All booking principles should be underpinned with the relevant local policies to provide clarity to operational staff.

1.4.5 Trusts should ensure booking processes are continually reviewed and updated as required to reflect local and regional requirements at an operational level.

1.4.6 The definition of a booked appointment is:

a) The patient is given the choice of when to attend or have a virtual appointment.
b) The patient is able to choose and confirm their appointment within the timeframe relevant to the clinical urgency of their appointment.
c) The range of dates available to a patient may reduce if they need to be seen quickly, e.g. urgent referrals or within two weeks if cancer is suspected.
d) The patient may choose to agree a date outside the range of dates offered or defer their decision until later.

1.4.7 Principles for booking Cancer Pathway patients:

a) All suspected cancer referrals should be booked in line with the agreed clinical pathway requirement for the patient and a maximum of 14 days from the receipt of referral.
b) Dedicated registration functions for red flag (suspect cancer) referrals should be in place within centralised booking teams.
c) Clinical teams must ensure triage, where required, is undertaken daily, irrespective of leave, in order to initiate booking patients.
d) Patients will be contacted by telephone twice (morning and afternoon).
e) If telephone contact cannot be made, a fixed appointment will be issued to the patient within a maximum of three days of receipt of referral.
f) Systems should be established to ensure the Patient Tracker / Multidisciplinary Team (MDT) Co-coordinator is notified of the suspected cancer patient referral, to allow them to commence prospective tracking of the patient.

1.4.8 Principles for booking Urgent Pathway patients:

a) Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff.
b) Referrals will be received, registered within one working day and forwarded to consultants for prioritisation.

c) If clinical priority is not received from consultants within 72 hours, processes should be in place to initiate booking of urgent patients according to the referrers's classification of urgency.

d) Patients will be issued with a letter inviting them to contact the Trust to agree and confirm their appointment in line with the urgent booking process.

e) In exceptional cases, some patients will require to be appointed to the next available slot. A robust process for telephone booking these patients should be developed which should be clearly auditable.

1.4.9 Principles for booking Routine Pathway patients:

a) Patients should be booked to ensure appointment (including virtual appointment) is within the maximum waiting time guarantees for routine appointments.

b) Referrals will be received, registered within one working day at booking teams and forwarded to consultants for prioritisation.

c) Approximately eight weeks prior to appointment, Trusts should calculate prospective slot capacity and immediately implement escalation policy where capacity gaps are identified.
Rotas are not normally available 8 weeks out (annual leave/study leave notification period is 6 weeks. What escalation policy is being followed and where are the capacity gaps being escalated to? If this is an already known and accepted capacity gap, eg, through discussions with HSCB, vacant posts, do we always have to escalate?

d) Patients should be selected for booking in chronological order from the Primary Targeting List (PTL).

e) Six weeks prior to appointment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment.

1.4.10 Principles for Booking Review Patients;

a) Patients who need to be reviewed within 6 weeks will agree their appointment (including virtual appointment) before they leave the clinic, where possible.

b) Patients who require a review appointment more than 6 weeks in advance will be added to and managed on a review waiting list.
c) Patients will be added to the review waiting list with a clearly indicated date of treatment and selected for booking according to this date.
d) Six weeks prior to the indicative date of treatment, patients are issued with a letter inviting them to contact the Trust to agree and confirm their appointment within a clinically agreed window either side of the indicative date of treatment.

1.4.11 It is recognised that some groups of patients may require booking processes that have additional steps in the pathway. These should be designed around the principles outlined to ensure choice and certainty as well as reflecting the individual requirements necessary to support their particular patient journey.

Is there any provision to change date required if patient does not accept reasonable offer?

1.5 VIRTUAL ACTIVITY

1.5.1 Virtual Activity relates to any planned contact by the Trust with a patient (or their proxy) for healthcare delivery purposes i.e. clinical consultation, advice, review and treatment planning. It may be in the form of a telephone contact, video link, telemedicine or telecommunication, e.g. email.

1.5.2 The contact is in lieu of a face-to-face contact of a patient/client, i.e. a face-to-face contact would have been necessary if the telephone/video link/etc. had not taken place.

1.5.3 The call/contact should be prearranged with the patient and /or their proxy. Patients should not be disadvantaged where a decision is made to assess their clinical need through the use of virtual clinics.
Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

1.5.4 The contact must be auditable with a written note detailing the date and substance of the contact is made following the consultation and retained in the patient's records.

1.6 COMPLIANCE WITH LEAVE PROTOCOL

1.6.1 It is essential that planned medical and other clinical staff leave or absence is organised in line with an agreed Trust Human Resources (HR) protocol. Thus it is necessary for Trusts to have robust local HR policies and procedures in place that minimise the cancellation/reduction of outpatient clinics and the work associated with the rebooking of appointments.

1.6.2 There should be clear medical and clinical agreement and commitment to this HR policy. Where cancelling and rebooking is unavoidable the procedures used must be equitable, efficient, comply with clinical governance principles and ensure that maximum waiting times for patients are not compromised.

1.6.3 The protocol should require a **minimum** of **six** weeks' notification of intended leave, in line with locally agreed HR policies, in order to facilitate Trusts booking teams to manage appointment processes **six** weeks in advance.

1.6.4 The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

1.7 VALIDATION

1.7.1 A continuous process of data quality validation should be in place to ensure data accuracy at all times. This should be undertaken as a minimum on a monthly basis. This is essential to ensure the efficiency of the elective pathway at all times. In addition, Trusts should ensure that waiting lists are regularly validated to ensure that only those patients who want or still require a procedure are on the waiting list.

1.7.2 Involvement of clinicians in the validation process is essential to ensure that waiting lists are robust from a clinical perspective. Trusts should ensure an ongoing process of clinical validation and audit is in place.

Have we anything set up for the ongoing clinical validation

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.

2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.

2.1.4 Fixed appointments should only be used in exceptional circumstances.

2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

Is there anything we need to have n place here?

2.2 KEY PRINCIPLES

2.2.1 Referrals into Trusts should be pooled where possible within specialties.

2.2.2 All new referrals, appointments and outpatient waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in three priorities, i.e.

1. Red flag (suspect cancer),
2. urgent and
3. routine.

No other clinical priority categories should be used for outpatient services.

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes that would make sense

2.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

2.2.4 Patient appointments for new and review should be **partially booked.** **In the case of red flag appointments and 14 day target, it is not always possible to partial book appointments. The principles in section 1 are applied, ie the 2 attempts at telephone contacts and 1 fixed appointment.**

2.2.5 The regional target for a maximum outpatient waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

2.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

2.2.7 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

2.2.8 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

2.2.9 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

2.2.10 Trusts will work towards providing a single point of contact for all patients with respect to outpatient appointment services. It is recognised that there may be services which require alternative processes.

2.2.11 Trusts should **not** use manual administration systems to record and report patients who have been booked.

2.2.12 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

2.3 NEW REFERRALS

2.3.1 All outpatient referrals (including those sent via Clinical Communication Gateway (CCG)) sent to Trusts will be registered within **one** working day of receipt. Referrer priority status must be recorded at registration.

2.3.2 Trusts will work towards a system whereby the location of all referrals (paper and electronic) not yet prioritised can be identified and tracked.

2.3.3 All referrals must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

2.3.4 All referrals will be prioritised (including those prioritised via E-Triage) within **a maximum of three** working days of date of receipt of referral. Note; Red flag referrals require **daily** triage.

2.3.5 Following prioritisation, referrals must be actioned on PAS and appropriate correspondence (including electronic), e.g. acknowledgement or appointment letter, issued to patients within **one** working day.

2.3.6 Inappropriate and inadequate referrals should be returned to the referral source immediately and the referral closed and managed in line with the PAS technical guidance.

2.4 CALCULATION OF THE WAITING TIME – STARTING TIME

2.4.1 The starting point for the waiting time of an outpatient new referral is the date the referral is received by the booking office/department.

2.4.2 In exceptional cases where referrals bypass the booking office (e.g. sent directly to a consultant) the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office and registered at the date on the date stamp.

2.5 REASONABLE OFFERS

2.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

2.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

2.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

2.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

2.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

2.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

2.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

2.6 REVIEW APPOINTMENTS

2.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

2.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

2.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

2.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

2.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

Not all patient contact is pre-arranged, there has been a number of virtual clinics following validation when contact is made with the patient at the point of validation and a decision/treatment plan agreed.

2.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

2.7.1 DNAs – New Outpatient

If a patient DNAs their new outpatient appointment the following process must be followed:

2.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

2.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

2.7.1(d) *Where patients are discharged from the waiting list (ref. 2.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

2.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

2.7.1(g) If the patient DNAs this second fixed appointment they will be removed from the waiting list and the steps in 2.7.1(d) should be followed.

2.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2 DNAs – Review Outpatient

If a patient DNAs their review outpatient the following process must be followed:

2.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

2.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

2.7.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

2.7.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks*

of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.

2.7.2(e) If the patient DNAs the second review appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

2.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

2.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

2.7.2(h) There may be instances for review patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

Is there any provision to change date required if patient does not accept reasonable offer/DNA or the consultant changes plan following review of notes?

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

If a patient cancels their outpatient appointment the following process must be followed:

2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

2.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

2.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

2.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

2.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

2.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

2.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

2.8.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

2.9 CLINIC OUTCOME MANAGEMENT

2.9.1 Changes in the patient's details must be updated on PAS and the medical records on the date of the clinic.

2.9.2 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

2.10 CLINIC TEMPLATE CHANGES

2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

2.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

2.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

2.12.1 Registrations that have been opened on PAS should **not** be left open. When a patient referral for a new outpatient appointment has been opened on PAS, and their referral information has been recorded correctly, the patient will appear on the waiting list and will continue to do so until they have been seen or discharged in line with the earlier sections of this policy.

2.12.2 When a patient has attended their new outpatient appointment their outcome should be recorded on PAS within **three** working days of the appointment. The possible outcomes are that the patient is:

- added to appropriate waiting list,
- discharged,
- booked into a review appointment or
- added to a review waiting list.

If one of the above actions is not carried out the patient can get lost in the system which carries a governance risk.

2.13 TIME CRITICAL CONDITIONS

2.13.1 All referrals for new patients with time critical conditions, should be booked in line with the agreed clinical pathway requirement for the patient and within a maximum of the regionally recognised defined timescale from the receipt of the referral (e.g. for suspect cancer (red flag) and rapid access angina assessment the timescale is 14 days).

2.13.2 Patients will be contacted by phone and if telephone contact cannot be made, a fixed appointment will be issued.

2.13.3 If the patient does not respond to an offer of appointment (by phone and letter) the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.

2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.

2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.

2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re;

- Acute activity definitions.
- Effective Use of Resources policy.

2.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage)
- Biologic therapies activity.
- Cancer related information.
- Centralised funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Outpatients who are to be treated for Glaucoma.
- Management of referrals for outpatient services.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

3.1 INTRODUCTION

3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.

3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

3.1.3 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations.** Local booking polices should be developed accordingly.

3.2 KEY PRINCIPLES

3.2.1 Referrals into Trusts should be pooled as the norm where possible.

3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for diagnostic services.

3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable)**.** Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.

3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.

3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.

3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

3.2.11 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there will be services which require alternative processes.

3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.

3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.

3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.

3.3.3 All requests must be prioritised and clinical urgency must be clearly identified. Clinicians and management will be responsible for ensuring that cover is provided for referrals to be read and prioritised during any absence.

3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.

3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.

3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

3.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointments, and
- at least **one** offer must be within Northern Ireland (NI), except in those cases where there are no alternative providers within NI.

The IT Systems currently being used for the management of the majority of diagnostics do not facilitate partial booking, however, the fixed appointment letters do ask patients to confirm and are issued with 3 weeks' notice where appropriate. The diagnostic booking teams follow this up with telephone calls to patients to confirm attendances.

3.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

3.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

3.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

3.5.5 Providers should have robust audit procedures in place to demonstrate compliance with the above.

3.5.6 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

3.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

3.6 FOLLOW UP APPOINTMENTS

3.6.1 All follow up appointments must be made within the time frame specified by the clinician. If a follow up appointment cannot be given at the specified time due to the unavailability of a session appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable follow up date should be discussed and agreed with the clinician.

3.6.2 Patients must be recorded on the IT system as requiring to be seen within a clinically indicated time. Trusts should actively monitor follow up patients on the review list to ensure that they do not go past their indicative time of treatment.

3.6.3 Follow up patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and the IT system updated.

3.6.4 Follow up patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with management guidance for follow up pathway patients.

3.7 PLANNED PATIENTS

3.7.1 Planned patients are those who are waiting to be recalled to hospital for a further stage in their course of treatment or investigation within specific timescales. This is usually part of a planned sequence of clinical care determined on clinical criteria.

3.7.2 These patients are not actively waiting for treatment to be initiated, only for planned continuation of treatment. A patient's care is considered as planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

3.7.3 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients must have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

3.7.4 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs.

3.8 PATIENTS LISTED FOR MORE THAN ONE DIAGNOSTIC TEST

3.8.1 Where more than one diagnostic test is required to assist with clinical decision making, the first test should be added to the waiting list with additional tests noted.

3.8.2 Where different clinicians working together perform more than one test at one time, the patient should be added to the waiting list of the clinician for the priority test (with additional clinicians noted) subject to local protocols.

3.8.3 Where a patient requires more than one test carried out on separate occasions the patient should be placed on the active waiting list for the first test and on the planned waiting list for any subsequent tests.

3.8.4 Where a patient is being managed in one Trust but has to attend another for another type of diagnostic test, monitoring arrangements must be in place between the relevant Trusts to ensure that the patient pathway runs smoothly.

There would be concern that a patient is only added to one waiting list, eg, a patient could require a number of different diagnostic tests to reach diagnosis and treatment plan, with varying waiting times for these tests, eg, a patient could be referred for a CT examination but also be added to the waiting list for an endoscopy procedure. A patient on cancer pathway could require PET and CT – these are different radiology modalities with different waiting lists. Cardiac patients could be listed for different examinations, eg, echo, stress test etc with varying waiting times.

The concern would be the risk that the patient would be closed off the system after the initial investigation or before all tests completed if only added to one waiting list.

3.9 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

3.9.1 <u>DNAs – Diagnostic Appointment</u>

If a patient DNAs their diagnostic appointment the following process must be followed:

3.9.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(b) Under exceptional circumstances a clinician may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with clinicians, regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should be offered.

3.9.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

3.9.1(d) *Where patients are discharged from the waiting list (ref. 3.7.1(a) above) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated*.

3.9.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referring clinician (and the patient's GP, where they are not the referring clinician) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.1(f) Where a patient DNAs a fixed diagnostic appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

3.9.1(g) If the patient DNAs this second fixed diagnostic appointment they will be removed from the waiting list and the above steps in 3.7.1(d) should be followed.

3.9.2 DNAs – Follow up Diagnostic Appointment

If a patient DNAs their follow up diagnostic appointment the following process must be followed:

3.9.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

3.9.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

3.9.2(c) Where the clinical decision is that a second appointment should **not** be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patients GP, where they are not the referring clinician) should also be informed of this.

3.9.2(d) *Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the review waiting list with a revised clinically indicated date at the date they make contact with the Trust.*

3.9.2(e) If the patient DNAs the second follow up appointment which has been partially booked then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

3.9.2(f) Where a patient DNAs a fixed follow up appointment, including virtual appointments, where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

3.9.2(g) There may be instances for follow up patients where the clinician may wish to review notes prior to any action to remove a patient because of a DNA or failure to respond to a partial booking letter. Trusts should ensure that there are locally agreed processes in place to administer these patients.

3.9.3 CNAs – Patient Initiated Cancellations of Diagnostic Appointment

If a patient cancels their diagnostic appointment the following process must be followed:

3.9.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

3.9.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

3.9.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

3.9.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

3.10 CNAs - HOSPITAL INITIATED CANCELLATIONS

3.10.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

3.10.2 The patient should be informed of the cancellation and the date of the new appointment.

3.10.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

3.10.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

3.11 SESSION OUTCOME MANAGEMENT

3.11.1 Changes in the patient's details must be updated on the IT system and the medical record on the date of the session.

3.11.2 When the test has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of session.

3.12 SESSION TEMPLATE CHANGES

3.12.1 Session templates should be agreed with the healthcare professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

3.12.2 Templates will identify the number of slots available for new red flag, new urgent, new routine, planned and follow up appointments; specify the time each session is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

3.12.3 All requests for template and temporary session rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for session template changes.

3.12.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

3.13 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

3.13.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

3.13.2 Transfers to alternative providers must always be with the consent of the patient and the receiving clinician and be managed in line with PAS technical guidance (see also Reasonable Offers, ref. 3.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

3.14 TECHNICAL GUIDANCE

3.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

3.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Diagnostic waiting time and report turnaround time.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Rapid angina assessment clinic (RAAC).
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).

- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

4.1 INTRODUCTION

4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.

4.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

Have we anything in place for this?

4.2 KEY PRINCIPLES

4.2.1 To aid both the clinical and administrative management of the waiting list, lists should be sub-divided and managed appropriately. Trusts will manage patients on one of three waiting lists, i.e.

1. active,
2. planned and
3. suspended.

4.2.2 All elective inpatient and daycase waiting lists should be managed according to clinical priorities. Priorities must be identified for each patient on the waiting list and allocated according to urgency of the treatment. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for inpatient and daycase services.

There are currently only 2 priority categories on PAS for referrals – urgent and routine. Red flags are identified by reason for referral code. Is this an opportunity to update PAS with a priority category for red flag? Yes this would make sense

4.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order, taking into account planned patients expected date of admission.

4.2.4 The regional targets for a maximum inpatient and daycase waiting times are outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

4.2.5 Maximum waiting times for urgent patients should be agreed locally with clinicians and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the consultant and capacity issues are quickly identified and escalated.

4.2.6 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.
Is this relevant to elective? Consultants normally select cases based on clinical priority etc.

4.2.7 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

4.2.8 Trusts should **not** use manual administration systems to record and report patients who have been booked.

4.2.9 Trusts should provide training programmes for staff which include all aspects of IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

4.3 PRE-ASSESSMENT

4.3.1 All patients undergoing an elective procedure (including endoscopy procedures) must undergo a pre-assessment. This can be provided using a variety of methods including telephone, video link, postal or face to face assessment.

4.3.2 Pre-assessment may include an anesthetic assessment or guidance on how to comply with pre-procedure requirements such as bowel preparation. It will be the responsibility of the pre- assessment team, in accordance with protocols developed by the relevant clinical teams, to authorise fitness for an elective procedure.

4.3.3 Only those patients that are deemed fit for their procedure may be offered a TCI date.

4.3.4 If a patient is assessed as being unfit for their procedure, their To Come In (TCI) date may be cancelled and decision taken as to the appropriate next action.

4.3.5 Pre-assessment services should be supported by a robust booking system.

4.4 CALCULATION OF THE WAITING TIME

4.4.1 The starting point for the waiting time of an inpatient/daycase admission is the date the appropriate clinician agrees that a procedure will be pursued as an active treatment or diagnostic intervention, and that the patient is clinically and socially fit to undergo such a procedure.

4.4.2 The waiting time for each patient on the elective admission list is calculated as the time period between the original decision to admit date and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

4.5 REASONABLE OFFERS - TO COME IN (TCI) OFFERS OF TREATMENT

4.5.1 The patient should be advised of their expected waiting time during the consultation between themselves and the health care provider/practitioner.

4.5.2 All patients must be offered reasonable notice. Patients should be made reasonable offers to come in (TCI) on the basis of clinical priority. Within clinical priority groups offers should then be made on the basis of the patient's chronological wait.

4.5.3 A reasonable offer is defined as:

- an offer of admission, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and a choice of **two** TCI dates, and
- at least **one** of the offers must be within N. I., except for any regional specialties where there are no alternative providers within NI.

The majority of elective procedures are fixed appointments, based on when consultants are available for theatre sessions, availability of ICU capacity if required, volume of predicted in-patient beds etc. This is a complex booking process which can be difficult to adapt with partial booking.
Does there need to be a guidance for fixed elective offers?

4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.

4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional

exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.

4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be “fit, ready, and able” to come in.

4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.

4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within **two** working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.

4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.

4.7.2 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).
- A recommended maximum period not exceeding **three** months.

4.7.3 No patient should be suspended from the waiting list without a suspension end date.

4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.

4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

4.7.9 Recommended practice is that no more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

4.8 PLANNED PATIENTS

4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.

4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between interventions. They will not be classified as being on a waiting list for statistical purposes.

4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.

4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

4.9.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

4.10 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR ADMISSION

DNAs – Inpatient/Daycase

4.10.1 If a patient DNAs their inpatient or daycase admission, the following process must be followed:

4.10.1(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second date should be offered or whether the patient can be discharged.

4.10.1(b) Where the clinical decision is that a second admission should be offered, the admission date must be agreed with the patient. Trusts should put in place local agreements with clinicians regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

4.10.1(c) Patients who DNA and are not discharged but offered a second date will have their waiting time clock reset to the date of the DNA.

4.10.1(d) Where the clinical decision is that a second date should not be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

4.10.1(e) *Patients being discharged from the list should be advised to contact the Trust if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original date, a clinical decision may be made to offer a second date. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

Is there a process in place for this the same as outpatients were a letter is sent to the patient and they phone in ?

4.10.1(f) If the patient DNAs the second admission offered then the above steps should be followed.

4.10.1(g) Where a patient DNAs a fixed admission date (i.e. they have not had the opportunity to agree/ confirm the date and time of their admission), they should be offered another date.

4.10.1(h) If the patient DNAs this second fixed admission, they will be removed from the waiting list and the steps in 4.10.1(e) should be followed.

4.10.1(i) Where a patient DNAs a pre-assessment appointment they will be offered another date. If they DNA this second pre-assessment appointment, they will be removed from the waiting list and the above steps in 4.10.1(e) should be followed.

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

If a patient cancels their inpatient/ daycase admission the following process must be followed:

4.10.2(a) Patients who cancel an agreed reasonable offer will be given a second opportunity to book an admission, which should ideally be within **six weeks** of the original admission date.

4.10.2(b) If a second agreed offer of admission is cancelled, the patient will not be offered a **third** opportunity.

4.10.2(c) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second admission, the Trust may exercise discretion to offer a third admission - this should include seeking a clinical review of the patient's case where this is appropriate.

4.10.2(d) Where a decision is taken not to offer a further admission, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

4.10.2(e) Where a patient CNAs a pre-assessment appointment they should be offered another date. If they CNA this second pre-assessment appointment, the above steps should be followed, as per 4.10.1(h).

4.10.2(f) Patients who cancel their procedure (CNA) will have their waiting time clock reset to the date the Trust was informed of the cancellation.