Particular Service user Circumstances

The approach to how an organisation communicates with a service user / family may need to be modified according to the service user's personal circumstances.

The following gives guidance on how to manage different categories of service user circumstances.

1.1 When a service user dies

When a SAI has resulted in a service users death, the communication should be sensitive, empathetic and open. It is important to consider the emotional state of bereaved relatives or carers and to involve them in deciding when it is appropriate to discuss what has happened.

1.2 Children

The legal age of maturity for giving consent to treatment is 16 years old. However, it is still considered good practice to encourage young people of this age to involve their families in decision making.

The courts have stated that younger children who understand fully what is involved in the proposed procedure can also give consent. Where a child is judged to have the cognitive ability and the emotional maturity to understand the information provided, he/she should be involved directly in the communication process after a SAI.

The opportunity for parents / guardians to be involved should still be provided unless the child expresses a wish for them not to be present. Where children are deemed not to have sufficient maturity or ability to understand, consideration needs to be given to whether information is provided to the parents / guardians alone or in the presence of the child. In these instances the parents' / guardians' views on the issue should be sought.

1.3 Service users with mental health issues

Communication with service users with mental health issues should follow normal procedures unless the service user also has cognitive impairment (see1.4 Service users with cognitive impairments).

The only circumstances in which it is appropriate to withhold SAI information from a service user with mental health issues is when advised to do so by a senior clinician who feels it would cause adverse psychological harm to the service user. However, such circumstances are rare and a second opinion may be required to justify withholding information from the service user.

In most circumstances, it is not appropriate to discuss SAI information with a carer or relative without the permission of the service user, unless in the public interest and / or for the protection of third parties.

1.4 Service users with cognitive impairment

Some individuals have conditions that limit their ability to understand what is happening to them.

In these cases communication would be conducted with the carer / family as appropriate. Where there is no such person, the clinicians may act in the service users best interest in deciding who the appropriate person is to discuss the SAI with.

1.5 Service users with learning disabilities

Where a service user / family has difficulties in expressing their opinion verbally, every effort should be made to ensure they can use or be facilitated to use a communication method of their choice. An advocate / supporter, agreed on in consultation with the service user, should also be identified. Appropriate advocates / supporters may include carer/s, family or friends of the service user or a representative from the Patient Client Council (PCC).

1.6 Service users with different language or cultural considerations

The need for translation and advocacy services and consideration of special cultural needs must be taken into account when planning to discuss SAI information. Avoid using 'unofficial translators' and / or the service users family or friends as they may distort information by editing what is communicated.

1.7 Service users with different communication needs

Service users who have communication needs such as hearing impaired, reduced vision may need additional support.

1.8 Service users who do not agree with the information provided

Sometimes, despite the best efforts the service user/family/carer may remain dissatisfied with the information provided. In these circumstances, the following strategies may assist:

- Facilitate discussion as soon as possible;
- Write a comprehensive list of the points that the service user / family disagree with and where appropriate reassure them you will follow up these issues.
- Ensure the service user / family has access to support services;
- Offer the service user / family another contact person with whom they may feel more comfortable.
- Use an acceptable service user advocate e.g. PCC or HSC layperson to help identify the issues between the HSC organisation and the service user / family and to achieve a mutually agreeable solution;

There may be occasions despite the above efforts the service user/family/carer remain dissatisfied with the HSC organisation's attempts to resolve their concerns. In these exceptional circumstances, the service user/family/carer through the agreed contact person, should be advised of their right to approach the Northern Ireland Public Services Ombudsman (NIPSO). In doing so, the service user/family requires to be advised by the HSC organisation that the internal procedure has concluded (within two weeks of this process having been concluded), and that the service user/family should approach the NIPSO within six months of this notification.

The contact details for the NIPSO are: Freephone Personal Information redacted by the USI r Progressive House, 33 Wellington Place, Belfast, BT1 6HN.

1.9 Service Users who do not wish to participate in the engagement process

It should be documented if the service user does not wish to participate in the engagement process.

Health and Social Care Board

Public Health Agency

What I need to know about a Serious Adverse Incident

Information for Service Users, Family Members and Carers

Insert Name of Organisation

This leaflet is written for people who use Health and Social Care (HSC) services and their families.

**The phrase service user / family member and carer is used throughout this document in order to take account of all types of engagement scenarios. However, when a service user has capacity, communication should always (in the first instance) be with them.*

Introduction

Events which are reported as Serious Adverse Incidents (SAIs) help identify learning even when it is not clear something went wrong with treatment or care provided.

When things do go wrong in health and social care it is important that we identify this, explain what has happened to those affected and learn lessons to ensure the same thing does not happen again. SAIs are an important means to do this. Areas of good practice may also be highlighted and shared, where appropriate.

What is a Serious Adverse Incident?

A SAI is an incident or event that must be reported to the Health and Social Care Board (HSCB) by the organisation where the SAI has occurred. It may be:

- an incident resulting in serious harm;
- an unexpected or unexplained death;
- a suspected suicide of a service user who has a mental illness or disorder;
- an unexpected serious risk to wellbeing or safety, for example an outbreak of infection in hospital;

A SAI may affect services users, members of the public or staff.

Never events are serious patient safety incidents that should not occur if the appropriate preventative measures have been implemented by healthcare providers. A small number of SAIs may be categorised as never events based on the Department of Health Never Events list.

SAIs, including never events, occurring within the HSC system are reported to the HSCB. You, as a service user / family member / carer, will be informed where a SAI and/or never event has occurred relating to treatment and care provided to you by the HSC.

Can a complaint become a SAI?

Yes, if during the follow up of a complaint the **(insert name of organisation)** identifies that a SAI has occurred it will be reported to the HSCB. You, as a service user / family member and carer will be informed of this and updated on progress regularly.

How is a SAI reviewed?

Depending on the circumstance of the SAI a review will be undertaken. This will take between 8 to 12 weeks depending on the complexity of the case. If more time is required you will be kept informed of the reasons.

The (**insert name of organisation**) will discuss with you how the SAI will be reviewed and who will be involved. The (**insert name of organisation**) will welcome your involvement if you wish to contribute.

Our goal is to find out what happened, why it happened and what can be done to prevent it from happening again and to explain this to those involved.

How is the service user or their family/carer involved in the review?

An individual will be identified to act as your link person throughout the review process. This person will ensure as soon as possible that you:

- Are made aware of the incident, the review process through meetings / telephone calls;
- Have the opportunity to express any concerns;
- Know how you can contribute to the review, for example share your experiences;
- Are updated and advised if there are any delays so that you are always aware of the status of the review;
- Are offered the opportunity to meet and discuss the review findings;
- Are offered a copy of the review report;

- Are offered advice in the event that the media make contact.

What happens once the review is complete?

The findings of the review will be shared with you. This will be done in a way that meets your needs and can include a meeting facilitated by **(insert name of organisation)** staff that is acceptable to you.

How will learning be used to improve safety?

By reviewing a SAI we aim to find out what happened, how and why. By doing this we aim to identify appropriate actions which will prevent similar circumstances occurring again.

We believe that this process will help to restore the confidence of those affected by a SAI.

For each completed review:

- Recommendations may be identified and included within an action plan;
- Any action plan will be reviewed to ensure real improvement and learning.

We will always preserve your confidentiality while also ensuring that opportunities to do things better are shared throughout our organisation and the wider health and social care system. Therefore as part of our process to improve quality and share learning, we may share the anonymised content of the SAI report with other HSC organisations'

Do families get a copy of the report?

Yes, a copy of the review report will be shared with service users and/or families with the service user's consent.

If the service user has died, families/carers will be provided with a copy of the report and invited to meet with senior staff.

Who else gets a copy of the report?

The report is shared with the Health and Social Care Board (HSCB) and Public Health Agency (PHA). Where appropriate it is also shared with the Coroner.

The Regulation and Quality Improvement Authority (RQIA) have a statutory obligation to review some incidents that are also reported under the SAI procedure. In order to avoid duplication of incident notification and review, RQIA work in conjunction with the HSCB / PHA with regard to the review of certain categories of SAI including the following:

- All mental health and learning disability SAIs reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986.

- Any SAI that occurs within the regulated sector for example a nursing, residential or children's home (whether statutory or independent) for a service that has been commissioned / funded by a HSC organisation.

In both instances the names and personal details that might identify the individual are removed from the report. The relevant organisations monitor the (**insert name of organisation)** to ensure that the recommendations have been implemented. The family may wish to have follow up / briefing after implementation and if they do this can be arranged by their link person within the (**insert name of organisation**).

All those who attended the review meeting are given a copy of the anonymised report. Any learning from the review will be shared as appropriate with relevant staff/groups within the wider HSC organisations.

Further Information

If you require further information or have comments regarding this process you should contact the nominated link person - name and contact details below:

Your link person is ……..…….

Your link person's job title is……..…..

Contact number …….

Hours of work……..……

Prior to any meetings or telephone call you may wish to consider the following:

Think about what questions and fears/concerns you have in relation to:

(a) What has happened?
(b) Your condition / family member condition
(c) On-going care

You could also:

- Write down any questions or concerns you have;
- Think about who you would like to have present with you at the meeting as a support person;
- Think about what things may assist you going forward;
- Think about which healthcare staff you feel should be in attendance at the meeting.

Patient and Client Council

The Patient Client Council offers independent, confidential advice and support to people who have a concern about a HSC Service. This may include help with writing letters, making telephone calls or supporting you at meetings, or if you are unhappy with recommendations / outcomes of the reviews.

Contact details:
Free phone number: Personal Information redacted by the USI

Appendix 3

Examples of communication which enhances the effectiveness of being open	
Stage of Process	**Sample Phrases**
Acknowledgement	"We are here to discuss the harm that you have experienced/the complications with your surgery/treatment" "I realise that this has caused you great pain/distress/anxiety/worry" "I can only imagine how upset you must be" "I appreciate that you are anxious and upset about what happened during your surgery – this must have come as a big shock for you" "I understand that you are angry/disappointed about what has happened" "I think I would feel the same way too"
Sorry	"I am so sorry this has happened to you" "I am very sorry that the procedure was not as straightforward as we expected and that you will have to stay in hospital an extra few days for observation" "I truly regret that you have suffered xxx which is a recognised complication associated with the x procedure/treatment." "I am so sorry about the anxiety this has caused you" "A review of your case has indicated that an error occurred – we are truly sorry about this"
Story	**Their Story** "Tell me about your understanding of your condition" "Can you tell me what has been happening to you" "What is your understanding of what has been happening to you" **Your understanding of their Story: (Summarising)** "I understand from what you said that" xxx "and you are very upset and angry about this"

	Is this correct? (i.e. summarise their story and acknowledge any emotions/concerns demonstrated.) “Am I right in saying that you……..” **Your Story** “Is it ok for me to explain to you the facts known to us at this stage in relation to what has happened and hopefully address some of the concerns you have mentioned? “Do you mind if I tell you what we have been able to establish at this stage?” “We have been able/unable to determine at this stage that……..” “We are not sure at this stage about exactly what happened but we have established that ……. We will remain in contact with you as information unfolds” “You may at a later stage experience xx if this happens you should …….”
Inquire	“Do you have any questions about what we just discussed?” “How do you feel about this?” “Is there anything we talked about that is not clear to you?”
Solutions	“What do you think should happen now?” “Do you mind if I tell you what I think we should do?” “I have reviewed your case and this is what I think we need to do next” “What do you think about that?” “These are your options now in relation to managing your condition, do you want to have a think about it and I will come back and see you later?” “I have discussed your condition with my colleague Dr x we both think that you would benefit from xx. What do you think about that?”
Progress	“Our service takes this very seriously and we have already started a review into the incident to see if we can find out what caused it to happen” “We will be taking steps to learn from this event so that we can

	try to prevent it happening again in the future” “I will be with you every step of the way as we get through this and this is what I think we need to do now” “We will keep you up to date in relation to our progress with the review and you will receive a report in relation to the findings and recommendations of the review team” “Would you like us to contact you to set up another meeting to discuss our progress with the review?” “I will be seeing you regularly and will see you next in….days/weeks. “You will see me at each appointment” “Please do not hesitate to contact me at any time if you have any questions or if there are further concerns – you can contact me by……” “If you think of any questions write them down and bring them with you to your next appointment.” “Here are some information leaflets regarding the support services we discussed – we can assist you if you wish to access any of these services”

Organisations may find this checklist useful an aide memoire to ensure a professional and standardised approach

Before, During and After Communication / Engagement Documentation Checklist

BEFORE	***Note taking***
Service users full name	
Healthcare record number	
Date of birth	
Date of admission	
Diagnosis	
Key HSC professional(s) involved in service user's care	
Date of discharge (if applicable)	
Date of SAI	
Description of SAI	
Outcome of SAI	
Agreed plan for management of SAI	
Agreed professional to act as contact person with the service user / family	

Service user / family informed incident is being reviewed as a SAI: • Date • By Whom • By what means (telephone call / letter / in person)	
Date of first meeting with the service user / family	
Location of first meeting (other details such as room booking, arrangements to ensure confidentiality if shared ward etc)	
Person to be responsible for note taking identified	
Person Nominated to lead communications identified	
Colleague/s to assist nominated lead	
Other staff identified to attend the disclosure meeting	
Anticipated service user / family concerns queries	
Meeting agenda agreed and circulated	
Additional support required by the service user / family, if any?	
The service user / family has been advised to bring a support person to the meeting?	
The service user consented to the sharing of information with others such as designated family members / support person?	

It has been established that the service user / family requires an interpreter? If yes, provide details of language and arrangements that have been or to be made.	

Signature: _____

***Date*:** _____

DURING	***Note taking***
There has been an acknowledgment of the SAI in relation to the service user / family experience.	
An apology / expression of regret provided	
The service user / family was provided with factual information regarding the adverse event	
The service user / family understanding of the SAI was established	
The service user / family was provided with the opportunity to: - Tell their story - Voice their concerns and - Ask questions	
The next steps in relation to the service user's on-going care were agreed and the service user was involved in the decisions made.	
The service user / family was provided with information in relation to the supports available to them.	
Reassurance was provided to the service user / family in relation to the on-going communication of facts when the information has been established and available – continuity provided.	
Next meeting date and location agreed	

Signature: _____

***Date*:** _____

AFTER

Circulate minutes of the meeting to all relevant parties for timely verification.
Follow through on action points agreed.
Continue with the incident review.
Keep the service user included and informed on any progress made – organise further meetings.
Draft report to be provided to the service user in advance of the final report (if agreed within review Terms of Reference that the draft report is to be shared with the service user prior to submission to HSCB/PHA).
Offer a meeting with the service user to discuss the review report and allow for amendments if required.
Follow through on any recommendations made by the incident review team.
Closure of the process is mutually agreed.
When closure / reconciliation was not reached the service user was advised of the alternative courses of action which are open to them i.e the complaints process.

Signature: _____

***Date*:** _____

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3827	19/08/2016	Safe, High Quality and Effective Care		Due to the move down from level 6 to outpatient department to the current OPD accommodation is not suitable to sustain numbers.	Risk of late diagnosis and treatment. Health and Safety and fire risk to patients and staff.	Reduction in the number of fracture patients that can attend each clinic to be reduced.	12/11/21 Refurbishment in DHH for fracture clinic will not take place within financial year 2021/2022. Await confirmation of funding for 2022/2023. 08/09/2021- accommodation for refurb not available as yet. 28/06/2021- remains a risk. Investigating refurbishing Phase 1 OPD in DHH for fracture clinic. Plans developed at a cost of £60k. Waiting to here if funding is to be approved before commencing work. 15/02/2021- remains a risk. Due to the Covid 19 pandemic DHH fracture clinics remain in CAH however still risk due to no social distancing. One DHH clinic has moved to an evening clinic from November 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 11/12/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH, unfortunately no capacity to date. 20/10/2020 - remains a risk. DHH fracture clinics remain in CAH however still risk to no social distancing. One DHH clinic moving to evening clinic from Nov 2020. Requested fracture accommodation in STH 10/8/2020 - Remain on risk register. DHH fracture clinic transferred to CAH due to covid pandemic. Need new accommodation in DHH to transfer service back large number of patients going through CAH on a Mon and Tuesday, CAH is not suitable for 2 consultant led clinics. 18.09.19 Remain on Register until capital allocation 24.06.19 - DHH T&O accomodation is priority 1 on the Trust's capital allocation list. To remain on the RR until new accomodation is complete. This will move the fracture clinic from level 2 SAU. 28/3/19 - fracture clinic in DHH continues to be located on level 3 DHH (SAU room), therefore numbers remain reduced. Remains on the capital allocation list 6/2/19 - as below no change to risk	HIGH	DIV
4018	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog	Delay in review of patients planned for screening/repeat procedures presenting adverse clinical risk.	INDC planned backlog in the following surgical specialties: urology, general surgery, ortho and chronic pain.	19/11/21 ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessions in DHH 16/09/2021- OSL update- continues to monitor backlog. Due to Covid 19 pressures there are reduced theatre sessions and therefore the focus is on red flag. 08/09/2021- Due to the increase in Covid ICU patients, theatres have decreased sessions down to 3 all day urgent bookable in CAH and one AM session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL continues to monitor planned IPDC backlog. Theatres sessions has increased with DHH restarting 14/06/2021 with 15 theatre sessions. Only RF and urgent at present. Validating top 10 longest waiters each month. 15/02/2021- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to Covid. Currently one 1 urgent bookable list per day Mond to Friday. clinically urgent and priority 2 patients being scheduled. The Trust is currently facing the 3rd surge. No urgent bookable in DHH. 11/12/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and priority 2/3 patients being scheduled. The Trust is currently facing the 2nd COVID surge. 1 urgent bookable each day in CAH and 3 days in DHH 20/10/2020- Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 due to COVID pandemic. Currently only clinically urgent and the red flag priority 2 patients being scheduled. The Trust is currently facing the 2nd COVID surge unsure if elective surgery will continue 10/8/2020 - Planned IPDC backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present.	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4019	15/10/2016	Provide safe, high quality care		Inpatient / Daycase Planned Backlog for Endoscopy	Delay in review of patients for planned screening/repeat procedures presenting adverse clinical risk.	Endoscopy planned backlog. Papers written and submitted to Director re risk. Requested HSCB funding for planned backlog clearance.	19/11/21 Currently only clinical urgent and red flag priority 2 patients are being scheduled for endoscopy. Planned backlog continues to increase as no planned patients are being booked. Validation of planned endoscopy patients is still ongoing. Endoscopy capacity has decreased due to Covid 19 pressures, the redeployment of theatre based workforce continues to impact on capacity within South Tyrone Hospital (STH). The day clinical centre was redeployed to STH day procedure admission ward during the pandemic which still remains in day procedure. This was a 14 bedded ward historically used to run two endoscopy lists 5 days a week simultaneously. Until they return to CAH it is not possible for STH to return to a 19 planned endoscopy list per week. 16/09/2021- Planned endoscopy backlog validation is still in progress 28/06/2021- planned endoscopy backlog is currently being validated by the Gastro and General Surgical Team. 15/02/2021- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. as no planned endoscopy patients are being scheduled. Validation of planned endoscopy patients has commenced. 20/10/2020- Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March due to the COVID pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. Colon patients being sent Qfit test then prioritised for their colon. Still working on IS contract 10/8/2020 - Planned IPDC endoscopy backlog continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for endoscopy. Backlog continues to grow at present. In process of securing contract to bring IS into the Trust for weekend endoscopy additional	HIGH	DIV
4021	12/04/2019	Provide safe, high quality care		Access Times (Outpatients) - General (not inclusive of visiting specialties)	Increase in access times associated with capacity gaps and emergent demand - Capacity gapin RF, urgent and routine.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL update SEC, New regional guidance has been approved for Outpatient admin validation this will be for ENT, Urology and Trauma and Orthopaedics. From April 19 admin validation has been ongoing, new regional technical guidance has been approved and will commence Jan 2022 and the validation team admin support will increase, recruitment in progress.Capacity reduced due to Covid 19 social distancing guidance which is decreasing the number of booked clinics. IPC guidance is continually reviewed and updated. 160921 OSL update- Within outpatients admin validation is ongoing within the following areas: ENT, BFH and orthopaedics. OSL progressing decision with IPC if clinic sizes can be increased. 08/09/2021 - Currently only red flag and some urgent patients are being booked however demand is still greater than capacity. Redeployment of DSU and Theatre staff to ICU for surgery reduces theatre capacity on CAH, STH and DHH sites. Six urgent bookable sessions in CAH, fourteen trauma sessions and five urgent bookable sessions in DHH with cancellation of day surgery and endoscopy. 28/06/2021- OSL and HOS continue to monitor longest waiters. Currently due to social distancing reduced numbers continue and only red flag and urgent patients being booked. Agreed to contact IPC to see if we can increase numbers at clinics. Admin validation to commence. 15/02/2021New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present. The trust is facing a 3rd surge at present. All outpatients cancelled again and outpatient staff redeployed. 0/10/2020 - New Outpatients backlog waiting times continues as a clinical risk. All outpatient cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag priority 2 patients being scheduled for surgery. Backlog continues to grow at present.	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
4022	12/04/2019	Provide safe, high quality care		Access Times (In-patient/Day Case) - General	Increase in access times associated with capacity gaps and emergent demand.	ATICs/SEC specialties with New Outpatients >52 weeks; urology, general surgery, Orthopaedics, Chronic Pain	19/11/21 OSL and HOS continue to monitor outpatient stragglers >52 weeks. we are currently booking P2 priority patients due to Covid 19 patients. 16/09/21 OSL update- OSL and HOS continue to monitor top ten longest waiters for inpatient/day case. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. This will result in ongoing backlog in planned and surveillance surgical patients. 28/06/2021- OSL and HOS continue to monitor. Top 10 longest waiters to be validated on a monthly basis. Theatres sessions have increased with DHH restarting 14.06.2021 with 15 theatre sessions. Only priority 2 elective surgery on CAH site. 15/02/2021- New outpatient long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Still only RF and urgent patients being scheduled. Surge 3 all outpatients have been cancelled and staff redeployed to support the Wards 11/12/2020 - New outpatients long waiting times continues as a clinical risk. Reduced outpatient capacity due to covid. Only RF and urgent patients being scheduled. Outpatient accommodation increased slightly from 14/12/2020 but not to full capacity. To continue with reduced numbers due to social distancing 20/10/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients being booked at present. Reduced capacity due to outpatient rooms being utilised for new covid processes, reduced patients per clinics for social distancing. New referrals have been reduced from March to June 2020 due to covid pandemic. 10/8/2020 - New outpatients long waiting times continues as a clinical risk. All elective surgery cancelled in March 2020 to due covid pandemic. Only clinically urgent and red flag new and review patients	HIGH	DIV
4131	03/12/2020	Safe, High Quality and Effective Care	Trustwide	Reduction in elective capacity due to covid restrictions-Urology ENT, Gen Surgery, Gynae and Orthopaedics	With the Covid-19 pandemic SEC ability to accommodate commissioned levels of activity is not being achieved resulting in increases in waiting times and volumes of patients on the elective and planned waiting list. As a result of increased waiting times and reduced capacity consequently patients may come to harm, increased levels of pain and discomfort and reduced quality of life	Mon-Friday 1x all day Urgent bookable on both sites CAH and DHH Due to limited elective capacity consultants clinically prioritise patients for surgery using the FSSA royal college guidelines, priority to cancer patients. Regional cancer rest meeting working towards equalising waiting times across the province. In house additionally from January 2021 on DHH site Endoscopy- weekend additional sessions in LV	12/11/2021ICU beds are currently sitting at 12.WIthin Elective Theatres there are 16 urgent bookable sessions in CAH and 5 urgent bookable sessionsin DHH. 08/09/2021 - Due to increase in Covid 19 ICU patients, theatres have decreased sessions down to three all day urgent bookable in CAH and one am session per day in DHH. THis will result in ongoing backlog in planned and surveillance surgical patients. Only priority 2 for CAH and DHH sites. 28/06/2021- DHH recommenced elective theatres x 15 sessions on the 07/06/2021. CAH elective sessions continue with reduced theatres- currently 2-3 urgent bookable per staff however this is staff dependent. Agency staff have taken leave July/August 21. 9/6/2021 the ongoing workforce issues will affect our ability to provide core operating sessions. Primarily for in patient theatres. The action in respect to recruitment is in place. advertisements are going out in June and 9 new registered nurses are due to commence work between June and Sept for CAH in patient theatres. we are currently working with the nurse bank and agency to attract theatres nurses and Dps from agency across mainland UK. 15/02/2021- ICU remains open to 16 patients, surge staff from day surgery and theatres/recovery remain in-situ. Currently in surge 3 03/12/2020- full de-escalation of CCaNNi critical care surge plan- this is currently medium surge and difficult to predict. Commencement of in house additionally from Jan 2021 for endoscopy and surgical specialties and the January sessions are currently being agreed. Increase urgent bookable theatre sessions	HIGH	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3802	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Nurse Recruitment for Adult and Paed theatres	Risk of being unable to cover all required theatre sessions with appropriately skilled theatre staff, therefore, there is a risk of sessions not being scheduled or being cancelled if insufficient skilled Theatre staff are not available.	We continue to use the Nursing Team in ATICs across all theatre departments. This includes cross site working, to ensure that we make the best use of our resources to cover the core confirmed sessions.	19/11/2021- no further update. 20/09/2021- Rolling nurse recruitment for Band 6 for paeds theatre is at advert. No paediatric surgery at present due to surge- redeployment of staff to ICU. 28/06/2021- Jan/Feb 2021x8 band 5 staff nurses recruited through peri-operative workstream. June 2021 band 5 applications closed, approx 8 band 5 have been recruited. Waiting on checks and start dates. Delivering of care x 1 Band 7 and 10 x Band 6's funding secured. ATICS going out to advertisement (3x CEPs Band 7- 1 funded and 2 at risk). 15/02/2021- regional peri operative recruitment drive closing date 05/02/2021, awaiting confirmation of applicants and interviews to be processed. ATICS remain with larger number of vacant adult and paediatric theatre nursing posts. 11/12/2020 - request through E&G for a commissioned paediatric nursing course for 21/22. Regional recruitment plans ongoing. HOS ATICS remains on group 20/10/2020 - regional recruitment plans ongoing. HOS ATICS sits on the group. 10/8/2020 - Since the covid-19 pandemic Paediatric theatre presently being used for outpatient ENT AGPs. No paediatric surgery currently on the DHH site. Only 2 paediatric nurses Band 6 at present, out for recruitment with BSO. Continues as risk. Continuing with recruitment drives for adult theatre nursing staff. Vacancies still remain. For retention Band 5 uplift to Band 6 successfully completed. 3/9/19 - only 3 paed nurses at present (1 is 16 hours only). Further nursing gap highlighted to AD and Director - paper attached 18/6/19 - Unfortunately continued high level of vacancies in ATICS. Theatre nursing paper has been submitted to the Acute Director. Continue to run main theatres in CAH and DHH at 30% reduction. Risk remains high. 28/3/19 - Continued high level of vacancies in theatres and risk to staffing main theatre sessions. Continue to run at 30% less theatre sessions for April 2019.	MOD	DIV
3804	27/05/2016	Safe, High Quality and Effective Care	Outpatients Dept	Pre Op Assessment	Pre-op assessment is currently under resourced to provide the number of assessments required and deal with the increase in demand to the service	Staffing has been structured within pre-op to cover the key areas ensuring the best use of the limited resources. We are currently proactively working to change the existing pre-op processes to ensure that patients are pre-assessed and passed fit before ever being scheduled for surgery. This impacts on the need for additional staffing as we are working to change the processes while having to continue with existing processes.	20/09/2021- Pre-op staffing currently matches the requirements for urgent bookable. Recruitment required. Will update as necessary. 28/06/2021- remains unchanged will discuss way forward with AD. 15/02/2021- remains unchanged. 11/12/2020 - remains unchanged. Internal audit completed and addressing recommendations 2010/2020 - remains unchanged 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 10/8/2020 - Pre-op assessment demand continues outweigh capacity. Out for recruitment BSO band 6. Requested planners to complete a business case to enhance pre-op service. 18/9/19 - Lead nurse is interviewing this week for new pre-op nursing staff. Pre-op is one of the projects submitted under demography monies. 18/6/19 - Ongoing works pressures continue in pre-op due to demand. Group met to progress pre-op paper however planners will be not support without confirmed funding stream. To remain on RR. 28/3/19 - Risks continue as below and additionality continues. Agency band 2 part time to start end of April 19 to support the B5/6 nursing staff. 6/2/19 - High sickness rate in pre-assessment at present. Additional hours offered to keep up with demand. Discuss additional admin B2 to be recruited as risk to support the B5/6	MOD	DIV

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3800	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	Anaesthetic cover for maternity services	We currently fail to meet the standards regard to anaesthetic cover for maternity theatres. There is a risk to the Maternity patients from having inadequate cover. The staff is approximately 2.0wte. The nursing levels do not meet the national guidelines. Risk of failing anaesthetic accreditation, currently do not meet the standards.	A paper is being completed with regard to sorting the deficit in both anaesthetic and nursing cover.	19/11/2021- no change 20/09/2021- no change 28/06/2021- no change 15/02/2021- risk remains the same 11/12/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 20/10/2020 - risk remains unchanged, however, in DHH elective c-sections are performed in the main theatres. 10/8/2020 - no further update. Risk continues. 18.09.19 - HOS & LN's have met and are meeting again in the next month to go through figures for the nursing requirement 18/6/19 - meeting was held between gynae and ATICs, business case to be progressed. To be kept on RR 28/3/19 - Next ATICS business meeting arranged for 19/4/19, await update from Dr Scullion. 6/2/19 - discussed at ATICS business meeting. Dr Scullion investigating the transfer of IMWH maternity theatres	MOD	DIV
3727	01/09/2015	Make the best use of resources	Anaesthetics, Theatres & Intensive Care Services	No equipment store available in Day Surgery Unit CAH	Currently there is a 2 bedded side room unable to be used for patients as it stores the equipment for this unit. This can impact on the availability of beds for the daycase list, particularly when lists are occurring simultaneously. Potential for harm; Potential delay of access to day surgery beds. Limited availability of segregation for patients for IPC reasons and also male/female.	Try to maximise the use of the existing 12 bed spaces. Continues to use the 2-bedded side room for equipment as this reduces the risk to patients and staff of equipment being stored in corridors, this would also be a fire hazard.	19/11/2021- no change 28/06/2021- remains unchanged no funding. 15/02/2021- remains unchanged still no capital funding 11/12/2020 - remains unchanged 20/10/2020 - remains unchanged, no capital funding identified. 10/8/2020 - Still no capital funding, risk remains the same. 18.09.19 Still no capital funding risk remains the same 18/6/19 - still no capital funding identified, risk remains the same. 28/3/19 - as below, risk remains as no capital funding identified. 6/2/19 - no capital funding, therefore risk remains the same.	MOD	DIV
4095	02/06/2020	Provide safe, high quality care a great place to work	Trustwide	Mishandling of Patient handover resulting in an Information Governance breach	There is a risk that the handover with patients details could be mislaid anywhere on site or in the community. Patient detail not being managed in a confidential manner thereby reveling the patient's private business and exposing the Trust to a breach in public confidence.	All disciplines of staff have been informed of the recent breaches in Information Governance and the consequence of same. All wards and departments have bins with clearly visible signage indicating they are for the disposal of the confidential handover prior to the end of their shift Regular reminders at patient safety briefings to adhere to Trust governance protocols Representative in Acute have met and agreed the content on the handovers. Incident and meeting note shared with OPPC, Peads and MH directorates.	12/11/20212 An Information Governance audit has taken place and results are pending to ascertain compliance with non identifiable patient from handovers.To await report to ascertain compliance to inform if this risk should remain on register. 20/09/2021- AD to confirm is this can be removed from risk register 28/06/2021- Additional confidential waste bins at doffing, exits and signs were erected re disposing confidential waste appropriately. 24/02/2021- continuously monitored 02/06/2020 Staff regularly reminded of necessity to adhere to Trust governance protocols.	LOW	DIV
750	28/07/2008	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	STH Theatres and Day Procedure Unit requires UPS/IPS syste,	Theatres and Day Procedure Unit at STH currently does not have any form of backup electrical supply other than the emergency generator; in the event of a power failure all power supplies to socket outlets will drop out for approx. 15 seconds until the generator comes on line.	Battery backup exists on the anaesthetic machine only.	12/11/2021- no change 20/09/2021- UPS/IPS need an injection of £200k. Estates are costing. 29/06/2021- less than 50% of the required installation has been completed. I have liaised with estates to advise of the next priorities if a phased approach for installation of further UPS/IPS is being considered when funding becomes available. I have listed the areas below detailing completed works in Green and the work that remains outstanding in red: Theatre 1 pendants Completed Theatre 2 pendants Completed Recovery area main theatre 6 bed spaces and defib plug Not completed DPU recovery 6 bed spaces and defib plug in reception Not completed DPU 1 procedure room pendants Not completed DPU 2 procedure room pendants Not completed DPU Decontamination unit (2 drying cabinets completed and 2 endoscope washers not completed) 15/02/2021- covid remains a priority for estates no change to risk 11/12/2020 - still with estates, priority to covid 20/10/2020 - no change and remains with estates. Priority being given to covid 10/8/2020 - no change, remains a risk. Helena to e-mail Estates re plan to address IPS/UPS. 18.09.19 No change	HIGH	HOS

ID	Opened	Principal objectives	Location (exact)	Title	Des/Pot for Harm	Controls in place	Progress (Action Plan Summary)	Risk level (current)	Register Holding
3801	27/05/2016	Safe, High Quality and Effective Care	Anaesthetics, Theatres & Intensive Care Services	JAG Accreditation	Due to the waiting times for patients having endoscopy procedures, we cannot achieve timeliness of appointments, and therefore, cannot achieve JAG accreditation. This is a regional issue and JAG are aware of same.	JAG is working with HSCB and the Trusts with regard to the revised JAG standards and the potential for 2 levels of accreditation.	12/11/2021 No ATICS business meeting interface 15/09/2021- unchanged. 28/06/2021- unchanged. 15/02/2021- priority given to covid pandemic. Significantly reduced capacity available on all day surgery sites. 11/12/2020 - remains the same, priority being given to covid pandemic 20/10/2020 - Due to covid pandemic remains unchanged, currently going into 2nd surge 10/8/2020 - Dr P Murphy is the Interim Endoscopy lead. Endoscopy waiting times continue to be an issue in achieving JAG accreditation. 18.09.19 Require a led for JAG 28/3/19 - next ATICS Business meeting Fri 19/4/19, to discuss taking JAG off the RR. 6/2/19 - Consider taking off Directorate RR to be discussed at next ATICS Business meeting.	MOD	HOS

WIT-32525

Rolling Commodes Exception Report (Ward Self-Audits), April 2022 - March 2023

Week	5

Site	Wards	Apr-22 w1	w2	w3	w4	w5	May-22 w6 w7 w8 w9	Jun-22 w10 w11 w12 w13 w14	Jul-22 w15 w16 w17 w18	Aug-22 w19 w20 w21 w22 w23	Sep-22 w24 w25 w26 w27	Oct-22 w28 w29 w30 w31	Nov-22 w32 w33 w34 w35 w36	Dec-22 w37 w38 w39 w40	Jan-23 w41 w42 w43 w44	Feb-23 w45 w46 w47 w48	Mar-23 w49 w50 w51 w52	Total Number of Weeks Returned per Ward out of 52 Weeks	Total Commode Returns % Compliance	Total Commode Cleanliness % Compliance
CRAIGAVON AREA HOSPITAL	**ATICS**																			
	Intensive Care Unit	1	1	1	1	1												5 Weeks	100%	
	Recovery CAH	1	1	1	1	1												5 Weeks	100%	
	CANCER SERVICES																			
	Mandeville	1	1	1	1	1												5 Weeks	100%	
	Haematology	1	1	1	1	1												5 Weeks	100%	
	MEDICAL																			
	1 North	1		1	1	1												4 Weeks	80%	
	1 South	1	1	1	1													4 Weeks	80%	
	2 North Respiratory	1	1	1	1	1												5 Weeks	100%	
	2 South			1		1												2 Weeks	40%	
	3 North	1	1	1	1	1												5 Weeks	100%	
	AMU	1	1	1	1	1												5 Weeks	100%	
	Cath Lab	1	1	1	1	1												5 Weeks	100%	
	Day Clinical Centre	1	1	1	1	1												5 Weeks	100%	
	Emergency Department	1	1	1	1													4 Weeks	80%	
	Ramone Ward 1 (Frailty)	1	1	1	1	1												5 Weeks	100%	
	Ambulatory Unit	1	1	1	1	1												5 Weeks	100%	
	SURGICAL																			
	Elective Admissions	1	1	1		1												4 Weeks	80%	
	3 South	1	1	1	1	1												5 Weeks	100%	
	4 North CESW	1	1	1	1	1												5 Weeks	100%	
	4 South CPCW	1	1	1	1	1												5 Weeks	100%	
	DSU	1	1		1	1												4 Weeks	80%	
	Gynae Ward	1	1	1	1	1												5 Weeks	100%	
	Orthopaedics	1	1	1	1	1												5 Weeks	100%	
	Trauma	1	1	1	1	1												5 Weeks	100%	
																		0 Weeks	0%	

Key

- Late Return
- Non-Compliant
- Nil return
- Not applicable

WIT-32526

Rolling Commodes Exception Report (Ward Self-Audits), April 2022 - March 2023

Site	Wards	Apr-22 w1	w2	w3	w4	w5	May-22 w6 w7 w8 w9	Jun-22 w10 w11 w12 w13 w14	Jul-22 w15 w16 w17 w18	Aug-22 w19 w20 w21 w22 w23	Sep-22 w24 w25 w26 w27	Oct-22 w28 w29 w30 w31	Nov-22 w32 w33 w34 w35 w36	Dec-22 w37 w38 w39 w40	Jan-23 w41 w42 w43 w44	Feb-23 w45 w46 w47 w48	Mar-23 w49 w50 w51 w52	Total Number of Weeks Returned per Ward out of 52 Weeks	Total Commode Returns % Compliance		Total Commode Cleanliness % Compliance
DAISY HILL HOSPITAL	CHILDRENS																				
	Daisy Unit	1	1	1	1	1												5 Weeks	100%		
	MEDICAL																				
	Emergency Department	1		1														2 Weeks	40%		
	Female Medical	1	1	1	1	1												5 Weeks	100%		
	Male Medical / CCU	1	1	1	1	1												5 Weeks	100%		
	Renal	1	1	1	1	1												5 Weeks	100%		
	Stroke & Rehabilitation Unit	1	1	1		1												4 Weeks	80%		
	SURGICAL																				
	Elective Admissions																	0 Weeks	0%		
	Female Surgical	1	1	1	1	1												5 Weeks	100%		
	High Dependency Unit	1	1	1	1	1												5 Weeks	100%		
	Male Surgical	1	1		1	1												4 Weeks	80%		
LURGAN HOSPITAL	Ward 1 Lurgan	1	1	1	1	1												5 Weeks	100%		
	Ward 2 Lurgan	1	1		1	1												4 Weeks	80%		
	Ward 3 Lurgan	1	1	1	1	1												5 Weeks	100%		
	Day Hospital	1	1	1	1	1												5 Weeks	100%		
SOUTH TYRONE HOSPITAL	ARW 1	1	1	1	1	1												5 Weeks	100%		
	ARW 2	1	1	1	1	1												5 Weeks	100%		
	E Floor	1	1	1	1	1												5 Weeks	100%		
	Theatre/Recovery STH	1	1	1	1	1												5 Weeks	100%		
St Lukes Hospital	Gillis Memory Centre	1	1															2 Weeks	40%		

Key
- Late return
- Non-compliant
- Nil return
- Not applicable

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Week 1	02-08/04/2022
Week 2	09-15/04/2022
Week 3	16-22/04/2022
Week 4	23-29/04/2022
Week 5	30/04-06/05/2022
Week 6	07-13/05/2022
Week 7	14-20/05/2022
Week 8	21-27/045/2022
Week 9	28/05-03/06/2022
Week 10	04-10/06/2022
Week 11	11-17/06/2022
Week 12	18-24/06/2022
Week 13	25/06-01/07/2022
Week 14	02-08/07/2022
Week 15	09-15/07/2022
Week 16	16-22/07/2022
Week 17	23-29/07/2022
Week 18	30/07-05/08/2022
Week 19	06-12/08/2022
Week 20	13-19/08/2022
Week 21	20-26/08/2022
Week 22	27/08-02/09/2022
Week 23	03-09/09/2022
Week 24	10-16/09/2022
Week 25	17-23/09/2022
Week 26	24-30/09/2022
Week 27	01-07/10/2022
Week 28	08-14/10/2022
Week 29	15-21/10/2022
Week 30	22-28/10/2022
Week 31	29/10-04/11/2022
Week 32	05-11/11/25022
Week 33	12-18/11/2022
Week 34	19-25/11/2022
Week 35	26/11-02/12/2022
Week 36	03-09/12/2022
Week 37	10-16/12/2022
Week 38	17-23/12/2022
Week 39	24-30/12/2022
Week 40	31/12/2022-06/01/2023
Week 41	07-13/01/2023
Week 42	14-20/01/2023
Week 43	21-27/01/2023
Week 44	28/01-03/02/2023
Week 45	04-10/02/2023
Week 46	11-17/02/2023
Week 47	18-24/02/2023
Week 48	25/02-03/03/2023
Week 49	04-10/03/2023
Week 50	11-17/03/2023
Week 51	18-24/03/2023
Week 52	25-31/03/2023

WIT-32528

Rolling Hand Hygiene Exception Report (Ward Self-Audits), April 2022 - March 2023

Week	5

Site	Wards	Apr-22					May-22				Jun-22					Jul-22				Aug-22					Sep-22				Oct-22				Nov-22					Dec-22				Jan-23				Feb-23				Mar-23				Total Number of Weeks Returned per Ward out of 52 Weeks	Total HH % Return Compliance	HH Weekly Exception overall % Compliance
		w1	w2	w3	w4	w5	w6	w7	w8	w9	w10	w11	w12	w13	w14	w15	w16	w17	w18	w19	w20	w21	w22	w23	w24	w25	w26	w27	w28	w29	w30	w31	w32	w33	w34	w35	w36	w37	w38	w39	w40	w41	w42	w43	w44	w45	w46	w47	w48	w49	w50	w51	w52			
CRAIGAVON AREA HOSPITAL	**ATICS**																																																							
	Intensive Care Unit	1	1	1	1	1																																															5 Weeks	100%	
	Recovery CAH	1	1	1	1	1																																															5 Weeks	100%	
	Theatres CAH	1	1	1	1	1																																															5 Weeks	100%	
	T&O Theatre/Recovery	1	1	1	1	1																																															5 Weeks	100%	
	CANCER SERVICES																																																							
	Mandeville	1	1	1	1	1																																															5 Weeks	100%	
	Haematology	1	1	1	1	1																																															5 Weeks	100%	
	CHILDRENS																																																							
	Blossom Centre	1			1	1																																															3 Weeks	60%	
	NeoNatal Unit	1	1	1	1	1																																															5 Weeks	100%	
	MATERNITY																																																							
	Maternity & MLU CAH		1	1	1	1																																															4 Weeks	80%	
	Delivery CAH	1	1	1	1																																																4 Weeks	80%	
	MEDICAL																																																							
	1 North	1		1	1	1																																															4 Weeks	80%	
	1 South	1	1	1	1																																																4 Weeks	80%	
	2 North Respiratory	1	1	1	1	1																																															5 Weeks	100%	
	2 South			1		1																																															2 Weeks	40%	
	3 North	1	1	1	1	1																																															5 Weeks	100%	
	AMU		1	1	1	1																																															4 Weeks	80%	
	Cath Lab	1	1	1	1	1																																															5 Weeks	100%	
	Day Clinical Centre	1	1	1	1	1																																															5 Weeks	100%	
	Dermatology	1	1	1	1																																																4 Weeks	80%	
	Emergency Department	1	1	1	1																																																4 Weeks	80%	
	Ramone Ward 1 (Frailty)	1	1	1	1	1																																															5 Weeks	100%	
	Ambulatory Unit	1	1	1	1	1																																															5 Weeks	100%	
	SURGICAL																																																							
	Elective Admissions	1	1	1		1																																															4 Weeks	80%	
	3 South	1	1	1	1	1																																															5 Weeks	100%	
	4 North CESW	1	1	1	1	1																																															5 Weeks	100%	
	4 South CPCW	1	1	1	1	1																																															5 Weeks	100%	
	Day Surgery Unit	1	1		1	1																																															4 Weeks	80%	
	Fracture Clinic CAH	1	1	1	1	1																																															5 Weeks	100%	
	Gynae Ward	1	1	1	1	1																																															5 Weeks	100%	
	Orthopaedics	1		1	1	1																																															4 Weeks	80%	
	Pre-Op Assessment	1	1	1	1	1																																															5 Weeks	100%	
	Thorndale Unit				1	1																																															2 Weeks	40%	
	Trauma	1	1	1	1	1																																															5 Weeks	100%	
																																																						0 Weeks	0%	

Key

- Late return
- Nil return
- Non-compliant
- Not applicable

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Rolling Hand Hygiene Exception Report (Ward Self-Audits), April 2021 - March 2022

Site	Wards	Apr-22 w1	w2	w3	w4	w5	May-22 w6	w7	w8	w9	Jun-22 w10	w11	w12	w13	w14	Jul-22 w15	w16	w17	w18	Aug-22 w19	w20	w21	w22	w23	Sep-22 w24	w25	w26	w27	Oct-22 w28	w29	w30	w31	Nov-22 w32	w33	w34	w35	w36	Dec-22 w37	w38	w39	w40	Jan-23 w41	w42	w43	w44	Feb-23 w45	w46	w47	w48	Mar-23 w49	w50	w51	w52	w53	Total Number of Weeks Returned per Ward out of 52 Weeks	Total HH % Return Compliance	HH Weekly Exception overall % Compliance
DAISY HILL HOSPITAL	**ATICS**																																																												
	Day Procedure Unit	1	1	1	1	1																																																					5 Weeks	100%	
	Theatre/Recovery DHH	1	1	1	1	1																																																				5 Weeks	100%	
	CHILDRENS																																																											
	Daisy Unit	1		1	1	1																																																			4 Weeks	80%	
	SCBU	1		1	1	1																																																					4 Weeks	80%	
	MATERNITY																																																										
	Delivery DHH		1	1	1	1																																																				4 Weeks	80%	
	Maternity DHH	1	1	1	1	1																																																				5 Weeks	100%	
	MEDICAL																																																										
	Direct Assessment Unit	1	1	1	1	1																																																				5 Weeks	100%	
	Emergency Department	1	1	1	1																																																					4 Weeks	80%	
	Female Medical	1	1	1	1	1																																																				5 Weeks	100%	
	Male Medical / CCU	1	1	1	1	1																																																				5 Weeks	100%	
	Renal	1	1	1	1	1																																																				5 Weeks	100%	
	Stroke & Rehabilitation Unit	1	1	1		1																																																				4 Weeks	80%	
	SURGICAL																																																										
	Elective Admissions	1	1	1	1	1																																																			5 Weeks	100%	
	Female Surgical	1	1	1	1	1																																																			5 Weeks	100%	
	High Dependency Unit	1	1	1	1	1																																																		5 Weeks	100%	
	Male Surgical	1	1		1	1																																																			4 Weeks	80%	
LURGAN HOSPITAL	Ward 1 Lurgan	1	1	1	1	1																																																		5 Weeks	100%	
	Ward 2 Lurgan	1	1		1	1																																																	4 Weeks	80%	
	Ward 3 Lurgan	1	1	1	1	1																																																5 Weeks	100%	
SOUTH TYRONE HOSPITAL	ARW 1	1	1	1	1	1																																																5 Weeks	100%	
	ARW 2	1	1	1	1	1																																																5 Weeks	100%	
	E Floor	1	1	1	1	1																																															5 Weeks	100%	
	Theatre/Recovery STH	1	1	1	1	1																																															5 Weeks	100%	

Key: Late return; Nil return; Non-compliant; Not Applicable

****Only monthly returns from hand hygiene audit (as per SHSCT standard) are required from these care settings.****

Site	Wards	Apr-22 w1	w2	w3	w4	w5	May-22 w6	w7	w8	w9	Jun-22 w10	w11	w12	w13	w14	Jul-22 w15	w16	w17	w18	Aug-22 w19	w20	w21	w22	w23	Sep-22 w24	w25	w26	w27	Oct-22 w28	w29	w30	w31	Nov-22 w32	w33	w34	w35	w36	Dec-22 w37	w38	w39	w40	Jan-23 w41	w42	w43	w44	Feb-23 w45	w46	w47	w48	Mar-23 w49	w50	w51	w52	w53	Total Number of Weeks Returned per Ward out of 52 Weeks	Total HH % Return Compliance	HH Weekly Exception overall % Compliance
Bluestone Unit	Bronte - Bluestone																																																												
	Silverwood - Bluestone																																																												
	Willows - Bluestone																																																												
	Cloughmore - Bluestone																																																												
	Rosebrook Bluestone																																																												
St Lukes Hospital	Gillis Memory Centre	1	1																																																											

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Week 1	02-08/04/2022
Week 2	09-15/04/2022
Week 3	16-22/04/2022
Week 4	23-29/04/2022
Week 5	30/04-06/05/2022
Week 6	07-13/05/2022
Week 7	14-20/05/2022
Week 8	21-27/05/2022
Week 9	28/05-03/06/2022
Week 10	04-10/06/2022
Week 11	11-17/06/2022
Week 12	18-24/06/2022
Week 13	25/06-01/07/2022
Week 14	02-08/07/2022
Week 15	09-15/07/2022
Week 16	16-22/07/2022
Week 17	23-29/07/2022
Week 18	30/07-05/08/2022
Week 19	06-12/08/2022
Week 20	13-19/08/2022
Week 21	20-26/08/2022
Week 22	27/08-02/09/2022
Week 23	03-09/09/2022
Week 24	10-16/09/2022
Week 25	17-23/09/2022
Week 26	24-30/09/2022
Week 27	01-07/10/2022
Week 28	08-14/10/2022
Week 29	15-21/10/2022
Week 30	22-28/10/2022
Week 31	29/10-04/11/2022
Week 32	05-11/11/25022
Week 33	12-18/11/2022
Week 34	19-25/11/2022
Week 35	26/11-02/12/2022
Week 36	03-09/12/2022
Week 37	10-16/12/2022
Week 38	17-23/12/2022
Week 39	24-30/12/2022
Week 40	31/12/2022-06/01/2023
Week 41	07-13/01/2023
Week 42	14-20/01/2023
Week 43	21-27/01/2023
Week 44	28/01-03/02/2023
Week 45	04-10/02/2023
Week 46	11-17/02/2023
Week 47	18-24/02/2023
Week 48	25/02-03/03/2023
Week 49	04-10/03/2023
Week 50	11-17/03/2023
Week 51	18-24/03/2023
Week 52	25-31/03/2023

Urology Team Departmental Meeting
Thursday 31st March 2022 at 12:45

Notes of meeting

Present: Wendy Clayton, Sarah Ward, Michael Young, Jenny McMahon, Leanne McCourt, Jeventine Asingei, John O'Donoghue, Sabahat Hasnain, Anthony Glackin, Laura McAuley, Kisnain, Hafs, Fiona Griffin, Susie Call

Apologies	Kate O'Neill
Covid update	Level 4 North & South covid outbreak Currently 31 covid inpatients and no patients in ICU
Public Inquiry update	• Being monitored keep on Agenda each month – meeting tonight at 5 p.m. • Wendy will keep everyone updated • Family interviews beginning in June • Work to be completed in relation to Section 21 questions • Better guidance on what is required and how we can support
NIECR sign off for speciality doctors	• John Flood – SAI action plan complete • Naomi Ferris – General Surgeons difficult to answer phone, juniors to get handover but nothing to handover. Needed for ward round – Wendy will speak with Amie • 3 South – juniors are not advised if bloods taken no FY1 Susie Cull – discussed training possibly as causing problems re. handover. • Protected review slots – Ronan circulated a recommendation re having a procedure for protected review slots (PR's). Each consultant has PR slots on their clinics, majority are used for MDM pts (cancer and stones) or pts returning after being seen at the HOT clinics However, everyone's clinics different depending on service
Elective/Outpatient activity update	**Hermitage** - Saba reqested to be sent a list of TURP patients that were not sent to Hermitage for TURP Saba will then confirm suitable as LVH day case – Sabahat will speak with Michael **Kingsbridge** – good Contract but having some amendments **352 –** successful – ok for next financial year **Flex cyst contract** – Wendy to investigate the possibility of a new flex cyst contract to include procedure, imaging, review, cystodiathermy **Susie Cull** – slow turnaround in the emergency theatre has been experienced over the last number of week. Mr Glackin also voiced concerns regarding communication problems – pathway needs to be clearly understood Wendy will speak with Emma Jane
Governance a. MDT Improvement plan/Urology SAI recommendations (Sarah Ward) MDT SAI recommendations w b. SAI action plans	- Sarah gave an overview of the MDT improvement recommendations as per attached document - Tumour sites – 11 in total - Discussed MDT SAI recommended work plan - Working alongside Mary Haughey – hoping to have finished Mary or June at latest - Sarah invited staff to look over and advise if they have queries (continued work being done)

i.	**SAI Action plan** Wendy included other SAI's sheet - Discussed SEC action plans 30/3/ c. Wendy to meet with Joanne regularly, these are discussed at patient safety meetings **Complaints / Complements** 1 Pers – waiting times 2 Perso – waiting times (Enniskillen patients)
Staffing	**Staffing** – concerning – recruitment ongoing for Urology Consultant, once Mr Young retires will be down to 3.5 permanent consultants and 1 locum Wendy to chase up recruitment with HSC elocum and Medical staffing teams
Urology CNS Update	• Leanne & Mary Haughey - working with National Cancer Control Programme Dublin re. prostrate review clinic – share experience • Typing backlog and lack of staff causing issues – need for solution as this will get worse – Catherine works 18 ¾ hrs Becky was typing – backlog to 28/2 • Lux service – Leanne will keep team updated • Jenny/Saba – female & male LUTS meetings – rearrange admin meeting re. PAS • Red beds/contact wards - Turnaround is slow - Emergency theatre is slow - Communication problem in recovery/theatre/ward – lack of communication – re covid status not communicated from ward and pathway
AOB	**None**
Next meeting	**Thur 7/4/22 at 12:45pm**

MDT SAI Recommendations Work Plan

Rec	From SAI Report
1	The Southern Health and Social Care Trust must provide high quality urological cancer care for all patients.
	How This Will Achieved From SAI Report
	This will be achieved by - Urology Cancer Care delivered through a co-operative multi-disciplinary team, which collectively and inter-dependently ensures the support of all patients and their families through, diagnosis, treatment planning and completion and survivorship.
Rec	**From SAI Report**
2	All patients receiving care from the SHSCT Urology Cancer Services should be appropriately supported and informed about their cancer care. This should meet the standards set out in Regional and National Guidance and meet the expectation of Cancer Peer Review.
	How This Will Achieved From SAI Report
	This will be achieved by - Ensuring all patients receive multidisciplinary, easily accessible information about the diagnosis and treatment pathway. This should be verbally and supported by documentation. Patients should understand all treatment options recommended by the MDM and be in a position to give fully informed consent.
Rec	**From SAI Report**
3	The SHSCT must promote and encourage a culture that allows all staff to raise concerns openly
	How This Will Achieved From SAI Report
	This will be achieved by - Ensuring a culture primarily focused on patient safety and respect for the opinions of all members. The SHSCT must take action if it thinks that patient safety, dignity or comfort is or may be compromised. Issues raised must be included in the Clinical Cancer Services oversight fortnightly agenda. There must be action on issues escalated.
Rec	***From SAI Report***
4	The Trust must ensure that patients are discussed appropriately at MDM and by the appropriate professionals.
	How This Will Achieved From SAI Report
	This will be achieved by - All MDMs being quorate with professionals having appropriate time in job plans.This is not solely related to first diagnosis and treatment targets. Re-discussion of patients, as disease progresses is essential to facilitate best multidisciplinary decisions and onward referral (e.g. Oncology, Palliative care, Community Services).
Rec	**From SAI Report**
5	The Southern Health and Social Care Trust must ensure that MDM meetings are resourced to provide appropriate tracking of patients and to confirm agreed recommendations / actions are completed
	How This Will Achieved From SAI Report

MDT SAI Recommendations Work Plan

	This will be achieved by - Appropriate resourcing of the MDM tracking team to encompass a new role comprising whole pathway tracking, pathway audit and pathway assurance. This should be supported by fail-safe mechanisms from laboratory services and Clinical Nurse Specialists as Key Workers A report should be generated weekly and made available to the MDT. The role should reflect the enhanced need for ongoing audit / assurance. It is essential that current limited clinical resource is focused on patient care.
Rec	**From SAI Report**
6	The Southern Health and Social Care Trust must ensure that there is an appropriate Governance Structure supporting cancer care based on patient need, patient experience and patient outcomes.
	How This Will Achieved From SAI Report
	This will be achieved by - Developing a proactive governance structure based on comprehensive ongoing Quality Assurance Audits of care pathways and patient experience for all. It should be proactive and supported by adequate resources.This should have an exception reporting process with discussion and potential escalation of deficits. It must be multidisciplinary to reflect the nature of cancer and work with other directorates.
Rec	**From SAI Report**
7	The role of the Chair of the MDT should be described in a Job Description, funded appropriately and have an enhanced role in Multidisciplinary Care Governance.
	How This Will Achieved From SAI Report
	Not specifically set out in the recommendation of the overarching report
Rec	**From SAI Report**
8	All patients should receive cancer care based on accepted best care Guidelines (NICAN Regional Guidance, NICE Guidance, Improving Outcome Guidance).
	How This Will Achieved From SAI Report
	This will be achieved by - Ensuring the multi-disciplinary team meeting is the primary forum in which the relative merits of all appropriate treatment options for the management of their disease can be discussed. As such, a clinician should either defer to the opinion of his / her peers or justify any variation through the patient's documented informed consent.
Rec	**From SAI Report**
9	The roles of the Clinical Lead Cancer Services and Associate Medical Director Cancer Services should be reviewed. The SHSCT must consider how these roles can redress Governance and Quality Assurance deficits identified within the report.
	How This Will Achieved From SAI Report
	Not specifically set out in the recommendation of the overarching report
Rec	**From SAI Report**
10	The families working as "Experts by Experience" have agreed to support implementation of the recommendations by receiving updates on assurances at 3, 6 and 12 monthly intervals.

MDT SAI Recommendations Work Plan

	How This Will Achieved From SAI Report
	Not specifically set out in the recommendation of the overarching report
Rec	**From SAI Report**
11	The Southern Health and Social Care Trust should consider if assurance mechanisms detailed above, should be applied to patients or a subset of patients retrospectively.
	How This Will Achieved From SAI Report
	Not specifically set out in the recommendation of the overarching report

ID	Incident date	Time	Site	Division	Service Area	Speciality	Loc (Exact)	Severity	Description	Action taken	Lessons learned	Approval status	Closed	Directorate	Staff groups
Personal Information	04/10/2021	01:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Ward is understaffed - (1)Wing 7 patients with assistance of 2, there is 2 1:1 unsettled patients, we are down 1 care assistant and 1 nurse initially. A nurse turned up to help but was sick after 4 hours. A patient complained that she was disregarded because of delayed help and of staff being racist on her- not attending her even she was asking help.	informed bed manager about the shortage of staffs, and arising issues with patient against staffs. Ad staffs becoming distress in return and wanting to leave the ward.	Ongoing staffing gaps throughout the trust.	Finally approved	17/11/2021	ACUTE	
Personal Information	11/02/2022	20:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	unwitnessed fall, found by staff. Another patient states he didn't fall but slid off the bottom of the bed while trying to stand up but didn't hit his head.	NEWS, gcs, Blood glucose carried out. nurse in charge informed. doctors informed and assessed. post falls pathway commenced. patient was hoisted back to bed, 1:1 supervision	Adequate staffing needed to facilitate 1:1 supervisions	Finally approved	15/02/2022	ACUTE	
Personal Information	29/06/2021	10:07	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	Security were requested by 3 South to assist staff with administering medication to an unsettled patient.	Security arrived to 3 South and stood by while nursing staff administered medication to a male patient. The patient remained calm throughout and security assistance was not required. Security were then stood down.	patient to be placed in most appropriate environment Staffing to be supplied from PNH is funding for same to support the ward Ensure staff and patient safety is focus Staff trained for MAPA	Finally approved	30/07/2021	ACUTE	
Personal Information	29/06/2021	15:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Patient Personal Information is a patient usually housed in woodlawn and has a hypoxic brain injury, usually 3:1 supervision and at times can take 5 to restrain him. While he has been in hospital woolawns had been providing 3 members of MAPA trained staff however last night they informed NIC that they could no longer provide these staff. Same escalated to Bed manager, lead nurse and HOS this am and shifts put out to bank for MAPA trained staff. Personal Information came in at 12MD to stay with Personal Information until he was discharged, during this time she did not get a break as there was no one MAPA trained to cover her, she also sustained injuries from patient, scratches on her face, chest and neck.	Security rang multiple times, LD consultant also in attendance all day, HOS + Lead nurse aware of no other MAPA trained staff on the ward but unable to locate any further. I asked multiple times could I get Personal Information anything, offered to ring security multiple times to relieve Personal Information for her breaks but she insisted she didn't want to further upset Personal Information.	more appropriate placement of patients by patient flow. also more appropriate admission pathways for patients with LD eg ACAH to his NH Patient had funding for level of supervision required, however as was moving homes, funding had stopped and ward was left with no trained staff to support.	Finally approved	29/06/2021	ACUTE	
Personal Information	10/08/2021	07:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ENT	3 South	Minor	As the front wing of 3south had been turned into a red zone with AGPs in progress, included airvo and NIV. Wen these patients were first brought up to 3south an AMU nurse that was trained in these procedures was nursing said patients. However due to pressures all over the hospital AMU have been unable to supply a trained nurse. Leaving 3south nurses to look after patients undergoing treatment with NIV/ Airvo. 10.8.21 came on duty with a patient on airvo and with no trained staff on was expected to nurse the airvo patient - with no training, leaving both myself and the patient at risk. Later on in the morning respiratory physio was on the ward and talked myself and some other nurses through the workings of airvo. This however does not equal adequate or legal training. Again I understand the pressure through out the hospital and realize everyone is being forced to do things out of their capabilities, it is my role as a nurse to escalate and document these concerns.	Senior management in the trust all acutely aware of the circumstances on the ward.	as above	Finally approved	27/08/2021	ACUTE	
Personal Information	12/11/2021	13:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ENT	3 South	Moderate	12.11.21 due DCN was unable to attend for duty as he was covid +ve, all week has been an intense struggle with staffing and lack of senior staff. band 7 out due to covid in house hold, two band 6s already out sick with DCN being the 3rd, one band 6 on night duty. I was unable to come to work yesterday. DCN escalated his absence as early as possible to lead nurse. Agency SN was able to take charge in the AM as she had only just left the trust and previously was a permanent member of staff in 3south with NIC experience. However in the afternoon the permanent staff left in 3south consisted off 2 band 5s that are less than a month qualified, a international nurse still in her preceptorship and still requiring a lot of support along with a band 5 still supernumery and it was only her 3rd shift on the ward and 2 agency nurses from 1North. a very junior band 5 less than a month qualified was left in charge with no support from management which thus left her extremely overwhelmed. SMT then made the decision to flip the ward out of hours and patientflow continued to put increasing pressure on this very junior nurse without offering any form of support and leaving her feeling bullied during the process.	Lead nurse aware of staffing issues on this date and assumingly same was escalated higher.	SMT to consider staff well being and better support	Finally approved	23/11/2021	ACUTE	
Personal Information	28/01/2021	09:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Moderate	UNABLE TO IDENTIFY MEMBER OF STAFF INVOVLED. NOTE PEOPLE IDENTIFIED ABOVE ARE PATIENT AND WITNESS ONLY. Entered the bay to find patient with non-rebreathe mask in situ sitting out in an armchair. Mask was attached to an empty portable oxygen cylinder in a delta rollator.	Checked patients oxygen sats which were 70%. Attached NRB mask to oxygen to provide oxygen therapy. Changed to face mask at 8L to maintain sats 92%. Informed nurse of patient. Informed doctor of patient and requested ABG and respiratory review.	All staff to be aware of all patients oxygen requirements - same on handovers now. all staff also to be vigilant in switching patients from ambulatory oxygen to piped oxygen as soon as possible after mobilizing. This is now on safety brief to make all staff aware as ward is very busy and has been short staffed - also note a lot of redeployed staff that haven't worked in a ward for some time so safety brief and handovers will raise awareness of same	Finally approved	31/01/2021	ACUTE	
Personal Information	21/04/2021	10:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	bed manager gave a handover on a new patient to come to our ward. it was handed over that the patient was coming from AMU he has history of falls, family not coping at home. this man came from A+E and he is confused up wondering about and needs 1-1 supervision. this was not handed over to us, we were not prepared. we already have 2 1-1 patients on the ward. we don't have enough staff this evening to care for 3 1-1 patients as well as provide safe and efficient care to all the other patients. staff feeling very frustrated and under pressure.	escalated to our lead nurse.	Appropriate information shared between teams to ensure safe patient care.	Finally approved	13/05/2021	ACUTE	
Personal Information	08/12/2021	03:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	another patient in the bay got up to go the toilet and alerted staff that patient was on the floor at his bedside.	he was quickly assessed for injuries, he denied hitting his head, he was assisted by 3 staff up off the floor onto bed. Vital signs and cns obs recorded as per hospital policy. HAN informed for FY1 doctor to review. nurse call bell left in his reach.	To ensure patients at risk of falls are under close supervision and ensure adequate shifts are put out for the acuity of the patients n the ward	Finally approved	07/02/2022	ACUTE	
Personal Information	18/01/2022	18:07	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Insignificant	Personal Information admitted to 3South 14/01/2022. Patient requiring 1-1 supervision and this was provided by security for initial 24 hours. On 18/01/2022 patient required 1-1 this was provided by ward HCA until 14.15. Bed managers had been contacted to request 1-1 from an alternate ward as staff were finding it difficult to manage Personal Information Patient was very agitated and has set off the fire alarm CAH 06 3rd floor zone E07.	Fire and rescue contacted, site manager informed, engineer on call contacted.	nil	Finally approved	31/01/2022	ACUTE	

Personal Information	19/05/2022	15:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Patient had been prescribed 0.9% NaCl with 40mmol KCL over 8 hours for treatment of HHS. Bag of fluids commenced at 10.40 by staff nurse Personal Information and checked by staff nurse Personal Information. At approximately 15.00 it was identified by SHO that patient had been receiving 5% dextrose with 40KCL therefor BM control not reliable. The incorrect fluids were stopped and the correct fluids commenced.	SHO advised of same, nurse in charge advised and all staff involved in same	Once again there were a number of areas of concerns identified within this incident 1: The knowledge of the management of HSS both by ward SHO and nursing staff. Clinical guidance for the safe management of these complex patients is in place with the ongoing inpatient diabetic ward rounds however the translation of policy and guidance into clinical practice is not solely reliant on the knowledge but the application within the clinical context. Is the management of patients treated for likely HHS suitable for a ward staffed by locum medical teams and a high volume of agency nursing staff? 2: Ensuring staff although on pressured timely situations continue to practice safely as per NMC and SHSCT. 3: Identifying additional gaps in the training for more specialized clinical conditions such as HHS and DKA, the use of the sliding scale proforma for pre & post operative patients. Link with DSN and surgical practice educator for same. Clinical supervision/debrief session to be arranged to reflect on the management of this patient.	Finally approved	23/05/2022	ACUTE	
Personal Information	13/01/2022	15:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ENT	3 South	Minor	patient nursed in corridor of ward, not in bed space there are no curtains, oxygen point, suction point or plugs for profiling bed this means the nursing staff are unable to give safe and adequate nursing care. the patients dignity and privacy are not able to be maintained the patient is assistance of 2 with a steady and has became increasingly confused throughout the day, she is distressed and agitated the nursing staff are going against their NMC code of conduct therefore risking their pins# if this patient were to require CPR I would not like to think of the outcome. patient safety, dignity and privacy should be at the forefront of our care and this has not been able to happen due to the position we have been put in we also have 1 extra patient in 2 double side rooms on the ward which have led to the same results of dignity, privacy and safety being questioned	bed manager aware of position of patient as it was HOS and AD who made this decision as per bed management complaints procedure given and explained to patient but unable to understand at present due to confusion	the senior nurse on duty to identify the most suitable patient to be placed as an extra on the ward, to accommidate the ed admission	Finally approved	15/03/2022	ACUTE	
Personal Information	22/04/2021	20:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Moderate	Start the shift with 3 nurses and 2 care assistant. The ward is very unsettled with 4 patient on 1:1 supervision. Sister on day duty aware of this and escalated to the Bed manager. They sent a HCA from AMU. But we still are short anyway from the beginning of the shift. The ward is unsettled due to the numbers of 1:1 supervision. We are pressure to work in the unsafe environment and afraid of the errors being made because of this. The emphasis should be on the Safety of the patient and at the same time staff.	This is reported to the Bed manager in Day and Night. The Sister on day duty aware of this staff deficit.	Exhaust all avenues to ensure adequate cover to maintain patient safety.	Finally approved		ACUTE	
Personal Information	29/06/2021	22:00	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	Night duty last night 29/6/21, back side has only 3 staff present[1 nurse, 2 HCA) 1 nurse did not come up to work, no call or early notice. Hospital is very short as well cannot give staff, able to call 1 nurse to work starting 2100hrs. Ward is very heavy with confused patients, 3 patients needs 1:1, 5 other patients were confused, needs assistance x2 or toileting. 2 patients that needs 1:1 walking and wants to wander up and down the ward. has total of 3 admissions from ED, 1 of which has NEWS 13, the other NEWS 10. 1 patient that is not 1:1 but confused,found lying on the floor(unwitness)	made sure all patients are safe despite lack of staff. other side of the ward HCAs help for the turning of patient. made sure all patients are turned, obs and medications given. contacted FY1 and SHO for assessments of unwell patients.	communication between ward, nurse bank and agencies. updated information by A&E staff on flow to ensure bed management aware of patient needs/condition.	Finally approved		ACUTE	
Personal Information	21/09/2021	17:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ENT	3 South	Minor	No communication to let 3south know that we did not have MA cover today. We also have no FY1 allocated to 3south to help with bloods or other jobs that SHOs struggle to complete. Ward short staffed today due to lack of HCA cover. this am we had no HCAs on the floor due to 1:1 shifts not being picked up. Senior management aware of staffing issues. SHO realized at 1730 that's no bloods had been taken. This obviously has the potential to leave patients at risk, also leaves more work for staff out of hours	Senior management aware of staffing issues on the ward today	Better communication & allocation of staffing	Finally approved	22/09/2021	ACUTE	
Personal Information	11/10/2021	17:45	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	ENT	3 South	Minor	Ward issues. No MA cover today for bloods, same escalated to bed managers. We were short staffed today so struggled to complete bloods ourselves until early afternoon. Doctors aware of no cover for bloods and did not attempt to do any bloods themselves (5 medics on ward in am between consultants and SHOS. out of 8 potential discharges only 2 letters were completed. one patient was awaiting OPATS but was never referred. one patient needed a blister pack and told letter wouldn't be completed in time - thus POC/transport couldn't be arranged one was for home after 6pm IV gent but letter never done so meds unavailable 3 patients bloods weren't back in time and letters not done. Labs contacted ward at 1745 to say that Personal Information HB was 67 previously 70 yesterday and 74 previous to that. Patient was group and held yesterday. I informed SHO Idris of HB result and he said he didn't know the patient, I said bay 1, bed 3 down the front which is the side your on, he said he didn't know the patient as he didn't see her and told me to ring fy1 oncall. Same done. Bed managers aware of ongoing issues	Fy1 oncall contacted re patient with low HB. Bed managers aware of ongoing issues with no MA cover and struggling to get discharge letters completed and was to escalate same to AD.	as above	Finally approved	16/03/2022	ACUTE	

Personal Information	25/02/2021	23:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	3 South	Minor	patient found on the outside of one south's fire exit door, banging and screaming at door. ward staff in one south contacted security. security x2 assisted patient up to three south using handheld assistance. patient assisted to side room. head to toe examination carried out by myself. no obvious injuries. patient very confused. found clothes to be dirty with soil/grit/gravel. patient stated she had fallen twice outside. last checked at 2300 as per rounding chart. phonecall from one south at approx 2330. accusing security and myself from pushing her down the stairs.	as patient stated she had two falls outside I commenced the post falls protocol for an unwitnessed fall. nok made aware contacted the bed manager to secure exit as appears to be broken - estates have been in and have fixed the door issue. asked bed manager for more staff as have safety issues in regards patient care - nil available. at time of incident there was only one staff nurse and HCA on the same ward side. the patient had went off the ward the night previous (was told by staff on ward that it took 6 staff members to assist this patient in from the lift area on nightshift 24th/25th feb) and I was concerned same would happen again - highlighted my concerns to SR Hannah prior to her shift ending as a lot of safety concerns on this side. I was advised the other side of ward warranted more HCA cover - as per SR if require help I may 'borrow staff from other side'. patient in bay one also needing a lot of nursing attention due to low bp and bay 2 patient was receiving a blood transfusion with taco observations - I feel this was an unfair delegation of patients, I nursed my group of patients as safely as I could.	Fluctuating delirium. Fire door checks by housekeeper ongoing. Falls policy ongoing	Finally approved	15/03/2021	ACUTE	

Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

ID	Incident date	Time	Site	Division	Service Area	Speciality	Loc (Exact)	Severity	Description	Action taken	Lessons learned	Approval status	Closed
Personal Information	28/02/2022	13:00	Craigavon Area Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	Thorndale Unit	Moderate	Patient records screened by Prof S. Identified use of Bicalutimide 50mg medication which would not be standard practice. Screened for SCRR internally and threshold met	Patient records subject to SCRR. Datix completed Patient appointed to review clinic to be advised of SCRR		In the holding area, awaiting review	
Personal Information	22/12/2021	13:00	Craigavon Area Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	Thorndale Unit	Moderate	RF referral Oct 2018 seen Dec 2018 and appropriate investigation. Post MDM review Feb 2019, commenced on bicalutamide 150mg but not referred for radical treatment. subsequent FU Dec 2019 and Jan 2020. letter from January 2020 consultation which was referral for EBRT not dictated until 24/3/2020. Subsequently seen by oncology and treated.	Patient seen at Outpatient clinic 22.12.21		In the holding area, awaiting review	
Personal Information	06/10/2020	09:00	Craigavon Area Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	Thorndale Unit	Moderate	Commenced on low dose (subtherapeutic) dose of bicalutamide for prostate cancer. subsequently increased to full dose of bicalutamide but in the setting of localized disease not licensed and outside of guidelines. No documentary evidence of discussion of radical treatment for prostate cancer (as per MDM recommendation). Concerns; 1) full discussion of MDM treatment recommendations not held with patient. 2) Patient commenced on sub-therapeutic dose of treatment and concern this low dose long term may have an adverse impact on disease outcome. 3) Patient commenced on bicalutamide monotherapy for localised prostate cancer which is outside of guidance and recognized as being less effective than standard treatment (and no indication for primary hormone treatment alone in the context of localized prostate cancer in a man fit for radical treatment).	Patient reviewed in clinic, treatment plan of surveillance agreed. Patient aware of concerns re previous treatment.		Being reviewed	
Personal Information	19/01/2021	10:00	Craigavon Area Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	Thorndale Unit	Minor	Staff member developed symptoms and arranged swab. Was not on duty when symptoms developed. Tested positive. Isolated at home. Nil work contacts. Schedule 3 Section 27.	Swabbing and isolation	As above	Finally approved	05/02/2021
Personal Information	09/03/2021	10:30	Craigavon Area Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	Thorndale Unit	Minor	Patient was referred in as red flag by GP with description of "penile ulcer 14/52". In the comment section of referral- reference is made to a name not that of the patient referred. Patient was subsequently triaged and booked to a red flag new clinic in Urology CAH. On attending today patient did not know why he was here and discovery of wrong referral was made. Patient was spoken to by Urology consultant.	GP surgery contacted to see if patient had any need to be referred to urology- also to bring to their attention a patient may have been missed.	When letter was received the name difference on the content of the letter and that of the patient should have been picked up.	Finally approved	09/03/2021
Personal Information	26/02/2022	11:30	Craigavon Area Hospital	Surgery and Elective Care	GENSUR	UROSUR	Thorndale Unit	Minor	Pt arrived for MRI red flag prostate. Pt had embolization coils to renal artery. This was not declared in safety section of request. Make and model of implants should be documented on request/sent to MRI in advance of booking to allow safety check to be performed. Slot was lost. Scan now delayed.	Scan rescheduled pending safety check of embolization coils. Referring clinician informed that details of all implants to be provided when referring.	ensure all provide make and model of all implants when referring for MRI to allow for safety checks	Finally approved	15/03/2022
Personal Information	02/06/2021	13:00	Craigavon Area Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	Thorndale Unit	Minor	Temperature logs for medicines fridge were audited for March, April and May 2021. 10 dates were not recorded for March 2021. SOP states if 6 or more lines have no data then a Datix incident must be recorded.	AD's have been emailed audit results which will be disseminated to particular leads/managers for area/dept.	ensure template reflects the operational days of the clinic so template not blank. Ensure robust checking procedures in place	Finally approved	20/07/2021
Personal Information	17/10/2020	12:00	Craigavon Area Hospital	Surgery and Elective Care	OUTPAT	OUTPAT	Thorndale Unit	Minor	Positive staff member	Swabbed by OH and isolation	as above	Finally approved	02/11/2020

Clayton, Wendy

From: Clayton, Wendy
Sent: 25 April 2022 11:21
To: Haynes, Mark
Subject: Actions from 1:1 meeting

Hi Mark

Actions following our 1:1 meeting today Monday 25/4/22.
It is bank holiday next Monday 2 May so I will send you a link for Mon 9 May

Topic	Discussion	Action
MITRE bladder cancer audit	Email from Melanie Audit to be complete for this Friday 30th April	Mark confirmed will be completed on time
AOB review clinics	Due to clinical sessions, on call and annual leave the only available Wed in May for an all day AOB review clinic is Wed 11th May in ACH	Wendy to organise clinic
Emma Giddings email Regional Urology demand capacity review	Mark and wendy went through Emma's queries	Response with comments emailed to Emma today 25/4/22
Laura and Saba email of 4/4/22 re Speciality doctor roles	Mark and Wendy discussed email. Agreed to meet with both Laura and Saba individually over the next month re support and career progression	Wendy to contact Stephen Wallace to ascertain if there is anything in the GMC for career development of non-consultant staff
Recruitment	Clinical Fellows – 2 x e-reqs complete 1. Susie's maternity leave to commence June 22 2. Backfill Fiona from Aug 22 Consultant recruitment – noted no applicants of the last Urology Consultant interviews Noted a further advert has gone out with closing date mid May 22	Wendy spoke with Joanne McMullan New advert as an enhanced advert in the GMC including New Zealand and Australia Joanne to discuss with Zoe re advertising for a Consulant Urology who is not on a specialists register. This would need to be as a locum for 2 years approx while working towards getting onto the register Joanne to get back to Mark and Wendy
Rota Co-ordination app	It was agreed that Urology would like to pilot a rota co-ordination app	Wendy to discuss further to Zoe to try and progress

Regards

Wendy Clayton
Acting Head of Service for ENT, Urology, Ophthalmology & Outpatients
Ext: Personal Information redacted by the

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Clinical Director – ENT/Urology

DIRECTORATE: Acute Services

RESPONSIBLE TO: Divisional Medical Director - Surgery and Elective Care
Divisional Medical Director – Urology Improvement

ACCOUNTABLE TO: Medical Director

COMMITMENT: 1 PA

LOCATION: Trust wide

Context:

The Clinical Director (CD) on behalf of the Divisional Medical Director (DivMD) will be a leader in Divisional Management Team and member of the Directorate Senior Management Team. The CD will report to the DivMD and will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The CD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The CD will have delegated responsibility on behalf of the DivMD within their areas Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the CD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Specialties / Areas Responsible For

- Ear Nose and Throat Surgery Trust wide.
- Urological Surgical Service Trust wide

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.
- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance –Staffing and Staff Management –Professional Performance Management –Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

Provide medical leadership and direction regarding strategic development of ENT Surgery and Urological surgical Services within the Southern Trust.

Ensure all clinical staff are aware of Trust policies and procedures in relation to good medical practice, and compliant with relevant standards and guidelines.

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.

- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full potential.
- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:
    (a) delivery of safe, high quality and effective person-centred care
    (b) secures activity and performance
    (c) maintains ongoing financial viability
    (d) is aligned to corporate goals
- The Clinical Director will work with the Divisional Medical Directors and the Assistant Director and professional leads, in partnership, to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation
To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of

Revalidation and Appraisal processes including undertaking at least 8 appraisals annually, equating to 0.25SPA of CD allocation.

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Consultants and any other relevant medical staff.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

   - Smoke Free policy
   - IT Security Policy and Code of Conduct

5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Clinical Director – ENT/ Urology

DIRECTORATE Acute Services

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *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** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they 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;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.
2. Hold a medical qualification, GMC registration with Licence to Practice and specialist accreditation (CCT).
3. Experience of leadership within a team that led to successful service development and/or quality improvement.
4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.
6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Mr Ted McNaboe, Interim Divisional Medical Director to allow further discussion of the role of Clinical Director in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Pamela Hall on Personal Information redacted by the USI

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/

Please note that interviews for this post will be held week commencing 28th March 2022 (subject to change).

The post will be for a period of 3 years and will be offered under a separate contract which will attract additional programmed activities of 1PA and a fixed management allowance of £7,400 per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement – which will then apply for the duration of the contract.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Southern Health and Social Care Trust

Quality Care - for you, with you

JOB DESCRIPTION

POST: Interim Divisional Medical Director – Surgery and Elective Care (Up to 24 Months Initially)

DIRECTORATE: Acute Services

RESPONSIBLE TO: Director of Acute Care

ACCOUNTABLE TO: Medical Director

COMMITMENT: 3 PAs

LOCATION: Trustwide

Context:

The Divisional Medical Director (DivMD) will be a leader of the Divisional Management Team, member of the Directorate Senior Management Team and Medical Directors divisional representative. The DivMD will have a lead role in ensuring the division maintains high quality, safe and effective services and will also contribute to the division's strategic direction.

The DivMD will embody HSC values of Openness & Honesty, Excellence, Compassion and Working Together. The Trust is firmly committed to embedding the "right culture" where everyone's "internal culture" or values are realized through the provision of caring, compassionate, safe and continuously improving high quality health and social care.

For the Southern Trust, the "right" culture is underpinned by a collective and compassionate leadership approach, model and behaviours. This Collective Leadership approach will be supported with the implementation of a more collective leadership (CLT) model within the Service Directorates.

Job Purpose:

The DivMD has a lead responsibility within the Division for the delivery and assurance surrounding all aspects of Professional and Clinical and Social Care Governance.

In partnership with the Assistant Director and Professional Leads the DivMD will also be responsible for setting divisional direction; service delivery; development; research and innovation; collaborative working; communication; financial and resource management; people management and development; information management and governance and performance management.

Main Duties / Responsibilities

- To develop a culture of collective and compassionate leadership.
- To medically lead on all aspects of patient safety.
- To lead on all aspects of medical professional and clinical and social care governance including:

• Professional Medical Governance – Staffing and Staff Management – Professional Performance Management – Appraisal and Revalidation • Adverse and Serious Adverse Incident Management • Litigation and Claims Management • Coronial Matters • Complaints • Morbidity and Mortality • Patient Safety (Including Infection Prevention and Control) • Medications management	• Research and Development • Risk Management / Mitigation and Reduction • Learning from Experience • Medical Education in conjunction with DMD/ Dir Med Ed • Medical Workforce development • Quality Improvement • Clinical Audit • Education, Training and Continuing Professional Development • Ensuring Delivery of Effective Evidence-Based Care • Patient and Carer Experience and Involvement • Medical leadership in delivery of MCA and Safeguarding

Specific Divisional Responsibilities

- On behalf of the Medical Director represent the Trust in regional service development discussions including the development of regionalized surgical services
- Represent the Trust on the Surgical Regional Priority Operational Group

Leadership Responsibilities

- To provide assurance on the quality of the professional, clinical and patient safety / Multi-Disciplinary Team systems, processes and meetings within the division.
- To promote quality improvement and to grow and embed a culture of Collective Leadership within the Division.
- To manage the clinical quality of care within the Division, promoting a climate of continuing excellence and developing a positive culture to ensure patient safety and outstanding clinical practice and performance.
- To promote and strengthen links with primary care services including communications and development of service pathway improvements.
- To develop and ensure guidelines and clinical pathways are maintained and embedded within clinical and social care governance structures and culture.
- To be a leader in the alignment and commitment of developing a culture that delivers caring, compassionate, safe and continuously improving high quality health and social care.
- To be a leader in developing an inspiring vision that is put into practice at every level within the division, identify clear, aligned objectives for all teams, departments and staff, provide supportive enabling people management, develop high levels of staff engagement, support learning, innovation and quality improvement in the practice of all staff.
- To be a leader in engagement within the Division and foster a climate that respects diversity and individual contribution, values team-working, encourages innovation and creative thinking, and develops individuals to achieve their full

potential.

- To strategically manage and develop the inter-relationships with primary care, the HSCB, and other key stakeholders, in order to develop effective patient pathways.
- To actively contribute to the development and delivery of the Trust strategy and business plan.
- To be a leader in the development and delivery of the Division business plan, ensuring that this plan ensures:

  (a) delivery of safe, high quality and effective person-centred care

  (b) secures activity and performance

  (c) maintains ongoing financial viability

  (d) is aligned to corporate goals

  The Divisional Medical Director with the Assistant Director and professional leads will work in partnership to achieve the above objectives.
- To be a leader in the development of key performance indicators for the Division and to ensure that effective performance management arrangements are in place.
- To ensure robust financial management of all medical staff across the Division.
- To contribute to the effective leadership and management of all staff within the Division, and professional leadership for medical staff.
- To contribute to the effective management of all staff within the division and work with colleagues in other Divisions and Corporate services in the pursuit of the corporate agenda and in the delivery of the objectives of other Divisions.
- To model the HSC values.
- To act as an advocate for the Division.
- To represent the Division at the relevant senior Trust meetings.
- To participate in Major Incident Planning for the Trust and to participate in the relevant on-call rota.
- To ensure that systems are in place so that all Health and Safety and other statutory requirements for patients, visitors, employees and contractors and the wider public are met.
- Further to discussion and agreement, to undertake other duties as and when required by the Director or Medical Director.
- Regularly review key service data in conjunction with Director/ Assistant Director/ Heads of Service and advise on delivery options.
- To provide quarterly updates on the progress of aspects of professional and social care governance.
- Perform any other duties that are consistent with the post.

Appraisal and Revalidation

To work with the Appraisal and Revalidation Team to ensure that all doctors are engaged in Appraisal and Revalidation in a timely fashion.

Through the Collective leadership team and medical management structures to ensure that areas of concern raised within the Appraisal and Revalidation process are addressed.

In conjunction with the Medical Director's Office to be involved in the oversight of Revalidation and Appraisal processes including undertaking at least 8 appraisals annually, equating to 0.25SPA of DivMD allocation.

Job Planning

- Provide leadership and support for Job planning process within the Directorate for Consultants, Associate Specialists and Specialty Doctors.
- Co-ordinate the implementation of Job Planning within Job Planning guidelines.
- Monitor the completion of Job Plans within agreed timescales.
- Undertake Job Planning for Clinical Directors (and Lead Clinicians) and any other relevant medical staff.
- Advise and mediate in cases that cannot be resolved by Clinical Directors within existing job planning guidance.
- Ensure that Job Planning process and outcomes reflects the Directorate's service capacity needs and Service and Budget Agreement with our Commissioner.

Implementation of HR policies for medical staff

- Co-ordinate and monitor implementation of all relevant policies including:
  Annual Leave
  Study Leave
  Performance
  Sickness absence
  Locum cover (long and short term)
- Liaise with Human Resources for appropriate advice and support.
- Liaise with the Director of Medical Education and Training and NIMDTA with regard to junior doctors in training for appropriate advice and support.

Budgetary management

- Monitor financial information on medical staffing to ensure staff costs are within budget including the Division's collective training and development budget for non-training medical staff.
- Receive reports from Finance and work with Finance staff support on management of the budget.
- Take account of medical staffing costs within the Job Planning context.

GENERAL REQUIREMENTS:

The post holder will be required to:

1. Ensure the Trust's policy on equality of opportunity is promoted through his/her own actions and those of any staff for whom he/she has responsibility.

2. Co-operate fully with the implementation of the Trust's Health and Safety arrangements, reporting any accidents/incidents/equipment defects to his/her manager, and maintaining a clean, uncluttered and safe environment for patients/clients, members of the public and staff.

3. The HSC Code of Conduct for Employees sets out the standards of conduct expected of all staff in the Southern Health & Social Care Trust and outlines the standards of conduct and behaviours required during and after employment with the Trust. Professional staff are expected to also follow the code of conduct for their own professions.

4. Adhere at all times to all Trust policies including for example:

- Smoke Free policy
- IT Security Policy and Code of Conduct

5. Contribute to ensuring the highest standards of environmental cleanliness within your designated area of work.

6. Co-operate fully with regard to Trust policies and procedures relating to infection prevention and control.

7. All employees of the trust are legally responsible for all records held, created or used as part of their business within the Trust including patients/clients, corporate and administrative records whether paper-based or electronic and also including emails. All such records are public records and are accessible to the general public, with limited exception, under the Freedom of Information act 2000 the Environmental Information Regulations 2004 and the Data Protection Acts 1998. Employees are required to be conversant with the Trusts policy and procedures on records management and to seek advice if in doubt.

8. Take responsibility for his/her own ongoing learning and development, including full participation in KSF Development Reviews/appraisals, in order to maximise his/her potential and continue to meet the demands of the post.

9. Represent the Trust's commitment to providing the highest possible standard of service to patients/clients and members of the public, by treating all those with whom he/she comes into contact in the course of work, in a pleasant, courteous and respectful manner.

This post may evolve over time and this Job Description will therefore be subject to review in the light of changing circumstances and is not intended to be rigid and inflexible but should be regarded as providing guidelines within which the individual works. Other duties of a similar nature and appropriate to the grade may be assigned from time to time.

It is a standard condition that all Trust staff may be required to serve at any location within the Trust's area, as needs of the service demand.

SOUTHERN HEALTH & SOCIAL CARE TRUST

PERSONNEL SPECIFICATION

JOB TITLE Divisional Medical Director

DIRECTORATE Surgery and Elective Care

Notes to applicants:

1. *You must clearly demonstrate on your application form how you meet the required criteria – failure to do so may result in you not being shortlisted. You should clearly demonstrate this for both the essential and desirable criteria.*
2. *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** – these are criteria all applicants MUST be able to demonstrate either at shortlisting or at interview. Applicants should therefore make it clear on their application form whether or not they 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;*

The following are essential criteria which will initially be measured at Shortlisting Stage although may also be further explored during the interview stage;

1. Applicants must be a permanent Consultant within the Southern Health and Social Care Trust.

2. Hold a medical qualification, GMC registration with Licence to Practice and specialist accreditation (CCT).

3. Experience of leadership within a team that led to successful service development and/or quality improvement.

4. Experience of having worked with a diverse range of stakeholders, both internal and external to the organisation, to achieve successful outcomes.

The following are essential criteria which will be measured during the interview stage.

5. Excellent communication skills, both orally and in writing.

6. Be prepared to undertake clinical management development.

IMPORTANT NOTES REGARDING SELECTION PROCESS / INTERVIEW PREPARATION:

A shortlist of candidates for interview will be prepared on the basis of the information contained in the application form. It is therefore essential that all applicants demonstrate through their application how and to what extent their experience and qualities are relevant to this post and the extent to which they satisfy each criterion specified, including clarification around equivalent qualifications.

Prior to interview all shortlisted applicants will be offered the opportunity to meet with Dr Maria O'Kane, Medical Director to allow further discussion of the role of Divisional Medical Director in the Trust. You can do this at any time during the application process or immediately following shortlisting. To arrange a suitable appointment please contact Emma Campbell on Personal Information redacted by the USI

You should also note that shortlisted applicants will be assessed against the criteria stated in this specification as it links to the NHS Healthcare Leadership Model. Candidates who are shortlisted for interview are therefore advised to familiarise themselves with this model to ensure that at interview they can adequately demonstrate they have the required skills to be effective in this demanding leadership role. Further information may be obtained from http://www.leadershipacademy.nhs.uk/healthcare-leadership-model/

Please note that interviews for this post will be held week commencing 5th July 2021 (subject to change).

The post will be for a period of 3 years and will be offered under a separate contract which will attract additional programmed activities of 3PA's and a fixed management allowance of £14,800 per annum. Successful applicants can opt to have the responsibility allowance superannuable or non-superannuable at the outset of the contract agreement – which will then apply for the duration of the contract.

WE ARE AN EQUAL OPPORTUNITIES EMPLOYER

Health and Social Care Board

Via Email Only

To: Chief Executives of each Health & Social Care Trust

From the Chief Executive

Health & Social Care Board
12-22 Linenhall Street
BELFAST
BT2 8BS

Tel: 0300 5550115
Web Site: www.hscboard.hscni.net

Email: Personal Information redacted by the USI

+ Accompanying Paper to all AD's

Date: 8 December 2021

Dear Colleague

REVISED INTEGRATED ELECTIVE ACCESS PROTOCOL (IEAP)

You will be aware of that work had been undertaken to revise the 2008 IEAP which concluded in June 2020.

The Department has considered the revised document and notes the changes that have been made to reflect pathway developments and new ways of working. The changes will have a minor, yet positive impact on patients/service users as reflected in the equality screening.

It has been agreed that the Waiting List Management Unit will support performance managing the implementation of the protocol.

I would appreciate if you could circulate within your respective Trusts for implementation and to note the protocol will be uploaded to the Departmental website.

Yours sincerely

Personal Information redacted by the USI

SHARON GALLAGHER
Chief Executive

Encs

cc: Jim Wilkinson
Lisa McWilliams

INTEGRATED ELECTIVE ACCESS PROTOCOL

June 2020

Integrated Elective Access Protocol

Protocol Summary -

The purpose of this protocol is to outline the approved procedures for managing elective referrals to first definitive treatment or discharge.

Version	**2.0** This guidance replaces the Integrated Elective Access Protocol, 30th April 2008.
Status	Approved
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	30th June 2020	Update and relaunch IEAP to provide updated regional guidance on administration of patients on elective care pathways.	L. Mc Laughlin, Regional IEAP Review Group.

Integrated Elective Access Protocol Review Group

The Integrated Elective Access Protocol Review Group consisted of;

Marian Armstrong, BHSCT,
Roberta Gibney, BHSCT
Andrea Alcorn, NHSCT,
Christine Allam, SEHST,
Anita Carroll, SHSCT,
Paul Doherty, WHSCT,
Deborah Dunlop, WHSCT,
Sorcha Dougan, WHSCT,
Donagh Mc Donagh, Integrated Care
Geraldine Teague, PHA
Linus Mc Laughlin, HSCB

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:	June 2022

Monitoring compliance with protocol

Monitoring compliance with the processes in this document should be part of Trusts internal audit processes.

Contents

Abbreviations

AHP	Allied Health Professional
CCG	Clinical Communication Gateway
CNA	Could Not Attend (appointment or admission)
DNA	Did Not Attend (appointment or admission)
DOH	Department of Health
CPD	Health and Social Care Commissioning Plan and Indicators of Performance Direction,
E Triage	An electronic triage system
GP	General Practitioner
HR	Human Resources (Trusts)
ICU	Intensive Care Unit
IEAP	Integrated Elective Access Protocol
IS	Independent Sector (provider)
IR(ME)R	Ionising Radiation (Medical Exposure) Regulations
IT	Information Technology
LOS	Length of Stay
MDT	Multidisciplinary Team
NI	Northern Ireland
PAS	Patient Administration System, which in this context refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting.
PTL	Primary Targeting List
SBA	Service and Budget Agreement
TCI	To Come In (date for patients)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 1

CONTEXT

1.1 INTRODUCTION

1.1.1 This protocol has been developed to define the roles and responsibilities of all those involved in the elective care pathway and to outline good practice to assist staff with the effective management of outpatient appointments, diagnostic, elective admissions and allied help professional (AHP) bookings, including cancer pathways and waiting list management.

1.1.2 The length of time a patient needs to wait for elective treatment is an important quality issue and is a visible public indicator of the efficiency of the hospital and AHP services provided by the Trust. The successful management of patients who wait for outpatient assessments, diagnostic investigations, elective inpatient or daycase treatment and AHP services is the responsibility of a number of key individuals within the organisation. General Practitioners (GPs), commissioners, hospital medical staff, allied health professionals, managers and clerical staff have an important role in ensuring access for patients in line with maximum waiting time targets as defined in the Department of Health (DOH) Commissioning Plan Direction (CPD) and good clinical practice, managing waiting lists effectively, treating patients and delivering a high quality, efficient and responsive service. Ensuring prompt timely and accurate communication with patients is a core responsibility of the hospital and the wider local health community.

1.1.3 The purpose of this protocol is to outline the approved processes for managing referrals to outpatient clinics, diagnostic procedures, elective procedures and operations and AHP booking procedures, through to discharge, to allow consistent and fair care and treatment for all patients.

1.1.4 The overall aim of the protocol is to ensure patients are treated in a timely and effective manner, specifically to:

- Ensure that patients receive treatment according to their clinical priority, with routine patients and those with the same clinical priority treated in chronological order, thereby minimising the time a patient spends on the waiting list and improving the quality of the patient experience.

- Reduce waiting times for treatment and ensure patients are treated in accordance with agreed targets.
- Allow patients to maximise their right to patient choice in the care and treatment that they need.
- Increase the number of patients with a booked outpatient or in-patient / daycase appointment, thereby minimising Did Not Attends (DNAs), cancellations (CNAs), and improving the patient experience.
- Reduce the number of cancelled operations for non-clinical reasons.

1.1.5 This protocol aims to ensure that a consistent approach is taken across all Trusts. The principles can be applied to primary and community settings, however it is recommended that separate guidance is developed which recognises the specific needs of the care pathway provided in these settings.

1.1.6 The purpose of this protocol is to define those roles and responsibilities, to document how data should be collected, recorded and reported, and to establish a number of good practice guidelines to assist staff with the effective management of outpatient, diagnostic, inpatient and AHP waiting lists. It will be a step-by-step guide to staff, and act as a reference work, for the successful management of patients waiting for treatment.

1.1.7 This protocol will be reviewed regularly to ensure that Trusts' policies and procedures remain up to date and that the guidance is consistent with good practice and changes in clinical practice, locally and nationally. Trusts will ensure a flexible approach to getting patients treated, which will deliver a quick response to the changing nature of waiting lists, and their successful management.

1.2 METHODOLOGY

1.2.1 The Department of Health (DOH) has set out a series of challenging targets for Trusts in Northern Ireland in the field of elective treatment management. Trusts will recognise the need to move the treatment agenda forward in the context of its shared responsibility for the delivery of these goals.

1.2.2 In this context, this protocol has been prepared to provide clarity of purpose within Trusts with a view to merging seamlessly with the policies of other agencies in the wider health community as they emerge.

1.2.3 This protocol has been prepared to clarify Trusts' medium and long-term objectives, set the context in which they will be delivered and establish the parameters within which staff at divisional, specialty and departmental levels will operate.

1.2.4 For the purposes of this protocol, the term;

- outpatient refers to a patient who has a clinical consultation. This may be face to face or virtual,
- elective admissions refer to inpatient and daycase admissions,
- inpatient refers to inpatient and daycase elective treatment,
- diagnostic refers to patients who attend for a scan / test or investigation,
- AHP refers to allied health professionals who work with people to help them protect and improve their health and well-being. There are thirteen professions recognised as allied health professions in Northern Ireland (NI),
- partial booking refers to the process whereby a patient has an opportunity to agree the date and time of their appointment,
- fixed booking refers to processes where the patient's appointment is made by the Trust booking office and the patient does not have the opportunity to agree/confirm the date and time of their appointment,
- virtual appointment refers to any appointment that does not involve the physical presence of a patient at a clinic, (see also 1.5 Virtual Activity).
- PAS refers to all electronic patient administration systems, including PARIS, whether in a hospital or community setting and those used in diagnostic departments such as NIPACS and systems used for other diagnostics / physiological investigations.

1.2.5 Trusts must maintain robust information systems to support the delivery of patient care through their clinical pathway. Robust data quality is essential to ensure accurate and reliable data is held, to support the production of timely operational and management information and to facilitate clinical and clerical training. All patient information should be recorded and held on an electronic system (PAS). Manual patient information systems should not be maintained.

1.2.6 All staff involved in the administration of waiting lists will ensure that Trusts' policies and procedures with respect to data collection and entry are strictly adhered to. This is to ensure the accuracy and reliability of data held on electronic hospital/patient administration systems and the waiting times for treatment.

1.2.7 Trusts should provide training programmes for staff which include all aspects of this Integrated Elective Access Protocol (IEAP). It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts. Trusts will provide appropriate information to staff so they can make informed decisions when delivering and monitoring this protocol. All staff involved in the administration of waiting lists will be expected to read and sign off this protocol.

1.2.8 This protocol will be available to all staff via Trusts' Intranet.

1.3 UNDERPINNING PRINCIPLES

1.3.1 Patients will be treated on the basis of their clinical urgency with urgent patients seen and treated first. The definition of clinical urgency will be defined and agreed at specialty / procedure / service level.

1.3.2 Patients with the same clinical need will be treated in chronological order on grounds of fairness, and to minimise the waiting time for all patients.

1.3.3 As part of a plan for the implementation of booking, Trusts must ensure their elective admission selection system is managed on a chronological basis within clinical priority.

1.3.4 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be "fit, ready, and able" to come in (TCI).

1.3.5 Trusts should design processes to ensure that inpatient care is the exception for the majority of elective procedures and that daycase is promoted. The principle is about moving care to the most appropriate setting, based on clinical judgement. This means moving daycase surgery to outpatient care and outpatient care to primary care or alternative clinical models where appropriate.

1.3.6 Referrals into Trusts should be pooled where possible as the norm within specialties.

1.3.7 Trusts will maintain and promote electronic booking systems aimed at making hospital appointments more convenient for patients. Trusts should move away from fixed appointments to partially booked appointments.

1.3.8 Trusts should also promote direct access services where patients are directly referred from primary and community care to the direct access service for both assessment and treatment. Direct access arrangements must be supported by clearly agreed clinical pathways and referral guidance, jointly developed by primary and secondary care.

1.3.9 For the purposes of booking/arranging appointments, all patient information should be recorded and held on an electronic system. Trusts should not use manual administration systems to record and report patient's information.

1.3.10 In all aspects of the booking processes, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language.** It is essential that patients who are considered at risk for whatever reason have their needs identified

and prioritised at the point of referral and appropriate arrangements made. Trusts must have mechanisms in place to identify such cases.

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.

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.

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.

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.

1.7.3 A New Technical Guidance has been drafted to facilitate Trusts in the recording of the validation work which can be found on the Data Standards Share Point site. Clinical Coding & Information Standards - StandardsandGuidance (hscni.net)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 2

GUIDANCE FOR MANAGEMENT OF OUTPATIENT SERVICES

2.1 INTRODUCTION

2.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of outpatient services, including those patients whose referral is managed virtually.

2.1.2 The administration and management of the outpatient pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

2.1.3 There will be dedicated booking offices within Trusts to receive, register and process all outpatient referrals.

2.1.4 Fixed appointments should only be used in exceptional circumstances.

2.1.5 In all aspects of the outpatient booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

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.

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.**

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.

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.

2.7.3 CNAs – Patient Initiated Cancellations of Outpatient Appointments

If a patient cancels their outpatient appointment the following process must be followed:

2.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

2.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

2.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

2.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

2.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

2.8 CNAs – HOSPITAL INITIATED CANCELLATIONS

2.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

2.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

2.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

2.8.4 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

2.9 CLINIC OUTCOME MANAGEMENT

2.9.1 Changes in the patient's details must be updated on PAS and the medical records on the date of the clinic.

2.9.2 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

2.10 CLINIC TEMPLATE CHANGES

2.10.1 Clinic templates should be agreed between the consultant and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

2.10.2 Templates will identify the number of slots available for red flag, urgent, and routine and review appointments; specify the time each clinic is scheduled to

start and finish; and identify the length of time allocated for each appointment slot.

2.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

2.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

2.11 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

2.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between hospitals or to independent sector (IS) providers.

2.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 2.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

2.12 OPEN REGISTRATIONS

2.12.1 Registrations that have been opened on PAS should **not** be left open. When a patient referral for a new outpatient appointment has been opened on PAS, and their referral information has been recorded correctly, the patient will appear on the waiting list and will continue to do so until they have been seen or discharged in line with the earlier sections of this policy.

2.12.2 When a patient has attended their new outpatient appointment their outcome should be recorded on PAS within **three** working days of the appointment. The possible outcomes are that the patient is:

- added to appropriate waiting list,
- discharged,
- booked into a review appointment or

- added to a review waiting list.

If one of the above actions is not carried out the patient can get lost in the system which carries a governance risk.

2.13 TIME CRITICAL CONDITIONS

2.13.1 All referrals for new patients with time critical conditions, should be booked in line with the agreed clinical pathway requirement for the patient and within a maximum of the regionally recognised defined timescale from the receipt of the referral (e.g. for suspect cancer (red flag) and rapid access angina assessment the timescale is 14 days).

2.13.2 Patients will be contacted by phone and if telephone contact cannot be made, a fixed appointment will be issued.

2.13.3 If the patient does not respond to an offer of appointment (by phone and letter) the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.4 If the patient refuses the first appointment they should be offered a second appointment during the same telephone call. This second appointment should be offered on a date which is within **14** days of the date the initial appointment was offered and refused. In order to capture the correct waiting time the first appointment will have to be scheduled and then cancelled on the day of the offer and the patient choice field updated in line with the technical guidance. This will then reset the patient's waiting time to the date the initial appointment was refused.

2.13.5 If the patient cancels **two** agreed appointment dates the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.6 If the patient has agreed an appointment but then DNAs the relevant clinical team should be advised before a decision is taken to discharge. Where a

decision is taken to discharge the patient, the patient's GP should be informed.

2.13.7 Where the patient DNAs a fixed appointment they should be offered another appointment.

2.13.8 If the patient DNAs this second fixed appointment the relevant clinical team should be advised before a decision is taken to discharge. Where a decision is taken to discharge the patient, the patient's GP should be informed.

2.13.9 With regard to 2.13.4 to 2.13.8 above, it is the responsibility of each individual Trust to agree the discharge arrangements with the clinical team.

2.13.10 If the patient is not available for up to **six** weeks following receipt of referral, the original referral should be discharged a second new referral should be opened with the same information as the original referral and with a new date equal to the date the patient has advised that they will be available and the patient monitored from this date.

2.14 TECHNICAL GUIDANCE

2.14.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re;

- Acute activity definitions.
- Effective Use of Resources policy.

2.14.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage)
- Biologic therapies activity.
- Cancer related information.
- Centralised funding waiting list validation.

- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Outpatients who are to be treated for Glaucoma.
- Management of referrals for outpatient services.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020)

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 3

GUIDANCE FOR MANAGEMENT OF DIAGNOSTIC SERVICES

3.1 INTRODUCTION

3.1.1 A diagnostic procedure may be performed by a range of medical and clinical professionals across many different modalities, including, diagnostic imaging, cardiac imaging and physiological measurement services. These may have differing operational protocols, pathways and information systems but the principles of the IEAP should be applied across all diagnostic services.

3.1.2 The principles of good practice outlined in the Outpatient and Elective Admissions sections of this document should be adopted in order to ensure consistent standards and processes for patients as they move along the pathway of investigations, assessment and treatment. This section aims to recognise areas where differences may be encountered due to the nature of specific diagnostic services.

3.1.3 The administration and management of requests for diagnostics, waiting lists and appointments within and across Trust should be consistent, easily understood, patient focused and responsive to clinical decision making.

3.1.4 It is recognised that diagnostic services are administered on a wide range of information systems, with varying degrees of functionality able to support full information technology (IT) implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

3.1.5 In all aspects of the diagnostic booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language as well as associated legislative requirements such as Ionising Radiation (Medical Exposure) Regulations.** Local booking polices should be developed accordingly.

3.2 KEY PRINCIPLES

3.2.1 Referrals into Trusts should be pooled as the norm where possible.

3.2.2 All diagnostic requests, appointments and waiting lists should be managed according to clinical priority. Priorities must be identified for each patient on a waiting list and allocated according to urgency of the diagnostic procedure. Trusts will manage patients in four priorities, i.e.

1. Red flag (suspect cancer),
2. urgent,
3. routine and
4. planned.

No other clinical priority categories should be used for diagnostic services.

3.2.3 Patients of equal clinical priority will be selected for booking in strict chronological order.

3.2.4 Trusts should work towards an appointment system where patient appointments are **partially booked** (where applicable). Where fixed appointments are being issued, Trusts should ensure that the regional IEAP guidance is followed in the management of patients.

3.2.5 The regional target for a maximum diagnostic waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

3.2.6 Maximum waiting times for urgent patients should be agreed locally with clinicians and/or service managers and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated and capacity issues are quickly identified and escalated.

3.2.7 The outcome of the diagnostic test must be available to the referrer without undue delay and within the relevant DoH targets / standards.

3.2.8 Trusts should ensure that specific diagnostic tests or planned patients which are classified as daycases adhere to the relevant standards in the Elective Admissions section of this document.

3.2.9 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

3.2.10 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

3.2.11 Trusts will work towards providing a single point of contact for all patients with respect to diagnostic appointment services. It is recognised that there will be services which require alternative processes.

3.2.12 Trusts should **not** use manual administration systems to record and report patients who have been booked.

3.2.13 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

3.3 NEW DIAGNOSTIC REQUESTS

3.3.1 All diagnostic requests will be registered on the IT system within **one** working day of receipt. Referrer priority status must be recorded at registration.

3.3.2 Trust diagnostic services must have mechanisms in place to track all referrals (paper and electronic) at all times.

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

3.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

3.3.5 Following prioritisation, requests must be actioned on the IT system and appropriate correspondence (including electronic) issued to patients within **one** working day.

3.3.6 Inappropriate and inadequate requests should be returned to the referral source and the referral closed and managed in line with the PAS/relevant technical guidance, where appropriate.

3.4 CALCULATION OF THE WAITING TIME – STARTING TIME

3.4.1 The starting point for the waiting time of a request for a diagnostic investigation or procedure is the date the request is received into the department.

3.4.2 All referral letters and requests, emailed and electronically delivered referrals, will have the date received into the department recorded either by date stamp or electronically.

3.5 REASONABLE OFFERS

3.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointments, and
- at least **one** offer must be within Northern Ireland (NI), except in those cases where there are no alternative providers within NI.

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.

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.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 4

GUIDANCE FOR MANAGEMENT OF ELECTIVE ADMISSIONS

4.1 INTRODUCTION

4.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of elective inpatient and daycase admissions.

4.1.2 The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

4.1.3 In all aspects of the elective admissions booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

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.

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.

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.

4.5.4 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the admission was refused.

4.5.5 This does not prevent patients being offered earlier appointment dates. If the patient is offered an admission within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

4.5.6 If the patient accepts an admission at short notice, but then cancels the admission, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

4.5.7 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

4.5.8 Providers should have robust audit procedures in place to demonstrate compliance with the above.

4.5.9 To ensure the verbal booking process is auditable, the Trust should make and cancel a TCI date using the date of the second admission date offered and refused for this transaction.

4.6 INPATIENT AND DAYCASE ACTIVE WAITING LISTS

4.6.1 Patients who are added to the active waiting list must be clinically and socially ready for admission on the day of the decision to add the patient to the waiting list, i.e. the patient must be "fit, ready, and able" to come in.

4.6.2 To ensure consistency and the standardisation of reporting with commissioners and the DoH, all waiting lists are to be maintained in the PAS patient information system.

4.6.3 Details of patients must be entered on to the computer system (PAS) recording the date the decision was made to admit the patient or add the patient to the waiting list within **two** working days of the decision being made. Failure to do this will lead to incorrect assessment of waiting list times.

4.6.4 Where a decision to add to the waiting list depends on the outcome of diagnostic investigation, patients should not be added to an elective waiting list until the outcome of this investigation is known. There must be clear processes in place to ensure a decision is made in relation to the result of the investigation and the clinical patient pathway agreed.

4.7 SUSPENDED PATIENTS

4.7.1 At any time a consultant is likely to have a number of patients who are unsuitable for admission for clinical or personal reasons. These patients should be suspended from the active waiting list until they are ready for admission.

4.7.2 A period of suspension is defined as:

- A patient suspended from the active waiting list for medical reasons, or unavailable for admission for a specified period because of family commitments, holidays, or other reasons i.e. a patient may be suspended during any periods when they are unavailable for treatment for personal or medical reasons (but not for reasons such as the consultant being unavailable, beds being unavailable etc.).

- A recommended maximum period not exceeding **three** months.

4.7.3 No patient should be suspended from the waiting list without a suspension end date.

4.7.4 Suspended patients should be reviewed one month prior to the end of their suspension period and a decision taken on their admission.

4.7.5 Every effort will be made to minimise the number of patients on the suspended waiting list, and the length of time patients are on the suspended waiting list.

4.7.6 Should there be any exceptions to the above, advice should be sought from the lead director or appropriate clinician.

4.7.7 Suspended patients will not count as waiting for statistical purposes. Any periods of suspension will be automatically subtracted from the patient's total time on the waiting list for central statistical returns.

4.7.8 No patient added to a waiting list should be immediately suspended. Patients should be recorded as suspended on the same day as the decision was taken that the patient was unfit or unavailable for admission/treatment.

4.7.9 Recommended practice is that no more than 5% of patients should be suspended from the waiting list at any time. This indicator should be regularly monitored.

4.8 PLANNED PATIENTS

4.8.1 Planned patients are those patients who are waiting to be admitted to hospital for a further stage in their course of treatment or surgical investigation within specific timescales.

4.8.2 These patients are not actively waiting for treatment, but for planned continuation of treatment. A patient is planned if there are clinical reasons that determine the patient must wait set periods of time between

interventions. They will not be classified as being on a waiting list for statistical purposes.

4.8.3 Trusts must have systems and processes in place to identify high risk planned patients in line with clinical guidance.

4.8.4 Trusts should be able to demonstrate consistency in the way planned patients are treated and that patients are being treated in line with the clinical constraints. Planned patients should have a clearly identified month of treatment in which it can be shown that the patients are actually being treated.

4.8.5 Trusts must ensure that planned patients are not disadvantaged in the management of planned backlogs, with particular focus on high risk surveillance pathway patients.

4.9 PATIENTS LISTED FOR MORE THAN ONE PROCEDURE

4.9.1 Where the same clinician is performing more than one procedure at one time, the first procedure should be added to the waiting list with additional procedures noted.

4.9.2 Where different clinicians working together will perform more than one procedure at one time the patient should be added to the waiting list of the clinician for the priority procedure with additional clinician procedures noted.

4.9.3 Where a patient requires more than one procedure performed on separate occasions or bilateral procedures by different (or the same) clinician, the patient should be placed on the active waiting list for the first procedure and the planned waiting list for any subsequent procedures.

4.10 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR ADMISSION

DNAs – Inpatient/Daycase

4.10.1 If a patient DNAs their inpatient or daycase admission, the following process must be followed:

4.10.1(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second date should be offered or whether the patient can be discharged.

4.10.1(b) Where the clinical decision is that a second admission should be offered, the admission date must be agreed with the patient. Trusts should put in place local agreements with clinicians regarding those referrals (e.g. red flag) or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

4.10.1(c) Patients who DNA and are not discharged but offered a second date will have their waiting time clock reset to the date of the DNA.

4.10.1(d) Where the clinical decision is that a second date should not be offered, Trusts should contact patients advising that as they have failed to attend they have been discharged from the waiting list. The referring clinician (and the patient's GP, where they are not the referring clinician) should also be informed of this.

4.10.1(e) *Patients being discharged from the list should be advised to contact the Trust if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original date, a clinical decision may be made to offer a second date. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

4.10.1(f) If the patient DNAs the second admission offered then the above steps should be followed.

4.10.1(g) Where a patient DNAs a fixed admission date (i.e. they have not had the opportunity to agree/ confirm the date and time of their admission), they should be offered another date.

4.10.1(h) If the patient DNAs this second fixed admission, they will be removed from the waiting list and the steps in 4.10.1(e) should be followed.

4.10.1(i) Where a patient DNAs a pre-assessment appointment they will be offered another date. If they DNA this second pre-assessment appointment, they will be removed from the waiting list and the above steps in 4.10.1(e) should be followed.

4.10.2 CNAs – Patient Initiated Cancellations of inpatient/daycase admission

If a patient cancels their inpatient/ daycase admission the following process must be followed:

4.10.2(a) Patients who cancel an agreed reasonable offer will be given a second opportunity to book an admission, which should ideally be within **six weeks** of the original admission date.

4.10.2(b) If a second agreed offer of admission is cancelled, the patient will not be offered a **third** opportunity.

4.10.2(c) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second admission, the Trust may exercise discretion to offer a third admission - this should include seeking a clinical review of the patient's case where this is appropriate.

4.10.2(d) Where a decision is taken not to offer a further admission, Trusts should contact patients advising that they have been discharged from the waiting list. The referring clinician (and the GP, where they are not the referring clinician) should also be informed of this.

4.10.2(e) Where a patient CNAs a pre-assessment appointment they should be offered another date. If they CNA this second pre-assessment appointment, the above steps should be followed, as per 4.10.1(h).

4.10.2(f) Patients who cancel their procedure (CNA) will have their waiting time clock reset to the date the Trust was informed of the cancellation.

4.11. CNAs - HOSPITAL INITIATED CANCELLATIONS

4.11.1 No patient should have his or her admission cancelled. If Trusts cancel a patient's admission the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

4.11.2 The patient should be informed of the cancellation and the date of the new admission booked.

4.11.3 Trusts will make best efforts to ensure that a patient's admission is not cancelled a second time for non-clinical reasons.

4.11.4 Where patients are cancelled on the day of an admission/operation as a result of not being fit, they will be suspended, pending a clinical review of their condition. The patient should be fully informed of this process.

4.11.5 Hospital initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of admission a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

4.12 TRANSFERS BETWEEN HOSPITALS or to INDEPENDENT SECTOR

4.12.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trust sites or to independent sector (IS) providers.

4.12.2 Transfers to alternative providers must always be with the consent of the patient and the receiving consultant and be managed in line with PAS technical guidance, (see also Reasonable Offers, ref. 4.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

4.13 TECHNICAL GUIDANCE

4.13.1 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

4.13.2 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- Recording inpatients who need to be added to the 28 day cardiac surgery waiting list.
- Recording paediatric congenital cardiac surgery activity.
- Centralised Funding waiting list validation.
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Obstetric and midwifery activity.
- Patients who are added to a waiting list with a planned method of admission.
- Pre-operative assessment clinics.
- Rapid angina assessment clinic (RAAC).
- Regional assessment and surgical centres.
- Patients waiting for a review outpatient appointment.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.

INTEGRATED ELECTIVE ACCESS PROTOCOL

SECTION 5

GUIDANCE FOR MANAGEMENT OF ELECTIVE ALLIED HEALTH PROFESSIONAL (AHP) SERVICES

5.1 INTRODUCTION

5.1.1 The following protocol is based on recommended good practice guidelines to assist staff with the effective management of the elective booking processes for elective Allied Health Professionals (AHP) services, including those patients whose referral is managed virtually.

5.1.2 Allied Health Professionals work with people of all age groups and conditions, and are trained in assessing, diagnosing, treating and rehabilitating people with health and social care needs. They work in a range of settings including hospital, community, education, housing, independent and voluntary sectors.

5.1.3 The administration and management of the AHP pathway from receipt of referral to appointment within and across Trusts must be consistent, easily understood, patient focused, and responsive to clinical decision-making.

5.1.4 For the purposes of this section of the protocol, the generic term 'clinic' will be used to reflect AHP activity undertaken in hospital, community (schools, daycare settings, leisure and community centres) or domiciliary settings (people's own home or where they live e.g. residential or nursing homes) as AHPs provide patient care in a variety of care locations.

5.1.5 AHP services are administered on a wide range of information systems, with varying degrees of functionality able to support full IT implementation of the requirements of the IEAP. Trusts should ensure that the administrative management of patients is undertaken in line with the principles of the IEAP and that all efforts are made to ensure patient administration systems are made fit for purpose.

5.1.6 There will be dedicated booking offices within Trusts to receive, register and process all AHP referrals.

5.1.7 Fixed appointments should only be used in exceptional circumstances.

5.1.8 In all aspects of the AHP booking process, additional steps may be required for **children, adults at risk, those with physical/learning difficulties and those who require assistance with language**. Local booking polices should be developed accordingly.

5.2 KEY PRINCIPLES

5.2.1 All referrals, appointments and AHP waiting lists should be managed according to clinical priority. A clinical priority must be identified for each patient on a waiting list and allocated according to urgency of the treatment. Trusts will manage new patients in two priorities, i.e.

1. urgent and
2. routine.

No other clinical priorities should be used for AHP services.

5.2.2 Patients of equal clinical priority will be selected for booking in strict chronological order.

5.2.3 Patient appointments for new and review should be **partially booked.** Where fixed appointments are being issued, Trusts should ensure that the IEAP guidance is followed in the management of patients.

5.2.4 The regional target for a maximum AHP waiting time is outlined in the Health and Social Care Commissioning Plan and Indicators of Performance Direction (CPD), https://www.health-ni.gov.uk/doh-management-and-structure (see Ministerial Priorities).

5.2.5 Maximum waiting times for urgent patients should be agreed locally with AHP professionals and made explicit, through internal processes, to booking office staff. Booking staff should ensure that patients are appointed within the clinical timeframe indicated by the professional and capacity issues are quickly identified and escalated.

5.2.6 Patients should not be disadvantaged where a decision is made to assess their clinical need through virtual activity.

5.2.7 Trusts should ensure that clinical templates are constantly reviewed to meet changes in demand and new clinical practice.

5.2.8 Data collection in respect of referrals and waiting times should be accurate, timely, complete and subject to regular audit and validation.

5.2.9 Trusts should **not** use manual administration systems to record and report patients who have been booked.

5.2.10 Trusts should provide training programmes for staff which include all aspects of this IEAP. It is expected that training will be cascaded to and by each clinical, managerial or administrative tier within Trusts.

5.3 NEW REFERRALS

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

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

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

5.3.4 All referrals will be prioritised (including those prioritised via E Triage) within **three** working days of date of receipt of referral.

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

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

5.4 CALCULATION OF THE WAITING TIME

5.4.1 The starting point for the waiting time of an AHP new referral is the date the clinician's referral or self-referral is received by the booking office or, for internal referrals, when the referral is received by the booking office/department. All referrals, including emailed and electronically delivered referrals, will have the date the referral received into the organisation recorded either by date stamp or electronically.

5.4.2 In cases where referrals bypass the booking office, (e.g. sent directly to an allied health professional), the Trust must have a process in place to ensure that these are date stamped on receipt, immediately forwarded to the booking office/department and registered at the date on the date stamp.

5.4.3 The waiting time for each patient is calculated as the time period between the receipt of the referral and the date at the end of the applicable period for the waiting list return. If the patient has been suspended at all during this time, the period(s) of suspension will be automatically subtracted from the total waiting time.

5.4.4 The waiting time clock stops when the first definitive AHP treatment has commenced.

5.5 REASONABLE OFFERS

5.5.1 For patients who are partially booked, a reasonable offer is defined as:

- an offer of appointment, irrespective of provider or location, that gives the patient a minimum of **three** weeks' notice and **two** appointment dates, and
- at least **one** offer must be within Northern Ireland (NI), except for any regional specialties where there are no alternative providers within NI.

5.5.2 If a reasonable offer is made to a patient, which is then refused, the waiting time will be recalculated from the date the reasonable offer was refused.

5.5.3 This does not prevent patients being offered earlier appointment dates. If the patient is offered an appointment within a shorter notice period (i.e. less than three weeks' notice) and refuses it they will not have their waiting time reset.

5.5.4 If the patient accepts an appointment at short notice, but then cancels the appointment, the waiting time can be recalculated from the date of the cancellation as the patient has entered into an agreement with the provider.

5.5.5 Urgent patients must be booked within the locally agreed maximum waiting time from the date of receipt. It is recognised that there will be occasional exceptions to this, where clinical urgency dictates that the patient is appointed immediately. Clearly defined booking protocols will be required to support specialties and booking staff.

5.5.6 Providers should have robust audit procedures in place to demonstrate compliance with the above.

5.5.7 To ensure the verbal booking process is auditable, the Trust should make and cancel an appointment using the date of the second appointment date offered and refused for this transaction.

5.6 REVIEW APPOINTMENTS

5.6.1 All review appointments must be made within the time frame specified by the clinician. If a review appointment cannot be given at the specified time due to the unavailability of a clinic appointment slot, a timeframe either side of this date should be agreed with the clinician. Where there are linked interventions, discussions on a suitable review date should be discussed and agreed with the clinician.

5.6.2 Patients must be recorded on PAS as requiring to be seen within a clinically indicated time. Trusts should actively monitor patients on the review list to ensure that they do not go past their indicative time of treatment.

5.6.3 Review patients who require an appointment within **six** weeks will be asked to agree the date and time of the appointment before leaving the department and PAS updated.

5.6.4 Patients requiring an appointment outside **six** weeks will be placed on a review waiting list, with the agreed clinically appropriate appointment date recorded, and be booked in line with implementation guidance for review pathway patients.

5.6.5 Virtual review appointments, e.g. telephone or video link, should be partially booked. If the patient cannot be contacted for their virtual review they should be sent a partial booking letter to arrange an appointment.

5.7 MANAGEMENT OF PATIENTS WHO DID NOT ATTEND (DNA) OR CANCELLED (CNA) THEIR APPOINTMENT

5.7.1 DNAs – New AHP Appointments

If a patient DNAs their new appointment, the following process must be followed:

5.7.1(a) Patients who have been partially booked will **not** be offered a second appointment and should be removed from the waiting list. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(b) Under exceptional circumstances the AHP professional may decide that a patient who DNAs a first appointment should not be removed from the waiting list and should be offered a second appointment. Trusts should put in place local agreements with AHP professionals, regarding those referrals or specialties where patients may be at risk (e.g. paediatrics or adults at risk) where a second appointment should always be offered.

5.7.1(c) Patients who DNA and are not discharged but offered a second appointment will have their waiting time clock reset to the date of the DNA.

5.7.1(d) *Where patients are discharged from the waiting list (ref. 5.7.1(a)) they should be advised to contact the Trust booking office within **four** weeks of the original appointment date if they consider that the appointment is still required. Where a patient makes contact within the **four** week deadline, and where the Trust considers that unforeseen or exceptional circumstances meant that the patient was unable to attend, the patient should be added to the waiting list at the date that they have made contact with the Trust. If a patient makes contact after the **four** week period they cannot be reinstated.*

5.7.1(e) If the patient DNAs the second appointment offered then the patient should **not** be offered another opportunity to be reinstated. The patient and referrer (and the patients GP, where they are not the referrer) will be informed that, as they have failed to attend their appointment, they have been discharged from the waiting list.

5.7.1(f) Where a patient DNAs a fixed new appointment (i.e. they have not had the opportunity to agree/confirm the date and time of the appointment) they should be offered another appointment.

5.7.1(g) If the patient DNAs this second appointment the above steps should be followed.

5.7.1(h) If a patient DNA's a virtual outpatient appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.2 DNAs – Review Appointments

If a patient DNAs their review appointment the following process must be followed:

5.7.2(a) Where a patient has been partially booked and does not attend, a clinical decision should be taken as to whether a second appointment should be offered or whether the patient can be discharged.

5.7.2(b) Where the clinical decision is that a second appointment should be offered, this should be partially booked.

5.7.2(c) Where the clinical decision is that a second appointment should **NOT** be offered, Trusts should contact patients advising that as they have failed to attend their appointment they will be discharged from the waiting list. The referrer (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.2(d) Patients being discharged from the list should be advised to contact the Trust booking office if they have any queries. Where unforeseen or exceptional circumstances meant that the patient was unable to attend, and the patient makes contact within **four** weeks of the original appointment date, a clinical decision may be made to offer a second appointment. Where this is the case, the patient should be added to the waiting list at the date they make contact with the Trust.

5.7.2(e) If the patient DNAs the second appointment offered then the patient should **NOT** be offered another opportunity to be reinstated. The patient and referrer will be informed that, as they have failed to attend their appointment, they will be discharged from the waiting list.

5.7.2(f) Where a patient DNAs a fixed review appointment where they have not had the opportunity to agree/ confirm the date and time of their appointment, they should be offered another appointment. If they DNA this second fixed appointment, the above should be followed.

5.7.2(g) If a patient DNA's a virtual outpatient review appointment this should follow the above protocol based on whether the appointment is partially booked or fixed. The Trust should ensure that the contact details of the patient are up to date and available.

5.7.3 **CNAs** – Patient initiated cancellations (new and review)

If a patient cancels their AHP appointment the following process must be followed:

5.7.3(a) The patient will be given a second opportunity to book an appointment (where this is still required), which should be within **six** weeks of the original appointment date.

5.7.3(b) Patients who CNA will have their waiting time clock reset to the date the Trust was informed of the cancellation.

5.7.3(c) If a second appointment is cancelled, the patient will **not** normally be given another appointment. Where a decision is taken not to offer a further appointment, Trusts should contact patients advising that they have been discharged from the waiting list. The referring professional (and the patient's GP, where they are not the referrer) should also be informed of this.

5.7.3(d) However, where unforeseen or exceptional circumstances mean that the patient had to cancel a second appointment, the Trust may exercise discretion to offer a third appointment. This should include seeking a clinical review of the patient's case where this is appropriate.

5.7.3(e) If a patient CNA's a virtual outpatient appointment this should follow the above protocol.

5.7.4 Trusts have a responsibility to ensure that children and adults at risk who DNA or CNA their outpatient, inpatient, diagnostic or AHP appointment are followed up by the most appropriate healthcare professional and a clear link to the referring clinician established.

5.8 CNAs – SERVICE INITIATED CANCELLATIONS

5.8.1 No patient should have his or her appointment cancelled. If Trusts cancel a patient's appointment, including a virtual appointment, the waiting time clock will not be re-set and the patient will be offered an alternative reasonable date at the earliest opportunity.

5.8.2 The patient should be informed of the cancellation and a new appointment partially booked.

5.8.3 Trusts will make best efforts to ensure that a patient's appointment is not cancelled a second time for non-clinical reasons.

5.8.4 Service initiated cancellations will be recorded and reported to the relevant department on a monthly basis. Where patients are cancelled on the day of appointment a new appointment should, where possible, be agreed with the patient prior to the patient leaving the department.

5.9 CLINIC OUTCOME MANAGEMENT

5.9.1 There are a number of locations within Trusts where patients present for their AHP consultation. This protocol applies to all AHP areas. It is the responsibility of the PAS/ IT system user managing the attendance to maintain data quality.

5.9.2 Changes in the patient's details must be updated on PAS and the medical records on the date of clinic.

5.9.3 When the consultation has been completed, and where there is a clear decision made on the next step, patient outcomes must be recorded on the date of clinic.

5.10 CLINIC TEMPLATE CHANGES

5.10.1 Clinic templates should be agreed between the relevant AHP professional and service manager. These should reflect the commissioning volumes associated with that service area in the Service and Budget Agreement (SBAs).

5.10.2 Templates will identify the number of slots available for new urgent and routine and review appointments; specify the time each clinic is scheduled to start and finish; and identify the length of time allocated for each appointment slot.

5.10.3 All requests for template and temporary clinic rule changes will only be accepted in writing. A minimum of **six** weeks' notice will be provided for clinic template changes.

5.10.4 All requests for permanent and temporary template changes should be discussed with the appropriate service or general manager.

5.11 TRANSFERS BETWEEN TRUSTS or to INDEPENDENT SECTOR

5.11.1 Effective planning on the basis of available capacity should minimise the need to transfer patients between Trusts or to independent sector (IS) providers.

5.11.2 Transfers to alternative providers must always be with the consent of the patient and the receiving AHP professional, (see also Reasonable Offers, ref. 5.5). Administrative speed and good communication are very important to ensure this process runs smoothly.

5.12 TECHNICAL GUIDANCE

5.12.1 See also Public Health Agency; https://www.publichealth.hscni.net/publications/ahp-services-data-definitions-guidance-june-2015 re Guidance for monitoring the Ministerial AHP 13 week access target.

5.12.2 See also Regional ISB Standards and Guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Standards%20and%20Guidance.aspx re acute activity definitions.

5.12.3 See also PAS technical guidance https://hscb.sharepoint.hscni.net/sites/pmsi/isdq/SitePages/Technical%20Guidance.aspx for recording;

- ICATS waiting times and activity (including paper triage).
- Patients treated (IP/DC) or seen (OP) by an independent sector provider.
- Management of waiting times of patients who transfer between NHS sites (either within NI or the rest of the UK).
- Patients who are to be treated as part of a waiting list initiative / additional in house activity.
- Recording Consultant Virtual Outpatient Activity (June 2020).
- AHP Virtual Consultation Guidance (to be issued).

Integrated Elective Access Protocol (IEAP)

Awareness Sessions for Admin and Clerical Staff within Acute Services Division

Mrs Pauline Matier
Mrs Sharon Glenny
Mrs Phyllis Richardson
Ms Wendy Clayton

OCTOBER/NOVEMBER 2008

Awareness Session Content

- Overview of Out-patient Target and Pathway
- Overview of Diagnostics Target and Pathway
- Overview of ICATS Targets and Pathway
- Overview of Cancer Targets and Pathway
- Study of Elective Targets and Pathway

Out-Patients

Mrs Pauline Matier

Out-Patients

- Achieved maximum waiting time of 13 weeks from referral to first OP appointment in March 2008
- Working towards achievement of 9 week target by end March 2009
  - Internal milestones to achieve this

Underpinning Principles

- Patients are treated on the basis of clinical urgency
- Patients with the same clinical need are treated in turn – Primary Target Lists (PTLs)
- To ensure equity chronological management should exist at specialty/sub-specialty level
- Patients managed in 2 streams – urgent and routine
- Referrals to be registered within 1 working day of receipt and be able to track through system
  - Centralised registration process and dedicated booking function

ICATS

Mrs Pauline Matier

ICATS – Key Messages

- All referrals will be received, registered and processed in nominated Hospital Registration Offices (HROs)
- Referrals will be registered and scanned within 24 hours of receipt and triaged within 3 working days of receipt
- All new and review patients should be partially booked
- Underpinning principles for out-patients apply to ICATS

Diagnostics

Ms Wendy Clayton

Diagnostics - Targets

- All patients will have their diagnostic investigation within 9 weeks of receipt of referral by end March 2009
  - This applies to all imaging, audiology, neurophysiology, urodynamics, cardiology and sleep studies
    - Internal milestones will be set

Diagnostics - DRTT

- The standard for diagnostic reporting turnaround time
  - Urgent Referrals: 100% of results must be verified and dispatched to the referring clinician within 2 (calendar) days of the test being undertaken
  - Routine Referrals: 75% of results must be verified and dispatched to the referring clinical within 2 weeks (14 calendar days, including weekends and public holidays) of the test being undertaken.
    - All routine tests must be reported on within 4 weeks (28 calendar) days.

		13 Week PTL					
		Sep-08			Oct-08		
		Sept DTL	Booked DTL	% Booked	Oct DTL	Booked DTL	% Booked
IMAGING	MAGNETIC RESONANCE IMAGING	4	4	100%	8	8	100%
	COMPUTERISED TOMOGRAPHY	0	0	#DIV/0!	0	0	#DIV/0!
	NON-OBSTETRIC ULTRASOUND	0	0	#DIV/0!	19	12	63%
	BARIUM ENEMA	27	25	93%	67	43	64%
	DEXA SCAN	0	0	#DIV/0!	0	0	#DIV/0!
	RADIO-NUCLIDE IMAGING	0	0	#DIV/0!	32	12	38%
PHYSIOLOGICAL MEASUREMENT	AUDIOLOGY - PURE TONE AUDIOMETRY	0	0	#DIV/0!	7	7	100%
	CARDIOLOGY - ECHOCARDIOGRAPHY	58	55	95%	229	200	87%
	CARDIOLOGY - PERFUSION STUDIES	0	0	#DIV/0!	0	0	#DIV/0!
	NEUROPHYSIOLOGY - PERIPHERAL NEUROPHYSIOLOGY	24	18	75%	91	46	51%
	RESPIRATORY PHYSIOLOGY - SLEEP STUDIES	1	1	100%	8	4	50%
	URODYNAMICS - PRESSURES & FLOWS	9	6	67%	14	4	29%
TOTAL		**123**	**109**	**89%**	**475**	**336**	**71%**

Key Messages

- Clinic outcomes must be recorded on the day
- A standard for reporting of tests will be introduced in 2008 and Trusts will be expected to monitor and audit compliance
- A continuous process of data quality validation must be in place
- Where more than one test is required, the first test should be added to the waiting list, with additional tests noted

TRUST TOTAL	Urgent Activity with Verified Report Within 48 Hour Target (% of Total Urgent Activity)		Urgent Activity with Verified Report Outside of 48 Hour Target (% of Total Urgent Activity)		Urgent Activity Unreported		Total Urgent Activity
	No	%	No	%	No	%	No
MRI	83	47%	88	50%	5	3%	**176**
CT	263	27%	653	67%	62	6%	**978**
US	147	28%	335	64%	40	8%	**522**
DEXA	0	0%	0	0%	0	0%	**0**
Ba Enema	14	38%	11	30%	12	32%	**37**
Nuclear Medicine	1	2%	61	97%	1	2%	**63**
TOTAL	**508**	**28.60%**	**1148**	**64.64%**	**120**	**6.76%**	**1776**

Diagnostics - Endoscopy

- Global Rating Scale (GRS)
  - Web based consensus recording quality improvements in endoscopic services in the NHS
  - Enables endoscopic services to assess how well they provide a patient centred service
  - Trust currently undergoing this process
  - Anticipate a number of changes in how this service is managed, eg, reporting of test results (DRTT)

Cancer

Ms Wendy Clayton

Cancer

- 31 Day target – achieved 95% in 07/08
  - To achieve 98% by 31st March 09
- 62 Day target – achieved 95% in 07/08
  - To achieve 95% by 31st March 09

Key Messages

- Communication with Cancer Trackers
- Cancer pathway crosses outpatients, diagnostics, daycases & inpatients
- All cancer patients on 'Red Flag' pathway are Urgent
- Management of 'Red Flag' patients should be in line with IEAP

Elective Admissions

Mrs Sharon Glenny
Mrs Phyllis Richardson

Elective Admissions - Targets

- 21 weeks maximum waiting time target achieved at 31st March 2008
- Working towards achieving maximum waiting time target of 13 weeks by 31st March 2009
  - Trust has set in place internal milestones to achieve this

Underpinning Principles

- The IEAP requires
  - High level of administrative management to include
    - Corporate, MD and AMDs, OSLs and clerical teams
  - More patient focus and greater transparency
    - Booked patient pathway
    - More patient choice
    - Pooling of lists
  - More discipline in terms of planning and notice
    - Consultant leave policy and scheduling of sessions

Key Messages

- Booking schedules will be developed to support patients having a choice of a date and time TCI – indicative dates should be discussed with patients
  - Fully booked elective pathway
- SDU Visit Recommendations in terms of Booking Processes – progress towards a booking strategy based on dedicated resources to manage the pathway, facilitating choice for patients
  - The Trust should consider development of a dedicated team to manage the booking process and the introduction of choice for theatre and endoscopy sessions, in line with IEAP guidelines
    - Centralised waiting list management – small pockets already in existence across different specialties

Key Messages

- All waiting lists must be maintained on hospital administration systems i.e. PAS
- Following a decision to admit, patients must be added to the relevant waiting list within 2 working days
  - Patients to be added to the Waiting List Form
- All OPCS codes must be entered onto PAS
- Patients should be added to either active or planned waiting lists according to policy definitions
  - Data definitions for Planned, Waiting List, Booked must be adhered to
- Clinical priorities must be identified – 2 streams "Urgent" and "Routine"

Key Messages

- Patients who have agreed the date and time of their admission, and who DNA, will normally be referred back to the referring clinician
- Under exceptional circumstances a clinician may decide that a 2nd admission date should be offered – the second admission date must be agreed with the patient
- Where a fixed appointment has been issued, patients will have 2 opportunities to attend
- If patients cancel their TCI date, they will be given a second opportunity (within 6 weeks)
- Where a hospital initiates a cancellation (for non-clinical reasons), an alternative reasonable TCI date will be offered within a maximum of 28 days

Underpinning Principles

- Robust process developed to ensure compliance with consultant leave policy
  - Taken forward by Medical Directorate Office
- Where a decision to admit depends on the outcome of diagnostic tests, patients should not be added to the elective waiting list until diagnostic results known
- Patients will be given reasonable notice
  - Minimum of 3 weeks and a choice of 2 admission dates

Development of Pre-Operative Services

- 100% of patients for elective procedure must have an appropriate form of pre-operative assessment by 31st March 2009
  - Interim target of 75% by 1st January 2009
- Pre-op assessment will be brought back to the out-patient stage of the journey, initiating with a health screening questionnaire on the day of DTA being made – 100% of patients
- Following review of questionnaire a percentage of patients will require a full face-to-face assessment – anticipated to happen within a week of initial assessment

Personal Treatment Plans (PTPs)

- Personal Treatment Plans must be put in place for patients who:
  - have been cancelled by the hospital
  - are suspended
  - are a potential breach
- The plan should be:
  - agreed with the patient
  - recorded in the patients notes
  - Monitored to ensure the PTP is delivered

Cancellations/DNAs

- Patient DNAs (after accepting reasonable offer) – remove
  - Creates – clinical risk/vulnerable adult
  - Communicate with GP re new date
- Patient cancels/refuses second reasonable TCI offer – can be removed (IS offer is regarded as reasonable)
- All waiting list removals should have a letter to GP and a letter to patient

Hospital Initiated Cancellations

- All hospital initiated cancellations should be escalated to appropriate line manager/operational support lead
- Patient must have another offer within month if maximum wait patient, or within 28 days
- Must have a personal treatment plan
  - New date before cancellation
  - Reason for cancellation recorded
- Letter to be issued with
  - New date
  - Reason for cancellation
  - Apology

Waiting List Suspensions

- Patients can be suspended for social or clinical reasons for a maximum period of 3 months
- If suspending a patient an action plan is needed prior to re-instatement on waiting list to check availablility/fitness for surgery
  - Waiting List Suspensions Policy and PTP
- Suspended patients will have a review date – all review dates will be set up for the 1st of the month (form)
- If unavailable for more than 3 months remove from waiting list
  - Letter to GP and patient
  - Re-refer back when fit and available
- Impact on students/pregnant patients
- Trusts are to ensure that suspension levels are no greater than 5%

Planned Patients

- Planned patients are defined as those patients who for clinical reasons require their treatment at a set point in time in the future
  - Endoscopy patients – repeat procedure in one year
  - Cataract patients – one eye added to waiting list, second procedure is planned
  - Injection patients – first injection waiting list, second and third is planned
- Patients should not be added to a planned waiting list where resource issues are the reasons for being planned, eg, lack of equipment
- Planned patients should be included in scheduling of theatre sessions bearing in mind patients expected admission date.
  - Guidance on the management of planned patients on PAS
- Currently a backlog of planned patients as the Trust focused on delivering access targets – a recovery plan has now been submitted to address the backlog

General Principles

- Don't add to waiting list if
  - Not clinically fit for surgery
  - Still awaiting for diagnostics which prevent surgery
  - Patient undecided or not available immediately
- Patients/GPs should know if patients are on a waiting list and should know if they are removed
- We have responsibility to offer reasonable notice
- Patients have a responsibility to:
  - confirm intention to attend, and
  - actually attend

General Principles

- Need to reduce hospital initiated cancellations and increase our planning cycle
- If it becomes known that a patient has not been added to a waiting list, or incorrectly added to a waiting list – this must be escalated immediately to the appropriate line manager/Operational Support Lead
  - Procedure for dealing with patients who have not been added, or incorrectly added to an elective waiting list
  - Affect on scheduling and Service Delivery Plans

The Way Forward

- Fully booked elective patient pathway
  - Patient attends OPD
  - Added to waiting list on day
  - Complete POA health screening questionnaire
  - If need TCI in less than 6/52 attend POA on same day and leave with date TCI
  - If need TCI after 6 weeks, receive partial booked appointment for POA or have telephone assessment
  - Leave POA appointment with date to come in if appropriate or action plan "to get ready"
- New process/thinking required to deliver this model
  - Links to new theatre management system with POA and direct theatre scheduling
  - Defined capacity planning
  - Administratively intensive initially

Service Delivery Unit Visit - Feedback

- Key recommendations/actions made both at a corporate and operational level
- All patients to be listed on PAS within 2 working days of a decision to list
  - Waiting List Additions Form
- All patients added to WLs should have their procedure coded
  - Achieved
- Patients will only be added to active waiting list if fit/available to come in
  - Trust should continue to monitor performance against standard
- Patients should be managed in 2 streams – urgent and routine
  - Achieved
    - Recognition of red flags

Service Delivery Unit Visit - Feedback

- Planned Patients should be monitored where the indicative month of treatment is in the past
  - A recovery plan to address the backlog to be developed
    - Submitted and funding secured to address backlog
  - Operational capacity planning must take into consideration clinical timeframes for planned patients
    - Service Delivery Plans
    - Scheduling of patients

Service Delivery Unit Visit – Feedback

- Suspended Patients
  - IEAP training programme must highlight the suspension standards and put in place processes to manage same
    - Awareness training today as well as supporting policy document
- Pooled Lists
  - Recognition of the good work in pooling of specialty specific waiting lists
  - Good practice should be shared across the organisation
    - Plans being developed initially for pressured specialties

Service Delivery Unit Visit - Feedback

- Agreed escalation process in place between admin staff (clerks/secretaries managing waiting lists) and operational/senior managers
  - Escalation process for cancellations, Omissions from waiting lists, etc included within this awareness session and supporting information pack
- Cancelled Operations
  - Levels and reasons for cancelling operations should be routinely monitored
    - Data collected via theatres
    - Theatre escalation policy

Appendices

- Please take these away with you today and read them!
  - Flow chart for booking process – draft format
  - Patients to be added to the waiting list form
  - Procedure for Dealing with Patients Who Have Not Been Added, or Incorrectly Added to an Elective Waiting List
  - Personal Treatment Plan (PTP) to be used when backdating patients onto waiting list for elective treatment
  - Guidance for the management of planned patients on PAS
  - End User Letter Codes
  - Procedure for Managing Waiting List Suspensions

Questions

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Integrated Elective Access Protocol (IEAP)

In-Patients and Day Cases
Awareness Sessions
Admin and Clerical Staff

November 2015

Elective Admissions - Targets

- Waiting Time Target – 13 weeks
- Back-stop targets in place for specialties
- Many specialties unable to hold the back-stop targets

Key Messages

IEAP section 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, ie, if there was a bed available tomorrow in which to admit a patient they are fit, ready, and able to come in*

Pre-Operative Services

- Pre-op service currently under review and new model for pre-op being developed
- This model will support the principle that patients are fit and ready for surgery before actually being added to the waiting list

Waiting Lists

- All waiting lists must be maintained on hospital administration systems i.e. PAS/Patient Centre
- Following a decision to admit, patients must be added to the relevant waiting list within 2 working days
  - Patients to be added to the Waiting List Form
- All OPCS codes must be entered onto PAS
- Patients should be added to either active or planned waiting lists according to policy definitions
  - Data definitions for Planned, Waiting List, Booked must be adhered to
- Clinical priorities must be identified – 2 streams "Urgent" and "Routine"
- Red flag patients must be recorded appropriately, eg, method of admission should be "SC", "SO", "SD or "SA"

Reasonable Offers

- *IEAP section 6.7.2, 6.7.3, 6.10.3*
- *"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 patient's chronological wait"*
- *"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 3 weeks' notice and two TCI dates."*
- *"...where fixed TCIs are still being issued, patients should have two opportunities to attend."*
- If a patient accepts an offer which is not three weeks notice, this is still reasonable

Key Messages

- Patients who have agreed the date and time of their admission, and who DNA, will normally be referred back to the referring clinician
- Under exceptional circumstances a clinician may decide that a 2nd admission date should be offered – the second admission date must be agreed with the patient
- Where a fixed appointment has been issued, patients will have 2 opportunities to attend
- If patients cancel their TCI date, they will be given a second opportunity (within 6 weeks where possible)
- Where a hospital initiates a cancellation (for non-clinical reasons), an alternative reasonable TCI date will be offered within a maximum of 28 days

Cancellations/DNAs

- Patient DNAs (after accepting reasonable offer) – remove
  - Communicate with GP re new date
- Patient cancels/refuses second reasonable TCI offer – can be removed (IS offer is regarded as reasonable)
- All waiting list removals should have a letter to GP and a letter to patient
  - CWLRPOAP – 3 letters print – patient, GP, consultant

Hospital Initiated Cancellations

- All hospital initiated cancellations should be escalated to appropriate Line Manager/Operational Support Lead
- Patient must have another offer within month if maximum wait patient, or within 28 days
- Must have a Personal Treatment Plan
  - New date before cancellation
  - Reason for cancellation recorded
- Letter to be issued with
  - New date
  - Reason for cancellation
  - Apology

Waiting List Suspensions

- No patient should be added to a waiting list and then immediately suspended – all patients should be clinically and socially available at the point of listing
- Patients can be suspended for social or clinical reasons for a maximum period of 3 months. This should be recorded on PAS on the same day as the decision was taken that the patient was unfit or unavailable for surgery.
- If suspending a patient an action plan is needed prior to re-instatement on waiting list to check availability/fitness for surgery
- Suspended patients will have a review date – all review dates will be set up for the 1st of the month
- These review dates are not necessarily an appointment for the patient, but a date for administrative management of the patient

Waiting List Suspensions

- The waiting list re-instatement date for patients returning back onto the WL should always be the 1st of the month
- If unavailable for more than 3 months remove patient from waiting list
  - Letter to GP and patient
  - Re-refer back when fit and available
- Trusts are to ensure that suspension levels are no greater than 5%
- Patients who need a TCI date before suspension ends should either be contacted by telephone and date confirmed, sent a word letter, or with agreement from Service Administrators WRI with admin work completed on the same day and WLS again on the same day

Planned Patients

- Planned patients are defined as those patients who for clinical reasons require their treatment at a set point in time in the future
  - Endoscopy patients – repeat procedure in one year
  - Cataract patients – one eye added to waiting list, second procedure is planned
  - Injection patients – first injection waiting list, second and third is planned
- Patients should not be added to a planned waiting list where resource issues are the reasons for being planned, eg, lack of equipment
- Planned patients should be included in scheduling of theatre sessions bearing in mind patients expected admission date.

Personal Treatment Plans (PTPs)

- Personal Treatment Plans must be put in place for patients who:
  - have been cancelled by the hospital
  - are suspended
  - are a potential breach
- The plan should be:
  - agreed with the patient
  - recorded in the patients notes and copied to Service Administrators to validate
  - Monitored to ensure the PTP is delivered

General Principles

- Robust process developed to ensure compliance with consultant leave policy
  - Taken forward by Medical Directorate Office
- Where a decision to admit depends on the outcome of diagnostic tests, patients should not be added to the elective waiting list until diagnostic results known
- Patients will be given reasonable notice
  - Minimum of 3 weeks and a choice of 2 admission dates

General Principles

- Don't add to waiting list if
  - Not clinically fit for surgery
  - Still awaiting diagnostics which prevent surgery
  - Patient undecided or not available immediately
- Patients/GPs should know if patients are on a waiting list and should know if they are removed
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- Patients have a responsibility to:
  - confirm intention to attend, and
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General Principles

- Need to reduce hospital initiated cancellations and increase our planning cycle
- If it becomes known that a patient has not been added to a waiting list, or incorrectly added to a waiting list – this must be escalated immediately to the appropriate Line Manager/Operational Support Lead
  - Procedure for dealing with patients who have not been added, or incorrectly added to an elective waiting list
  - Affect on scheduling and Service Delivery Plans

SBA
Service and Budget Agreement

- This is the level of activity the Trust must deliver for each specialty – out-patients and elective
- Commissioned by Department of Health
- Tolerance of 5% on delivery

House-Keeping

- Dates in the past - must be updated on PAS in a timely manner – this affects SBA performance and waiting times and may ultimately affect the patient not being selected for further procedure date
- Out-Patients with Procedure – these need recorded within 2 working days from date of clinic. A number of specialties are reliant on this activity to count towards SBA delivery, eg, urology and gynae. Coding forms should be completed by clinicians at out-patients.
- Admission Reason/Operation Description - both fields should be used to record the operation description. The operation description field must also be used to record information from the WLA form completed at clinic, eg, consultant only to do, shared trust wide, etc. All information should be recorded in capitals (no lower case characters)
- Planned Patients - If a patient's condition has changed and they clinically urgent requiring admission, the actual method of admission "PL" should not be changed – this will appear on waiting list reports as excessive waiters

House Keeping

- Scheduling Drive
- This should now be used to record all arranged admissions. This is a monthly schedule of all elective and day case lists Used by a variety of staff in forward planning in times of bed pressures
- Used in projecting expected activity down to case level.
- Invaluable in your own teams in times of annual and sickness absence to ensure lists are adequately scheduled and dealt with
- Summary of Monthly Schedule
- Not every specialty completing this, but as a administrative tool is very useful to ensure that sessions are scheduled well ahead, confirmations secured, lists added to TMS etc.

House Keeping

- TMS
- If the scheduling drive is being used to record theatre lists, the management team will be able to access sessions from there in times of bed pressures etc, and therefore sessions on TMS recorded 2 days in advance is sufficient
- If the scheduling drive is not being used, the management team are unable to view the lists and this becomes labour intensive contacting staff to add patients to TMS and is inefficient in responding to Director enquiries.

Questions

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Integrated Elective Access Protocol (IEAP)

Marian Armstrong and Rachel Stewart

Belfast Health and Social Care Trust

Objective of this session

- To explain the principles
- Cut through the ‘jargon’
- Understand what your role is in the process
- Provide you with a reference point

Belfast Health and Social Care Trust

Introduction

- What is IEAP?
- Why do we need it?
- Management of outpatients
- Management of inpatients & day cases
- What does it mean for you in your role?

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What is IEAP?

Integrated Elective Access Protocol has been developed by the Department of Health Performance and Service Improvement Team.

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Why do we need it?

To support elective pathway

- The Elective Pathway is the management of all Outpatient and Inpatient Waiting lists and booking protocol. It helps to define the roles and responsibilities of those involved in this pathway
- It set out how data should be recorded and reported
- It outlines good practice in the effective management of outpatient, diagnostic and inpatient waiting lists
- The principles are transferable to hospital and community

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Management of Outpatients

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

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Management of Outpatients

There are 4 ways that Outpatient referrals come into the Trust

- GP referrals are sent through (CCG) Clinical Communication Gateway – an electronic system which allows GPs to refer directly into the Trust.
- Internal referrals - consultant to consultant within Trust waiting time starts from date referral was received by either secretary or appointments office whichever is 1st
- External referrals - other consultant from outside the Trust waiting starts from date received by Trust
- There are also internal and external referrals which come in from the Private Sector

It is essential that the secretary MUST send any referrals that are received directly to the appointments office.

Belfast Health and Social Care Trust

Management of Outpatients

- All referrals to be registered within ***1*** working day of receipt, and are able to be tracked through the PAS system. This starts the patients clock on the waiting list.
- Patients treated on the basis of clinical urgency
  3 streams only ***Red Flag***, ***Urgent*** and ***Routine***
- Patients with same clinical need are treated in chronological order. This is achieved through pooling within speciality.

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Management of Outpatients

- Triage of referrals

  All referrals should be triage within 3 working days

  Following triage referrals must be actioned on PAS within 1 working day

  GP routine and urgent referrals will be added to Outpatient waiting lists. GP red flag referrals will be appointed to a clinic within 14 days of receipt.

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Management of Outpatients

- Booking of Urgent and Routine Appointments.

Minimum of **3** weeks notice should be provided for all urgent and routine patients

Routine appointments are booked via partial booking system.

Patients invited to contact booking office to arrange their Appointment. There are 3 different appointment types – face to face, telephone and video

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Management of Outpatients

- Reasonable offers

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 (N.I.), except for any regional specialties where there are no alternative providers within N. I.

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.

Management of Outpatients

- Cancellations by patient

If a patient rings to cancel their appointment the patient should be given a second opportunity to book an appointment which should be within **6** weeks of the original appointment

If a second appointment is cancelled the patient will not normally be offered a third appointment and will be referred back to the referrer

Management of Outpatients

DNA's

- If a patient does not attend their appointment after having agreed it through partial booking, they will not be offered a second appointment and will be referred back to the referrer.

  Only in exceptional circumstances a clinician may decide that a patient should be offered a second appointment.

- A patient has also the opportunity to contact the Appointments office within 4 weeks of the original appointment date to make a further appointment if they feel they still require an appointment

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Management of Outpatients

- Cancellation by Hospital

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

All leave which may affect a clinic operating should be booked in advance with a minimum of **six** weeks notice so as to avoid patients being booked into these clinics

The booking team should have responsibility for monitoring compliance with the notification of leave protocol, with clear routes for escalation, reporting and audit.

What does this mean for you in your role?

- Remember the internal timescales!!

  all referrals to be registered within **1** working day of receipt

  all referrals to be prioritised within **3** working days

  all referrals to be actioned on PAS within **5** days from receipt of referral

  partial booking processes to meet **3** week minimum notice for patients

- Importance of data quality!!

- If this is not happening we need to know about it to fix it!!

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Outpatient Receptionist Responsibilities

- Update patient Demographic details on PAS.
- Ensure patient attendance is recorded on PAS, eg ATT, DNA.
- Ensure EVERY patient (including DNA's) has an outcome recorded eg further appointment given, placed on relevant waiting list, discharged, boarding card sent to Inpatient Waiting List Office.
- Ensure all patient notes are case note tracked/IFIT at the end of each clinic and forwarded securely to the relevant secretary or other requested location.

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Management of inpatient & day cases

The administration and management of elective admissions within and across Trusts must be consistent, easily understood, patient focused and responsive to clinical decision making

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Management of inpatient & day cases

- All waiting lists are to be maintained on PAS/BOIS
- Details of patients must be entered off the boarding card within **2** working days of the decision to admit being made
- Inpatient care should be the exception in the majority of elective cases
- Patients should not be added to a waiting list unless there is a real expectation that they will be treated
- Patients will be treated in order of their clinical need

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Management of inpatient & day cases

- Patients with the same clinical need must be treated in chronological order
- Patients should be added to either **active** or **planned** lists according to policy definitions
- Patients treated on the basis of clinical urgency

  2 streams only **urgent** and **routine** unless a surgical priority code is issued

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Management of inpatient & day cases

- Booking schedules should support patients having a choice of date and time of their 'to come in' (TCI) date
- Where a decision to admit depends on the outcome of diagnostic tests, patients should not be added until results known
- Robust process developed to ensure compliance with consultant leave policy (same as with outpatients)
- Patients will be given reasonable notice minimum **3** weeks and choice of **2** admission dates
- Patients can be suspended for social or clinical reasons for a maximum period of **3** months

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Management of inpatient & day cases

- Suspended patients will have a review date – all review dates will be set for the 1st of the month
- Trusts should ensure that suspension levels are no greater than 5%
- Planned patients are waiting to be recalled to hospital based on clinical grounds, rather than on resource requirements
- Patients who have chosen the date and time of the their admission, and who DNA, will normally be referred back to the referring clinician
- Where a fixed appointment has been issued, patients will have 2 opportunities to attend

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Management of inpatient & day cases

- If patients cancel their TCI date, they will be given a second opportunity (within **6** weeks)
- Where a hospital initiates a cancellation (for non-clinical reasons), an alternative date will be offered within a maximum of **28** days
- Treatment plans should be in place for patients who:-
  - Have been cancelled by the hospital
  - Are suspended
  - Are a potential breach
- Pre-operative assessment services must be developed for all patients to be admitted for elective procedures
- A Covid test is required to be booked before an admission or procedure.

HSC Belfast Health and Social Care Trust

What does this mean for you in your role?

- Remember the internal timescales!!

Details of patients must be entered within **2** working days of the decision to admit being made

- Importance of data quality!!
- If this is not happening we need to know about it to fix it!!

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Data Quality

High levels of data quality needed to ensure IEAP protocols are applied fairly

Current reports

- Open registrations
- Open referrals
- Missing outcomes
- New booked into review
- No datewait or datewait same as appointment date
- Waiting list validation

Data Quality

- Open registrations

Patients with no future review date who are not on a waiting list.

Potential risk: Patients not reviewed within an appropriate timeframe.

Data Quality

- Open referrals

What is an open referral?

Patients referred for new or review appointments who have not been booked into an appointment or added to a waiting list.

Potential risk: Patients may be missed or not added to waiting lists in the correct order.

Data Quality

- Missing outcomes

What is a missing outcome? Patients who have been booked in to an appointment on PAS but have not had their outcome recorded i.e. Attended, Cancelled by Patient, DNA.

Potential risk:

Patients who have attended may need a further appointment within 6 weeks / should have been placed on a hold and treat list for review appointment / discharged.

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Data Quality

- New booked into review

Patients who have been referred as new and have been booked into a review appointment will not appear on the Trust weekly waiting list report as waiting for new.

Potential risk: These patients will not appear on the Trust's weekly OP waiting list report as waiting for "new" and if patient booked to a review appointment which is cancelled they will not show on the NOP

Data Quality

- No datewait or datewait same as appointment date

All patients who are booked or admitted from a waiting list should have a datewait value greater than the day of admission. Where this is not the case indicates that the process for admitting patients electively is not being adhered to.

Potential risk: If waiting lists are not being managed properly, patients may be missed, not treated in the correct order or wait longer than necessary.

Data Quality

- Waiting list validation

Are patients on waiting lists under the correct urgency codes – particular focus on adherence to IEAP principles and red flag referrals.

Potential risk: Patients not be treated in the correct priority order or wait longer than necessary.

SAI's

- Ophthalmology – historic source code used for referral which mapped to review appointment type rather than new.

- Cons to Cons referral – letter not forwarded by admin team to appointments office

Available resources to help

- Checklist
- IEAP guidance link on Trust Hub
- Local training manuals
- Waiting list office / appointments office / governance team

Belfast Health and Social Care Trust

Finally any questions?

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Urology PERFORMANCE – December 2021

Urology Priority 2 update as at 09/12/2021:

- P2B = 58 pts
- P2C = 82 pts
- P2D = 233 pts

Total = 373 pts

The priority 2 case load includes a mixture of proven cancers, clinically suspected cancers, and benign disease. Within the proven cancer patients a small number are undergoing multimodality treatment and have narrow treatment windows.

In order for our decision making to be objective and transparent as we assign our limited capacity to patients requiring surgery, it is agreed that we approach this activity along the following priorities, using waiting time (days on surgical waiting list) as the additional metric.

Priority A = proven cancer with short treatment window post chemotherapy / radiotherapy
Priority B = proven cancer
Priority C = suspected cancer
Priority D = benign disease

New Outpatient waiting lists (with no dates)

Total new outpatients on waiting list = **5145 patients**

- There are 134 Red Flags with longest wait = **12 weeks**
- There are 1498 Urgent patients with longest wait = **291 weeks**
- There are 3474 Routine patients with longest wait = **297 weeks**

09/12/2021

Tumour site	Number W/L	Longest wait (weeks)	Comments
Haematuria	61	3 weeks	**61 patients left to book, 2 stragglers, 1 of which patient an inpatient. Once cleansed waiting time only 1-3 weeks**
Prostate	33	12 weeks 8 weeks 1-4 weeks	**Patient waiting 12 weeks is due to a cancellation**
Others	39	5 weeks	
Testes	1	3 week	
TOTAL	134	12 weeks	**Patient waiting 12 weeks is due to a cancellation. Once WL cleansed of 3 stragglers waiting time will be 1-5 Weeks**

New URGENT Outpatients waiting with no dates

	Urgent	Routine
	Dec-21	Dec-21
Weeks waiting	Total with no dates	Total with no dates
0-10	162	215
11-21	111	130
21-30	90	130
31-40	130	122
41-50	96	97
51-60	95	78
61-70	81	84
71-80	111	77
81-90	62	55
91-100	209	154
101-110	177	150
111-120	91	170
121-130	2	154
131-140	1	153
141-150	2	147
151-160	1	139
161-170	0	173
171-180	2	127
181-190	1	138
191-200	1	101
201-210	1	102
211-220	1	106
221-230	1	112
231-240	3	108
241-250	0	117
251-260	0	107
261-270	0	103
271-280	2	76
281-290	1	74
291-300	1	63
301-310	0	12
Total	1435	3574

Urology Referrals per year (year is April-March)

Year	**Total	Average per month
2017-2018	6208	517
2018-2019	6622	551
2019- 2020	6338	528
2020-2021	4589	382
2021-2022 (to 30th November 21)	3668	458

Review outpatient backlog update (as at for 1st December 2021)

	Nov-21		Dec-21	
	Total	**Longest date**	**Total**	**Longest Date**
Glackin	56	May-20	63	May-20
O' Donoghue	441	Mar-17	385	Mar-17
Young	558	Dec-16	519	Dec-16
Haynes	114	Feb-19	125	Feb-19
Omer	46	Mar-18	66	Mar-18
Khan	37	Apr-21	27	May-21
O' Brien	345	Jul-13	326	Jul-13
Tyson	58	May-19	58	May-19
Jacob	42	Jul-17	42	Jul-17
Total	**1697**		**1611**	

Adult Inpatient and Day case waiting lists – position of 10/12/2021

Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Glackin	62	154	63	246	46	164	47	172
O'Donoghue	173	302	35	341	49	253	51	349
Young	203	378	58	383	158	371	157	383
Haynes	85	324	50	361	42	240	40	284
Khan	17	50	3	38	35	119	12	57
O'Brien	138	383	48	374	16	381	20	345
Tyson	39	252	8	138	15	133	9	139
Jacob	13	280	15	298	13	210	70	265
Omer	16	348	1	8	37	68	7	55
Solt	4	151	1	121	4	122	1	121
Total	**750**		**282**		**415**		**414**	

Summary Adults – total = 1861 pts
Urgent Inpatients = 750 patients; longest wait 383 Weeks
Routine Inpatients = 282 patients; longest wait 383 weeks
Urgent days = 415 patients; longest wait 381 weeks
Routine days = 414 patients, longest wait 383 weeks

Urology PERFORMANCE – March 2022

Urology Priority 2 update as at 16/03/2022:

	13/01/2022	20/01/2022	10/02/2022	16/03/2022
P2A	0	0	1 (Done 10/02/2022)	0
P2B	43	36	48	18
P2C	90	92	65	48
P2D	236	249	235	215
TOTAL	**369**	**377**	**349**	**281**

The priority 2 caseload includes a mixture of proven cancers, clinically suspected cancers, and benign disease. Within the proven cancer patients a small number are undergoing multimodality treatment and have narrow treatment windows.

In order for our decision making to be objective and transparent as we assign our limited capacity to patients requiring surgery, it is agreed that we approach this activity along the following priorities, using waiting time (days on surgical waiting list) as the additional metric.

Priority A = proven cancer with short treatment window post chemotherapy / radiotherapy
Priority B = proven cancer
Priority C = suspected cancer
Priority D = benign disease

New Out Patient Waiting List (with no dates)				
	16/02/2022		16/03/2022	
Urgency	**No on WL**	**Longest Wait**	**No on WL**	**Longest Wait**
Red Flags	268	11 weeks	229	19 weeks
Urgent	1454	309 weeks	340	310 weeks
New Urgents with 352			1015	313 weeks
Routine	3642	315 weeks	3632	
Total	**5364**		**5216**	

Red Flag NOP Breakdown					
	16/02/2022		16/03/2022		
Tumour site	**Number on W/L**	**Longest wait (weeks)**	**Number on W/L 16/03/2022**	**Longest wait**	**Comments**
Haematuria	104	11 weeks	75	19 Weeks 11 Weeks	19 Weeks = Upgrade 7 patients to book then longest wait will be 4 weeks
Prostate	75	10 Weeks	61	7 weeks	
Others	88	10 weeks	91	10 weeks	
Testes	2	5 weeks	2	7 weeks	
TOTAL	**269**	**11weeks**	**229**	**19 Weeks**	

New URGENT/ROUTINE Outpatients waiting with no dates. ***As at 16/03/2022***

- 500 New Urgent longest waiters where transferred to the independent sector on 10th January. A further 300 New urgent longest waiters where then transferred 31st January. There has also been an additional 50 patients sent to backfill patients who are returned to Trust
- A further 300 urgent NOP have been transferred in March to be seen in April. With 100 Red Flags to be transferred also ant the end of the month
- Removing the patients transferred to IS the total number of New Urgents is 342.
- Our Longest Urgent NOP waiter is **310 Weeks** Due to an upgrade from Routine
- Due to patients returning to trust for reasons such as not being suitable for IS or refusing IS or 352 being unable to contact our Trust 2nd longest waiter is **210 weeks**.
- There are 151 patients who have returned to trust from 352 due to reasons such as not being suitable for IS or refusing IS or 352 being unable to contact

Breakdown of 352 Urology NOP as at 16/03/2022

Consultation Booked	197
Discharged	368
Awaiting Investigation Results	23
Procedure TBA	94
Investigation TBA	40
Investigation Booked	87
Procedure Booked	43
Consultation TBA	469
Awaiting Discharge	19
Review TBA	46
Review Booked	1
(blank)	
Grand Total	1387

NOP WL breakdown as at 16/03/2022

	Urgent	Routine	Urgent	Routine	Urgent	Routine
	Jan-22	Jan-22	Feb-22	Feb-22	Mar-22	Mar-22
Weeks waiting	Total with no dates	Total with no dates	Total with no dates	Total with no dates	Total with no dates	Total with no dates
0-10	184	216	189	208	206	176
11-20	95	109	110	118	143	149
21-30	95	109	98	123	84	99
31-40	115	138	81	127	84	116
41-50	124	121	116	119	106	125
51-60	77	81	86	96	101	123
61-70	96	83	77	77	52	70
71-80	102	71	78	81	76	80
81-90	82	69	110	74	84	66
91-100	119	111	55	53	58	66
101-110	196	134	192	154	103	123
111-120	163	171	166	149	147	136
121-130	10	160	77	170	95	168
131-140	0	161	2	153	10	155
141-150	0	144	0	152	3	164
151-160	2	128	1	147	1	134
161-170	0	163	2	137	1	131
171-180	2	170	0	174	1	161
181-190	2	130	3	124	0	164
191-200	0	104	2	136	3	134
201-210	0	108	1	98	2	99
211-220	1	92	1	102	1	98
221-230	0	114	0	106	0	100
231-240	1	112	0	111	0	108
241-250	2	110	3	108	2	109
251-260	0	118	0	115	0	119
261-270	0	105	0	107	0	116
271-280	1	87	0	101	0	97
281-290	2	72	2	76	1	89
291-300	0	82	1	73	1	69
301-319	1	31	1	73	3	100
Total	**1472**	**3604**	**1454**	**3642**	**1368**	**3644**

Urology Referrals per year (year is April-March)

Year	**Total	Average per month
2017-2018	6208	517
2018-2019	6622	551
2019- 2020	6338	528
2020-2021	4589	382
2021-2022 (to 28th February 2022)	5203	473

Review outpatient backlog update (as at for 23rd March 2022)

	Jan-22		Feb-22		Mar-22	
	Total	**Longest Date**	**Total**	**Longest Date**	**Total**	**Longest Date**
Glackin	73	May-20	95	May-19	88	May-20
O' Donoghue	405	Mar-17	394	Mar-17	373	Mar-17
Young	500	Dec-16	475	Dec-16	478	Dec-16
Haynes	121	Feb-19	123	Feb-19	120	Feb-19
Omer	69	Mar-18				
Khan	15	May-21	149	Jul-17	62	Jul-17
O' Brien	288	Jul-13	234	Jul-13	187	Jul-13
Tyson	43	May-19			81	Sep-18
Jacob	4	Jul-17				
Solt	10	Oct-19	10	Oct-19		
Fel	4	Dec-20	3	Jan-21		
Mr Brown			2	Apr-17	2	Apr-17
Total	**1532**		**1485**			

Inpatient and Day Case position as at 17/02/2022								
Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Glackin	59	164	64	256	56	174	49	182
O'Donoghue	186	312	37	351	49	254	61	359
Young	206	388	58	393	187	381	173	392
Haynes	87	334	51	371	42	250	41	294
Khan	37	289	20	308	46	220	80	275
O'Brien	130	393	46	384	14	391	18	355
Tyson	63	358	9	148	54	143	25	149
Total	**768**		**285**		**448**		**447**	

Summary of February 2022 position

Summary Adults – total = 1948 pts
Urgent Inpatients = 768 patients; longest wait 393 Weeks
Routine Inpatients = 285 patients; longest wait 393 weeks
Urgent days = 448 patients; longest wait 391 weeks
Routine days = 447 patients, longest wait 392 weeks

Inpatient and Day Case position as at 23/03/2022								
Consultant	Urgent Ins	Weeks Waiting	Routine Ins	Weeks waiting	Urgent D/C	Weeks waiting	Routine DC	Weeks waiting
Glackin	57	169	62	261	59	174	50	187
O'Donoghue	182	317	36	356	49	259	63	364
Young	197	393	59	398	167	370	179	397
Haynes	89	339	51	376	50	255	41	299
Khan	39	294	20	313	49	225	77	280
O'Brien	104	398	43	389	13	396	15	360
Tyson	63	363	26	148	61	148	24	154
Total	**731**		**297**		**448**		**449**	

Summary of March 2022 position

Summary Adults – total = 1925 pts
Urgent Inpatients = 731 patients; longest wait 398 Weeks
Routine Inpatients = 297 patients; longest wait 398 weeks
Urgent days = 448 patients; longest wait 396 weeks
Routine days = 449 patients, longest wait 397 weeks

SOUTHERN HEALTH AND SOCIAL CARE TRUST

Targets for Cancer 2020/21

98% of patients diagnosed with cancer should receive their first definitive treatment within 31 days of decision to treat and at least 95% of patients urgently referred with a suspected cancer should begin their definitive treatment witin 62 days.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

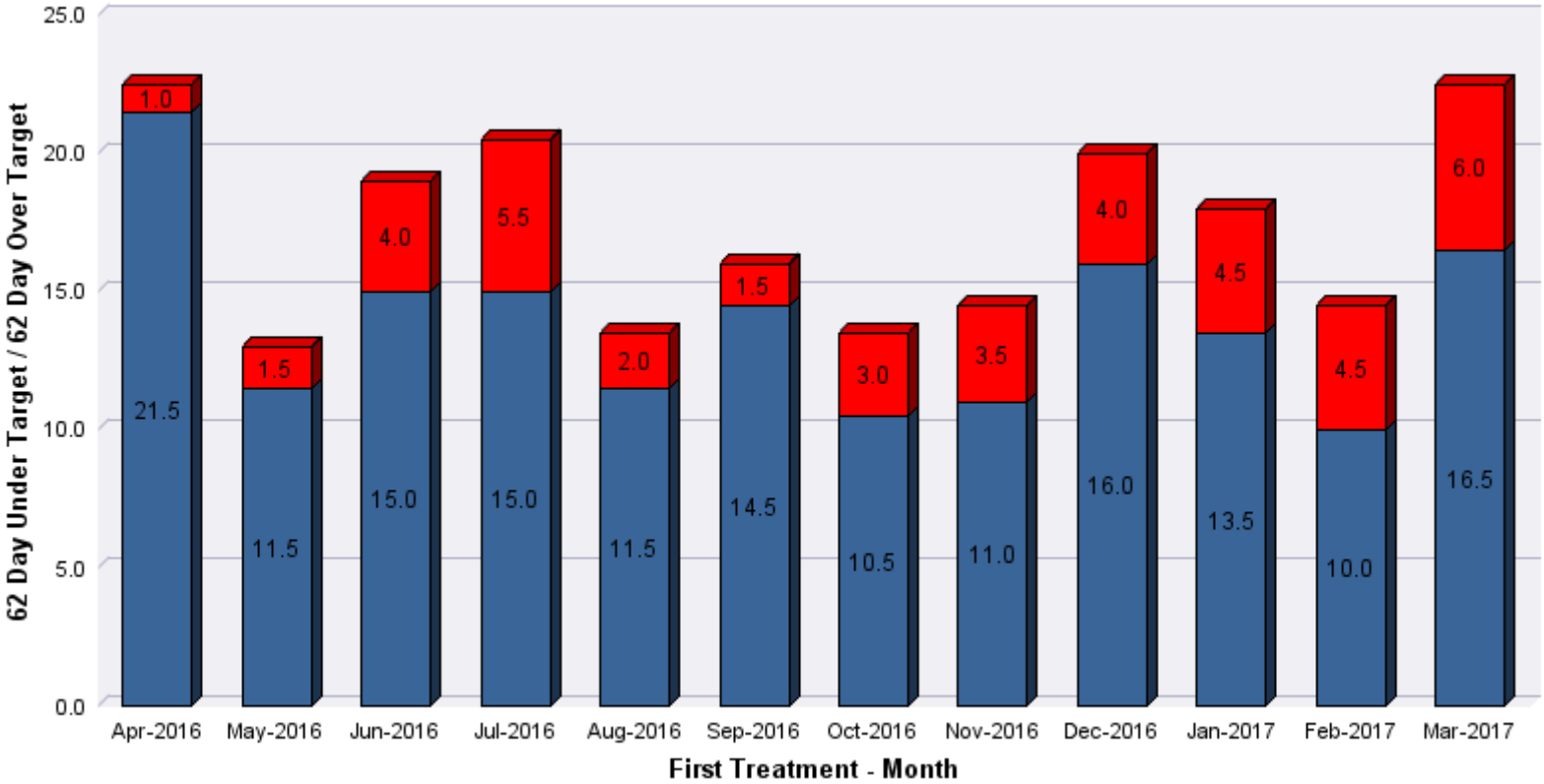
62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2016 TO 31/03/2017

MONTHLY

First Treatment - Month	62 Day Under Target	62 Day Over Target	MONTHLY TOTAL - 62 DAYS
Apr-2016	21.5	1.0	22.5
May-2016	11.5	1.5	13
Jun-2016	15.0	4.0	19
Jul-2016	15.0	5.5	20.5
Aug-2016	11.5	2.0	13.5
Sep-2016	14.5	1.5	16
Oct-2016	10.5	3.0	13.5
Nov-2016	11.0	3.5	14.5
Dec-2016	16.0	4.0	20
Jan-2017	13.5	4.5	18
Feb-2017	10.0	4.5	14.5
Mar-2017	16.5	6.0	22.5
Sum:	166.5	41.0	207.5

Notes: 62 day patients that are transferred between Trusts and breach share 0.5 of that breach. ie. 0.5 assigned to Trust first seen and 0.5 assigned to Trust first treated.



SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

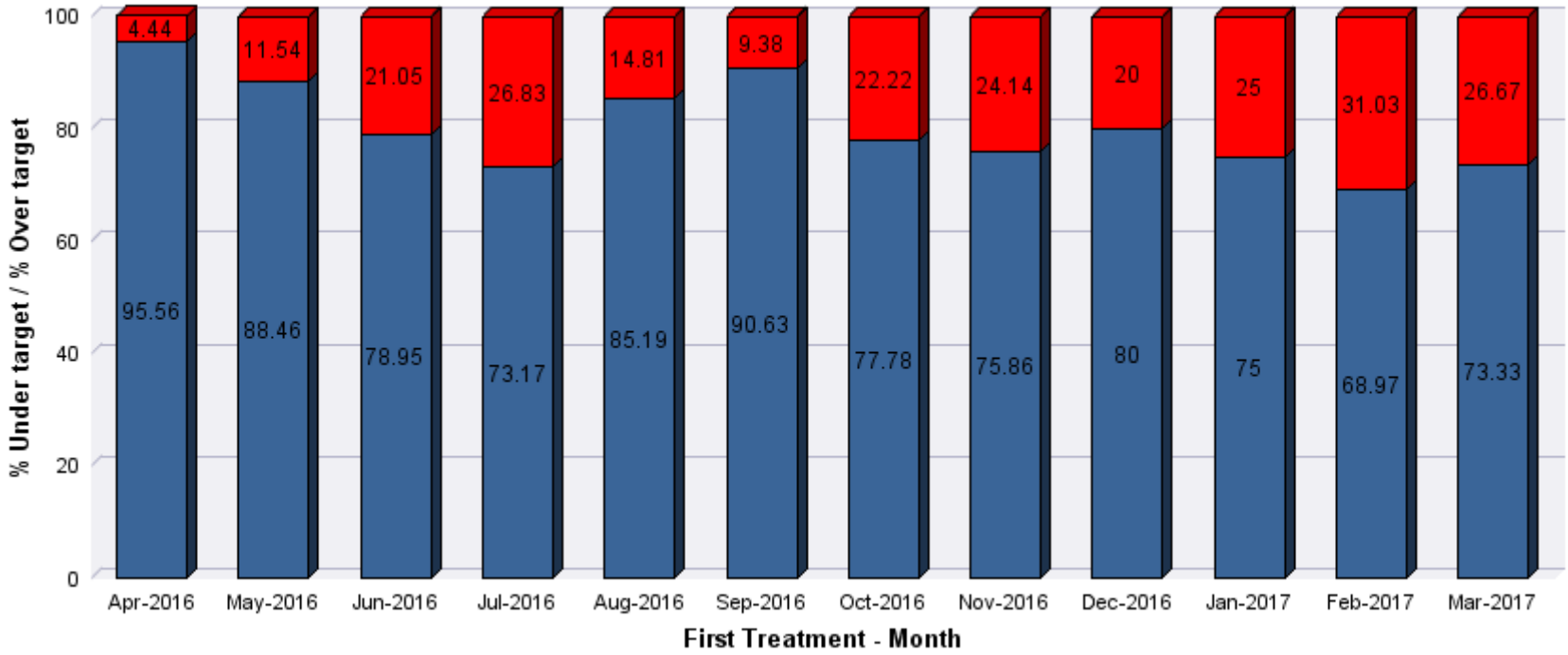
FROM 01/04/2016 TO 31/03/2017

MONTHLY

First Treatment - Month	% Under target	% Over target
Apr-2016	95.56	4.44
May-2016	88.46	11.54
Jun-2016	78.95	21.05
Jul-2016	73.17	26.83
Aug-2016	85.19	14.81
Sep-2016	90.63	9.38
Oct-2016	77.78	22.22
Nov-2016	75.86	24.14
Dec-2016	80	20
Jan-2017	75	25
Feb-2017	68.97	31.03
Mar-2017	73.33	26.67

CUMULATIVE

% Under target	% Over target
80.24	19.76



Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

SOUTHERN HEALTH AND SOCIAL CARE TRUST

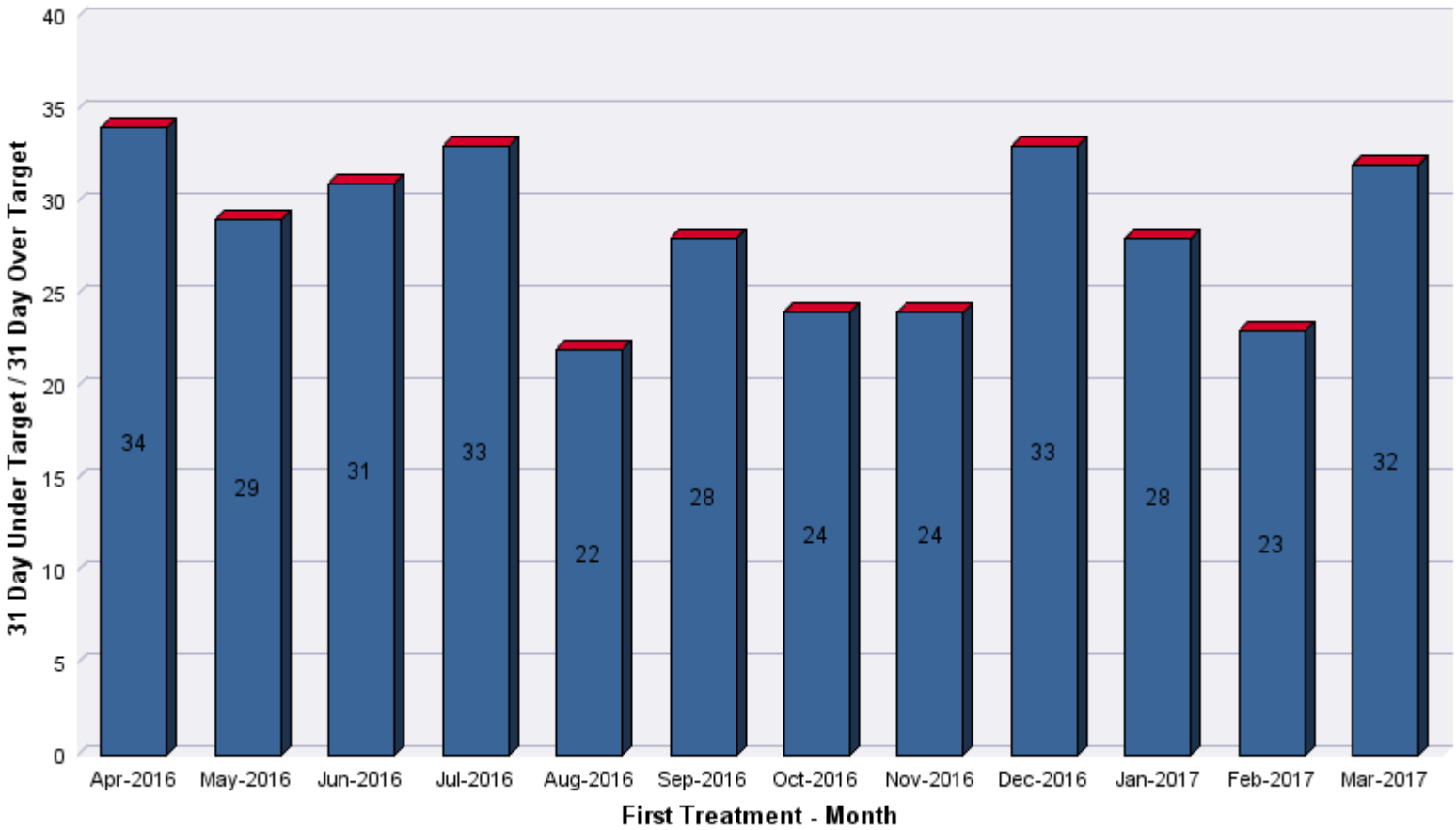
CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2016 TO 31/03/2017

MONTHLY

First Treatment - Month	31 Day Under Target	31 Day Over Target	MONTHLY TOTAL - 31 DAYS
Apr-2016	34	0	34
May-2016	29	0	29
Jun-2016	31	0	31
Jul-2016	33	0	33
Aug-2016	22	0	22
Sep-2016	28	0	28
Oct-2016	24	0	24
Nov-2016	24	0	24
Dec-2016	33	0	33
Jan-2017	28	0	28
Feb-2017	23	0	23
Mar-2017	32	0	32
Sum:	341	0	341



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CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

FROM 01/04/2016 TO 31/03/2017

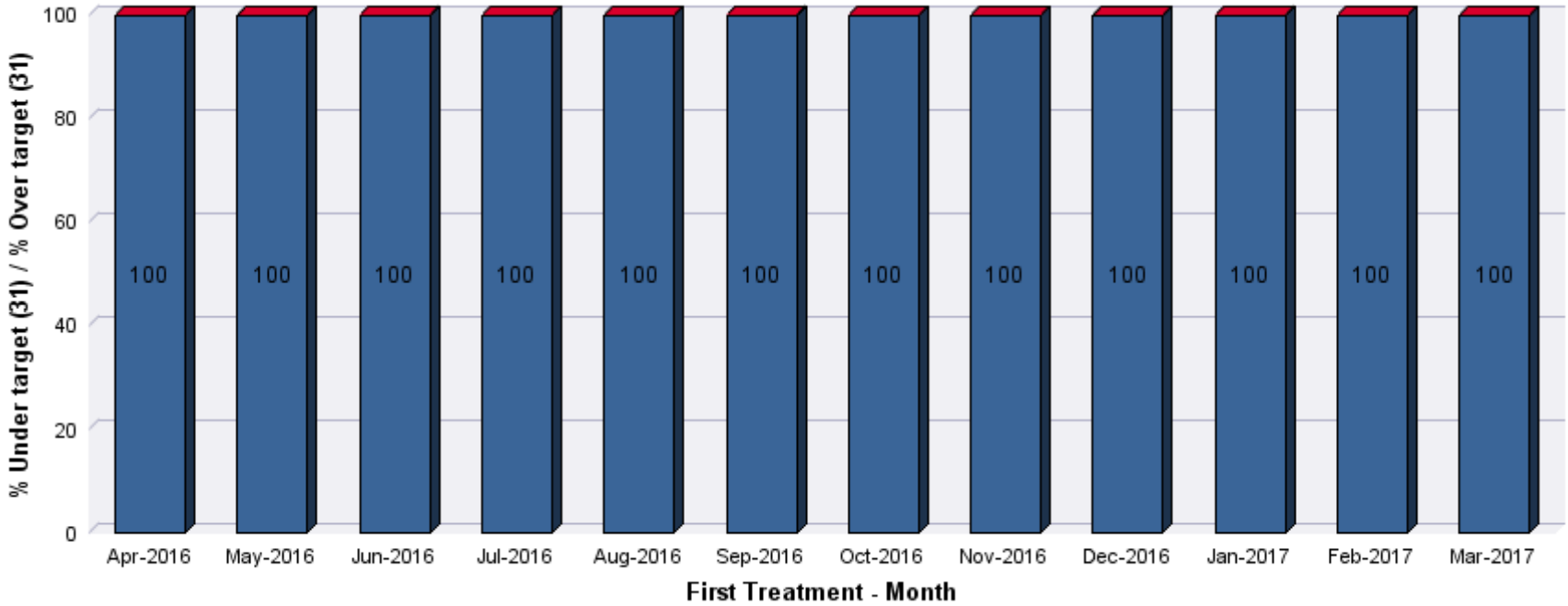
31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

MONTHLY

First Treatment - Month	% Under Target	% Over Target
Apr-2016	100	0
May-2016	100	0
Jun-2016	100	0
Jul-2016	100	0
Aug-2016	100	0
Sep-2016	100	0
Oct-2016	100	0
Nov-2016	100	0
Dec-2016	100	0
Jan-2017	100	0
Feb-2017	100	0
Mar-2017	100	0

CUMULATIVE

% Under target (31)	% Over target (31)
100	0



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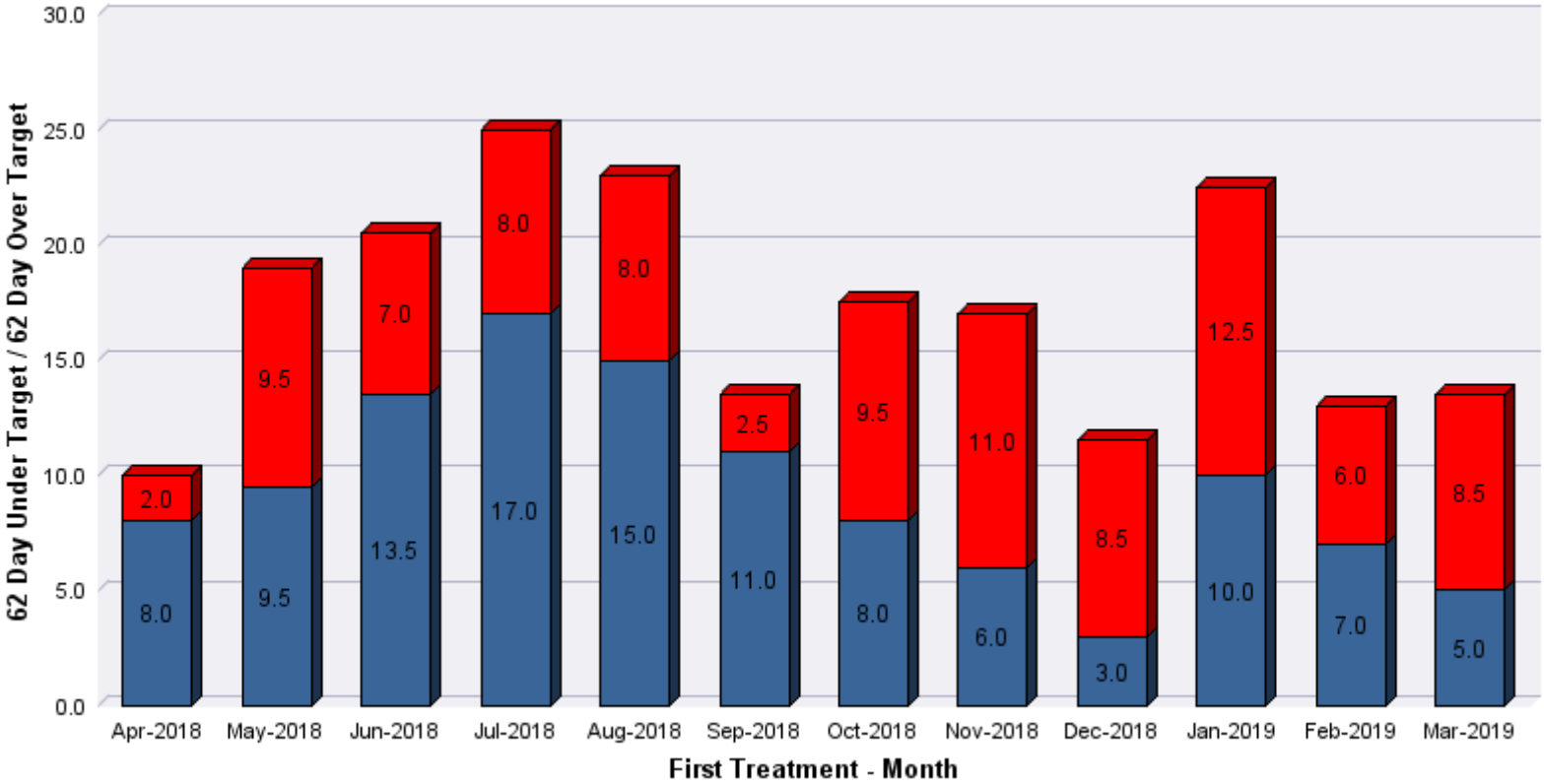
62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2018 TO 31/03/2019

MONTHLY

First Treatment - Month	62 Day Under Target	62 Day Over Target	MONTHLY TOTAL - 62 DAYS
Apr-2018	8.0	2.0	10
May-2018	9.5	9.5	19
Jun-2018	13.5	7.0	20.5
Jul-2018	17.0	8.0	25
Aug-2018	15.0	8.0	23
Sep-2018	11.0	2.5	13.5
Oct-2018	8.0	9.5	17.5
Nov-2018	6.0	11.0	17
Dec-2018	3.0	8.5	11.5
Jan-2019	10.0	12.5	22.5
Feb-2019	7.0	6.0	13
Mar-2019	5.0	8.5	13.5
Sum:	113.0	93.0	206

Notes: 62 day patients that are transferred between Trusts and breach share 0.5 of that breach. ie. 0.5 assigned to Trust first seen and 0.5 assigned to Trust first treated.



Produced By Directorate of Peformance and Reform, Informatics Division, Acute Information Team

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62 DAY COMPLETED WAITS FROM REFERRAL TO FIRST DEFINITIVE TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

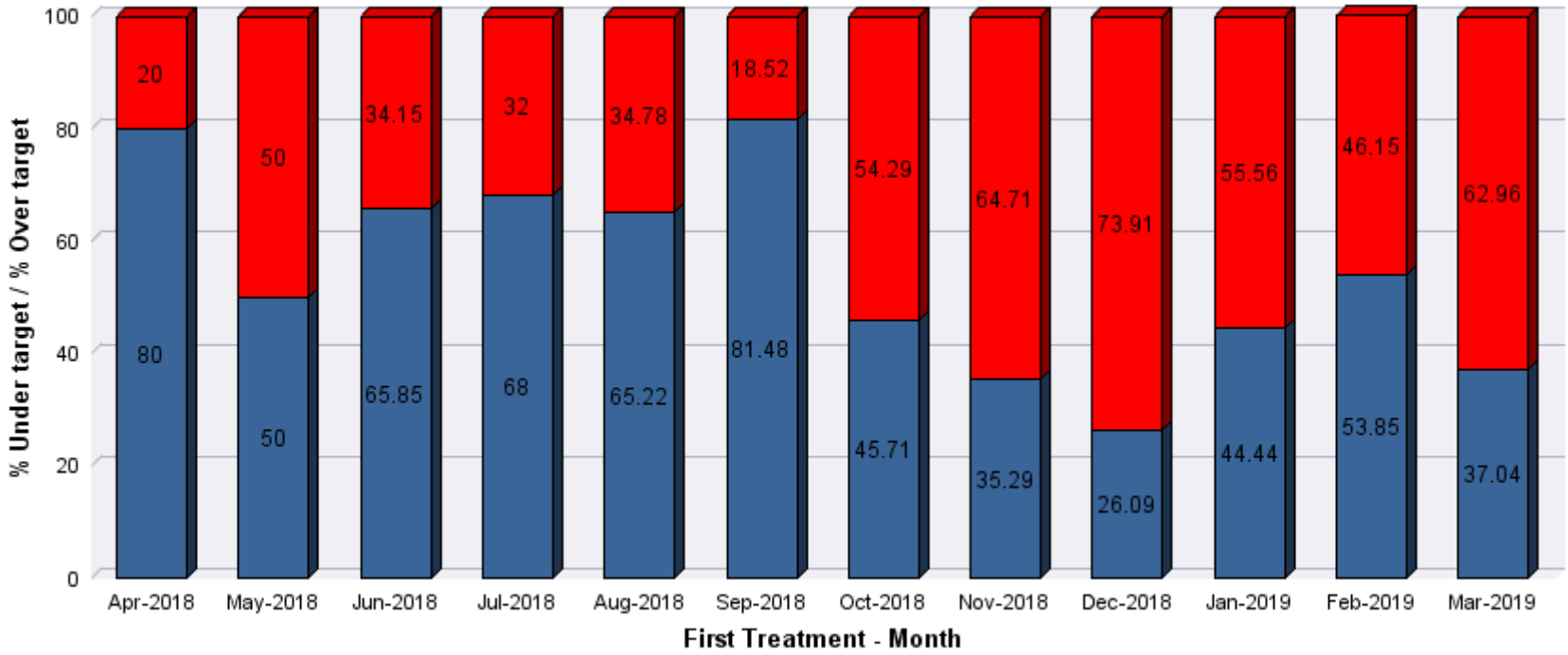
FROM 01/04/2018 TO 31/03/2019

MONTHLY

First Treatment - Month	% Under target	% Over target
Apr-2018	80	20
May-2018	50	50
Jun-2018	65.85	34.15
Jul-2018	68	32
Aug-2018	65.22	34.78
Sep-2018	81.48	18.52
Oct-2018	45.71	54.29
Nov-2018	35.29	64.71
Dec-2018	26.09	73.91
Jan-2019	44.44	55.56
Feb-2019	53.85	46.15
Mar-2019	37.04	62.96

CUMULATIVE

% Under target	% Over target
54.85	45.15



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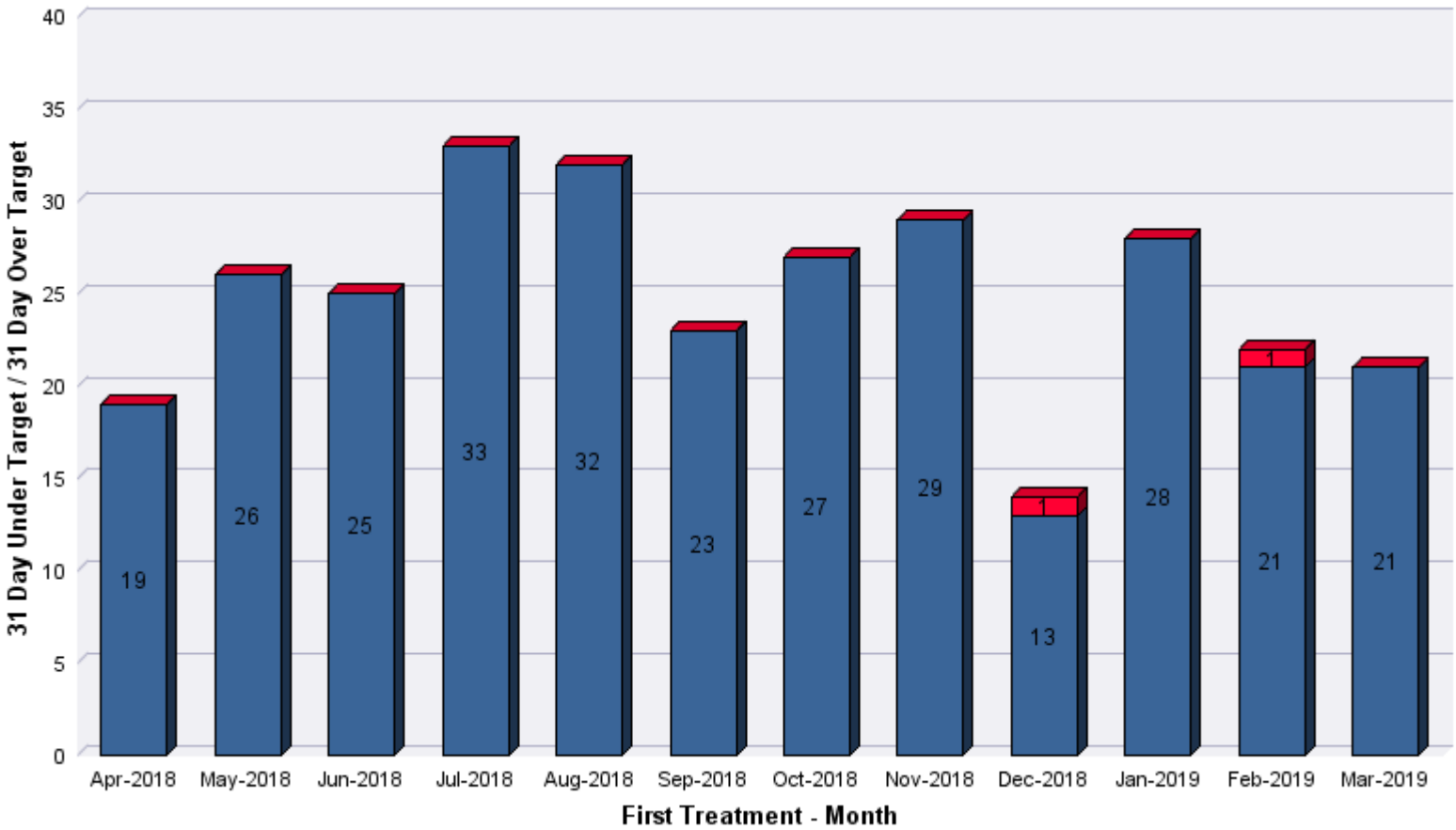
31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW

FROM 01/04/2018 TO 31/03/2019

MONTHLY

First Treatment - Month	31 Day Under Target	31 Day Over Target	MONTHLY TOTAL - 31 DAYS
Apr-2018	19	0	19
May-2018	26	0	26
Jun-2018	25	0	25
Jul-2018	33	0	33
Aug-2018	32	0	32
Sep-2018	23	0	23
Oct-2018	27	0	27
Nov-2018	29	0	29
Dec-2018	13	1	14
Jan-2019	28	0	28
Feb-2019	21	1	22
Mar-2019	21	0	21
Sum:	297	2	299



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SOUTHERN HEALTH AND SOCIAL CARE TRUST

CANCER TARGET MONITORING - 'SUSPECT TUMOUR SITE' = UROLOGICAL CANCER

FROM 01/04/2018 TO 31/03/2019

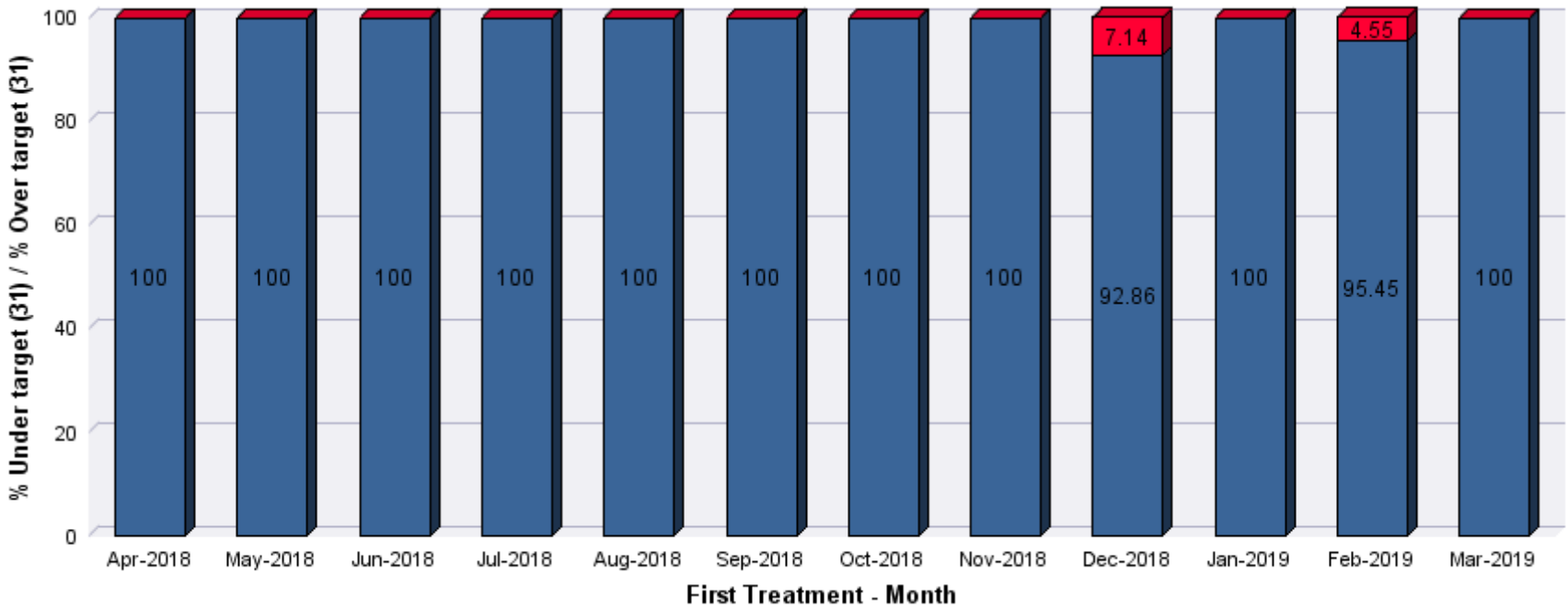
31 DAY COMPLETED WAITS FROM DECISION TO TREAT TO TREATMENT DATE - MONTHLY AND CUMULATIVE VIEW %

MONTHLY

First Treatment - Month	% Under Target	% Over Target
Apr-2018	100	0
May-2018	100	0
Jun-2018	100	0
Jul-2018	100	0
Aug-2018	100	0
Sep-2018	100	0
Oct-2018	100	0
Nov-2018	100	0
Dec-2018	92.86	7.14
Jan-2019	100	0
Feb-2019	95.45	4.55
Mar-2019	100	0

CUMULATIVE

% Under target (31)	% Over target (31)
99.33	0.67



Received from Wendy Clayton on 08/07/2022. Annotated by the Urology Services Inquiry.

Cancer Access Standards Meeting
Thursday, 20th December 2012 at 10.00am
Meeting Room, Admin Floor, CAH (VC Available)

Present:	Ronan Carroll (Chair)	Angela Montgomery	Wendy Clayton
	Fiona Reddick	Anne McVey	Trudy Reid
	Amie Nelson	Lisa McAreavey	Kay Carroll
	Martina Corrigan	Mary Burke	Dr Rankin

Agenda	Summary of Discussion	ACTION
Apologies	Patricia McStay, Eileen Murray, Sharon Glenny	
Notes of last meeting	Notes of previous meeting were agreed	
November 12 performance reports	Ronan discussed November performance dashboard. 14D Breast = 100% 62D = 87% 31D = 100% Internal risks: 1- 1st Haematuria appointment – Martina advised that there will be an extra haematuria clinic every week commencing 2nd week in January. This will be an additional 6 RF slots. Mr Brown has also agreed to increase this clinic in DHH by 2 slots. Wendy raised that the increasing requests for RF CT Urogram is increasing the pressure in radiology. Martina is to discuss with the consultants if urine & flex is normal should CT still be red flagged 2- Urology Surgery – these are escalated to Martina as soon as possible and are then escalated to Consultants for solutions who have been able to prevent some breaches for January 3- General Surgery 1st appointments – the number of RF slots on each of the consultants clinics are being increased 4- Gynae surgery – this was a possible risk but surgery dates are being held for patients to help prevent them breaching Regional risks: 1- PET	Martina to discuss CT Urogram with Consultants

	2- Thoracic Surgery There is a meeting tomorrow morning to discuss fitness for surgery & PET – Dr Convery is attending on behalf of SHSCT	
November Breach Reports	Wendy gave a detailed report of each of the breaches for November 62D Internal – 5 62D External – 1 31D Internal – 0 Areas of concern were discussed. 1- Prostate biopsies – Martina advised that they are finding that there are less patients having a TRUS the biopsy on the same day. Dr Rankin raised the issue of lost capacity and suggested would there be a way of planning this better and perhaps the patient being contacted before the appointment 2- EUS – only carried out in CAH & Belfast. Ronan advised that there is currently a regional review being carried out. Dr Rankin advised would it be better for 2 half day lists than a full day list as this would reduce the loss of days. 3- Delay in Triage – Dr Rankin reminded everyone of report sent by Katherine Robinson regarding triage and advised all Heads of Service that they should be chasing this up Wendy also gave an overview of December, January & February breaches to date. Dr Rankin advised that those patients over day 28 and still requiring investigation should be given priority to help prevent breaching Breaches to be fed back to Consultants at Specialty meeting	Martina to speak to the CNS to see if it is possible to contact patients before they come to the prostate clinic Ronan to look at EUS Heads of Service to monitor triaging Heads of Service to feedback breaches to Consultants
Cancer PTL	Ronan went through the patients who are currently on the Cancer PTL that are over day 40 on their pathway. Ronan expressed his thanks to the group for the hard work which is undertaken to prevent a large number of breaches	

Downgrading RF	As from 03/12/12 Consultants can now downgrade red flags on triage if the referral does not meet the criteria of the NICE suspect cancer referral guidance	
RF Operational Issues	Angela gave a summary of tracker operational pressures: • one area that was difficult for trackers was getting clinic outcomes due to no clinic outcome sheet being completed or left out for collection by trackers • clinic letters not typed quickly It was agreed that a clinic outcome sheet needs to be completed and a copy left to be collected by the cancer tracking team. The Heads of Service advised that they had previously raised this issue so it was agreed that correspondence should be sent from Dr Rankin	Fiona to draw up correspondence to Dr Rankin asking her to circulate round the Consultants that clinic outcome sheets must be completed
Date of next meeting	Thursday, 17th January 2013 at 10am Meeting Room, Admin Floor CAH	

Southern Health and Social Care Trust

Cancer Performance Dashboard Report November 2012

CANCER PERFORMANCE SUMMARY REPORT - Nov 2012

	% Breast 2WW	% 31D Performance	% 62D Performance
September 2012	100%	99%	89%
October 2012	100%	100%	83%
November 2012	100%	100%	87%

Inter-Trust Transfer Breachers – 62 Day

	Nov-11	Dec-11	Jan-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct 12	Nov 12
Breast	0	0	0	0	1	0	0	0	0	1	0	0
Colorectal	0	0	2	2	0	0	0	1	1	1	0	0
ENT	1	0	2	0	0	0	0	0	1	0	1	0
Haematology	0	0	0	0	1	0	0	0	0	0	0	0
Gynae	0	1	0	0	0	1	0	0	0	1	0	0
Lung	0	1	1	1	5	1	1	1	1	2	1	0
Other	0	0	0	0	0	0	1	0	0	0	0	0
Skin	0	0	0	0	0	0	0	0	0	0	0	0
UGI	1	0	0	1	0	0	1	3	0	0	1	0
Urology	2	0	1	0	0	0	1	0	1	1	0	1
Oral Surgery	0	0	0	0	0	0	0	0	0	1	0	0
Total	**4**	2	6	4	7	2	4	5	4	7	3	1

Internal Breaches – 62 Day

	Nov-11	Dec-11	Jan-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct 12	Nov 12
Breast	0	0	0	0	0	0	0	0	1	0	0	0
Colorectal	0	0	0	0	0	0	0	0	0	0	0	0
ENT	0	0	0	0	0	0	0	0	0	0	0	1
Gynae	1	0	0	1	0	0	1	0	1	0	0	0
Haem	0	0	1	0	0	0	0	1	0	0	0	0
Lung	0	0	0	0	0	0	0	1	0	1	0	2
Skin	0	0	0	0	0	0	0	0	0	0	0	0
UGI	0	0	0	0	0	0	0	0	0	0	0	1
Urology	1	2	1	1	0	1	1	3	1	0	4	1
Total	**2**	**2**	2	2	0	1	2	5	3	1	4	5

Day 31 Breaches

	Nov-11	Dec-11	Jan-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct 12	Nov 12
Breast	0	0	0	0	0	0	0	3	0	0	0	0
Colorectal	0	0	0	0	0	0	0	0	0	0	0	0
ENT	0	0	0	0	0	0	0	0	0	0	0	0
Gynae	1	0	0	1	0	0	0	0	2	1	0	0
Lung	0	0	0	0	0	0	0	0	0	0	0	0
Skin	0	0	0	0	0	0	0	0	1	0	0	0
UGI	0	0	0	0	0	0	0	0	0	0	0	0
Urology	0	0	0	0	0	0	0	2	0	0	0	0
Total	**1**	**0**	1	**0**	0	1	0	5	3	1	0	0

Modality	Internal/External	Reason
Urology	Internal 62D	• Patient only appeared on CaPPS at day 23 due to delay in triage • Delay in 1st Haematuria appointment (Day 29) • Delay in Flexible Cystoscopy (36 day wait) • Delay in surgery (49 day wait) • Pathway complete day 113
Urology	External 62D	• Delay in management with regards to PSA levels • Delay in TRUSB (27 day wait) • ITT day 73 • Pathway complete on day 102
UGI	External 62D	• Delay in PET & EUS (28 day combined wait) • ITT day 57 • Pathway complete day 77
ENT	External 62D	• Delay in 1st appointment (Day 25) • Difficult to diagnose • ITT day 56 on CaPPs but written referral sent D35 • Pathway complete day 70
Lung	External 62D	• Complex case, requiring CT-guided biopsy and PET CT • ITT day 35 • Pathway complete day 73
Lung	External 62D	• Delay in 1st appointment (Day 19) • Complex diagnostic pathway, required repeat bronchoscopy, CT-guided biopsy and PET CT. • ITT'd day 48 • Pathway complete on day 96

Risk Areas for January 2013

Internal

- Urology pathways – 1st haematuria outpatient apt and flexis
- Urology surgery
- 1st outpatient appointment for general surgery and breast 2 week
- Lung pathway due to complex diagnostic testing and repeat bronchs
- Gynae surgery 1st definitive treatment due to leave
- Lymphoma pathways - It has regionally been agreed to monitor all Lymphoma suspect patients along a 62 day target e.g if patient starts as a suspect ENT or UGI and converts to confirmed lymphoma cancer this is to continue along the 62 day pathway but transfer to haematology confirmed cancer (keeping original referral date)

External

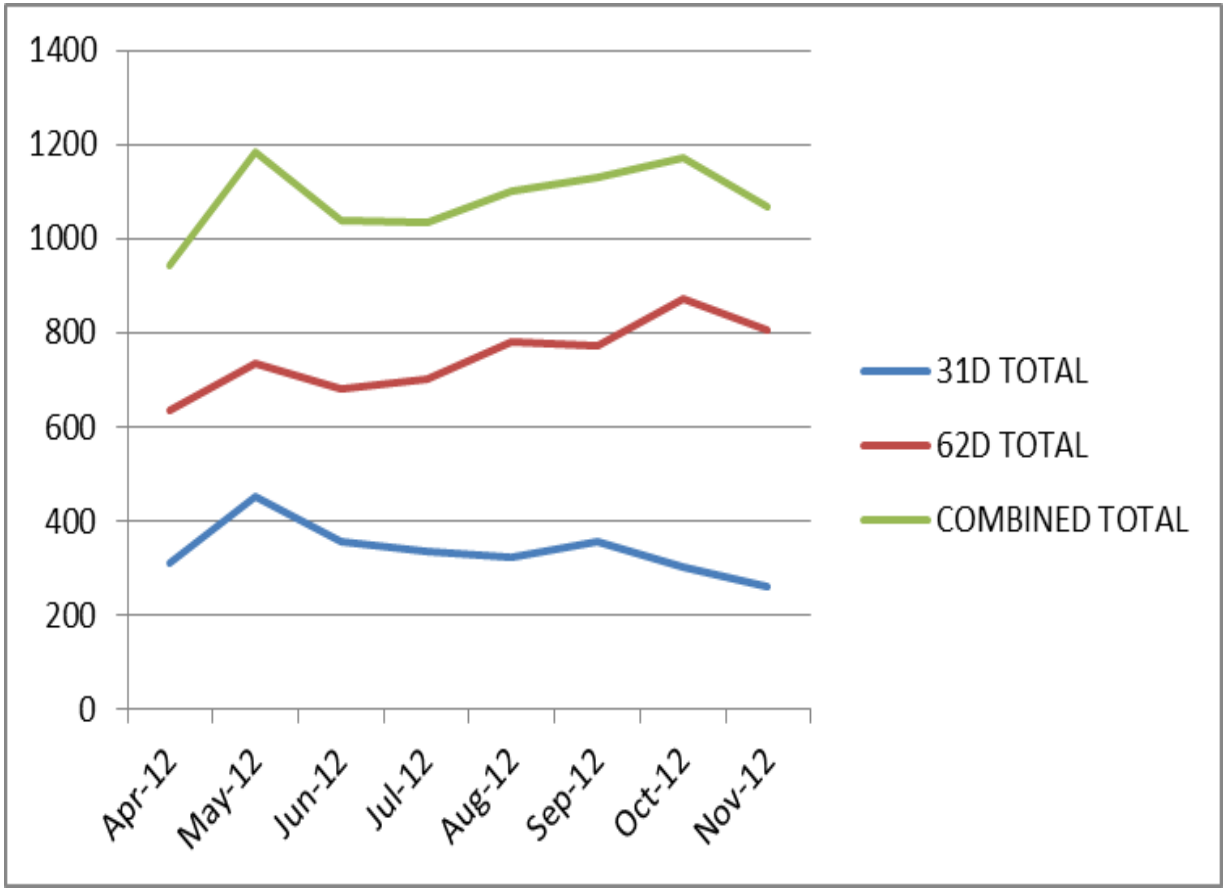
- Lung and Upper GI patients are at risk due to PET capacity
- Access to Thoracic surgical assessment and surgery slots.
- Brachytherapy

REFERRAL – SUSPECT 2012/13

62 DAY REFERRAL	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	TOTAL
Brain/Central Tumour	3	1			2	1			**7**
Breast Cancer	72	101	142	125	133	127	190	186	**1076**
Gynae Cancers	73	84	60	53	52	70	89	74	**555**
Haematological Cancers	6	8	9	5	5	8	6	10	**57**
Head/Neck Cancer	45	41	39	45	44	40	53	46	**353**
Lower Gastrointestinal Cancer	151	166	130	145	174	169	166	171	**1272**
Lung Cancer	39	38	35	31	45	34	31	34	**287**
Other Suspected Cancer	7	27	20	13	26	57	25	16	**191**
Sarcomas					1		1		**2**
Skin Cancers	105	114	126	126	147	139	152	118	**1027**
Testicular Cancer	1	1		4	1	3	1	1	**12**
Upper Gastrointestinal Cancer	68	73	81	89	84	57	82	54	**588**
Urological Cancer	64	79	40	64	65	67	75	95	**549**
Total	**634**	**733**	**682**	**700**	**779**	**772**	**871**	**805**	**5976**

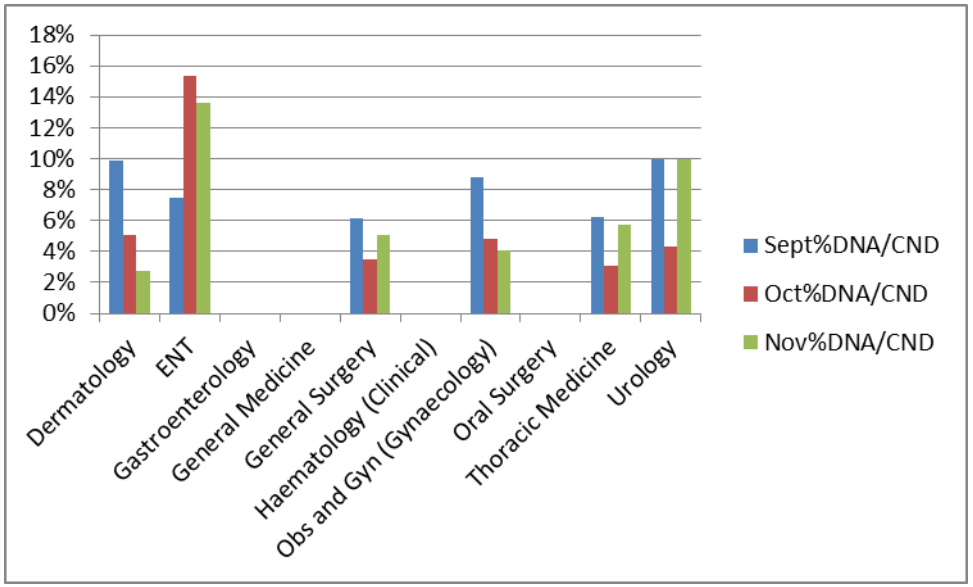
31 DAY REFERRAL	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	TOTAL
Brain/Central Tumour	7	9	11	4	7	7	5	2	**52**
Breast Cancer	47	64	28	36	44	62	49	33	**363**
Gynae Cancers	23	27	37	56	29	36	32	31	**271**
Haematological Cancers	22	22	10	14	17	13	13	12	**123**
Head/Neck Cancer	20	20	14	14	12	16	10	7	**113**
Lower Gastrointestinal Cancer	45	52	44	54	47	42	35	28	**347**
Lung Cancer	30	46	44	27	40	46	34	33	**300**
Other Suspected Cancer	2	5	3		3	6	1	1	**21**
Sarcomas		1						2	**3**
Skin Cancers	33	72	70	42	44	39	34	25	**359**
Testicular Cancer	1	1	1						**3**
Upper Gastrointestinal Cancer	50	55	46	49	41	34	40	25	**340**
Urological Cancer	28	77	47	38	39	55	49	63	**396**
31D TOTAL	**308**	**451**	**355**	**334**	**323**	**356**	**302**	**262**	**2691**
62D TOTAL	**634**	**733**	**682**	**700**	**779**	**772**	**871**	**805**	**5976**
COMBINED TOTAL	**942**	**1184**	**1037**	**1034**	**1102**	**1128**	**1173**	**1067**	**8667**

April – Nov 2012 Suspect Cancer Referrals



Red Flag Outpatient DNA

	Aug-12			Sep-12			Oct-12			Nov-12		
Speciality	**Attendances**	**DNA&CND**	**Aug %DNA/CND**	**Attendances**	**DNA&CND**	**Sept%DNA/CND**	**Attendances**	**DNA&CND**	**Oct%DNA/CND**	**Attendances**	**DNA&CND**	**Nov%DNA/CND**
Dermatology	98	11	10%	91	10	10%	112	6	5%	70	2	3%
ENT	39	2	5%	37	3	8%	44	8	15%	38	6	14%
Gastroenterology	0	0	0%	0	0	0%	0	0	0%	7	0	0%
General Medicine	15	0	0%	11	0	0%	12	0	0%	13	0	0%
General Surgery	291	22	7%	323	21	6%	330	12	4%	340	18	5%
Haematology (Clinical)	10	0	0%	2	0	0%	11	0	0%	12	0	0%
Obs and Gyn (Gynaecology)	39	3	7%	52	5	9%	99	5	5%	71	3	4%
Oral Surgery	8	0	0%	8	0	0%	6	0	0%	9	0	0%
Thoracic Medicine	34	4	11%	30	2	6%	32	1	3%	33	2	6%
Urology	29	1	3%	9	1	10%	22	1	4%	27	3	10%
	563	43	7%	563	42	7%	668	33	5%	620	34	5%



62Day Confirmed Cancers

Tumour Site	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct 12	Nov 12
Breast	11	8	9	16	8	5	14	8	10	11	12	9	5
Gynae	4	2	2	2	1	5	1	7	0	3	6	4	3
Haem	0	1	2	0	2	2	1	0	2	2	0	2	2
ENT	1	1	1	3	2	0	0	0	1	1	0	4	2
LGI	5	6	7	4	6	3	6	2	5	5	6	3	6
Lung	4	4	4	4	4	8	2	2	3	7	9	0	4
Other	0	0	0	0	1	0	1	1	0	0	0	0	0
Sarcomas	1	0	0	0	0	0	0	0	0	0	1	0	0
Skin	6	5	6	9	7	7	13	7	6	8	9	13	7
UGI	3	2	2	4	4	0	4	2	3	4	4	2	2
Urology	16	11	10	13	9	5	14	9	13	12	7	14	13
Total	51	40	43	55	44	35	56	38	43	53	54	52	44
% 62 confirmed	45%	44%	38%	42%	41%	42%	41%	31%	38%	41%	43%	38%	37%

31Day Confirmed Cancers

Tumour Site	Nov-11	Dec-11	Jan-12	Feb-12	Mar-12	Apr-12	May-12	Jun-12	Jul-12	Aug-12	Sep-12	Oct 12	Nov 12
Brain	0	0	0	2	1	1	0	3	0	0	3	0	0
Breast	9	2	8	9	10	6	14	4	8	7	13	12	12
Gynae	3	7	8	5	4	4	5	4	2	9	7	5	4
Haem	5	5	5	8	4	4	9	8	4	4	6	3	3
ENT	1	4	6	2	3	1	3	2	4	2	2	4	3
LGI	11	9	10	11	5	10	7	10	14	5	7	11	10
Lung	9	6	8	13	14	8	6	16	5	7	9	12	7
Other	0	0	1	1	1	3	1	0	1	0	0	2	1
Sarcomas	0	0	0	1	1	0	0	0	0	0	0	1	1
Skin	2	1	2	1	2	2	10	15	17	16	16	16	15
UGI	5	4	7	8	6	2	5	3	4	4	3	5	5
Urology	18	12	15	15	13	7	19	21	10	21	13	13	14
	63	50	70	76	64	48	79	86	69	75	79	86	75
TOTAL 31+62 D	114	90	113	131	108	83	135	124	112	128	143	138	119
% 31D confirmed	55%	56%	62%	58%	59%	58%	59%	69%	62%	59%	57%	62%	63%