

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

DRAFT

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 policies 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:

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|-------------------------------|---|--------------------|
| 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 (today’s 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, today’s 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*.

Built on PAS

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.

Not Yet Built on PAS

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)

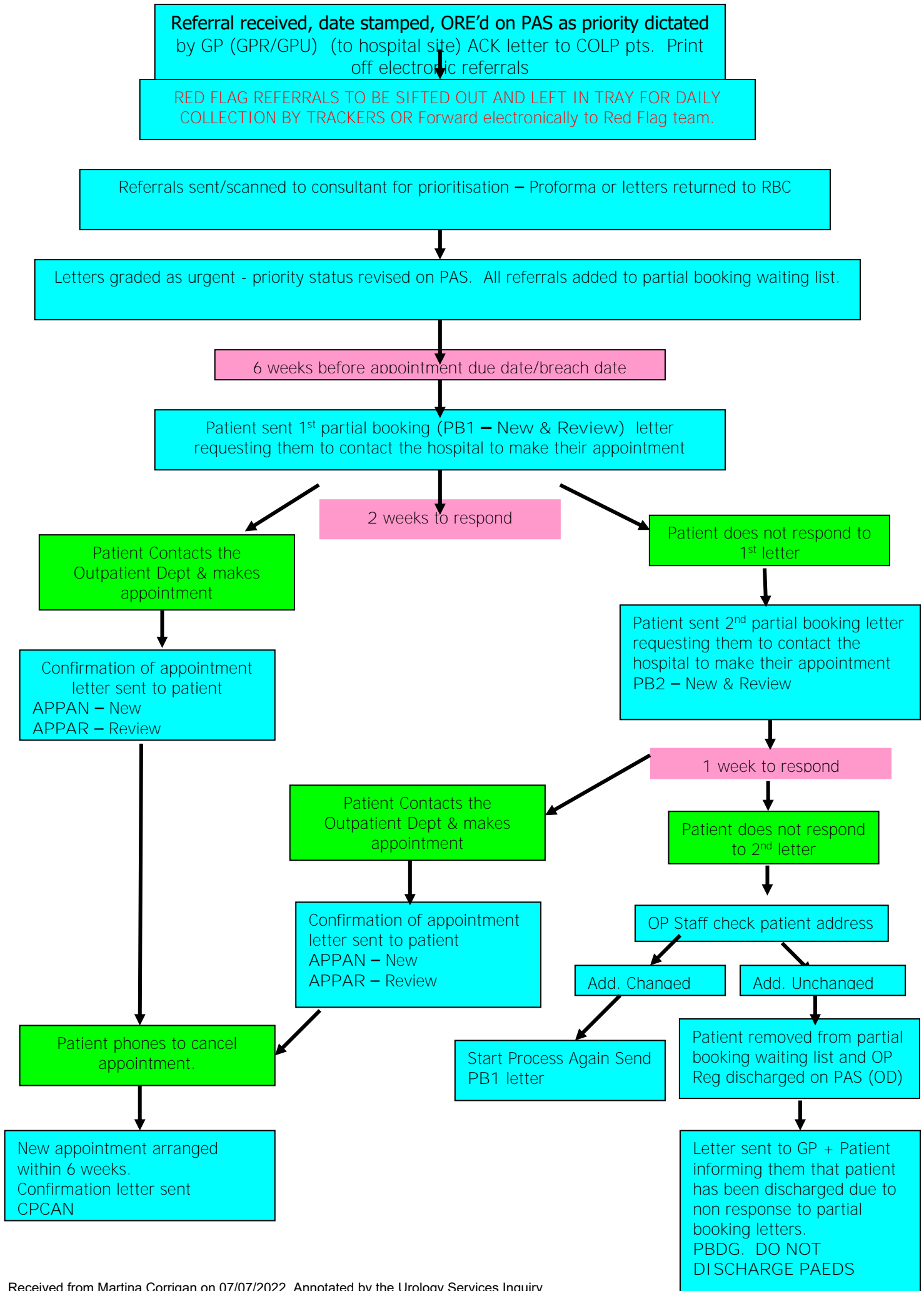
| Timeslot | NR | REV |
|----------|----|-----|
| 9.00 | 2 | 1 |
| 9.10 | 2 | 1 |
| 9.20 | 2 | 1 |
| 9.30 | 2 | 1 |
| 9.40 | 2 | 1 |
| 9.50 | 1 | 1 |
| 10.00 | 1 | 1 |

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.

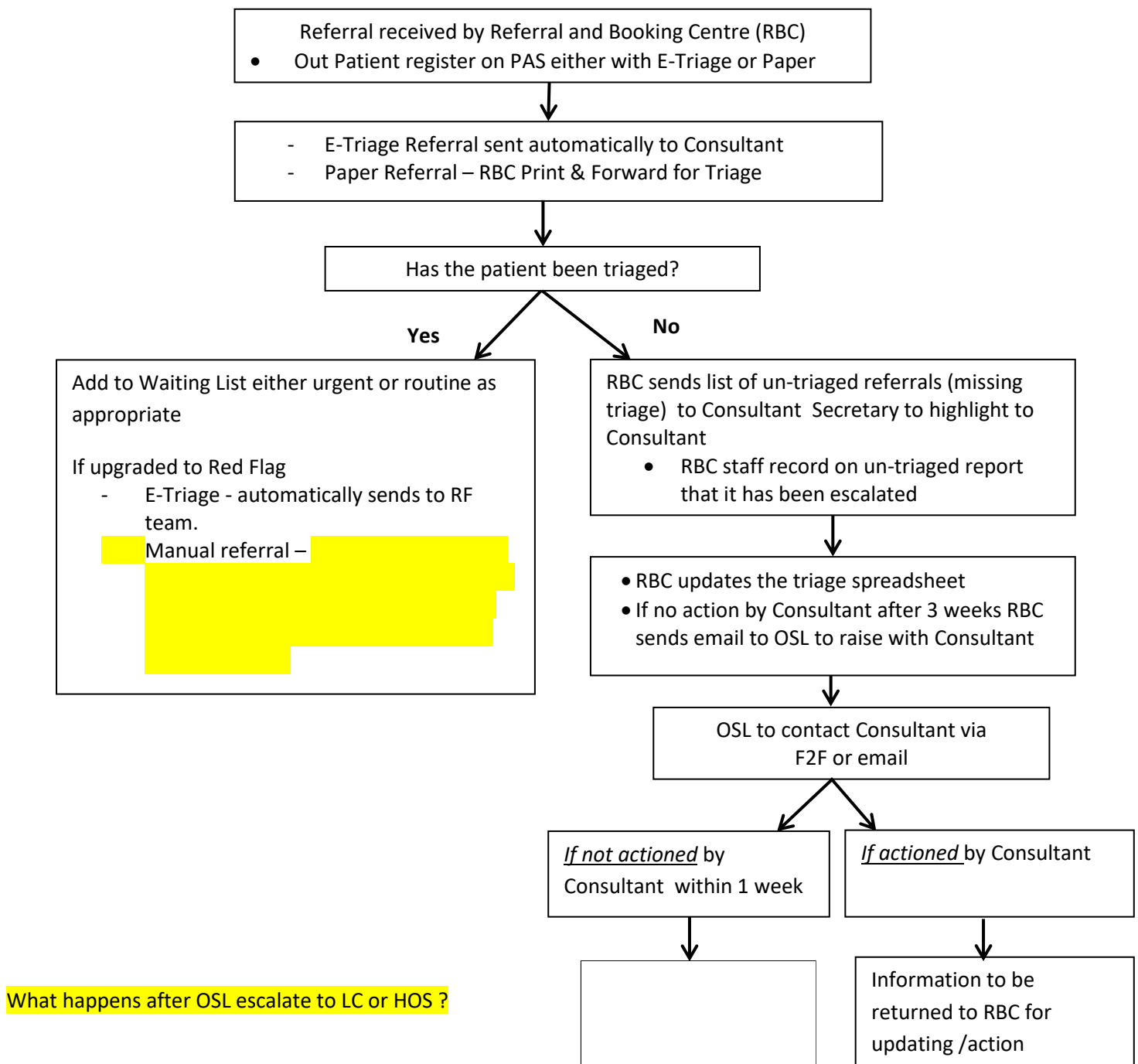
- Record on PAS that the clinic is reduced to xx amount of patients, and any other instructions you have received, eg no NR patients after 10.30 am.
- Record the information in the calendar at the back of the Select File.
- Record the information in the diary.
- Record the information in the cancelled clinic spreadsheet.
- File the e-mail in the cancelled clinic team folder.
- Make the necessary reductions to the clinic.

PARTIAL BOOKING ROUTINE APPOINTMENTS – RBC

- 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

Care Review Tool for Urology Patients

Section 1

This section should be completed as soon as is possible.

If it is deemed appropriate to complete Section 2, it should be completed within 8 Weeks (56 days) of selected patients' deaths.

| | | | |
|--|--|-------------------------|--|
| Patient identification number: | | Gender: | |
| Date of birth (dd/mm/yyyy) | | Age: | |
| Date of Incident | | Date Incident Reported: | |
| Date of death (if relevant) | | | |
| Location of death (if relevant) | | | |
| Was the patient identified as being within the last 12 months of life? | | | |
| Cause of death (if known) | | | |
| Primary diagnosis, including ICD-10 code (if known) | | | |
| Co-morbidities | | | |
| Healthcare teams involved in the patient's care at the time of incident | | | |
| Patient summary (can be completed by the clinical team) | | | |
| | | | |
| Concerns from family members or carers about the patient's care (please outline concerns, or state if there were no concerns) | | | |
| Concerns from staff about the patient's care (please outline concerns, or state if there were no concerns) | | | |

Time taken to complete Section 1 of this form (minutes):

Date of completion:

Name of person completing Section 1:

Job title of person completing Section 1

Care Review Tool for Urology

Section 2

Please state the information sources used for the review, including the names of the electronic systems accessed:

2.1. Phase of care: Triage (where relevant)

- Was triage conducted in a timely manner?
- Was the triage outcome assigned an appropriate level of priority given the information available at the time?

Please record your explicit judgements about the triage process and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.2. Phase of care: Initial assessment or review (where relevant)

- Where the investigations, prescribing, diagnosis and clinical management approach and communications with patient, primary care and MDT teams appropriate?
- Where diagnostic tests or investigations requested in a timely manner and with sufficient clinical information to allow appropriate onward prioritisation?

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.3. Phase of care: Review of Diagnostics (where relevant)

- Where diagnostic tests or investigations reviewed in a timely manner with appropriate further actions taken?
- Where any required actions adequately communicated to patient / primary care / MDT teams?
- Please list medication if known and relevant, and comment on medication monitoring where appropriate

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.4. Phase of care: Ongoing Outpatient Care (where relevant)

- Was ongoing review scheduled at appropriate intervals?
- Where referrals made to other teams / professionals appropriately and in a timely manner?
- Where any further required tests / investigations requested and performed in line with good current practice?
- Please list medication if known and relevant, and comment on medication monitoring where appropriate

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.5. Phase of care: Admission and Initial Management (approximately the first 24 hours) (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

Care Review Tool for Urology

2.6. Phase of care: Ongoing Inpatient Care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☒

Section not applicable ☐

Care Review Tool for Urology

2.7. Phase of care: Care during a procedure (excluding IV cannulation) (where relevant)
Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.
Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.8. Phase of care: Perioperative care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐

4 Good care ☐

3 Adequate care ☐

2 Poor care ☐

1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.9. Phase of care: Discharge plan of care (where relevant)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.10. Other area of care (please specify)

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

Care Review Tool for Urology

2.11. Overall care

Please record your explicit judgements about the quality of care the patient received and whether it was in accordance with current good practice.

Areas identified where learning could occur, including areas of good practice, should be included in addition to any potential areas of further investigation.

Please also include any other information that you think is important or relevant.

Please rate the care received by the patient during this phase as:

5 Excellent care ☐ 4 Good care ☐ 3 Adequate care ☐ 2 Poor care ☐ 1 Very poor care ☐

Section not applicable ☐

2.12. If care was below an acceptable standard, did it lead to harm?

If yes, please provide details and state an action plan

Care Review Tool for Urology

2.13. If the patient died considered more likely than not to have resulted from problems in care delivery or service provision?
If yes, please provide details and state an action plan (consider whether a serious incident investigation is required).

2.14. If a family member, carer, or staff raised concerns, please outline any feedback provided and state who was responsible for providing this feedback. Please state further action required.
If no feedback was provided, please consider how the outcome of this review should be fed back to the relevant people, considering the duty of candour principle.

2.15. Were the patient records adequate for the purpose of the review?

Yes ☐

No ☐

Please outline any difficulties in accessing appropriate information:

Time taken to complete Section 2 of this form (minutes):

Date of completion:

Name of person completing Section 2:

Job title of person completing Section 2:

Assessment of problems in healthcare for Urology patients

In this section, the reviewer is asked to comment on whether one or more specific types of problem(s) were identified and, if so, to indicate whether any led to harm. Please circle correct response.

Problem types

| | |
|--|--|
| <p>1. Problem in assessment, investigation or diagnosis</p> | <p>Yes No</p> |
| <p>Did the problem lead to harm?</p> | <p>No Uncertain Yes</p> |
| <p>In which phase(s) did the problem occur?</p> | <p>Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care</p> |
| <p>2. Problem with medication / IV fluids / electrolytes / oxygen</p> | <p>Yes No</p> |
| <p>Did the problem lead to harm?</p> | <p>No Uncertain Yes</p> |
| <p>In which phase(s) did the problem occur?</p> | <p>Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care</p> |

Care Review Tool for Urology

| | |
|---|---|
| <p>3. Problem related to treatment and management plan</p> <p>Did the problem lead to harm?</p> <p>In which phase(s) did the problem occur?</p> | <p>Yes No</p> <p>No Uncertain Yes</p> <p>Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care</p> |
| <p>4. Problem related to operation / invasive procedure <i>(other than infection control)</i></p> <p>Did the problem lead to harm?</p> <p>In which phase(s) did the problem occur?</p> | <p>Yes No</p> <p>No Uncertain Yes</p> <p>Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care</p> |
| <p>5. Problem with infection management</p> <p>Did the problem lead to harm?</p> <p>In which phase(s) did the problem occur?</p> | <p>Yes No</p> <p>No Uncertain Yes</p> <p>Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation)</p> |

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| | |
|--|---|
| | Perioperative care Discharge plan of care Other area of care |
| 6. Problem in clinical monitoring (including failure to plan, to undertake, or to recognise and respond to changes) Did the problem lead to harm? In which phase(s) did the problem occur? | Yes No No Uncertain Yes Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care |
| 7. Problem in resuscitation following a cardiac or respiratory arrest (including cardiopulmonary resuscitation (CPR)) Did the problem lead to harm? In which phase(s) did the problem occur? | Yes No No Uncertain Yes Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care |
| 8. Problem of any other type not fitting the categories above (including communication with patients and carers and organisational issues) Did the problem lead to harm? In which phase(s) did the problem occur? | Yes No No Uncertain Yes Triage Initial assessment or review Review of Diagnostics Ongoing Outpatient Care |

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| | |
|--|--|
| | Admission and Initial Management Ongoing Inpatient Care Care during a procedure (excluding IV cannulation) Perioperative care Discharge plan of care Other area of care |
|--|--|

PROPOSAL FOR STRUCTURED CLINICAL RECORD REVIEW

DRAFT V1 - 17th February 2021

Background

1. On the 23rd November 2021 the Minister for Health gave direction for the initiation of a Public Inquiry regarding the Clinical Practice of Mr Aidan O'Brien, Consultant Urologist.
2. Although yet to be developed, the terms of reference for Public Inquiry will consider Mr O'Brien's practice across all of his clinical activity. This will likely include reviews involving individual patient cases where a potential adverse outcome was identified.
3. While ensuring that the work of the Public Inquiry is not disrupted or delayed, in the interests of maintaining patient safety it remains incumbent on the Trust to ensure that where potential patient safety incidents are identified, a proportionate patient safety review should take place to inform learning and develop safer systems in a timely manner.
4. Remaining cognisant of regional parameters and requirements for the identification, review and learning from Adverse and Serious Adverse Incidents (SAI) as set out in the HSCB *Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)* the Trust has sought to provide an alternative, proportionate and robust review structure that can be utilised to review SAI's in a timely manner.
5. Any patient safety review process will function and report within the existing clinical governance arrangements for the Trust and as such be subject to quality assurance processes and an appropriate level of scrutiny.

Title of Review Structure

6. The Trust is mindful that any proposed alternative review structure should be demarcated clearly as different to the SAI process. It is therefore important that for clarity for service users, staff and the public that the title should articulate this clearly.

Proposal 1 – The name of the review mechanism will be titled STRUCTURED CLINICAL RECORD REVIEW (SCRR)

Underpinning Review Methodology

7. To ensure confidence in the SCRR process an adoption of a robust and validated method will be required. To this end, the Trust has spoken to the Royal College of Physicians with a view to adapting the underpinning principles and methodology found in the Structured Judgement Review (SJR) Process.
8. The Royal College of Physicians SJR combines clinical-judgement based review methods with a standard format. The format requires reviewers to make safety and

quality judgements over phases of care, to make explicit written comments about care for each phase, and to score care for each phase.

9. As an outcome of the SJR the result is a short but rich set of information about each case in a form that can also be aggregated to produce knowledge about clinical services and systems of care.
10. The objective of the SJR method is to look for strengths and weaknesses in the caring process, to provide information about what can be learnt about the hospital systems where care goes well, and to identify points where there may be gaps, problems or difficulty in the care process.
11. In order to answer these questions, there is a need to look at: the whole range of care provided to an individual; holistic care approaches and the nuances of case management and the outcomes of interventions.
12. The Trust proposes developing an adapted form from the base Royal College of Physicians SJR template and seeking Royal College of Surgeons agreement. The Trust envisages that the tool will be developed in two sections to consider both inpatient and outpatient care provided.

Proposal 2 – The underpinning methodology will be based on the Royal College of Physicians Structured Judgement Review tool

Identification of Cases for Structured Clinical Record Reviews

13. The inclusion criteria and thresholds for cases in the SCRR process will remain in keeping with those set out in the HSCB *Procedure for the Reporting and Follow up of Serious Adverse Incidents (November 2016)* with particular reference to section 4.2 of the document which outlines the following specific criteria:
 - Serious injury to, or the unexpected/unexplained death of a service user
 - Unexpected serious risk to a service user and/or staff member and/or member of the public
 - Unexpected or significant threat to provide service and/or maintain business continuity
14. Where appropriate the Trust will continue to screen adverse incidents, complaints and returns from patient record reviews for consideration of inclusion in the SCRR process.

Proposal 3 – The Trust will maintain the same screening criteria, thresholds and processes for SCRR as is currently in place for SAIs

Conducting Structured Clinical Record Reviews

15. The Trust recognises the requirement to conduct SCRR in a timely manner to identify and action learning and system changes as appropriate. In this regard the Trust

proposes engaging the services of an independent Consultant Urologist via the Royal College of Surgeons to conduct the SCRR process who has training, knowledge and experience in applying Structured Judgement Review methodology.

16. To support the process for conducting the SCRR the Trust clinical governance teams will source and share records electronically and support the development of 'timelines' that will support the reviewer in their task completing the SCRR.

Proposal 4 – The Trust will seek to engage an Independent Consultant Urologist Subject Matter Expert to conduct SCRR's and ensure that appropriate clinical governance support is available to facilitate each review

Engaging Patients and Families in Structured Clinical Record Reviews

17. The Trust places paramount importance on the need to fully involve patients and families are engagement in the SCRR process. The Trust recognises that the communication of the SCRR process to patients and families is crucial in terms of setting expectations of outcomes and how this will relate to the work of the Public Inquiry.
18. To support this work the Trust has appointed a dedicated Urology Service User Liaison Officer to communicate and support patients and families who are part of the SCRR process.
19. The outline proposed family engagement strategy is as follows:
 - a. Once the requirement for an SCRR is identified, the patient or family is notified via phone-call and then follow up letter informing of the decision to conduct a SCRR. Communication will include details of what the review process is, what the expected outcomes will be and how this process links to the Public Inquiry. The communication will also contain the contact details of the Service User Liaison Officer who can offer individual patient and family support.
 - b. The review will be conducted by the independent Consultant Urologist and the judgement and outcomes recorded.
 - c. The Service User Liaison Officer will share the report's findings with the patient and family for their review and comment.
 - d. The Service User Liaison Officer will return feedback to the Consultant Urologist from the family if received.
 - e. A final copy of the SCRR will be shared with the family and arrange any required further follow-up or discussions required with the Trust Urology service.

Proposal 5 – The Trust will utilise the Service User Liaison Model to engage patients and families with set milestones as outlined

Timescales for Completion of Structured Clinical Record Reviews

20. Although to be formally agreed it is expected that each SCRR should be completed within 8 weeks in line with the regional timescales for Level 1 Significant Event Audits..

Proposal 6 – The timescale for completion of each SCRR should be a maximum of 8 weeks

Initiating Learning and Change from the SRCC


21. The Trust will incorporate the learning and findings from SCRR's into existing clinical governance streams. This includes ensuring that:
- a. Where actionable outcomes are identified, these are taken forward to improve services
 - b. learning for regional bodies is shared via HSCB
 - c. assurance on action closure is provided to the UAG
 - d. Where a SRCC identifies the requirement for a more in-depth review, this is flagged for consideration at the Trust and HSCB weekly meeting.


Proposal 7 – The process of learning and change from SRCC will be embedded in Trust clinical governance structures and appropriate escalations for learning and if required further review is considered


UNAFI

Incident Oversight Group Minutes
8th March 2021 at 8.30am via Zoom Meeting

| <u>Attendance</u> | <u>Apologies</u> | |
|---|---|--|
| Patricia Kingsnorth Dr Maria O’Kane Dr Damian Gormley Martina Corrigan Ronan Carroll Stephen Wallace Vivienne Toal Jane McKimm Siobhan Hynds Mark Haynes Suzanne Barr | None noted | |
| <u>Agenda Item</u> | <u>Discussion</u> | <u>Actions</u> |
| 1. Review of previous meeting minutes and actions | Minutes reviewed and agreed | Actions updated accordingly throughout the main body of the Minute |
| <u>Management of Patient Reviews</u> | | |
| 2. Private Practice Audit | Martina advised that there was one private patient identified as having only waited 2 weeks for their procedure when other patients have waited up to 91 weeks. Martina advised that IA had completed the first part of the Audit (outpatients/inpatient and Day cases), and that they had moved on to diagnostics (300 queries), and scripts that had been presented to pharmacy. Melanie noted that there is not just a capacity issue, but | Terms of Reference for the Internal Audit have been shared with Dr O’Kane. |




| | | |
|--|--|--|
| | <p>that there will be a lot of support needed to get this work completed. Martina advised that there is a meeting with her and Internal Audit this afternoon to start on these queries, to gage the timescales to complete the work.</p> <p>Martina advised that Mr Haynes had started on Saturday 6th March to look chronologically at the review backlog – from those he has reviewed there was 1 private patient and 1 potential private patient from 2015</p> <p>Dr O’Kane advised that there is a Private Practice policy – Clinicians referring in, to ensure that there are handovers and updated information.</p> | <p>Martina to keep the group posted on time taken to complete work and support required.</p> <p>Martina to send information of two private patients to Dr O’Kane and ask Mark to look at these clinically to give clinical surety as there may be a probity issue.</p> <p>Specific parts of private patient policy to be sent to ensure that correct processes are being followed when referring in.</p> |
| 3. Update on Radiology and MDM Review | no further update from 01/03/2021 | |
| <p>4. IPT for Review Process</p>  <p>Urology Inquiry IPT - draft 8 15.12.2020.c</p> | Maria and Vivienne advised that there is a level of legal input into this, 2 consultancy solicitors required. | Further review and discussions needed before being finalized |
| <p>5. Additional Subject Matter Expertise</p> <ul style="list-style-type: none"> - British Association of Urological Surgeons - British Association of Urological Nurses | <p>Stephen updated the group that a Consultant Urologist has been secured and will be able to assist with the stage of record review.</p> <p>Patient review form was signed off on last Thursday, so can start being used. Mark used on Saturday and advised that it can take a lot of time to complete. Mark advised that as the form is</p> | Stephen to provide name of Consultant |

| | | |
|--|--|---|
|  UROLOGY PATIENT REVIEW FORM v6.doc | <p>based on each episode then if the patient has multiple episodes it can take significant amount of time. He has been completing as part of out-patient clinics – adds at least 5/10 mins per consultation time. Martina and Mark have agreed to book 10 patients per clinic as some patient consultations take quite a bit of time.</p> <p>Mark stated that the form gives structure to justifying of the raising of concerns. Martina advised that Mr Glackin is going to do chart review on these backlog patients to see how the form works for doing the reviews with this method.</p> | <p>Time to complete Review Form to continue to be monitored.</p> |
| <p>6. Royal College of Surgeons Engagement</p> <ul style="list-style-type: none"> - Selection of Records - Costing | <p>Martina advised that she had requested the first 18 charts and these will be delivered to the AMD office for Medical input on identifying which notes need scanned. The remainder of the patients are being identified through a piece of work being done by a member of admin staff and Martina thanked Vivienne for his release to assist with this.</p> | <p>Once ready to send to Stephen for randomized selection of the remaining patients</p> |
| <p>7. Bicalutamide Patient Review</p> | <p>No further updates for this meeting</p> | |
| <p>8. Engagement of ISP to undertake waiting list work</p> | <p>Paused, work being currently conducted internally. Group to discuss further standardisation of patient assessments</p> | <p>Mark to consider standardisation of patient assessment protocols</p> |
| <p>9. Telephone Support Service / Patient Triage Update</p> | <p>No further call or emails to Information line/email</p> | |
| <p>10. MDM Processes</p> | <p>Dr O’Kane reviewed this further over the weekend, there remains a lot of work still to be completed.</p> | <p>Stephen and Dr O’Kane to meet later to discuss further</p> |
| <p>Professional Governance</p> | | |
| <p>11. GMC Discussions –</p> | <p>The Trust continues to gather information to send them.</p> | <p>Stephen to ring Kate Watkins in GMC</p> |
| <p>12. Litigation / DLS Update</p> | <p>Work remains ongoing</p> | <p>Stephen to link in with Lynne Hainey in Litigation</p> |

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|--|---|--|
| <p>13. Grievance Process-</p> | <p>Vivienne advised that <small>Personal information redacted by USI</small> responded to Zoe Parks re: 3 dates for appeal hearing. The reply back from him made some reference to original grievance and that it was felt it was not a fair process. It is his father's position that he will put through a public inquiry. He outlined that there is no objection to appeal panel and his father will not be attending any further meeting.</p> <p>Correspondence outlined some issues and stated that they believed Mr A O'Brien would be met with hostility and this would cause further trauma to him. This has been forwarded to June.</p> <p>Siobhan advised that within the letter from Mr O'Brien it said that we have all the information, therefore the Trust is considering if they ask the panel not to hear appeal but review the original decision/ case, if panel need to clarify anything they do not have the benefit to get information from Mr A O'Brien. So, rather than appeal, with clear TOR, the Trust would ask the panel to review the previous grievance instead.</p> <p>There are 2 panel members.</p> | <p>Update from previous mins: Vivienne explained the Trust had tried to get in contact with AOB to progress grievance appeal however no further response to date. On this basis, the Trust had moved to offer a range of dates to Mr O'Brien's representative for the appeal hearing with a request for response by 4th March 2021.</p> <p>Consideration to be given to the best way forward regarding the grievance.</p> |
| <p>14. Administration Review Update –</p>  <p>Admin Review Process V10 18 Feb 2</p> | <p>Martina has linked in with Siobhan and advised that the focus of this work has been the need to look at processes and share with GMC, the majority of this review was only in relation to AOB, therefore it is felt there is a need for 2 reports – 1 GMC and 1 Trust assurance, therefore a more generalized report.</p> <p>Siobhan noted that she felt some of the context was missing, as the report reads as if there was a wide scale problem as there was no preamble</p> | <p>Further work to be completed to the report, specifically into providing appropriate context to completing the review.</p> |



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| | <p>contained and rationale as to why being looked at. How we close the gap and assurance to stop in the future. Problem not across the board. She highlighted that other clinicians looking at the document, may think it was including them. Further work required to complete this – 1 detailed and 1 overarching. (GMC and Trust assurance) Ronan stated that AOB was able to do these things as system not there to track and monitor. The Trust needs to recognize the shortcomings and have an action plan at the start of report where the Trust sets context out that there was a need to put processes right from the learnings found.</p> | |
| Serious Adverse Incidents (SAIs) Review | | |
| <p>15. Update on Current SAI Progress</p> <ul style="list-style-type: none"> - Screening - Initial Feedback on outcomes from Dr Hughes | <p>At the UAG meeting was held last week – the Trust had advised that SAI reports would be shared with the families and the Urology Clinical Teams today (Monday 8 March), however, due to correspondence from Mr O'Brien's solicitors over the weekend the release of these reports have been paused on the recommendation of the Trust's legal team.</p> <p>Patricia advised that the families were aware that the reports would be released over the next number of weeks but had not been given a set date. However, as the name of the Chair of the Inquiry was most likely being announced today it was agreed that Patricia would contact the families once she was aware of the Chair and would advise them that they would be updated on the reports as soon as we can in order to avoid giving a set</p> | <p>Timetable to be agreed today</p> <p>Patricia to link in with families re: delay</p> <p>Martina to email Urology Team advising of delay in disclosing report. Reason for delay should not be disclosed at this stage.</p> |

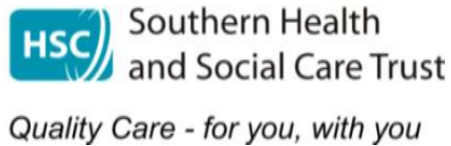
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| | <p>timeframe which could change.</p> <p>Martina agreed to email the Urology Clinical Team that there had been a delay in the reports being issued and that she would be in touch once she had a new date of issue.</p> | |
| <p>16. Initial SAI Recommendations</p> <p> Action plan 69120.docx</p> | <p>This Action plan relates to the previous SAI's and Stephen advised the rationale for the Action Plan was to keep track of the ongoing work and focus all in one action plan.</p> <p>Martina informed the group that there are 2 outstanding areas – there has been discussion around job plans, Michael and Mark to give time to triage however, further consideration for Clinical Nurses to support triage to be given.</p> <p>Sharing pathways with GPs – Martina is currently liaising with Rose McCullough and one of the Consultants is linking with GP meetings. Rest are closed</p> <p>All actions relating to Acute have been implemented bar 2.</p> | |
| <p>17. Structured Judgement Review Process – (SJR)</p> <p>  DRAFT Structured Clinical Record Review DRAFT - PROPOSAL FOR STRUCTURED CI</p> | <p>Stephen informed the group that the Board has seen SJR and are happy with it. There is a meeting with Royal Collage of Physicians on Thursday which will hopefully have the form signed off and ready to use as of next week and start.</p> <p>He explained that all patients will be reviewed using SJR and any anomalies noted, there will be an SAI.</p> | <p>Stephen to give update re: RCP Thursday 11th March 2021 meeting re: SJR</p> |
| 18. Family Liaison Role | Fiona ready to support and linking in with some | |



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|----------------------------------|--|--|
| | families | |
| Communications | | |
| 19. Media / Assembly Questions – | <p>Jane advised that it is anticipated the chair will be announced today, not on Assembly business agenda but it is her understanding the announcement will happen today. There have been no other queries. She informed that there is no expectation that the Trust will notify families of this, however, she will link in with David to gage if this is correct.</p> <p>Jane commented that there remains a level of uncertainty around the SAIs and Public Inquiry as the latter is the overarching legal process, whereas the information from the SAI's supports it. The group agreed that it was unclear how the dual pathways would work alongside one another. Dr O'Kane explained that the appointment of a Chair to the Public Inquiry would assist in this clarity as there becomes a focus point.</p> <p>Jane stated that once she receives information from David re: announcement and appropriateness of telling families she would notify Melanie and Patricia in order to progress if needed.</p> | |
| Any other Business | | |
| 20. Overarching report | <p>Section 5 summary timeline to be amended as it was felt that there were patient identifiers included. Main body of report remains.</p> <p>Melanie clarified that the draft reports should only be shared with the Urology team, the families and the Cancer and Clinical Services. And only a summary should be provided to Clinical</p> | |



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| | Governance at this stage. Dr O’Kane noted that GMC were to be made aware of its availability should they want it. Patricia will be overseeing the sharing of the document. | |
| 21. MDM Assurance Meeting | Dr O’Kane and Stephen meeting with NHS England at 12pm today re: MDMs and possible assurance benchmarks. | Update to be provided at next meeting |
| Date of next meeting: 15 th March 2021, 8.30am via zoom | | |



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.

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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 SAs. 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 |
|--|---|
| <ul style="list-style-type: none"> Recruitment of experienced staff – | <ul style="list-style-type: none"> Complete recruitment documentation as soon as possible Liaise with Human Resources |
| <ul style="list-style-type: none"> Staff Backfill | <ul style="list-style-type: none"> 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.

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

| | |
|---------------|--|
| Name | |
| H&C Number | |
| Date of Birth | |

Appointment Patient Details

| | |
|--|--|
| Presenting Condition(s) | |
| Summary of Appointment Patient Summary | |

Commented [GL1]: Does this information relate to the review appointment? Is the review appointment as part of a recall or is it any of the review appointments that pt's may have been called to/had already?
If it's any of the review appointments that pt's may have been called to/had already – now sure previous review apts have been captured?

Commented [GL2]: Will the pts have a presenting condition – are they not likely to have one or more diagnoses, based on their previous care and treatment from the Consultant?

Commented [GL3]: As above- is this a summary of the planned review/recall appointment?
Are you content to leave to free text only?

Regarding the patients current care

| | Question | Y / N / Unable to Determine | Details |
|---|---|-----------------------------|---------|
| 1 | Is the present diagnosis / diagnoses reasonable? (<i>'Reasonable' to consider if diagnosis / diagnoses is consistent with investigations and examinations carried out to date, is there a requirement for further investigations / examinations to confirm diagnosis / diagnoses?</i>) | | |
| 2 | Are the current medications prescribed appropriate? (<i>'Appropriate' to consider if prescribing is consistent with current best evidence based practice, are any deviations from guidance recorded and rationale fully noted?</i>) | | |
| 3 | Is a secure clinical management plan currently in place? (<i>'Secure Clinical Management Plan' to consider if the current</i> | | |

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Commented [GL4]: Could be more than one diagnosis, neurology recall found % os pts had more than one diagnosis. Need to define what is meant by 'reasonable'?

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Commented [GL5]: Need to define what mean by 'appropriate' in this context.

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Commented [GL6]: Need to define what mean to 'secure clinical management plan' in this context.

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| | | | |
|----------|--|--|--|
| | <i>patient treatment pathway is optimal and in line with current best evidence based practice and guidance).</i> | | |
| 4 | If there is not a secure clinical management plan in place please document immediate actions required to be taken | | |

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Based on the information available at the time of previous reviews, please answer the following to the best of your knowledge. If a determination cannot be made please give reasons why.

Commented [GL7]: What does 'at the time' mean here?

| No. | Question | Y / N / Unable to Determine | Details |
|------------|---|------------------------------------|----------------|
| 4 | Were appropriate and complete investigations carried out for all relevant conditions? <i>('Appropriate' to consider if investigations consistent with current best evidence based practice at the time of review, are deviations from guidance recorded and rationale fully noted?)</i> | | |
| 5 | Were the medications prescribed reasonable/appropriate? <i>('Appropriate' to consider if prescribing was consistent with current best evidence based practice at the time of previous review, are deviations from guidance recorded and rationale fully noted?)</i> | | |
| 6 | Was/Were the diagnosis / diagnoses reasonable? -at the time? <i>('Reasonable' to consider if diagnosis / diagnoses is consistent with investigations and examinations carried at the time of review, was there a requirement for further investigations / examinations to</i> | | |

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Commented [GL9]: Need to take account of possibility of more than one diagnosis, and that there potentially is likely to be an investigative and diagnostic pathway relevant to each diagnosis

Commented [GL10]: Need to define what 'at the time' means/relates to

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| | | | |
|----------|---|--|--|
| | <i>confirm diagnosis / diagnoses?)</i> | | |
| <u>7</u> | Was the clinical management approach taken reasonable? <i>('Reasonable' to consider if clinical management plan if the patient treatment pathway at the time was optimal and in line with best evidence based practice and guidance available at that time.)</i> | | |
| <u>8</u> | Were there unreasonable delays within the Consultants control with any aspect of care (reviews, prescribing, diagnostics, dictation etc) <i>('Unreasonable Delays' to consider if diagnosis required more urgent treatment / intervention that was received based on best evidence based practice and guidance available at that time. The Southern Health and Social Care Trust will consider any delays in treatment highlighted to assess if these were within the Consultants control or due to systematic issues e.g. length of waiting lists)</i> | | |
| <u>9</u> | On balance, did the patient suffer any harm or detriment as a result of any of the above questions (4-9) ? | | |

Commented [GL11]: See above comments

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Is 'delay' the only parameter of interest?




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Commented [GL13]: Is this 'as a result' of delay?
If relates to 'delay' only, are you content this is sufficient?

Clinical Professional Reviewing Care

| | |
|---------------------|--|
| Name | |
| Title | |
| Date of Appointment | |



Admin Review Processes

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|-------------------|---|--|--|---|---|--|
| 1. Triage | <p><u>Pre 2014</u> Due to the delayed triage of referrals, the decision was taken to add to the OP waiting list the referral at the clinical priority that the GP had assigned.</p> | <p><u>2014-2017</u> For routine and Urgent GP referrals, non-adherence and non-enforcement of the IEAP, resulted in referrals not being returned within the appropriate timeframe, which then resulted in a lost opportunity to either upgrade or downgrade urgent/routine referrals</p> | <p><u>2017-current</u> The introduction of e-Triage on 27/3/17 enabled referrals to be monitored with respect to the triage process.</p> <p>The revised triage process (draft) detailed in the word document below is based on the current IEAP also addresses these issues of timely and appropriate triaging</p> <p> TRIAGE PROCESS DEC 20 (1).docx</p> | <p><u>Current</u> Consultant-to-Consultant referrals (including outside of Trust) are not currently managed through e-Triage so there is still a risk that these could be delayed.</p> <p>Remaining specialties that still do not use e-Triage are being addressed</p> <p> Services not using eTriage.docx</p> | <p>Consultant to Consultant referrals to be added to e-Triage and the PDF SOP to be updated</p> <p> Consultant to Consultant Referrals.</p> <p>Remaining specialties to be added to e-Triage</p> <p>The triage process continues to be monitored weekly and needs to be complied to and enforced where necessary</p> | <p>AD for FSS</p> <p>Transformational Lead to work with Service Leads for specialties still not on e-Triage and to implement same.</p> <p>June 2021</p> <p>AD FSS and divisional AD's</p> <p>Ongoing</p> |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|------------------------------|--|--|--|---|---|--|
| 2. Undictated Clinics | Some patients not having a letter dictated following an outpatient consultation resulting in no outcome recorded on PAS. | There is no system or process that provides assurance that each outpatient consultation generates an outpatient outcome letter | All Medical staff must understand that a letter is required for every outpatient attendance. | A limitation with the G2 system is that it simply records speech and generates a letter. However G2 is unable to correlate the letter dictated against the outpatient attendance. | <p>The Trust has been working on the G2/PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics.</p> <p>Update typing SOP to highlight that when a letters is not dictated for a patient that the secretary raises with the consultant and line manager in the first instance. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters</p> | <p>The Referral and Booking Centre Manager.</p> <p>June 2021</p> <p>The Referral and Booking Centre Manager.</p> <p>Ongoing</p> <p>Heads of Services with their Clinical Teams at Induction/Changeover</p> |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|--------------------------|--|---|--|--|--|--|
| | | | | | <p>Monthly typing reports require to be produced and shared throughout all divisions</p> <p>At Junior doctor changeover inductions, the importance of timely and accurate dictating of all outpatients they have reviewed must be highlighted to them.</p> | <p>IT Team with BSO and the clinical teams</p> <p>June 2021</p> |
| 3. Hospital Notes | Patient's hospital records electronically casenote tracked to a consultant and a location. | When patients hospital records were required same not in the tracked location | <p>Current tracking system is a function on Patient Administrative System (PAS)</p> <p>Missing Charts are investigated and an IR1 form is completed if not found</p> | <p>There is currently no system which identifies that a chart is not where it is tracked to other than manual searches.</p> <p>Need to establish whether or not as part of the induction and training there is a SOP governing the tracking of patient hospital records?</p> | <p>Any missing notes need to have an IR1 raised to highlight the problem. These should be reported to the respective areas.</p> <p>All staff managing patient notes should be reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible.</p> | <p>Acute Director</p> <p>April 2021</p> |

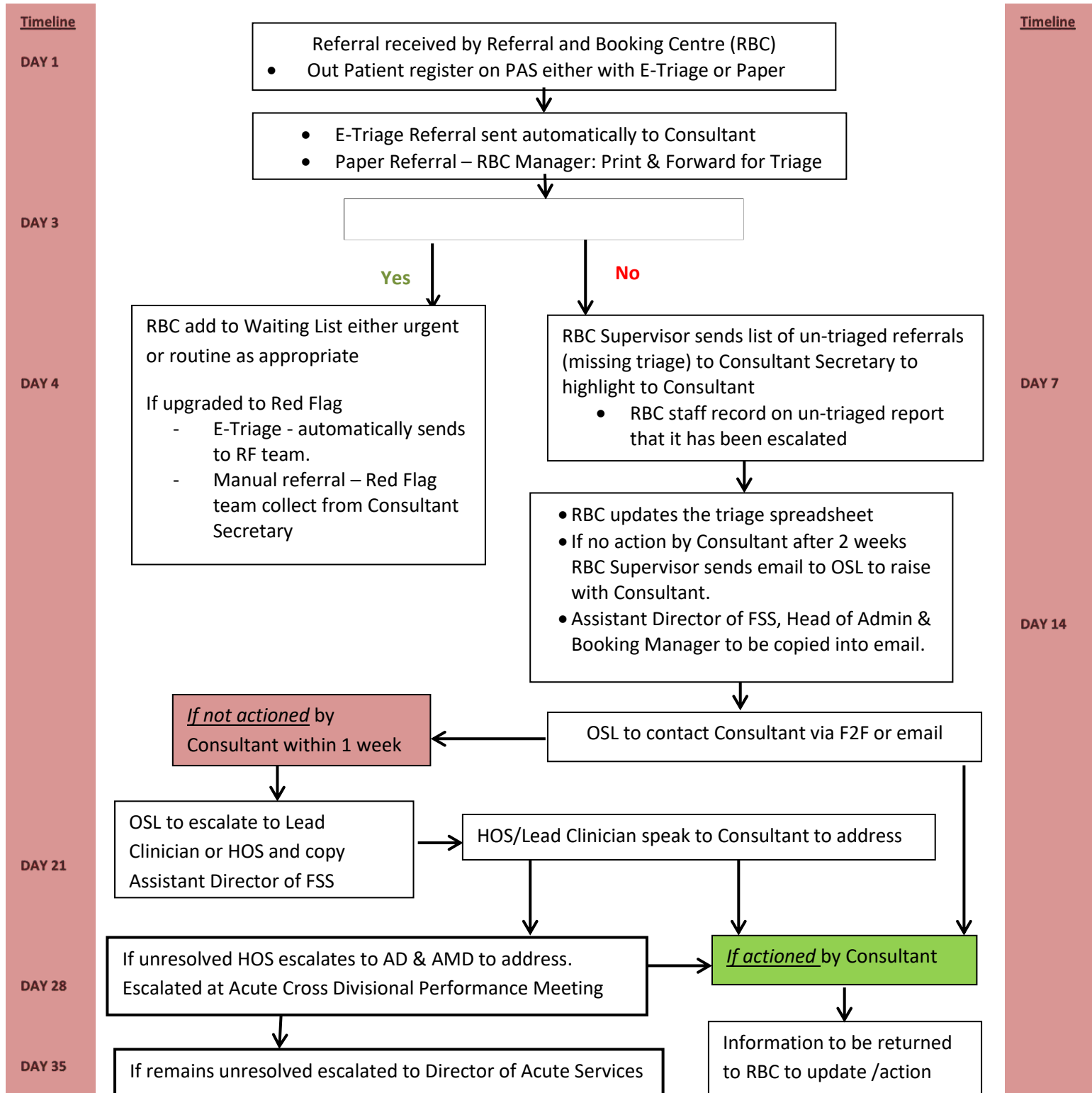
| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|-------------------|----------------------|-------------------------------|--------------------------------|---------------------|---|---|
| | | | | | <p>We also need to remind consultants that all charts are tracked in their name and that it is their responsibility to ensure the notes are kept in the location that the notes are tracked to.</p> <p>Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period.</p> <p>Business Case for IFit which is an electronic tracking system using barcode technology (as used in other Trusts in NI) to be considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project This had been previously submitted and approved but no funding identified.</p> | <p>Assistant Director – Functional Support to resubmit to Trust's SMT in new financial year.</p> <p>April 2021</p> |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|----------------------------|---|---|--|---|---|---|
| 4. Private Patients | Patients who had been initially reviewed privately were added to the waiting list in a non-chronological manner | No monitoring of patients seen privately where they are entered onto the waiting list | This is governed by the Private Patient policy | It relies on the integrity of the consultant to comply with the private patient policy. | <p>Revise the policy for paying patients in the Trust and share with all clinical teams.</p> <p> Guide-to-Paying-Patients-Southern-Trust-</p> <p>Data Quality Release notice for recording of private patient activity on PAS to be shared amongst clinical teams.</p> <p> 0023-18 PAS OP REFERRAL PRIVATE</p> | <p>Deputy Medical Director and AD for Medical Directorate April 2021</p> <p>Functional Services to reissue the Data Quality Release notice for the recording of private patient activity on PAS with all teams.</p> <p>November 2020 Complete</p> |

- 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 directs 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.



Note: This process will incur a minimum of 5 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.

| Services not using e-triage | |
|------------------------------------|--|
| ORTHOPAEDIC GERIATRICS | Planned e-triage commencement Jan/Feb 2021 |
| HAEMATOLOGY | Planned implementation postpone due to service pressures |
| NEPHROLOGY | Currently taking a break from e-triage, will relook at recommencing early 2021 |
| GENERAL MEDICINE | Minimal referrals to this service but working with service looking towards implementation early 2021 |
| BREAST SURGERY | Consultants not currently keen on e-triage – reengaged with service |
| GERIATRIC MEDICINE | Currently engaging with service |



Quality Care - for you, with you

ADMINISTRATIVE & CLERICAL Standard Operating Procedure

| | | |
|-------------------------------|------------------------------------|---|
| Title | Consultant to Consultant Referrals | |
| S.O.P. Section | Referral and Booking Centre | |
| Version Number | v1.0 | Supersedes: v0.1 |
| Author | Katherine Robinson | |
| Page Count | 3 | |
| Date of Implementation | January 2011 | |
| Date of Review | January 2012 | To be Reviewed by: Admin and Clerical Manager's Group |
| Approved by | Admin and Clerical Manager's 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 to recognise a referral is in place from one consultant to another.

Implementation

This procedure is already effective and in operation in the Referral and Booking Centre.

Consultant to Consultant Referrals

The secretary for the consultant referring the patient should OP REG the patient on PAS with the OP REG date being the date the decision to refer was made (eg the clinic date)

This is done by using the Function:

DWA – ORE.

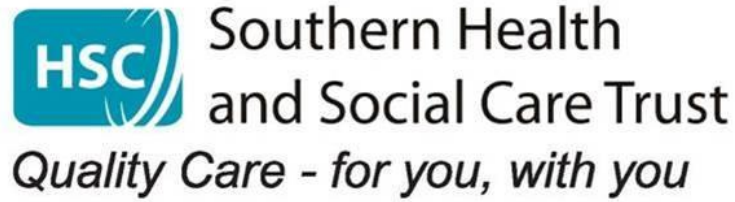
The name of the *referring consultant* should be entered into the comment field NOT the name of the consultant being referred to. Referrals should then be directed to the Referral and Booking Centre not to the secretary.

This will ensure that the patient now appears on a PTL and that the booking clerks will know who referred the patient and when.

When doing this the **Referral Source should be OC** (Other Consultant) **and NOT CON.**

Patients registered with a referral source as 'Con' do not appear on a PTL and can be missed.

Although all referrals are date stamped when they are received into the Referral and Booking centre – the original referral date will remain and will not be amended.



A GUIDE TO PAYING PATIENTS

V.2 [11th February 2016]

| DOCUMENT – VERSION CONTROL SHEET | |
|----------------------------------|---|
| Title | Title: Guide to Paying Patients Version: 2 |
| Supersedes | Supersedes: Guidelines for Management of Private Patients |
| Originator | Name of Author: Anne Brennan Title: Senior Manager Medical Directorate |
| Approval | Referred for approval by: Anne Brennan Date of Referral: 27 th March 2014 to: <ul style="list-style-type: none"> Trust Senior Management Team Trust LNC |
| Circulation | Issue Date: 16 th October 2014 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff |
| Review | Review Date: February 2017 Responsibility of (Name): Norma Thompson Title: Senior Manager Medical Directorate |

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1. INTRODUCTION

- 1.1 The Trust came into existence on 1 April 2007 and is responsible for providing acute care across three sites namely:-
 - Craigavon Area Hospital, Portadown
 - Daisy Hill Hospital, Newry
 - South Tyrone Hospital, Dungannon
- 1.2 The Trust welcomes additional income that can be generated from the following sources:-
 - Private Patients
 - Fee Paying Services
 - Overseas Visitors
- 1.3 All income generated from these sources is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.
- 1.4 All policies and procedures in relation to these areas will be carried out in accordance with Trust guidelines.
- 1.5 For further information please do not hesitate to contact the Paying Patient Office.
[email: paying.patients@southerntrust.hscni.net or
<http://www.southerndocs.hscni.net/paying-patients/>]

2. OBJECTIVES

- 2.1 The purpose of this guideline is to:
 - Standardise the manner in which all paying patient practice is conducted in the organisation.
 - Raise awareness of the duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services within the Trust.
 - Raise awareness of the duties and responsibilities of all Trust staff, clinical and non-clinical in relation to the treatment of paying patients and fee paying services within the Trust.
 - Ensure fairness to both NHS patients and fee paying patients at all times.
 - Clarify for relevant staff the arrangements pertaining to paying patients and to give guidance relating to
 - record keeping
 - charging

- procedures and
- responsibilities for paying patient attendances, admissions and fee paying services.
- Clarify charging arrangements when consultants undertake fee paying services within the Trust.

3. CATEGORIES OF WORK COVERED BY THIS GUIDE

3.1 Fee Paying Services

- 3.1.1 Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

3.2 Private Professional Services *(also referred to as 'private practice')*

- 3.2.1 The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions.
- 3.2.2 Work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

3.3 Overseas Visitors

- 3.3.1 The National Health Service provides healthcare free of charge to people who are a permanent resident in the UK/NI. A person does not become an ordinarily resident simply by having British Nationality; holding a British Passport; being registered with a GP, or having an NHS number. People who do not permanently live in NI/UK are not automatically entitled to use the NHS free of charge.
- 3.3.2 **RESIDENCY** is therefore the main qualifying criterion.

4. POLICY STATEMENT

- 4.1 Medical consultant staff have the right to undertake Private Practice and Fee paying services within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review and with the approval of the Medical Director.
- 4.2 This Trust provides the same care to all patients, regardless of whether the cost of their treatment is paid for by HSC Organisations, Private Medical Insurance companies or by the patient.
- 4.3 Private Practice and Fee Paying services at the Trust will be carried out in accordance with:
- The Code of Conduct for private practice, the recommended standard of practice for NHS consultants as agreed between the BMA and the DHSSPS (Appendix 2).
 - Schedule 9 of the Terms and Conditions of the Consultant contract which sets out the provisions governing the relationship between HPSS work and private practice (Appendix 8).
 - The receipt of additional fees for Fee Paying services as defined in Schedule 10 of the Terms and Conditions of the Consultant Contract (Appendix 1).
 - The principles set out in Schedule 11 of the above contract (Appendix 5).
- 4.4 All patients treated within the Trust, whether private or NHS should, where possible:
- be allocated a unique hospital identifier
 - be recorded on the Patient Administration System and
 - have a Southern Health & Social Care Trust chart.
- 4.5 The Trust shall determine the prices to be charged in respect of all income to which it is entitled as a result of private practice or other fee paying services which take place within the Trust.

5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

5.1 Private Practice

- 5.1.1 While Medical consultant staff have the right to undertake Private Practice within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review, it is the responsibility of consultants, prior to the provision of any diagnostic tests or treatment to:
- ensure that their private patients (whether In, Day or Out) are identified and notified to the Paying Patients Officer.

- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, Pathologist, hospital charges. Leaflets can be obtained from the Paying Patients Officer or the Paying Patients section of Southern Docs website – Irrelevant redacted by the USI
- obtain prior to admission and at each outpatient attendance a signed, witnessed Undertaking to Pay form (Appendix 3) which must then be sent to the Paying Patient Officer for the relevant hospital at least three weeks before the admission date. This document must contain details of all diagnostic tests and treatments prescribed.
- Establish the method of payment at the consultation stage and obtain details of insured patients' private medical insurance policy information. The Trust requires this information to be forwarded to the Paying Patient Officer **prior to admission** so that patients' entitlement to insurance cover can be established. This should be recorded on the Undertaking to Pay form [Appendix 3].
- Ensure that all patients, where appropriate, are referred by the appropriate channels, i.e. GP/other consultant.
- Ensure that private patient services that involve the use of NHS staff or facilities are not undertaken except in emergencies, unless an undertaking to pay for treatment has been obtained from (or on behalf of) the patient, in accordance with the Trust's procedures.
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.

5.2 Fee Paying Services - see Appendix 1 for examples

5.2.1 The Consultant job plan review will cover the provision of fee paying services within the Trust. Consultants are required to declare their intention to undertake Fee Paying Services work by forwarding the Paying Patient Declaration form to the Medical Director's office.

5.2.2 A price list for fee paying services is available from the Paying Patients Office or the Paying Patients section of Southern Docs website – Irrelevant redacted by the USI It is the responsibility of the Consultant to ensure that the Trust is reimbursed for all costs incurred while facilitating fee paying services work undertaken. These costs could include:

- use of Trust accommodation;
- tests or other diagnostic procedures performed;
- radiological scans.

5.2.3 Consultants who engage in fee paying activities within the Trust are required to remit to the Trust on a quarterly basis the income due.

- 1.2.4 Consultants should retain details of all patients seen for medical legal purposes. These should be submitted by the consultant on a quarterly basis along with the corresponding payment. See Section 11 for further details.

5.3 Additional Programmed Activities

- 5.3.1 Consultants should agree to accept an extra paid programmed activity in the Trust, if offered, before doing private work. The following points should be borne in mind:
- If Consultants are already working 11 Programmed Activities (PAs) (or equivalent) there is no requirement to undertake any more work.
 - A Consultant could decline an offer of an extra PA and still work privately, but with risk to their pay progression for the year in question.
 - Any additional PAs offered must be offered equitably between all Consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other Consultants.
- 5.3.2 Consultant Medical Staff are governed by The Code of Conduct for Private Practice 2003 (at Appendix 2).

6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

6.1 New Consultants

- 6.1.1 Newly appointed consultants (including those who have held consultant posts elsewhere in the NHS, or equivalent posts outside the NHS) may not undertake private practice within the Trust or use the Trusts facilities or equipment for private work, until the arrangements for this have been agreed in writing with the Trust Medical Director. A job plan must also have been agreed. An application to undertake private practice should be made in writing to the Medical Director through completion of the Paying Patient Declaration. New consultants permitted to undertake private work must make themselves known to the Paying Patients Officer.

6.2 Locum Consultants

- 6.2.1 Locum consultants may not engage in Private Practice within the first three months of appointment and then not until the detailed Job Plan has been agreed with the relevant Clinical Manager and approval has been granted by the Medical Director. This is subject to the agreement of the patient/insurer.

6.3 Non Consultant Grade Medical Staff

- 6.3.1 Non-consultant medical staff practitioners such as Associate Specialists may undertake Category 2 or private outpatient work, with the approval of the

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

- 6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

- 7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

- 7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

- 7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

- 7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

- 7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

- 7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

7.7 Clinical Priority

- 7.7.1 A change of status from Private to NHS must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient.

7.8 Change of Status Form

- 7.8.1 Where a change of status is required a 'Change of Status' Form (Appendix 4) must be completed and sent to the Paying Patients Officer. This includes the reason for the change of status which will be subject to audit and must be signed by both the consultant and Paying Patients Officer. The Paying Patients Officer will ensure that the Medical Director approves the 'Change of Status' request.
- 7.8.2 It is important to note that until the Change of Status form has been approved by the Medical Director the patient's status will remain private and they may well be liable for charges.

8. TRUST STAFF RESPONSIBILITIES RELATING TO PRIVATE PATIENTS AND FEE PAYING SERVICES

- 8.1 A private patient is one who formally undertakes to pay charges for healthcare services regardless of whether they self-pay or are covered by insurance and all private patients must sign a form to that effect (Undertaking to Pay form at Appendix 3) prior to the provision of any diagnostic tests or treatments. Trust staff are required to have an awareness of this obligation.
- 8.2 The charge which private patients pay to the Trust covers the total cost of the hospital treatment excluding consultant fees. Trust staff are required to perform their duties in relation to all patients to the same standard. No payment should be made to or accepted by any non-consultant member of Trust staff for carrying out normal duties in relation to any patients of the Trust.

9. OPERATIONAL ARRANGEMENTS

- 9.1 Each hospital within the Trust has a named officer [Paying Patients Officer] who should be notified in advance of all private patient admissions and day cases. The Paying Patient Officer is responsible for ensuring that the Trust recovers all income due to the Trust arising from the treatment of private patients.
- 9.2 The Paying Patients Officer, having received the signed and witnessed Undertaking to Pay **Form at least three weeks** before the planned procedure will identify the costs associated with the private patient stay, will confirm entitlement to insurance cover where relevant and will raise invoices on a timely basis. [See Flow Chart 1]
- 9.3 The Medical Director will advise the Paying Patients Officer when a consultant has been granted approval to undertake private practice. The Paying Patients Officer will advise the consultant of the procedures involved in undertaking private practice in the Trust.

- 9.4 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
- 9.5 This framework applies to all patients seen within this Trust. It is therefore a fundamental requirement of Clinical Governance that all patients treated within the Trust must be examined or treated in an appropriate clinical setting.
- 9.6 Any fee or emolument etc. which may be received by an employee in the course of his or her clinical duties shall, unless the Trust otherwise directs, be surrendered to the Trust. For further information please see Southern Trust Gifts and Hospitality Standards of Conduct policy.

9.7 Record Keeping Systems and Private Patients

- 9.7.1 All patients regardless of their status should, where possible, be recorded on Hospital Systems and their status classified appropriately. These systems include for example:
- Patient Administration System (PAS)
 - Northern Ireland Maternity System (NIMATS)
 - Laboratory System
 - Radiology System(e.g. Sectra, PACS, NIRADS, RIS etc)

9.8 Health Records of Private Patients

- 9.8.1 All hospital health records shall remain the property of the Trust and should only be taken outside the Trust to assist treatment elsewhere:
- when this is essential for the safe treatment of the patient
 - when an electronic record of the destination of the notes is made using the case note tracking system
 - when arrangements can be guaranteed that such notes will be kept securely
 - provided that nothing is removed from the notes
- 9.8.2 Consultants who may have access to notes for private treatment of patients must agree to return the notes without delay. Either originals or copies of the patient's private notes should be held with their NHS notes. Patients' notes should not be removed from Trust premises. Requests for notes for medico-legal purposes should be requested by plaintiff's solicitor through the normal channels.
- 9.8.3 Since the Trust does not have a right of access to patient notes held in non NHS facilities, when patients are seen privately outside the Trust their first appointment within the Trust, unless with the same consultant, will be treated as a 'new appointment' rather than a 'review appointment'.

- 9.8.4 In the event of a 'Serious Adverse Incident' or legal proceedings the Trust may require access to private patient medical records which should be held in accordance with GMC Good Record Keeping Guidance.

9.9 Booking Arrangements for Admissions and Appointments

- 9.9.1 A record of attendance should be maintained, where possible, for all patients seen in the Trust. All private in, day and out patients should as far as possible be pre-booked on to the hospital information systems. Directorates are responsible for ensuring that all relevant information is captured and 'booking in' procedures are followed. Each department should ensure that all such patients are recorded on PAS etc. within an agreed timescale which should not extend beyond month end.

9.10 Walk Ins

- 9.10.1 A private patient who appears at a clinic and has no record on PAS should be treated for record keeping purposes in exactly the same manner as an NHS patient (walk in) i.e. relevant details should be taken, registry contacted for a number and processed in the usual fashion. A record should be kept of this patient and the Paying Patient Officer informed.

9.11 Radiology

- 9.11.1 All patients seen in Radiology should be given a Southern Health and Social Care hospital number.

9.12 Private Patient Records

- 9.12.1 All records associated with the treatment of private patients should be maintained in the same way as for NHS patients. This includes all files, charts, and correspondence with General Practitioners.
- 9.12.2 Accurate record keeping assists in the collection of income from paying patients.
- 9.12.3 It should be noted that
- any work associated with private patients who are not treated within this Trust or consultants private diary work and correspondence associated with patients seen elsewhere should not be carried out within staff time which is paid for by the Trust.

9.13 Tests Investigations or Prescriptions for Private Patients

- 9.13.1 The consultant must ensure that the requests for all laboratory work, ie. radiology, prescriptions, dietetics, physiotherapy etc. are clearly marked as Private.
- 9.13.2 Consultants should not arrange services, tests investigations or prescriptions until the person has signed an Undertaking to Pay form which will cover the episode of care [Appendix 3]. This must be submitted three weeks before any planned procedure.

9.14 Medical Reports

- 9.14.1 In certain circumstances Insurance Companies will request a medical report from the consultant. It is the consultant's responsibility to ensure that this report is completed in the timeframe required by the insurance company otherwise the Trust's invoice may remain unpaid in whole or in part until the report has been received and assessed.

10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

10.1 Charges to Patients

- 10.1.1 Where patients, who are private to a consultant, are admitted to the hospital, or are seen as outpatients, charges for investigations/diagnostics will be levied by the hospital. A full list of charges is available from the Paying Patient Office on request. Patients should be provided with an estimate of the total fee that they will incur **before** the start of their treatment.
- 10.1.2 Prices are reviewed regularly to ensure that all costs are covered. A calendar of pricing updates will be agreed.

10.2 Charges for Use of Trust Facilities for Outpatients

- 10.2.1 It is the responsibility of the Doctor to recover the cost from the patient and reimburse the Trust, on a quarterly basis, for any outpatients which have been seen in Trust facilities. [See Flow Chart 2]
- 10.2.2 A per patient cost for the use of Trust facilities for outpatients is available. This will be reviewed annually.
- 10.2.3 It is responsibility of the doctor to maintain accurate records of outpatient attendances. It is an audit requirement that the Trust verifies that all income associated with use of Trust facilities for outpatients has been identified and collected. Accordingly, Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees as outlined above.
- 10.2.4 A Undertaking to Pay form will only be required if investigations/diagnostics are required.

10.3 Basis of Pricing

- 10.3.1 Charges are based on an accommodation charge, cost of procedure, including any prosthesis, and on a cost per item basis for all diagnostic tests and treatments e.g. physiotherapy, laboratory and radiology tests, ECGs etc. They do not include consultants' professional fees. Some package prices may be agreed.

10.4 Uninsured Patients – Payment Upfront

- 10.4.1 Full payment prior to admission is required from uninsured patients. Consultants should advise patients that this is the case. The patient should be advised to contact the Paying Patients Officer regarding estimated cost of treatment. [See Flow Chart 4]

10.5 Insured Patients

- 10.5.1 The Undertaking to Pay Form also requires details of the patient's insurance policy. The Paying Patients Officer will raise invoices direct to the insurance company where relevant, in accordance with the agreements with individual insurance companies.
- 10.5.2 Consultants, as the first port of contact and the person in control of the treatment provided, should advise the patient to obtain their insurance company's permission for the specified treatment to take place within the specified timescale. [See Flow Chart 4]

10.6 Billing and Payment

- 10.6.1 The Paying Patients Officer co-ordinates the collation of financial information relating to patients' treatment, ensures that uninsured patients pay deposits and that invoices are raised accordingly. The financial accounts department will ensure all invoices raised are paid and will advise the Private Patient Officer in the event of a bad debt.

10.7 Audit

- 10.7.1 The Trust's financial accounts are subject to annual audit and an annual report is issued to the Trust Board, which highlights any area of weakness in control. Adherence to the Paying Patient Policy will form part of the Trust's Audit Plan. Consultants are reminded that they are responsible for the identification and recording of paying patient information. Failure to follow the procedures will result in investigation by Audit and if necessary, disciplinary action under Trust and General Medical Council regulations.

11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

- 11.1 Consultants may see patients privately or for fee paying services within the Trust only with the explicit agreement of the Medical Director, in accordance with their Job Plan. Management will decide to what extent, if any, Trust facilities, staff and equipment may be used for private patient or fee paying services and will ensure that any such services do not interfere with the organisation's obligations to NHS patients. This applies whether private services are undertaken in the consultant's own time, in annual or unpaid leave. [See Flow Chart 3]

- 11.2 In line with the Code of Conduct standards, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients.

11.3 Fee Paying Services Policy (Category 2)

- 11.3.1 Fee Paying Services (Category 2) work is distinct from private practice, however it is still non NHS work as outlined in the 'Terms and Conditions for Hospital Medical and Dental Staff'. Refer to schedules 10 and 11 (Appendices 1 & 5 respectively) for further details.
- 11.3.2 There are a number of occasions when a Category 2 report will be requested, and they will usually be commissioned by, employers, courts, solicitors, Department of Work and Pensions etc. the report may include radiological opinion, blood tests or other diagnostic procedures
- 11.3.3 It is the responsibility of the Doctor to ensure that the Trust is reimbursed for all costs incurred in undertaking Category 2 work, this not only includes the use of the room but also the cost of any tests undertaken.
- 11.3.4 In order to comply with the Trusts financial governance controls it is essential that all Fee Paying services are identified and the costs recovered. It is not the responsibility of the Trust to invoice third parties for Category 2 work.
- 11.3.5 It is the responsibility of the Doctor to recover the cost from the third party and reimburse the Trust, on a quarterly basis, for any Category 2 services they have undertaken, including the cost of any treatments/tests provided.
- 11.3.6 The Category 2 (room only) charge per session will be reviewed annually.
- 11.3.7 A per patient rate may be available subject to agreement with the Paying Patient Manager
- 11.3.8 It is responsibility of the doctor to maintain accurate records of Category 2 attendances. It is an audit requirement that the Trust verifies that all income associated with Category 2 has been identified and collected.
- 11.3.9 Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees of Category 2 work as outlined above and should be submitted no later than ten days after the quarter end.
- 11.3.10 In order to comply with Data Protection requirements, Doctors must therefore inform their Category 2 clients that this information is required by the Trust and obtain their consent. Consultants should make a note of this consent.
- 11.3.11 Compliance to this policy will be monitored by the Paying Patient Manager and the Medical Director's Office.
- 11.3.12 The Consultant is responsible to HM Revenue and Customs to declare for tax purposes all Category 2 income earned. The Trust has no obligation in this respect.

- 11.3.13 Any Category 2 work undertaken for consultants by medical secretaries must be completed outside of their normal NHS hours. Consultants should be aware of their duty to inform their secretaries that receipt of such income is subject to taxation and must be declared to HM Revenue and Customs. It is recommended that Consultants keep accurate records of income and payment.

12. RENUNCIATION OF PRIVATE FEES

- 12.1 In some departments, consultants may choose to forego their private fees for private practice or for fee paying services in favour of a Charitable Fund managed by the Trust that could be drawn upon at a later stage for, by way of example, Continuous Professional Development / Study Leave.
- 12.2 For income tax purposes all income earned must be treated as taxable earnings. The only way in which this income can be treated as non taxable earnings of the consultant concerned is if the consultant signs a 'Voluntary Advance Renunciation of Earnings form' (Appendix 7) and declares that the earnings from a particular activity will belong to a named charitable fund and that the earnings will not be received by the consultant. In addition a consultant should never accept a cheque made out to him or her personally. To do so attracts taxation on that income and it cannot be subsequently renounced. Therefore all such income renounced in advance should be paid directly into the relevant fund. Income can only be renounced if it has not been paid to the individual and a Register of these will be maintained by the Charitable Funds Officer.
- 12.3 The Trust will be required to demonstrate that income renounced in favour of a Charitable Fund is not retained for the use of the individual who renounces it. Thus, in the event of any such consultant subsequently drawing on that fund, any such expenditure approval must be countersigned by another signatory on the fund.

13. OVERSEAS VISITORS - NON UK PATIENTS

(Republic of Ireland, EEA, Foreign Nationals)

PLEASE NOTE THIS IS ONLY A BRIEF GUIDE FOR FURTHER INFORMATION PLEASE CONTACT THE PAYING PATIENT OFFICE

- 13.1 The NHS provides healthcare free of charge to people who are 'ordinarily resident' in the UK. People who do not permanently live in the UK lawfully are not automatically entitled to use the NHS free of charge.
- 13.2 **RESIDENCY** is therefore the main qualifying criterion, applicable regardless of nationality, being registered with a GP or having been issued a HC/NHS number, or whether the person holds a British Passport, or lived and paid taxes or national insurance contributions in the UK in the past.

- 13.3 Any patient attending the Trust who cannot establish that they are an ordinary resident and have lawfully lived in the UK permanently for the last 12 months preceding treatment are not entitled to free non ED hospital treatment whether they are registered with a GP or not. A GP referral letter cannot be accepted solely as proof of a patient's permanent residency and therefore entitlement to treatment.
- 13.4 For all new patients attending the Trust, residency must be established. All patients will be asked to complete a declaration to confirm residency, (regardless of race/ethnic origin). If not the Trust could be accused of discrimination.
- 13.5 Where there is an element of doubt as to whether the patient is an 'ordinary resident' eg no GP/ H&C number or non UK contact details, the Paying Patients Officer must be alerted immediately.

13.6 Emergency Department

- 13.6.1 Treatment given in an Emergency Department, Walk in Clinic or Minor Injuries Unit is free of charge if it is deemed to be immediate and necessary.
- 13.6.2 The Trust should always provide immediate and necessary treatment whether or not the patient has been informed of or agreed to pay charges. There is no exemption from charges for 'emergency' treatment other than that given in the accident and emergency department. Once an overseas patient is transferred out of Emergency Department their treatment becomes chargeable.
- 13.6.3 All patients admitted from Emergency Department must be asked to complete declaration of residency status.
- 13.6.4 This question is essential in trying to establish whether the patient is an overseas patient or not and hence liable to pay for any subsequent care provided.
- 13.6.5 If the patient is not an ordinary resident or there is an element of doubt eg no GP/ no H&C Number, the patient should be referred to Paying Patients Office to determine their eligibility.
- 13.6.6 If the person has indicated that they are a visitor to Northern Ireland, the overseas address must be entered as the permanent address on the correct Patient Administrative System and the Paying Patients Office should be notified immediately.

13.7 Outpatient Appointments

- 13.7.1 In all cases where the patient has not lived in Northern Ireland for 12 months or relevant patient data is missing such as H&C number, GP Details etc the patient must be referred to the Paying Patients Office to establish the patient's entitlement to free NHS treatment. This must be established before an appointment is given.

13.8 Review Appointments

- 13.8.1 Where possible follow up treatment should be carried out at the patient's local hospital, however if they are reviewed at the Trust they must be informed that they will be liable for charges.
- 13.8.2 If a consultant considers it appropriate to review a patient then they must sign a statement to this effect waiving the charges that would have been due to the Trust.

13.9 Elective Admission

- 13.9.1 A patient should not be placed onto a waiting list until their entitlement to free NHS Treatment has been established. Where the Patient is chargeable, the Trust should not initiate a treatment process until a deposit equivalent to the estimated full cost of treatment has been obtained.

13.10 Referral from other NHS Trusts

- 13.10.1 When a Consultant accepts a referral from another Trust the patients' status should, where possible, be established prior to admission. However, absence of this information should not delay urgent treatment.
- 13.10.2 The Trust will operate a policy of 'Stabilise and Transfer'.

14. AMENITY BED PATIENTS

- 14.1 Within the Trust's Maternity Service, a number of beds are assigned Amenity Beds. It is permissible for NHS patients who require surgical delivery and an overnight stay to pay for any bed assigned as an Amenity Bed. This payment has no effect on the NHS status of the patient. All patients identified as amenity will be recorded on PAS as APG and an Undertaking to Pay for an Amenity Bed form (Appendix 6) should be completed ideally before obtaining the amenity facilities.

15. GLOSSARY

Undertaking to Pay Form

Private Patients may fund their treatment, or they may have private medical insurance. In all cases Private Patients must sign an 'Undertaking to Pay' form (Appendix 3). This is a legally binding document which, when signed prior to treatment, confirms the patient as personally liable for costs incurred while at hospital and confirms the Patient's Private status. ALL private patients, whether insured or not are obliged to complete and sign an 'Undertaking to Pay' form, prior to commencement of treatment. Consultants therefore, as the first point of contact should ensure that the Paying Patients Officer is advised to ensure completion of the 'Undertaking to Pay' form.

Fee Paying Services

Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

Private Professional Services *(Also referred to as 'private practice')*

- the diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions (Appendix 1).
- work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

Non UK patients

A person who does not meet the 'ordinarily resident' test.

Job Plan

A work programme which shows the time and place of the consultant's weekly fixed commitments.

16. APPENDIX 1: SPECIFIC EXAMPLES OF FEE PAYING SERVICES - SCHEDULE 10

1. Fee Paying Services are services that are not part of Contractual or Consequential Services and not reasonably incidental to them. Fee Paying Services include:
 - a. work on a person referred by a Medical Adviser of the Department of Social Development, or by an Adjudicating Medical Authority or a Medical Appeal Tribunal, in connection with any benefits administered by an Agency of the Department of Social Development;
 - b. work for the Criminal Injuries Compensation Board, when a special examination is required or an appreciable amount of work is involved in making extracts from case notes;
 - c. work required by a patient or interested third party to serve the interests of the person, his or her employer or other third party, in such nonclinical contexts as insurance, pension arrangements, foreign travel, emigration, or sport and recreation. (This includes the issue of certificates confirming that inoculations necessary for foreign travel have been carried out, but excludes the inoculations themselves. It also excludes examinations in respect of the diagnosis and treatment of injuries or accidents);
 - d. work required for life insurance purposes;
 - e. work on prospective emigrants including X-ray examinations and blood tests;
 - f. work on persons in connection with legal actions other than reports which are incidental to the consultant's Contractual and Consequential Duties, or where the consultant is giving evidence on the consultant's own behalf or on the employing organisation's behalf in connection with a case in which the consultant is professionally concerned;
 - g. work for coroners, as well as attendance at coroners' courts as medical witnesses;
 - h. work requested by the courts on the medical condition of an offender or defendant and attendance at court hearings as medical witnesses, otherwise than in the circumstances referred to above;
 - i. work on a person referred by a medical examiner of HM Armed Forces Recruiting Organisation;
 - j. work in connection with the routine screening of workers to protect them or the public from specific health risks, whether such screening is a statutory obligation laid on the employing organisation by specific regulation or a voluntary undertaking by the employing organisation in pursuance of its general liability to protect the health of its workforce;
 - k. occupational health services provided under contract to other HPSS, independent or public sector employers;
 - l. work on a person referred by a medical referee appointed under the Workmen's Compensation (Supplementation) Act (Northern Ireland) 1966; work on prospective students of universities or other institutions of further education, provided that they are not covered by Contractual and Consequential Services. Such examinations may include chest radiographs;

- m. Appropriate examinations and recommendations under Parts II and IV of the Mental Health (Northern Ireland) Order 1986 and fees payable to medical members of Mental Health Review Tribunals;
- n. services performed by members of hospital medical staffs for government departments as members of medical boards;
- o. work undertaken on behalf of the Employment Medical Advisory Service in connection with research/survey work, i.e. the medical examination of employees intended primarily to increase the understanding of the cause, other than to protect the health of people immediately at risk (except where such work falls within Contractual and Consequential Services);
- p. completion of Form B (Certificate of Medical Attendant) and Form C (Confirmatory Medical Certificate) of the cremation certificates;
- q. examinations and reports including visits to prison required by the Prison Service which do not fall within the consultant's Contractual and Consequential Services and which are not covered by separate contractual arrangements with the Prison Service;
- r. examination of blind or partially-sighted persons for the completion of form A655, except where the information is required for social security purposes, or by an Agency of the Department of Social Development, or the Employment Service, or the patient's employer, unless a special examination is required, or the information is not readily available from knowledge of the case, or an appreciable amount of work is required to extract medically correct information from case notes;
- s. work as a medical referee (or deputy) to a cremation authority and signing confirmatory cremation certificates;
- t. medical examination in relation to staff health schemes of local authorities and fire and police authorities;
- u. delivering lectures;
- v. medical advice in a specialised field of communicable disease control;
- w. attendance as a witness in court;
- x. medical examinations and reports for commercial purposes, e.g. certificates of hygiene on goods to be exported or reports for insurance companies;
- y. advice to organisations on matters on which the consultant is acknowledged to be an expert.

17. APPENDIX 2 - A CODE OF CONDUCT FOR PRIVATE PRACTICE

November 2003

Recommended Standards of Practice for NHS Consultants

An agreement between the BMA's Northern Ireland Consultants and Specialists Committee and the Department of Health, Social Services and Public Safety for consultants in Northern Ireland.

A CODE OF CONDUCT FOR PRIVATE PRACTICE: RECOMMENDED STANDARDS FOR NHS CONSULTANTS, 2003

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Part I: Introduction

Scope of Code

- 1.1 This document sets out recommended standards of best practice for NHS consultants in England about their conduct in relation to private practice . The standards are designed to apply equally to honorary contract holders in respect of their work for the NHS. The Code covers all private work, whether undertaken in non-NHS or NHS facilities.
- 1.2 Adherence to the standards in the Code will form part of the eligibility criteria for clinical excellence awards.
- 1.3 This Code should be used at the annual job plan review as the basis for reviewing the relationship between NHS duties and any private practice.

Key Principles

1.4 The Code is based on the following key principles:

- NHS consultants and NHS employing organisations should work on a partnership basis to prevent any conflict of interest between private practice and NHS work. It is also important that NHS consultants and NHS organisations minimise the risk of any perceived conflicts of interest; although no consultant should suffer any penalty (under the code) simply because of a perception;
- The provision of services for private patients should not prejudice the interest of NHS patients or disrupt NHS services;
- With the exception of the need to provide emergency care, agreed NHS commitments should take precedence over private work; and
- NHS facilities, staff and services may only be used for private practice with the prior agreement of the NHS employer.

Part II: Standards of Best Practice

Disclosure of Information about Private Practice

- 1.2 Consultants should declare any private practice, which may give rise to any actual or perceived conflict of interest, or which is otherwise relevant to the practitioner's proper performance of his/her contractual duties. As part of the annual job planning process, consultants should disclose details of regular private practice commitments, including the timing, location and broad type of activity, to facilitate effective planning of NHS work and out of hours cover.
- 2.2 Under the appraisal guidelines agreed in 2001, NHS consultants should be appraised on all aspects of their medical practice, including private practice. In line with the requirements of revalidation, consultants should submit evidence of private practice to their appraiser.

Scheduling of Work and On-Call Duties

- 2.3 In circumstances where there is or could be a conflict of interest, programmed NHS commitments should take precedence over private work. Consultants should ensure that, except in emergencies, private commitments do not conflict with NHS activities included in their NHS job plan.
- 2.4 Consultants should ensure in particular that:
- private commitments, including on-call duties, are not scheduled during times at which they are scheduled to be working for the NHS (subject to paragraph 2.8 below);
 - there are clear arrangements to prevent any significant risk of private commitments disrupting NHS commitments, e.g. by causing NHS activities to begin late or to be cancelled;

- private commitments are rearranged where there is regular disruption of this kind to NHS work; and private commitments do not prevent them from being able to attend a NHS emergency while they are on call for the NHS, including any emergency cover that they agree to provide for NHS colleagues. In particular, private commitments that prevent an immediate response should not be undertaken at these times.
- 2.5 Effective job planning should minimise the potential for conflicts of interests between different commitments. Regular private commitments should be noted in a consultant's job plan, to ensure that planning is as effective as possible.
- 2.6 There will be circumstances in which consultants may reasonably provide emergency treatment for private patients during time when they are scheduled to be working or are on call for the NHS. Consultants should make alternative arrangements to provide cover where emergency work of this kind regularly impacts on NHS commitments.
- 2.7 Where there is a proposed change to the scheduling of NHS work, the employer should allow a reasonable period for consultants to rearrange any private sessions, taking into account any binding commitments entered into (e.g. leases).

Provision of Private Services alongside NHS Duties

- 2.8 In some circumstances NHS employers may at their discretion allow some private practice to be undertaken alongside a consultant's scheduled NHS duties, provided that they are satisfied that there will be no disruption to NHS services. In these circumstances, the consultants should ensure that any private services are provided with the explicit knowledge and agreement of the employer and that there is no detriment to the quality or timeliness of services for NHS patients.

Information for NHS Patients about Private Treatment

- 2.9 In the course of their NHS duties and responsibilities consultants should not initiate discussions about providing private services for NHS patients, nor should they ask other NHS staff to initiate such discussions on their behalf.
- 2.10 Where a NHS patient seeks information about the availability of, or waiting times for, NHS and/or private services, consultants should ensure that any information provided by them, is accurate and up-to-date and conforms with any local guidelines.
- 2.11 Except where immediate care is justified on clinical grounds, consultants should not, in the course of their NHS duties and responsibilities, make arrangements to provide private services, nor should they ask any other NHS staff to make such arrangements on their behalf unless the patient is to be treated as a private patient of the NHS facility concerned.

Referral of Private Patients to NHS Lists

- 2.12 Patients who choose to be treated privately are entitled to NHS services on exactly the same basis of clinical need as any other patient.
- 2.13 Where a patient wishes to change from private to NHS status, consultants should help ensure that the following principles apply:

- a patient cannot be both a private and a NHS patient for the treatment of one condition during a single visit to a NHS organisation;
- any patient seen privately is entitled to subsequently change his or her status and seek treatment as a NHS patient;
- any patient changing their status after having been provided with private services should not be treated on a different basis to other NHS patients as a result of having previously held private status;
- patients referred for an NHS service following a private consultation or private treatment should join any NHS waiting list at the same point as if the consultation or treatment were an NHS service. Their priority on the waiting list should be determined by the same criteria applied to other NHS patients; and
- should a patient be admitted to an NHS hospital as a private inpatient, but subsequently decide to change to NHS status before having received treatment, there should be an assessment to determine the patient's priority for NHS care.

Promoting Improved Patient Access to NHS Care and Increasing NHS Capacity

- 2.14 Subject to clinical considerations, consultants should be expected to contribute as fully as possible to maintaining a high quality service to patients, including reducing waiting times and improving access and choice for NHS patients. This should include co-operating to make sure that patients are given the opportunity to be treated by other NHS colleagues or by other providers where this will maintain or improve their quality of care, such as by reducing their waiting time.
- 2.15 Consultants should make all reasonable efforts to support initiatives to increase NHS capacity, including appointment of additional medical staff.

Part III – Managing Private Patients in NHS Facilities

- 3.1 Consultants may only see patients privately within NHS facilities with the explicit agreement of the responsible NHS organisation. It is for NHS organisations to decide to what extent, if any, their facilities, staff and equipment may be used for private patient services and to ensure that any such services do not interfere with the organisation's obligations to NHS patients.
- 3.2 Consultants who practise privately within NHS facilities must comply with the responsible NHS organisation's policies and procedures for private practice. The NHS organisation should consult with all consultants or their representatives, when adopting or reviewing such policies.

Use of NHS Facilities

- 3.3 NHS consultants may not use NHS facilities for the provision of private services without the agreement of their NHS employer. This applies whether private services are carried out in their own time, in annual or unpaid leave, or – subject to the criteria in paragraph 2.8 - alongside NHS duties.
- 3.4 Where the employer has agreed that a consultant may use NHS facilities for the provision of private services:

- the employer will determine and make such charges for the use of its services, accommodation or facilities as it considers reasonable;
 - any charge will be collected by the employer, either from the patient or a relevant third party; and
 - a charge will take full account of any diagnostic procedures used, the cost of any laboratory staff that have been involved and the cost of any NHS equipment that might have been used.
- 3.5 Except in emergencies, consultants should not initiate private patient services that involve the use of NHS staff or facilities unless an undertaking to pay for those facilities has been obtained from (or on behalf of) the patient, in accordance with the NHS body's procedures.
- 3.6 In line with the standards in Part II, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients. Only in unforeseen and clinically justified circumstances should an NHS patient's treatment be cancelled as a consequence of, or to enable, the treatment of a private patient.

Use of NHS Staff

- 3.7 NHS consultants may not use NHS staff for the provision of private services without the agreement of their NHS employer.
- 3.8 The consultant responsible for admitting a private patient to NHS facilities must ensure, in accordance with local procedures, that the responsible manager and any other staff assisting in providing services are aware of the patient's private status.

18. APPENDIX 3 - PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

HSC Southern Health
and Social Care Trust
Quality Care - for you, with you

PRIVATE / NOT ORDINARILY RESIDENT IN UK NOTIFICATION AND UNDERTAKING TO PAY FORM

Private Patient: Yes ☐ No ☐ Non-Ordinarily Resident in UK: Yes ☐ No ☐

| | | | |
|--------------------|---------------|--------------|--------------------------|
| Name of Patient: | | | |
| Address: | | | |
| Postcode: | Telephone No: | | |
| Date of Birth: | | | |
| H&C Number: | | | |
| Name of Insurer: | | Self Funding | <input type="checkbox"/> |
| Insurer Policy No: | | | |

I have been seeing this person as a private patient. They are to be admitted / referred to
Hospital on _____ as an _____

| Inpatient Referral | <input type="checkbox"/> | Obstetrics | Medical | Surgical | T & O |
|--|--------------------------|----------------------------|----------------------------|----------------------------|----------------------------|
| | | Estimated Duration of Stay | Estimated Duration of Stay | Estimated Duration of Stay | Estimated Duration of Stay |
| Day Case Referral | <input type="checkbox"/> | | | | |
| Diagnostics (Inpatient or Outpatient) | <input type="checkbox"/> | Laboratory | Radiology [please detail] | Other [e.g. Pharmacy] | |
| | | [please detail] | | | |
| | | | | | |

| Undertaking to Pay Confirmation To be completed by Consultant | | | |
|---|--|------|--|
| I have advised the patient named above of the estimated hospital charges and of my fees | | | |
| Signed Consultant | | Date | |
| Undertaking to Pay To be completed by the person who will pay the account | | | |
| I understand and agreed to pay Southern Health and Social Care Trust all charges ¹ associated with this episode of care ² . Where the Consultant may deem further procedures/investigations necessary which will incur additional charges, I understand that this may result in a different cost from that quoted to me and I undertake to pay the full costs incurred. | | | |
| Signed Patient | | Date | |

RETURN TO PAYING PATIENTS OFFICE CRAIGAVON AREA HOSPITAL/DAISY HILL
HOSPITAL [email:payingpatients@southerntrust.hscni.net]

¹ A list of Tariffs is available from the Private Patients office

² Episode of Care – The total treatment of either an inpatient or day case patient from diagnosis through to discharge

19. APPENDIX 4 APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

APPLICATION FOR THE TRANSFER OF PRIVATE PATIENT TO NHS STATUS

| | |
|-----------------------------------|--|
| Name of Patient: | |
| Address: | |
| Postcode: | |
| Date of Birth: | |
| H&C Number: | |
| Name of Consultant | |
| Date of Last Private Consultation | |

I have been seeing this person as a private patient. He/she has now been referred to Hospital as an NHS patient.

| | | Clinical Priority |
|---------------------|--------------------------|-------------------|
| Inpatient Referral | <input type="checkbox"/> | |
| Outpatient Referral | <input type="checkbox"/> | |
| Day Case Referral | <input type="checkbox"/> | |

| | |
|-------------------|--|
| Signed Consultant | |
| Effective Date | |

Consultants are reminded that in good practice a patient who changes from private to NHS status should receive all subsequent treatment during that episode of care under the NHS as outlined in A Code of Conduct for Private Practice.

PLEASE FORWARD TO PAYING PATIENTS OFFICE [paying.patients@southerntrust.hscni.net]

20. APPENDIX 5 PRINCIPLES GOVERNING RECEIPT OF ADDITIONAL FEES – SCHEDULE 11

Principles Governing Receipt of Additional Fees - Schedule 11

1. In the case of the following services, the consultant will not be paid an additional fee, or - if paid a fee - the consultant must remit the fee to the employing organisation:
 - any work in relation to the consultant's Contractual and Consequential Services;
 - duties which are included in the consultant's Job Plan, including any additional Programmed Activities which have been agreed with the employing organisation;
 - fee paying work for other organisations carried out during the consultant's Programmed Activities, unless the work involves minimal disruption and the employing organisation agrees that the work can be done in HPSS time without the employer collecting the fee;
 - domiciliary consultations carried out during the consultant's Programmed Activities;
 - lectures and teaching delivered during the course of the consultant's clinical duties;
 - delivering lectures and teaching that are not part of the consultant's clinical duties, but are undertaken during the consultant's Programmed Activities.
 - Consultants may wish to take annual leave [having given the required 6 week notice period] to undertake fee paying work [e.g. court attendance] in this instance the consultant would not be required to remit fees to the Trust.

This list is not exhaustive and as a general principle, work undertaken during Programmed Activities will not attract additional fees.

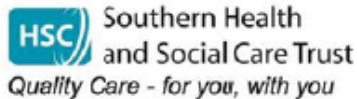
2. Services for which the consultant can retain any fee that is paid:
 - Fee Paying Services carried out in the consultant's own time, or during annual or unpaid leave;
 - Fee Paying Services carried out during the consultant's Programmed Activities that involve minimal disruption to HPSS work and which the employing organisation agrees can be done in HPSS time without the employer collecting the fee;
 - Domiciliary consultations undertaken in the consultant's own time, though it is expected that such consultations will normally be scheduled as part of Programmed Activities¹;
 - Private Professional Services undertaken in the employing organisation's facilities and with the employing organisation's agreement during the consultant's own time or during annual or unpaid leave;
 - Private Professional Services undertaken in other facilities during the consultant's own time, or during annual or unpaid leave;
 - Lectures and teaching that are not part of the consultant's clinical duties and are undertaken in the consultant's own time or during annual or unpaid leave;

- Preparation of lectures or teaching undertaken during the consultant's own time irrespective of when the lecture or teaching is delivered.

This list is not exhaustive but as a general principle the consultant is entitled to the fees for work done in his or her own time, or during annual or unpaid leave.

And only for a visit to the patient's home at the request of a general practitioner and normally in his or her company to advise on the diagnosis or treatment of a patient who on medical grounds cannot attend hospital.

21. APPENDIX 6 - UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED



UNDERTAKING TO PAY CHARGES FOR AN AMENITY BED

| | |
|------------------|--|
| Name of Patient: | |
| Address: | |
| Postcode: | |
| Date of Birth: | |
| Hospital Number: | |

Site: Craigavon ☐ Daisy Hill ☐

I was allocated an amenity bed on (date): _____ (time)

Ward: _____ Consultant: _____

I undertake to pay the Southern Health Social Care Trust £39 per night for an amenity bed, which has been provided for me at my request.

Number of days Amenity Bed required: _____

I understand that if I am required to stay in hospital more days than anticipated, the midwifery staff will ask me if I wish to continue and pay for the amenity bed, or if I wish to be transferred to the open ward.

Patient's Signature: _____ Date: _____

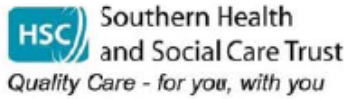
Midwife's Signature: _____ Date: _____

To be completed by WARD CLERK OR MIDWIFE when patient is being transferred /discharged from an amenity bed.

Date transferred / discharged from amenity bed _____

Signed by midwife / ward clerk when transferred / discharged _____

22. APPENDIX 7 – AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES



AGREEMENT FOR THE VOLUNTARY ADVANCE RENUNCIATION OF EARNINGS FROM FEE PAYING ACTIVITIES

I (name) _____

Request that any monies due to me from patients in relation to fees from
(description of activity)

Shall be transferred to (Charity title and reference) _____

For its sole use in the advancement of its aims in accordance with the Trust Deed until directed otherwise by me in writing.

This request is to take effect from (date): _____

Signed, sealed and delivered

by:

(Full name in BLOCK CAPITALS) _____

Date: _____

In the presence of: _____

Date: _____

Address:: _____

_____ **Postcode:** _____

23. APPENDIX 8 - PROVISIONS GOVERNING THE RELATIONSHIP BETWEEN HPSS WORK AND PRIVATE PRACTICE - SCHEDULE 9

1. This Schedule should be read in conjunction with the 'Code of Conduct for Private Practice', which sets out standards of best practice governing the relationship between HPSS work and private practice.
2. The consultant is responsible for ensuring that their provision of Private Professional Services for other organisations does not:
 - result in detriment to HPSS patients;
 - diminish the public resources that are available for the HPSS.

Disclosure of information about Private Commitments

3. The consultant will inform his or her clinical manager of any regular commitments in respect of Private Professional Services or Fee Paying Services. This information will include the planned location, timing and broad type of work involved.
4. The consultant will disclose this information at least annually as part of the Job Plan Review. The consultant will provide information in advance about any significant changes to this information.

Scheduling of Work and Job Planning

5. Where a conflict of interest arises or is liable to arise, HPSS commitments must take precedence over private work. Subject to paragraphs 10 and 11 below, the consultant is responsible for ensuring that private commitments do not conflict with Programmed Activities.
6. Regular private commitments must be noted in the Job Plan.
7. Circumstances may also arise in which a consultant needs to provide emergency treatment for private patients during time when he or she is scheduled to be undertaking Programmed Activities. The consultant will make alternative arrangements to provide cover if emergency work of this kind regularly impacts on the delivery of Programmed Activities.
8. The consultant should ensure that there are arrangements in place, such that there can be no significant risk of private commitments disrupting HPSS commitments, e.g. by causing HPSS activities to begin late or to be cancelled. In particular where a consultant is providing private services that are likely to result in the occurrence of emergency work, he or she should ensure that there is sufficient time before the scheduled start of Programmed Activities for such emergency work to be carried out.
9. Where the employing authority has proposed a change to the scheduling of a consultant's HPSS work, it will allow the consultant a reasonable period in line with Schedule 6, paragraph 2 to rearrange any private commitments. The employing organisation will take into account any binding commitments that the consultant may have entered into (e.g. leases). Should a consultant wish to reschedule private commitments to a time that would conflict with Programmed Activities, he or she should raise the matter with the clinical manager at the earliest opportunity.

Scheduling Private Commitments Whilst On-Call

10. The consultant will comply with the provisions in Schedule 8, paragraph 5 of these Terms and Conditions. In addition, where a consultant is asked to provide emergency cover for a colleague at short notice and the consultant has previously arranged private commitments at the same time, the consultant should only agree to provide such emergency cover if those private commitments would not prevent him or her returning to the relevant HPSS site at short notice to attend an emergency. If the consultant is unable to provide cover at short notice it will be the employing organisation's responsibility to make alternative arrangements and the consultant will suffer no detriment in terms of pay progression as a result.

Use of HPSS Facilities and Staff

11. Where a consultant wishes to provide Private Professional Services at an HPSS facility he or she must obtain the employing organisation's prior agreement, before using either HPSS facilities or staff.
12. The employing organisation has discretion to allow the use of its facilities and will make it clear which facilities a consultant is permitted to use for private purposes and to what extent.
13. Should a consultant, with the employing organisation's permission, undertake Private Professional Services in any of the employing organisation's facilities, the consultant should observe the relevant provisions in the 'Code of Conduct for Private Practice'.
14. Where a patient pays privately for a procedure that takes place in the employing organisation's facilities, such procedures should occur only where the patient has given a signed undertaking to pay any charges (or an undertaking has been given on the patient's behalf) in accordance with the employing organisation's procedures.
15. Private patients should normally be seen separately from scheduled HPSS patients. Only in unforeseen and clinically justified circumstances should a consultant cancel or delay an HPSS patient's treatment to make way for his or her private patient.
16. Where the employing organisation agrees that HPSS staff may assist a consultant in providing Private Professional Services, or provide private services on the consultant's behalf, it is the consultant's responsibility to ensure that these staff are aware that the patient has private status.
17. The consultant has an obligation to ensure, in accordance with the employing organisation's procedures, that any patient whom the consultant admits to the employing organisation's facilities is identified as private and that the responsible manager is aware of that patient's status.
18. The consultant will comply with the employing organisation's policies and procedures for private practice

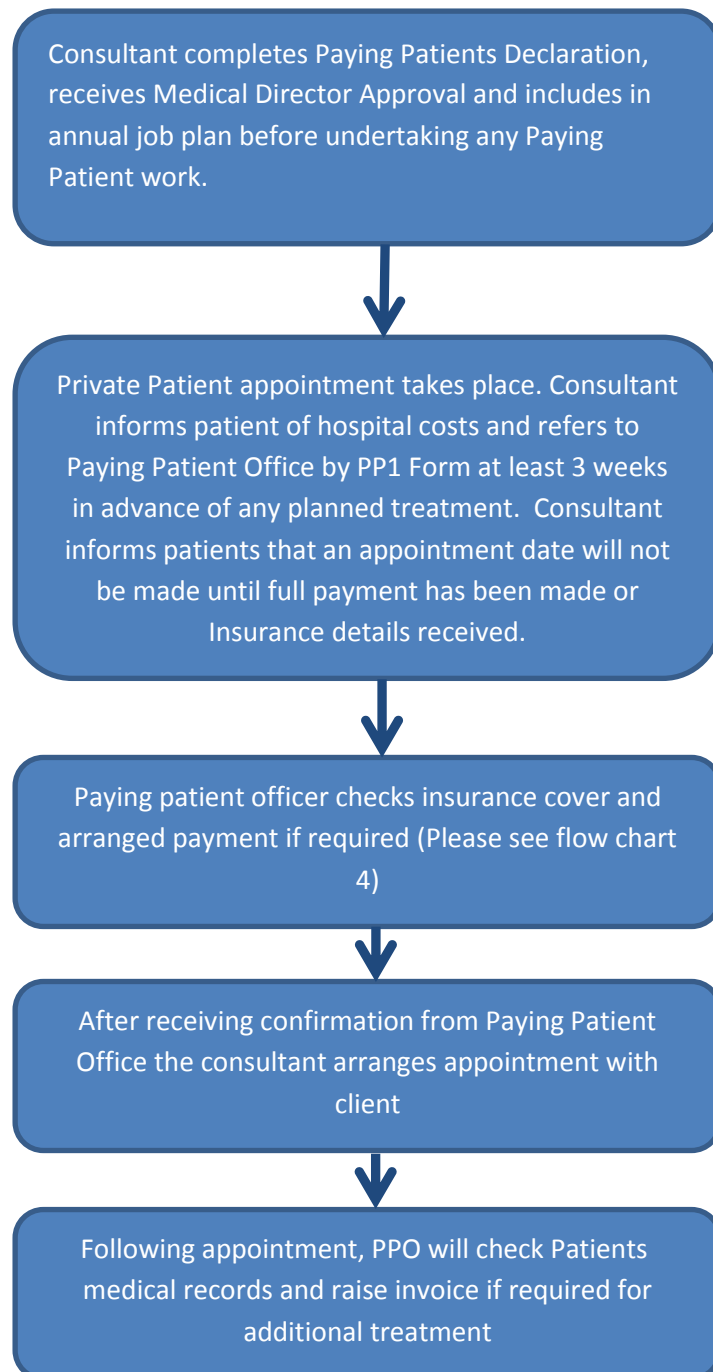
Patient Enquiries about Private Treatment

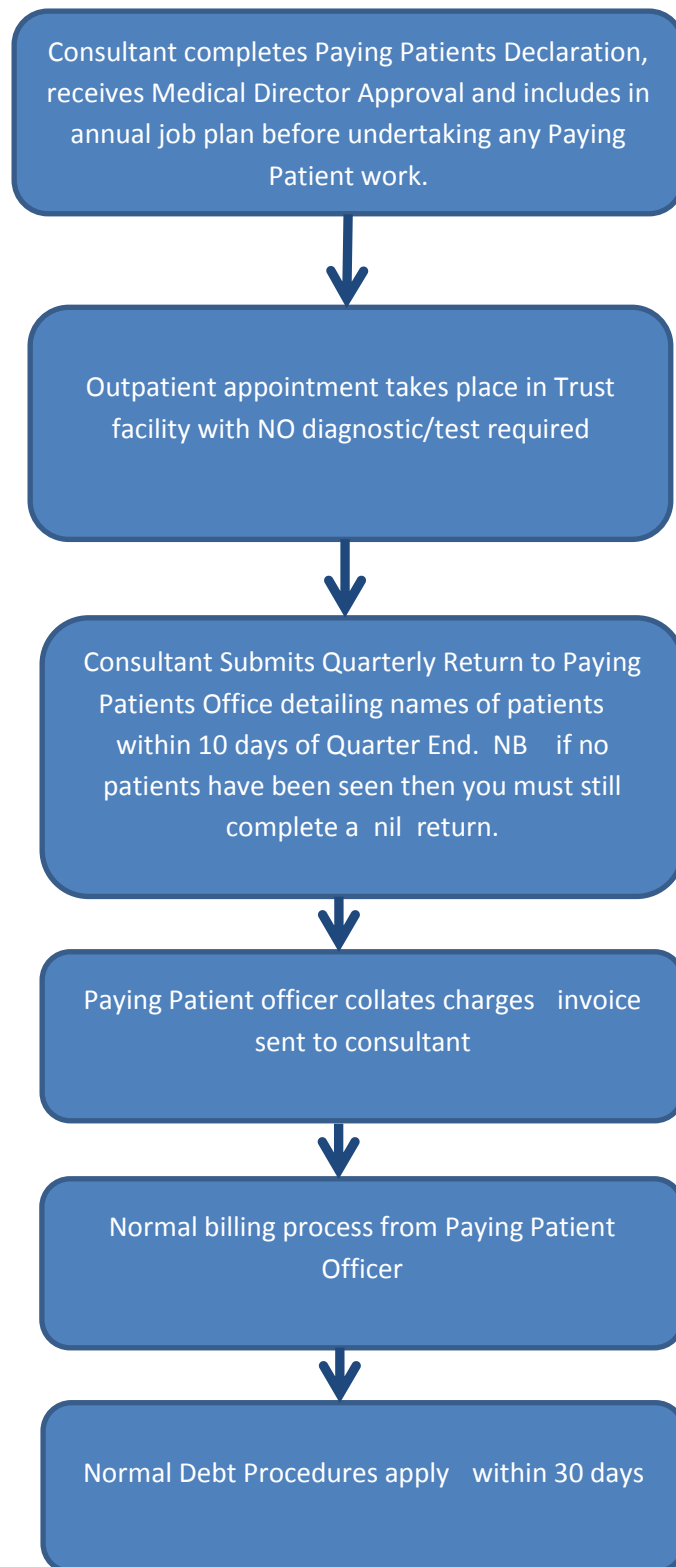
19. Where, in the course of his or her duties, a consultant is approached by a patient and asked about the provision of Private Professional Services, the consultant may provide only such standard advice as has been agreed between the employing organisation and appropriate local consultant representatives for such circumstances.

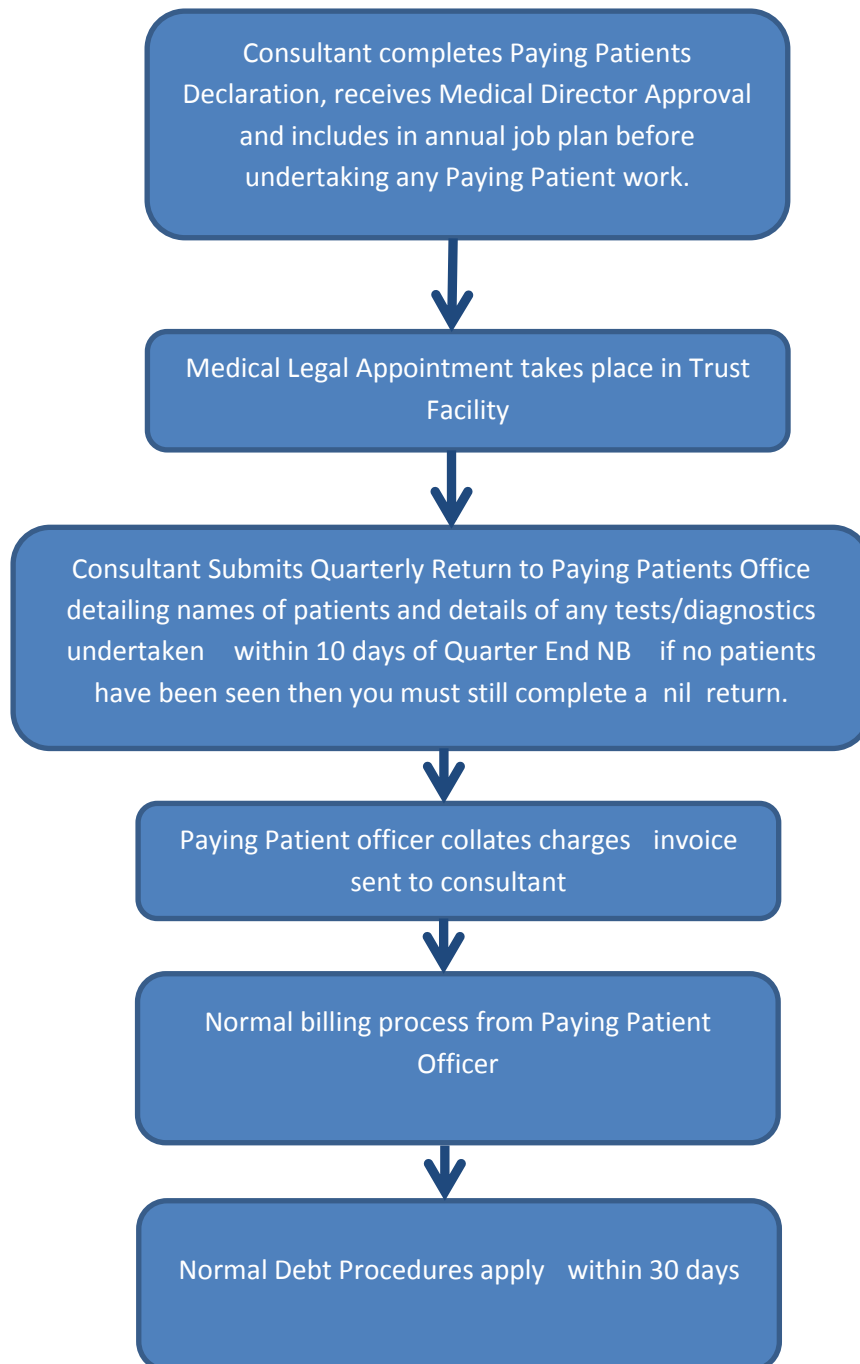
20. The consultant will not during the course of his or her Programmed Activities make arrangements to provide Private Professional Services, nor ask any other member of staff to make such arrangements on his or her behalf, unless the patient is to be treated as a private patient of the employing organisation.
21. In the course of his/her Programmed Activities, a consultant should not initiate discussions about providing Private Professional Services for HPSS patients, nor should the consultant ask other staff to initiate such discussions on his or her behalf.
22. Where an HPSS patient seeks information about the availability of, or waiting times for, HPSS services and/or Private Professional Services, the consultant is responsible for ensuring that any information he or she provides, or arranges for other staff to provide on his or her behalf, is accurate and up-to-date.

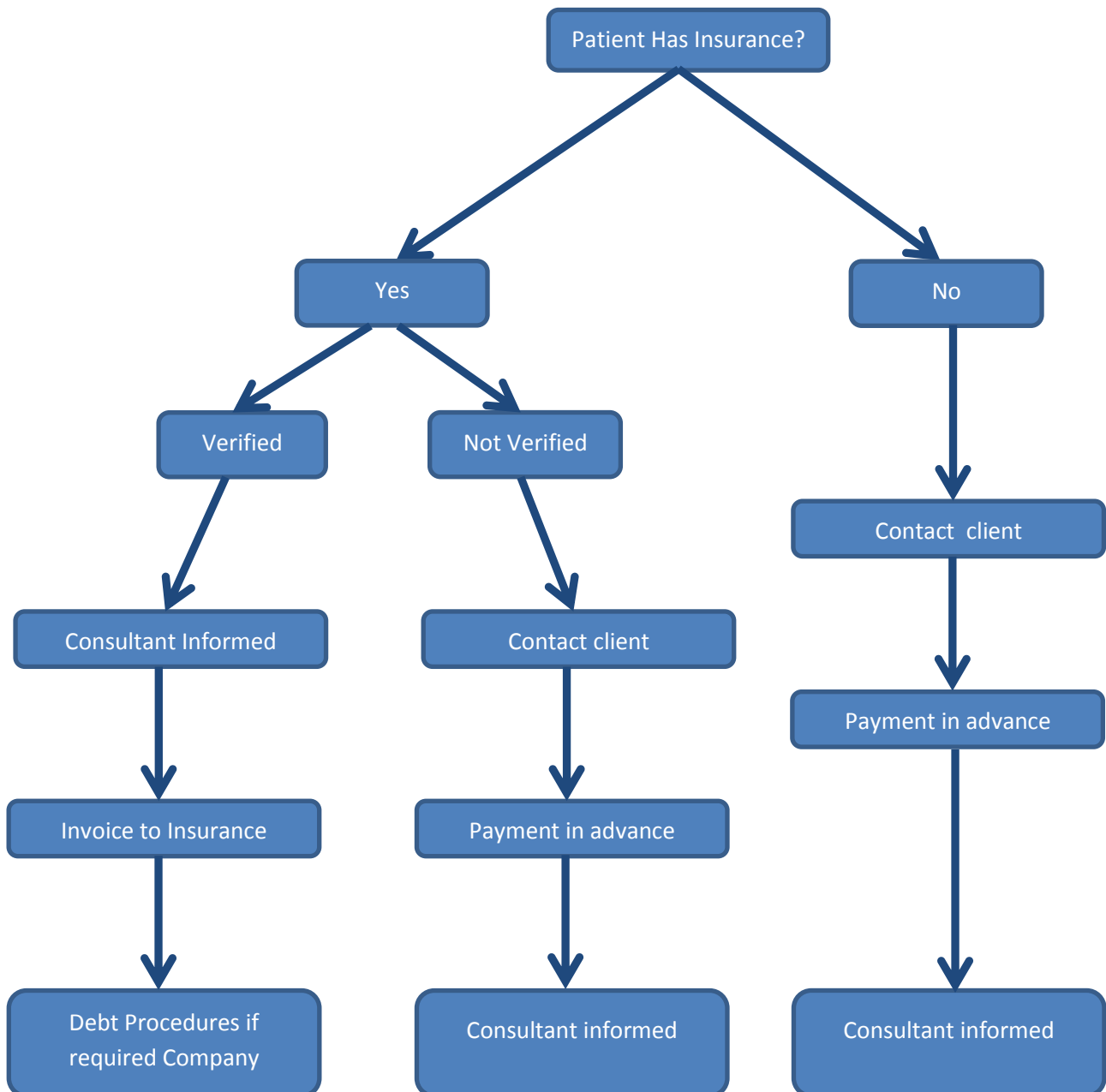
Promoting Improved Patient Access to HPSS Care

23. Subject to clinical considerations, the consultant is expected to contribute as fully as possible to reducing waiting times and improving access and choice for HPSS patients. This should include ensuring that, as far as is practicable, patients are given the opportunity to be treated by other HPSS colleagues or by other providers where this will reduce their waiting time and facilitate the transfer of such patients.
24. The consultant will make all reasonable efforts to support initiatives to increase HPSS capacity, including appointment of additional medical staff and changes to ways of working.

24. FLOW CHART 1 - PAYING PATIENTS [Inpatients]

25. FLOW CHART 2 - PAYING PATIENTS [Outpatients]

26. FLOW CHART 3 - PAYING PATIENTS [Fee Paying Services]

27. FLOW CHART 4 – PATIENT INSURANCE

Query Request Form

Requires Immediate Response: Yes

Reason for Immediate Response: Required as an action following Internal Audit review of management of private patients

☐

Data Definition

☒

Recording Issue

☒

Technical Guidance

☐

Other

Name:

Personal Information redacted by USI

Date: 8th August 2018

Organisation: BHSCT

Contact Number:

Personal Information redacted by USI

Subject Heading: PAS OP Referral Source Code – Private to NHS

a) Issue: *Please provide as much detail as possible in order for the query to be considered and resolved as quickly as possible. This query form will be published on SharePoint when resolved.*

Belfast Trust requests a Referral Source Code on PAS for outpatients who change status from Private to NHS. Currently there is no guidance for identifying such patients.

Patient who attends Trust as a private patient has category recorded as PPG. When treatment completed OP registration should be closed with Discharge Reason – Treatment Completed, however if during their treatment the patient decides to change status to NHS the OP registration should be closed with Discharge Reason – Transfer to NHS and a new OP registration opened:

PAS with referral source PTN (Private to NHS) (suggested code), mapped to Internal Value (2) and CMDS Value (11) on Referral Source Masterfile and category as NHS.

This will ensure that the original category of PPG is not overwritten to NHS and the information recorded as per the Draft Technical Guidance on Private and Overseas Patients is not lost.

Belfast Trust request that the above is adopted as regional PAS Technical Guidance.

b) Response:

When a patient transfers from Private to NHS during their treatment period the OP registration should be closed using:

Discharge Reason code: TNHS – Transfer from Private to NHS

A new OP registration should be opened using:

Referral Source code: PTN – Private to NHS

Approved by: Acute Hospital Information Group

Date: 11/09/2018

Response Published: Yes / No

Email: Personal Information redacted by USI







HSC Data Standards Helpdesk: Personal Information redacted by USI






These forms are available on the Information Standards & Data Quality SharePoint Site at

Personal Information redacted by USI

Action Plan Urology 69120

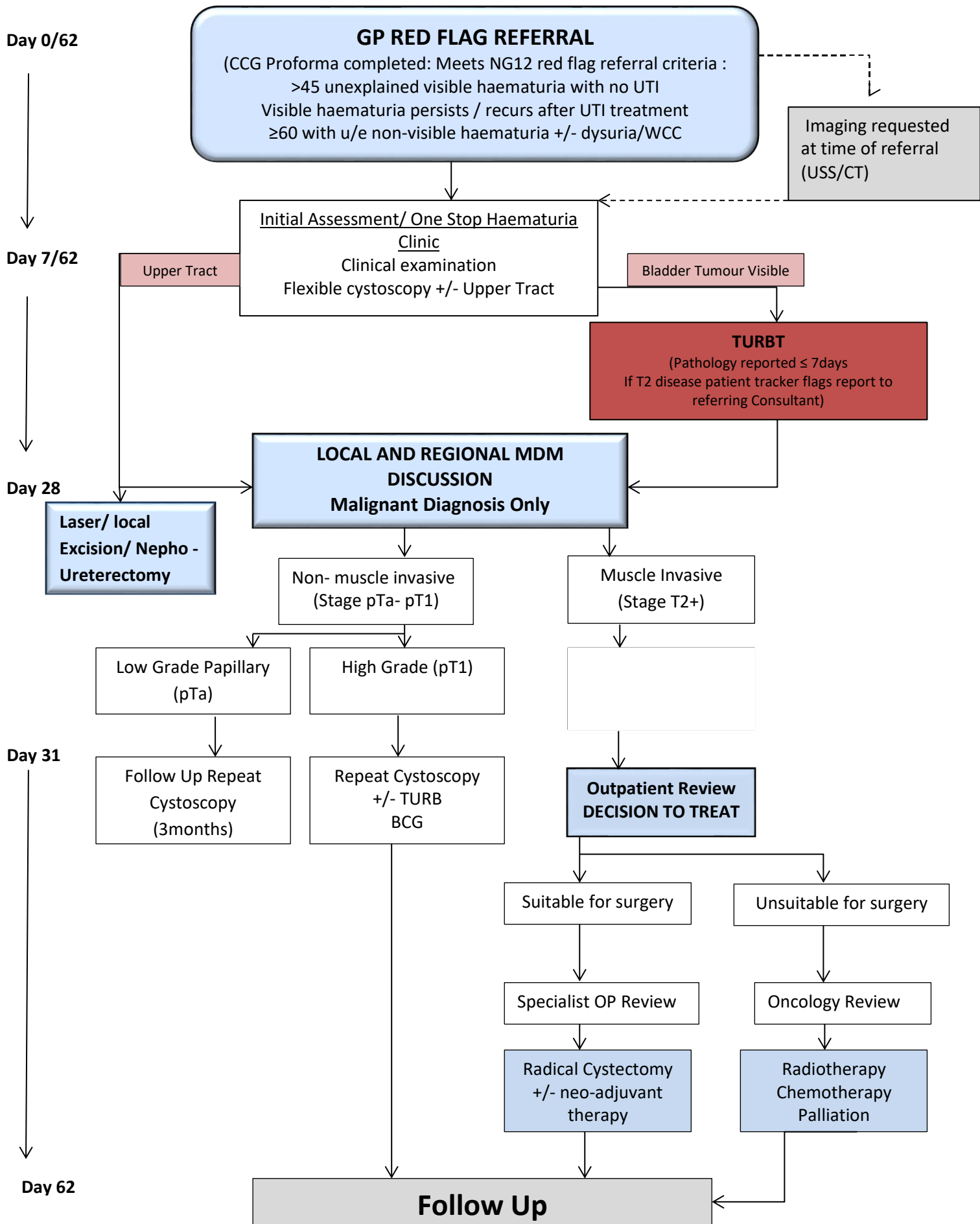
| Reference number | Recommendations | Designated responsible person | Action required | Date for completion / timescale | Date recommendation completed with evidence |
|------------------|--|-------------------------------|----------------------|---------------------------------|---|
| 1 | HSCB should 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 | <p>TRUST</p> <p>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.</p> | 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. | | <p>NiCan pathway.</p> <p> Bladder Cancer Pathway March 2020</p> <p> Revised Prostate Diagnostic Pathway C</p> <p> Female Lower Urinary Tract Sympto</p> <p> Female Urinary Tract Infection.docx</p> <p> Male Lower Urinary Tract Symptoms.docx</p> <p> male urinary tract infections.docx</p> |
| 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. Imca.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 | | | |

NICaN SUSPECT BLADDER CANCER REFERRAL AND DIAGNOSTIC PATHWAY



NICA 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>

ECOG <2 or CCI <5

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**

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

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

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

**Watchful Waiting /
Symptomatic management**

(Refer to NICA 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.

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
- Palpable Bladder
 - refer to Urology
- Atrophic Vaginitis
 - 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

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.

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

Ultrasound 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)

- 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

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 $\geq 300\text{ml}$ >> 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**

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**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 20 th February 2008 | | |
| Comments by | Close of Play - Friday 7 th March 2008 | | |
| 2nd Draft | 27 th March 08 | | |
| Final Protocol Date Approved | 30 th April 08 | | |
| Issue Date | Friday 9 th 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 | | |

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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' policies 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 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, 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 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 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 DNE 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

DRAFT

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, 30 th 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. |

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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.

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Abbreviations

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|----------|--|
| 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

DRAFT

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 health 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

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

DRAFT

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 policies 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

DRAFT

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 policies 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 DNAs – Diagnostic Appointment

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.

DRAFT

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

DRAFT

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 policies 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.

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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

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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 policies 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

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agus Sábháilteachta Poiblí**

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**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 20 th February 2008 | | |
| Comments by | Close of Play - Friday 7 th March 2008 | | |
| 2nd Draft | 27 th March 08 | | |
| Final Protocol Date Approved | 30 th April 08 | | |
| Issue Date | Friday 9 th 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 | | |

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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' policies 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 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, 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 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 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 DNE 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

DRAFT

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, 30 th 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. |

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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.

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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

DRAFT

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 health 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

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INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

DRAFT

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 policies 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

DRAFT

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 policies 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 DNAs – Diagnostic Appointment

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.

DRAFT

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

DRAFT

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 policies 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.

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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

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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 policies 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 (today’s 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, today’s 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*.

Built on PAS

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.

Not Yet Built on PAS

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)

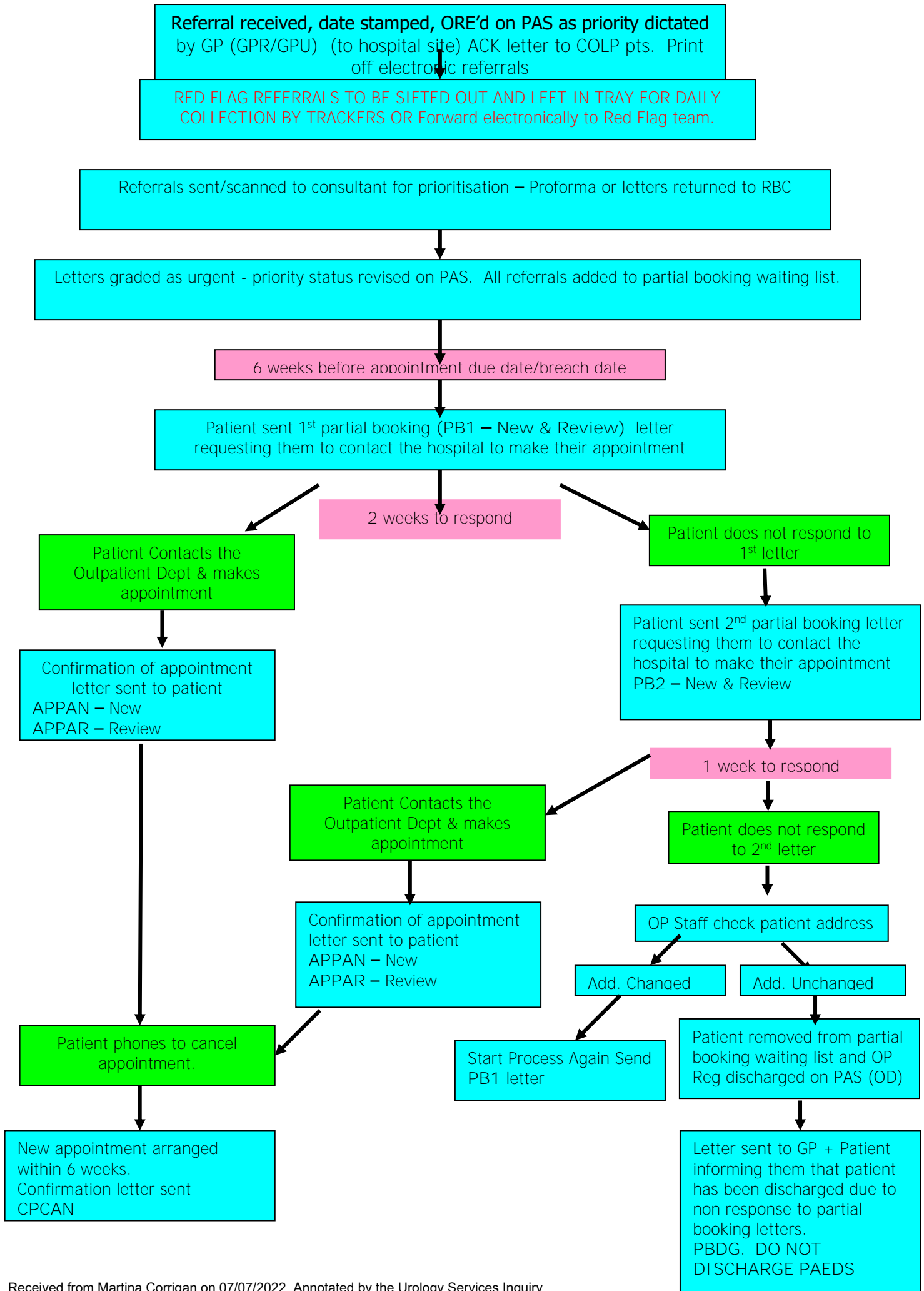
| Timeslot | NR | REV |
|----------|----|-----|
| 9.00 | 2 | 1 |
| 9.10 | 2 | 1 |
| 9.20 | 2 | 1 |
| 9.30 | 2 | 1 |
| 9.40 | 2 | 1 |
| 9.50 | 1 | 1 |
| 10.00 | 1 | 1 |

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.

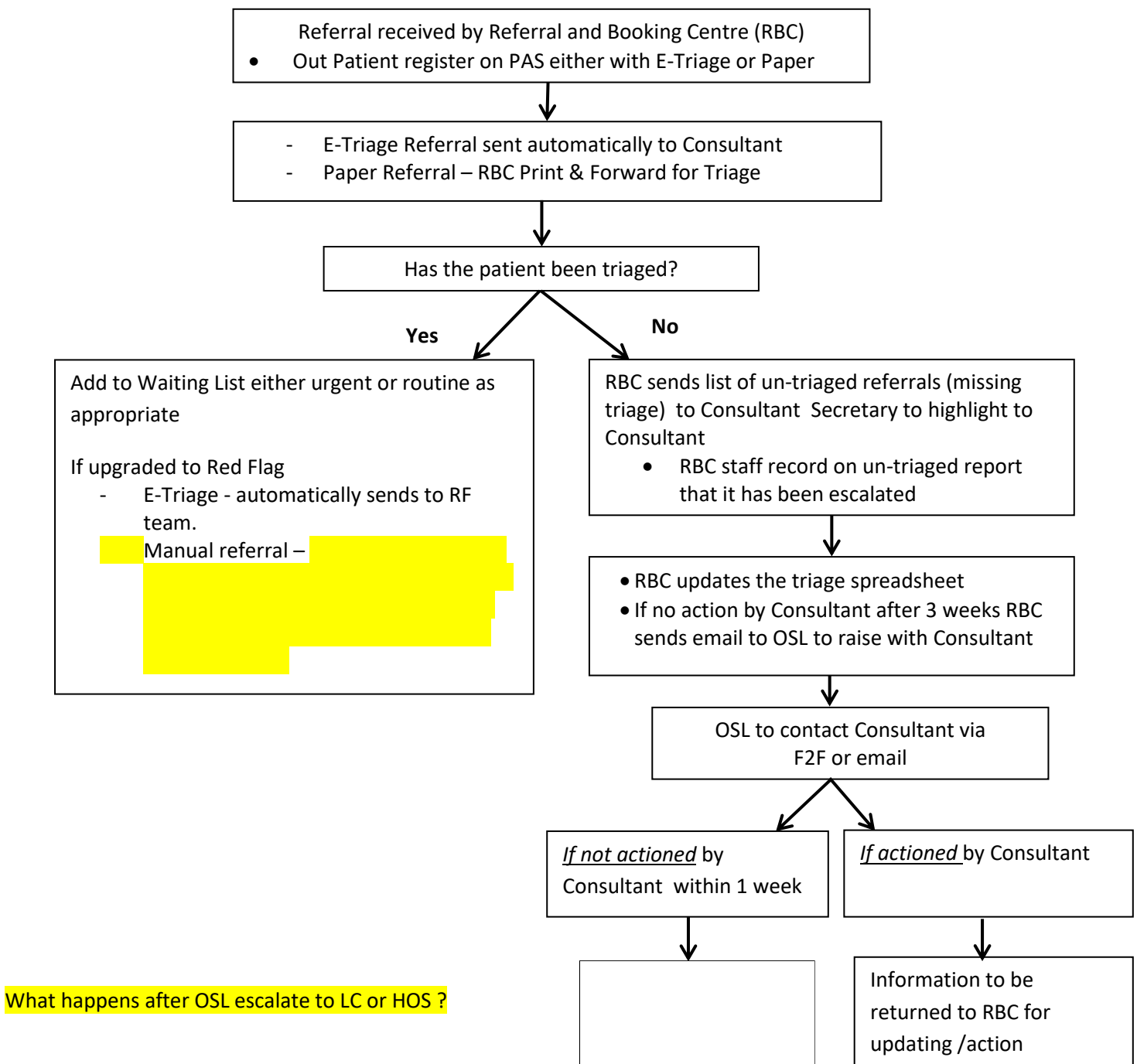
- Record on PAS that the clinic is reduced to xx amount of patients, and any other instructions you have received, eg no NR patients after 10.30 am.
- Record the information in the calendar at the back of the Select File.
- Record the information in the diary.
- Record the information in the cancelled clinic spreadsheet.
- File the e-mail in the cancelled clinic team folder.
- Make the necessary reductions to the clinic.

PARTIAL BOOKING ROUTINE APPOINTMENTS – RBC

- **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




**Incident Oversight Group Minutes
15th March 2021 at 8.30am via Zoom Meeting**

| Attendance | Apologies | |
|---|---|--|
| Patricia Kingsnorth Dr Maria O’Kane Dr Damian Gormley Martina Corrigan Stephen Wallace Jane McKimm Siobhan Hynds Ronan Carroll Suzanne Barr | Melanie McClements Mark Haynes Vivienne Toal | |
| Agenda Item | Discussion | Actions |
| 1. Review of previous meeting minutes and actions | Minutes reviewed and agreed | Actions updated accordingly throughout the main body of the Minute |
| Management of Patient Reviews | | |
| 2. Private Practice Audit | Dr O’Kane explained that management of private patients focuses very much on how patients come from private health care to NHS care. It would be expected that the Consultant gives a clinical handover, although it is unclear if this happens. Private Patient Policy needs revamped with clear clinical responsibilities and appraisal, reviews etc, she confirmed that there is a need for tighter controls as there appears to be a lot of detail about the processes, and we would need to add more to the content around patient safety practices. Dr O’Kane also highlighted that this is a regional issue and not just unique to the Southern Trust. | Ongoing work is needed to review the current policy, |
| 3. Update on Radiology and MDM Review | Martina advised that Professor Sethia has started reviewing the past MDM patients and that he had shared the forms for 7 patients. He has advised her that some cases will be straightforward but it will take a bit of time to work through others and that it would seem that he will need at least 3-4 weeks | Stephen to link in with the Royal College of Surgeons re: sourcing additional assistance |

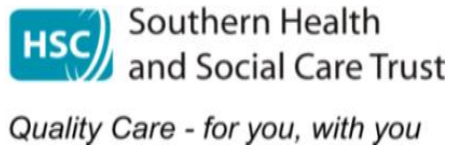
| | | |
|---|--|--|
| | <p>to get them all done (187 patients) and therefore it would appear that Professor Sethia will need assistance. Dr O’Kane stressed the need to ensure anyone involved is indemnified.</p> <p>Stephen that he and Dr O’Kane had met with NICAN on 9 March 2021 to try and understand the role of MDM regionally and if the Southern Trust were any different to others in the region; it was determined that some Trusts have a more robust MDM’s where patients are reviewed for reoccurrence and not just when they have had their first definitive treatment. He explained peer review does not look at patient level as this was done through individual audit. NICAN are doing a scoping exercise with rest of Trusts beyond peer review. NICAN are identifying UK mainland documents and identifying organisations for the Southern Trust MDM process – Stephen noted it will be a while before resolution from NICAN. The PHA has shared a document, from 2010 and Stephen has created a baseline questionnaire to assist with structures. It is hoped to get a baseline internally to help with fundamentals across all MDMs so we understand what we do.</p> <p>Dr O’Kane advised that the documents are very process driven but less about patient care, possibly as the documents are so old. There are assumptions that MDM has oversight and expectations for patient care. Patricia advised that the Board want to know can we share report with NICAN, Dr O’Kane answered that this would be a decision for the SAI Chair at finalised point. It was acknowledged that wider circulation will be needed for example RQIA once the reports were finalised.</p> | <p>with patient reviews – query Hugh Gilbert/ Dermot Hughes?</p> <p>Patricia to check with SAI Chair, Dermot, the appropriateness of sharing the finalised report with NICAN and RQIA.</p> |
| <p>4. IPT for Review Process</p>   <p>Urology Inquiry IPT - Band 8B_Service draft 8 15.12.2020.(Manager for Public In</p> | <p>Stephen outlined the job description for a post advertised in Belfast Trust and indicated that appears to include the function of collating witness statements and managing the process of public inquiries, duties etc and seems to be wide ranging. He highlighted that there are elements the Trust have not considered.</p> | <p>Siobhan agreed to have a look at the Job Description</p> |
| <p>5. Additional Subject Matter</p> | <p>Stephen informed that the Urology Consultant Edward Tudor for SJR Contact</p> | |

| | | |
|---|--|---------------------------------------|
| <p>Expertise</p> <ul style="list-style-type: none"> - British Association of Urological Surgeons - British Association of Urological Nurses | | |
| <p>6. Royal College of Surgeons Engagement</p> <ul style="list-style-type: none"> - Selection of Records - Costing | <p>Martina and Stephen met with Jessica from RCS on 11 March 2021 and acknowledged that there will be ongoing communication re: record transfer. The patient hospital numbers are now ready for randomisation selection. Martina informed some of the cohorts are short in numbers, for example, Andrology was to have a sample of 10 patients however there were only 5 patients referred in for Andrology in 2015 so it was agreed by the group that we would take from other groups to make up 100 patients. Stephen advised that costing is to be finalised as it will need a direct award.</p> | |
| <p>7. Bicalutamide Patient Review</p> | <p>No further updates for this meeting</p> | |
| <p>8. Engagement of ISP to undertake waiting list work</p> | <p>No update for this meeting</p> | <p>Mark to update at next meeting</p> |
| <p>9. Telephone Support Service / Patient Triage Update</p> | <p>Martina updated that there have been no further calls/emails – one patient has contacted the Information line a second time to reiterate how full of praise he had for Mr O’Brien and to check who his care had been transferred to. The patient appears to have been discharged by Mr O’Brien in 2014 and seems to have been a private patient of his, Martina has agreed to make contact with him to discuss and if needed Mark has agreed to take over his care. Mark and Martina have agreed to leave time at the end of his Saturday clinic to respond to any clinical queries that may have been raised during the week</p> | |
| <p>10. MDM Processes</p> | <p>Update as noted in agenda item 3</p> | |
| <p>Professional Governance</p> | | |

| | | |
|--|---|---|
| 11. GMC Discussions – | Stephen advised there is a three way meeting between the Trust, GMC and Department of Health at 11.30 on Tuesday 16 th March. | Update to be given following meeting on 16 th March 2021 |
| 12. Litigation / DLS Update | Work remains ongoing – given the earlier discussion around reports being shared with one patient’s solicitor it would suggest it could be going to litigation. | |
| 13. Grievance Process- | Siobhan advised that a draft letter had been sent to DLS for review before responding to Mr O’Brien and they were just waiting to hear back from DLS., She advised that he has indicated in his reply that he is not participating through the appeal process, he will just go through Public Inquiry –although is not withdrawing appeal. The Trust has asked the panel to look at it from a review perspective, so they can engage with him and will update him. The plan is to reply as soon as DLS comes back with confirmation to do so. | |
| 14. Administration Review Update –  Admin Review Process V10 18 Feb 2 | No further update | |
| Serious Adverse Incidents (SAIs) Review | | |
| 15. Update on Current SAI Progress - Screening - Initial Feedback on outcomes from Dr Hughes | Dr O’Kane advised that the plan is to share the reports on Tuesday (16 th) and DLS were to speak to Senior counsel today, but the Trust are still awaiting to hear. Martina queried could the | Egress to be used with ‘guest’ permissions to restrict sharing. |

| | | |
|--|---|---|
| | reports go electronically to the Urology and Cancer teams so as to ensure they all had access at the same time. It was agreed that the reports should be uploaded to Egress 'guest' permissions and Martina would share with the Teams. Patricia advised that the reports would be going to families also, with one patient who has a solicitor and wants it to go to them. These would be sent when permission had been obtained from DLS | Dr O'Kane and Stephen to link in with DLS so that there is clear direction on the sharing of the reports. On receiving this, to update Martina. |
| 16. Initial SAI Recommendations  Action plan 69120.docx | Dr O'Kane advised that there is a need for an oversight group to be established to start to implement these actions. | Oversight Group to be established |
| 17. Structured Judgement Review Process – (SJR)   DRAFT Structured Clinical Record Review DRAFT - PROPOSAL FOR STRUCTURED CI | Training on 18 th and 25 th March 2021 | |
| 18. Family Liaison Role | Fiona linking in with families, she will phone them in advance to let them know reports will be out. Spoke to them regarding announcement of the Chair of the Inquiry and advised them that the reports would be shared within the next few weeks | |
| Communications | | |
| 19. Media / Assembly Questions – | Jane advised that there has been nothing last week, and remarked that there had been minimal media coverage about the Chair being appointed – She updated that there had been a general | |

| | | |
|---|--|---|
| | meeting with MLAs and whilst the topic of Mr O'Brien had been raised this had been all positive towards him | |
| Any other Business | | |
| 20. Complaints | No further complaints | |
| 21. Coronial Processes | Damian advised that he had received a document (Interface Paper) from the Medical Advisor which confirmed that no response was needed from coroner as the public inquiry takes precedence. He explained that if the public inquiry feels an individual case needs reviewed, it would go ahead. This is a Parliamentary document which was published in 1959 in NI. | |
| 22. Counter Fraud | This will be ongoing as cases are identified. | |
| 23. Declaration re CURE | One return outstanding | Stephen to link in with Mark to try and resolve |
| 24. Public Inquiry Update Chair Appointed Securing Records for Public Inquiry | Christine Smith QC has been appointed as Chair of the Inquiry. Stephen advised that he has linked in with Catherine Weaver re: Destruction of Records within the Trust has ceased to support the Inquiry work. | |
| Date of next meeting: 22 nd March 2021, 8.30am via zoom | | |



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.

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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 SAs. 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 |
|--|---|
| <ul style="list-style-type: none"> Recruitment of experienced staff – | <ul style="list-style-type: none"> Complete recruitment documentation as soon as possible Liaise with Human Resources |
| <ul style="list-style-type: none"> Staff Backfill | <ul style="list-style-type: none"> Complete recruitment |

| Risk Identified | Mitigation Measure |
|---|---|
| | documentation as soon as possible <ul style="list-style-type: none"> • Liaise with Human Resources |
| <ul style="list-style-type: none"> • Securing Funding | <ul style="list-style-type: none"> • Liaise with PHA and HSCB regarding additional funding required to support the SAI/Inquiry. |
| <ul style="list-style-type: none"> • Volume of calls received by the information line will exceed expectations leading to further complaints | <ul style="list-style-type: none"> • Monitoring of call volumes • Extending the operational hours to receive calls • Increasing the number of call handlers |
| <ul style="list-style-type: none"> • Number of clinics is insufficient to cope with the demand for review appointments | <ul style="list-style-type: none"> • Monitoring the number of review appointments required • Monitoring clinics and virtual clinics • Increasing the number of virtual clinics |
| <ul style="list-style-type: none"> • Current Service Provision will be impacted by the additional clinics being taken forward and Waiting Lists will continue to grow. | <ul style="list-style-type: none"> • Current provision continues • Utilise independent resources • Provide evening/weekend clinics |
| <ul style="list-style-type: none"> • Red flag appointments will not be seen within the required timeframe | <ul style="list-style-type: none"> • Monitor all current referrals and red flag appointments |
| <ul style="list-style-type: none"> • Reputation of Trust | <ul style="list-style-type: none"> • 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.



JOB DESCRIPTION

| | |
|------------------------|---|
| POST: | Service Manager Public Inquiry and Trust Liaison |
| LOCATION: | Muckamore Abbey Hospital AND Royal Victoria Hospital with travel between Trust sites required |
| BAND: | 8B |
| REPORTS TO: | Interim Director, Learning Disability Services |
| RESPONSIBLE TO: | Chief Executive |

Job Summary / Main Purpose

In the first instance, the post holder will be responsible through the Director for Learning Disability Services, and working closely with the Co-Director Risk and Governance, for ensuring that the Trust meets the legal requirements of the Inquiries Act 2005 in respect of the Muckamore Abbey Hospital Public Inquiry. The post holder will also act as the Trust's Liaison Officer for the Inquiry Panel, the Directorate of Legal Services and other external stakeholders, for example, the Department of Health.

This is a permanent post and as such it is recognised that while the focus will in the first phase be on the Muckamore Abbey Hospital Public Inquiry, there will be future requirements for such a role following the completion of this particular Inquiry.

Main Duties / Responsibilities

For each of the following, the postholder will;

- Provide administrative support to the Public Inquiry Oversight Steering Group and any Task and Finish Groups which may arise. This will include the organisation of agendas, the co-ordination of papers and reports and completion of accurate and concise minutes to record key issues and decision-making.
- Be responsible for preparation of briefing notes to the Oversight Steering Group, the Executive Team and Trust Board, and the preparation of other ad hoc briefings as required.
- Oversee the collation, cataloguing, storage and maintenance of evidence anticipated to be required for the Public Inquiry, and evidence subsequently submitted to the Inquiry.
- Ensure that there is a safe, secure and retrievable system for storage of evidence anticipated to be required for the Inquiry, and for storage of evidence that is subsequently submitted to the Inquiry.
- Be responsible for briefing and supporting staff who are required to participate in the Inquiry and for providing guidance on best practice throughout the Inquiry process.
- Respond to any queries of the Inquiry Panel and the Director of Legal Services and to ensure the timely provision of witness evidence, and other evidence, as stipulated by the Inquiry Panel.

- WIT-29968
- Be responsible for developing and maintaining governance processes associated with implementation of agreed recommendations, actions and learning from the findings of the Public Inquiry.

Setting Direction and Service Delivery

- Provide effective leadership in the co-ordination of the Trust's response to the Muckamore Abbey Hospital Public Inquiry ensuring that the Trust meets its statutory duties.
- Oversee the co-ordination, collation and provision of evidence, including witness evidence, as required by the Inquiry Panel and/or Directorate of Legal Services, in line with Trust Policy and Regional Guidance on the Provision of Witness Statements.
- Ensure that there is a safe, secure and retrievable system for storage of evidence anticipated to be required for the Inquiry, and for storage of evidence that is subsequently submitted to the Inquiry.
- Ensure that there are systems and processes in place to optimise the timeliness and responsiveness to the Inquiry Panel requests.
- Provide timely information to employees in the requesting of reports and statements required by the Inquiry Panel.
- Ensure that the relevant line manager is aware that a member of staff is being asked to attend the Inquiry.
- Ensure that staff who are required to participate in the Public Inquiry receive adequate support throughout the entire Inquiry process, keeping the team informed of developments in the case and dates and times of any consultations. This will include supporting the relevant directorate management team to guide them through the process and ensure their preparedness to enable them to support staff.
- Escalate any concerns in relation to potential delays in the provision of information to the Inquiry Panel through the Trust's assurance/accountability framework to the Executive Team.
- Provide administrative support to the Public Inquiry Oversight Steering Group and any Task and Finish Groups which may arise. This will include the organisation of agendas, the co-ordination of papers and reports and completion of accurate and concise minutes to record key issues and decision-making.
- Be responsible for preparation of briefing notes to the Oversight Steering Group, the Executive Team and Trust Board, and the preparation of other ad hoc briefings as required.

Corporate Management

- Contribute to the Trust's overall corporate governance processes to ensure its compliance with public sector values and codes of conduct, operations and accountability.

Collaborative Working and Communication

- Establish collaborative relationships and networks with internal and external stakeholders.
- Engage with stakeholders across the organisation including the Risk and Governance Team and the Medical Directors Office to ensure the provision of accurate and timely information to the Inquiry Panel.
- Work collaboratively with external stakeholders including the Directorate of Legal Services and the PSNI.
- Responsible for developing and maintaining sound internal and external communications systems.

- Represent the Trust, as appropriate, on external groups and to represent the Director where appropriate and as required in respect of the Trust's approach to the Public Inquiry.

Financial and Resource Management

- Responsible for the management of any financial allocation/budget associated with the Trust's preparation and involvement in the Public Inquiry, in conjunction with financial management colleagues.

People Management and Development

- Be responsible for the line management of the Assurance Co-ordinator.
- Promote the corporate values and culture of the organisation through the development and implementation of relevant policies and procedures, and appropriate personal behaviour.
- Be responsible for ensuring that the Health and Social Care Records service complies with employment law and is consistent in their application of the Trust's policies.
- Be responsible for ensuring that staff are appraised at least annually and Knowledge and Skills framework is in place.
- Be responsible for his/her own performance and take action to address identified personal development areas.
- Manage recruitment processes, to ensure staff are recruited in a timely and professional manner and vacancies are filled appropriately.

General Responsibilities

Employees of the Trust are required to promote and support the mission and vision of the service for which they are responsible and:

- At all times provide a caring service and to treat those with whom they come into contact in a courteous and respectful manner.
- Demonstrate their commitment by their regular attendance and the efficient completion of all tasks allocated to them.
- Comply with the Trust's Smoke Free Policy.
- Carry out their duties and responsibilities in compliance with the Health and Safety Policies and Statutory Regulations.
- Adhere to Equality and Good Relations duties throughout the course of their employment.
- Ensure the ongoing confidence of the public in-service provision.
- Maintain high standards of personal accountability.
- Comply with the HPSS Code of Conduct.
- The post holder will promote and support effective team working, fostering a culture of openness and transparency. The post holder will ensure that they take all concerns raised with them seriously and act in accordance with Belfast Trust's Whistleblowing Policy and their professional code of conduct, where applicable.
- The post holder will, in the event of a concern being raised with them, ensure it is managed correctly under the Belfast Trust's Whistleblowing Policy, and ensure that feedback/learning is communicated at individual, team and organisational level regarding the concerns raised, and how they were resolved.

Information Governance

All employees of Belfast Health & Social Care Trust are legally responsible for all records held, created or used as part of their business within the Belfast Health and

WFT-29970
Social Care Trust, including patient/client, corporate and administrative records whether paper based or electronic and also including e-mails. All such records are public records and are accessible to the general public, with limited exceptions, under the Freedom of Information Act 2000, the Environment Regulations 2004, the General Data Protection Regulation (GDPR) and the Data Protection Act 2018. Employees are required to be conversant and to comply with the Belfast Health and Social Care Trust policies on Information Governance including for example the ICT Security Policy, Data Protection Policy and Records Management Policy and to seek advice if in doubt.

For further information on how we use your personal data within HR, please refer to the Privacy Notice available on the HUB or Your HR

Environmental Cleaning Strategy

The Trusts Environmental Cleaning Strategy recognises the key principle that "Cleanliness matters is everyone's responsibility, not just the cleaners" Whilst there are staff employed who are responsible for cleaning services, all Trust staff have a responsibility to ensure a clean, comfortable, safe environment for patients, clients, residents, visitors, staff and members of the general public.

Infection Prevention and Control

The Belfast Trust is committed to reducing Healthcare associated infections (HCAIs) and all staff have a part to play in making this happen. Staff must comply with all policies in relation to Infection Prevention and Control and with ongoing reduction strategies. Standard Infection Prevention and Control Precautions must be used at all times to ensure the safety of patients and staff.

This includes:-

- Cleaning hands either with soap and water or a hand sanitiser at the appropriate times (WHO '5 moments');
- Using the correct '7 step' hand hygiene technique;
- Being 'bare below the elbows' when in a clinical environment;
- Following Trust policies and the Regional Infection Control Manual (found on intranet);
- Wearing the correct Personal Protective Equipment (PPE);
- Ensuring correct handling and disposal of waste (including sharps) and laundry;
- Ensuring all medical devices (equipment) are decontaminated appropriately i.e. cleaned, disinfected and/or sterilised;
- Ensuring compliance with High Impact Interventions.

Personal Public Involvement

Staff members are expected to involve patients, clients, carers and the wider community where relevant, in developing, planning and delivering our services in a meaningful and effective way, as part of the Trust's ongoing commitment to Personal Public Involvement (PPI).

Please use the link below to access the PPI standards leaflet for further information.

http://www.publichealth.hscni.net/sites/default/files/PPI_leaflet.pdf

Clause: *This job description is not meant to be definitive and may be amended to meet the changing needs of the Belfast Health and Social Care Trust.*



PERSONNEL SPECIFICATION

JOB TITLE / BAND: Service Manager, Public Inquiry and Trust Liaison / Band 8B

DEPT / DIRECTORATE: Muckamore Abbey Hospital AND Royal Victoria Hospital with travel between Trust sites required / Adult Social & Primary Care

Notes to applicants:

1. You must clearly demonstrate on your application form under each question, how you meet the required criteria as failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.
2. Shortlisting will be carried out on the basis of the essential criteria set out below, using the information provided by you on your application form. Please note the Trust reserves the right to use any desirable criteria outlined below at shortlisting. You must clearly demonstrate on your application form how you meet the desirable criteria.
3. Proof of qualifications and/or professional registration will be required if an offer of employment is made – if you are unable to provide this, the offer may be withdrawn.

ESSENTIAL CRITERIA

The following are **ESSENTIAL** criteria which will initially be measured at shortlisting stage although may also be further explored during the interview/selection stage. You should therefore make it clear on your application form whether or not you meet these criteria. Failure to do so may result in you not being shortlisted. The stage in the process when the criteria will be measured is stated below.

| Factor | Criteria | Method of Assessment |
|---|--|----------------------------------|
| Experience Qualifications Registration | <ul style="list-style-type: none"> Have a university degree or relevant professional qualification at graduate or diploma level AND worked for at least 2 years in a *senior management role in a complex organisation OR Have worked for at least 3 years in a *senior management role in a major complex organisation. <p>Note *senior management role will be considered to be at Band 8A or equivalent or above.</p> | Shortlisting by Application Form |
| Other (e.g. Driving etc.) | <ul style="list-style-type: none"> Full UK Driving Licence and access to a car. <p><i>'Where disability prohibits driving, this criteria will be waived if the applicant is able to organise suitable alternative arrangements.'</i></p> | Shortlisting by Application Form |

| | | |
|---|---|---|
| Knowledge Skills Abilities | <ul style="list-style-type: none"> • Delivered against challenging performance management programmes for a minimum of 2 years meeting a full range of key targets and making significant improvements. • Have worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes for a minimum of 2 years. • Successfully demonstrate high level people management, leadership and organisational skills for a minimum of 2 years. • Have good communication skills (written, oral, presentational and interpersonal) with the ability to communicate effectively with all levels of staff within the Trust, and outside the organisation. • Have the ability to collate and critically analyse statistical and qualitative information and the ability to make and take decisions after analysis of options and implications. • Ability to multi-task and continue to function to a high standard when under pressure. • Determination, drive to succeed, perseverance, and resilience. • IT literacy -proficient in MS Word, Excel, PowerPoint, etc. | Shortlisting by Application Form And / Or Interview |
|---|---|---|

DESIRABLE CRITERIA

Desirable criteria will **ONLY** be used where it is necessary to introduce additional job related criteria to ensure files are manageable. You should therefore make it clear on your application form how you meet these. Failure to do so may result in you not being shortlisted.

| Factor | Criteria | Method of Assessment |
|---|--|-------------------------------------|
| Experience Qualifications Registration | <ul style="list-style-type: none"> • Experience of working with legal services and/or working on legal processes. | Shortlisting by Application Form |

NOTE:

Where educational/professional qualifications form part of the criteria you will be required, if shortlisted for interview, to produce original certificates *and* one photocopy of same issued by the appropriate authority. Only those certificates relevant to the shortlisting criteria should be produced. If educational certificates are not available an original letter *and* photocopy of same detailing examination results from your school or college will be accepted as an alternative.

If successful you will be required to produce documentary evidence that you are legally entitled to live and work in the United Kingdom. This documentation can be a P45, Payslip, National Insurance Card or a Birth Certificate confirming birth in the United Kingdom or the Republic of Ireland. **Failure to produce evidence will result in a non-appointment.**

Where a post involves working in regulated activity with vulnerable groups, post holders will be required to register with the Independent Safeguarding Authority.

Healthcare Leadership Competencies

Candidates who are shortlisted for interview will need to demonstrate at interview that they have the required competencies to be effective in this demanding leadership role.

The competencies concerned are set out in the NHS Healthcare Leadership Model, details of which can be found at:

<http://www.leadershipacademy.nhs.uk/resources/healthcare-leadership-model>.

Particular attention will be given to the following:




- Inspiring shared purpose
- Leading with care
- Evaluating information
- Connecting our service
- Sharing the vision
- Engaging the team
- Holding to account
- Developing capability
- Influencing for results

HSC Values

Whilst employees will be expected to portray all the values, particular attention is drawn to the following values for this role

| | |
|--|--|
| <p>What does this mean?</p>  <p>Working together</p> <p>We work together for the best outcome for people we care for and support. We work across Health and Social Care and with other external organisations and agencies, recognising that leadership is the responsibility of all.</p> | <p>What does this look like in practice?</p> <ul style="list-style-type: none"> • I work with others and value everyone's contribution • I treat people with respect and dignity • I work as part of a team looking for opportunities to support and help people in both my own and other teams • I actively engage people on issues that affect them • I look for feedback and examples of good practice, aiming to improve where possible. |
|  <p>Excellence</p> <p>We commit to being the best we can be in our work, aiming to improve and develop services to achieve positive changes. We deliver safe, high quality, compassionate care and support.</p> | <ul style="list-style-type: none"> • I put the people I care for and support at the centre of all I do to make a difference • I take responsibility for my decisions and actions • I commit to best practice and sharing learning, while continually learning and developing • I try to improve by asking 'could we do this better?' |
|  <p>Openness & Honesty</p> <p>We are open and honest with each other and act with integrity and candour.</p> | <ul style="list-style-type: none"> • I am open and honest in order to develop trusting relationships • I ask someone to help when needed • I speak up if I have concerns • I challenge inappropriate or unacceptable behaviour and practice. |
|  <p>Compassion</p> <p>We are sensitive, caring, respectful and understanding towards those we care for and support and our colleagues. We listen carefully to others to better understand and take action to help them and ourselves.</p> | <ul style="list-style-type: none"> • I am sensitive to the different needs and feelings of others and treat people with kindness • I learn from others by listening carefully to them • I look after my own health and wellbeing so that I can care and support others. |



Admin Review Processes

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|-------------------|--|--|--|---|---|--|
| 1. Triage | <p><u>Pre 2014</u> Due to the delayed triage of referrals, the decision was taken to add to the OP waiting list the referral at the clinical priority that the GP had assigned.</p> <p>.</p> | <p><u>2014-2017</u> For routine and Urgent GP referrals, non-adherence and non-enforcement of the IEAP, resulted in referrals not being returned within the appropriate timeframe, which then resulted in a lost opportunity to either upgrade or downgrade urgent/routine referrals</p> | <p><u>2017-current</u> The introduction of e-Triage on 27/3/17 enabled referrals to be monitored with respect to the triage process.</p> <p>The revised triage process (draft) detailed in the word document below is based on the current IEAP also addresses these issues of timely and appropriate triaging</p> <p> TRIAGE PROCESS DEC 20 (1).docx</p> | <p><u>Current</u> Consultant-to-Consultant referrals (including outside of Trust) are not currently managed through e-Triage so there is still a risk that these could be delayed.</p> <p>Remaining specialties that still do not use e-Triage are being addressed</p> <p> Services not using eTriage.docx</p> | <p>Consultant to Consultant referrals to be added to e-Triage and the PDF SOP to be updated</p> <p> Consultant to Consultant Referrals.</p> <p>Remaining specialties to be added to e-Triage</p> <p>The triage process continues to be monitored weekly and needs to be complied to and enforced where necessary</p> | <p>AD for FSS</p> <p>Transformational Lead to work with Service Leads for specialties still not on e-Triage and to implement same.</p> <p>June 2021</p> <p>AD FSS and divisional AD's</p> <p>Ongoing</p> |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|------------------------------|--|--|--|---|---|--|
| 2. Undictated Clinics | Some patients not having a letter dictated following an outpatient consultation resulting in no outcome recorded on PAS. | There is no system or process that provides assurance that each outpatient consultation generates an outpatient outcome letter | All Medical staff must understand that a letter is required for every outpatient attendance. | A limitation with the G2 system is that it simply records speech and generates a letter. However G2 is unable to correlate the letter dictated against the outpatient attendance. | <p>The Trust has been working on the G2/PAS interface. This major piece of work required integration with the help of BSO. It is now in 'live' mode and is being piloted by one consultant with positive feedback. This will provide the Trust with more assurance around the dictation of outpatient clinics.</p> <p>Update typing SOP to highlight that when a letters is not dictated for a patient that the secretary raises with the consultant and line manager in the first instance. Secretaries to stipulate on their backlog reports if they know of any undictated clinics/letters</p> | <p>The Referral and Booking Centre Manager.</p> <p>June 2021</p> <p>The Referral and Booking Centre Manager.</p> <p>Ongoing</p> <p>Heads of Services with their Clinical Teams at Induction/Changeover</p> |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|--------------------------|--|---|--|--|--|--|
| | | | | | <p>Monthly typing reports require to be produced and shared throughout all divisions</p> <p>At Junior doctor changeover inductions, the importance of timely and accurate dictating of all outpatients they have reviewed must be highlighted to them.</p> | <p>IT Team with BSO and the clinical teams</p> <p>June 2021</p> |
| 3. Hospital Notes | Patient's hospital records electronically casenote tracked to a consultant and a location. | When patients hospital records were required same not in the tracked location | <p>Current tracking system is a function on Patient Administrative System (PAS)</p> <p>Missing Charts are investigated and an IR1 form is completed if not found</p> | <p>There is currently no system which identifies that a chart is not where it is tracked to other than manual searches.</p> <p>Need to establish whether or not as part of the induction and training there is a SOP governing the tracking of patient hospital records?</p> | <p>Any missing notes need to have an IR1 raised to highlight the problem. These should be reported to the respective areas.</p> <p>All staff managing patient notes should be reminded of the need for accuracy on PAS when tracking notes and patient records should be returned to file as soon as possible.</p> | <p>Acute Director</p> <p>April 2021</p> |

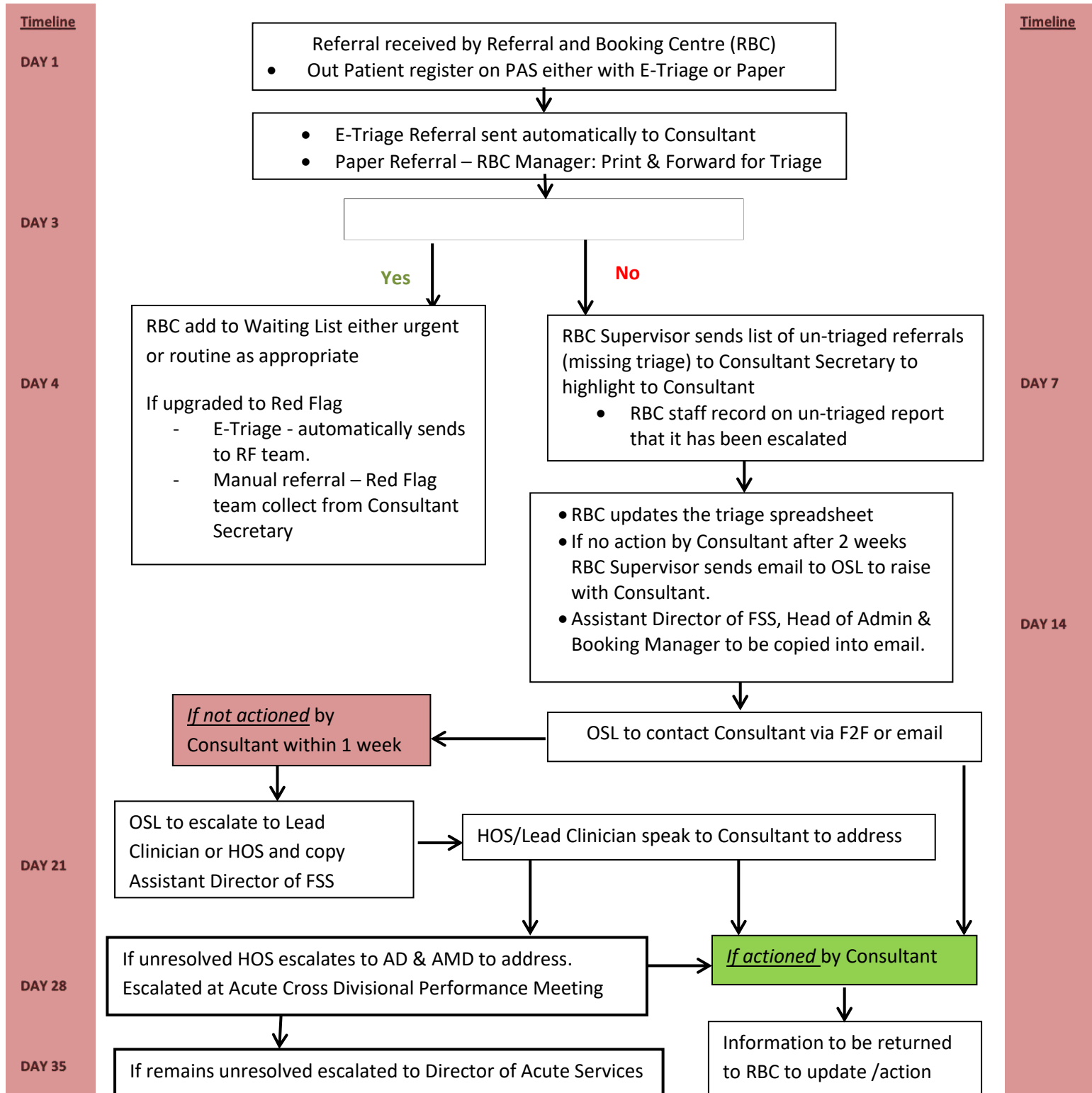
| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|-------------------|----------------------|-------------------------------|--------------------------------|---------------------|---|---|
| | | | | | <p>We also need to remind consultants that all charts are tracked in their name and that it is their responsibility to ensure the notes are kept in the location that the notes are tracked to.</p> <p>Service Administrators to do spot-checks of offices and highlight any issues of charts being stored beyond a reasonable time period.</p> <p>Business Case for IFit which is an electronic tracking system using barcode technology (as used in other Trusts in NI) to be considered for funding until the NI Electronic Patient Record replaces paper records under the Encompass Project This had been previously submitted and approved but no funding identified.</p> | <p>Assistant Director – Functional Support to resubmit to Trust's SMT in new financial year.</p> <p>April 2021</p> |

| Issues Identified | Description of issue | Gaps that led to the problems | Policies or processes in place | Ongoing Risks/Flaws | Action Required | Owner of Action and date for completion |
|----------------------------|---|---|--|---|---|---|
| 4. Private Patients | Patients who had been initially reviewed privately were added to the waiting list in a non-chronological manner | No monitoring of patients seen privately where they are entered onto the waiting list | This is governed by the Private Patient policy | It relies on the integrity of the consultant to comply with the private patient policy. | <p>Revise the policy for paying patients in the Trust and share with all clinical teams.</p>  <p>Guide-to-Paying-Patients-Southern-Trust-</p> <p>Data Quality Release notice for recording of private patient activity on PAS to be shared amongst clinical teams.</p>  <p>0023-18 PAS OP REFERRAL PRIVATE</p> | <p>Deputy Medical Director and AD for Medical Directorate April 2021</p> <p>Functional Services to reissue the Data Quality Release notice for the recording of private patient activity on PAS with all teams.</p> <p>November 2020 Complete</p> |

- 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 directs 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.



Note: This process will incur a minimum of 5 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.

| Services not using e-triage | |
|------------------------------------|--|
| ORTHOPAEDIC GERIATRICS | Planned e-triage commencement Jan/Feb 2021 |
| HAEMATOLOGY | Planned implementation postpone due to service pressures |
| NEPHROLOGY | Currently taking a break from e-triage, will relook at recommencing early 2021 |
| GENERAL MEDICINE | Minimal referrals to this service but working with service looking towards implementation early 2021 |
| BREAST SURGERY | Consultants not currently keen on e-triage – reengaged with service |
| GERIATRIC MEDICINE | Currently engaging with service |



Quality Care - for you, with you

ADMINISTRATIVE & CLERICAL Standard Operating Procedure

| | | |
|-------------------------------|------------------------------------|---|
| Title | Consultant to Consultant Referrals | |
| S.O.P. Section | Referral and Booking Centre | |
| Version Number | v1.0 | Supersedes: v0.1 |
| Author | Katherine Robinson | |
| Page Count | 3 | |
| Date of Implementation | January 2011 | |
| Date of Review | January 2012 | To be Reviewed by: Admin and Clerical Manager's Group |
| Approved by | Admin and Clerical Manager's 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 to recognise a referral is in place from one consultant to another.

Implementation

This procedure is already effective and in operation in the Referral and Booking Centre.

Consultant to Consultant Referrals

The secretary for the consultant referring the patient should OP REG the patient on PAS with the OP REG date being the date the decision to refer was made (eg the clinic date)

This is done by using the Function:
DWA – ORE.

The name of the *referring consultant* should be entered into the comment field NOT the name of the consultant being referred to. Referrals should then be directed to the Referral and Booking Centre not to the secretary.

This will ensure that the patient now appears on a PTL and that the booking clerks will know who referred the patient and when.

When doing this the **Referral Source should be OC** (Other Consultant) **and NOT CON.**

Patients registered with a referral source as 'Con' do not appear on a PTL and can be missed.

Although all referrals are date stamped when they are received into the Referral and Booking centre – the original referral date will remain and will not be amended.



A GUIDE TO PAYING PATIENTS

V.2 [11th February 2016]

| DOCUMENT – VERSION CONTROL SHEET | |
|----------------------------------|---|
| Title | Title: Guide to Paying Patients Version: 2 |
| Supersedes | Supersedes: Guidelines for Management of Private Patients |
| Originator | Name of Author: Anne Brennan Title: Senior Manager Medical Directorate |
| Approval | Referred for approval by: Anne Brennan Date of Referral: 27 th March 2014 to: <ul style="list-style-type: none"> Trust Senior Management Team Trust LNC |
| Circulation | Issue Date: 16 th October 2014 Circulated By: Medical Directorate Issued To: As per circulation List: All Medical Staff |
| Review | Review Date: February 2017 Responsibility of (Name): Norma Thompson Title: Senior Manager Medical Directorate |

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1. INTRODUCTION

- 1.1 The Trust came into existence on 1 April 2007 and is responsible for providing acute care across three sites namely:-
 - Craigavon Area Hospital, Portadown
 - Daisy Hill Hospital, Newry
 - South Tyrone Hospital, Dungannon
- 1.2 The Trust welcomes additional income that can be generated from the following sources:-
 - Private Patients
 - Fee Paying Services
 - Overseas Visitors
- 1.3 All income generated from these sources is deemed to make a valued contribution to the running costs of the Trust and will be reinvested to improve our facilities to benefit NHS and private patients alike.
- 1.4 All policies and procedures in relation to these areas will be carried out in accordance with Trust guidelines.
- 1.5 For further information please do not hesitate to contact the Paying Patient Office.
[email: paying.patients@southerntrust.hscni.net or
<http://www.southerntrust.hscni.net/paying-patients/>]

2. OBJECTIVES

- 2.1 The purpose of this guideline is to:
 - Standardise the manner in which all paying patient practice is conducted in the organisation.
 - Raise awareness of the duties and responsibilities within the health service of medical staff engaging in private practice and fee paying services within the Trust.
 - Raise awareness of the duties and responsibilities of all Trust staff, clinical and non-clinical in relation to the treatment of paying patients and fee paying services within the Trust.
 - Ensure fairness to both NHS patients and fee paying patients at all times.
 - Clarify for relevant staff the arrangements pertaining to paying patients and to give guidance relating to
 - record keeping
 - charging

- procedures and
- responsibilities for paying patient attendances, admissions and fee paying services.
- Clarify charging arrangements when consultants undertake fee paying services within the Trust.

3. CATEGORIES OF WORK COVERED BY THIS GUIDE

3.1 Fee Paying Services

- 3.1.1 Any paid professional services, other than those falling within the definition of Private Professional Services, which a consultant carries out for a third party or for the employing organisation and which are not part of, nor reasonably incidental to, Contractual and Consequential Services. A third party for these purposes may be an organisation, corporation or individual, provided that they are acting in a health related professional capacity, or a provider or commissioner of public services. Examples of work that fall within this category can be found in Schedule 10 of the Terms and Conditions (Appendix 1).

3.2 Private Professional Services *(also referred to as 'private practice')*

- 3.2.1 The diagnosis or treatment of patients by private arrangement (including such diagnosis or treatment under Article 31 of the Health and Personal Social Services (Northern Ireland) Order 1972), excluding fee paying services as described in Schedule 10 of the terms and conditions.
- 3.2.2 Work in the general medical, dental or ophthalmic services under Part IV of the Health and Personal Social Services (Northern Ireland) Order 1972 (except in respect of patients for whom a hospital medical officer is allowed a limited 'list', e.g. members of the hospital staff).

3.3 Overseas Visitors

- 3.3.1 The National Health Service provides healthcare free of charge to people who are a permanent resident in the UK/NI. A person does not become an ordinarily resident simply by having British Nationality; holding a British Passport; being registered with a GP, or having an NHS number. People who do not permanently live in NI/UK are not automatically entitled to use the NHS free of charge.
- 3.3.2 **RESIDENCY** is therefore the main qualifying criterion.

4. POLICY STATEMENT

- 4.1 Medical consultant staff have the right to undertake Private Practice and Fee paying services within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review and with the approval of the Medical Director.
- 4.2 This Trust provides the same care to all patients, regardless of whether the cost of their treatment is paid for by HSC Organisations, Private Medical Insurance companies or by the patient.
- 4.3 Private Practice and Fee Paying services at the Trust will be carried out in accordance with:
- The Code of Conduct for private practice, the recommended standard of practice for NHS consultants as agreed between the BMA and the DHSSPS (Appendix 2).
 - Schedule 9 of the Terms and Conditions of the Consultant contract which sets out the provisions governing the relationship between HPSS work and private practice (Appendix 8).
 - The receipt of additional fees for Fee Paying services as defined in Schedule 10 of the Terms and Conditions of the Consultant Contract (Appendix 1).
 - The principles set out in Schedule 11 of the above contract (Appendix 5).
- 4.4 All patients treated within the Trust, whether private or NHS should, where possible:
- be allocated a unique hospital identifier
 - be recorded on the Patient Administration System and
 - have a Southern Health & Social Care Trust chart.
- 4.5 The Trust shall determine the prices to be charged in respect of all income to which it is entitled as a result of private practice or other fee paying services which take place within the Trust.

5. CONSULTANT MEDICAL STAFF RESPONSIBILITIES

5.1 Private Practice

- 5.1.1 While Medical consultant staff have the right to undertake Private Practice within the Terms and Conditions of the new Consultant Contract as agreed within their annual job plan review, it is the responsibility of consultants, prior to the provision of any diagnostic tests or treatment to:
- ensure that their private patients (whether In, Day or Out) are identified and notified to the Paying Patients Officer.

- ensure full compliance with the Code of Conduct for Private Practice (see Appendix 2) in relation to referral to NHS Waiting Lists.
- ensure that patients are aware of and understand the range of costs associated with private treatment including hospital costs and the range of professional fees which the patient is likely to incur, to include Surgeon/Physician, Anaesthetist, Radiologist, Pathologist, hospital charges. Leaflets can be obtained from the Paying Patients Officer or the Paying Patients section of Southern Docs website – Irrelevant redacted by the USI
- obtain prior to admission and at each outpatient attendance a signed, witnessed Undertaking to Pay form (Appendix 3) which must then be sent to the Paying Patient Officer for the relevant hospital at least three weeks before the admission date. This document must contain details of all diagnostic tests and treatments prescribed.
- Establish the method of payment at the consultation stage and obtain details of insured patients' private medical insurance policy information. The Trust requires this information to be forwarded to the Paying Patient Officer **prior to admission** so that patients' entitlement to insurance cover can be established. This should be recorded on the Undertaking to Pay form [Appendix 3].
- Ensure that all patients, where appropriate, are referred by the appropriate channels, i.e. GP/other consultant.
- Ensure that private patient services that involve the use of NHS staff or facilities are not undertaken except in emergencies, unless an undertaking to pay for treatment has been obtained from (or on behalf of) the patient, in accordance with the Trust's procedures.
- Ensure that information pertaining to their private patient work is included in their annual whole practice appraisal.

5.2 Fee Paying Services - see Appendix 1 for examples

5.2.1 The Consultant job plan review will cover the provision of fee paying services within the Trust. Consultants are required to declare their intention to undertake Fee Paying Services work by forwarding the Paying Patient Declaration form to the Medical Director's office.

5.2.2 A price list for fee paying services is available from the Paying Patients Office or the Paying Patients section of Southern Docs website – Irrelevant redacted by the USI It is the responsibility of the Consultant to ensure that the Trust is reimbursed for all costs incurred while facilitating fee paying services work undertaken. These costs could include:

- use of Trust accommodation;
- tests or other diagnostic procedures performed;
- radiological scans.

5.2.3 Consultants who engage in fee paying activities within the Trust are required to remit to the Trust on a quarterly basis the income due.

- 1.2.4 Consultants should retain details of all patients seen for medical legal purposes. These should be submitted by the consultant on a quarterly basis along with the corresponding payment. See Section 11 for further details.

5.3 Additional Programmed Activities

- 5.3.1 Consultants should agree to accept an extra paid programmed activity in the Trust, if offered, before doing private work. The following points should be borne in mind:
- If Consultants are already working 11 Programmed Activities (PAs) (or equivalent) there is no requirement to undertake any more work.
 - A Consultant could decline an offer of an extra PA and still work privately, but with risk to their pay progression for the year in question.
 - Any additional PAs offered must be offered equitably between all Consultants in that specialty; if a colleague takes up those sessions there would be no detriment to pay progression for the other Consultants.
- 5.3.2 Consultant Medical Staff are governed by The Code of Conduct for Private Practice 2003 (at Appendix 2).

6. RESTRICTIONS ON PRIVATE PRACTICE FOR CONSULTANT MEDICAL STAFF

6.1 New Consultants

- 6.1.1 Newly appointed consultants (including those who have held consultant posts elsewhere in the NHS, or equivalent posts outside the NHS) may not undertake private practice within the Trust or use the Trusts facilities or equipment for private work, until the arrangements for this have been agreed in writing with the Trust Medical Director. A job plan must also have been agreed. An application to undertake private practice should be made in writing to the Medical Director through completion of the Paying Patient Declaration. New consultants permitted to undertake private work must make themselves known to the Paying Patients Officer.

6.2 Locum Consultants

- 6.2.1 Locum consultants may not engage in Private Practice within the first three months of appointment and then not until the detailed Job Plan has been agreed with the relevant Clinical Manager and approval has been granted by the Medical Director. This is subject to the agreement of the patient/insurer.

6.3 Non Consultant Grade Medical Staff

- 6.3.1 Non-consultant medical staff practitioners such as Associate Specialists may undertake Category 2 or private outpatient work, with the approval of the

Medical Director following confirmation that the practitioner undertakes such work outside his/her programmed activities as per their agreed job plan.

- 6.3.2 Other than in the circumstances described above, staff are required to assist the consultant to whom they are responsible with the treatment of their private patients in the same way as their NHS patients. The charge paid by private patients to the hospital covers the whole cost of the hospital treatment including that of all associated staff.

7. CHANGE OF STATUS BETWEEN PRIVATE AND NHS

7.1 Treatment Episode

- 7.1.1 A patient who sees a consultant privately shall continue to have private status throughout the entire treatment episode.

7.2 Single Status

- 7.2.1 An outpatient cannot be both a Private and an NHS patient for the treatment of the one condition during a single visit to an NHS hospital.

7.3 Outpatient Transfer

- 7.3.1 However a private outpatient at an NHS hospital is legally entitled to change his/her status for any a subsequent visit and seek treatment under the NHS, subject to the terms of any undertaking he/she has made to pay charges.

7.4 Waiting List

- 7.4.1 A patient seen privately in consulting rooms who then becomes an NHS patient joins the waiting list at the same point as if his/her consultation had taken place as an NHS patient.

7.5 Inpatient Transfer

- 7.5.1 A private inpatient has a similar legal entitlement to change his/her status. This entitlement can only be exercised when a significant and unforeseen change in circumstances arises e.g. when they enter hospital for a minor operation and they are found to be suffering from a different more serious complaint. He/she remains liable to charges for the period during which he/she was a private patient.

7.6 During Procedure

- 7.6.1 A patient may request a change of status during a procedure where there has been an unpredictable or unforeseen complexity to the procedure. This can be tested by the range of consent required for the procedure.

7.7 Clinical Priority

- 7.7.1 A change of status from Private to NHS must be accompanied by an assessment of the patient's clinical priority for treatment as an NHS patient.

7.8 Change of Status Form

- 7.8.1 Where a change of status is required a 'Change of Status' Form (Appendix 4) must be completed and sent to the Paying Patients Officer. This includes the reason for the change of status which will be subject to audit and must be signed by both the consultant and Paying Patients Officer. The Paying Patients Officer will ensure that the Medical Director approves the 'Change of Status' request.
- 7.8.2 It is important to note that until the Change of Status form has been approved by the Medical Director the patient's status will remain private and they may well be liable for charges.

8. TRUST STAFF RESPONSIBILITIES RELATING TO PRIVATE PATIENTS AND FEE PAYING SERVICES

- 8.1 A private patient is one who formally undertakes to pay charges for healthcare services regardless of whether they self-pay or are covered by insurance and all private patients must sign a form to that effect (Undertaking to Pay form at Appendix 3) prior to the provision of any diagnostic tests or treatments. Trust staff are required to have an awareness of this obligation.
- 8.2 The charge which private patients pay to the Trust covers the total cost of the hospital treatment excluding consultant fees. Trust staff are required to perform their duties in relation to all patients to the same standard. No payment should be made to or accepted by any non-consultant member of Trust staff for carrying out normal duties in relation to any patients of the Trust.

9. OPERATIONAL ARRANGEMENTS

- 9.1 Each hospital within the Trust has a named officer [Paying Patients Officer] who should be notified in advance of all private patient admissions and day cases. The Paying Patient Officer is responsible for ensuring that the Trust recovers all income due to the Trust arising from the treatment of private patients.
- 9.2 The Paying Patients Officer, having received the signed and witnessed Undertaking to Pay **Form at least three weeks** before the planned procedure will identify the costs associated with the private patient stay, will confirm entitlement to insurance cover where relevant and will raise invoices on a timely basis. [See Flow Chart 1]
- 9.3 The Medical Director will advise the Paying Patients Officer when a consultant has been granted approval to undertake private practice. The Paying Patients Officer will advise the consultant of the procedures involved in undertaking private practice in the Trust.

- 9.4 Clinical governance is defined as a framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
- 9.5 This framework applies to all patients seen within this Trust. It is therefore a fundamental requirement of Clinical Governance that all patients treated within the Trust must be examined or treated in an appropriate clinical setting.
- 9.6 Any fee or emolument etc. which may be received by an employee in the course of his or her clinical duties shall, unless the Trust otherwise directs, be surrendered to the Trust. For further information please see Southern Trust Gifts and Hospitality Standards of Conduct policy.

9.7 Record Keeping Systems and Private Patients

- 9.7.1 All patients regardless of their status should, where possible, be recorded on Hospital Systems and their status classified appropriately. These systems include for example:
- Patient Administration System (PAS)
 - Northern Ireland Maternity System (NIMATS)
 - Laboratory System
 - Radiology System(e.g. Sectra, PACS, NIRADS, RIS etc)

9.8 Health Records of Private Patients

- 9.8.1 All hospital health records shall remain the property of the Trust and should only be taken outside the Trust to assist treatment elsewhere:
- when this is essential for the safe treatment of the patient
 - when an electronic record of the destination of the notes is made using the case note tracking system
 - when arrangements can be guaranteed that such notes will be kept securely
 - provided that nothing is removed from the notes
- 9.8.2 Consultants who may have access to notes for private treatment of patients must agree to return the notes without delay. Either originals or copies of the patient's private notes should be held with their NHS notes. Patients' notes should not be removed from Trust premises. Requests for notes for medico-legal purposes should be requested by plaintiff's solicitor through the normal channels.
- 9.8.3 Since the Trust does not have a right of access to patient notes held in non NHS facilities, when patients are seen privately outside the Trust their first appointment within the Trust, unless with the same consultant, will be treated as a 'new appointment' rather than a 'review appointment'.

- 9.8.4 In the event of a 'Serious Adverse Incident' or legal proceedings the Trust may require access to private patient medical records which should be held in accordance with GMC Good Record Keeping Guidance.

9.9 Booking Arrangements for Admissions and Appointments

- 9.9.1 A record of attendance should be maintained, where possible, for all patients seen in the Trust. All private in, day and out patients should as far as possible be pre-booked on to the hospital information systems. Directorates are responsible for ensuring that all relevant information is captured and 'booking in' procedures are followed. Each department should ensure that all such patients are recorded on PAS etc. within an agreed timescale which should not extend beyond month end.

9.10 Walk Ins

- 9.10.1 A private patient who appears at a clinic and has no record on PAS should be treated for record keeping purposes in exactly the same manner as an NHS patient (walk in) i.e. relevant details should be taken, registry contacted for a number and processed in the usual fashion. A record should be kept of this patient and the Paying Patient Officer informed.

9.11 Radiology

- 9.11.1 All patients seen in Radiology should be given a Southern Health and Social Care hospital number.

9.12 Private Patient Records

- 9.12.1 All records associated with the treatment of private patients should be maintained in the same way as for NHS patients. This includes all files, charts, and correspondence with General Practitioners.
- 9.12.2 Accurate record keeping assists in the collection of income from paying patients.
- 9.12.3 It should be noted that
- any work associated with private patients who are not treated within this Trust or consultants private diary work and correspondence associated with patients seen elsewhere should not be carried out within staff time which is paid for by the Trust.

9.13 Tests Investigations or Prescriptions for Private Patients

- 9.13.1 The consultant must ensure that the requests for all laboratory work, ie. radiology, prescriptions, dietetics, physiotherapy etc. are clearly marked as Private.
- 9.13.2 Consultants should not arrange services, tests investigations or prescriptions until the person has signed an Undertaking to Pay form which will cover the episode of care [Appendix 3]. This must be submitted three weeks before any planned procedure.

9.14 Medical Reports

- 9.14.1 In certain circumstances Insurance Companies will request a medical report from the consultant. It is the consultant's responsibility to ensure that this report is completed in the timeframe required by the insurance company otherwise the Trust's invoice may remain unpaid in whole or in part until the report has been received and assessed.

10. FINANCIAL ARRANGEMENTS - PRIVATE PATIENTS

10.1 Charges to Patients

- 10.1.1 Where patients, who are private to a consultant, are admitted to the hospital, or are seen as outpatients, charges for investigations/diagnostics will be levied by the hospital. A full list of charges is available from the Paying Patient Office on request. Patients should be provided with an estimate of the total fee that they will incur **before** the start of their treatment.
- 10.1.2 Prices are reviewed regularly to ensure that all costs are covered. A calendar of pricing updates will be agreed.

10.2 Charges for Use of Trust Facilities for Outpatients

- 10.2.1 It is the responsibility of the Doctor to recover the cost from the patient and reimburse the Trust, on a quarterly basis, for any outpatients which have been seen in Trust facilities. [See Flow Chart 2]
- 10.2.2 A per patient cost for the use of Trust facilities for outpatients is available. This will be reviewed annually.
- 10.2.3 It is responsibility of the doctor to maintain accurate records of outpatient attendances. It is an audit requirement that the Trust verifies that all income associated with use of Trust facilities for outpatients has been identified and collected. Accordingly, Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees as outlined above.
- 10.2.4 A Undertaking to Pay form will only be required if investigations/diagnostics are required.

10.3 Basis of Pricing

- 10.3.1 Charges are based on an accommodation charge, cost of procedure, including any prosthesis, and on a cost per item basis for all diagnostic tests and treatments e.g. physiotherapy, laboratory and radiology tests, ECGs etc. They do not include consultants' professional fees. Some package prices may be agreed.

10.4 Uninsured Patients – Payment Upfront

- 10.4.1 Full payment prior to admission is required from uninsured patients. Consultants should advise patients that this is the case. The patient should be advised to contact the Paying Patients Officer regarding estimated cost of treatment. [See Flow Chart 4]

10.5 Insured Patients

- 10.5.1 The Undertaking to Pay Form also requires details of the patient's insurance policy. The Paying Patients Officer will raise invoices direct to the insurance company where relevant, in accordance with the agreements with individual insurance companies.
- 10.5.2 Consultants, as the first port of contact and the person in control of the treatment provided, should advise the patient to obtain their insurance company's permission for the specified treatment to take place within the specified timescale. [See Flow Chart 4]

10.6 Billing and Payment

- 10.6.1 The Paying Patients Officer co-ordinates the collation of financial information relating to patients' treatment, ensures that uninsured patients pay deposits and that invoices are raised accordingly. The financial accounts department will ensure all invoices raised are paid and will advise the Private Patient Officer in the event of a bad debt.

10.7 Audit

- 10.7.1 The Trust's financial accounts are subject to annual audit and an annual report is issued to the Trust Board, which highlights any area of weakness in control. Adherence to the Paying Patient Policy will form part of the Trust's Audit Plan. Consultants are reminded that they are responsible for the identification and recording of paying patient information. Failure to follow the procedures will result in investigation by Audit and if necessary, disciplinary action under Trust and General Medical Council regulations.

11. FINANCIAL ARRANGEMENTS FOR FEE PAYING SERVICES

- 11.1 Consultants may see patients privately or for fee paying services within the Trust only with the explicit agreement of the Medical Director, in accordance with their Job Plan. Management will decide to what extent, if any, Trust facilities, staff and equipment may be used for private patient or fee paying services and will ensure that any such services do not interfere with the organisation's obligations to NHS patients. This applies whether private services are undertaken in the consultant's own time, in annual or unpaid leave. [See Flow Chart 3]

- 11.2 In line with the Code of Conduct standards, private patient services should take place at times that do not impact on normal services for NHS patients. Private patients should normally be seen separately from scheduled NHS patients.

11.3 Fee Paying Services Policy (Category 2)

- 11.3.1 Fee Paying Services (Category 2) work is distinct from private practice, however it is still non NHS work as outlined in the 'Terms and Conditions for Hospital Medical and Dental Staff'. Refer to schedules 10 and 11 (Appendices 1 & 5 respectively) for further details.
- 11.3.2 There are a number of occasions when a Category 2 report will be requested, and they will usually be commissioned by, employers, courts, solicitors, Department of Work and Pensions etc. the report may include radiological opinion, blood tests or other diagnostic procedures
- 11.3.3 It is the responsibility of the Doctor to ensure that the Trust is reimbursed for all costs incurred in undertaking Category 2 work, this not only includes the use of the room but also the cost of any tests undertaken.
- 11.3.4 In order to comply with the Trusts financial governance controls it is essential that all Fee Paying services are identified and the costs recovered. It is not the responsibility of the Trust to invoice third parties for Category 2 work.
- 11.3.5 It is the responsibility of the Doctor to recover the cost from the third party and reimburse the Trust, on a quarterly basis, for any Category 2 services they have undertaken, including the cost of any treatments/tests provided.
- 11.3.6 The Category 2 (room only) charge per session will be reviewed annually.
- 11.3.7 A per patient rate may be available subject to agreement with the Paying Patient Manager
- 11.3.8 It is responsibility of the doctor to maintain accurate records of Category 2 attendances. It is an audit requirement that the Trust verifies that all income associated with Category 2 has been identified and collected.
- 11.3.9 Doctors are required to submit a quarterly return to the Paying Patient office with the names of the patients seen together with details of any treatment or tests undertaken. This information should accompany the payment for the relevant fees of Category 2 work as outlined above and should be submitted no later than ten days after the quarter end.
- 11.3.10 In order to comply with Data Protection requirements, Doctors must therefore inform their Category 2 clients that this information is required by the Trust and obtain their consent. Consultants should make a note of this consent.
- 11.3.11 Compliance to this policy will be monitored by the Paying Patient Manager and the Medical Director's Office.
- 11.3.12 The Consultant is responsible to HM Revenue and Customs to declare for tax purposes all Category 2 income earned. The Trust has no obligation in this respect.

- 11.3.13 Any Category 2 work undertaken for consultants by medical secretaries must be completed outside of their normal NHS hours. Consultants should be aware of their duty to inform their secretaries that receipt of such income is subject to taxation and must be declared to HM Revenue and Customs. It is recommended that Consultants keep accurate records of income and payment.

12. RENUNCIATION OF PRIVATE FEES

- 12.1 In some departments, consultants may choose to forego their private fees for private practice or for fee paying services in favour of a Charitable Fund managed by the Trust that could be drawn upon at a later stage for, by way of example, Continuous Professional Development / Study Leave.
- 12.2 For income tax purposes all income earned must be treated as taxable earnings. The only way in which this income can be treated as non taxable earnings of the consultant concerned is if the consultant signs a 'Voluntary Advance Renunciation of Earnings form' (Appendix 7) and declares that the earnings from a particular activity will belong to a named charitable fund and that the earnings will not be received by the consultant. In addition a consultant should never accept a cheque made out to him or her personally. To do so attracts taxation on that income and it cannot be subsequently renounced. Therefore all such income renounced in advance should be paid directly into the relevant fund. Income can only be renounced if it has not been paid to the individual and a Register of these will be maintained by the Charitable Funds Officer.
- 12.3 The Trust will be required to demonstrate that income renounced in favour of a Charitable Fund is not retained for the use of the individual who renounces it. Thus, in the event of any such consultant subsequently drawing on that fund, any such expenditure approval must be countersigned by another signatory on the fund.

13. OVERSEAS VISITORS - NON UK PATIENTS

(Republic of Ireland, EEA, Foreign Nationals)

PLEASE NOTE THIS IS ONLY A BRIEF GUIDE FOR FURTHER INFORMATION PLEASE CONTACT THE PAYING PATIENT OFFICE

- 13.1 The NHS provides healthcare free of charge to people who are 'ordinarily resident' in the UK. People who do not permanently live in the UK lawfully are not automatically entitled to use the NHS free of charge.
- 13.2 **RESIDENCY** is therefore the main qualifying criterion, applicable regardless of nationality, being registered with a GP or having been issued a HC/NHS number, or whether the person holds a British Passport, or lived and paid taxes or national insurance contributions in the UK in the past.